Humanitarianism and the Quantification of Human Needs

Minimal Humanity

Joël Glasman

First Published in 2020

ISBN: 978-0-367-22215-4 (hbk)
ISBN: 978-1-003-00695-4 (ebk)
ISBN: 978-0-367-46416-5 (pbk)

6 Vulnerability

Impartial algorithms and analog malnutrition

DOI: 10.4324/9781003006954-7

Funder: Universität Bayreuth

Routledge
Taylor & Francis Group
LONDON AND NEW YORK

This book is the outcome of research conducted within the Africa Multiple Cluster of Excellence at the University of Bayreuth, funded by the Deutsche Forschungsgemeinschaft (DFG, German Research Foundation) under Germany's Excellence Strategy – EXC 2052/1 – 390713894.

"In this innovative and grounded study, Joël Glasman reveals how it came to be that the smallest unit of our shared humanity—its least common denominator—is neither you nor me, but the calorie, the liter of water, the metrics of our need in our moments of deepest distress. This fascinating work deserves wide readership and demands deep reflection."

— Gregory Mann, author of From Empires to NGOs in the West African Sahel: the Road to Nongovernmentality (2015)

"Combining a provocative perspective with a meticulous eye for detail, Joël Glasman's insightful history traces humanitarian efforts to define human suffering through an index of vital needs. Minimal Humanity reminds us of the fundamental complexity of apparently simple matters."

— Peter Redfield, author of Life in Crisis: The Ethical Journey of Doctors Without Borders (2013)

"This is a fascinating historical study of how and why humanitarian organizations quantified basic human needs over the course of the 20th century. Glasman (Univ. of Bayreuth, Germany) provides an engaging intellectual genealogy of the transition from subjective approaches to evaluating suffering to relying on allegedly objective and universal measurements. Using methods such as measuring the left arms of children for malnutrition allowed humanitarian organizations to claim they avoided politicizing assistance. However, organizations frequently debated how needs should be defined, as Glasman describes in detail with the *Sphere Handbook*, a humanitarian needs manual published in the 1990s. Just as humanitarian organizations claimed to be serving a generic humanity not defined by culture or politics, aid personnel also promoted an idea of consensus between the global North and South regarding needs. The author convincingly argues that this aspirational ideal of a common, measurable set of needs actually obscures the financial and political inequities between North and South, using Cameroon as a case study of the political and economic realities of how needs are measured in a humanitarian crisis. Specialists in humanitarianism should definitely read this book."

— J. M. Rich, Marywood University, Choice Review, Highly Recommended, November 2020 Vol. 58 No. 3

"In his insightful and wonderfully jargon-free book, *Humanitarianism and the Quantification of Human Needs*, Joël Glasman delves into the history of what he calls the "bookkeeping of human suffering on a world scale (...) Glasman's book is much richer than can be described here. It is highly recommended for scholars of refugees, humanitarianism, data, and the production of knowledge. Given his extremely readable writing style, the book can also be recommended to those engaged in the humanitarian field who may not have the time or patience to slog through other academic critiques of their work."

— Brett Shadle, African Studies Review

6 Vulnerability

Impartial algorithms and analog malnutrition

Let us return to Frank, bent over his Excel spreadsheets (see Chapter 5). If humanitarian quantification could be condensed into legal categories, his task would have been easy enough. Since it is not possible, from an international law perspective, to be a "refugee," an "asylum seeker," an "internally displaced person," a "third-country national," and part of the "host population" all at the same time, these numbers would add up well. In such a configuration, the "humanitarian caseload" would be presented as a summary of watertight categories. If needs were summarized according to legal status, UNHCR could produce the ensemble of necessary figures practically on its own, or with IOM, and Frank's work, as well as that of the OCHA, would be superfluous.

But the humanitarian gaze is not restricted to a legal point of view. There was a broad range of actors involved in humanitarian work in Cameroon: At least 6 ministries, 11 donors, 12 UN agencies, and 49 different NGOs, and they had different – and often conflictual – point of views. Every week, hundreds of pages accumulated on Frank's desk: Reports, bulletins, and notes about projects ranging from food distribution to malaria treatment, from shelter construction to the organization of health clinics and field hospitals. Even if the reports resembled one another in their prose, peppered with Anglicisms, and their pronounced taste for unpronounceable acronyms, they raised different issues. Many types of knowledge beyond the legal lens were mobilized: Medical, economic, logistic, pedagogical, etc. In order to counterbalance the weight of UNHCR, OCHA tried to emphasize other ways of looking at needs, by constructing the composite category of "vulnerability." For OCHA, presenting a vision of an ensemble of needs allowed them to construct a "common advocacy" from all the agencies and NGOs, despite internal differences. OCHA wanted to enable common communication when it came to donors, politics, and the wider public, as well as common programming for projects (allocation of funds and project follow-up), just as for aid evaluation.[1] The international metric of needs thus acted as a strategic element to maintain a semblance of cohesion in the humanitarian arena, to fabricate a "consensus" in the competitive field of aid.

This chapter follows first (in sections 1 and 2) the production of statistics on the "vulnerability" of populations, the statistics of children suffering from acute malnutrition. This indicator was chosen here because it makes up part of one

DOI: 10.4324/9781003006954-7

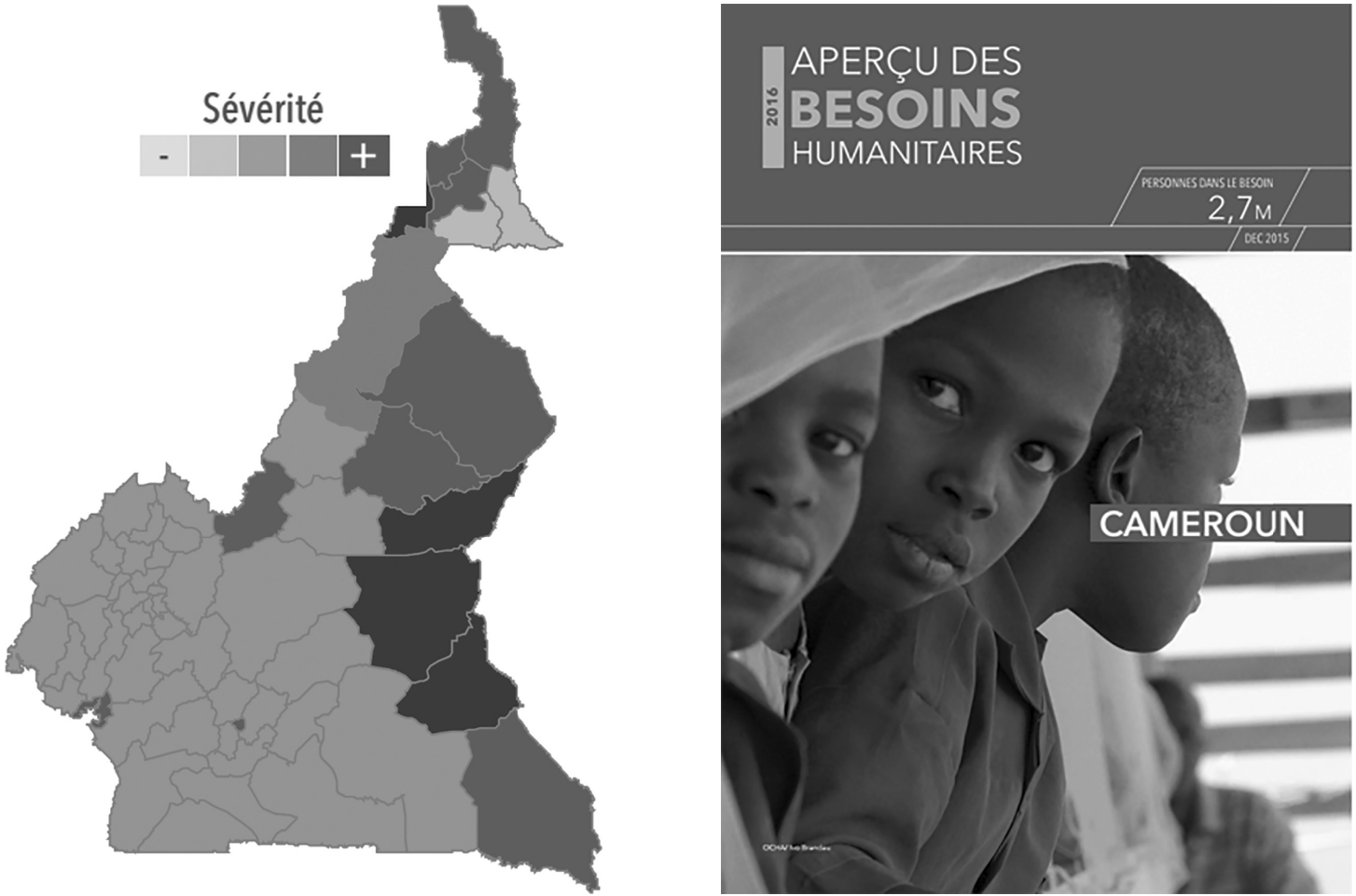

Figure 6.1 Map of vulnerability in Cameroon according to OCHA.
Source: OCHA. *Cameroun: Aperçu des besoins humanitaires*. Yaoundé: OCHA 2016.

of the least-contested aid figures: First, because undernourished children have long constituted one of the privileged targets of humanitarian aid,[2] and second, because malnutrition statistics are considered, for technical reasons, some of the most robust in emergency situations. The allocation of resources through humanitarian agencies clearly shows that the categories of "refugees" and "malnourished children" are considered to rank among the most legitimate targets of humanitarian aid. In Cameroon, the UN's humanitarian aid did not target *all* people classified as "in need." Less than half of "people in need" were in fact assisted by the agencies (1.1 million people targeted out of 2.7 million total). However, certain categories were fully targeted: That was the case for refugees and children under five years of age with acute malnutrition.[3]

Once the statistics of acute malnutrition are established, I analyze the role of this knowledge in the construction of a consensus in the heart of the humanitarian field. As the concept of consensus was presented in Chapter 4, we shall see here how Frank and his software produced a map of "vulnerability" that reconciled the different data derived simultaneously from legal statutes, medical data, economic analysis, etc. We shall see that the software program played a crucial role, instructed by an algorithm, to confer order to the humanitarian field. The informational tool thus plays a role that is far from that which the literature on the "data revolution" would like to ascribe to it. While only being the last link in a long and eclectic figure-production chain, Frank's algorithm was tasked with rendering the heterogenous data equivalent. However, it is questionable whether it makes needs assessment more "transparent," as only a few people truly understand what the algorithm does to the data.

Needs through the lens of vulnerability (1): Counting the malnourished

In Cameroon, hunger has only recently – in the past decade or so – become a subject of study.[4] Unlike the other countries in the region, Cameroon has not been seen as a country of hunger.[5] Before the 1990s, the principal numbers had to do with agricultural production (for example, the food production index) and were produced by the Ministry of Agriculture (and the UN's Food and Agriculture Organization, FAO). There were some surveys on living standards at the beginning of the 1960s (budgets and household consumption, especially in terms of food),[6] as well as the first national survey about nutrition in 1978,[7] but they remained sporadic. It was not until the 1990s that systematic surveys were put in place: First, consumption surveys according to households (ECAM – Cameroonian Household Survey: 1996, 2001)[8] conducted by the Ministry of the Economy[9] which included a component on food consumption; second, surveys on demographics and health conducted by the Ministry of Economy and the Ministry of Public Health (EDS – Demographic and Health Surveys: 1991, 1998, 2004). These surveys were notably informative about food consumption in households and the rate of chronic malnutrition (stunted growth).[10] The surveys showed that there were more and more malnourished children in Cameroon: Among children under five

Table 6.1 Quantitative surveys on hunger in Cameroon (2006–2016) ©Glasman

Period		*Context*	*Survey or Program*	*Institution and Objectives*
2006	Sept.	*Sahelian food crisis (2005)*	• Food and Nutrition Policy in Cameroon; Nutrition Report UNICEF Cameroon	Michael Golden & Yvonne Grellety create the first situational analysis on care for acute malnutrition
2007	Jan.–March		• 3rd Cameroonian Household Survey (ECAM 3)	Survey on household consumption, with a section on food, applying to all of Cameroon (Ministry of the Economy)
	May–June		• 1st Global Analysis of Food Security and Vulnerability (CFSVA)	Food security survey on rural Cameroon (Cameroon except for Yaoundé and Douala), by the Ministry of Agriculture with the FAO and the World Food Programme (WFP)
	Aug.	*Central African refugee crisis*	• Nutrition and mortality survey by MSF (Anne Laure Page)	East of Cameroon (CAR refugee population)
			• Debut of the Integrated Management of Acute Malnutrition Programme (PCIMA) in Cameroon	East of Cameroon (all population)
2009		*"Hunger riots" (2008/2009)*	• Decree on the National Programme for Food Security	
2010		*Sahelian food crisis (2010)*	• Update to the national Cameroonian protocol for care for malnutrition and Introduction of PCIMA in the North and FarNorth	North of Cameroon
2011	Jan.–Aug.		• 4th Demographic and Health Survey (EDS) with Multiple Indicator Cluster Surveys (MICS)	Demographics and health, including nutrition UNICEF and Ministry of Public Health; all of Cameroon
	April–May		• 2nd Global Analysis of Food Security and Vulnerability (CFSVA)	Rural Cameroon (Cameroon except for Yaoundé and Douala), by the Ministry of Agriculture with the FAO and WFP
			• 1st SMART Survey	UNICEF and Ministry of Public Health, North and East (acute malnutrition)
2012			• UNICEF Survey on care for acute malnutrition in Cameroon	Situational analysis on acute malnutrition SUN covering chronic malnutrition
			• Cameroon participates in "Scaling Up Nutrition" (SUN)	
			• 2nd SMART Survey	UNICEF and Ministry of Public Health, North and East (acute malnutrition)

2013	July–Aug.		• 3rd SMART Survey	UNICEF and Ministry of Public Health, North and East (acute malnutrition)
2014		*Central African refugee crisis*	• 4th Cameroonian Household Survey (ECAM 4)	Survey on household consumption, with a section on food, applying to all of Cameroon (Ministry of the Economy)
	April–May		• Nutritional and mortality survey by MSF/ Epicentre	Central African refugees in the East
	June		• Action Contre la Faim exploratory mission	Central African refugees in the East
	May–June		• Multisectoral survey on nutrition, health, water, hygiene, and sanitation	Central African refugees from the Gado site (UNICEF, the Ministry of Public Health, et al.)
	Aug.–Sept.		• Multisectoral survey on nutrition, health, water, hygiene, and sanitation	Central African refugees from the Timangolo site (UNICEF, the Ministry of Public Health, et al.)
	Sept.–Oct.		• 4th SMART Survey	UNICEF and Ministry of Public Health, North and East (acute malnutrition)
	June–Oct.		• 5th Demographic and Health Survey (EDS) with Multiple Indicator Cluster Surveys (MICS)	Demographics and health, including nutrition UNICEF and Ministry of Public Health; all of Cameroon
	Dec.		• Evaluation of harvests and food availability	Food security, East and North, Ministry of Agriculture with FAO and WFP
2015	Jan.–March	*Nigerian refugees and IDPs in the North*	• 1st SENS Survey	On CAR refugees in the camps in the East and Adamawa (UNHCR)
	Sept.		• Evaluation of food security (National Programme for Food Security)	North and East, Ministry of Agriculture and WFP.
	Oct.		• 5th SMART Survey	North and East, UNICEF and Ministry of Public Health (acute malnutrition)
2016	Aug./ Sept.		• 2nd SENS Survey	Central African and Nigerian refugees "out-of-camp" (UNHCR/ FAIRMED)
	Oct.		• 6th SMART Survey	UNICEF and the Ministry of Public Health, North and East
	Dec.		• Evaluation of food security (National Programme for Food Security)	North and East, Ministry of Public Health and WFP.

(the benchmark population), one in four children suffered from chronic malnutrition in 1991, rising to one in three in 2004.[11] These surveys also strongly indicate the rates of acute malnutrition – around 5% – with large regional disparities.

Starting in 2006, a succession of crises attracted the attention of public authorities to the problem of hunger. One expert reported that "In 2006, there was nothing about malnutrition in Cameroon."[12] The Sahelian food crisis of 2005 struck the North and Far North regions of Cameroon. The Cameroonian government therefore implemented a "National Policy on Food Security and Nutrition" and UNICEF produced the first situational analysis of the mechanism of care for acute malnutrition. In 2007, the massive arrival of refugees from CAR led to localized studies on the Eastern region – notably, a survey by MSF on the malnutrition of refugees. The government put an Integrated Management of Acute Malnutrition Programme (PCIMA) in place. In 2008, so-called "hunger riots" affected Yaoundé and Douala, cities until then considered spared from the food crises.[13] The government decided to implement a National Food Security Program. In 2010, a new food crisis affected the Sahelian region of Cameroon, and the government decided to update its national protocol for handling malnutrition. Within a few years, hunger had become an object of public interest.

Two kinds of surveys focused on "crisis"[14] situations: First, these were food security surveys, which evaluated agricultural production and market evolution (grain prices, for example), as well as families' capacity to respond (vulnerability). The most important of these surveys, the Comprehensive Food Security and Vulnerability Analysis (CFSVA), was led by the Ministry of Agriculture, with technical support from the FAO and WFP.[15]

Second, there were also surveys on acute malnutrition, for which we can distinguish three types of figures: a) figures produced in the framework of timely surveys, organized by humanitarian organizations to respond to a precise question on a place and at a given time (for example, the nutritional survey performed by MSF/Epicentre at Garoua Boulai in May 2014); b) figures on active screening and admission to nutritional health programs: They dealt with the number of children currently in care (for example, the number of children in ambulatory nutrition centers and nutritional therapeutic centers);[16] and c) the surveys about nutritional health "monitoring": Dealing with the nutritional elements of the Demographic and Health Surveys (EDS), Multiple Indicator Cluster Surveys (MICS), and annual nutritional surveys (SMART). All of these surveys were led by the Ministry of Public Health with the technical expertise of UNICEF. In 2014–2016, it was the SMART (*Standardized Monitoring and Assessment of Relief and Transitions*) survey that produced the most robust numbers on acute malnutrition in Cameroon.[17] This survey produced two figures each year: The prevalence of acute malnutrition and infant mortality. UNICEF's SMART survey was, however, uniquely interested in Cameroonians. The nutritional status of refugees was studied separately, in the framework of the SENS surveys led by UNHCR (yearly in principle, but irregularly in practice).

The reports that accumulated between 2011 and 2017 thus painted the picture of a double nutritional crisis: One found in two large areas a high preponderance

of severe acute malnutrition, going from 1 to 3% (the emergency threshold being 2%): First, in northern Cameroon (the North and Far North regions), because of the droughts and floods which began in 2011, and the war between Boko Haram and the Cameroonian army starting in 2014; second, in the east of Cameroon (East and Adamawa regions) with the arrival of Central African refugees.

The principal objective of the SMART survey was to calculate a rate of acute malnutrition in children under five years old,[18] concentrating on four regions: East Cameroon, Adamawa, the North, and the Far North. It was carried out under the direction of the Ministry of Public Health by a technical expert from UNICEF.[19] The UNICEF coordinator was accompanied by about 40 surveyors – agents from the Ministry of Public Health, nurses, and students, all trained in the specific methods of the survey.[20] These surveyors were hired for the duration of the survey (three weeks) and were organized in small teams of four people: One supervisor (the most experienced, charged with verifying the data); one team leader (required to conduct the interviews, and, throughout, master the vernacular languages of the surveyed persons);[21] one analyzer; and one assistant analyzer (responsible for taking anthropometric measurements).[22]

The first stage consisted of selecting those to be surveyed. The sample size had to be estimated. This estimation was made while considering the expected prevalence of malnutrition and the level of precision desired in the survey.[23] Thus, to estimate rates of acute malnutrition in Adamawa, it was calculated that one had to measure 337 children under five years old. To find these children, how many families needed to be visited?[24] As a function of the average size of households in the region (5.4% per household, on average) and the percentage of the target population (children under five constitute 19.2% of households), the team estimated the number of households to visit to find the required number of children and added a 10% margin of error to be sure of having a sufficient number in the case of no responses. They chose to visit at least 402 households.[25]

To ensure that the survey was representative, it was necessary for each household in the chosen region to have absolutely the same statistical chances to be surveyed. The simplest thing would have been to draw the households at random from an exhaustive list in Adamawa. But of course, such a list did not exist. Therefore, one had to move on to the cluster sampling technique – two-stage drawing: First, the population as a whole was split up into small geographical sectors, villages (the term "census zone" (*zone de dénombrement*) was used) where there was already a population estimate available.[26] To find 402 households, how many villages did they have to visit? Thanks to the population figures – Adamawa is a region of a little over 1.2 million inhabitants – it was estimated that 25 villages would need to be visited. 25 villages were randomly drawn, each with a chance of being chosen that was proportional to its population size. Then, within the selected villages, households were randomly selected. Each person in the sector had therefore an equal chance of selection (a "probability proportional to the size of the population").

The sampling was, however, accompanied by terrible uncertainty: All the figures were calculated as a function of the figures of known populations – those

calculated based on the population census that dated to 2005. The population figures were an estimation of the evolution, an estimation that derived from the assumption of a continuous demographic growth that is equally significant every year (and did not account for migration: See Box 5.1 on the population census in Cameroon in Chapter 5). Now it was necessary to randomly draw villages (clusters) to visit: The census zones provided by the Bureau of Statistics were entered into the ENA[27] software, and the results were impatiently awaited: It was the software that designated which villages were to be visited. Eventually, the team left the office, got into the Jeeps, and went out into the field.

The second stage was to select the households to visit for every village, again, randomly: In Adamawa, approximately 16 households were to be selected per village. But first, the team had to find the census zones – the territorial survey units. Then, in these zones, they had to find the villages. However, the maps furnished by the Bucrep were outdated. The names on the map did not always correspond to the names used by the inhabitants. There had been departures, arrivals, floods, lootings: Certain villages no longer existed – others had been displaced. There was a lot of driving. Adamawa has a total area of 63,701 square kilometers, with only 14 inhabitants per square kilometer. There are forests, mountains, bumpy roads, and sometimes, no road at all.

Once the team finally reached the villages, they knocked on the door of the village chiefs to get a more detailed estimate of the number of inhabitants in the village, the number of households, and their geographical placement. Some chiefs gave a vague estimate, gave a total population number, or had difficulties in understanding what the surveyors mean by "household" (an expert notion that differed from common sense notion of a "family"). Others conversely provided precise lists of the households of their village – for instance chiefs who had already hosted other humanitarian projects in the past.[28] In any case, everything had to be verified, because some chiefs, wishing to increase their chances of obtaining food aid for their people, may have overestimated the number of inhabitants. Therefore, the team went through the village, knocking on every door, noting the name of each head of the family, counting. One village inhabitant acted as a guide for the day – a health care worker, a student, a son of the chief, etc.[29]

The counting of households can take time. The "households" are the basic unit of statistical nutrition surveys. But how should they be defined? Is a household

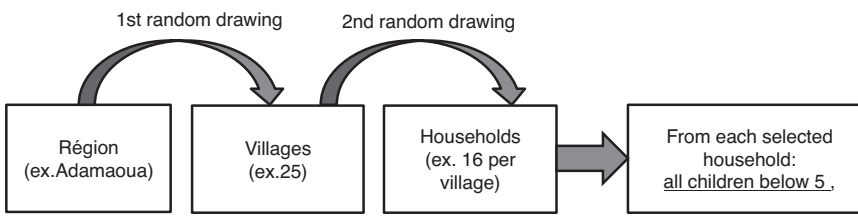

Figure 6.2 Cluster sampling with SMART methodology in Cameroon.

a group of persons who share the same roof? Who share communal resources? Who recognize the authority of one head of family? The SMART survey considered the determining criterion to be the sharing of food: A household is a group of people who, most often, share a cooking pot.[30] That means that the people could live on the compound, share one courtyard, without forming a "household." That also means that one can be married and have children together without forming a "household." In a polygamous family, one also has to question the spouses to learn whether or not they prepare and consume food separately. For example, let us take a plot where one man lives with his four wives and their respective children. If each wife prepares food every day for her own children, four households are counted. If, rather, they take turns cooking for all those who live on the land (the first wife on Mondays, the second on Tuesdays, etc.), one would count it as one single household (that thus includes five adults and all the children).[31] The number of households around a compound were enumerated clockwise, and written on the doors with a piece of chalk:

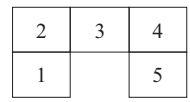

Figure 6.3 Numerating households with chalk.

Once the count was complete, 16 households to be visited could finally be randomly selected. Only the 16 selected households would be considered in the statistical treatment. However, sometimes it was necessary to visit some others out of politeness – that of the village chief for instance, who requested that his family be counted too, or that of an anxious neighbor, who felt neglected: "Please you must come. Why haven't you come to survey me?" In those cases, those supplementary households were surveyed for the sake of delicacy, but not taken into account in the statistics. In the evening, the families to be surveyed were notified: The town crier informed the residents: "Don't go to the fields tomorrow!"

The next morning, at 7:00 a.m., the team tackled the heart of the survey: The questionnaire. The team leader asked the mothers: "We are gathering information about the members of the family: How many are present? How many have left? How many are dead?"[32] Some questions were considered funny ("What have you eaten today?"), others intimate, difficult to respond to in public ("Are you currently pregnant?"), others were sorrowful ("Have you recently lost a child?"). They frequently switched from language to language: French, Fula, Maka, Badjé. The interviewers smiled with their subjects about the local names for foods, and they offered comfort for the suffering they had endured and condolences for lost children.

Finally, the interviewers had to ask about the children's ages – because the nutritional survey only dealt with children from six months to five years. That could take

CALENDRIER DES EVENEMENTS _enquete Nutritionnelle_ Population affectees par l'afflux des refugies. Region de l'Est. Aout 2015						
Saisons	**Calendrier agricole**	**Fêtes religieuses**	**Evènements nationaux**	**Mois / années**	**"Age (mois)"**	**Calendrier musulman/foulbe**
Abondance des pluies,	Ramassage des champignons/chenilles, Récoltes arachides		Vacances scolaires	Aug 15	0	Fin **Djouldadou**, Debut **sioutouralou**
Pluies,	Ramassage des chenilles	fete du Ramadan (17)	Vacances scolaires	Juillet-15	1	Fin du **soumaye**, Debut **Djouldadou**
Pluies	Début chenilles, Début culture coton, tabac	Debut du ramadan (18)	Fête des mères et pères/ Fin des cours	Juin-15	2	Fin **Wairadou soumaye**, Debut **Soumaye**
Début pluie/Fin chasse	Début culture/Fin de récolte du miel/ Semences Arachides		Fête de travail (1)/Fêtes des mères	mai-15	3	Fin **Soumetoudou Waoube**, Debut **Wairadou Soumaye**
Fin chaleur/	Abondance de miel/Semences arachides / Abondance mangues	Paques (20)	Congé de Pâques,	Avril-15	4	6. Debut **Soumetoudou Waoube**
Début chaleur/Début pluies	des mangues/Récolte de s ésame et de miel/Commerce du coton/Culture des champs			Mars-15	5	5. Debut **Bandjarou Sakittindou**
Fin froid	Début des mangues, Récolte de sésame et riz/Début de chasse		Fête des amoureux/	fevrier-15	6	Debut **Bandjarou Toumbidou**
Abondance de froid,	Début récolte café, coton, tabac, riz	Maouloud (14)	Fête Bonne année	Janvier-15	7	Debut **Bandjarou Arandou**
Abondance de froid,	Début récolte café, coton, tabac	Noel		Decembre-14	8	**Haram Sakitindou**
Début saison sèche/ Début froid,	Période de pêche	toussaint	Début transhumance	Novembre-14	9	Debut **Haram Toumbidou**(5/11) **Debut an 1435**
Fin saison des pluies		Fete du Mouton	Rentrée scolaire	Octobre-14	10	Debut **Haram Arandou**
Abondance des pluies,	Récoltes/ Récoltes arachides			Septembre-14	11	Debut **Laihadji**
Abondance des pluies,	Ramassage des champignons/chenilles, Récoltes arachides		Vacances scolaires	août-14	12	Fin **Douldadjou debut Sioutoralou**
Pluies,	Ramassage des chenilles	fete du Ramadan (28/07)	Vacances scolaires	Juillet-14	13	Fin **Soumaye**, Debut **Douldadjou**
Pluies	Début chenilles, Début culture coton, tabac	Debut du ramadan (29)	Fête des mères et pères/ Fin des	Juin-14	14	Debut **Soumaye**
Début pluie/Fin chasse	Début culture/Fin de récolte du miel/ Semences Arachides		Fête de travail (1)/Fêtes des mères	Mai-14	15	Fin **Soumetoudou Waoube**, Debut **Wairadou Soumaye**
Fin chaleur/	Abondance de miel/Semences arachides / Abondance mangues	Paques (20)	Congé de Pâques,	Avril-14	16	6. Debut **Soumetoudou Waoube**
Début chaleur/Début pluies	des mangues/Récolte de sésame et de miel/Commerce du coton/Culture des champs			Mars-14	17	5. Debut **Bandjarou Sakittindou**
Fin froid	Début des mangues, Récolte de sésame et riz/Début de chasse		Fête des amoureux/	fevrier-14	18	Debut **Bandjarou Toumbidou**
Abondance de froid,	Début récolte café, coton, tabac, riz	Maouloud (14)	Fête Bonne année	Janvier-14	19	Debut **Bandjarou Arandou**
Abondance de froid,	Début récolte café, coton, tabac	Noel		Decembre-12	20	**Haram Sakitindou**
Début saison sèche/ Début froid,	Période de pêche	toussaint	Début transhumance	Novembre-12	21	Debut **Haram Toumbidou**(5/11) **Debut an 1435**
Fin saison des pluies		Fete du Mouton	Rentrée scolaire	Octobre-12	22	Debut **Haram Arandou**
Abondance des pluies,	Récoltes/ Récoltes arachides			Septembre-13	23	Debut **Laihadji**

Figure 6.4 The calendar of events to find out date of birth used for SMART. (extract). UNICEF/ACF August 2015. Courtesy of ACF

time. In Adamawa, half of the children had no known birth date.[33] For others, the interviewers had to discuss with the mother: When was he born? Before the last school vacation? The rainy season or the dry season? They relied on the harvest calendar, religious holidays, national events. Each region, each community, each village could have a different way of dating. Some counted. Others placed a pebble in a bowl for each year. They had to agree on the current month: Is it a month with 31 days, a farming month, or a lunar month in the year 1435 after Hegira?

Then they started on the measurements. They only took a few minutes per child, but beforehand, the scale had to be adjusted with a standard weight of 5 kilograms, the height of the yardstick verified with the reference stick, and the MUAC band's flexibility verified on a pipe. It is important because all of these instruments deteriorate. The MUAC ribbon folds, it can no longer be extended, and it has to be changed every two days. The scale gets decalibrated, and it has to be changed every week. On the yardstick, the reading ribbon disintegrates quickly. The measurements should always be taken in the same order: First, weight, taken twice for the smallest children, unclothed. Then, the arm circumference. Last, they measured height: The child lying down for the smallest, standing for the largest. That was the most delicate measurement, the one that can frighten the children. They started with the bravest children – or with the oldest, even if they are "past the age."[34]

The assistant helped the child get positioned correctly, the measurer said the measurement out loud: "125 . . . no, 127!" The team leader wrote it down. If the child had an arm circumference of less than 125 millimeters, they were suffering from acute malnutrition – less than 115 indicated severe malnutrition (see Chapter 3 on the history of these thresholds). In that case, they were prescribed nutrition supplements (*Plumpy'Sup*) and referred to the health center. It sometimes happens, too, that one had to measure children that were outside of the anticipated sample – if the community liaison remarked, for example, that the child of a family next door to the surveyed household seemed to be in a bad way, he was measured, he was referred, he was given Plumpy. A nutritional survey is never solely a reconnaissance instrument – it is always just as much a humanitarian intervention.

The day began at 7:00 a.m. Around 1:00 or 2:00 p.m., the 16 selected households had been visited; the supervisor could enter the data into the computer.[35] The ENA software verified the plausibility of the numbers: In the table, it underlined in red the instances of figures that seemed surprising and which could be the result of typographical errors: Did the age of a child exceed 60 months? Did all the children in one village have the same weight? Several following arm circumference figures read "0.5"? Everything had to be checked.[36] If children had been absent in the selected households at the time of the visits, the surveyors returned at the end of the afternoon to take measurements. Then, they collected the material and returned to the village chief to thank him. They paid the guide. Finally, they got back into the Jeep and went to the next village to perform the census.

In the evening, if the internet password was working, the supervisor transferred the day's data to the survey coordinator in the regional office. With 10 teams of

4 surveyors, they needed 12 days to visit all the villages, to which they needed to add days for travel, data entry, etc. The coordinator and the UNICEF consultant ultimately calculated that of the 344 children measured in the Adamawa region, 20 had a brachial perimeter under the minimum threshold. That put the prevalence of acute malnutrition at 5.8% – that is, for a total population in this region estimated at 224,017 children under five years old, a total of 15,233 suffered from acute malnutrition. The survey concluded that there was severe and growing acute malnutrition in Cameroon, with strong disparities: Less than 1% in a part of East Cameroon, close to 14%, a rate approaching the emergency threshold (15%), in the most-affected region, the Far North.[37]

Needs through the lens of vulnerability (2): The limits of nutritional surveys

The nutritional surveys were far from perfect – a fact of which those who conduct them were well aware. First, there was a strong geographical bias: The surveys were only led in regions identified as being in crisis (drought, war, refugees). Thus, no surveys were taken in regions that were not affected by these crises (the south and west of the country).[38] Yet nothing was preventing "pockets of acute malnutrition"[39] in these regions. Even in the places where food was estimated to be sufficient, the prevalence of acute malnutrition was not impossible, because this pathology is also linked to other illnesses (parasites, malaria, diarrhea, etc.). There is thus a circular effect created by these surveys: The regions that are studied the most are those for which the health indicators are bad, but the indicators are only produced for the most studied regions. So, paradoxically, it is not solely the nutrition surveys that reveal malnutrition, but a combination of crises.

There is also an inverse geographical bias: The most dangerous regions were not visited by nutritional surveys like SMART. The departments bordering on Nigeria in the Far North region were under threat by Boko Haram and thus often excluded from surveys: They remained therefore poorly understood.[40] Yet the "blind spots are those in which the situation is the gravest."[41]

The second bias was temporal. The nutritional surveys were conducted at a specific moment in time (generally September or October for the SMART survey). But malnutrition is a seasonally dependent pathology. For instance, there were "peaks of malnutrition" in the month of July, so the integrated health centers (CNTI and CENA) saw the number of patients increase at that time. It is the end of the hunger season, the "hunger gap," the moment when, in the Sahelian zone, the granaries are empty. The hunger season begins in May or June and can continue until August or September in the North of Cameroon. But seasonality changes according to year (a function of rainfall) and according to region (the millet-growing Sahelian zone and the yam-growing bimodal forest have different harvest calendars). The complex causes of malnutrition (lack of food, malaria, diarrhea, HIV/AIDS, etc.) make it an extremely variable pathology: "Each country is different, each year is different," one specialist sums it up.[42]

Seasonality makes year-to-year comparison difficult – if, for technical or administrative reasons, a survey had to be delayed, or pushed up, it became incomparable with the surveys from the previous or following years. It was then impossible to know whether the crisis was getting worse, or if it varied due to seasonal effects.[43] Acute malnutrition is a pathology that appears and disappears rapidly. Let us take the case of edemas, one of the principal clinical symptoms of Kwashiorkor: A child who has edemas does not have them for long – less than two weeks. After that, he either heals or dies. Therefore, "The problem of edemas is underestimated" by nutritional surveys.[44] This is because the surveys only intervene at one specific time: "You may very well have done your survey one month before the situation deteriorates, thereby missing the problem," explains one specialist.[45]

Because of the biases that weigh on nutritional surveys, specialists insist on the importance of contextual elements to be able to "read" the numbers produced by these surveys: The results of a nutritional survey say little if one does not cross-reference them with health-monitoring reports, food security surveys, harvest analyses, rains, droughts, health center admissions records, etc.[46]

Let us take an example: Despite increased humanitarian aid, the rates of acute malnutrition in East Cameroon remained elevated in 2015. What does one do with this information? Are certain groups not able to access the aid? Is the distributed food inadequate? Is it consumed or resold?[47] What are the links between the traumas of war or mental health and food – are some children abandoned by their parents? In some groups of siblings, do some children receive less care compared to others? What are the links between nomadism and "abandonment" of medical treatment during migration? What is the connection between malnutrition and HIV/AIDS – the prevalence of which is little-understood[48] – in the region?

The biases of nutritional surveys are well-known to experts. However, they are poorly managed, and this becomes all the more acute when drawn from typical situations (for instance refugee camps). In Cameroon, there were three types of surveys: The survey about Cameroonians in rural areas (the SMART survey, conducted by UNICEF) presents a first case: The survey method was sound and subject to a fairly wide consensus. Here, it was the diversity of regional situations and places encountered on-site that rendered comparability difficult and gave the most important bias.

The second, and simplest case, was that of surveys dealing with refugees living in official camps. The methods for these surveys were subject to consensus, and there were largely inspired by the SMART method. The refugee sites were the best-studied areas, scrutinized by several NGOs (MSF, Première Urgence, Action Contre la Faim) that conducted their own surveys, as well as UNICEF and the Red Cross. The UNHCR put a specific survey methodology in place for malnutrition, the SENS survey, adapted to refugee camps. The principal advantage of the camp was that it offered experts a panopticon. It allowed comparability in time and space. Sites, in spite of arrivals and departures, gave comparable unities from one period to the other, and they concentrated problems thus rendered visible to the naked eye: "Even seen at first glance, there was a difference between Gado and Timangolo [the latter being in worse health conditions]," a nutritionist recalled.[49]

In the camps, surveyors could easily access the survey populations. Here, they were concentrated and fairly easily identified, and because they were dependent on external interventions, often disposed to dedicate time to the surveys – thus, the surveyors could allow themselves questionnaires that were sometimes long (more than ten pages of questionnaires for multi-sectorial surveys) and demanded an investment of time from those surveyed. Finally, the random sampling of the populations to be surveyed was made possible by prior census and the administrative grid of the camps: "Working on the site is ideal, everyone is in place, it is laid out well."[50]

Finally, the most complex case was that of surveys about refugees that did not live in the camps. This population was poorly understood, poorly surveyed, and difficult to access. However it had become strategic for the UNHCR to be able to produce numbers on this population. On the global scale – that is, at the Geneva headquarters – the UNHCR defended the settling of refugees outside of refugee camps. Because it had faced severe criticism over the last decade, the UN agency now officially pushed for an "alternative to camps."[51] But on the ground, the UNHCR was more and more constrained to give numbers if it did not want to resort to figures produced by its competitors, and we have seen how an NGO like MSF could use the numbers it produced for criticism. This is why the UNHCR developed its own method of nutritional survey in recent years, the SENS method, which tried to take these questions back into its own hands. But the extension of this method outside of the sites was found to be particularly difficult.

In the beginning of 2015, following criticism about its healthcare for refugees in Cameroon, UNHCR launched a first large malnutrition survey. This began late, one year after the arrival of the refugees, and what is more, it was limited to Central African refugees living in camps. It thus omitted the Nigerian refugees who arrived in the north of the country, as well as Central African refugees dispersed in the villages – that is, in total, more than three-quarters of the refugee population in Cameron.[52] A second survey was thus planned, but realizing it turned into a nightmare. Endlessly delayed by technical problems, it finally started in November 2015, was postponed to February 2016, postponed again to August, and finally finished in November. In the end, the lag between the two refugee surveys (March 2015 for the refugees in the camps, November 2016 for the refugees outside of the camps) rendered comparison of the results impossible. By the time the results of the second survey were published, the programming decisions for 2017 had already been made several months before, anyway.[53]

Why such a fiasco?

The Cameroonian survey was an innovation for UNHCR: It was the first time that an "off-site SENS"[54] survey was conducted. For this grand premiere, UNHCR's ambition was to produce incontestable results: The organization relied on a sound methodology – the "on-site SENS" survey – itself based on the most elevated standards – the SMART survey, which acted as a standard value of nutritional expertise. The UNHCR released 54 million CFA [ca. €82,322]. It mobilized

600 volunteers from an NGO that specialized in epidemiology and was well-rooted in Cameroon,[55] recruited 25 experienced surveyors from the pool of the Health Ministry, hired the three "focal points" of the Health Ministry who were specialists in nutrition in the affected regions, as well as an outside consultant, a recognized expert in nutritional surveys. Finally, it was provided with powerful partners – UN agencies, NGOs, ministries[56] – and even the expertise of the prestigious Centers for Disease Control and Prevention.[57] UNHCR's reputation was at stake: The organization had to balance its ambition to coordinate the totality of the response for refugees with its capacity to respond to their needs, including in terms of medical and food aid. However, its competitors believed that UNHCR lacked credibility in this areas. As the leader of one of the largest donors in Yaoundé put it, "We are not financing UNHCR's SENS survey. UNHCR does not have nutrition expertise."[58]

After some months, it became evident that the costs of the survey were going to explode. They would need more surveyors, more vehicles, and more gasoline than initially anticipated. They would need to buy more badges, more hats, and more survey material, as well as hold more meetings. The SMART team sought to survey more than 2000 refugee children.[59] But where to find them? They needed to use the same two-stage sampling method as the one used for SMART.

However, the UNHCR survey not only had to randomly select 2,000 children's names from among the Cameroonian population or draw 2,000 children's names from among the refugees in a camp, but rather had rather to find 2,000 randomly selected among the children (under five years old) from the population of refugees that lived in villages. This was much more difficult. They needed to start by making a list of refugees and locating them. However the database that counted the refugees was not adapted for a nutritional survey – the tracking of people was not precise enough to allow for random selection. They would have to perform the census by hand: Visiting each village in which there were refugees, and distinguishing, in the heart of the population of the villages, who is "Cameroonian," who is a "non-refugee foreigner," and who is a "refugee." Among this last group, one had to distinguish those who were from the "old caseload" (having arrived before 2014), and those who belong to the "new caseload" (having arrived since 2014).[60] But how could one recognize the refugees? Most could present a ProGres report from 2014, but there were also older refugees with papers from 2008, as well as some with biometric papers produced in 2015 (see Chapter 5 on registration). The survey team had to drive the hundreds of kilometers along the routes from the East and Adamawa in a Jeep. Sometimes, they had to finish on foot, due to impassable roads. The volunteers of FAIRMED Cameroon, a partner NGO of UNHCR, crisscrossed the villages with a two-sided sheet of paper to which all the possible versions of refugee papers were pasted: They compared these with the papers furnished by the villagers. Certain refugees did not yet have papers – they presented "tokens," these provisional tickets on green or blue paper that authorize them to line up for registration.[61]

The census lasted from November 2015 to January 2016. It produced a database adapted for the survey. The results were judged to be satisfactory, but the

surveyors were exhausted. The team took a break, and decided to meet up in the month of February to start the survey. They could not wait too long, or the counted persons might have left, to return to Central Africa, to continue on their way to a parent, or to migrate. There was a significant number of nomads, shepherds, and itinerant farmers. The rainy season could force people to leave. The distance between the census and the survey could degrade the results.

When February arrived, the UNHCR team assembled in Bertoua, where the survey was supposed to begin. But the surveyors went on strike. They refused the offered per diem: The UNHCR proposed 15,000 CFA [ca. €21], whereas UNICEF gave 20,000 [ca. €30]! The conditions of the survey were much harder: Data collection that was forecast to last two months (as opposed to 20 days for the survey directed by UNICEF) with lodging at one's own expense in a hotel.[62] Impossible to work in these conditions: They wanted to negotiate.

March arrived: Everyone was unnerved. UNHCR, accused of incompetence, the partner NGO, accused of mismanaging money, the outside consultant, accused of ignorance about Cameroon, the surveyors, treated like deadbeats. The survey was repeatedly said to be starting soon, but it was suspended by decision of the ethics committee – an authoritative body made up of 20 Cameroonian experts assembled by the Ministry of Public Health. The reason was that UNHCR had been ambitious: The SENS survey was not a nutritional survey limited to a few indicators – like SMART – but rather a complete questionnaire that dealt with acute malnutrition, infant nutrition, food security, water, hygiene, mosquito coverings,

Figure 6.5 Household counting via chalk marking. SENS: UNHCR, Adamawa, August 2016
Source: ©Valentin Gague

Figure 6.6 Interview and questionnaire. SENS; UNHCR; Adamawa, August 2016.
Source: ©Valentin Gague

Figure 6.7 Interview and questionnaire. SENS; UNHCR; Adamawa, August 2016.
Source: ©Valentin Gague

Figure 6.8 Entering the measures into the smartphone. SENS; UNHCR; Adamawa, August 2016.

Source: ©Valentin Gague

etc.[63] One point in particular piqued the attention of the ethics committee: The blood draw that was needed to test for anemia. Outside of classical anthropometric measurements, the survey protocol called for a small pinprick in a child's finger in order to estimate the lack of iron.[64] However, all blood collection was subject to a decision of the ethics committee.[65] But the ethics committee delayed its meeting. It promised to meet soon. But the decision was stalled, then taken up again, and negotiated. It would eventually require 250,000 CFA [ca. €381] of supplementary administrative fees – then a kickback of 700,000 CFA [ca. €1067].[66]

Finally, the survey began in August. It finished in September, in the middle of the rainy season. The vehicles got bogged down, the surveyors walked kilometers on foot, and they carried out the measurements under tropical rain. They experienced delays in the delivery of materials, software problems, and anger from local authorities exasperated to have been waiting for several months. One year after the beginning of the census, the survey had exhausted the participants of whom many – including the international consultant and team leader – were quitting the project prematurely due to illness.

The construction of consensus: Inequalities as a "public secret"

As we see, the production of data about malnutrition is not an easy process, and malnutrition experts are the first to acknowledge this. Sometimes, it works nearly

according to the plan (as in the case of SMART), and sometimes it does not (as in the case of the SENS inquiry outside the camps). In all cases, producing data has costs in terms of time, energy, and money. And in all cases, it includes a material process that does not take place in ether, but in a muddy and complex environment. Aid experts are well aware of this. How is it then that their hesitations and their self-criticism about their data are lost in the process of aggregation? At this point, we should return to the notion of "consensus" discussed in Chapters 4 and 5, and to introduce the notion of the "public secret" that has been coined by Paul W. Geissler. Paradoxically, the focus of humanitarian experts on "people in need" tends to obscure the fact that these people live in the middle of groups, of communities, of societies where there are also less-poor people, and even rich people. The construction of a huge statistical category of "2.7" million people in need transforms a power relationship into an ontological property. Inequalities, as well as the power relationships that induce them, are well-known to humanitarian experts – but they barely appear in the data produced by them.

The limits of the data about needs are well-known to the experts who produce them. In their final reports, the survey leaders always include a methodological note that constitutes a warning to the reader about the figures offered in the report. Likewise, in private conversations on-site, the surveyors and volunteers who produce the data often express doubts on the quality of the numbers, showing contradictions and blind spots. However, a whole mass of information known by the members of the humanitarian community never appears in the overview reports on acute needs. The data on vulnerability are purified, selected, and aggregated such that they are silent on a whole suite of information on inequalities. This is neither a plot nor a machination. The production of a "non-knowledge zone" is at once well-known by the agents who produce the knowledge and absent from the formal reports produced by these agents, as it is constitutive of humanitarian epistemology.[67]

The principal objective of the "needs assessment" is to construct a consensus. One should remember that methods for needs assessment were often born in contexts of political conflicts, in which numbers were grossly manipulated by political and conflicting parties. The great crises that have given rise to the construction of new humanitarian knowledge were also wars of propaganda – the war in Biafra (1967–1970), the famine in Ethiopia (1984–1985), the genocide in Cambodia (1975–1979), and the genocide in Rwanda (1994). The objective of humanitarian agencies was to construct a space for discussion that was as autonomous as possible in relation to public opinion dominated by media enterprises and political actors. But the price for the autonomy of humanitarian knowledge was the abandonment of the problem of inequalities.

Why this blind spot? Because the current normative cornerstone of humanitarian aid is an "ethics of collaboration."[68] The normative documents of which the humanitarian experts avail themselves describe a *community* of equals that *collaborate* with one another in an *autonomous* fashion, *independently* and *voluntarily*. The central idea of the Humanitarian Charter adopted in 2011 by major organizations was that aid relied on a relationship of equals among the different aid actors.[69]

This document said nothing about the inequalities between North and South, between UN agencies and NGOs, donors and operational actors, public and private actors, and expatriates and local employees. Power relations were withheld, as were economic, social, and cultural differences. The Charter defined the work relationships as a *partnership* among actors turned together toward a goal established by *consensus*, a *shared conviction*, and *common principles* that were *universal*. It is this fiction of a consensual collective that constitutes, for the Charter, a *shared humanitarian belief*. The Charter defined this collective as politically impartial and non-partisan. It fostered relationships of *coordination and collaboration* with the governments of the nations concerned and with the affected populations. These principles of action also rested on the *transparency of information* that circulates as much within the heart of the humanitarian community as it does toward external actors.

The egalitarian fiction can be found at all levels of humanitarian action. This ethics regulated the relation between surveyor and surveyed in Cameroon: The "beneficiaries" of humanitarian aid all participated in the surveys in a "voluntary" and "equal" manner. For example, the nutritional surveys ensured an equal chance to participate in the survey by means of a random draw. But in the field, the surveyors were in reality ceaselessly negotiating the participation of this person and that. The reason for the presence of some at the moment of the survey and the absence of others (nomads in the middle of migration, or people gone to the fields, for example) was not questioned. Likewise, the inequalities among camp refugees and village refugees were not questioned, even though they had a strong impact on their ability to respond to the long questionnaires of the SENS survey.

The egalitarian fiction was also at play in the relationships among humanitarian workers. There were strong class inequalities between the top and bottom of the humanitarian pyramid, between expatriates and nationals, UN and NGO employees, and high-level UNHCR executives and refugees participating in an on-site survey for a week. But in humanitarian work, the ideal prevails that everyone is freely participating in the same collective action. This is why many groups of humanitarian workers were called "volunteers": United Nations Volunteers, Red Cross volunteers, and FAIRMED volunteers, themselves helped by "community liaisons" ("relais communitaires," ReCo). Surveyors, mobilizing agents, translators, and guides were thus all, in principle, "volunteers" who received no salary, but on a case-by-case basis, "indemnities," "damages," "per diems," or "defrayments" (reimbursement for transportation, lodging, food, etc.). In practice, the "volunteers" perceive – justifiably – these per diems as a kind of salary – which was demonstrated by the frequent demands, work stoppages, and volunteer protests whenever there was a reduction of the per diem.

Work inequalities continually weigh on the rhythm of the surveys, their function, and their quality, and they have a direct influence on the figures produced – yet, in the final reports, they are carefully ignored. Of course, the participants are not ignorant that they are working in an unequal society. Each one knows that the functionaries employed by the UN agencies and the punctual volunteers do not live in the same neighborhoods, drive around in the same vehicles, or eat the same food. But the egalitarian fiction is maintained throughout the duration of the collective work. When there are communal breaks and meals, they choose a

restaurant whose prices are accessible to everyone, they highlight the work accomplished in common, and they carefully avoid questions that touch on social status – the volunteers put on a good face while remaining silent about their difficulty in holding on until the end of the month, while the expatriates avoid subjects that preoccupy them in their normal discussions.[70]

The construction of consensus: Pacifying the relations between competing organizations

The egalitarian fiction is crucial to the relationship between the different institutional actors. To understand how OCHA calculated humanitarian needs in Cameroon, one must understand the diversity of humanitarian actors (see Figure 6.9).

These actors had contradictory interests. A first fracture line separated the Cameroonian state actors on one side, and international organizations and NGOs on the other. For example, the government wanted the Central African and Nigerian refugees to return to their own country as fast as possible, while the NGOs worked toward their local integration. That is why the government grouped refugees in camps (in the North, in the camp of the Minawao),[71] whereas UN agencies demanded the opening of a second camp.[72] UN agencies critique national governments in a less direct fashion than do NGOs (in particular those, like MSF, who consider "advocacy" and "witnessing" as important aspects of their professional culture). However even the UN institutions worked more or less voluntarily with the government. An agency like UNICEF, which was committed to staying in Cameroon for the long term, had more perennial connections with Cameroonian administrative services than agencies like OCHA or UNHCR, who arrive in times of crisis and have more distant connections.[73]

Figure 6.9 Aid agencies in Cameroon.

Humanitarian NGOs in Cameroon in 2016

International Committee of the Red Cross (ICRC),
Cameroon Red Cross Society (CRC),
French Red Cross (CRF),
International Federation of Red Cross and Red Crescent Societies (IFRC),
Action Contre la Faim (ACF-France),
Adventist Development and Relief Agency (ADRA),
Africa Humanitarian Action (AHA),
Care International (CARE),
Afrique Solidarité (ASOL-Suisse),
Catholic Relief Service (CRS),
Counterpart International (COUNTERPART),
FAIRMED (FAIRMED),
Global Health Systems Solutions (GHSS),
Global Viral (GV),
Good Neighbors (GN),
Helen Keller International (HKI),
ICAP-Columbia University (ICAP),
International Emergency and Development Aid Relief (IEDA),
International Medical Corps (IMC),
International Relief and Development (IRD),
InterSOS (INTERSOS),
Johns Hopkins University (JHU),
Management Sciences for Health (MSH),
Médecins Sans Frontières Switzerland (MSF-S),
Plan International Cameroon (PLAN),
Planète Urgence (PU),
Première Urgence Internationale (PU-AMI),
Sightsavers (SIGHTSAVERS),
Netherlands Development Organization (SNV),
Solidarité Internationale (SI),
SOS Village d'Enfants (SOS),
Well Grounded (WG),
Action Locale pour un Développement Participatif et Autogéré (ALDEPA),
Alliance Médicale pour l'Action Internationale (ALIMA),
Alliance des Villes pour le Partenariat (ALVP),
Association Camerounaise pour l'Education Environnementale (ACEEN),
Association Camerounaise pour le Marketing Social (ACMS/PSI),
Association pour la Promotion Humaine dans la Vallée de Logone (SANA Logone),
Cellule d'Appui au Développement Participatif et Intégré (CADEPI),
Centre d'Appui à la Recherche et au Pastoralisme (CARPA),
Centre Optionnel pour la Promotion et la Régénération Economique et Sociale-Secteur Afrique (COPRE-SA),
Comité Diocésain pour le Développement (CDD),
Gestion des Terres et des Eaux au Sahel (GTE-Sahel), Green Safe (GS),
Institut des Femmes et Filles Maria Yinda (IFFC),
Organisation pour le Développement Communautaire et l'Assainissement du Milieu (ODCAM),
Organisation pour le Développement Rural Intégré (ODRI),
Public Concern (Public Concern),
Solidarités d'Afrique (SdA),
Volunteers Without Borders (VSF)

Figure 6.9 (Continued)

A second fracture line separated UN organizations and NGOs. This vertical conflict was present in the testimonies of NGO actors, who chafed under the supervision of UN organizations. In the eastern regions of Cameroon, for example, UNHCR – which was the coordinating organization, the donor for the NGOs, and the principal logistical operator, all at once – was the object of criticism raised after the beginning of the 2014 crisis. Accused by MSF of having underestimated the emergency in May, it was then accused by the Red Cross and Action Contre la Faim (ACF) of neglecting certain refugee sites and not respecting international logistical standards (See Chapter 5 on this point).[74] Insofar as UNHCR was the lead, it judged the work of the NGOs, but as an operator, it is also took part in the humanitarian competition for parts of the market – an ambiguous position that irritated other actors.[75]

Finally, there was a subtler, but still structural, fracture between the actors of the different activity sectors ("urgentists" versus "developmentalists," aid for refugees versus aid for other populations, food aid versus medical care, etc.).[76] The issue at stake in this horizontal conflict was the procurement of one part of the "humanitarian market,"[77] that is, one part of the funds accorded by the donors and by private giving, which also implied access to the site, to national and international institutions, and to important European and North American media. To assert this right to these scarce humanitarian resources, one also has to emphasize a specific understanding of the populations in need. The diagnostic adopted justified the mode of intervention from the outset. In the east of Cameroon in 2014, NGOs were competing for UNHCR funds. The "urgentists" prioritized the figures of acute malnutrition and elevated mortality among refugees to legitimize emergency interventions (food distribution, emergency health projects, infant nutrition, etc.), whereas the "developmentalists" privileged local integration, the safeguarding of local markets, etc. Finally, there were fine distinctions in the heart of each intervention sector that produced conflicts. For example, among the "urgentists," the NGOs specializing in nutrition (like ACF) competed for funds with NGOs specializing in food aid (like AHA).[78]

In this context, the list of numbers chosen to establish the "humanitarian balance sheet" of a country could easily become an object of conflict – or an object of pacification. This was particularly visible in the way Frank – the OCHA technician whom we met in the previous chapter – worked. How to construct the map of the distribution of needs in Cameroon? What indicators to choose? What indicators to eliminate? How to combine the indicators in a way in which no organization feels neglected?

The first step: OCHA gathered the humanitarian organizations in ten sectors (food security, nutrition, water/hygiene/sanitation, health, shelter, education, protection, child protection, sexual violence and hate crimes, early recovery). All the organizations that were involved in a particular sector met under the direction of the UN agent who coordinated the sector (UNICEF by the nutrition sector, UNHCR for protection, WFP for food, WHO for health, etc.). Then, each sector chose between three and five indicators that represented the entirely of the problem of this sector from a list of possible indicators proposed by OCHA. After

many sectorial discussion meetings and meetings with OCHA, each sector took up the chosen indicators (percentage of children suffering from acute malnutrition as related to the population of the district, percentage of refugees, percentage of internally displaced persons, percentage of destroyed schools, unemployment rates, percentage of people in food insecurity, percentage of homeless people, number of medical consultations per day, etc.).

The second step: The indicators needed to be weighted, to be able to compile them and render them visible at the same time on a synthetic map. But to which indicators should the most importance be given? How can one compare a percentage of *refugees* and a percentage of *malnourished children*? Frank, OCHA's data manager, centralized the data furnished by the lead agencies of each sector.[79] On his software, the comparison tool for humanitarian needs (which looked like a large Excel spreadsheet), he asked each sectorial coordinating organization to enter the chosen indicators: UNICEF's nutrition specialist entered the infant mortality rate as the first indicator, the percentage of children under five suffering from severe acute malnutrition as the second, etc.[80] The numbers were entered by health district or by department. Frank's computer (still held together with scotch tape) therefore translated all the given figures into indicators normalized from 0 to 1 (expressed as a percentage of the maximum score, with 0 for a "normal situation" and 1 for the most "serious situation"): This normalization permitted the sector-by-sector calculation of a sector's internal indicators in terms of an arithmetic average,[81] for example:

$$\text{NutritionIndicator} = \frac{(\textit{Nutrition Indicator 1} + \textit{Nutrition Indicator 2} + \ldots \textit{Nutrition Indicator n})}{n}$$

The third step was the most delicate: To construct a general score for each district that represented all the needs of the entire district population in every sector (its *vulnerability*) – and without alienating the humanitarian organizations that were involved in the different sectors. Here again, the software program used by Frank saved the day: It calculated a general score that was the geographic average of the indicators of all the sectors:[82]

$$\text{General score} = \frac{(\textit{Health Indicator} * \textit{Education Indicator} * \textit{Nutrition Indicator} * \textit{Sector n Indicator})}{n}$$

Here, in principle, each sector had an equal part in the general score. This decision, however, was not the fruit of research on the relative value of sectors in public health – it was the product of the explicit decision of OCHA to create a formal equality of the sectors to avoid conflicts: "in order to avoid potentially long and fruitless discussions which could limit the tool's ability to achieve consensus."[83] Herein lies the power of the algorithm: The production, by way of mathematical averages, of a consensus between humanitarian actors. The resulting statistics on "vulnerability" might be overdetermined by the intrinsic logic of the humanitarian field.

Conclusion

The description of the production chain of figures thus invites us to question the relationship between the production of knowledge and internal competition in the humanitarian field.

First, the "distancing" permitted to humanitarian experts does not signify that the face-to-face interactions become less numerous. Contrary to what the literature on the "data revolution" (including the critical literature) might lead one to believe, quantification does not necessarily signify less direct reporting. It is often even the opposite. Quantification surveys often lead to new interactions. This starts in the headquarters of organizations: Meetings multiply and people visit each other's offices or in restaurants – including on the subject of digital or immaterial "data" ("have you seen the email from X about Y?"). But the surveys also multiply face-to-face interactions on the ground: Interviews with refugees, the refugees' representatives, chiefs, mothers, community liaisons, etc. It would be correct to say that the effect of technologies on face-to-face interactions is not neutral. But it would be wrong to think that more quantification necessarily signifies *less* face-to-face interactions. These interactions are in fact embedded more and more – that is, made possible, but also constrained – by prior calculations. For example, in the SMART survey, computer-driven random drawings decided which villages in a region would be visited, and thereby which encounters between surveyors and villagers could take place. The effect of the digitalization of data on face-to-face relations is not a zero-sum game.

In what way does humanitarian expertise produce specific knowledge (that is, knowledge that is distinguished from other forms of knowledge) about populations? The salient point of humanitarian expertise is to treat needs according to a general accounting of suffering. This form of investigation is extremely efficient in that it furnishes at low cost, in brief periods, and despite difficult working conditions, objective knowledge that is transportable, commensurable, and universalizable. The permanent *tour de force* that is humanitarian quantification transforms human suffering into individual needs, each autonomous and interchangeable.

The first consequence of this mode of knowledge is an outrageous separation between quantitative and qualitative data. The numerical descriptions of crises are the object of a growing budgetary effort, whereas textual descriptions are often excluded. If standardized methods (like SMART or the ProGres database) concentrate on the smooth circulation of figures on the ground at headquarters and on their "rise in globality" by aggregation, the upturn of qualitative observations contained in the reports is, on the other hand, travelling much worse – above all because they contradict the figures.[84]

The second consequence of this way of understanding suffering is a euphemizing of inequalities and power relationships. The focus on quantifiable "needs" allows one to jump directly from individuals to the general population by means of a statistical aggregate, without having to pass through intermediary institutions, the chiefs, *big men*, prefects, administrators, entrepreneurs, and all other intermediate positions of power. Humanitarian expertise allows suffering to be seen as a soil-less reality.

This knowledge, however, is not only symbolic: It has real effects on the people concerned (effects of waiting and hope, the promise of an intervention) as well as on the actors engaged in the humanitarian field (a real allocation of finances, or "discharge," to echo Béatrice Hibou)[85] – which leads us to the question of power: The quantification of humanitarian needs is never an operation for the sake of pure knowledge (if such a thing even exists). The operations of knowledge are *always* linked to interventions. For example, in the case of registration of refugees, there is an operation at once cognitive and performative. However, it would be reductive to see in humanitarian government merely a local variety of a biopolitical, neoliberal, or neocolonial power. Certainly, the quantification of needs contributes to the reification, depoliticization, and naturalization of needs according to the principle of a universalist ontology. But the humanitarian field still leaves room for aid agencies to deploy different strategies.

It is, moreover, this uncertainty and this fragility of the field that seem to be one of the principal issues in the production of figures: The construction of a humanitarian consensus. This has to do with contributing to the pacification of the humanitarian field by producing numbers, all while distinguishing it from the political space and the space of aid beneficiaries. The object of the evaluation of needs is to limit conflict between humanitarian organizations (in other words, to regulate competition among organizations). This happens notably through relegating arbitrage to "black boxes" (like OCHA's magic formula allowing for the addition of indicators). This does not increase the "transparency" of data, because only a handful of actors really master the complete production chain of the indicators of needs.

Notes

1 In OCHA's version, the humanitarian project cycle included five steps: Needs assessment, strategic planning, resource mobilization, implementation, and evaluation.
2 See Chapter 3. For a critique of humanitarian aid's focus on children, see Last, Murray. Putting children first. *Disasters* 18, no. 3 (1994): 192–202. On the image of an emaciated child in Biafra, see Herten, Lasse. A wie Auschwitz, B wie Biafra: Der Bürgerkrieg in Nigeria (1967–1970) und die Universalisierung des Holocaust. *Zeithistorische Forschungen in Contemporary History* 8 (2011).
3 See OCHA. *Cameroon: Humanitarian Needs Overview 2016*. Yaoundé: December 2015.
4 Interview with UNICEF Nutrition specialist. UNICEF Headquarters. 17 August 2015.
5 This contrasts notably with the Sahelian countries (Niger, Chad, Mali) which have been the subject of sustained attention by food aid programs since the 1970s (Bonnecase, Vincent. *La Pauvreté au Sahel. Du savoir colonial à la mesure internationale*. Paris: Karthala, 2011), but also with Nigeria, which, along with Biafra, was the object of a great deal of media and scientific attention.
6 Winter, G. *Trois enquêtes sur les niveaux de vie effectuées de 1961 à 1965*, Office de la recherche scientifique et technique outre-mer (ORSTOM) report: "Enquête dans le Nord-Cameroun (1961–1962)," "Enquête dans l'Adamaoua (1963–1964)," "Enquête à Yaoundé et dans la zone cacaoyère autour de la capitale (1964–1965)."
7 Republic of Cameroon. *National nutrition survey*. Yaoundé: Cameroon, 1978.
8 Enquête Camerounaise auprès des Ménages.
9 Full name: Ministry of the Economy, Planning, and Regional Development.

10 The EDS also gives rates of acute malnutrition, but its periodicity does not allow for much precision. In the east and the north of Cameroon, chronic malnutrition was elevated. In 7 out of 10 regions, more than 30% of children under five years old suffered from chronic malnutrition. Chronic malnutrition is not treatable, but it is preventable: The targets of aid programs are pregnant women and children from 0 to 2 years of age.

11 That is, 24.4% in 1991, 32% in 2004. A figure confirmed by the following: 33% in 2011. This is above the threshold of "elevated" malnutrition according to the WHO (30%). Republic of Cameroon, EDS, 1991: 126; Republic of Cameroon, EDS, 2004: 202; and Republic of Cameroon, EDS MICS, 2011: 159.

12 Skype Interview with Hélène Schwartz and Yvonne Grellety (Nutrition specialists). February 2016.

13 The 2008 crisis in Cameroon followed an increase in the price of foodstuffs and gas. In February 2008, 14 urban transportation companies organized a significant strike in Yaoundé and Douala. The criticism of the price hike was echoed by political criticism, and then, one month later, President Paul Biya had the constitution changed to allow himself a supplementary presidential mandate. The police and army repression of the demonstrators led to dozens of deaths (if not hundreds, according to some human rights organizations). Eboko, Fred. Cameroun: Acteurs et logiques des émeutes de 2008. In *Alternatives Sud. Etat des résistances dans le Sud* (2008): 53–57. www.cetri.be/Cameroun-acteurs-et-logiques-des?lang=fr (Accessed 2017-05-03). The 2008 crisis that affected numerous African countries was not a crisis of the supply disruption but rather a crisis of accessibility of foodstuffs of the urban poor. This crisis was triggered by the rapid increase of international rice prices in 2007/2008 and by its local impact (because of anticipatory speculation, on the price of local traditional grains (corn, millet, sorghum)). That is why this crisis also affected countries that had generally been spared by food crises (the Ivory Coast, Togo, Cameroon). Janin, Pierre. Surveiller et nourrir: Politique de la faim. *Politique africaine* 119 (2010): 5–22, here p. 9. On this crisis, see Lang, Tim. Crisis? What Crisis? The normality of the current food crisis. *Journal of Agrarian Change* 10, no. 1 (2010): 87–97, here p. 22. Headed, Derek and Fan, Shenggen. Anatomy of a crisis: The causes and consequences of surging food prices. *Agricultural Economics* 39 (2008): 371–392.

14 The surveys were linked to different types of interventions: Surveys on food security led to emergency food distribution (baskets of grain, beans, oil, salt) as well as programs aimed at rehabilitation (Food for Work and Food for Training) from the World Food Programme, and development (livestock vaccinations, vegetable cultivation assistance, etc.) from the FAO. The malnutrition surveys informed interventions in public health, with medical care (the distribution of High-Energy Biscuits and Plumpy'Sup in the case of moderate acute malnutrition, medical care in the nutritional therapeutic centers with Plumpy'Nut, and medical follow-up in the case of severe acute malnutrition).

15 Interview with senior staff member at World Food Programme. World Food Programme Headquaters Yaoundé. November 2014 and Interview with Vulnerability and Mapping Officer at World Food Programme. World Food Programme Headquaters Yaoundé. November 2014.

16 Centres de Nutrition Ambulatoires (CNA) and Centres de Nutrition Thérapeutique Intensif (CNTI).

17 UNICEF and Ministry of Public Health. *SMART Nutritional Survey: Final report: 2011, 2012, 2013, 2014, 2015, 2016.* The SMART method is one of the most widespread evaluation methodologies today. It was developed at the beginning of the 2000s by a small group of North American experts with cooperation from the United States (USAID), an American public health institution (the Centers for Disease Control and Prevention), a UN agency (UNICEF), and a large NGO (Action Contre la Faim Canada). UNICEF'S SMART coordinators encountered in Cameroon were trained in this method by ACF Canada in Dakar.

18 The indicators collected by the SMART survey were 1) Nutrition of children aged 6 months to 60 months (five years): a) acute malnutrition (moderate acute malnutrition and severe acute malnutrition); b) chronic malnutrition (developmental delays); and c) low weight. 2) Nutrition (prevalence of malnutrition and food diversity) of women in the reproductive age group (15–49 years). 3) Mortality of the general population (gross death rate and causes of death, by a retrospective mortality survey of the three preceding months).

19 It was the SDAM (the Department of Food and Malnutrition – Sous-direction à l'alimentation et à la malnutrition) that piloted the survey, validated the survey protocol, recruited the surveyors, and assured the liaison with administrative services (regional governors, prefects, mayors, health officials [regional health delegates], and traditional chiefs [chefs, *lamidos*]). The implication of the Ministry of Public Health at all these stages was of the highest importance for SMART. In contrast, the SENS survey led by UNHCR, which maintained more distant ties with the Ministry, had much more trouble on the ground. The SMART survey was financed by ECHO, and cost between 80,000 and 100,000 Euros.

20 The surveyors were recruited from a pool of candidates pre-selected by the Ministry of Public Health. The training (questionnaires, anthropometric measurements, database) lasted for five days, but most of the surveyors had undertaken multiple surveys and were therefore already experienced in these techniques. There was one survey coordinator who worked for UNICEF (a Cameroonian), ten team supervisors (of which 9 were Cameroonians sent by the health administration and 1 was a foreign SMART consultant for UNICEF), and 30 Cameroonian surveyors. There were 15 women and 26 men. (UNICEF and Ministry of Public Health. *SMART Nutritional Survey: Final Report 2015*, Appendices.)

21 Besides French, the team leaders for the East spoke Fang; those for Adamawa, Gbaya; those for the North, Mbum; and those for the Extreme North, Kirdi – all in addition to Fula, which is spoken in all regions.

22 The ten teams were divided by region (two teams in the East, two in Adamawa, three in the North, and three in the Extreme North).

23 In reality, the calculations of sampling were more complex, because they included a "cluster effect" that sought statistically to correct the risk of too-homogenous villages. One example of the calculation of the sample size: UNICEF and the Ministry of Public Health. *SMART Nutritional Survey: Final report 2015*: 17–18.

24 The SMART method used the terms "stratum" to designate the *region* to be surveyed, "cluster" to designate the *village* (or the neighborhood, or the segment of the neighborhood, according to the researched population), and "household" to designate the *families* to be studied. This technical terminology was justified by the differences in analytical units of the statistical survey and the social units expressed both in administrative language (for example, it could happen that one studied a region in two rounds, so in two "strata") and in a common language (for example, a "village" on the statistical plan does not necessarily correspond to a "village" in the sense in which the people who live there understand it).

25 UNICEF and the Ministry of Public Health. *SMART Nutritional Survey: Final Report 2015*: 18.

26 The Central Bureau of the Census and Population Studies (BUCREP) in Cameroon cut the territory up into "census zones," which are geographical spaces limited to 700–1000 persons. A census zone can incorporate several villages (hamlets, neighborhoods).

27 Emergency Nutrition Assessment (ENA) was the software developed by Action Contre la Faim for the SMART survey.

28 The inhabitants of the east and the north of Cameroon had long experience with development and humanitarian projects. They knew – by reputation, at least – the large institutions like HCR, WFP, UNICEF, PLAN, Red Cross, etc.

29 The guide received 3,000 CFA [ca.€5] in compensation for his help during the day.

30 The SMART survey's definition of a household therefore differed from that of the SENS survey, for which sharing the same roof was a second determining criterion.
31 One can easily see for the interviewees that responding to such questions – that is, rendering public and formalized those rules that are often private and sometimes implicit – can bring up sensitive issues. Moreover, the surveyors must often adjudicate, because the real-life circumstances of the sharing or not-sharing of meals are often far from two ideal-typical situations (for example, certain people who live on a particular plot might usually take their meals elsewhere).
32 These questions correspond to the retrospective mortality survey.
33 Date of birth was known for 48% of children in Adamawa. This percentage varied widely among the regions. See UNICEF and the Ministry of Public Health. *SMART Nutritional Survey: Final report 2015*.
34 The presence of bilateral edemas was also observed. In the UNHCR SENS survey, blood was drawn to test for anemia (see later in this chapter).
35 There was a double entry: A first entry of the forms on-site, then a second once they have returned to the regional office.
36 The ENA software did the first plausibility report after the on-site entry, and a second one once all the data were entered, estimating the statistical probability of the distribution of data (for example, the sex ratio).
37 UNICEF and the Ministry of Public Health. *SMART Nutritional Survey: Final Report 2015*: 33.
38 Interview with a Nutritionist at UNICEF. UNICEF Headquarters, Yaoundé. November 2014.
39 Skype interview with Hélène Schwartz and Yvonne Grellety, Nutrition specialists (authors of the report "*Evaluation prise en charge de la Malnutrition aigüe au Cameroun*"). February 2016.
40 The fourth SMART survey (2014) thus excluded nine border *arrondissements* (districts) in the East region. Most of the surveys excluded the eight arrondissements of the Extreme North that share a border with Nigeria.
41 Interview with SMART consultant for UNICEF. UNICEF Headquarters, Yaoundé, February 2016.
42 *Ibid.* The consultant estimated that the ideal period for a SMART survey would be the beginning of the hunger season (May/June), but that was impossible given the administrative plan.
43 Thus, the SMART survey from 2012, realized in the post-harvest period, was hardly comparable with that of 2013.
44 Skype interview with Hélène Schwartz and Yvonne Grellety, nutrition specialists, February 2016.
45 Interview with SMART consultant for UNICEF. UNICEF Headquarters, Yaoundé. Interview February 2016.
46 This challenge also makes projections for planning the response a delicate issue (the "projection of the caseload" about probable admissions for the years to come).
47 Part of the corn distributed by the World Food Programme was resold by households that consumed more manioc. (Crushing and cooking corn has an important cost in terms of time and wood.)
48 Screening for HIV/AIDS was done by health services, but certain MSF doctors were doubtful about the reliability of the declared prevalence figures, which were considered abnormally low.
49 Timangolo had in fact higher rates of acute malnutrition. Interview with nutrition specialist UNICEF. UNICEF Bertoua, March 2016.
50 *Ibid.*
51 UNCHR. *Policy on alternatives to camps*. UNHCR/HCP/2014/9, 22 July 2014.
52 Interview with a Senior Officer at UNHCR Headquarters, Yaoundé, March 2016.
53 The UNHCR's "Country Operational Plan" for 2017 was established in March 2016.

54 UNHCR. *SENS survey on Central African refugees offsite in the regions of the East, Adamawa, and the North of Cameroon*. November 2016.
55 FAIRMED, an NGO which has been present in Cameroon since 1959.
56 Among the survey partners: UNICEF, WHO, WFP, UNFPA, Action Contre la Faim, African Humanitarian Aid, International Medical Corps, CARE, French Red Cross.
57 One of the most powerful (American) institutions in the domain of epidemiology.
58 Leader of one of the largest international donors, Yaoundé, February 2016.
59 In total, 2,622 refugee children were surveyed (UNHCR, SENS survey 2016).
60 The "SENS Survey" database was different from the "ProGres" database. For instance, the name of the village indicated in the ProGres database did not always correspond to a real village; the refugees could be registered in one village but live in another; there were villages that did not exist in the ProGres database, there were non-registered refugees, etc. The report modestly stated the "incompatibility" of the two databases (UNHCR, SENS survey 2016: 57). The new database thus distinguished six categories of persons: 1. Cameroonians from the visited villages (East, Adamawa, and North regions), 2. The previous refugees in the East, 3. The previous refugees in Adamawa, 4. The new refugees in the East, 5. The new refugees in Adamawa, and 6. The Nigerian refugees in the North of Cameroon (Minawao Camps). The distinction between "previous" and "new" was a subject of discussion. Some experts estimated that the refugees (majority Christian) who arrived in 2013 should be placed on the same health program as the "new" refugees (majority Muslim), whereas the survey treated them differently.
61 Interview with UNHCR Nutrition Officer. UNHCR Headquarters, Yaoundé, March 2016; Interview with nurse and SMART and SENS surveyor. Regional Hospital of Bertoua. March 2016; Interview with SMART and SENS staff member. Regional Hospital of Bertoua, March 2016.
62 Interview with SMART and SENS staff member. Regional Hospital of Bertoua, March 2016.
63 These items correspond to survey areas that were specialized and partly codified (for example, the ANJE module, study of best practices for the Nutrition of Infants and Young Children (Alimentation du Nourrisson et du Jeune Enfant)).
64 A team of SENS-surveyors thus consisted of one driver, one team leader, two anthropometric measurers, one interviewer, and one hemoglobin doser.
65 On the question of blood tests in the history of colonial and postcolonial central Africa, see White, 2000.
66 A sum reported by two witnesses – one from the Ministry of Public Health, and the other from UNHCR.
67 For the concept of "public secret" and an overview of works on "non-knowledge" or "unknown knowns," see Geissler, P. Wenzel. Public secrets in public health: Knowing not to know while making scientific knowledge. *American Ethnologist* 40, no. 1 (2013): 13–34.
68 Which is, in part, inspired by the scientific "ethics of collaboration" described by Geissler (Geissler, 2013).
69 Sphere Project. *Humanitarian charter and minimum standards in disaster response*, Third edition, Geneva: Sphere Project 2011. The "Charter" followed – while being strongly distinguished from – preceding charters of international aid, among others, the "Colonial Development and Welfare Act" (1940) of the late colonial empire, the collection of bilateral accords from 1960–1980 during the Cold War, and the Red Cross Code of Conduct from 1990 and 2000.
70 See Geissler, 2013.
71 In March 2017, the UNHCR indicated a population of 62,000 inhabitants for the Minawao Camp. http://data.unhcr.org/SahelSituation/settlement.php?id=214&country=502&region=73#doc_1 (Accessed 2017-03-10). UNICEF Emergency Coordinator at UNICEF Headquarters. Yaoundé, 2016-02-26.
72 To the east, while 70% of refugees lived outside of the sites, the mayors and prefects criticized NGOs that privileged aid to refugees – at the expense of Cameroonians.

73 This was apparent from nutritional surveys: UNICEF associated the Ministry of Public Health with different stages of the SMART survey, whereas the UNHCR conducted the SENS survey more autonomously.
74 The Sphere standards were not respected by the UNHCR according to participants in certain sectors (the WASH: Water, Sanitation and Hygiene). Country Director at Action Contre la Faim (ACF). Batouri, 2014-12-05.
75 Criticism on the allocation of funds was omnipresent. At the end of 2014, NGOs depending on the UNHCR for funding said that they did not know whether or not their projects would be financed for next year. Interview with senior staff of the French Red Cross in Cameroon. Yaoundé. November 2014.
76 Dauvin, Pascal and Siméant, Johanna. *Le travail humanitaire: Les acteurs des ONG, du siège au terrain*. Paris: Presses de Sciences Po, 2002: 124–136.
77 Carbonnier, 2015: 37–66.
78 For nutrition specialists, acute malnutrition is a pathology that requires medical care. Nutritional supplements like Plumpy'Sup and F75 milk are considered to be therapeutic products to be consumed according to a precise framework. In October and November 2014, ACF accused the NGO AHA of making massive distributions of Plumpy'Sup between the sites of Mbilé and Lolo, outside of all medical control. Interview with nutritionist doctor at Action Contre le Faim, ACF Headquarters in Cameroon, Batouri, December 2014. Interview with an ACF head of mission, Action Contre le Faim (ACF), Batouri, December 2014. Interview with an AHA senior staff, African Humanitarian Agency (AHA), Yaoundé, December 2014.
79 Interview with an OCHA senior staff, OCHA Headquarters, Yaoundé, March 2016.
80 Interview with a nutrition specialist at UNICEF, UNICEF Headquarters, Yaoundé, February 2016.
81 This addition could be weighted: For example, if the agency responsible for a sector considers one indicator to be more important or more reliable than another, it could multiply it by a factor of its choice.
82 Each sector is thus equal in the general score: There was no weighting of the sector indicators to obtain a final score, which was explicitly in order to avoid conflicts of interest among the representative organizations of different sectors (OCHA. *Guidance: Humanitarian needs comparison tool*. August 2014: 12).
83 OCHA. *Guidance: Humanitarian needs comparison tool*. Geneva/ New York 2014: 12.
84 SMART survey reports contained, for example, methodological notes that informed readers about the conditions of validity of the figures put forward. But if the figures themselves were often re-copied and cited, the methodological precautions that accompanied them were, by contrast, rarely mentioned.
85 Hibou, Béatrice. La 'décharge,' nouvel interventionnisme. *Politique africaine* 1, no. 73 (1999): 6–15.

References

Bonnecase, Vincent. *La Pauvreté au Sahel. Du savoir colonial à la mesure international*. Paris: Karthala, 2011.

Dauvin, Pascal, and Siméant, Johanna. *Le travail humanitaire: Les acteurs des ONG, du siège au terrain*. Paris: Presses de Sciences Po, 2002.

Geissler, P. Wenzel. Public secrets in public health: Knowing not to know while making scientific knowledge. *American Ethnologist* 40, no. 1 (2013): 13–34.

Headed, Derek, and Fan, Shenggen. Anatomy of a crisis: The causes and consequences of surging food prices. *Agricultural Economics* 39 (2008): 371–392.

Herten, Lasse. A wie Auschwitz, B wie Biafra: Der Bürgerkrieg in Nigeria (1967–1970) und die Universalisierung des Holocaust. *Zeithistorische Forschungen in Contemporary History* 8 (2011).

Hibou, Béatrice. La 'décharge,' nouvel interventionnisme. *Politique africaine* 1, no. 73 (1999): 6–15.

Janin, Pierre. Surveiller et nourrir: Politique de la faim. *Politique africaine* 119 (2010): 5–22.

Lang, Tim. Crisis? what crisis? The normality of the current food crisis. *Journal of Agrarian Change* 10, no. 1 (2010): 87–97.

Last, Murray. Putting children first. *Disasters* 18, no. 3 (1994): 192–202.

OCHA. *Guidance: Humanitarian needs comparison tool*. Geneva/New York: OCHA 2014.

OCHA. *Cameroon: Humanitarian Needs Overview 2016*. Yaoundé: December 2015.

Pommerolle, Marie-Emmanuelle. Les violences dans l'extrême-Nord du Cameroun: le complot comme outil d'interprétation et de luttes politiques. *Politique Africaine* 138, no. 2 (2015): 163–177.

UNCHR. *Policy on alternatives to camps*. UNHCR/HCP/2014/9. 2014-07-22.

UNHCR. *SENS survey on Central African refugees offsite in the regions of the East, Adamawa, and the North of Cameroon*. November 2016.

UNICEF and the Ministry of Public Health. *SMART Nutritional Survey. Final Report 2015*: 17–18.