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This edition of Field Exchange carries a number of articles which challenge the effectiveness of our standard responses to food and nutrition emergencies. A review undertaken in the Great Lakes region (see research section) is highly critical of food security responses over the past 5 years. Criticisms included the adoption of too narrow a range of interventions, many of which were judged to be inappropriate, short-term and overly focused on the food production side rather than nutrition. Issues of cost-efficiency were also highlighted when alternative interventions may have been implemented at a ‘fraction of the cost’. Another review of nutrition programming in the southern Africa region undertaken on behalf of UNICEF and WFP included a focus on the emergency response during 2001-3 emergency (see research section). This element of the review raised serious questions over the effectiveness of selective feeding programmes with regard to coverage and impact. A field article by John Moore and Mara Berkley-Matthews in this issue on difficulties of attending and managing SFPs in war-ravaged northern Uganda highlight how the success of many such programmes are highly context specific although programme staff did manage to introduce measures to circumnavigate some of the security related problems of attendance.

In shining contrast Field Exchange carries a field article by Kristy Allen about a highly successful monetisation programme in Bulawayo. The Market Assistance Pilot Program (MAPP) is providing beneficiaries in Zimbabwe’s second largest city, Bulawayo, with a low-cost maize alternative – sorghum - through existing commercial channels.

The price of sorghum is determined by income, household size, and the retail price gap between maize and sorghum. Retailers are also permitted a 15% mark-up on the product to ensure profitability. Local processors, distributors and retailers are also encouraged to invest in producing the product locally, the first step towards ensuring sustainable production at the local level.

The MAPP targeted more than 800,000 families in the Bulawayo area. Preliminary estimates suggest that the sorghum meal prices allowed most poor families in the target area to purchase sufficient food to feed all family members three meals per day for the six month duration of the pilot program. 77% of the high-density population (460,000 people) were being fed per month by the MAPP. In recognition of the MAPP’s impact and its potential to assist many more vulnerable households, USAID Food for Peace has approved a MAPP expansion to Gweru, targeting over 100,000 urban poor; an expansion to Chitunguiza, targeting 250,000 urban poor; and the continuation of the original program in Bulawayo.

Findings of a recent CIDA funded systematic literature review (to be reported in the next issue of Field Exchange) on six types of emergency intervention (GFD, SFP, TR, BNP, sorghum, etc.) show very little published literature on the impact or cost of these programmes. A review by HPN (see research section of this issue) of both this published and grey literature of the impact of a broad range of humanitarian responses found a similar dearth of information. This review states that the humanitarian system currently lacks the skills and capacity to successfully measure or analyse impact.

There would now appear to be a growing body of support for introducing systems to ensure more effective monitoring of impact of humanitarian responses and awareness that knee-jerk standard responses often involve food aid may not always be appropriate or effective. At the same time, newer types of programming in the era of HIV/AIDS involving food aid need careful monitoring especially with regard to cost-efficiency. The soon to be published CIDA review will argue that there is currently no agency with overall responsibility for monitoring cost-efficiency of interventions. Thus, standard interventions are routinely trotted out by agencies for a variety of reasons (many of which do not necessarily relate to need, i.e. agency mandate, area of expertise, visibility, ease of accountability, availability of food aid rather than cash, etc). This means that there is no overall collation of information on effectiveness or cost, there is a lack of analysis of the grey literature and that opportunities which may arise in certain emergency contexts for controlled impact assessments are not capitalised upon. At the same time donors do not apply cost-efficiency criteria to proposals. There is a pressing need to remedy this situation. One solution may be to appoint an agency whose primary mandate is to compare cost-efficiency of different types of intervention in the humanitarian sector. This agency would also need to keep a close eye on assessing impact and cost-efficiency of newly emerging types of intervention, e.g. HIV/nutrition programming, before such programmes are rolled out on a large scale or become part of standard agency practice.

Finally, Field Exchange is pleased to be able to publish the findings of one of the first studies on impact of HIV/AIDS on food and economic security at community level. The article written by Celia Petty and John Seaman is based on a study of a modified form of Household Economy Assessment conducted in four countries. In two of the countries (Swaziland and Mozambique) researchers examined HIV/AIDS impact and found that in Swaziland, omitting the costs associated with illness and funerals, extra adult mortality attributable to HIV/AIDS over the past 5 years has caused a fall of approximately 8%-12% in total community disposable income. However, the economic impact on individual affected households is specific to that household, and ranges from a small improvement in income/adult equivalent (e.g. death of an unemployed adult) to devastating loss (e.g. loss of one or more salaried / public sector workers). Overall, the net effect is to make very little change to the proportion of households falling below the defined poverty line.

The research provides a measure of the distribution of poverty in the study communities and casts doubt over the feasibility of deriving ‘simple’ HIV/AIDS related poverty indicators. This has implications for the design of social protection and welfare policies, as well as wider macro-economic policy debates. For example, if only orphans were identified as eligible for free primary education or health care, many poor children would be excluded and some better off children included.

We hope you enjoy this issue of Field Exchange

Jeremy Shoham

Any contributions, ideas or topics for future issues of Field Exchange? Contact the editorial team on email: office@ennonline.net
A Market Support Programme to Address an Urban Food Crisis in Zimbabwe

By: Kristy Allen

Kristy Allen-Shirley is the Communications Coordinator for the Consortium for Southern Africa Food Security Emergency (C-SAFE), based in Johannesburg, South Africa. C-SAFE is in its second year of implementation for a coordinated ‘developmental relief’ programme in Malawi, Zambia, and Zimbabwe. The C-SAFE membership includes World Vision, Catholic Relief Services, CARE, ADRA, Emmanuel International, Save the Children and Malawi Red Cross, and is funded by USAID’s Office of Food For Peace.

It is extremely difficult to address urban food emergencies through traditional general ration programmes. The logistic and targeting challenges are particularly daunting. The market support programme described in this article demonstrates an alternative type of intervention which circumvents many of these difficulties. This type of programme may also be suited to certain rural contexts and may offer a model for future programming (Ed).

A 10kg bag of sorghum will feed seven members of the Tshuma household.

During a time when Zimbabwe’s urban population has seen its purchasing power slashed by soaring inflation and widespread unemployment, at a time of limited access to food, an innovative market intervention is working to rebuild the flagging commercial sector and sustain the urban poor.

The USAID funded Market Assistance Pilot Programme (MAPP) is providing beneficiaries in Zimbabwe’s second largest city, Bulawayo, with a low-cost maize alternative - sorghum - through existing commercial channels. C-SAFE, comprised of Catholic Relief Services (CRS), World Vision (WV) and CARE, took the step of piloting the programme in September 2003 as the combined effects of drought, poor economic policy and HIV/AIDS had left livelihoods frayed and urban communities powerless to emerge from a state of chronic food insecurity.

Relief and development projects have traditionally focused on rural areas, however in Zimbabwe’s case the needs in urban areas are equally critical. Massive market failures, the evaporation of infrastructure and critical wounding of the local economy means that the ability of urban households to recuperate losses is limited. At the same time prospects for hunger relief are poor.

The MAPP

As an alternative to traditional food distributions, C-SAFE approached existing commercial entities that could facilitate a program aimed at ‘filling the market gap’ with an affordable maize-substitute. A proposal to use sorghum initially encountered resistance from both retailers and consumers, given its lack of commercial presence in the local market for several generations. However, within weeks 70 retail outlets in the Bulawayo suburbs agreed to sell the cereal. Demand exploded from 30 tons to 300 tons a day and by November 2003, seven local millers were milling and packaging the USAID sorghum to meet consumer demand.

At the height of demand, MAPP sorghum had an average shelf life of less than one hour. Retailer Caroline Makoni of Lucky 7 store in the high-density suburb of Pumula is quoted as saying “During November, the sorghum would sell out in no time. The availability of a cereal in our store really provided a much-needed and affordable essential to customers. Today there is a little maize available on the market, though it is comparative-ly expensive, so most of my customers still rely on the sorghum.” Lucky 7’s three tonne orders now sell out in about two weeks. Each 10kg bag currently retails for Z$6000 (USD1.20).

The price of sorghum set by C-SAFE is determined by income, household size, and the retail price gap between maize and sorghum. When cereal prices rise, the potential for side marketing increases, so C-SAFE monitors the market activity and adjusts the sorghum price accordingly. Retailers are also permitted a 15% mark-up on the product to ensure profitability. The sorghum is an easy to sell commodity and although it is priced to move, it stays in the target market.

Profits made by the purchase of sorghum are then reinvested in the programme. Local processors, distributors and retailers are also encouraged to invest in producing the product locally, the first step towards ensuring sustainable production at the local level - which is the ultimate goal of the MAPP initiative.

MAPP has also contracted the country’s fourth largest milling operation (Induna Foods) to begin processing the sorghum meal.

Impact of the programme

MAPP has been instrumental in the resuscitation of the milling sector. By September 2003, most of the big milling companies were operating at most, one day a week, while some smaller companies were lying idle. Prior to MAPP, only one miller had experience in milling sorghum. By the end of the pilot phase, six additional millers had gained expertise in milling sorghum. MAPP was instrumental in building capacity of the millers. Retailers also reported increased sales of commodities as a result of retailing sorghum, indicating that MAPP also helped revive business in the retail sector.

The MAPP targeted more than 800,000 families in the Bulawayo area. Preliminary estimates suggest that the sorghum meal prices allowed most poor families in the target area to purchase sufficient food to feed all family members three meals per day for the six month duration of the pilot programme.

The vulnerable low-income households could easily access the sorghum meal from the retail outlets. However, retail outlets did not exclude the higher income households and targeting will continue to be a challenge, especially during periods of maize meal shortage.

Case studies

Sibusiwse Tshuma, 31, a mother of five and sorghum consumer explained that prior to the MAPP intervention in her area, her family, whose children range from 7 to 15 years of age, would consume just one meal a day. The sorghum bought from her local store has provided

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Field Article
the family with two bonus meals each day. “It is so very important to have the sorghum available to us at a good price. For us, it has become so expensive to pay for schooling, clothes and other necessities. Basic supplies are hard to find and we continue to struggle each day. The extra meals each day are improving our health and energy for my children.”

Faith Ncube has been purchasing sorghum regularly over the last six months from her local store in suburban Luveve. The 10kg bag she buys each week feeds her household of four adults and three children. She admits that she would prefer maize if she could afford it, but the family’s income will only stretch to a sorghum purchase. Faith affirms, “We use the sorghum for breakfast and lunch, which is better than six and three children. She admits that she would much prefer maize if she could afford it, but the family’s income is only enough for us to afford anything else.” The Luveve grocery store sells around 400 10kg bags a week to its urban poor customers.

The Bulawayo market is now consuming around 1000 tonnes of MAPP sorghum each month. In fact, 77% of the high-density population (460,000 people) are being fed per month by the MAPP.

Evaluation of the programme.
Following implementation for eight months, C-SAFE requested an external evaluation. Specific objectives of the evaluation were:

(i) Assess compliance to donor (USAID), Government of Zimbabwe (GOZ) and international NGO (CRS, WV and CARE) operational requirements, regulations and standards for food distribution.

(ii) Assess programme performance in accordance with programme objectives.

(iii) Make recommendations for MAPP expansion.

A team of independent consultants conducted the external evaluation from 15 April - 31 May 2004.

Data collection was in two parts

(a) The implementation of a quantitative end of project survey involving 540 randomly selected households where data collection was coordinated by C-SAFE and data analysis by the consultants.

(b) Stakeholder consultations, key informant interviews and review of project documents by the consultants.

The main lessons detailed in the evaluation may be summarized as follows:

(i) Contrary to the initial misconceptions by retailers, the urban population in Bulawayo accepted sorghum meal. This finding emphasized that sorghum was appropriate for local conditions and preferences.

(ii) Low-income households will always self select and continue purchase of sorghum meal as long as it is affordable compared to maize meal.

(iii) Sorghum meal was preferred as a breakfast cereal rather than thick porridge.

(iv) To increase the nutritive value of sorghum meal, there is scope for fortification with vitamins and essential minerals for use by HIV/AIDS patients.

(v) The rate of milling should be determined by demand. However, it is difficult to cast demand in an environment where GMB grain supplies are erratic. This pilot phase has been vital in indicating monthly trends in consumer demand for sorghum meal. This will help effective planning for the production of sorghum meal during expansion.

(vi) Extraction rates are crucial in sorghum milling. There is need to understand the determinants of extraction rates.

(vii) It took approximately nine months to clear the first consignment of sorghum. It is therefore important to note that storage costs will always be high due to the slow movement of the commodity.

(viii) Beneficiaries prefer 5kg packages as the majority of the low-income households are on weekly wages or petty trade and therefore cannot afford purchase of large quantities at a time.

(ix) Leakage and side marketing will always occur if sorghum meal prices are too low when compared to maize meal. This invariably occurs during periods of maize meal shortages.

In order to improve implementation of the intervention, the following recommendations were proposed:

(i) The format of the monthly reports should be standardized. It is critical that data presented in all reports is adequately checked for accuracy.

(ii) A Working Group made up of relevant experts from the C-SAFE consortium should be set up to regularly review the implementation of the expansion.

(iii) Stakeholder participation and support is critical to the success of the programme.

(iv) Debtors Age Analysis records should be maintained so as to monitor that agreed credit limits and periods are not exceeded by debtors.

(v) MAPP has identified millers who are capable of delivering a quality product at the required extraction rate. These millers should be given first preference to participate in expansion of the programme.

(vi) Targeting criteria should be continuously reviewed to ensure that the most vulnerable are reached.

(vii) The hyperinflationary environment will demand frequent reviews of sorghum meal prices making it impossible for MAPP to keep to the prices printed on the packages. MAPP should consider abolishing the printing of the retail price on the package but instead, insist on the display of a big banner indicating the price of the meal at the retail outlets. Consistent display of this banner would allow retailers to remain on the programme. In addition, during expansion, the programme could invest in a bi-weekly bulletin to inform beneficiaries on sorghum meal price and other related issues.

(viii) Cleaner sorghum grain should be imported from the USA. If this is not possible, the programme should consider cleaning the bulk grain before bagging to get rid of the dust and plant residue. Quality assessment tests should be conducted on each consignment. It is not essential that the sorghum be de-hulled as most of the millers have the capacity to do this.

(ix) A study to look at the sorghum extraction rates and its determinants should be commissioned.

(x) Sorghum milling has been commercialized in Botswana and South Africa. The quality of the sorghum meal should be standardized across millers. Before expansion, acceptable ‘quality parameters’ should be defined for each miller to adhere to. In addition, spot-checks on the quality of the sorghum meal should be conducted both at the miller and retail premises.

(xi) A clear strategy for bran disposal should be developed. It is strongly suggested that bran disposal should be left to the millers.

(xii) The programme targeted groups who, due to financial constraints, have problems accessing sufficient food to meet nutritional requirements. To increase the nutritive value of the sorghum meal, fortification with micronutrients, vitamins and essential minerals should be considered.

Expansion of the programme

In recognition of the MAPP’s impact and its potential to assist many more vulnerable households, USAID Food for Peace has approved a MAPP expansion to Gweru, targeting over 100,000 urban poor and an expansion to Chitungwiza, targeting 250,000 urban poor; and the continuation of the original programme in Bulawayo.

This vital expansion will support C-SAFE’s goal to improve and maintain the nutritional status of targeted vulnerable groups; increase support to households affected by HIV/AIDS; increase and maintain agricultural productivity and improve market linkages.

C-SAFE partners believe that the MAPP is a highly promising intervention with a workable exit strategy that leaves behind sustainable working relationships. It links all levels of community from consumers to small-scale traders to experienced millers and eventually aims to link with local producers of sorghum. Because sorghum is also a drought resistant crop, it’s better suited to the semi-arid climate of Matabeleland than maize. MAPP had anticipated that proceeds from the programme would be used to support initiatives that would promote local production of sorghum. Though this programme did not demonstrate any progress on this objective this will be a focus for beneficiaries in the future.

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A recent study set out to estimate trends in childhood underweight by geographic region worldwide in order to determine whether the UN Millennium Development Goals (MDGs) were on track. The MDGs aim to reduce by half the prevalence of underweight among children younger than 5 years between 1990-2015. The source of data for the study was the World Health Organisation (WHO) global database on child growth and malnutrition which includes data on approximately 31 million children under five years participating in 419 national nutrition surveys in 139 countries from 1965 through to 2002. The work was based on a time series study of prevalence of underweight, defined as: weight for age of the NCHS2 and WHO reference population. The prevalence was calculated as follows: (weight < 2 standard deviations below the mean weight for age of the NCHS2 and WHO reference population) divided by the population at risk age group. Linear mixed-effects modelling was used to estimate prevalence rates and numbers of underweight children by region in 1990 and 2015 and to calculate the changes to these values between the two years.

Worldwide, underweight prevalence was projected to decline from 26.5% in 1990 to 17.6% in 2015, a change of -34% (95% confidence interval, -43% to -25%). In developed countries, the prevalence was estimated to decrease from 1.6% to 0.9%, a change of -41% (95% CI, -92% to 34%). In developing regions, the prevalence was forecasted to decline from 30.2% to 19.3%, a change of -36% (95% CI, -45% to -26%). In Africa, the prevalence of underweight was forecasted to increase from 24% to 26.8%, a change of 12% (95% CI, 8% to 16%). In Asia, the prevalence was estimated to decrease from 35.1% to 18.5%, a change of -47% (95% CI, -58% to -34%). Worldwide, the number of underweight children was projected to decline from 163.8 million in 1990 to 113.4 million in 2015, a change of -31% (95% CI, 40% to -20%). Numbers are projected to decrease in all sub-regions except those of sub-Saharan, Eastern, Middle and Western Africa, which are expected to experience substantial increases in the number of underweight children.

A number of limitations to the study are highlighted. These include limited availability of trend data, surveys not always done randomly, variations in data quality and not accounting for uncertainty in each survey’s prevalence estimate (an estimate of variance for each prevalence was not included in the regression analysis so confidence intervals are likely to be too narrow).

The authors conclude that an overall improvement in the global situation is anticipated; however neither the world as a whole nor the developing regions, are expected to achieve the MDGs. This is largely due to the deteriorating situation in Africa where all sub-regions except northern Africa meet all estimated micronutrient and essential fatty acid requirements of infants aged < 6 months.

Feeding recommendations for infants of HIV-infected mothers in developing countries remain controversial. The World Health Organisation (WHO) recommends that “when replacement milk is acceptable, feasible, affordable, sustainable and safe, avoidance of all breast-feeding by HIV-infected mothers is recommended; otherwise, exclusive breastfeeding is recommended during the first months of life”. WHO/UNAIDS/UNICEF recommend several variations of exclusive breastfeeding and replacement milk for infants of HIV-infected mothers. The replacement milks include commercial infant formula and home-prepared modifications of evaporated milk, powdered full cream milk (PM), and fresh full cream milk (FM).

Little is known about the nutritional adequacy and feasibility of breast milk replacement options recommended by WHO/UNAIDS/UNICEF. A recent study set out to explore suitability of the 2001 feeding recommendations for infants of HIV-infected mothers in a rural region of KwaZulu Natal, South Africa. The study looked specifically at suitability with respect to adequacy of micronutrients and essential fatty acids, cost, and preparation times of replacement milks.

Nutritional adequacy, cost, and preparation time of home-prepared replacement milks containing powdered full cream milk (PM) and fresh full cream milk (FM) and different micronutrient supplements: (1) 2g UNICEF micronutrient sachet, (2) government supplement routinely available in district public health clinics, and (3) the best available liquid paediatric supplement found in local pharmacies were compared. Costs of locally available ingredients for replacement milk were used to calculate monthly costs for infants aged one, three and six months. Total monthly costs of ingredients of commercial and home-prepared replacement milks were compared with each other and the average monthly income of domestic or shop workers. Time needed to prepare one feed of replacement milk was simulated.

Nutritional adequacy: When mixed with water, sugar, and each micronutrient supplement, PM and FM provided > 50% of estimated required amounts of vitamins E and C, folate acid, iodine and selenium and < 75% for zinc and pantothenic acid. PM and FM made with UNICEF micronutrient sachets provided 30% adequate intake for niacin. FM prepared with any micronutrient supplement provided no more than 32% vitamin D. All PMs provided more than adequate amounts of vitamin D. Compared with the commercial formula, PM and FM provided 8-60% of vitamins A, E and C, folic acid, manganese, zinc, and iodine. Preparations of PM and FM provided 11% minimum recommended linoleic acid and 67% minimum recommended alpha linolenic acid per 450 ml mixture.

Cost and preparation time: It took 21-25 minutes to optimally prepare 120 ml of replacement feed from PM or commercial infant formula and 30-35 minutes for the fresh milk preparation. PM or FM cost approximately 20% of monthly income averaged over the first six months of life, commercial formula cost approximately 32%.

The main conclusions of the study were that no home prepared replacement milks in South Africa meet all estimated micronutrient and essential fatty acid requirements of infants aged < 6 months. Commercial infant formula is the only replacement milk that meets all nutritional needs. Revisions of WHO/UNAIDS/UNICEF HIV and infant feeding course replacement milk options are needed. If replacement milks are to provide total nutrition, preparations should include vegetable oils, such as soybean oil, as a source of linoleic and alpha linolenic acids and additional vitamins and minerals.
Measuring the Impact of Humanitarian Aid
Summary of published paper1

A recent HPG Briefing Paper reports on research into how the humanitarian community measures and analyses the impact of humanitarian assistance. The study is based on a review of the published and grey literature within the humanitarian sector and more broadly, interviews with aid agency staff and two commissioned papers covering impact measurement in the food and nutrition and health sectors.

The review concludes that the humanitarian system has been poor at analysing impact though promising approaches are now starting to be developed. It states that a major constraint has been the lack of an accepted definition of impact within the humanitarian sector and that the definitions current within the development field may not fully capture the particular nature of humanitarian work. In particular, the concept of positive change is central in developmental definitions of impact, but in humanitarian aid the aim is often to avert negative change (for example to prevent famine). The review also points out that analysing the impact of a humanitarian intervention is not straightforward, particularly in the dynamic and chaotic environments of complex emergencies. The difficulties of the operating environment, the need to act quickly in situations of immediate crisis, an organisational culture that values ‘getting on with the job’ and the fact that there is little consensus around the core objectives of humanitarian aid - all make analysing impact difficult. Techniques that are standard in the social science community, such as the use of control groups, are not widely used, and humanitarian practitioners tend to lack the skills needed to gather and interpret information.

Key findings of the research are as follows:

Moving beyond the project level
- Concern for the impact of humanitarian aid should not be narrowly restricted to the project level. There is a need for greater investment in research, sector and system-wide evaluations that can ask difficult and important questions about; the overall impact and coverage of the humanitarian enterprise, roles and responsibilities for humanitarian outcomes, and the broader political dimensions within which the humanitarian system operates.
- Project-based approaches that focus on determining the impact of a particular intervention through a causal pathway from inputs to impact should be complemented by approaches that start with changes in people’s lives and that situate change in the broader external environment.
- Questions of impact should not be limited to the evaluation process. In the humanitarian sphere, a concern with change in the short term implies a need for impact to be considered in ongoing monitoring processes, and through techniques such as real-time evaluation.

Measuring impact: skills, capacity and resources
- Impact in any context is difficult to measure and attribute; this difficulty is exacerbated in the dynamic and chaotic environments of complex emergencies. This does not mean, however, that it is impossible, and greater efforts could be made.
- The humanitarian system often lacks the skills and capacity to successfully measure or analyse impact. Greater investment therefore needs to be made in human resources and research and evaluation capacity if the desire to focus more on results is to be realised.

Measuring impact science and participation
- The humanitarian system has been consistently poor at ensuring the participation of affected populations. Much could be learnt from innovations in participatory approaches in the development sphere, and possibly from customer-focused approaches in the private sphere.
- There is a place for both art and science in impact measurement: scientific, analytical and participatory approaches can often be complementary.

Indicators and objectives
- Analysis and impact could be improved through greater clarity about the objectives of humanitarian assistance, and by more consistent assessment of needs.
- Process indicators can sometimes be used as proxies for impact when there is strong evidence of a link between the action being monitored and an expected impact. There is a need for greater investment in strengthening the evidence base for how activities, such as supplementary feeding or support to health clinics, relate to humanitarian outcomes such as reductions in mortality or malnutrition.

Results-based management: potential and dangers
- Results-based management systems (focused on outcomes and impact rather than outputs and activities) are being introduced in a number of humanitarian organisations. However, it is too early to say whether they will significantly improve the measurement and analysis of impact. Experience from elsewhere suggests that there will be a need for caution; in particular, measurement may remain largely focused on outputs and not impact.
- The increased focus on results which comes such systems carries a risk that the harder-to-measure aspects of humanitarian action such as protection could be neglected.

The way forward
- The study suggests that sufficient and appropriate tools and methods exist to provide reliable analysis of the impact of humanitarian aid whatever the context. It is the appropriate use and adaptation of these tools to the particular context and constraints that is lacking as a consequence of insufficient investment in skills and capacity development within the humanitarian sector. The study suggests that addressing this gap would have implications beyond the improved practice of impact assessment but would also lead to clearer objectives for aid, more robust risk and needs assessments, better research into what works and what doesn’t and greater emphasis on community participation.


Nutrition Programming in the Southern Africa Emergency
Summary of unpublished report1

A review of UNICEF and World Food Programme (WFP) nutrition programming was carried out in six southern African countries (Lesotho, Malawi, Mozambique, Swaziland, Zambia and Zimbabwe) in the context of recent emergency programming and longer-term nutritional challenges in the region. The overall goal was to enhance appropriate and effective nutrition programming by UNICEF, WFP and their partners in the southern Africa region.

Three main areas were covered:
(i) the pre-crisis nutrition context;
(ii) the emergency nutrition programming undertaken by UNICEF/WFP; both jointly and separately; and
(iii) the way forward for both agencies.

The focus was on selective feeding (therapeutic and supplementary feeding), HIV/AIDS and nutrition, prevention of maternal to child transmission of the HIV virus (PMTCT), orphans and vulnerable children (OVC), home based care (HBC), nutrition information (surveys and surveillance systems) and on partnership, capacity and resource issues.

The review arose out of an understanding that the southern Africa crisis has long-term dimensions, and that these need to be addressed through increasingly innovative approaches that are appropriate to the context.

The emergency

The emergency followed widespread crop failures and substantial shortfalls in domestic production in the 2001/2 growing season. The situation was exacerbated by a number of country-specific institutional and governance factors. Thirteen million people were reported to be facing severe food shortages and, in the absence of a more comprehensive humanitarian response, widespread famine was predicted.

A number of factors underpinned the focus on food-specific active feeding that dominated much of the UNICEF and WFP emergency response. Key amongst these was the high level of HIV/AIDS in the region in conjunction with pervasive concerns around the possibility of a ‘new variant famine’\(^2\). Furthermore, the key assessment methodology employed at the outset of the emergency was based on a food deficit model. Although subsequent vulnerability assessments and food aid distribution and household vulnerability these data were used almost exclusively to determine allocation of food aid by district. Opportunities for alternative forms of response such as cash transfers, monetisation of food aid, agricultural support programmes, water and sanitation and health care provision were therefore largely missed.

In the event, the anticipated nutrition emergency did not occur. While this may in part be attributed to the substantial food aid response, there are unanswered questions for the future regarding how significant food insecurity in the region can coexist with high levels of HIV/AIDS and low levels of wasting. The need for a more sophisticated and expanded analysis of the relationship between these factors is crucial.

There are unanswered questions for the future of significant food insecurity in the region. There is sufficient capacity to strengthen national services to address chronic malnutrition. Nonetheless, the key assessment methodology employed at the outset of the emergency was based on a food deficit model. Although subsequent vulnerability assessments and household vulnerability these data were used almost exclusively to determine allocation of food aid by district. Opportunities for alternative forms of response such as cash transfers, monetisation of food aid, agricultural support programmes, water and sanitation and health care provision were therefore largely missed.

UNICEF emergency response

UNICEF’s country plans include nutrition surveillance, nutrition guidelines for people living with HIV/AIDS, the nutrition elements of preventive HIV transmission (PMTCT), Orphans and Vulnerable Children (OVC) and home-based care (HBC) programming, the treatment of severe malnutrition and, to a lesser degree, community based or managed nutrition activities.

UNICEF’s response to the crisis varied across the region. In some countries, the on-going programme continued with expansion in some key areas. In other countries, there was a rapid scale up of national capacity to provide treatment for the anticipated increase in numbers of severely and moderately malnourished children and in filling the significant nutrition information and coordination gaps that typified the crisis. In general, these activities represented new areas of nutrition programming, placing considerable resource demands on the agency and the development of emergency nutritionists and in managing the frequently tense engagement with government nutrition departments\(^3\).

In general, given the high level of investment, the focus on selective feeding yielded very disappointing results. In particular, the level of demand and uptake of services for therapeutic feeding was lower than anticipated. In some countries, the anticipated increase in numbers of severely malnourished children and in moderately malnourished children and in filling the significant nutrition information and coordination gaps that typified the crisis. In general, these activities represented new areas of nutrition programming, placing considerable resource demands on the agency and the development of emergency nutritionists and in managing the frequently tense engagement with government nutrition departments\(^3\).

WFP emergency response

Following FAO/WFP Crop and Food Supply Assessment Missions conducted during the main harvest season in April and May 2002, the first Regional Emergency Operation (EMOP) was launched in July 2002. This appealed for assistance for over 10 million people largely through general food distributions. The second regional EMOP by contrast, was more targeted (6.5 million target group) and focused on nutritional well being and livelihood objectives. This re-focus reflects a growing shift in the organisation to diversify modes of emergency intervention and to develop more sophisticated responses. Activities included targeted food distribution and vulnerable group feeding, food for work and food for training, and food provision through nutrition and maternal and child health care facilities. HIV/AIDS programming also expanded and some new areas of programming were developed over the crisis period e.g. HIV sensitisation linked to general ration distributions. Most of WFP’s relatively new and more innovative programming, which in large part has an HIV focus, is currently small-scale. Throughout the crisis period, WFP also supported the food security and vulnerability assessments which were instrumental in geographic and temporal target-

The level of demand and uptake of services for therapeutic feeding was grossly overestimated in some countries in the region, and there was insufficient capacity to strengthen national services to address chronic malnutrition. Nonetheless, the key assessment methodology employed at the outset of the emergency was based on a food deficit model. Although subsequent vulnerability assessments and household vulnerability these data were used almost exclusively to determine allocation of food aid by district. Opportunities for alternative forms of response such as cash transfers, monetisation of food aid, agricultural support programmes, water and sanitation and health care provision were therefore largely missed.

In some countries UNICEF offices have seized the opportunity to increase the focus on integrated community based approaches to meeting the diverse needs of HIV/AIDS affected groups. This projects, though relatively small-scale, provide considerable scope for replication, dissemination of key findings and, critically, for programme expansion with WFP.

WFP faces considerable challenges in ensuring that the intended scaling up of projects either under the protracted relief and recovery operations or under country programmes allows for appropriate and more finely tuned targeting as well as integration with non-food responses to maximise the food element and to avoid stand-alone feeding programmes that have been the hallmark of specific actions for WFP feeding programmes in the past. Furthermore, evidenced based programming will be the basis on which WFP is increasingly judged. It is therefore vital that programme objectives are carefully considered, prioritised and made explicit.

1. The term ‘new variant famine’ (NVF) was coined to reflect growing concerns about the impact of HIV/AIDS on food security. The theoretical premise of NVF is that HIV/AIDS increases vulnerability to food insecurity through a number of mechanisms i.e. increasing dependency ratios, increased food aid dependency, the increasing numbers of economically active adults etc. Hence, when a shock such as drought and crop loss occurs, households are far less able to employ coping strategies. The result, according to NVF theory, is that such shocks will lead to far worse outcomes than would have occurred in the absence of HIV/AIDS. However, the NVF hypothesis is as yet unsubstantiated.

2. Tensions emanated partly from the failure of some newly recruited emergency staff to fully consult with their national counterparts and partly from a reluctance on the part of the national nutrition bodies to adopt an emergency approach and therefore neglect normal nutrition programming activities.
New Sphere Standards for Food Security, Nutrition and Food Aid

Summary of published paper

An article in Disasters examines the recent revision of the Sphere Minimum Standards in disaster response relating to Food Security, Nutrition and Food Aid.

The new standards on Food Security reflect the importance of guaranteeing key food security elements, i.e. access to adequate food through own food production or other sources of entitlement, stability of food supply and availability through local markets, nutritional adequacy, cultural acceptability and adequate quality of food assistance (see box 1).

The article also describes how the revision attempted to incorporate the principles of the Humanitarian Charter, as well as relevant human rights principles and values into the Sphere Minimum Standards. The initial aim of the revision was to ensure that the standards better reflected the principles embodied in the Humanitarian Charter. This was later broadened to ensure that key legal standards and principles from human rights and humanitarian law were considered and also incorporated, in part to fill the ‘protection gap’ within the existing standards. For example, in the food aid chapter it states “Monitoring and evaluation: at community level, random visits to households receiving food aid can help to ascertain the acceptability and usefulness of the ration, and also to identify people who meet the selection criteria but who are not receiving food aid. Such visits can also ascertain if extra food is being received and where it is coming from (e.g. as a result of commandeering, recruitment or exploitation, sexual or otherwise (p.171)”.

In relation to the food security, nutrition and food aid standards, it was agreed by participants in the revision process that the human right to adequate food and freedom from hunger should be incorporated. In relation to more general principles underlying the Humanitarian Charter, itself drawn largely from human rights and humanitarian law, it was agreed that there was a need to strengthen ‘protection’ elements within the standards and a need to incorporate the basic principles of the right to life with dignity, non-discrimination, impartiality and participation (see new food security standard 1 above), as well as to explore the relevance of the concept of the progressive realisation of the right to food.

The questions raised in linking rights to operational standards required thought, on the one hand, about whether the technical standards reflected a deep understanding of the values expressed within the legal instruments, and whether the existing standards were adequate in relation to those legal rights. On the other hand, it also required reflection on how operational standards like Sphere could give concrete content to human rights, such as the right to food and the right to be free from hunger. However, the authors acknowledge that there remain challenges in examining what a rights-based approach will mean in terms of the role of humanitarian agencies as duty-bearers of rights, given that the primary responsibility rests with state governments. It will also require reflection on the modes and mechanisms of accountability that are brought to bear in ensuring the implementation of the Minimum Standards.

The authors conclude that it will be important to evaluate how meaningful the rights basis of Sphere is to users of the hand-book and how that affects actions and decisions in the midst of humanitarian crisis.

The initial aim of the revision was to ensure that the standards better reflected the principles embodied in the Humanitarian Charter. This was later broadened to ensure that key legal standards and principles from human rights and humanitarian law were considered and also incorporated, in part to fill the ‘protection gap’ within the existing standards.

The authors acknowledge that there remain challenges in examining what a rights-based approach will mean in terms of the role of humanitarian agencies as duty-bearers of rights, given that the primary responsibility rests with state governments.

Box 1: Minimum Standards on Food Security, Nutrition and Food Aid, some examples:

**Assessment and analysis standard 1:** Food Security

Where people are at risk of food insecurity, programme decisions are based on a demonstrated understanding of how they normally access food, the impact of the disaster on current and future food security, and hence the most appropriate response.

**Food security standard 1:** General food security

People have access to adequate and appropriate food and non-food items in a manner that ensures their survival, prevents erosion of assets and upholds their dignity.

**Primary production**

Primary production mechanisms are protected and supported.

**Income generation**

Where income generation and employment are feasible livelihood strategies, people have access to appropriate income-earning opportunities, which generate fair remuneration and contribute towards food security without jeopardising the resources on which livelihoods are based.

**Access to markets**

People’s safe access to market goods and services as producers, consumers and traders is protected and promoted.

Selling rice in Bo Market, Sierra Leone.

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The aid community has reacted to many crises in the Great Lakes region with a multitude of interventions aimed explicitly at improving the food security of people affected by the conflict. A recent study under the direction and support of Save the Children UK set out to answer the following questions about these interventions:

- What responses have agencies and institutions in the region used to promote food security?
- How do these interventions compare with the constraints to food security that can be or have been identified?
- Are there any constraints which agencies have not addressed, and if so, why?
- Are there any institutional or structural factors which affect how organisations have responded to food insecurity, and what impact have these had on the quality of response?

Seven case studies were conducted. These were:

- In Burundi, the responses in 2000 to 2001 to the lengthy drought in Kirundo Province, and the forced displacement of the civilian population of Busumbire Rural Province from 1999 to 2001;
- In DRC, two urban crises - the volcanic eruption in Goma in January 2002 and the ethnic war in Bunia town in 2003, and interventions as displaced people returned home to the Masisi plateau in 1999-2005;
- In Uganda, the displacement in Kasese District from 1996 to 2000 caused by armed conflict, and the situation in Gulu District, where war with the Lord’s Resistance Army has led to the displacement of almost the entire rural population.

The case studies were chosen on the basis of representing the full range of crises and the range of interventions used in the region as well as there being good information available on people’s livelihoods and food security constraints.

Conclusions

Although it stresses that the situation is not homogeneous or entirely cash-based and that individuals take significant risks to deliver assistance to the crisis affected, the study identified a number of weaknesses in the aid effort:

- Most food security interventions failed to address needs.
- Agencies used the same narrow range of responses in nearly all circumstances. These short-term responses were repeated each year in the region’s chronic crises while longer term efforts to tackle the causes of food insecurity remained too small-scale.
- Due to various pressures agencies were unable to think through appropriateness of response. Food was given out where it was known to be plentiful and seeds were given to people who needed it.
- Seed distributions and nutrition interventions in particular were implemented widely even though they were based on a series of questionable assumptions that remained largely untested.
- Responses focused narrowly on food production.
- Food for work programmes were seldom appropriate and the relative appropriateness of food-based versus cash-based interventions was inadequately examined.
- Assessments were not done to determine the real constraints to food security and livelihoods. On a positive note, the cases showed that rapid assessment is possible even in insecure environments.
- In many cases information was already available but not used.
- Responses were often not cost-effective.
- Most actors gave a low priority to learning lessons and finding out about the impact of the interventions.

Recommendations

The study report makes a number of recommendations which many of which relate to the programme cycle.

Assessment and analysis:

- All food security interventions (with the exception of immediate responses lasting up to two or three weeks) should be based upon assessments of livelihoods. These assessments need to be made before deciding what to do.
- Analysis and programming for food security need to focus on much wider issues than merely food, and need to incorporate economic thinking. This will probably lead to a greater use of market and cash interventions.
- A longer-term analytical perspective is needed, even for relatively short-term interventions. Frameworks also need to take greater account of conflict and discrimination, including how gender and intra-household issues.
- All this requires people with the right skills and experience therefore agencies need to invest in capacity development of staff.
- Donors should be consistent in their demand or proper analysis before funding interventions.

Monitoring, evaluation and inter-agency coordination:

- Agencies should spend more time, energy and resources on monitoring, evaluation and learning as emergency responses can only evolve if lessons are learnt and institutions.
- There is also a need for a livelihoods security information system in the Great Lakes Region with clear links to an agency with a coordination mandate, like OCHA.

Programming ideas:

In addition to current responses other intervention options need to be considered and evaluated. These range from facilitating access to land, to market interventions, increasing access to labour, asset creation and retention, and support to the productive environment. New implementation modalities could be considered in view of the operational constraints in the region. Some agencies are experimenting with ‘remote access’ programming or with ‘war-proof’ projects that support livelihoods without having visible targets for attack. This work needs prioritising.

Impact and cost-effectiveness:

Agencies need wide-ranging reviews of emergency nutrition interventions (supplementary feeding, nutrition education, demonstration gardens, cooking lessons) and the distribution of seeds and tools. Given that resources are always limited, comparison of cost benefit calculations for alternative interventions should be carried out. Currently, the data from which to make cost-effectiveness comparisons is limited, and simple methods for measuring cost-effectiveness, which can be applied by multiple agencies, should be developed and adopted.

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This article describes the experiences of using an adapted household economy assessment approach in Uganda, Ethiopia, Swaziland and Mozambique. In Uganda and Ethiopia the approach was used to look at the impact of falling coffee prices on household poverty while in Mozambique and Swaziland the assessment estimated impact of HIV/AIDS on livelihoods and economic status. The main focus of the article is on the findings of the Mozambique and Swaziland assessment on impact of HIV/AIDS. This is particularly topical in the humanitarian sector as in spite of the common usage of terms such as ‘new variant famine’ and the increasingly accepted view that the HIV/AIDS pandemic is having a marked impact on food security, there is very little empirical evidence. The work described below is an almost unique snapshot of the impact of HIV/AIDS at community and household level. To some extent the findings counter the prevailing view that HIV/AIDS decimates local economies and livelihoods in high prevalence areas (Ed).

This article describes a new approach to poverty analysis and household level modelling. The method is based on the established Household Economy Approach (HEA), and has been designed to assess the effects of policy changes and other defined shocks on disposable income and living standards. Four pilot studies were carried out during 2003 in Uganda, Ethiopia, Swaziland and Mozambique by Save the Children UK (SCUK).

Fieldwork for each of the case studies was carried out by teams around 6 local staff; selection criteria included knowledge of the local language and prior experience of household level interviewing. Although the time required to cover each population varied according to the pattern of settlement and complexity of household demography, teams found that an average of around 90 household interviews could be completed over 6 a day period.

The Swaziland pilot study was carried out in a rural community in the Highvelt region, close to the South African border. In addition to standard household economy information, details of household demography were recorded covering a 5-year period. The previous employment of household members aged 21-50, who had died during this period was documented, as well as details of orphaned children who had joined the household.

For this study data collection and analysis of disposable income was conducted using the same techniques as in the Uganda and Ethiopia studies. Households were ranked according to disposable income per adult equivalent and those falling below the standard of living threshold.

A New Household Economy Method for Assessing Impact of Shocks

By Celia Petty and John Seaman

Overview of methodology: the Individual Household Economy Approach

The individual household method differs from standard HEA in three ways:

1. A random sample of individual households is used (usually obtained by village mapping/ transect walks). Standard HEA is based on analysis of households that are ‘typical’ of a defined wealth group.

2. Results are expressed in terms of household disposable income (rather than the ability of a household to acquire food, given some level of non-food expenditure). The output produced shows the impact on household living standards across the population, given a defined change.

3. Because each individual household is described (rather than the ‘typical’ household), there is the possibility of extending the data set and model to include changes within the household e.g. in the case of HIV, changes to household demographic composition.

Data collection and analysis

Villages are mapped and transect walks used to draw a representative sample of households. Information is then collected using standard methods. These include desk research, key informant interviews, focus group discussions and interviews with individual households.

The basic data set required from each household is:

- (i) Household demography, including gender and age.
- (ii) The sources and amounts of household income from each income source.
- (iii) Land and livestock holdings.

Additional extended interviews establish the local costs of food and basic items, which are used to establish a standard of living threshold.

For this study data collection and analysis of disposable income was conducted using the same techniques as in the Uganda and Ethiopia studies. Households were ranked according to disposable income per adult equivalent and those falling below the standard of living threshold.

The focus of the pilot studies was a) the household impact of falling coffee prices and b) the impact of HIV/AIDS on household economy. The effect of falling coffee prices was selected as the relationship between household poverty and internationally traded commodities is poorly understood and has attracted wider public interest. The impact of HIV/AIDS on household economy was selected as this subject presents major methodological problems (e.g. the difficulty of establishing control groups) which household economy methods are well suited to deal with. The debate around HIV/AIDS and food security also remains highly controversial. This article mainly presents the findings from the pilot studies in Mozambique and Swaziland, which examined HIV/AIDS and household economy.

It should be noted that the analysis from the case studies refers to the study sites only1.
old were identified. In the Swaziland study, which used whole village enumeration rather than a representative sample, additional information was collected on:

(i) Household demography, the presence of orphans in the household, the year in which the parent/s of orphans died and their parent/s previous employment. The presence of orphans in the household was used as a proxy for HIV/AIDS.

(ii) Employment histories of currently employed adults. This was undertaken to gain a better understanding of changes in the labour market.

(iii) Maize yields per hectare and the use of farm inputs over the past four years. These data were collected to assess returns on agricultural investments at different levels of input.

The Mozambique study was carried out in a semi-rural community, close to a district trading centre, with an HIV/AIDS prevalence of around 20%. In this study, a representative sample of households was used rather than a complete enumeration.

Presentation of the household data.

The output of the studies is presented as disposable income i.e. cash remaining to the household after basic food needs have been met. This is standardised in terms of the number of ‘adult equivalents’ in each household (i.e. gross household food energy requirement / an average adult male/ female energy requirement). A standard of living threshold was developed for each site, to identify the proportion of households with disposable income below this level. For our purposes, the cut off was based on the costs of primary education for all children in the household, and the cost of basic household and personal items required to meet minimum social norms.

Review of main findings and policy inferences

Ethiopia and Uganda: The economic impact of coffee price fluctuations

Individual HEA analysis showed that in the Ethiopia sites, the absence of alternative income sources either from agricultural or off-farm employment meant that households across the income range were extremely vulnerable to the effects of falling coffee prices. Sensitivity to coffee price changes was high (0.7%-1.5% increase in income for each 1% change in coffee price). This contrasts with low to negligible sensitivity in Uganda (see figure 1): (0.02% to 0.14% for each 1% change in coffee price).

At a macro policy level, this suggests that a change to coffee pricing that had a strong poverty impact in the Ethiopia sites would have a far weaker effect in the Uganda sites. The Uganda study showed that higher levels of wealth were only achieved by households that had access to salaried employment. Even if coffee prices were restored to pre-slam levels, coffee would not provide a reliable route out of poverty. Moreover, niche market projects (marketing high quality organic beans etc) missed the poorest households, although they did benefit households in the middle income range.

As a methodological trial, the coffee studies were conducted in non-randomly sampled villages. To quantify the relationship between coffee prices and poverty at a national level, it would be necessary to scale up to include all coffee-producers.

Figure 1: Estimated change in household disposable income from specified price and production change

Figure 2: Ratio children < 16 years age: people > 16 years

Households with orphans shown in red.

Figure 3: Ratio children < 17 years age: people > 17 years

Households with orphans shown in red.

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4 As this was the first time the method had been used to assess HIV/AIDS impacts across a community, whole village enumeration was carried out for completeness.

5 The use of orphans as a ‘best available’ proxy, and the definition of orphan (loss of one or both parents) are discussed in the case study documents.

6 17 years was chosen as the cut off, as it is the age at which young people in the study communities are likely to become economically active.
Households in the Mozambique site and 23% in HIV/AIDS affected and non-affected) remained income from salaried, off farm employment. Further analysis of the characteristics of the poorest households in the two sites showed that there was no single ‘cause’ of poverty.

In the Mozambique site, although widows headed a disproportionate number of the poorest households, we were not able to ascertain on the available information, whether these households were poor before the husband died. A number of in-depth interviews with widows suggested that wealthier households had been able to diversify their income (e.g. profitable trading activities) on the death of a salaried male. Households that did not have the skills or capital to diversify remained poor.

In Swaziland, of the poorest 23 households (those falling below the standard of living threshold), 5 had suffered a ‘catastrophic’ fall in income as a result of adult deaths over the past 5 years. HIV/AIDS was not the ‘cause’ of the households who had suffered an AIDS death, or were supporting orphans from outside the community.

To explore changes in the wider economic context, we looked at the effects of the recent withdrawal of farm input subsidies in Swaziland and Mozambique on household economy. The study findings provide information that is directly relevant to policy and programming decisions, where the aim is to strengthen household economy and resilience to shocks. These include:


The research provides a measure of the distribution of poverty in the study communities and casts doubt over the feasibility of deriving ‘simple’ HIV/AIDS related poverty indicators. This has implications for the design of social protection and welfare policies, as well as wider macro economic policy debates. For example, if only orphans were identified as eligible for free primary education, or if only poor orphans were considered, the poor but not orphans would be excluded and some better off children included.

2. Asset protection and income generation

Individual HEA analysis provides a quantita- tive account of how a local economy works, a measure of potential demand and an objective assessment of productive capacities at household level. By providing realistic estimates of returns on investment for different enterprise alternatives, the approach could be incorporated in the design of micro credit and other economic interventions.

3. Targeting welfare and other forms of direct assistance.

HEA methods provide a basis for identifying, costing and targeting safety nets and other interventions at a community level. In rural contexts, these might range from ‘one off’ grants or loans to assist restocking or pay for agricultural inputs, to waiving of service fees and longer term social welfare support.

A key inference from the HIV/AIDS studies is the importance of work at community level. Given the varied circumstances that face the poorest households, household specific needs must be identified and connected to relevant services or resources. Interventions, such as targeted food aid, distributed through school feeding projects, mother and child health (MCH), and community based orphan support programmes have been widely canvassed as a means of miti- gating the effects of HIV/AIDS (e.g. FAQ 2003). However, the view here is that the poorest households, which have lost labour and cash income through HIV/AIDS, could best be assisted by this mechanism, is not wholly supported by either study. There would be some scope for food distribution to selected poor households.

Conclusions

Better empirical data on the characteristics of the poorest households raises the prospect of a more effective set of responses. This can assist in selecting poor pro interventions, identifying typologies of households and targeting resources accordingly, as indicated in the pilot study results. At a more general level, it is clear that action in response to problems that emerge from the studies requires coordination and collabora- tion between a range of national and local government departments, major funding agencies and local and international NGOs.

By providing analysis based on representative samples of individual households, individual HEA methods allow decision makers to model the potential impact on living standards of different policy alternatives and ultimately, to measure actual impact against objectives.

Scaling up to larger populations and areas

The four pilot studies were all small scale. This may be appropriate for some applications (e.g. NGO project work). Other questions, e.g. monitoring the impact of coffee price changes or interventions to increase the value of coffee production, may be appropriate for some applications (e.g. NGO project work). Other questions, e.g. monitoring the impact of coffee price changes or interven- tions to increase the value of coffee produc- tion other field research techniques routinely covered in many social science degrees.

As in the coffee studies, the wealthiest house- holds in both communities derived most of their income from salaried, off farm employment.

At both sites the majority of households (both HIV/AIDS affected and non-affected) remained above the standard of living threshold (9% of households in the Mozambique site and 23% in

The Household Economy Approach (Seaman J et al, SCF 2000)

Refugee Numbers Decline

The global number of refugees fell by 18% to 17.1 million in 2003 - the smallest number in a decade, according to Ruud Lubbers the United Nations High Commissioner for Refugees, who announced the new data just before World Refugee day on June 20th. The decline can be attributed to several factors including increased international efforts to find solutions for uprooted people. There has also been an unprecedented level of voluntary repatriation during the past 2 years. Some 3.5 million displaced people returned to their countries last year, mostly Afghans from Pakistan and Iran.

From a published paper: Bosch X. Refugee numbers down as more people return home. The Lancet 2004; 363:2148 (26 June)

For further information see; The LANCET, vol 363, June 26th, 2004, pp 2148

World Health Organisation Admits Targets on AIDS Drugs May be Unrealistic

In its World Health report 2004, the World Health Organisation (WHO) said that AIDS was the leading single cause of death among adults aged 15-59 around the world and that in 2003, three million people died of AIDS related diseases and five million became infected with HIV.

WHO said funds were sufficient to cover the $5.5 billion needed to achieve its stated goal of getting antiretroviral drugs to three million people with HIV in poor countries by the end of 2005 (the three by five target) but admitted it still had a long way to go. By the end of 2004 WHO will have achieved only 25% of the ‘three by five’ target. “The stakes are high: rapid expansion of antiretroviral treatment is a large, complex and difficult undertaking” said WHO’s director general, Dr Lee Jong-wook, in an introduction to the report which calls for an unprecedented level of international coordination. “It certainly cannot be done by one agency working on its own. Partnerships are indispensable for a task of this magnitude” said Dr Lee, who is staking his reputation on achieving what he admitted may be an unrealistic goal.

Since antiretroviral treatment was introduced in Europe and North America in the 1990s, death rates from AIDS related diseases have dropped by 80%. In contrast AIDS death rates elsewhere and particularly in southern Africa have shot up. In South Africa and Botswana, the AIDS epidemic has nearly halved life expectancy over the past decade from about 60 years to 35 years. One in 12 Africans have HIV infection and as many as nine out of 10 people do not know they are infected.

The report states that expanding antiretroviral treatment would cost $35 to $40 per capita. Once that was done, more people would volunteer to test for HIV.

The trends in HIV prevalence among pregnant women attending the same antenatal clinics since 1997 show that the epidemics in the countries of southern Africa are much larger than elsewhere in sub-Saharan Africa and that the gaps seem to be widening. In eastern Africa there is evidence of a modest decline. “In western Africa prevalence is now roughly one-fifth of that in southern Africa and no rapid growth is occurring. These striking differences are supported by data from population based surveys and research studies” the report says.

For further information see; Fleck, F (2004): WHO admits its target on AIDS drugs may be unrealistic. BMJ, volume 328, 15th May, News, pp 1151

The report can be accessed at www.who.int/whr/2004

1. That a nutritionally appropriate food basket is formulated to meet local needs and that it is coordinated and arrives on time, not one commodity one month and another the next. Some food commodities are needed in small amounts, for example iodized salt and fortified blended foods, but their inclusion and delivery are often critical to positive nutrition outcomes. The importance of micronutrients in achieving the goals of emergency operations is increasingly understood and there is evidence of the need for greater use of fortified foods than in the past.

2. Coupling food with essential non-food inputs is important in nutrition programming. WFP requires cash resources for a variety of nutrition and public health activities, including local milling / fortification of cereals, local procurement of fortified blended foods and support for complementary activities such as nutrition education, training and de-worming. An ability to offer sustained improvements in nutrition will therefore depend on strong collaboration with partners skilled in nutrition and public health and information management.

3. Improved linking of emergency programming with non-emergency activities is required so that underlying processes contributing to malnutrition can be effectively tackled in the long run.

For further information contact; Rita Bhatia at Rita.Bhatia@WFPORG
Core Group of agencies and experts have been working together for a number of years to develop a training manual on infant feeding for emergency field workers. Infant feeding issues have gradually come to light over the past decade as more young infants presented at therapeutic feeding centers and more emergencies occurred in "bottle feeding cultures".

The 'Core Group' started to engage around the need to properly train emergency field workers on appropriate infant feeding and continued in a spirit of inter-sectoral collaboration to produce a set of comprehensive training materials on the subject.

A meeting in Oxford in July 2004 hosted by the ENN (at its new home) was the latest in a series. Its main objectives were to agree and finalise the production of Module 2 of the training manual, to explore appropriate dissemination and awareness raising about the training materials, and to initiate strategic thinking beyond development of materials for capacity-building.

On the third day of the meeting ACF presented a description of its infant feeding program in Afghanistan, outlining practices, experiences and difficulties managing severely malnourished infants less than six months, and lactation difficulties in this age-group. This included nutritional, psychosocial and environmental influences and perspectives.

It was proposed and agreed that ENN could, in addition to its technical input, provide an 'institutional home' for the Code Group coordination.

Agreed short term priorities for the Core Group were:
- Making the finalized Module 2 available on the web
- Dissemination and awareness raising among agencies working in nutrition in emergencies
- Orientation workshop for major INGOs
- Field testing of the module in collaboration and as a part of the CARE project on Infant Feeding in Emergencies
- Development of a plan for rolling out training

Module 2 is the second in a series of training material developed for emergency field workers. Module 2 is to be treated as a living document which will be updated and changed according to feedback and emerging evidence. The Core Group responsible for the development of the module are keen to receive feedback on the use of the module, particularly from field workers. Send any comments to office@ennonline.net.

Target audience

For Module 1, the target is all emergency relief workers, including those involved in site management, or responsible for technical tasks such as water, sanitation, and supplies. These people are important in establishing conditions for adequate infant feeding, but may be only indirectly concerned with the care of mothers/caregivers and infants.

For Module 2, the target is health and nutrition workers who are directly concerned with the care of mothers/caregivers and infants. It provides specific practical knowledge about how to help individual mothers and other caregivers with infant feeding.

Module 2 should be used after trainees have studied Module 1.

Each Module consists of:
- A Manual to be given to each participant.
- Overhead Figures, for use as transparencies or a flip chart.
- Presenter’s Notes (in Module 1).

The Manuals include small copies of all the overhead figures, to make private study easier.

Those studying Module 2 should already have studied Module 1, and should have its Manual available for reference. Module 1 can be rapidly presented in one hour, although it is recommended to allow two or three hours, for a more interactive approach. The Presenter’s Notes for Module 1 give plans for one-, two- and three-hour use.

Module 2 consists of five Core Parts, which can be covered in five hours of group teaching. Additional Parts give more details on specialised topics.

Each Additional Part can be studied or taught separately. If they are all included with the Core Parts in group teaching, the entire session would take a full day.

Module 1 trainers pack complete with participant’s manuals is available from the Emergency Nutrition Network, Unit 13 Standingford House, Cave Street, Oxford OX4 1BA, UK (post and packaging charges apply).

Module 1 and Module 2 are both available free for download from www.ennonline.net.
On the 28th of July 2004 Médecins Sans Frontières (MSF) announced the closure of all medical programmes in Afghanistan. The decision was taken in the aftermath of the killing of five MSF aid workers in a deliberate attack on June 2nd, when a clearly marked MSF vehicle was ambushed in the North-western province of Badghis.

Although government officials presented MSF with credible evidence that local commanders conducted the attack, they have neither detained nor publicly called for their arrest. MSF have declared in a press statement that the lack of government response to the killings represents a failure of responsibility and an inadequate commitment to the safety of aid workers on its soil.

Following the assassinations, a Taliban spokesperson claimed responsibility for the murders and stated that organisations like MSF who work for American interests, are targets and would be at risk of further attacks. MSF argue that not only is this accusation false but it is particularly galling given MSF’s commitment to separate aid from political agendas.

MSF has continued to provide health care throughout difficult periods of Afghanistan’s history over the past 24 years, regardless of the political party or military group in power.

The MSF press statement declared that “The violence directed against humanitarian aid workers has come in a context in which the US backed coalition has consistently sought to use humanitarian aid to build support for its military and political ambitions. MSF denounces the coalition’s attempts to co-opt humanitarian aid and use it to win hearts and minds”. Only recently, on May 12th 2004, MSF publicly condemned the distribution of leaflets by the coalition forces in southern Afghanistan in which the population was informed that providing information about the Taliban and al Qaeda was necessary if they wanted the delivery of aid to continue.

Until the assassinations, MSF provided health care in 13 provinces with 80 international volunteers and 1,400 Afghan staff. Projects included the provision of basic and hospital level health care as well as tuberculosis treatment and programmes to reduce maternal mortality. In the weeks following the statement, MSF intend to complete the hand over of its programmes to the Ministry of Health and other organizations.

The statement concludes by stating that “As MSF leaves Afghanistan, we mourn the loss of our five colleagues. At the same time MSF takes this decision with great sadness for the people we will fail to assist.”

Further information is available at: http://www.msf.org
Dear Field Exchange

A need for quality control, consistency and diligence for articles published in Field Exchange

As an experienced practitioner and trainer in refugee public health nutrition, I have enjoyed reading the various nutrition-related articles published in this newsletter. There is no doubt that “Field Exchange” has become a reference for both expatriate and field staff with and without a background in nutrition in terms of planning, implementing and evaluating food and nutrition programs. However, over the last four years I have realized that the quality of published articles is highly variable. Therefore took a content analysis of articles and pictures published in this newsletter from issue 13 through to issue 21. The following are my findings:

Inconsistent and inaccurate definition of “global acute malnutrition”: The article by Regine Kopplow, Field Exchange 2003, Issue 20 page 22-26 is an appropriate example.

• In this article, the classification of moderate malnutrition by MUAC was “≥110 ≥124mm” and “≥185 ≥220 mm” in chil
dren and women respectively. The correct cut-off points that should have been used by international
definition of moderate malnutrition are: MUAC “≥110 ≤124 mm” for children and “≥185 ≤220 mm” for women.

• The BMI has been expressed as % rather than “kg/m²”.

• The global acute malnutrition prevalence as defined by W/H and BMI did not include unilateral
oedema (usually the cut-off point for global acute malnutri
tion was presented as W/H <80% and/or oedema in children or BMI <18.5 kg/m² (vary by
NGOs) and/or oedema in adults). This was to include the
prevalence of oedematous malnutrition underestimates
global and severe acute malnu-
trition. This problem was also evident in articles by

• Children and women referred for weight and height measure
ment were those with a MUAC “≥124 mm” and “≥220 mm” respec-
tively. These were children and women with normal anthropo-
metric measurement. Hence, the reported global acute malnu-
trition rates in children and wom-
en should be questioned. It has been customary to refer children with a MUAC <135 mm (and not ≥124 mm as suggested by the
article) for weight and height
measurement in order to compute W/H index.

• In the article, under the heading “targeting” paragraph 3, it is
stated: “all households with at least one per-
son fulfilling MUAC criteria (women £220mm and
children £ 124mm) were issued with a ‘MUAC screening
card’. What do £220 mm and 124 mm mean? If this was a typographic mistake, why was the same error repeated through our article under the headings “ MUAC screening”, “Weight for Height”, and “Body Mass Index”? Similarly, under the heading “nutrition and food security”, of the same article, it is my view that “In 5% of female
measured had a MUAC <215 mm, indicating chronic severe malnutrition”. What does chronic severe malnutrition mean?

In an article by Grabosch, E (2002, Issue 17 p20), figure 1 depicts a categorisation of severe malnutri-
tion. It classifies acute malnutrition into three
categories: 1) complicated malnutrition, 2) sev-
er unclassified malnutrition and 3) moderate unclassified malnutrition. Criteria for complicated malnutrition are W/H <80% or bilateral pitting oedema or MUAC<110 mm and one of the following: anorexia, LRTI, high fever, severe dehydratation, severe anemia and
not alert. Criteria for severe unclassified mal-
nutrition are W/H <70 or bilateral pitting oed-
ema or MUAC<110mm plus appetite, clinical-
ally well and alert. The confusion is over what the term “complicated malnutrition” means. It is not clear why W/H <80% was taken to be
equivalent of MUAC<110mm (and not MUAC 125mm). In other words, if this new classifica-
tion held then we would otherwise not be recorded or shared with
the ENN. We are also only too aware that agencies
which accentuate ‘Eurocentrism’. Mr Renzaho also questions whether we obtain permission
for not obtaining more articles from local staff
or at least acknowledging the contribution of
local staff and for using photographic images which accentuate ‘Eurocentrism’. Mr Renzaho also questions whether we obtain permission
from each person whose photograph is used. In
our defence we would like to say that we encourage authorship from local staff as much as possible and that our partner agency nutri-
tionists attempt to support local staff in writing
articles. There have been many notable success-
s. However, where this is not possible it seems
prudent to still record the experience through international agency staff authorship rather than lose the experience entirely. If local staff
have not been involved in writing a piece then attribution cannot take place. However, it is in
our view a little unfair to jump from this to an
accusation that international agency staff are perpetuating the “exploitative nature” and “neo-colonial attitude ingrained in humanitarian
assistance programmes”. The ENN are in fact
attempting to increase the participation of southern based individuals/agencies. We have
recently submitted two proposals for funding
specifically to strengthen our capacity to target
southern based agencies (ministries, local
NGOs and church groups), with information about
the ENN and Field Exchange, Finally, a
editor is levelled at Field Exchange regarding
photographs. Most photographs are provided by
government agencies. Clearly, we cannot ask permis-
sion to publish these photos from the subject.
Where Field Exchange staff take photos (this
only happens occasionally) we of course as a
matter of policy ask the subject for their permis-
sion to publish the photograph. We are well
aware of the ethical issues associated with the
need to avoid representing subjects as passive victims.
We are also only too aware that agencies
(including World Vision) struggle with the very
real conflict of representing reality while not
wishing to perpetuate ingrained Eurocentrict
views. We do our best to steer a middle ground.

We would like to thank Mr Renzaho for his
vigilance in scrutinising our publication in order
that typographical errors or misleading
statements (where these exist) can be highlighted.

Editor
This article discusses the problem of accurately estimating the target population for the planning of emergency nutrition programmes and presents a tool developed by Save the Children UK aimed at improving the process. The problem of not finding the predicted number of malnourished children when you start a nutrition programme is widely reported. This can often be because programme coverage is poor and outreach systems are weak, because the response is late and malnutrition rates have spontaneously improved or because the target population was overestimated in the first place. This latter problem will be dealt with in this article, drawing on the experience of Save the Children UK’s emergency nutrition programmes in Darfur, Sudan (2002) and Gola Oda, Ethiopia (2003).

The accuracy of the estimate of target population size has a knock-on effect on the size of the budget requested in the proposal, the design of the programme (to maximise coverage and speed of operations) the capacity put in place at each distribution point or feeding centre and the morale of staff as they seek to reach all those eligible for the programme.

Estimating the target population in Darfur, Sudan

When Save the Children UK developed proposals for emergency feeding in Darfur, Sudan in 2002, it estimated that the drought-affected population living in the eight rural councils was 476,195 people. The number of direct beneficiaries of the project was estimated to be 43,724 people of whom there were 32,528 moderately malnourished children, 6,434 severely malnourished children and 4,762 pregnant or lactating women. The proposal was written to cover eight rural councils but due to funding constraints was reduced to the five worst affected. The figures for the numbers of malnourished children for the programme were calculated as follows:

The total population in each rural council was multiplied by 17% to obtain the number of children under five years. The number of children under five years was then multiplied by the percentage of children found to be moderately and severely malnourished in the survey: the figure was different for each rural council because separate surveys were done for each (see Table 1). This number was then doubled as it was anticipated that the project would last for 4 months and would therefore be able to admit two rounds of children in the time it was open. The inbuilt assumptions were that the rate at which children were becoming malnourished would not change, that the proportion of malnourished children at the start of the programme would all be admitted and that admissions would continue throughout the programme as more children became malnourished.

Problems with the method of estimation

There were however certain problems with the calculation of numbers of malnourished people resulting in over-estimations of the numbers of beneficiaries expected in both programmes.

Table 1: Prevalence of malnutrition in surveys conducted in April / May 2002

<table>
<thead>
<tr>
<th>Food Economy Zone</th>
<th>Goz</th>
<th>Pastoral</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rural Council</td>
<td>Fasher</td>
<td>Mellit</td>
</tr>
<tr>
<td>Prevalence of global malnutrition (&lt;-2 z-score and/or œdema)</td>
<td>35 (31.6-38.4)</td>
<td>25.4 (22.3-28.5)</td>
</tr>
<tr>
<td>Prevalence of severe malnutrition (&lt;-3 z-score and/or œdema)</td>
<td>6.2 (4.5-7.9)</td>
<td>2.5 (1.1-3.1)</td>
</tr>
</tbody>
</table>

Table 2: Predicted beneficiaries and Actual beneficiaries of the Gola Oda nutrition programme 2003

<table>
<thead>
<tr>
<th></th>
<th>Predicted numbers</th>
<th>Actual numbers</th>
<th>As a percentage of predicted numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drought-affected population of the district</td>
<td>115,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Direct beneficiaries of the project</td>
<td>6233</td>
<td>2935</td>
<td>47%</td>
</tr>
<tr>
<td>Moderately malnourished children</td>
<td>4,600</td>
<td>2390</td>
<td>52%</td>
</tr>
<tr>
<td>Severely malnourished children</td>
<td>460</td>
<td>232</td>
<td>50%</td>
</tr>
<tr>
<td>Pregnant or lactating malnourished women</td>
<td>1173</td>
<td>313</td>
<td>27%</td>
</tr>
</tbody>
</table>
The multiplier (17%) used for children under five includes children <6 months which the programme did not admit (except in very small numbers into the hospital). Weight for height z score was used in the surveys to estimate the number of malnourished children while children were actually admitted into the programme using weight for height percent of the median. The latter measure leads to lower rates while the former measure is routinely used for survey reporting.

It was assumed that the rate of malnutrition would remain constant (at the rates recorded in the April surveys) thereby justifying a doubling of the number of beneficiaries through the life of the programme. The anthropometric surveys in November (1 month after programme start) showed a significant reduction in the levels of malnutrition compared to those found pre-programme.

By the end of November (2.5 months into programme implementation) the programme had only reached 368 severely malnourished children, 5590 moderately malnourished children and 3310 pregnant and lactating women.

Lesser degrees of over-estimation were found in Ethiopia where a recent evaluation of Save the Children’s emergency nutrition response in Gola Oda showed (Table 2) that only about half of those predicted to be in need of the programme were actually reached even though the programme coverage was estimated by coverage survey to be 80%.

Getting a more accurate estimate

Based on the problems identified in these two evaluations Save the Children has developed a spreadsheet to help programme staff to more accurately estimate the size of the target population for proposals and for planning programme design.

In order to make this calculation the following parameters are needed:

- Size of the population
- Proportion of the population aged < 5 years and > 6 months (aged 6-59 months)
- Prevalence of moderate and severe malnutrition in percentage of the median.
- Coverage expected. The level of coverage which can realistically be achieved will vary according to the context. The Sphere handbook states that, for the standards on malnutrition to be addressed, the coverage of supplementary and therapeutic feeding programmes should be more than 50% in rural areas, more than 70% in urban areas and more than 90% in a camp situation. (The Sphere Project, 2004).

The spreadsheet shown on right presents example data for a total population of 300,000 with 24% moderate malnutrition and 4% severe malnutrition. The expected coverage is 80% for supplementary feeding and 60% for therapeutic feeding because the supplementary feeding programme will have, in this example, a larger number of distribution points. The spreadsheet indicates that the estimated size of the target population is 8640 for targeted supplementary feeding (with a range of 7920-9360) and a target population of 1080 for therapeutic feeding (with a range of 840-1620).

Limitations of the spreadsheet

The spreadsheet does not take into account the incidence of malnutrition i.e. the number of new cases of malnutrition which appear after the start of the programme. The estimated target population calculated only includes those identified as malnourished on the day of the anthropometric survey (the prevalence). It does not take into account any new cases of malnutrition which may develop during the programme implementation. The incidence of malnutrition will depend largely on the extent to which the emergency response prevents new cases from occurring as well as the expected duration of the emergency, e.g. when a new harvest is expected. For example, incidence is likely to be much lower if measures are in place to prevent infection from occurring (e.g. water and sanitation) and to address household food insecurity (such as a general ration, livestock interventions, cash etc).

In the current version the spreadsheet does not make an adjustment for programmes which rely on fraud, e.g. when a new harvest is expected. For example, if a programme relied on community workers to visit house to house and refer children below a certain MUAC cut-off - some of those children eligible for the programme would be automatically excluded thereby affecting the coverage which can ultimately be achieved. This is because MUAC and weight for height do not identify the same children as malnourished. The spreadsheet could be easily adjusted to take this into account.

In addition the spreadsheet relies heavily on the accuracy of the estimates of total population and prevalence of malnutrition. Population estimates are often notoriously inaccurate and often have to be validated in the field through door counts, re-registration etc. Migration complicates this problem further and if the population is mobile or people are being continually displaced, any estimates of the target population will be subject to change.

The accuracy of the prevalence of malnutrition equally relies on a representative sample having been taken over an area where the prevalence of malnutrition is believed to be generally uniform. Standard methodologies should be applied to ensure the prevalence of malnutrition is reliable for programme planning (for example see Save the Children UK, 2004, Emergency nutrition assessment: guidelines for field workers. In press).

For further details or a copy of the freely available spreadsheet contact Anna Taylor, email: a.taylor@savethechildren.org.uk

References:
Save the Children UK 2004, Emergency Nutrition Assessment: guidelines for field workers
Since 2002, Agago County in Pader district, Northern Uganda, has been at the centre of the ‘world’s biggest forgotten emergency’. In 2002 the Ugandan Government’s attempt to extinguish the Lord’s Resistance Army, ‘Operation Iron Fist’, precipitated the return of rebel forces into Ugandan territory from Sudan and a wave of killing and displacement that had not subsided by the middle of 2004. As a result, the people of Agago County have suffered two years of intensive, continuous terror and displacement at the hands of rebel forces. Humanitarian needs are immense. The World Food Programme has warned it will soon be unable to cope with the escalating food needs of the displaced population in Northern Uganda, which now numbers at least 1.6 million. Another 200,000 refugees have also been affected by the conflict. OCHA estimates that there are 279,256 people displaced within Pader District.

Nutrition Survey Findings

GOAL has carried out two nutritional and household surveys in the past 12 months (Table 1) and is about to implement a third assessment in the coming weeks.

In the six month period between the August 2003 and February 2004 surveys there was a dramatic decrease, from 83.1% to 19.3%, in the number of households relying on their own crop production as a main food source, while the percentage of households utilizing the market as the primary source of food increased from 13.7% to 71.6%. These trends were reflected in an increase in the market prices of millet, sorghum and beans. The predominant underlying factor behind these findings was the high level of insecurity acting to discourage agricultural production. In excess of 70% of households interviewed by GOAL were registered to receive WFP food rations.

Other key factors adversely affecting nutritional status were found to be poor environment, water, sanitation and public health facilities. The GOAL surveys found that just 17.4% of children over 9 months of age had evidence of any vaccination coverage, almost 30% of households used unprotected water sources, and over 27% of children were weaned onto solid foods inappropriately. Child Mortality Rates in Under 5 year olds were found to be at the threshold of emergency levels (2.1/10,000/day in August 2003, increasing to 2.8/10,000/day in February 2004). These survey findings prompted GOAL to undertake a number of measures in order to meet humanitarian needs.

GOAL’s support for Supplementary Feeding Programmes (SFPs) and Therapeutic Feeding Centres (TFCs) in Agago County

In June 2002 GOAL had begun activities within Agago County, providing support to the nutrition unit (TFC and SFP) at the Mission Hospital in Kalongo (the urban centre of Agago County), managed by the Comboni Fathers. This support increased in July 2003 with additional funding from OFDA, and GOAL began to work with the Directorate of District Health Services (DDHS). In May 2004 GOAL also undertook to help set up and monitor SFP activities in six outlying village locations in Agago County.

The six satellite Supplementary Feeding Centres (SFCs) were opened in response to the difficulties reported by mothers travelling with their malnourished children to Kalongo each week. Food is now taken to where the need is, and the mothers do not need to use unsafe roads. The SFCs are all run from existing DDHS health centres in towns, villages and IDP camps under military protection. All SFCs are operational over two days every second week, distributing a two week supplementary ration to beneficiaries.

The TFC operates over 24 hours despite limited human resources. The programme functions with three trained nurses and additional staffing provided predominantly by unqualified personnel.

Table 1: Malnutrition prevalence from nutrition surveys in Kalongo town in August 2003 and February 2004

<table>
<thead>
<tr>
<th></th>
<th>August 2003</th>
<th>February 2004</th>
</tr>
</thead>
<tbody>
<tr>
<td>Global Acute Malnutrition (GAM)</td>
<td>11.6% (8.6 - 14.3)</td>
<td>4.7% (3.5 - 6.4)</td>
</tr>
<tr>
<td>Severe Acute Malnutrition (SAM)</td>
<td>2.9% (1.6 - 4.2)</td>
<td>0.7% (0.3 - 1.5)</td>
</tr>
</tbody>
</table>

1 UN Emergency Relief Coordinator, Jan Egeland, 10 November 2003.
nurse aides. The ratio of staff to patients during the harvest period (November - May) is approximately 1:10. However this ratio can increase to 1:1 during the hunger gap period, and the number of TFC admissions increases and problems with recruitment exacerbate the problem of poor staff to patient ratios. Education and health infrastructures throughout Uganda have been significantly paralyzed as a direct consequence of the conflict. Appropriately qualified staff are therefore in short supply, and agencies experience chronic difficulties in locating and ‘coaching’ appropriate staff back into the conflict-affected area.

Data available from Kalongo TFC and SFP records reflect the dramatic upsurge in population displacement and food insecurity as a result of insecurity and the consequent disruption of planting and harvesting activities. Programme admissions numbers are therefore also high in the SFC and by 14% in the TFC between 2002 and 2003.

The harvest period for the north of Uganda runs from July/August to November/December with a three month ‘hunger gap’ between May and July. Admission trends so far for 2004 indicate that the food security and nutritional situation in Kalongo is currently (May 2004) treating the highest number of beneficiaries so far recorded (155 in May 2004), almost three times higher than the numbers for May last year. TFC numbers give a similar picture, with 59 beneficiaries in May 2004, double the number treated in May 2003.

These trends are somewhat reinforced by the bi-annual surveys carried out by GOAL in Kalongo town (Table 1). The first of these was carried out in August of 2003 and the second in February of 2004. Not surprisingly, the GAM and SAM were both worse in 2003 at the end of the hunger period, with GAM at 11.6% (95% CI: 8.6% - 14.3%) and SAM at 2.9% (95% CI: 1.6% - 4.2%), as opposed to the end of the harvest period in February 2004 where GAM was 4.2% (95% CI: 3.5-6.4%) and SAM was 0.7% (95% CI: 0.3-1.5%).

In addition, as a result of continued sporadic terrorizing activities of rebel factions in the area, planting and harvesting practices have reduced significantly over the last 18 months to two years. GOAL therefore anticipates an extension of the hunger period in 2004 due to limited crop yields with programme beneficiary numbers to remain significantly over the last 18 months to two years.

In contrast, current defaulter rates from the TFC are well within accepted levels, indicating that the feeding programmes are valued, trusted and well accepted and that people are willing to bring their children for nutritional and medical treatment when it is necessary.

The six satellite SFP centres were established as a means of increasing accessibility to more families in Agago County as well as reducing defaulter rates. GOAL has also tried to create an incentive for parents to continue to bring vulnerable children to the programme by providing non-food items to all attendees at various stages throughout treatment and upon successful discharge from the programme.

Whether this strategy will have a significant impact remains to be seen. As the situation worsens it is likely that the population will become more needy and defaulter rates may therefore improve automatically. Recent studies carried out by GOAL staff investigating defaulter rates indicated that the main reason for programme defaulting is insecurity. Other explanations included conflicting demands on time - such as families attempting to maintain land and crops, forgetting the appointment, losing their card or an illness within the family. The majority of Kalongo-based women have two households to manage, a daytime residence as well as a nocturnal temporary residence in a more secure location which also needs to be maintained. This unique phenomenon of daily household displacement before dark impedes family routine and restricts their ability to engage in agricultural and income generating activities.

In contrast, current defaulter rates from the TFC are well within accepted levels, indicating that the feeding programmes are valued, trusted and well accepted and that people are willing to bring their children for nutritional and medical treatment when it is necessary.

The Future?

The current political and security dynamics do not suggest that there is likely to be an improvement in the nutritional and food security situation in the county in the near future. GOAL anticipates that it will be engaged in nutritional support programmes throughout Agago County as long as needs exist and security and donor resources allow. The sight of abandoned farm plots from the air tells a chilling story regarding Northern Uganda - there is a war and Ugandans are losing. The organization of teams, the crying and screaming of children suspended from Salter scales and stretched along height boards, the paper chain of surveys and data entries and the tapping of nutritionist’s computers in quest of Z-scores and global malnutrition rates will be justifiably here for some time to come. Agago County is a textbook example of war and its effects on civilian populations. The impact of this crisis on nutritional status continues to unfold, presenting GOAL with new challenges. Our greatest challenge is to compliment nutritional activities with provision of adequate shelter, water, sanitation and health - otherwise, our impact will be insignificant, and we owe more than that to the people of Agago County.

For further details, contact Monica Corish at: mcorish@goal.ie

Child with Marasmus in Kalongo, Pader.

Child with naso-gastric tube in feeding centre.

Mother and children in feeding centre.
Summary of an evaluation by Save the Children UK and Tulane University reviewing their experiences of utilising the Community Managed Targeting Distribution (CMTD) approach in Southern Africa.

CMTD approach to food aid targeting in three countries; Tanzania (1998-99, in Singida and Dodoma regions), Zimbabwe (2001-3, in Binga, Kariba and Zvumba districts) and Malawi (2002-3, in Salima and Mchinji Districts). CMTD is an approach designed to enhance community participation in, and leadership of, the distribution process. It is based upon the principle that beneficiary communities themselves are best placed both to identify and target the most vulnerable or crisis-affected households in their communities, as well as to undertake and manage the distribution process itself.

The three country settings varied considerably. The Tanzania programme was designed to protect livelihoods in populations facing repeated adverse seasons; the Malawi programme aimed to prevent deterioration due to a rapidly worsening food security crisis; and the Zimbabwe programme aimed to prevent deterioration in a similar agricultural context to Malawi, but compounded with a highly complex political, agricultural and economic climate. The CMTD approach was adapted to each context giving rise to significant differences in 1) the targeting guidelines developed for project staff to follow; 2) the issues that arose; 3) the targeting procedures actually followed in the field, and 4) success of the programmes as defined by various types of monitoring data.

The author of the evaluation undertook a comprehensive review of reports related to these programmes, both those written by SC UK and those written by external evaluation consultants. Key informant interviews were also held with SC UK programme staff for each of the country programmes. Gaps in the monitoring data were identified and highlighted in the evaluation report. There were five major conclusions from the evaluation. These were as follows:

i) Due largely to contextual factors (political, social, cultural), Tanzania and Malawi were best able to achieve true community managed targeting and distribution. In contrast, the Zimbabwe programme diverged from the original CMTD protocols in the face of a very complex and challenging political environment. In this case the control of food resources was (and continues to be) highly politicised and decision-making responsibilities more centralised in the hands of local authorities. This required SC UK Zimbabwe to develop innovative mechanisms for promoting accountability of decision makers to beneficiaries.

ii) While CMTD requires less agency staff involvement during the distribution process itself than traditional agency-run distribution programmes, the initial sensitisation of government leaders and targeted communities can be quite time-consuming. The process involves village level public meetings at the outset to ensure full community participation. It also involves establishing partnerships with central, district and local leaders and the transfer of responsibility from formal leaders to community members or community-based committees.

iii) Considerable effort was invested in establishing a detailed Household Economy Assessment (HEA)-based needs assessment as a foundation for developing appropriate target criteria. However beneficiary communities diverged from these criteria to some degree according to local perceptions of need. In Zimbabwe, for example, 70-81% of households were under-registered. There were also many reports of insufficient food supply relative to need leading to a degree of community support for redistribution. Redistribution of food aid from targeted poor households to those who are better off was also believed by some to promote long-term food security of the community, given the vital role of the better off in supporting the poor. In addition many of those who were appropriately targeted shared their food with others. In Tanzania, over 15% of the food was consumed by individuals considered to be outside of the household.

iv) While circumstances are appropriate for the implementation of CMTD, it should be considered due to its relative success (such as in Tanzania) and the potential long-term community benefits of local programme management and participatory decision-making. CMTD will be most feasible where the agency has a long term presence in the target community and the programme is directed towards livelihood support rather than prevention of mortality in an acute emergency.

v) Additional field-level research should be conducted on how CMTD might be implemented more quickly, given the clear benefits of community managed targeting in the era of HIV/AIDS and the urgency of finding means of targeting HIV/AIDS affected households. Increasingly, implementing agencies report that targeting households with AIDS-related vulnerability is difficult in the field. CMTD allows communities to target such vulnerable households without requiring outside agencies to seek documentation of beneficiaries' HIV status. Communities themselves are best placed to identify those in need of assistance, and CMTD allows communities to identify and target the chronically ill without the administrative, stigmatising burden of identifying PLWHA explicitly.

For further information, contact Anna Taylor, email: a.taylor@savethechildren.org.uk

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1 Community Managed Targeting and Distribution of Food Aid: A review of experiences of SC UK in southern Africa by Ellen Mathys. December 2003
The ENN interviewed Steve Collins, co-founder of VALID in a coffee bar near Farringdon in the City of London. Steve established VALID with Alistair Hallam in March 1999. They originally met while working on the multi-donor Rwanda evaluation in 1995. Their first encounter involved an argument over agency responses in the Great Lakes region with Steve assuming Alistair to be ‘a desk-bound pen-pusher’ and Alistair seeing Steve as one of the “loud mouthed done it once before so I’m an expert brigade”. The frank exchange of views seemed to sow the seeds of a friendship. Both ended up sharing a flat and working together on a number of evaluation consultancies and setting up humanitarian operations together. During this period Steve and Alistair talked a lot about their frustration with the lack of humanitarian agency learning, the poor evidence base for practice as well as the generally low level of professionalism amongst humanitarian agency staff. These discussions led to the idea of setting up an agency which would primarily aim to strengthen the evidence base for practice, support professional development and also allow them to follow through projects working as partners with agencies (‘unlike consultancies where project reports are often left to gather dust’).

Incredibly, Alistair signed up for medical school in 1998 and continued his studies to qualification while co-directing and managing the work of VALID. Steve remembers Alistair’s agonising over whether to go to medical school – in fact the only time he remembered beating Alistair at tennis was when Alistair was totally preoccupied on the final day for sending in the application form for medical school.

VALID ticked along for a year or so with Steve and Alistair doing a number of consultancies/evaluations in the humanitarian sphere. Initially the focus of Valid work was evaluation and they performed a number of evaluations including the DEC evaluations of the response to the floods in Mozambique, the DEC evaluation of humanitarian response in the Balkans (jointly with ODI), and more recently the evaluation of the DEC agencies response in Southern Africa. The Community based Therapeutic Care (CTC) work for which VALID is most renown began in Ethiopia in 2000 when after the regional government in Wolayta forbade agencies from setting up TFC, VALID worked with Concern and Oxfam to set up community based programs to treat severe malnutrition. Steve took the findings from Ethiopia, which were generally positive regarding CTC, to the annual SCN meeting in Nairobi arguing that this was the future of treatment for severe malnutrition. Some agencies bought into this while others were either ambivalent or downright hostile. Steve recognises that going in with all guns blazing (as was his style at the time) may not have been the best approach and probably set back the cause for a while. Soon however, Concern Worldwide agreed to fund the development of CTC for three years working with Valid in a
number of countries to test and develop the model. Several experts were assembled, e.g. Andrew Tomkins from ICH, Jeya Henry from Brookes, Johan Pottier from SOAS and Mark Myatt from UCL. These individuals provided high level technical support in the design phase of CTC projects. Additional staff were taken on with VALID helping a number of agencies to implement these programmes, e.g. SC UK in Darfur and the DRC, Tear Fund in South Sudan. The funding from Concern allowed VALID to pursue a coherent and well structured research program aimed at systematically developing a strong multi-discipline evidence base for CTC. CTC is now being adopted by many agencies while donor interest and support has spiralled. In Steve’s words, ‘we have changed a lot with CTC and I don’t think I’m just bigging it up because it was VALID that did it’.

Steve plans to extend the CTC model to deliver other types of services, i.e. health care. VALID are now moving into the HIV/AIDS arena. With the strong linkages between health, malnutrition and HIV, Steve argues that CTC provides the perfect entry point for interventions to address HIV/AIDS. CTC is in many ways analogous to Home Based Care (HBC). However, external agency support to HBC runs the risk of undermining the community ethos, while the CTC experience shows that by starting off treating acute malnutrition CTC interventions gives agencies a non-stigmatizing entry point that gives them time and space to build confidence in the approach at community level whilst gradually expanding to complement informal support networks rather than usurp them. Another planned development for CTC that relates to HIV is the use of pro-biotics and micronutrients supplementation in RUTF. Pro-biotics can be delivered in RUTF and have a marked impact on diarrhoea - the lacto-bacilli remain dormant until delivery. Furthermore, recent research shows how vitamin B, C and E supplementation can delay the development of stage four HIV from stage 3 by up to 30%. RUTF can therefore provide treatment for diarrhoea and essential additional macro and micronutrients for those suffering from HIV/AIDS.

Perhaps inevitably, the interview turned to a discussion about agency institutional issues. Steve mused on his opinion of INGOs towards whom he sometimes has an ambivalent attitude. Mostly, he admires the generosity of spirit behind NGOs and their desire to effect positive change for the disadvantaged. However, at times, he is disturbed by their appetite for profile and positive PR to facilitate fund raising. He worries that this requirement for positive spin erodes the ability of agencies to be truthful and can lead to overly defensive behaviour and resulting inability to be transparent about mistakes. This obviously translates into failure to learn. He feels that VALID have a culture where owning up to mistakes and activities which have not worked out has allowed much learning. Steve explained how VALID is legally a company with share-holders and does not have fund raisers. Instead, funding comes from contracts with donors or INGOs and means that Valid has to be really efficient in terms of it’s income and expenditures as ultimately money is raised on the basis of results not profile. VALID has to be really efficient in terms of it’s income and expenditures as ultimately money is raised on the basis of results not profile. VALID are not a charity so cannot guarantee income by appealing and acquiring expertise. Many are producing publications and some are enrolling on Phds.

Steve says that he dislikes too formal a structure/organisation and hopes to keep the ‘vibe’ of VALID fairly informal. As he quipped, there haven’t been any resignations as yet. He wants VALID to grow but not to become a monolith. At the same time he sees the potential for more experienced staff to ‘bud off’ and form groups which they manage more autonomously. There is no question that VALID has a unique institutional culture - probably a reflection of the individuals responsible for setting it up. There is also no question that VALID has made a unique and valued contribution to the humanitarian sector through its work on CTC.
IFE Core group meeting  
Held in Oxford 19th-21st July

Suzi Villeneuve (unicef), Sultana Khanum (WHO).
Mary Corbett, Gabrielle Palmer.
Marie Mc Grath

Felicity Savage, Suzi Villeneuve (UNICEF).
Fiona OReilly and Rebecca Norton (TdH), field testing the infant feeding training manual.

Ann Burgess and Marie Mc Grath (ENN).
Mary lungaho and Fathia Abdalla (UNHCR).
People in Aid

**WFP/UNICEF**
Regional workshop on HIV/Nutrition programming held in Johannesburg on 30th June and 1st July.

Fiona Watson and Carmel Dolan

Magdalena Moshi WFP Lesotho, Augustino Munyiri UNICEF Lesotho, and Dr Rumishael Shoo UNICEF Regional Health Adviser

Break in presentations at WFP/UNICEF meeting in Johannesburg

Mutinta Hambayi from WFP ODJ and Abdirahman Meygag WFP Namibia

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

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

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

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

The ENN would like to correct an attribution in the last issue of Field Exchange made with regard to the summary of ongoing research entitled “Taking forward research on adult malnutrition” (page 11 in issue 22). The attribution should have been for both Dr Jane Knight and Laura Wyness.

The ENN would like to correct the caption for the first picture in the ‘People in Aid’ section on page 29 of Field Exchange issue 22. This first team photo is in fact of the Tearfund team in southern Sudan and not the Concern Team.

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The Team

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

Rupert Gill is ENN administrator and project co-ordinator, based in Oxford.

Dan George is the ENN finance assistant, working part-time in Oxford.

The Emergency Nutrition Network is a company limited by guarantee and not having a share capital. Registered in England and Wales number: 4889844
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