

Field Exchange

Emergency Nutrition Network

Special focus on urban food security & nutrition



Contents.....

Field Articles

- 4 Impact of urban livelihood intervention post Haiti earthquake
- 7 Addressing urban food security through electronic cash transfer in Kenya
- 10 Cash voucher programme and rabbit raising intervention in Gaza
- 13 **Postscript**
Dealing with urban emergency: lessons from Oxfam's EFSL activities in three cities
- 15 Aquaponics in Gaza
- 38 Debunking urban myths: access & coverage of SAM-treatment programmes in urban contexts
- 40 Use of cash vouchers in tropical storm emergency response in the Philippines
- 55 Spotting the invisible crisis: early warning indicators in urban slums of Nairobi, Kenya
- 59 Nutrition security emergency programming in diverse urban contexts
- 68 Early results from urban SAM treatment programme in Chad
- 69 The roll out of IMAM in Kenya's urban slums

Research

- 17 Causal modelling to explore malnutrition in children in Bangladeshi urban slums
- 19 Considerations regarding coverage standards for selective feeding programmes
- 21 Understanding access to nutritious food by poor urban pregnant women and lactating mothers and their children in Kisumu, Kenya
- 24 Severe malnutrition in children presenting to health facilities in an urban slum in Bangladesh
- 25 Gatekeepers in Mogadishu
- 27 Review of urban gardens programme for HIV-affected women and children
- 28 Review of food security and nutrition amongst urban poor
- 30 Review of urban food security targeting methodology and emergency triggers
- 33 British Red Cross urban learning scoping study
- 35 Global survey of the implementation of UNHCR's Policy on Refugee Protection and Solutions in Urban Areas
- 37 Malnutrition research in urban Africa: issues and opportunities

News

- 43 Coverage Monitoring Network Profile
- 44 Profiling methodology for displaced people in urban areas
- 44 Nutrition Exchange flyer - pass it on
- 44 Tools to support cash transfer programmes
- 45 IASC strategy on meeting humanitarian challenges in urban areas
- 45 World Disasters Report: Urban risk
- 45 The Food Security and Livelihoods in Urban Settings Working Group
- 45 Food for Cities discussion forum
- 46 Children in an urban world
- 47 Ensuring Access to Health Care: Operational Guidance on Refugee Protection and Solutions in Urban Areas
- 47 ALNAP review of lesson learned from responding to urban disasters
- 47 ALNAP urban resources
- 47 ACF guide to identification of vulnerable people in urban environments
- 48 Syria: an 'urban' humanitarian crisis
- 48 Urban refugees debate forum
- 49 UNHCR operational guidance for promoting livelihoods and self-reliance for urban refugees
- 49 Time to Think Urban.....Kenya

Views

- 50 Nutrition and the urban consumer
- 52 Why do we still have refugee camps?
- 54 **Postscript**

Evaluation

- 62 Impact evaluation of cash, food vouchers, and food transfers among Colombian refugees and poor Ecuadorians in urban Ecuador
- 65 Evaluation of post 2007 election violence recovery programme in Kenya
- 67 Donor lessons on linking emergency and development funding in urban programming

Agency Profile

- 72 Norwegian Refugee Council



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From the Editor.....

This Field Exchange special issue on Urban Food Security and Nutrition aims to provide some insights into the learning and experience of a broad range of agencies, and highlight some of the remaining gaps in knowledge and areas for research and development. This special edition focuses on programmes responding to rapid and slow onset natural disasters and displacement. The research, evaluations, news and views have been carefully selected to showcase the type of work that is being developed, but it is not a comprehensive body of work; rather a snapshot of current thinking and practice. In a couple of editions time, ENN will produce a special Syria edition, elaborated in a news piece on page 48, which will deal with refugee urban populations and host communities caught up in crisis.

As of 2008, the majority of the world's population lives in urban areas*. By 2030, over 60% of the world's population will live and work in urban environments. The speed and scale of urbanisation today are far greater than ever in the past, overstressing governments and the international community's capacities. This implies overwhelming new challenges for cities in poorer countries; they will need to build new urban infrastructure – houses, power, water, sanitation, roads, commercial and productive facilities – more rapidly than cities anywhere before. The bulk of urban population growth is likely to be in smaller towns and cities, which lack the political capital, capacities and resources to cope with rapid urbanisation.

Sub-Saharan Africa is the world's fastest urbanising region and has the highest proportion of slum** dwellers (72% of its urban population). Asia is the region that will host the highest number of new urban dwellers, rising from 1.36 billion to 2.64 billion by 2030. In Latin America and the Caribbean, rapid urbanisation started in the 1960's and it is now the most urbanised region in the world, with 78% of its population living in urban areas¹.

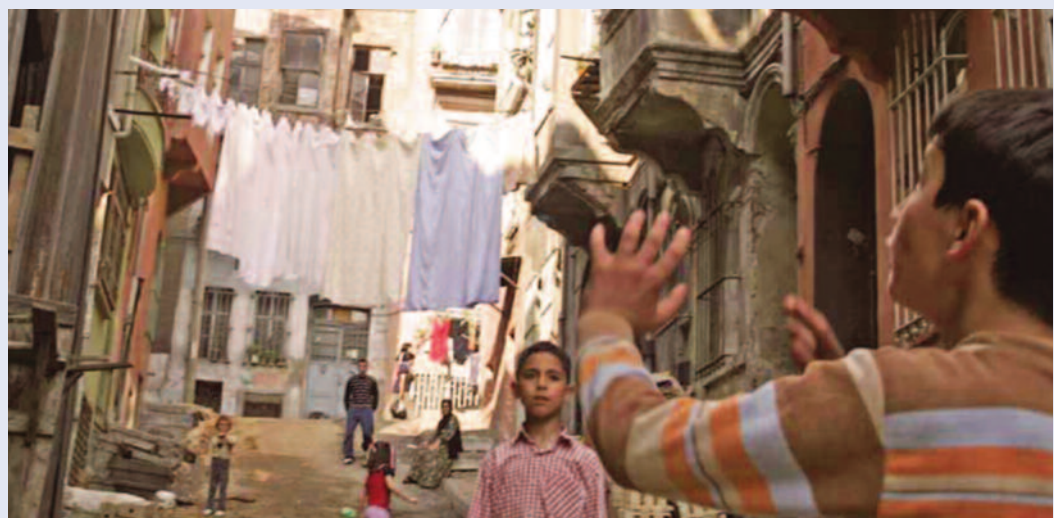
Urban poverty and vulnerability are concentrated in slums. One billion people already live in slums (15% of the total of the world's population of 7 billion); by 2030, this number will double. The United Nations Millennium Declaration articulates the commitment to improve the lives of at least 100 million slum dwellers by the year 2020 – Target 11 of Goal No 7.

As population and poverty urbanises, so do disaster risks and humanitarian crises. The global assessment report on disaster risk reduction identifies urbanisation as one of the three key drivers of future disaster risk². Whereas rapid and uncontrolled urbanisation is constructing escalating risks, the number and vulnerability of at-risk populations are also rising. Haiti's earthquake has demonstrated that urban disasters' scale and complexity defy humanitarian actors, with their accumulated experience in rural areas, to renovate their strategies and tools.

This growth is in the context of a global economic downturn, sustained food price rises and reoccurring complex emergencies. Urban food insecurity and malnutrition are rarely monitored or captured by early warning systems, and data is not disaggregated at the level of urban slums. Although urban food security and nutrition programmes are emerging, they are struggling to raise their profile and strategically engage donors.

Urban emergencies over the last 10 years have included:

- conflict in Syria and Mogadishu



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- earthquakes in Gujarat, Bam and Port au Prince
- floods in Manila, Dhaka and Sindh
- organised urban gang crime in Guatemala city, Honduras and El Salvador
- massive IDP and refugee influxes in Beirut, Amman, Bamako due to conflict, and in Nairobi and Addis due to the indirect effect of climate change and drought
- political unrest in Harare and Gaza
- landslides in La Paz and Guatemala city

In the coming years, there are both rapid and slow onset urban emergencies predicted, including an earthquake that will affect the Kathmandu valley and beyond, and a burgeoning slum population across Sub-Saharan Africa.

However, cities are also engines of growth and loci of social, cultural and political dynamics that can leverage rural, national and global level change – as demonstrated by the democratisation movements during the Arab Spring in 2011, in Africa in the 1990's or in Latin American in the 1980's. Cities are economic and cultural magnets for migrants in search of economic opportunities or freedom from oppressive social or gender norms. Cities are the markets where food consumption, distribution and processing patterns set the rules for food producers. Cities are the first contributors to, and potential first victims of, climate change and environmental depredation.

Many international non-governmental organisations (INGOs) have been running small scale urban programmes over the last 10 years, but approaches, skills, learning, policy and funding is in its infancy compared to the rural programmes where there is experience and learning from the last 70 years. There have been the assumptions that markets are integrated, labour opportunities are widely available, urban spaces enable access and there is availability of food and health care. This may be the case for some urban dwellers, but as urban slums grow (they make up around 60% of Nairobi as described in the field articles from Kenya in this edition), and population densities rise (around a million people live in 1 square mile in cities like Mumbai and Manila), there are vulnerable households that cannot meet their immediate needs and as a result become acutely food insecure and malnourished. The Save the Children/NutritionWorks (2012) review of food security and nutrition in the urban poor is reviewed in this edition and further discusses these issues (page 28).

Challenges

There have been a large number of papers written on the challenges of urban programming and how it differs from rural programming in its complexity.

However, there are very few guidelines that translate the challenges into adapted approaches to urban programme and policy. What is clear is that we must adapt rural approaches to differing urban contexts, understanding that 'communities' do not exist in the same way as in rural areas, that there are multiple stakeholders and that we cannot hope to scale up to meet the needs of the whole city. Therefore, we need to invest more in strengthening partners and states capacity to respond, to work hand in hand with development actors, utilising skills that humanitarian agencies do not typically possess such as power analysis and governance skills, as well as strengthening our risk analysis and disaster preparedness to ensure that we can best organise our meagre resources over large and complex spaces. These issues are touched upon in a 2012 review by ALNAP of lessons learned from urban emergencies, summarised in this issue (page 47).

Preparedness

Although preparedness is not a recognised strength of humanitarian agencies, it is essential in working alongside communities to build resilience and ensure a division of resources, labour and prioritisation for vulnerable urban communities. Good risk analysis should include a full power analysis and will provide the opportunity to link humanitarian and development programming in a 'one programme approaches' that reduce silos and ensures more effective programming. The complexities of power relations in urban settings can be immense, a great insight is provided in an article about 'gatekeepers' to aid in Mogadishu by the Somalia Cash Consortium (page 25). Few organisations have urban strategies, but where they do exist (e.g. Oxfam GB 2012) there is generally agreement that there should be a governance framework for interventions with a strong focus on working with the state rather than direct service provision.

Slow onset & triggers

Although humanitarian imperatives dictate that humanitarian responses reflect need, this has not been the case for slow onset or hidden urban emergencies. Rapid onset urban emergencies normally receive good media coverage and funding, but urban contexts affected by food price rises, an influx of refugees or internally displaced people (IDPs), or where there is a subtlety changing political or conflict situation, have seen little or no urban specific funding.

¹ UNFPA. State of world population. Unleashing the potential of urban growth, 2007.

<http://www.unfpa.org/swp/2007/english/introduction.html>

² UNISDR, 2011

Current early warning systems or national data often does not capture the vulnerability and seasonality of changing food insecurity and malnutrition in slums, and this lack of data makes it difficult to demonstrate humanitarian need. The nature of slums means that they are often not formally recognised by Governments, as doing so would require the state to provide services, infrastructure and safe habitats. So capturing this data will be both political and also require a change in triggers or cut-offs applied in rural areas. For example, a global acute malnutrition (GAM) rate of 8% in a slum may not exceed the threshold for emergency response, but due to the population concentration, may mean that there is the same number of malnourished children as in a rural area. These issues are further discussed in a review of urban food security targeting methodology and emergency triggers (Oxford Policy Management (OPM), Oxfam GB, Concern International, ACF International) on page 30.

Assessments and analysis

Although ACF have developed guidelines for the assessment of sustainable livelihoods and urban vulnerabilities (summarised in this issue), they have not been widely utilised by the international community. Analysis is severely hampered by the lack of disaggregated data for food security and nutritional indices, although where data does exist it is clear that there are some urban slums where vulnerability is as bad as or worse than rural areas within the same countries. The Food Security Cluster Urban Working Group is reviewing tools and guidelines and working to coordinate different agency approaches, but in the meantime there is no consensus on assessment approaches or triggers for analysis and this urgently needs addressing. An article by Concern Worldwide and the African Population and Health Research Centre (APHRC) Kenya shares the findings of operational research in Kenya to identify indicators that can help detect the 'tipping point' from chronic need to crisis in vulnerable urban populations. Their experience demonstrates how unpredictable and heterogeneous urban populations are. This work has been undertaken as part of the Indicator Development for Surveillance of Urban Emergencies (IDSUE) project, a five year research study funded by the USAID Office of U.S Foreign Disaster Assistance (OFDA).

Targeting

Evaluations have shown that community based targeting, which is commonly used in rural areas, has a high exclusion error when used in urban areas, as outlined by the Oxfam evaluation from Nairobi, Gaza and Port au Prince PAGE 30 This is for a number of reasons including the lack of homogeneity, high population concentrations, multiple stakeholders, and distances within cities is further complicated by criminal gangs, corrupt bureaucracy and business people, and groups that do not wish to be identified such as IDPs and refugees. Initial work by ACF, Concern and Oxfam has explored other approaches to targeting in urban contexts (page 30). This is another area that needs urgent attention and consensus to ensure a multi-agency approach can be reached.

Interventions

From urban interventions, analysis and programme evaluations over the last 10 years, it is clear that cash transfers are very effective means of meeting immediate needs in urban contexts where everything from access to toilets, water, rent, transport, electricity, education and health needs to be purchased (Oxfam evaluation, page X). For example, vulnerable households in Nairobi will spend up to 85% on food, water and energy purchases, leaving little for rental, health, sanitation and education. Cash transfers can be effective vehicles for piloting social protection models alongside Governments and enabling this modelling to influence policy and provision of social protection

to a broader group of urban poor. This has been done in the Oxfam Nairobi programme in urban settlements, shared in a field article (see page X). Urban evaluations show that regular cash transfers not only improve food security but also boost social capital and can empower women during cash transfer programmes to play a more active financial role within the household. This shift in the gender dynamic can be maintained if the programme incorporates strategies to do so.

Nutrition and food security

The main determinants of food, livelihood and nutrition security are the same for urban and rural areas. However, there is a wide variation in the factors that affect these determinants. For example, urban households are more dependent on food purchase, which, if they have sufficient purchasing power, can lead to a more varied diet and higher reliance on 'ready-made' and fast foods, compared to rural households. Food access has a direct impact on dietary diversity and has been seriously affected by rising food and fuel prices, conflict, and the primary or secondary effect of natural disasters in urban areas across the globe.

Poor female-headed urban households or those with high dependency ratios tend to have a dietary diversity equal to that of the rural poor, however existing tools for analysis, such as food consumption scores, tend to be misleading in urban areas where diets may appear diverse, but quantities of dairy products or meat consumed might be negligible. As the urban poor tend to be dependent on income from precarious informal sector jobs that rarely meets their consumption needs, they are more likely to employ risky coping mechanisms, including high levels of debt. Women are more likely than men to have less secure and irregular jobs that are not subject to labour laws and do not offer social or medical benefits. This affects breastfeeding, infant feeding and child care practices, especially for those without family support who must adapt their work patterns or use poor quality childcare. A gender aware perspective is reflected in a research article by the Royal Tropical Institute (Netherlands) and the Bondo University College (BUC) that describes a study to profile the causes of undernutrition in a Kenyan urban slum (Kisumu) identifying needs and strategies to improve child nutrition from women's perspective especially.

Over-crowding, poor water and sanitation, pollution, open sewerage and contamination are commonplace in informal settlements and slums. They have a significant impact on child and household health. Where urban data has been disaggregated by wealth group or studies have focused on the urban poor, high rates of undernutrition (both acute and chronic malnutrition) have been recorded for children under 5 years of age, which are comparable with or higher than the rates in rural under 5 year olds. Data that exists for urban poor women reveals high rates of undernutrition combined with rising levels of overweight or obesity in some cases, reflecting the 'double burden of malnutrition' (this is reflected in the Save the Children/NutritionWorks review cited earlier that includes a summary case study from Bangladesh). Rising to the challenge, the increased volume of humanitarian programmes in urban settings has been met by innovative and varied programming in many diverse contexts from cash and voucher programmes in Haiti, Democratic Republic of Congo (DRC) and the Philippines (reflected in articles by ACF) to rooftop gardening and aquaponics in Gaza (shared by FAO) to rabbit rearing in Gaza (Oxfam programming).

Malnutrition – wasting and stunting – is a daily reality of impoverished urban populations. This is often a 'hidden' problem, as reflected in an article by

ALIMA on their early experiences of an urban programme in Chad that has been inundated with admissions for treatment of malnutrition (page 68). Routine screening for stunting as well as wasting is one recommendation from MSF emerging from research in an urban slum in Bangladesh (page 24). Rollout of integrated management of acute malnutrition in urban contexts is increasingly a priority for governments, such as in Kenya (see the news piece by UNICEF, Ministry of Health Kenya and Concern), and reflected in service expansion (as reflected in an article by Concern Worldwide). An article by the Coverage Monitoring Network 'debunks' some of the myths that surround access and coverage of severe acute malnutrition treatment in urban contexts, while a research piece by Ernest Guevarra, Saul Guerrero and Mark Myatt explores considerations around coverage standards for selective feeding programmes. These all point to the significant caseload of malnutrition in urban settlements and slums that often remains below the 'emergency' radar.

Donors

Currently donors are primarily funding rapid onset short term urban responses, but are reluctant to engage in slow onset crisis as they feel that urban vulnerability is primarily chronic. The large donors are yet to develop urban funding strategies and although there is interest in this area, progress is slow. This is another key area for focus, as without clear consensus on what constitutes an urban emergency and what the exit strategy will be, then urban interventions will continue to be patchy and disconnected. An interesting article in this edition shares experiences from a donor perspective (Swedish International Development Cooperation Agency (SIDA)), through an evaluation by Development Initiatives of a SIDA funded emergency programme in Kenya. One of the key lessons was the need to link humanitarian funding to extend the gains of emergency projects.

Urban programmes require a much greater focus on political literacy, power analysis, negotiation skills, security analysis and management, land policies, informal tenure, urban planning, knowledge of urban markets, private sector engagement, and use of information communication technology, social media and mass communication, than is typically the case in rural humanitarian responses. Donors and the international community will be required to work very closely together to ensure that the additional skills required for urban programme and policy are captured.

Laura Phelps, Guest Editor,
Formerly Oxfam GB, now Norwegian Refugee Council

*** Urban areas:** *There is no internationally agreed definition for urban. Urban areas range from small towns to megacities, and are typically characterised by:*

- *Administrative criteria such as a threshold population size (2,000 to 50,000 people)*
- *High population density*
- *Economic function: the majority of inhabitants are not dependent on agriculture*
- *Concentrations of infrastructure, basic services and economic assets (paved streets, lighting, transport).*
- *Heterogeneous and mobile populations, fragmented social networks.*
- *Complex governance systems with a multiplicity of actors.*

****Slums:** *UN-Habitat defines a slum household as one that lacks one or more of the following:*

- *Access to improved water*
- *Access to improved sanitation*
- *Security of tenure*
- *Durability of housing*
- *Sufficient living area*

Cash for work helped to clear rubble and support public health initiatives

Impact of urban livelihood intervention post Haiti earthquake

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This article draws heavily on an Oxfam case study¹ written by Philippa Young and Emily Henderson and edited by Laura Phelps and Carol Brady, from Oxfam GB. More programme details have been added in this article by the authors, with thanks to Gabriel Tobias and Laura Phelps, Oxfam GB for their help in the process.

This article describes the nature and short term impact of activities by Oxfam to aid economic and livelihood recovery in the immediate aftermath of the Haiti earthquake in 2010.

On 12 January 2010, an earthquake measuring 7.0 on the Richter scale struck Haiti. Approximately 3.5 million people resided in areas directly affected by the earthquake, which led to the death of 220,000 people. As a consequence, 1.5 million people were initially displaced internally in the metropolitan and rural areas. The earthquake also resulted in substantial food insecurity and loss of livelihoods in an already desperately poor country with limited availability of basic services and precarious income earning potential of its poorest citizens.

Assessments and impact of earthquake

Several assessments were carried out in the immediate aftermath of the earthquake. A rapid Emergency Food Security and Livelihoods (EFSL) assessment was conducted by Oxfam in February 2010 using the Household Economy Approach (HEA)¹. The focus group discussions (FGDs) involved were conducted in each quartier of Carrefour Feuilles in Port-au-Prince (PaP) to determine the differences between the wealth groups and to define vulnerability criteria, access to food, access to income, and other food security indicators. FGD participants were also asked what EFSL interventions would help households from the various wealth groups; activities such as community canteens and support for tradesmen were repeatedly requested.

An interagency Emergency Markets Mapping and Analysis (EMMA)³ assessment was also conducted in February 2010. The EMMA assessment was conducted by various organisations (including Oxfam) over a two-week period. The study focused on the four markets of rice, beans, construction labour and corrugated iron. It found that there was a breakdown in the market chain, particularly around storage, security and access to formal and informal credit. Small retailers and middlemen were the badly affected part of the supply chain with loss of their productive assets. The results of the construction labour survey element showed that there was a shortage of skilled labour in Haiti. Furthermore, many of the skilled labourers had lost their equipment in the earthquake so local availability of skilled labour would not be sufficient to address the reconstruction demand. Overall, the EMMA demonstrated that the markets were functioning well and that cash could be used as a modality for vulnerable households to access their basic needs which resulted in wide-scale cash transfer programmes across multiple agencies.

An Emergency Food Security Assessment (EFSA) was conducted between February and March 2010 and coordinated by the CNSA (Coordination Nationale de la Sécurité Alimentaire). It concluded that the earthquake antagonised the high levels of food insecurity observed prior to the earthquake, increasing the number of food insecure to about 1,281,127 people with 638,118 in PaP, Delmas and Carrefour. This represented 52% of the population, of whom 31% were dependant on food aid or other social support. The remaining 21% were managing to meet their food needs through

copied strategies, such as reducing the number of meals and selling off assets. Households with a poor or borderline food consumption increased from 17% to 30% after the earthquake and female-headed household and single parent households, irrespective of their gender, were more vulnerable.

Information on the impact of the earthquake on chronic poverty and coping strategies was largely anecdotal. Poverty was seen to worsen, with people taking out loans just to eat. In Croix des Bouquets, Oxfam staff observed that women were taking on sex work to feed their families. Poverty levels were estimated at 30-50% in PaP and up to 80% in Carrefour.

Wealth groups and income

Prior to the earthquake the very poor comprised 30% of the population of the bidonvilles (shanty towns), and typically had an income of 9,500 to 12,500 gourdes/month. The poor comprised 35% of the bidonville population and had an income of 12,500 to 17,500 gourdes/month. The middle comprised 25% of the bidonville population and had an income of 17,500 to 25,000 gourdes/month. The very poor had no productive assets, whereas the poor typically had a bicycle or wheelbarrow, and the middle group had a bicycle or motorcycle.

It was generally understood that there were six basic income sources for most households in the bidonvilles of PaP. These were:

- Street hawking: Very poor and poor groups
- Casual labour: Very poor, poor and middle groups
- Salaried employment: Middle and better off groups
- Petty trade/small business: Very poor, poor and middle groups
- Larger businesses: Better off
- Remittances: All groups

Following the earthquake, fewer differences were seen between these wealth groups and all were seriously affected. The poorest groups lost assets and daily labour opportunities. Small businesses were damaged and were affected by lack of customer purchasing power. Oxfam's challenge was to respond in a way that benefited the most vulnerable while attempting to also build opportunities for economic recovery through a holistic market based approach, in an environment where extreme poverty and lack of livelihoods opportunities had been the norm even prior to the earthquake.

Oxfam programmatic activities

The absence of strong governance in Haiti has led to the birth and development of a vibrant yet largely un-empowered civil society base in PaP. Oxfam had a long history of working with several partners and community based organisations

¹ For a link to the original case study: <http://www.alnap.org/resource/6999.aspx>

² A guide to the HEA approach is available at: http://www.savethechildren.org.uk/sites/default/files/images/HEA_Guide.pdf

³ Guide to EMMA and resources at: <http://emmatoolkit.org/HaitiEMMAlink>: http://emmatoolkit.org/wp-content/uploads/EMMA_Haiti_Case_Study_forweb.pdf

(CBOs) in PaP before the earthquake and sought to build on these relationships in the immediate aftermath of the earthquake in order to forge a sense of harmony and community led programming, to build capacity of partner organisations and to ensure stronger transparency and accountability of Oxfam and partner programming to all stakeholders. It also became very clear that in order to have successful programmes, partners and local CBOs were absolutely critical in order to help Oxfam determine the most vulnerable households and also to help maintain harmony in such a complex and potentially volatile environment.

Based on the various assessments following the earthquake, the overall goal of Oxfam's EFSL programme in PaP, Delmas, Carrefour and Croix des Bouquets was to contribute to the survival needs and subsequent economic and livelihoods recovery of vulnerable households. In order to achieve this, a multi-tiered approach was designed, tailored to varying levels of need, vulnerability and capacity. This was undertaken in collaboration with local stakeholders to verify vulnerability and the worst affected urban areas. In total, there were 25,253 beneficiary households, or 126,265 beneficiary individuals, of Oxfam's programme during its first year.

The following activities were carried out during the first 6 months of the programme:

Community canteens for extremely vulnerable households: This project was designed as an immediate food security intervention to provide lunch for all members of vulnerable families over an 8 week period. Selection criteria were agreed in partnership with local actors and targeted those families in desperate need and without other support. These households tended to comprise the elderly, single/women headed households and households with high dependency ratios. A total of 3,662 households benefited from hot food in the canteens as well as unconditional grants of 7,000 gourdes (USD\$175) to help them meet other basic needs and prevent debt accumulation. There were 195 canteens scattered in Oxfam's working areas that provided meals to 80 people per day. The canteens were implemented through existing small street restaurants, operated by often very vulnerable women ('restauratrices') who had also been extremely affected by the earthquake with loss of homes, assets and crucially for economic recovery, customer purchasing power. These women were also provided with grants of 5,000 gourdes (\$125) to

support them to boost their businesses, fuel-efficient stoves to help them reduce expenditure on charcoal, business management training and nutrition awareness training to help them make highly nutritious meals at the lowest possible prices using local produce available in the markets.

Basic needs grants for very vulnerable households: An unconditional one-off grant of 8,000 gourdes (approximately \$200) was provided to support 5,352 households to cover their basic needs, to prevent debt accumulation and to try and recapitalise micro-businesses where possible.

Cash for work (CFW) for the vulnerable but able bodied: Twenty days of CFW provided a source of income to the very poor or poor households with limited skills but with able-bodied members and benefited 5,931 households. A variety of activities were undertaken, including digging drainage canals to prevent flooding in over-populated urban slums.

Livelihoods recovery grants for micro-entrepreneurs: Livelihoods of the poorest in PaP are essentially based on street hawking and minor petty trade. The majority of hawkers lost all their material and accumulated debt. Thus these grants of 5,000 gourdes (approximately \$125) were provided to 10,083 households to support them to re-start their small businesses or to invest in something more appropriate.

Support to tradespeople as suppliers of essential services in the community: The design of this activity was based on the initial EFSL assessment where every community asked for support to tradespeople in order to have access to basic services at community level. Grants of an average of \$500 were provided to 780 people who had a trade or specialist skills (e.g. plumbers, bakers, welders, builders, etc.) to re-establish their trade and replace lost tools. Activities were targeted at those who had more than 5 to 10 years' experience in their trade, were operating in the area prior to the earthquake but had lost their capital and equipment, and were willing to restart their trading activity. In Croix des Bouquets, Oxfam also experimented with vouchers for tools through selected stores in collaboration with its logistics team. On balance, it was felt that cash was simpler and allowed more freedom and flexibility to tradespeople in order to recapitalise. Oxfam employed a group of welders to fit out grocery stores in Carrefour and also developed a database of recapitalised tradespeople to share with other nongovernmental organisations (NGOs) who were looking for specific skills such as carpentry, etc.

Support to grocery stores as suppliers of basic goods essential to the community: The design of this activity arose from the EMMA in which it was established that community stores used by the majority of households at quartier level, had been destroyed, resulting in people having to travel further to access their essential food needs and spend more money on transport. This activity targeted 88 grocery storekeepers who had been key service providers prior to the earthquake with high customer bases in Oxfam's working areas. The support consisted of the provision of a grant of \$1000 and a loan of \$1000 provided by a local micro-finance institution. Store owners were also provided with business management training to support them with the day to day running of their businesses. Out of the 88 stores, 15 were provided with 20 ft metal shipping containers to replace the destroyed shops. Welders from Carrefour who were recapitalised through the support to tradespeople activity, were employed to make necessary modifications to the shops to enable them to function effectively.

Accountability and coordination

Accountability and partnership structure

In order to respond to the unique challenges of working in such a complex urban environment, Oxfam wanted to engage and operate with and through partners and local civil society as much as possible. Although Oxfam had worked with partners in Carrefour Feuilles for many years, details of these partners were not well managed and accessible to the team responding to the earthquake. Following the earthquake there was a need to have updated information on civil society operations in order to better understand community support structures and vulnerability. The case study of Carrefour Feuilles, PaP in Box 1 details an accountability and partnership structure that operated at the interface between beneficiaries, civil society, Oxfam and partners.

Cash coordination group

The Cash Learning Partnership (CaLP)⁴ set up a cash coordination group and was a key coordinating body for all agencies involved in the response. This group initially worked to standardise acceptable daily work rates that had been proposed by the government and then began discussing wider cash and subsequently livelihoods strategies. Oxfam co-chaired the cash working group in Port au Prince and took the lead in developing a tool for monitoring and evaluating cash transfer programming in collaboration with other agencies. The objective was to have one inter-agency M&E tool that could be used to evaluate any kind of cash-based programme and encourage inter-agency usage in order to be able to compare results across organisations for similar interventions. Inter-agency coordination on cash transfer programmes ensured cross-learning, exchange on technical constraints and solutions, strategic thinking and strengthened the efforts of agencies advocating with donors and government for the promotion of good quality cash transfer programmes.

Programme impact

Oxfam conducted a monitoring review in July 2010 to check the results and impact of its programme:

CFW

Overall, 88% of the households had spent all of their income and 11% were able to save some of their income. Money was spent on food (28%), water, fuel, other goods and equipment, as well as health. Overall, 18% of beneficiaries were able to start or restart an income generating activity from the income of the CFW. An average of 11 days work was insufficient to support income generation capacity recovery for the beneficiaries. This led to an increase in the number of days of each work rotation to 20 days. Evaluations by other agencies found that even with 24 days of work, up to 90% of the money was spent on food. Recommendations for the minimum number of days for CFW therefore ranged from 36-48 days.

Community canteens

The canteens enabled an increase in the average number of meals per day from 1.6 after the earthquake to 2.1 during the programme (2.6 being the average before the earthquake). However the programme did not manage to support families to reach and sustain their intake before the earthquake; the number of households having three meals per day dropped from 44% during the canteens to 25% after the programme. This is consistent with the fact that households had not yet reached their income levels from before the earthquake and that food remained the main

⁴ <http://www.cashlearning.org>



A woman working at one of Oxfam's canteens that provides a daily hot meal to local people

expenditure (22%). Exactly half of beneficiaries considered that the duration of the canteens programme was too short and that it should have lasted around 6 months. Monitoring of the income of restaurant owners showed a substantial increase in the average income of households, from 20% just after the disaster to 40% after the canteens programme. Distribution of fuel efficient stoves also resulted in a 50% decrease in charcoal consumption. Only 36% of the hot food vendors involved in the canteens programme had been able to restart their restaurant by themselves, on average three weeks to one month after the earthquake. The remainder were able to restart their activity as a result of the Oxfam canteens. Nearly half (46%) of the hot food vendors were able to acquire assets or do something that they could not have done without the support received, e.g. reimbursement of debts. Nearly three-quarters (73%) planned to continue with the restaurant activity after the canteen programme. Figures show their increased income was due to a slight increase in restaurant revenue but mainly to a diversification in income generating activities (especially petty trade).

Support to small businesses

Eighty four per cent of beneficiaries of livelihoods recovery cash grants had used at least part of the grant to procure goods and/or equipment to reinforce or start a business and 87% had restarted an economic activity. Grocery stores all became functional but it is still unclear what percentage paid back loans to the micro-finance institution. Tradespeople informed Oxfam that cash rather than vouchers was preferable in order to obtain high quality, low price material of their choice. The vast majority of tradespeople invested in their particular trade and some also used the opportunity to invest in a second small business. Oxfam has not had the opportunity to follow up with these beneficiaries to check the longer-term impact of this intervention on their livelihoods.

Oxfam conducted a second small impact survey at the end of 2010 based on the HEA approach to assess the impact of its programmes. Three households were interviewed in detail on how they had survived since the earthquake, how they had accessed food and income and how Oxfam's contribution had affected their lives. The broad conclusion was that Oxfam's work had brought a positive contribution but that households were nowhere near to their pre-earthquake situation and had precarious unsustainable livelihoods. It was found that the value of these households' debts were around 3-4 times higher than the value of the grants that Oxfam had distributed. Oxfam used this information for advocacy with other organisations in the cash working group in order to allow flexibility to redefine programmes with a higher value of grant and built findings into subsequent proposals.

Lessons learned

Key lessons learned were:

It was difficult to differentiate support needed for recovery from disaster and support needed to address poverty. Poverty was endemic in the earthquake affected areas so that humanitarian action required addressing the disaster and the root causes of vulnerability, i.e. poverty. The programme aim therefore becomes 'reach acceptable levels of livelihoods' rather than the pre-earthquake status of populations.

In a dense urban context, it is important to have very clear geographical focus and not expand too widely. The EFSL team initially followed the water, sanitation and hygiene (WASH) team in terms of area selection, which meant that financial, human resources and logistics resources were spread very thinly. The resources would have been more effectively utilised if they had been concentrated in fewer areas and grant sizes been higher.

Beneficiary selection processes can be highly politicised and require Oxfam staff to spend considerable time on beneficiary verification. This needs to be factored into the planning from the start. Relationships with mayors and other local authority representatives proved to be complex, especially given the political opportunities afforded through beneficiary selection. Systematic and transparent work with

Box 1: Accountability and partnership structure – a case study of Carrefour Feuilles, PaP

In its original EFSL assessment, Oxfam included a question within its FGDs to ask communities to identify those organisations that best represented them and their needs. Results produced a total of over 60 community based organisations, as well as the original five Oxfam partners.

Oxfam hosted an initial meeting to discuss the results of its EFSL assessment and ideas for programme responses and invited those CBOs it was able to contact to attend. During the ensuing discussions and after hearing differing opinions, it became clear that Oxfam would need to forge a clear strategy for working with civil society in order to create an atmosphere of collaboration and transparency for the utmost effectiveness in response to the earthquake.

Oxfam's Carrefour Feuilles team quickly organised the first 'accountability meeting' in order to discuss and decide on programme activities and to design a partnership strategy that would be conducive to programme success. During the first meeting, Oxfam presented the problems facing the area, beneficiary needs, ideas for beneficiary vulnerability and selection criteria and ideas for activities to address needs. There was great debate on vulnerability and a vulnerability mapping exercise of the most affected areas was organised in order to achieve consensus on the most affected areas for Oxfam to operate in. Finally, after lengthy debate, Oxfam, its partners, local authority and CBO representatives agreed on core beneficiary selection criteria for key activities although the methods of selection were more difficult to agree upon.

CBO members felt that Oxfam's historical partners would not be able to represent their specific communities and social groups and demanded greater accountability be given in selecting vulnerable beneficiaries. In order to address these concerns, Oxfam adopted an inclusion strategy with the agreement of all. Oxfam organised a rapid capacity building session detailing Oxfam's core values and the importance of the just selection of vulnerable beneficiaries without any bias or discrimination. Carrefour Feuilles was divided into five zones and each of the five Oxfam partners was given the responsibility of supervising the work of groups of CBOs within its operating areas. CBOs and partners were given several days to complete lists of people matching vulnerability criteria in their working areas and were given financial support to cover their administration needs. Oxfam staff rapidly cross-checked 10% of beneficiaries recorded in order to ensure qualification. Whereas most CBOs submitted lists of highly vulnerable beneficiaries, a very few submitted lists with beneficiaries of questionable vulnerability. These CBOs were dismissed from Oxfam's collaboration list.

Once beneficiary lists had been agreed, the next step was to organize the administration and management of projects. It was clear that Oxfam would not be able to engage effectively with such a large number of CBOs. Implementation of activities was therefore managed by Oxfam partners and the supervision of Oxfam staff, but CBOs were invited to weekly accountability meetings to comment on the effectiveness of operations and to report on any problems encountered in their communities. It became clear in these meetings that civil society did not feel adequately represented in relief programming and discussions became aggressive and volatile. Oxfam needed to think of a new strategy to minimise the complexity of working with so many organisations, but to achieve the right amount of accountability and transparency in its work that would be acceptable to all parties.

It was decided to form a community accountability committee where all civil society actors would feel adequately represented. This committee would act as an intermediary between Oxfam, its partners, civil society in general and beneficiary communities. The committee would have members elected from civil society organisations who were felt able to represent the community at large and to ensure that voices were heard from all levels of society.

Overall objectives were as follows:

- To reduce conflict and foster collaboration for a more constructive working environment between all concerned parties
- To increase inclusion and understanding
- To ensure transparent beneficiary selection
- To increase the visibility of Oxfam and partner activities and improve reputation
- To reinforce local capacity
- To facilitate a programme exit strategy

Oxfam supervised elections of members of 'Comphare', the community accountability committee, and eight members were ultimately elected including two women and onereligious leader who played the role of overall adviser. The committee was set up in a rented office space in Carrefour Feuilles and equipped with donated office equipment. Committee members were provided with stipends to enable them to spend adequate time supervising Oxfam and partner activities and talking to communities and CBOs. Comphare played a key facilitation role in subsequent general accountability meetings and represented community voices to Oxfam and its partners.

In addition, Oxfam had a free call 400 number for members of the community. The phone service had several functions: to provide information or clarification on Oxfam activities, to allow community members to report incidences of gender violence or security incidents, to gather both positive and negative feedback, and to allow community members to register complaints.



Food cooked by Marie Carole Boursiquot, canteen owner, Carrefour Feuilles

the CBOs and local representatives enabled Oxfam and partners to enforce agreed vulnerability criteria even where relationships with local authorities were difficult.

The 'markets approach' – aiming at supporting grocery stores, tradespeople and small restaurant owners to rebuild affected parts of the supply chains and the supply of basic goods and services – was very ambitious in the first phase. It was concluded that there should have been a dedicated market team to allow other first phase activities to go ahead more quickly.

More CFW was required to provide steadier cash injection and improve the chances of economic recovery.

Programmes should prepare for logistical and financial delays, e.g. lack of availability of tools, reduced capacities of finance institutions following a disaster and processing time for payrolls and payments.

Financial institutions lost much of their capacity so it was difficult to make beneficiary payments on time during the CFW programme. Payment systems need to be organised well in advance with a proper evaluation of financial institutions.

Beneficiary payment processes were improved once Oxfam signed its agreement with Unitransfer (cash transfer agency specialised in remittances transfers).

Vouchers production and names verification processes proved to be a challenge and different systems were tested. To speed up the processes, standard approaches could be designed in advance also as part of contingency planning.

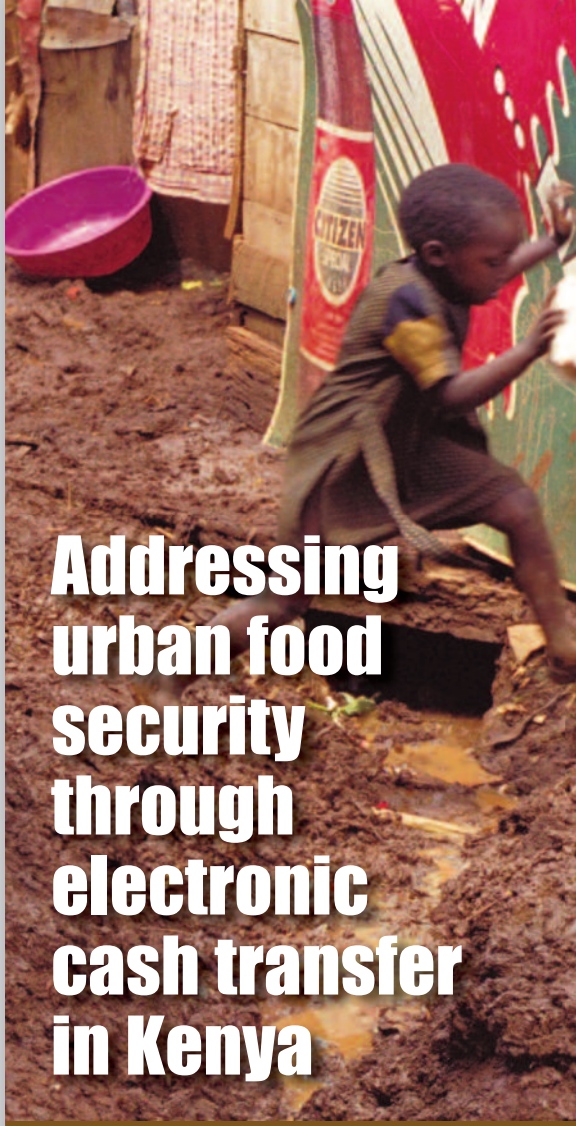
Oxfam had very strong relationships with local partners but needed to improve its dissemination of information to the communities. Despite the feedback systems put in place (freephone 400, accountability meetings), beneficiaries said during the monitoring review that they hadn't received enough information on the activities.

Monitoring and evaluation was integrated late in the implementation process which prevented feeding in of information for phase 2 strategic planning. The pressure to deliver and respond to the enormous and urgent needs at the beginning of the response posed a substantial challenge to launching early M&E.

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Shop owners who had assets damaged during the earthquake were supported to re-stock



Addressing urban food security through electronic cash transfer in Kenya

By Sumananjali Mohanty



Sumananjali Mohanty has been working with Oxfam Kenya programme for the past four and half years, initially as the Urban Food Security and Livelihood Advisor (2009-2012)

and currently as the Social Protection Advisor for the Country Programme. The author has 17 years of experience in development and humanitarian programming, in rural and urban contexts, in India and Kenya.

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This article describes a social protection case study in Nairobi in urban informal settlements. It is based on an Oxfam case study¹ with some updates

The Nairobi urban cash transfer programme was designed in response to the Government announcement in January 2009 declaring the country's food crisis a national disaster. The emergency was a slow-onset crisis triggered by significant rises in food prices. Whilst all major consumption items were available on the market, prices had rocketed with maize meal rising by 133%, beans by 96%, vegetables by 55%, and oils and fats by 77% between 2007 and 2008. The overall combined price of the basic needs basket of poor households rose by 63%, even though wages had not seen a corresponding increase, in fact falling by 21%. The price rises were due to a combination of factors including the global food price crisis, low food grain production, impact of the 2007-08 post-election violence and reduction of cross-border inputs.

Government statistics estimated that 9.5 million people were at risk of starvation, with 4.1 million reportedly from the urban informal settlements. While the government interventions concentrated on the arid and semi-arid districts in the country, the urban vulnerable groups remained untargeted, mainly due to inadequate monitoring of key indicators and hence lack of clear comprehensive data. In response to the food crisis, Oxfam GB and Concern Worldwide developed a joint proposal to address the urban crisis. The project objective was to improve the food and income security of the most vulnerable groups in the urban informal settlements. The expected outcomes included:

- establishment of a social protection programme for the urban poor
- development of a cash transfer system, and
- identification of appropriate emergency (slow onset) indicators for use in the urban context.

The project started in October 2009 in Mukuru and Korogocho informal settlements of Nairobi and ended in January 2012. The project had three phases – response, recovery and exit. The response phase involved monthly cash transfers to offer immediate relief to target communities being affected by the increase in food prices. In the medium term (recovery), households that needed alternative livelihood support to exit from long term cash transfers were linked to business entrepreneurship, skill building, micro-finance institutions, cash for work projects, etc. However, there were many households, especially those headed by the elderly, or the bedridden who were in need of

regular cash transfers or social protection for the longer term. To ensure that such households were able to receive long term benefits, Oxfam engaged with the Ministry of Gender, Children and Social Development to invest in social protection for the urban poor and vulnerable population (exit phase). Concurrently Oxfam, with its Consortium partner, Concern Worldwide, also sought to influence key stakeholders to develop a coordinated and systematic monitoring approach for emergency indicators in the urban context.

Understanding urban vulnerability

A number of assessments contributed to Oxfam's understanding of urban vulnerability in Nairobi. The Kenya Food Security Steering Group (KFSSG) carries out two food security assessments every year, post short rains and post long rains to analyse the food security situation in the different livelihood zones in the country. The Integrated Food security Phase Classification (IPC) tool is used as the analytical framework for situational and response analysis. The short rains assessment of 2009 showed that Nairobi informal settlement residents were highly reliant on the market as the major source of all their household food (90%) and non-food needs. It was also established that approximately 30% of the population were unable to cover their basic needs while 80% of households reported purchasing food on credit from local vendors. In addition, there was little opportunity for urban food production so that access to food was highly dependent on cash exchange. All the 17 basic food commodities were available in the market. Food insecurity in the Nairobi urban area was therefore due to reduced access rather than availability.

A study undertaken by Oxfam GB, Concern Worldwide and Care International in Kenya² highlighted that comprehensive and disaggregated data on the food security and nutritional status of the poorest residents of urban informal settlements was either scanty or non-existent. Key indicators in the urban areas were not reliably or systematically monitored in a coordinated fashion, which made it very difficult to identify an emergency food security situation within a context of extreme chronic poverty. The study recommended an appropriate and coordinated emergency response in urban areas, and development of emergency indicators.

Groups that were found to be particularly vulnerable in the Nairobi urban area included female-headed households, the elderly, households with chronically sick individuals, and households with orphans and other vulnerable children (OVC). According to the World Bank study of 2006, although over two-thirds (68%) of adult slum dwellers were economically active, the unemployment rate was high (26%). Furthermore, 49% of young people aged 15-24 years in poor households were reportedly unemployed. Unemployment amongst the youth stood at around 2.5 million (2006) and was held to be one of the key factors behind the increasing levels of insecurity and violence in the informal settlements, the post-election violence of early 2008 being one manifestation of this. Disaggregating by gender, women were found to be almost five times more likely to be unemployed than men; the unemployment rate was 49% among women compared with 10% among males. A high proportion of the females were engaged in micro-enterprises. The most common micro-enterprises found in the informal settlements fall into the following broad categories:

- retailing and food services, including trading/

hawking/kiosks and food preparation and sales (informal trading)

- small manufacturing/production, construction, and repair of goods (popularly known as *jua kali*)
- general services such as hairdressers, laundry, transport, medicine, photo studios
- entertainment services, including bars, brewing and pool tables.

Informal trading and *jua kali* are of particular importance in Nairobi's informal economy. A study carried out in 2004 showed that the street-vending sub-sector had a daily capital stock value of 70 million Ksh (approx \$864,684 USD). However, there has been a steady attrition of street trading activities over the last few years, with kiosks being demolished by the City Council as a way of improving Nairobi's image. The *jua kali* sub-sector involves manufacturing, repair and provision of services across a number of trades - welding, metal work, vehicle mechanics, carpentry and construction work. It serves residents both in the informal settlements and formal housing areas, as well as the formal business sector.

The prevalence rates of chronic malnutrition are higher in Nairobi's informal settlements than the national rates - almost one in two children compared to one in three nationally. Malnutrition is caused by chronic food insecurity and higher rates of morbidity and mortality due to more limited access to quality health care, poor and expensive water and sanitation, overcrowding and inadequate care practices.

The 2006 World Bank study showed that average monthly per capita income among poor households was 2,776 Ksh (Approx \$34 USD) with the median monthly amount being 2,444 Ksh (Approx \$30 USD). The 'very poor' wealth group typically has an annual average income of 20,000 to 40,000 Ksh (approx \$247 - \$494 USD). In comparison, the income required to cover basic needs is about 60,000 Ksh (approx \$741 USD) leaving a deficit of 40,000 to 20,000 Ksh. Very poor households typically purchase 90% of their food, as they have limited opportunity for food production. This leaves this group extremely vulnerable to price increases.

To cope with their reduced purchasing power, 90% of households surveyed in the KFSSG analysis reported having reduced meal frequency and dietary diversity. More than 60% skipped meals and nearly 80% reported purchasing food on credit from local vendors. Many also started engaging in high-risk livelihood strategies such as prostitution, crime, brewing/selling illegal brews and child labour. Up to 30% of the children have been taken out of school, rates of prostitution have increased to around 30%, whilst rates of scavenging among children were reported to have increased to around 30%. Residents also reported reducing expenditure on non-food items and social services (such as water, soap, sanitation, health and education).

Intervention to improve food security and livelihood

The overall goal of the Oxfam and Concern Worldwide programme was to improve livelihood security of the most vulnerable urban Nairobi informal settlement dwellers in response to the cumulative shocks and stresses. The specific objectives were:

- To improve access to food of the most vulnerable households in selected informal settlements in Nairobi



The regular cash transfer enables children to access education if they are not required to work

- To develop longer-term food and income security initiatives

The selection criteria used for targeting the vulnerable were:

- Child headed household not benefiting from the cash transfer programme or any other food support
- People living with HIV (PLWHIV) or other terminal illness with no support, with special consideration for the bedridden
- Elderly persons above 55 years taking care of three or more OVC
- Single mothers taking care of three or more OVC
- PLWHIV taking care of OVC on anti-retrovirals (ARVs)
- Households taking care of OVC on ARVs
- Pregnant and lactating mothers with a mid-upper arm circumference (MUAC) of <18.5cm (indicating acute malnutrition)
- Children with a MUAC of <13.5 cm

Beneficiaries were identified using community-based selection criteria through stakeholder's consultation including village elders, youth representatives, women leaders, government bodies, faith-based organisations and community-based organisations. The Consortium and its partners then verified the beneficiaries through random visits to beneficiaries' homes, cross-checking against statistics provided by the Area Advisory Council, Food by Prescription programme.

The Consortium implemented the programme jointly through their respective partners. Oxfam's partner - Mukuru Slum Development Projects (MSDP) in Mukuru and Concern Worldwide's partner - Redeem Gospel Church in Korogocho - were responsible for community mobilisation and sensitisation on the project. They facilitated community based targeting of beneficiary households, trained the community health workers, and monitored and reported to the Consortium on the status of the beneficiary households. The Consortium's role has been in validating the beneficiary households, training and supporting partner organisations on cash transfer programming and transferring monthly cash transfers to the beneficiaries. Oxfam as the lead in the Consortium was also responsible for developing monitoring frameworks, donor contract management, fundraising for the project, lobbying and advocacy with the Ministry for social protection in urban areas, as well as facilitating linkages with partner organisations wherever necessary.

¹ <http://www.alnap.org/pool/files/nairobi.pdf>

² The Nairobi slums/informal settlements - an emerging food security emergency within extreme chronic poverty, A compilation and synthesis of key food security, livelihood, nutrition and public health data, April 2009



Monica Akinyi is a single mother with three children. She works as a casual labourer, washing clothes for a few shillings a time. She had to carry her two malnourished children while she searched for work.

With her first payment, Monica spent the entire amount on food. For her second, she bought supplies for her business, which is now making a profit. For the first time, she was also able to buy small toys for her children. Monica's children are healthier and happier thanks to this programme.

Implementation method for cash transfers

Vulnerable and food poor households were provided with cash transfer through mobile phones. Oxfam entered into an agreement with Safaricom (service provider) and availed the database from them for cash transfers. Oxfam staff underwent a training programme to operate the database. Simultaneously at the community level, households registered their phone numbers with Safaricom's MPESA (that allows money transfers). About 40% of the households did not have phones, so the households were given sim cards and because of resource constraints, a couple of phones were positioned with the community health workers in each village, which the beneficiaries could access.

The grants were 1,500 Ksh per month (\$12.5 USD). Initially the monthly grant amount was proposed as 2,475 Ksh per household, which was 33% of the cost of the household's food basket given the high food price situation. The project advocated for the Government to start the social protection in urban informal settlements and an agreement between the Government and the Consortium was reached. However, Government decided to support the project with a monthly cash transfer of 1500 Ksh instead of the proposed 2475 Ksh per household in order to be on a par with other government social protection programmes, such as the older persons cash transfer and the OVC programmes.

Monthly cash transfers were provided to 5,000 households for a period of 8-10 months. Approximately 40% of the households exited as they could save from the monthly cash transfers to invest into their business. The remaining households continued to receive the monthly cash transfers, as well interventions to build their alternative livelihoods. Oxfam continued to advocate with the Government to take on households who were unable to graduate with alternative livelihood strategies and were in need of longer-term social protection programmes.

Results and impact

Household food security at the beginning and end of the project is shown in Figures 1 and 2 respectively that reflects increased food intake, with clear impact on food security. It has enabled uptake of ARVs by supporting adequate food intake amongst PLHIV and reduced the need for individuals to resort to transactional sex to obtain food. There were high levels of satisfaction from recipients and from local stakeholders and positive community and relational impacts.

The project improved investment in the future with impacts including households starting successful businesses, improved school attendance (children not required to scavenge for food), improved grades (better concentration as not hungry) and debts paid off.

As outlined earlier, the project had a three-phase exit strategy, phase one addressed immediate basic needs through cash transfer, phase two addressed the labour market, while phase three explored accessibility to financial services and social protection. Under the labour market component, beneficiaries benefitted from skills transfer programmes, which facilitated their access to the labour market. The Consortium tried to link the beneficiaries to potential work opportunities in the city council, factories and other enterprises in the industrial area. Under phase three, the Consortium negotiated with financial institutions like Equity Bank to try to bring some of their services to the informal settlements, and worked closely with the Ministry of Gender, Children and Social Development to have a social protection programme for the poor households.

Key successes

At the local level

The pilot initiative has been dubbed as an investment rather than a handout. Each target household has been able to build its livelihood and income enhancing capacity which will help build their resilience to future shocks. This is possible mainly because this is an urban programme and households depend on the market for their livelihoods. The cash transfer has made the local market more vibrant as the households have more to spend and traders are able to bring in more commodities. The use of the electronic money transfer through MPESA proved very efficient and effective. It is replicable, but only in similar urban settings where mobile connectivity is good and cash withdrawal points are easily accessible to targeted households.

At the national level

The Government of Kenya through the Ministry of Gender Children and Social Development finally adopted the design of Oxfam's cash transfer pilot and now is implementing urban cash transfers for the poor and vulnerable which is known as Urban Food Subsidy Programme (UFSP) since October 2011. To start with, the Government chose Mombasa, the second largest city in Kenya and is reaching out to 10,200 households. The government plans to expand it to Nairobi and Kisumu in the coming years. It is a programme that is fully funded by the Government's taxpayer's money from the Treasury. Oxfam has not only advocated with the Government for the adoption an urban safety net programme but also provides technical assistance to the Ministry and the County Government of Mombasa in order to build their capacities to enable them implement a cost effective and efficient safety net programme. Oxfam was also actively engaged with the Social Protection Policy formulation which was approved by the Parliament in May 2012, which has an explicit focus on the urban poor.

Programme design

The broad and long-term design of the project at the outset – from response to recovery and exit – has meant that resources could be raised and distributed accordingly; different donor priorities were matched to different project components. Government partnerships, together with multi-agency cooperation, have been strong. The community-based approach has been effective and has been seen as a legitimate operational process.

Lessons learned

Maintaining good partnerships with government for the short and long term success of social protection programmes is vital. It is necessary to both align with the government standards and be innovative and flexible in the initial approach of project design, to maximise support.

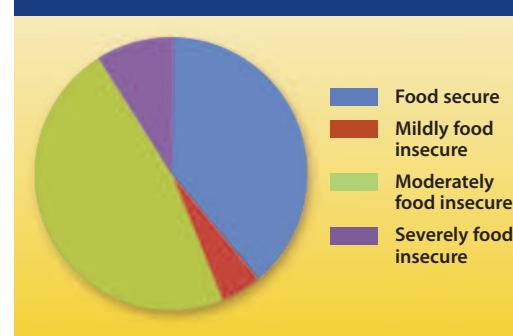
In Kenya, for any safety net that involves cash transfer, the intended households need to possess a National Identity Card in order to benefit from it. Through Oxfam's pilot in the informal settlement, there was the realisation that many needy households could not benefit from the project because of this criterion. This can be only possible if organisations do a direct envelope cash transfer instead of using any other form of delivery mechanism, as all service providers are bound by the Financial Statutory Regulations of the Country. Thus it is of utmost importance to mobilise communities and sensitise them about the worth of possessing National Identity Cards and facilitate that households register to avail the same.

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Figure 1: Household food security at the beginning of the intervention



Figure 2: Household food security at the end the intervention



The Gaza context

The prolonged stalemate in the Middle East peace process, on-going conflict, continued access restrictions and internal Palestinian divisions have resulted in a protracted crisis where humanitarian assistance is critical to improve food security.

The Gaza Strip is an urban economy, heavily reliant on intensive trade, communication and movement of people. The area has been subjected to an on-going blockade implemented in June 2007, so that in the longer term, its economy is fundamentally unviable under present circumstances. Gaza is currently 'kept alive' through external funding/humanitarian assistance and the informal tunnel economy¹.

In 2012, a total of 1.6 million people representing 34% of households in Palestine were food insecure, a dramatic rise from 27% only one year before. In the Gaza Strip, food insecurity levels among households surged from 44% to 57% during this time. In Gaza, households with low resilience to food insecurity are spending up to 56% of their disposable income on purchasing food, jeopardising the quality and quantity of food they consume.

Gaza has a very high population density, with 4,500 people per square kilometre². It is estimated that it will increase from its current population of 1.6 million people today to 2.1 million people by 2020, and 2.7 million people by 2028, resulting in a density of more than 7,562 people per square kilometre³. This demographic explosion compounds chronic food insecurity in Gaza. Infrastructure, electricity, water, sanitation, municipal and social services are already not keeping pace with the needs of this quickly growing population. Furthermore, 70% of the people living in Gaza are refugees⁴, the vast majority of whom still live in crowded refugee camps with no access to land or water resources.

The people of Gaza remain worse off than they were in the 1990s, despite increases in real per capita gross domestic product (GDP) over the past three years. Unemployment is high and affects women and youth in particular. Although unemployment in the Gaza Strip decreased from 36.6 % in 2011 to 28.2 % in 2012 largely due to expansion of the construction sector, wages remained low with many

highly dependent on humanitarian assistance. Gaza's per capita GDP is expected to grow only modestly in the coming years, making it ever more difficult for Gazans to secure a decent living. The challenges will only become more acute, particularly if the current political status quo continues.

¹ The Gaza Strip smuggling tunnels are passages that have been dug under the Philadelphi Corridor, a narrow strip of land, 14 km (8.699 miles) in length, situated along the border between the Gaza Strip and Egypt. For a more detailed write-up, see: Gaza's Tunnel Phenomenon: The Unintended Dynamics of Israel's Siege. Nicolas Pelham. Journal of Palestine Studies, Vol 41, no. 4 (summer 2012). P6. Full article at: <http://palestinejournal.org/journals.aspx?id=11424&jid=1&href=fulltext>

² UNSCO, 2012. "Gaza in 2020: A liveable place?" United Nations Country Team in the occupied Palestinian territory. August 2012.

³ Ibid.

⁴ These refugees fall under the protection of the United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA). UNRWA deals specifically with Palestine refugees in its five areas of operation in Jordan, Lebanon, the Syrian Arab Republic, West Bank and the Gaza Strip. UNHCR is responsible for Palestine refugees outside UNRWA's areas of operation.



Cash voucher programme and rabbit raising intervention in Gaza

A young beneficiary of the rabbit raising intervention

By Elena Qleibo, Ena'am Abu Nada, Wasseem Mushtaha and Julie Campbell



Elena Qleibo is the Oxfam Food Security Coordinator for the Gaza programme. She has been working in Gaza in different programme positions since 2006



Ena'am Abu Nada has a diploma in social work and is a Food Security and Livelihoods for the Oxfam Gaza programme



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Julie Campbell is Gaza Head of Mission for Oxfam

Thanks to Laura Phelps (Oxfam GB HQ) for her technical support to the programme and to the article development. Thanks to WFP for their energy and flexibility in working creatively with Oxfam in Gaza. Thanks also to MA'AN Development Centre who are Oxfam team's 'hands on the ground'. Thanks to the local civil society institutions and local government with whom we work and support, who are key to Oxfam's advocacy and programming achievements.

This article is based on an Oxfam case study with updates provided by Oxfam staff.

As outlined in the introductory background to Gaza, the population is chronically food secure with severely limited livelihood and economic opportunities. One of the consequences has been that previously self-reliant families have been progressively falling into poverty. These predominantly lower-middle class or middle class households have been severely affected by the increased restrictions and economic constraints. Their resources have been slowly depleted and they now represent a group referred to as 'the new poor'.

Oxfam in Gaza

Oxfam has had a presence in Gaza since 2000 although its field office was only opened in 2006. This article describes two Oxfam led interventions in Gaza: the value based voucher (VBV)/cash voucher programme and small scale (rabbit) breeding. Both projects were implemented by MA'AN Development Centre, a Palestinian non-governmental organisation (NGO) registered under the Ministry of Interior and an Oxfam partner since 2006. The mission of MA'AN is to work towards sustainable human development in Palestine.

The Value Based Voucher (VBV)/cash voucher programme

Evolution of the programme

The voucher programme was due to start in January 2009. However, the 'Cast Lead' war on Gaza by the Israeli government temporarily halted the start-up of the operation. Instead, Oxfam carried out emergency food distribution for three months for 30,000 individuals (c.7,500 households (HHs)). When markets were stable again, the project started as a VBV in Gaza city and the north. It targeted one category of family (between 5 and 8 members) and worked with 23 shops, with a caseload of 2,335 HHs (c.15,000 beneficiaries). It aimed to moderate the increase in global food prices that was turning some lower middle class families into

Marwan Sakar, Food value voucher beneficiary

Marwan Sakar lives with his wife and four children aged between 4 – 11 years old, in Khan Younis.

Ten years ago, Marwan had a good job in Israel where he worked as a builder and would earn up to 200 NIS per day. After the closure of the crossing between Gaza and Israel in 2000, he lost his job and as a result, his only way of making a living.

Marwan now works part time, carrying flour and bean sacks at a local market. The work is irregular; he estimates that he works 2 days per week. They live in a house that is owned by Marwan’s parents in the refugee camp in Khan Younis. There is a poor sewage network around the area that produces bad smell and in winter allows for dirty rainwater to flood the house.

Before receiving the VBV voucher, the family would only eat falafel, zatar and bread, now they have cheese, yogurt and oil in their diet which has significantly improved the health of their children

His young daughter has nephrotic syndrome, a kidney disorder due to lack of protein in the diet and has problems with her chest because of the dampness on the walls. One of Marwan’s sons suffers from anaemia. The health of both children has improved noticeably in a few months.

They joined the VBV project in January 2013. They receive 67 NIS weekly.

He comments: “Before joining the VBV, we received flour and rice from CHF. Any assistance is helpful not to be hungry. The SAHTEIN card allows me not only to provide better food for the family, it also gives us the chance to go out shopping. The children enjoy going out to the shop and getting the food. I always buy them something small to eat when we go shopping. I have regained my dignity in front of my family”.



Shopkeepers who trade the vouchers for specific goods

Najwa Abudaka, 62 years, supermarket owner

Najwa and her husband opened up their first supermarket in 1995. Najwa’s husband originally worked as a farmer, but as their 3 sons grew up and moved out, Najwa did not want to be alone in the house any longer, so they decided to go into business together.

Prior to the blockade in 2007, they owned two supermarkets. After the blockade came into place, one third of Gaza’s businesses closed, including one of Najwa’s supermarkets. Najwa said “It was tough after blockade, everybody lost their jobs and nobody was spending any money.”

In 2010, Najwa became a supplier on Oxfam’s ‘Value Based Voucher’ system. She sells food items to an extra 160 households through the Sahtein card. This income generates an extra \$1000 per month for the business. It helps to pay for three members of staff and has gone into buying extra food items to keep in store (for when there are food item shortages) and helps with electricity and rent for the business and her three sons.

Najwa’s supermarket is the only supermarket in the area that offers the value based vouchers.

Najwa’s husband died in 2011.

what was termed the ‘new poor’. These cash vouchers allowed for the provision of commodities that were high in animal protein, such as eggs and cheese, which were not provided by in-kind food distribution. A certain number of commodities were available in designated shops. The VBV was to run as a pilot from October 2009 to December 2010. It was extended in the same form until the end of 2012.

Oxfam GB and WFP prompted the Mid-term Review (MTR) carried out from January to March 2011. This review made a series of important recommendations that were ‘signed off’ by WFP in June 2011¹. The first major transformation was the change from a paper voucher to an E-voucher, with a debit card, that begun in July 2011 with the same caseload. After a joint SWOT² analysis workshop between WFP and Oxfam GB in April 2011, a doubling of the caseload with the new cash voucher modality was scheduled for the 1st of January 2012. This targeted 30,000 beneficiaries of four HH categories (different groups of families according to size, see Table 1 later) distributed in 46 shops and choosing from 10 commodities. A review update was also scheduled to take place by June 2012 of the overall WFP cash voucher programme³ and signed off by the end of the year. This last review recommended important improvements that have already started to make their way into the programme, such as inclusion of more commodities and the piloting of a combined modality of voucher and flour. By 1st January 2013 there was a combined caseload of 50,000 beneficiaries receiving a cash voucher, choosing from 15 commodities in 60 shops, and a combined caseload receiving a smaller cash voucher and a flour ration according to family size, involving 53 shops.

Current programme objectives

The objective of the cash voucher assistance is to meet immediate food needs and enhance food consumption and dietary diversity of the most vulnerable and food-insecure non-refugee population⁴. Its aim is to target households living between the absolute and the relative poverty lines in urban and peri-urban areas of Gaza. Many of the beneficiaries are the ‘new poor’, having recently lost their livelihoods as a result of the movement restrictions imposed by the blockade. Important links are being developed with Oxfam’s Danish International Development Agency (DANIDA) funded economic development project to enhance the participation of small-producers and increase the multiplier effect on Gaza’s closed economy.

Household (HH) Category	1	2	3	4
HH size (no. of individuals)	1-2	3-5	6-8	9 +
Value in ILS of the weekly cash voucher	14	39	67	96
Value in ILS of the monthly cash voucher	56	156	268	384

Implementation method

The VBV aims to ensure beneficiaries have access to a healthy and balanced diet through existing market mechanisms. The interlinked objectives of this strategy are:

- Provide beneficiaries with access to a balanced food basket which includes animal protein rich food such as dairy products and eggs, as well as staple food such as bread, wheat flour and rice.
- Use local shops as procurement and distribution mechanisms to ensure cash is directly injected into the local economy at the micro level, with the intention to have a positive impact on local (West Bank and Gaza Strip origin) production, employment and small business.
- Provide beneficiaries with the advantage of greater choice and flexibility of day, time and food items to purchase.
- Provide multiplier effects with other projects, such as the DANIDA economic development project lead by Oxfam GB.

The paper voucher was originally distributed monthly to beneficiaries in booklets of four vouchers. It has been replaced with a debit card called Sahtein. Each cash voucher is worth 64 Israeli New Shekel (ILS) (about \$17 USD). The monetary value of the voucher was calculated on the basis of the market value of the food assistance basket delivered by WFP and partners to an average sized household in the Gaza Strip. The cash vouchers can be exchanged for a selection of food items considered by WFP to provide a diversified ‘food basket’. Four of these nine items are locally produced and support local producers and manufacturers. The food basket provides 4,828 kcal per day per household. Cash vouchers are issued according to household size (see Table 1). A total of 23 supermarkets across the three governorates have been involved in the project.

Beneficiaries

In line with the recommendation of both the MTR and the more recent review of the voucher programme in mid-2012, some additional 30,000 beneficiaries who were initially registered and targeted with in-kind food ration assistance through CHF International, were transferred to the voucher assistance through Oxfam GB. Some 20,000 received the VBV only, while 10,000 were part of a pilot combining in-kind distributions and the voucher as part of the safety net transfer modality in the Gaza strip. The violence in Gaza between the 14th and the 21st November 2012 did not halt project implementation. As of January 2013, the VBV programme has reached 60,000 beneficiaries located in the five Gaza governorates of the Gaza

¹ The Voucher Programme in the Gaza Strip, Mid Term Review, by Pantaleo Creti, Commissioned by WFP and Oxfam GB

² Strengths, Weaknesses, Opportunities, Threats

³ Review of voucher assistance as a safety-net modality in the Gaza Strip. Ben Mountfield, September 2012

⁴ In Gaza, refugees fall within the UNRWA mandate, whilst non-refugees are targeted by WFP.

Strip, including Gaza Governorate, Khan Younis, North Gaza, Deir al Balah and Rafah.

Targeting criteria

Since January 2012, WFP has been operating a new targeting methodology called the Proxy Means Test Formula (PMTF). The PMTF is the main method to determine whether a household is eligible for WFP assistance or not. Through a series of standard questions, the income of a household is estimated. If the estimated income is below the deep poverty line the household is eligible for WFP assistance.

In addition to the PMTF and to refine the targeting of the proxy formula, WFP utilises the Food Consumption Score (FCS) to determine the type of assistance most suitable to the profile of a household. Given that the cash voucher programme provides increased access to a wider range of staple and fresh foods, eligible beneficiary households with poor FCS, indicating poor dietary diversity, are prioritised as participants of the programme. Oxfam GB is carrying out nutrition awareness campaign programme that is dealing with nutrition and best uses of the commodities provided by the cash voucher. An examination of the FCS in a sample of 600 beneficiaries of the VBV is being planned for the end of the first cycle of the Nutrition Awareness Campaign programme. This will be ready by the end of the year.

Exclusion criteria include HHs where any member has an UNRWA⁵ card (except women holding an UNRWA card married to a non-refugee in Gaza); HHs benefiting from other staple food programmes; Palestinian Authority, United Nations (UN) or international NGO employees and households receiving cash benefits that places them above the deep poverty line.

Feedback mechanisms

Each shop has a box for complaints, suggestions and recommendations. Oxfam GB staff check the boxes and collect the available letters on a weekly basis. All letters are classified according to subject. The required action is taken on a monthly basis during the updating of the monthly beneficiaries' list.

Impact

Anecdotal evidence gathered during stakeholder interviews suggested that the voucher scheme had an immediate beneficial effect. A number of parents reported an improvement both in their own and their children's health. This was especially so in the reduction of symptoms associated with rickets and anaemia.

Roll-out in 2014 and beyond

This is currently being discussed at programme and management levels. Consideration is being given to further strengthening linkages between



Nariman Farahat, a mother of six children and one of the beneficiaries of the VBV scheme

DANIDA's economic development project, which in turn focusses on increasing links between small food processors and the voucher programme. Improvements are ongoing and new pilots are being considered for 2014, as well as inclusion of new commodities.

Rabbit raising in Gaza

Oxfam supports a small scale animal breeding programme in Gaza that includes rabbit raising, hens (broilers and egg layers) and sheep. The rabbit rearing intervention was launched in November 2009 as a 12 month ECHO-funded project to protect the livelihoods of unemployed people and to enable very poor households to increase consumption of protein- or vitamin-rich food. The intention was to increase household consumption of fresh meat and allow beneficiaries to sell surplus rabbits to local markets at affordable prices. The intervention was also expected to empower women, as household members recognise the economically productive role that women play. The project was implemented by MAAN Development Centre. A total of 286 Gazan households were involved. Further funding was secured from SYS, a Gulf donor, in 2011. A new proposal has been submitted but has not yet received feedback from the donor (as of Sept 2013).

Targeting

Beneficiaries included both refugees and non-refugees and were identified according to the following criteria:

- Households experiencing long-term unemployment or loss of livelihoods
- Female-headed households, if the women or a member of the family are able to participate in project activities
- Households with a daily income lower than the World Bank poverty line of \$1.6 USD per person per day
- High dependency ratio households – for example, large households with insufficient economic productive capacity
- Households that are not beneficiaries of the European Commission funded PEGASE mechanism⁶
- Strong motivation and commitment
- Space for the hutches

Intervention

Each beneficiary received 4 female and one male rabbit along with sufficient cages, 200 kg of fodder, and a veterinary kit. Training was provided to all beneficiaries. A survey, four months after beneficiaries received their rabbits and equipment, found immediate and positive impacts of the rabbit raising intervention:

- Nearly all (97.6%) of rabbit beneficiaries had consumed, sold or donated an average of 21 kg of rabbit meat a month, equivalent to a value of 534 ILS (approx \$140 USD) per month.
- The beneficiaries reported that the number of rabbits had trebled in the first four months and

households had an average of 36 rabbits to continue rabbit rearing.

- Overall, 71.4% of the beneficiaries had reduced their level of debt, and 52% of beneficiaries stated that they were able to avoid crisis sales of household assets.

An Oxfam evaluation during the first phase of the programme found that prospects of sustainability were relatively high, due to a strong sense of ownership of assets provided, a good level of knowledge and skills among the beneficiaries, relatively low maintenance and operational cost and commitment by implementing partners to provide follow-up services⁷. A more recent Oxfam evaluation finalised in January 2013⁷ found that two years after the initial support, 50% of rabbit kits that were distributed were still in operation. A profitability analysis conducted by the evaluation team on a small sample of beneficiaries estimated that the return from the rabbit kit would be about 1,978 ILS (\$520 USD) in the first year, and 3,940 ILS (\$1036 USD) and 4,559 ILS (\$1899 USD) in the subsequent years. Oxfam are planning to conduct an Emergency Market Mapping and Analysis (EMMA) focusing on risk and viability in October 2013. This will be followed by some market research in December 2013.

Key successes include:

- Successful livelihood diversification
- Dietary improvement
- Increased sense of dignity
- Sustainable and profitable project design
- Improved household recognition of the economic potential of women
- Accessible for a wide range of people, as it is home based, and does not require hard physical labour.

The January 2013 evaluation recommends carrying out further investigation of cost effectiveness, fodder and market links, as well as household sustainability of the intervention. This issue is going to be pursued to support the design of a 'closing the gap' programme for increased household sustainability. There will be an EMMA assessment of this market as a first step to identify risks and opportunities, followed by a more traditional market research component.

For more information, contact: Elena Qleibo, FSL Coordinator Gaza Programme, email: egleibo@oxfam.org.uk or Julie Campbell, Gaza Head of Mission, email: jcampbell@oxfam.org.uk.



A man receives rabbits as part of the intervention

⁵ United Nations Relief and Works Agency for Palestine Refugees

⁶ A mechanism to channel EU and international assistance as a contribution to the building of the Palestinian State.

⁷ Small scale livestock production support in Gaza. Brief study of impacts, costs-effectiveness and sustainability. January 2013. Ruth McCormack, Oxfam. Available on request (see contacts at end of the article).



The rooftops of the Nairobi slums, where up to 60 per cent of the city's inhabitants live

Dealing with urban emergency: lessons from Oxfam's EFSL activities in three cities

By Ian MacAuslan and Laura Phelps



Ian MacAuslan leads Oxford Policy Management (OPM)'s education, early childhood development and labour portfolio and is a senior consultant in social protection. He works on programme strategy, design, monitoring and evaluation, specialising in qualitative research on access to education, social protection, child labour, food security, and urban issues.



Laura Phelps is a public health nutritionist with over 14 years of experience in food security and livelihoods, in both emergency and recovery phases. For the last 11 years she has worked for Oxfam, and since 2010 she has been the cross sector urban humanitarian lead for programme and policy development. Laura has recently moved to the Norwegian Refugee Council where she will be the global Urban Displacement Expert focusing on developing NRC as a leading urban agency for urban displacement.

The authors acknowledge the contributions of Oxfam staff, particularly the team in Nairobi and a special mention for Sumanajali Mohanty, Oxfam Kenya.

Postscript

This article considers the findings from the assessments of three Oxfam urban emergency food security and livelihoods (EFSL) programmes in Nairobi (Kenya), Port-au-Prince (Haiti) and Gaza¹ (insights into these programmes are provided in three separate field articles in this issue of Field Exchange²). The purpose of the assessments was to explore:

- *Appropriateness, timeliness and impact:* whether programmes were well designed for the emergency and were initiated in a timely manner such that they had a positive impact.
- *Targeting:* whether programmes were able to select those most in need of assistance in a timely and cost effective manner.

The article describes some characteristics of urban vulnerability, and then considers how well these programmes have been able to perform, before drawing some lessons for organisations seeking to work more on urban emergency response.

The methodology for each study was based on a review of documents and semi-structured interviews and group discussions with programme officers, other stakeholders, and participants in the programmes.

Urban vulnerability: a growing challenge

Urban vulnerability is not very well understood but four clear points are worth noting.

First, urban populations now exceed rural populations globally (as shown in Figure 1) and are growing very quickly. The slum population is also growing rapidly, though there are considerable uncertainties about how many people live in slums, and how quickly they move in and out.

Second, urban vulnerability is based on exposure to risks around markets, health and sanitation, and social and political relations. This is typically more complex than the risk profiles in rural areas. The market exposure means that responses working through cash are often the most appropriate. The social and political fragmentation means that targeting mechanisms cannot easily work through communities and face risks of capture by powerful actors for their own purposes.

Third, while urban poverty rates seem lower than rural poverty rates in most countries, slum poverty rates are often higher and more intense, with child mortality and health indicators particularly poor. Urban food insecurity is a very real issue, but is generally not as severe as in rural areas. Although malnutrition prevalence rates tend to be higher in rural areas, high urban population density means that there are many more malnourished individuals per unit of area in slums.

Fourth, urban areas change very rapidly. The rapid change means that it is vital to have clearly defined triggers for scaling up and scaling down emergency programmes.

How well have Oxfam's urban EFSL programmes fared?

The three programmes described in the field articles differed substantially and responded to very different types of vulnerability:

- The Nairobi Urban Social Protection Programme (NUSPP) responded to stagnant incomes and price increases and spikes related to the drought in the Horn of Africa in 2009. This is a slow onset urban emergency. The response included cash transfers, cash for work, skills training and business grants, and advocacy to the government for scale-up.
- Oxfam's Emergency Food Security and Livelihoods (EFSL) responded to the earth quake in Port-au-Prince in 2010. This is a rapid onset urban emergency. The response included cash for work, food and cash grants, training and in kind transfers.
- The Gaza Food Security and Livelihoods Programme (GFSL) responded to a chronic political and economic crisis, as well as the protracted impact of the Cast Lead military operation in the winter of 2008/09. This is a conflict-related urban emergency. The response included cash for work, a voucher programme, training and support to income generation.

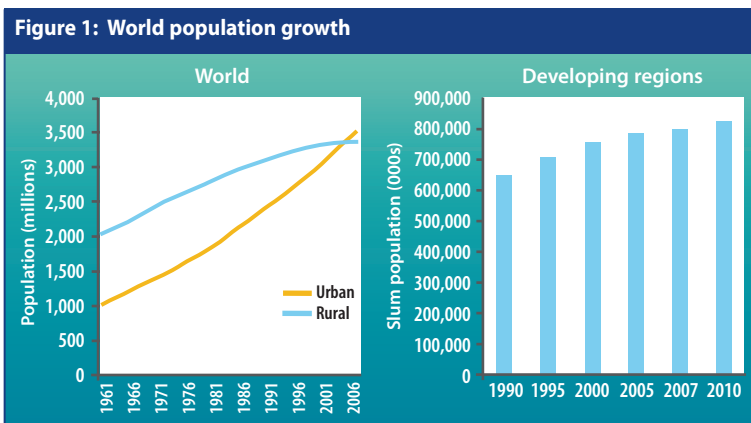
Appropriateness, timeliness and impact

Overall, the EFSL interventions were highly appropriate, but varied in their timeliness, and therefore their programme impact.

Nairobi

The objectives of the NUSPP were appropriate to the acute stress overlain on the chronic poverty of urban informal Nairobi, and the intervention was timely. Given the extent of vulnerability in urban informal areas, it was sensible to engage with the government and others to achieve a greater scale and to aim to develop a government-led programme. There were a number of design features that could probably have been adjusted to maximise impact. For example, the targeting approach and process could have been more clearly specified and the value of some transfers could have been revised to ensure the most vulnerable households received the transfer for longer, rather than a small number of households benefitting from a large transfer.

The impact of the NUSPP was very positive. First, the cash transfer and livelihoods activities improved the food consumption of recipients, saved lives of those on anti-retrovirals, helped them



Sources: World population from World Development Indicators. Urban populations are defined as those living in settlements over 1 million. Slum population from State of the World's Cities 2011, page 32.

reduce (though not always avoid) the use of negative coping strategies (such as prostitution, crime, and removing children from school), helped recipients pay off debt and helped some recipients start or restart businesses, some of which are generating positive returns. The impact of the business training and grants is less clear, but seem positive on a small-scale, though these are unlikely to be retained at scale. Second, the government adopted the cash transfer aspects of the programme and is in the process of scaling these up, thereby greatly enhancing Oxfam's impact.

Port-au-Prince

The Port-au-Prince EFSL objectives were in general appropriate to the post-earthquake context, but the interventions appeared to be based more on pragmatism than on a comprehensive livelihood analysis. Deeper analysis to start would have helped to allocate resources more efficiently, but there was also a compulsion to respond quickly. Some aspects of value for money – such as the choice of cash transfer provider – could have been improved.

The EFSL activities had different positive impacts individually. Taken together, however, it is not clear that they were able to prevent the serious negative consequences of the earthquake as most recipients continued to cut essential expenditures from their budgets. This should be seen in the context of the scale of the disaster. Positive impacts included:

- The short-term guaranteed employment programme helped households repay debt and cover basic needs.
- Community canteens provided food to the most vulnerable and this increased the number of meals they consumed per day.
- Cash transfer programmes increased their credit worthiness and financial inclusion. The impact was constrained by delayed implementation.

Gaza

The GFSL has evolved over time in relation to the changing context in Gaza. This includes support to a long-term, chronic humanitarian situation and an emergency response following Cast Lead, the Israeli military offensive in 2008-09. The programme operates in a complex environment with limited opportunities for diversified funding and with restrictions imposed on engagement with the local authorities. Activities could have been made more urban specific for sustainability and the efficiency of implementation improved.

The GFSL had broadly positive impacts on recipients without significant negative impacts.

Positive impacts include:

- The cash for work programme helped participants to repay debt and cover basic household needs, and improved their creditworthiness, but did not lead to further investment.
- The programme developed the social capital of participants through a greater feeling of self-esteem and meeting new people.

Targeting

Overall, the programmes targeted reasonably well, but were let down by high levels of exclusion error in Nairobi and Port au Prince as well as unsystematic approaches. Targeting indicators and methodology, as well as trigger indicators for entry and exit, require more field based research and design.

Nairobi

The NUSPP sought to target the most vulnerable households in urban informal Nairobi. The targeting process for the cash transfers used local officials

and volunteers to develop indicators of vulnerability and then to identify vulnerable households. The targeting outcomes were probably reasonable in terms of exclusion and inclusion errors, which is impressive given the challenges of urban targeting. However, the reliance on these local officials with minimal effective external verification raises some significant risks for targeting effectiveness. More experimentation with different methods going forward (including a census and scorecard-type approach) would help learn lessons for a scaled programme. The process of allocating exit activities (cash for work, skills transfer and business grants) relied too much on self-targeting and word-of-mouth, and was probably therefore not as effective.

Port-au-Prince

The Port-au-Prince EFSL targeting process was participatory and specific, using a household level scorecard. Oxfam staff spent considerable time on verification and this delay caused households to lose resources. Perhaps, however, given the scale of disaster, blanket targeting, or targeting using an indicator that included isolation (e.g. geographic distance from markets) or displacement (e.g. whether the household has been forced to move by disaster), might have used resources more effectively.

Gaza

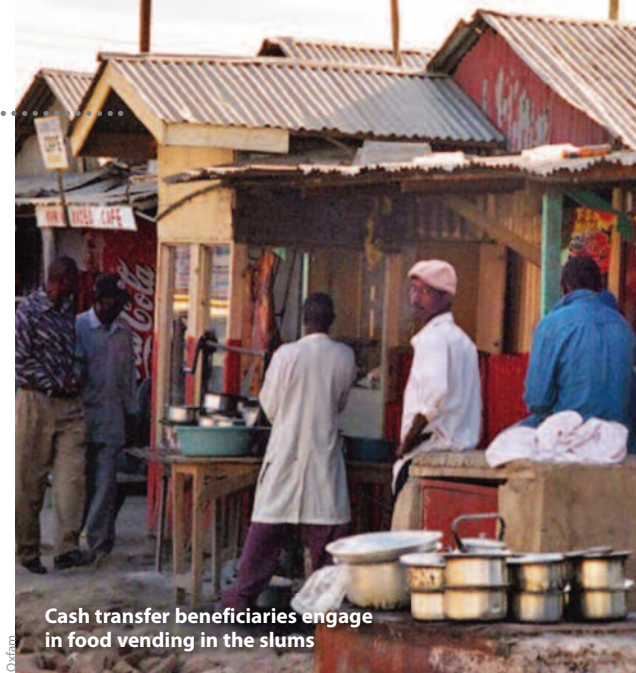
The GFSL used a very well structured targeting analysis methodology using community rankings to target geographically and scorecards to target households. This led to a high degree of targeting effectiveness in each of the different project interventions. Nevertheless, this could have been improved through making the scorecard indicators more specific to the urban context and possibly including indicators such as isolation, displacement and low food consumption and human capital. Households who had recently fallen into poverty (for instance due to the blockade) were less likely to be targeted until they had lost their assets. It may be that assisting them before this would be more efficient. However, it is recognised that with funding limitations and large numbers of eligible recipients, this may not always be possible. Currently, proxy measures have combined with food consumption scores to refine targeting, and a complaints mechanism has been set up in 2012.

Conclusions: how can organisations engage in urban emergencies?

EFSL work in urban areas is gaining importance and will continue to grow in importance as urban populations grow and their vulnerabilities increase, particularly if food prices continue to be volatile. Oxfam has been generally effective in implementing EFSL programmes in urban areas, and these programmes seem to have a significant positive impact on a growing urban vulnerable population.

For most organisations, implementing urban programmes will require overcoming some significant internal and external constraints. These are partly due to the historical (and previously justified) balance of resources in most organisations in favour of rural areas, but also to some attitudes that urban areas are better able to cope. The assessment here suggests that these attitudes are decreasingly appropriate. Organisations should therefore devote resources to improving the share of their programming that is urban.

Addressing situations of chronic poverty (as is the case in all three case studies here) requires a much more comprehensive and a better resourced approach than is currently used. Approaches such as Oxfam's 'one programme approach' are important and urban programmes should be designed to



Cash transfer beneficiaries engage in food vending in the slums

cover the same geographical areas and enable an 'expand and contract model' for scale up to emergency response, followed by transition back into the development programme. This would promote urban resilience.

EFSL programming in urban areas should aim to prevent households' welfare from further deteriorating through the use of negative coping strategies, and to help households begin the process of rebuilding. However, EFSL programming cannot be expected to address underlying vulnerabilities or chronic poverty, and this is where good governance and sustainable livelihoods programming needs to compliment EFSL work. For example, safety net cash transfers have longer term social protection objectives, but these should be supported through good governance and essential services support.

We conclude with some brief specific recommendations:

- NGOs have an important role to play in terms of developing and testing appropriate responses to food insecurity and crisis, and engaging with governments and other stakeholders to help to institutionalise these responses.
- Triggers for entry and exit for urban social protection responses are vital but currently not developed¹.
- Further comparisons are needed between cash transfers, poverty scorecards, extractive questionnaires and proxy means tests in urban areas.
- Cash transfers are an effective first response to urban disasters to meet immediate needs in food, water, shelter, transport and healthcare.
- Innovative technology used appropriately can be very helpful to speed the response (through digital data gathering) and make transfers (through phones or bank cards).
- As urban programming is a relatively new area with little established evidence based practice, all new programmes should be designed and funded with a strong M&E capacity, as well as a significant research component, to ensure that learning, particularly on targeting, is fed back into future scale up and replication of models developed.

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¹ Oxfam GB Emergency food security and livelihoods urban programme evaluation. Final report. Ian MacAuslan and Laura Phelps, March 2012. The full report is available from OPM, see contacts at end of article.

² The Haiti and Nairobi field articles include updated information that will not have been considered in the OPM assessments

³ For more recent work on this since this review was carried out, see the final report of a review of urban food security targeting methodology and emergency triggers, by Ian MacAuslan and Maham Farhat (July 2013). This report is summarised in this edition of Field Exchange.

Aquaponics in Gaza



Rooftop gardening in Gaza

FAO, Gaza

By Christopher Somerville and Cyril Ferrand



Christopher Somerville holds an MA in Development Studies and has led on a number of UNFAO urban agriculture projects in Gaza since

January 2012, including the project described in this article.



Cyril Ferrand is an agronomist and has worked for the Emergency and Rehabilitation Division of FAO since 1999, previously working with

ACF. He covered major humanitarian crisis, including in particular Kosovo, Afghanistan, Southern Sudan and Somalia.

The authors would like to acknowledge the FAO West Bank and Gaza Strip coordination office – and especially the Food Security Unit – for their support and analysis in writing this article.

This exact article has not been previously published but a similar article was published in FAO Aquaculture Newsletter under the title 'Aquaculture on Rooftops in Gaza' in December 2012.

Field Article

Gaza's population has been forced to adapt to their extraordinary circumstances, outlined in the introduction on Gaza (page 10). Chronic food insecurity is compounded by the imposed buffer zone on land and fishing restrictions off the coast have further impeded agricultural efforts to produce enough food locally to fulfil the needs of Gaza's population. At present, some 5,500 workers rely fully or partially on fishing activities for their livelihood, including about 3,500 fishers and 2,000 workers employed in associated enterprises (boat builders, transporters of fish, etc.)¹. Restricted access to the sea in recent years have driven thousands to look for work elsewhere, such as in casual labour or construction.

FAO response

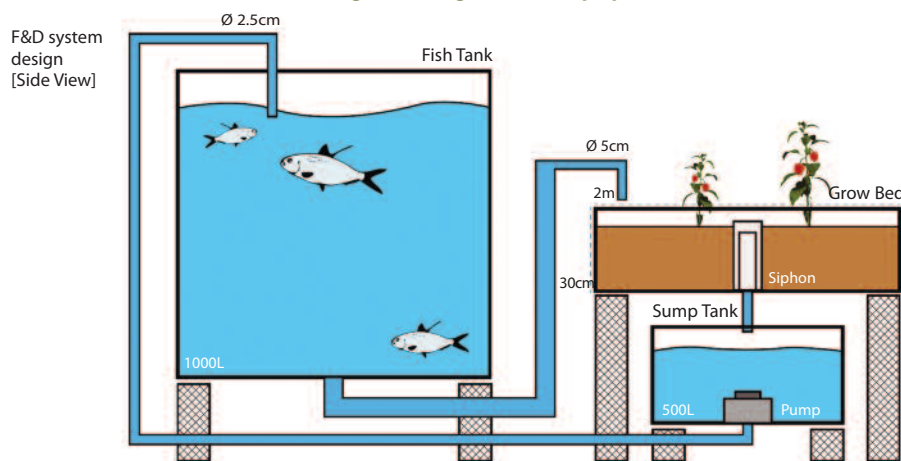
In response to the crisis in Gaza – and in particular, the needs of food insecure female-headed households in urban areas – FAO implemented several small scale urban food production projects in partnership with a number of European donors. Providing food-insecure households with the means and knowledge to grow their own food proved to be a successful way of reducing their vulnerability. FAO's internal evaluations have shown that activities such as backyard and rooftop gardens (see Box 1), along with small rabbit, chicken and fish units, boost the quality of food consumed by poor households and also provide a modest source of additional income through sales of surplus production. This article focuses on experiences with back yard and rooftop aquaponics in Gaza.

Aquaponics pilot

As one of the fastest growing food production sectors, small-scale aquaculture activities have the potential to stabilise livelihoods of poor rural and coastal families in the Gaza Strip. Fish-farming also benefits agriculture, with nutrient-rich water from ponds used to irrigate and fertilise nearby open-field crops, yielding two outputs (both fish and crops to eat and sell) from one input (fish feed). Farmed fish are an inexpensive and highly nutritious food source. Further, sales of fish are carried out by specialised traders, who buy large amounts from the farms and then sell them to local retailers. Transport within the Gaza Strip is relatively unproblematic, and the sale of fish on the local market does not require sophisticated logistics as it can be easily done and regulated according to local needs. The aquaculture ponds themselves are a sustainable source of livelihoods for beneficiaries, established to be used for years to come.

In 2012, through a generous contribution from the Kingdom of Belgium, a follow-up emergency food production initiative was launched which included the pilot of small-scale aquaponic units on rooftops (see Box 2 and Figure 1) and supported by training. Given that access to good agricultural land and water will continue to be a chronic issue within Gaza, aquaponics can serve as an applicable food production option mainly due to efficient water utilisation and easy installation of each production unit (fish and plant) on any flat, urban platform using local low-tech materials.

Figure 1: Diagram of an aquaponic unit



Box 1: Rooftop and home gardens

The FAO's efforts in the Gaza Strip to support emergency agricultural activities have included provision of rooftop and home gardens and agricultural inputs. The project targets poor and vulnerable families in urban and peri-urban areas through the provision of agricultural inputs and technical support to develop and demonstrate simple household garden and aquaculture systems for vegetable and fish production in Gaza. All beneficiaries received training (animal care, proper use of tools, irrigation systems, crop management, planting times, seedling preparation, fertilization, organic and natural pest control and seedling protection techniques) in order to maximize the use of inputs received.

Backyard gardens

Beneficiaries were provided with backyard garden kits consisting of small ruminants (chicken and rabbits), varieties of high quality vegetable seeds and drip irrigation networks. Through these inputs, beneficiaries were able to increase their household

food consumption, as well as generate some income from selling the excess produce and animals.

Rooftop gardens

Rooftop garden kits consisted of inputs for food production including fish tanks and 11cm x 4m PVC pipes for plant production—a form of integrated aquaculture & agriculture developed by local expertise in Gaza. As a result of these inputs, beneficiaries enhanced their household's access to an important source of animal protein for consumption.

Results

Project beneficiaries reported an increased level of household food consumption, as they are able to produce fresh vegetable and animal produce in their own homes. Also, beneficiaries report that their rooftop and home gardens have provided them with extra income through selling surplus produce at local markets.

The pilot project was implemented in 2012 and involved 15 beneficiaries in Gaza City who received aquaponics kits. This included a locally-made 1 metre³ fibreglass fish tank, grow beds filled with volcanic gravel, an electric pump, PVC pipes/ fittings and water quality monitoring kits. Other inputs for each unit were given including tilapia fingerlings (a freshwater fish), fish food and enough vegetable seedlings for one growing season. Once assembled, each beneficiary had a fully fledged 'flood and drain' aquaponics unit with a 4m² growing space and a maximum fish stocking density of 20 kg.

Each pilot unit costs \$1500-\$2000 including the plants required for one season. Maintenance requirements are quite low, largely involving replacing the water pump every 2-3 years; the pump costs between 6-10% of the overall unit cost. All the input costs per year (water, electricity, seedlings, fingerlings, pump depreciation, water test kits), amounts to about half the value of the production per year. So in theory and generally speaking, \$1 invested = \$2 dollars of production. In terms of output this can vary widely, since new users are encouraged to practice polyculture and grow what they need. Using a simple example, at maximum capacity, one unit could produce 20-25 lettuce heads per week and 35-40 kg of fish per year. As the units are small scale, the production is suitable for individual household consumption – households typically have at least 6 people.

The unit design, tailored to adapt to the unique environmental and logistical realities in Gaza, was a marriage of an initial small-scale Integrated Aquaculture Agriculture (IAA) unit locally designed in Gaza with external expertise on aquaponics technology. Although there was initial success when the IAA unit was piloted during the project's first phase, questions were raised as to whether poor families in Gaza could successfully utilise the new aquaponics units as they demand a higher educational capacity for operation. It was highlighted early on in the project cycle that the training course and materials for each beneficiary needed to be as simple and as accessible as possible to ensure success.

Initial results

The initial 15 rooftop aquaponics units showed some promising results. Most of the beneficiaries exerted considerable effort into the management of their units and most harvested a summer crop that was used for household consumption. For some beneficiaries, it reduced the need to purchase food (such as tomatoes, peppers, eggplants) in local markets. Others paid less attention to reaching the full production potential of their units and concentrated more on growing some of their favourite herbs and vegetables. Every beneficiary mentioned that they thoroughly enjoyed managing their units. Some were very thankful that they could now grow nutritious and pesticide-free vegetables for their families while others seemed to really appreciate a quiet green space of their own, inside the busy city of Gaza. Individual cases have reflected encouraging outcomes in this new project year (see Box 3 for one example).

Challenges

Although success stories have been recorded, the initial pilot work encountered obstacles, mostly due to the context-specific challenges presented in Gaza. Households throughout the strip must endure daily power cuts that can easily last up to eight hours or more. This has unfortunately led to fish mortality, particularly during the hot summer months when the capacity for water to hold dissolved oxygen reduces as the water temperature increases above 30 C°.



Rooftop gardening in Gaza

Information received from various project monitoring trips highlighted the existence of some cultural barriers. The idea of growing vegetables without the use of soil has been quite a paradigm shift for some of the beneficiaries, with some still relatively sceptical of the total added value to which soilless culture units can provide. One major lesson learnt in light of this was to implement a complementary public awareness campaign on any new technology, particularly that of aquaponics which is a substantial diversion from traditional agricultural practices. Such campaigns can overcome initial cultural barriers and prevent a potential 'false start' syndrome within participating communities.

Future plans

Building on the pilot, the latest project – which started on 1 January 2013 and will be implemented over a 12-month period – will further build on the successful 'flood and drain' aquaponics units in Gaza City and its surrounding villages. Roughly 100 new units have been planned for the city, each one costing just over \$1000 including the live inputs. This is cheaper per unit compared to the pilot, with FAO having negotiated the best prices from the right suppliers, learning lessons from the pilot.

Other activities include the upgrading of 54 existing beneficiaries' integrated aquaculture units to aquaponic units. The cost to convert from one to the other is about \$300-\$400 (price for submersible pump and materials for a bio-filter). Further, emergency inputs, training and technical support will be provided to enable food insecure households located in urban areas and refugee camps in the Gaza Strip to grow vegetables, and stock fish and small ruminants.

As much of the technology utilised in these interventions is still relatively new, any future efforts to scale up the units to a commercial or community level would need to begin on a small-scale. Also, under future interventions, universities and extension service providers in Gaza could be approached to explore and review best practice for aquaponics in the Gaza Strip, possibly introducing new techniques to alleviate some of the problems experienced in the pilot phase. For example, solar power and battery-powered air pumps have the potential to reduce fish mortality caused by low oxygen levels in the fish tanks during summer, although solar panels (requiring also energy convertor + battery) are very expensive at small scale.

The project will continue to focus on female producers offering the means for them to secure fresh, nutritious food and potentially generate a supplemental income for their family.

Box 2: What is aquaponics?

Aquaponics is a sustainable food production system which integrates aquaculture (growing fish) and hydroponics (growing plants without soil) whereby both agricultural practices mutually benefit from each other's presence in one production unit.

Aquaponics relies on the nitrification process whereby waste from the fish is converted by nitrifying bacteria, which are hosted naturally within the unit, into an organic nutrient solution for the growing vegetables. The vegetables then absorb the nutrients from the water which essentially purifies it as it re-circulates back into the fish tank. Under this production technique, two products (fish and vegetables) can be harvested from only one input. Also, due to the recirculation and recycling of water, aquaponics only requires a fraction of the water needed for traditional soil-based agriculture in the Middle East. See Figure 1.

Box 3: Aquaponics potential – a case study

Without any formal training and with basic technical support from FAO, Iyad Al Attar, an aquaculturalist based in Beit Lahiya, has transformed his small aquaculture farm by integrating a semi-commercial sized plant production component to his operation. Iyad, who was initially involved with supplying materials and fish to FAO for these emergency food production initiatives, took the basic information on aquaponics he acquired while installing units with FAO staff in Gaza and invested in transforming his livelihood into the largest aquaponics unit in Gaza with his own money. FAO staff are closely monitoring Iyad's progress and providing technical support whenever possible as this latest development will hopefully shed light on the income generating potential that semi-commercial aquaponic systems can bring to vulnerable farmers in Gaza.

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¹ Number of registered fishermen according to the Palestinian Authority Department of Fisheries.

Research

Causal modelling to explore malnutrition in children in Bangladeshi urban slums

By Sophie Goudet



Figure 3: Pregnant women building a causal tree using photographs



Sophie is a nutritionist with over nine years experience with international agencies in nutrition and health within developing countries. Her research interest lies in approaches to tackling infant and young child malnutrition in urban slums.

The research in Dhaka, Bangladesh, was supported by Bangladeshi Rural Advancement Committee (BRAC) and Action Contre la Faim. The author thanks BRAC staff working in the slums for their constant support. The author is also grateful to the mothers, their children, and the BRAC community health workers living in the slums for their time, understanding, and willingness to share their knowledge.

Location: Urban slum, Bangladesh

What we know: Undernutrition is highly prevalent in infants and young children in the urban slums of Dhaka. Research reports poor awareness by caregivers of malnutrition and poor health amongst infants and children in urban slums. Understanding IYC caregivers' perceptions is crucial to design better interventions to improve IYC's nutritional health.

What this study adds: Qualitative research, adapted to the slum challenges, amongst pregnant women and community health workers identified inappropriate care, inappropriate environment, inappropriate food and flooding as the root causes of malnutrition in an urban slum in Dhaka. Policy recommendations emerging are to consider flooding as a major determinant of malnutrition, encourage emergency preventative nutritional interventions and focus on water and sanitation issues during the rainy season.

This paper presents a participant driven technique developed to explore the root causes of malnutrition in infants and young children (IYC) customised to the constraints of conducting research in urban slums. The tool aims to support exploration of the perceptions of slum dwellers regarding root causes of malnutrition. The research took place within urban slums of Dhaka, Bangladesh from November 2008 to May 2009 with the support of BRAC¹ and Action Contre la Faim (ACF). The participants were pregnant women and community health workers. The findings of the research have been published elsewhere².

Perception of root causes of malnutrition

In Bangladesh, research shows that IYC suffer from high levels of malnutrition in the urban slums of Dhaka. IYC are frequently born with a low weight and are exposed to high morbidity and mortality risks. The high food insecurity level in the households combined with poor adult nutritional health and an early engagement of children with income generation activities, mean that IYC chances for catch up growth are extremely low and that the risks of becoming or remaining malnourished are high. Exploring perception of root causes of malnutrition is important in a context where it may not be considered or reported by caregivers while prevalence of malnutrition is high. In Bangladesh, previous research showed that there was a lack of understanding of malnutrition and poor health in IYC by caregivers living in urban slums. Malnutrition was not reported as a cause of death

in contrast to diarrhoea, respiratory disease, trauma and stillbirth³. Despite high reported mortality rates, children's health was predominantly reported by household heads to be good to very good⁴. In this context, it could be hypothesized that a situation where the majority of children are to some extent sick and malnourished is considered 'normal' by parents. It could also be that the study was carried out during the dry season during which IYC are in relative better health than in the rainy season. Understanding IYC caregivers' perceptions is crucial to design better interventions to improve IYC's nutritional health.

Practical constraints of conducting research in urban slums

Slums in Bangladesh are well known to be violent and stressful places where crime and drug dealing take place. Domestic abuse, fights between household members and neighbours are common. Conducting fieldwork can be extremely challenging and access to communities needs to be constantly negotiated through gatekeepers and local intermediaries. Slum dwellers are often hostile and reluctant to respond to questions/share views with outsiders and researchers are held under constant suspicion until trust can be built which can take significant time. In addition to the time required to build trust, the time constraints of research participants themselves needs to be considered. Women slum dwellers strive for survival by working long days, typically in garment factories, and have limited time available. This tool was designed to take these two constraints into account.

To overcome the barrier of being an outsider, it was decided that the sessions would be hosted by a well known and recognised organisation already working in the slums – BRAC (Bangladeshi Rural Advancement Committee). Since 2007, BRAC ran the 'Manoshi' programme⁵ reaching 5.7 million people living in Dhaka slums and focused on the promotion of neonatal and pregnant women's health. This provided an entry point for this research to access community health workers and pregnant women. BRAC birthing huts located in the slums were used as meeting focal points.

¹ BRAC is a development organisation based in Bangladesh dedicated to alleviate poverty by empowering the poor, and helping them to bring about positive changes in their lives by creating opportunities for the poor.

² Goudet SM, Faiz S, Bogin BA, Griffiths PL. "Pregnant Women's and Community Health Workers' Perceptions of Root Causes of Malnutrition Among Infants and Young Children in the Slums of Dhaka, Bangladesh." *American Journal of Public Health* 101.7 (2011) :1225-33.

³ Podymow T, Turnbull J, Islam M, Ahmed M. Health and social conditions in the Dhaka slums. *International Society for Urban Health*. 2002. Available at: <http://www.isuh.org/download/dhaka.pdf>. Accessed June 25, 2008.

⁴ Hussain A, Ali K, Kvale G. Determinants of mortality among children in the urban slums of Dhaka city, Bangladesh. *Trop Med Int Health*. 1999;4(11):758.

⁵ The Manoshi project was developed by BRAC to establish a community-based health programme targeted at strengthening and leveraging maternal and child mortality in the urban slums of Bangladesh. The programme is funded by the Bill and Melinda Gates Foundation under the Community Health Solutions (CHS) initiative aiming at strengthening and leveraging community organisations and participants to scale up proven interventions in community settings (BRAC 2009, Khan & Ahmed 2006).

To minimize the time required by participants, the meetings were organised around BRAC training sessions for health workers and antenatal sessions for pregnant women. The choice of focus group discussion (FGD) rather than other ethnographic techniques was to respond to the time constraints, as this technique has the advantage of enabling the identification of emerging themes rapidly.

Causal model

The construction of a causal model is used to better understand the perception of the underlying contributory factors of a phenomenon. Causal models have been used previously in qualitative nutrition research. The determinants of malnutrition can take days to be identified by participants and several sessions are sometimes necessary. Figure 1 shows an extract of a causal model built by health promoters in Peru to explore the poor health and well being of children. In this example, it was interesting to note that some health promoters believed that anaemia could be transmitted by mosquitoes. The causal models were compared to distinguish between the health professionals and the population's perceptions on the perceived causes of infantile illnesses.

For this research, the participants worked together to explore their perception of malnutrition and to define the determinants of malnutrition in IYC. Because of the limited time available, only a short version of the full causal model technique was used. The participants were limited to choosing a maximum of 9 determinants compared to an open construction with an unlimited number of determinants in the full model.

Selecting community health workers and pregnant women

The criteria used (being pregnant or a community health worker) were chosen to compare views between different groups exposed to the issue of malnutrition. It was expected that differences

between the participant groups would result as previous research has shown; health professionals tend to consider micro-biological factors while mothers tend to emphasize factors related to child behaviour. In this research, pregnant women and community health workers had different perceptions of the determinants of malnutrition. There were variances in the perception of root causes but also in their level of importance. These differences should be taken into account when designing interventions in the slums as they influence the way nutrition programmes will be received by participants. If interventions are mapped onto knowledge, they are more likely to be successful.

Use of photographs and pile sorting

The photographs used were mainly taken by the researcher during participant observations in the slums. The rest were sourced from the internet. Photographs found online were taken in Bangladesh or India. It was verified that they were no cultural differences that would have made them unfamiliar to participants. The photographs were selected to be representative of the determinants as presented in the UNICEF conceptual framework, e.g. food, environment, socio-economic status, care, health, nutrition, education, water-sanitation and hygiene. Figure 2 gives an example of some of the photographs used. These photographs were selected for their representation of a topic, for example a photograph showing a women cooking could represent the topic food or nutrition. In the first phase, participants were asked to group photographs with the same characteristics into different piles. The purpose was mainly for the participants to become familiar with the photographs and to explore their perceptions associated with the representation in the picture. As the researcher's own perceptions were different from participants, some picture would be understood in a different way to the researcher's initial intention. Understanding these differences in perception was also useful for developing a richer comprehension of participants. The results of this initial sorting are not presented here.

In the second phase, participants were asked to tell a story beginning with "this child is malnourished because..." The participants were asked to select one photograph representing the most malnourished child and subsequently nine other photographs among 72 explaining potential reasons as to why this child was malnourished. This allowed participants to explore as a group what



Figure 2: Example of photographs used for the building of conceptual framework with the photograph description/representation

- Picture 1 – A women cooking/food or nutrition
- Picture 2 – A view of a slum/environment or health
- Picture 3 – A boy standing on an elevated, broken wooden path/environment or care
- Picture 4 – A man working/socio-economic status
- Picture 5 – A view of a slum next to a garbage pit/environment or health

they saw to be the root causes of malnutrition. Practically, the photographs were organized and ranked in a tree shape (with some guidance from the researcher).The top picture (1st picture selected) representing a malnourished child and nine photographs below symbolizing the roots of malnutrition ranked into immediate and underlying causes. Figure 3 shows participants working on the construction of a causal tree using photographs and Figure 4 shows a completed causal tree.

Data collection and analysis

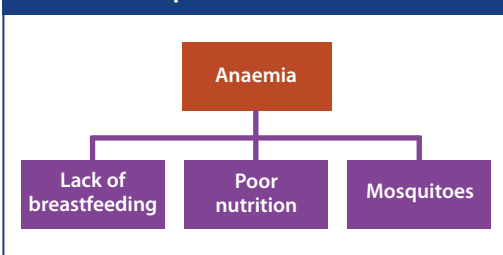
In total, ten FGDs with an average of 10 participants were organized lasting 60-90 minutes each. Participants' socio-economic profiles and household food security status was assessed at the beginning of the session through very short questionnaires. Each conceptual framework made in photographs during FGDs was translated into a formal conceptual framework using the theme associated with the picture as defined by the group (example in Figure 4). An overall conceptual framework was constructed, combining all the models and representing all the roots identified.

In this research, the overall conceptual framework showed four main groups of root causes of malnutrition resulting from the analysis of the FGDs. These were: 1) inappropriate care, 2) inappropriate environment, 3) inappropriate food and 4) flooding. A qualitative data analysis and research software was used to identify emerging themes and to compare themes across the different groups.

The tool was successful in meeting the constraints of conducting research in slums and encouraged participation through presenting the tasks as a fun, game like, experience. It led to formative findings that shaped policy recommendations to consider flooding as a major determinant of malnutrition, encourage emergency preventative nutritional interventions and focus on water and sanitation issues experienced during the rainy season.

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Figure 1: Extract of a causal model built by the health promoters



source: Lefèvre et al. 2004

Figure 4: A completed causal tree diagram (left) based upon one completed by community health workers (right)



Considerations regarding coverage standards for selective feeding programmes

By Ernest Guevarra, Saul Guerrero and Mark Myatt



Ernest Guevarra leads Valid International's coverage assessment team. He has formal training as a physician and a public health practitioner and invaluable informal training as a community worker from the communities with whom he has worked. Most recently, he has worked in Sierra Leone, Niger, Sudan, Ethiopia, and Ghana.



Saul Guerrero is Head of Technical Development at ACF-UK and a founder of the Coverage Monitoring Network. Prior to joining ACF, he worked for Valid International in the research & development of the CTC model. He has supported SAM treatment programmes in over 20 countries.



Mark Myatt is a consultant epidemiologist. His areas of expertise include surveillance of communicable diseases, epidemiology of communicable diseases, nutritional epidemiology, spatial epidemiology, and survey design. He is currently based in the UK.

Introduction

The SPHERE set of standards for the coverage of therapeutic feeding programmes are:

- Rural settings > 50%
- Urban settings > 70%
- Camp settings > 90%

We believe that these standards are simplistic:

No methods for estimating coverage are specified. This is important because there are several methods for estimating coverage. Some of these lack precision, tend to produce biased results, or can yield impossible coverage estimates (i.e. coverage above 100%).

No estimator is specified. It is not clear whether the estimator should or should not include cases in treatment who meet neither programme admission nor discharge criteria (i.e. recovering cases). In some programmes this can strongly influence the coverage estimate. A worst case of this potential source of confusion was observed in a community based management of acute malnutrition (CMAM) programme in Bangladesh. In this programme, coverage calculated using only active severe acute malnutrition (SAM) cases (*point coverage*) was 0% and coverage calculated using active and recovering SAM cases (*period coverage*) was almost 90%.

The split into rural, urban, and camp contexts may be too coarse to be meaningful. For example, refugee camps can be very different places from internally displaced persons (IDP) camps in terms of security and access to services. Urban settings are seldom homogenous. Important categories of settlement such as informal peri-urban communities appear to have been overlooked. Peripatetic¹ lifestyles/food economies such as transhumant (seasonal) pastoralism have been overlooked.

The context-specific standards appear to have been established without recourse to evidence. Experiences with Community Therapeutic Care (CTC) and CMAM programmes over more than a decade suggest satisfactory levels of coverage are more difficult to achieve in urban settings than the SPHERE standards suggest. A Coverage Monitoring Network review of coverage assessments from 104 CMAM programmes undertaken between April 2003 and March 2013 found that 40% of rural programmes met or exceeded the 50% coverage standard but that no urban or camp programmes met the appropriate coverage standard. For urban contexts, the standards appear to be ambitious. For rural contexts, the standards

appear to be unambitious. This is also an argument for improving the way we do urban programming.

No consideration is given to space. It is unclear whether the standard applies to an overall average or is to be achieved everywhere in the programme area.

No consideration is given to time. No guidance is given as to when coverage should be assessed. This assumes that coverage is 'switched on' rather than achieved through considerable care and effort. It reflects the 'build it and they will come' ethos that has been associated with many recent CMAM coverage failures.

SPHERE simplifies coverage to a single figure. Over a decade of experience with CTC and CMAM programmes shows that coverage is a complicated issue and that considerably more than a single coverage estimate is required to inform and reform programmes to increase coverage, effectiveness, and met need.

In this article, we concentrate on issues of space and time and argue that the SPHERE standards need further definition in order to take these factors into account.

Space

SPHERE standards are unclear as to whether the standard applies to an overall average or is to be achieved everywhere in the programme area. Figure 1 illustrates the problem.

The overall average coverage achieved is 50% but coverage is spatially uneven. It is very high in half of programme site catchment areas and very low in the other half. Nowhere is coverage close to the 50% average. Concentrating on an overall average can lead to poor programme management decisions. In the programme illustrated in Figure 1

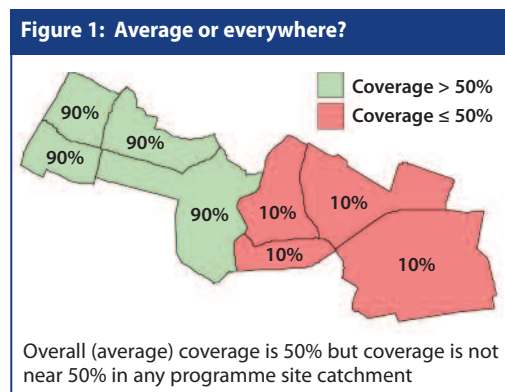
we might be tempted to maintain the status quo (i.e. because we appear to have met the coverage standard) rather than focus attention on applying the good practice seen in the successful programme sites to the failing programme sites.

Figure 1 is an extreme example specifically created to illustrate a point but coverage in failing programmes is often very patchy. Figure 2, for example, shows coverage found by a Centric Systematic Area Sampling (CSAS) survey in a CMAM programme in Niger. The average overall coverage in this programme was estimated to be about 18%. Coverage estimates for the separate grid squares ranged from between zero and 80%. Coverage was patchy. A programme in which the overall average coverage is 18% but is not patchy and a programme in which the overall average coverage is 18% and is patchy are both failing programmes, but will probably require very different changes in order to improve coverage. Effective monitoring and evaluation of CMAM programmes therefore requires that overall average coverage results be accompanied by an indication of the patchiness of coverage.

Concentrating on an overall coverage estimate can lead to us making poor programme decisions that allow a situation of poor equity of treatment to evolve or be maintained. Rights-based standards such as SPHERE should not allow this to happen. This means that we should be applying the standard in the sense of it being met everywhere rather than being met as an overall average. One practical implication of this approach is the need for coverage assessment methods that can reveal spatial variation in coverage. Appropriate methods (e.g. SQUEAC, SLEAC, CSAS, and S3M)² are available. These methods provide mapping of coverage as well as information on coverage bottlenecks needed to inform programme reforms.

Time

The SPHERE standards have no temporal component. There is no specification of how long it should take for the standard to be achieved. They read as if coverage is something that can be



¹ Those who travel from place to place, especially based in places for relatively short periods of time, e.g. nomadic pastoralism, nomadic hunter-gathering, itinerant craftspeople/traders/workers, show people, gypsies, tinkers, travellers, squatters

² SQUEAC: Semi-Quantitative Evaluation of Access and Coverage; SLEAC: Simplified LQAS Evaluation of Access and Coverage; S3M: Simple Spatial Survey Method. See overview at <http://www.brixtonhealth.com/updateRAM02.pdf>

‘switched on’ when, in reality, coverage is something that takes time and effort to achieve.

Figure 3 shows a simple model of how coverage changes over time. If no very poor programme design decisions have been made and proper attention has been paid to community sensitisation and mobilisation, then coverage will increase rapidly until the standard is met or exceeded. The key question is:

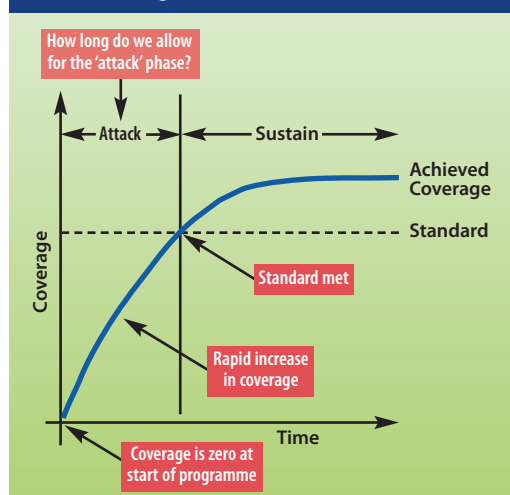
How long do we allow before the coverage standard should be met or exceeded?

This is not a simple question. The answer will vary by context. A simple example of contrasting contexts is emergency vs. development settings. In an emergency setting we would want a very short attack phase, measured in days or weeks, and resources will usually be available to achieve this. In a development setting we often find ourselves working in poorly functioning health systems operating with severely constrained resources. In such settings we accept, or are forced to accept, a longer attack phase measured in months or years. The question is also complicated by spatial issues such as the spatial distribution of the population, health facilities, and the prevalence and incidence of acute malnutrition. The utilitarian principal of providing the greatest good for the greatest number will usually apply. This means that we will make an effort to triage communities into those that most require the intervention (high need), those that least require the intervention (low need), and those in between (moderate need). We would then allow different durations of attack phase for each group. For example:

Need category	Acceptable duration of the attack phase	
High	Short	3 – 6 months
Moderate	Moderate	1 – 2 years
Low	Long	2 – 5 years

An issue arising from this rational approach to programming (i.e. the most effort for the most cases) is that current mainstream tools for assessing the prevalence of acute malnutrition (e.g. SMART) are capable of presenting only wide area averages with estimators that are incapable of providing usefully precise estimates of SAM prevalence with sample sizes that can be collected at reasonable cost. We urgently need prevalence assessment methods that can reveal spatial variation in the prevalence of moderate acute malnutrition (MAM) and SAM. Methods to do this are currently under development by UNICEF, VALID International, GAIN, and Brixton Health.

Figure 3: A simple model of how coverage changes over time



The audit cycle: A framework for monitoring and evaluating coverage

In development settings, when we may achieve standards after a long effort, we need a framework that allows us to monitor whether we are on track for meeting standards and what, if any, programme changes are needed. For this we propose an audit cycle (Figure 4).

The audit cycle aims to provide continual and incremental improvements to practice. This means that the standard should be increased once the previous standard has been met. The aim of audit is to approach best practice over a number of audit cycles. Once best practice has been achieved (e.g. in CMAM programmes in rural settings this means coverage levels of 80% or higher), the audit process continues in order to confirm that best practice is being sustained.

Standards in the audit cycle are interim targets. This means that it is legitimate to set an early standard that is below the SPHERE standard because it is a milestone on the path to meeting the SPHERE standard. The SPHERE standard should also be seen as just a milestone on the path to best practice.

Box 1 illustrates the use of the audit cycle as a framework for coverage monitoring.

Conclusion

Standards such as those proposed by SPHERE are not without value. There is room for improvement. There is need for well-defined and nuanced standards. In this article we have proposed:

- Coverage standards be applied everywhere rather than as an overall average that might not apply anywhere.
- Coverage standards include context specific time elements which may be influenced by spatial factors.
- Coverage standards should be part of a monitoring and evaluation framework designed to provide continuous and incremental improvements to programming. We propose the audit cycle for this.

These proposed changes to the current SPHERE coverage standards require assessment tools that can map need and coverage. They also require organisations that have the skills and the will to apply these tools and move the coverage monitoring agenda forward. We already have tools (i.e. SQUEAC, SLEAC, CSAS, S3M surveys and the audit cycle) and organisations (e.g. The Coverage Monitoring Network) to facilitate some of these proposals. Further work is required on developing tools that can map need.

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Figure 4: The audit cycle for monitoring and evaluation

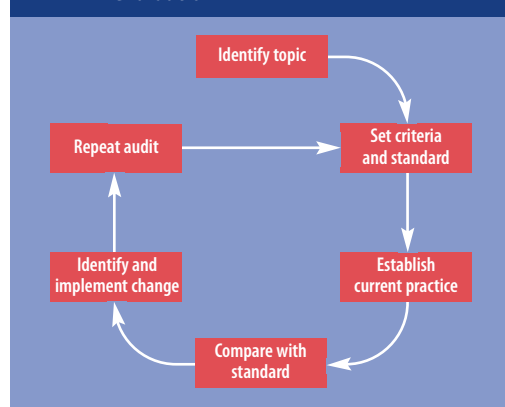
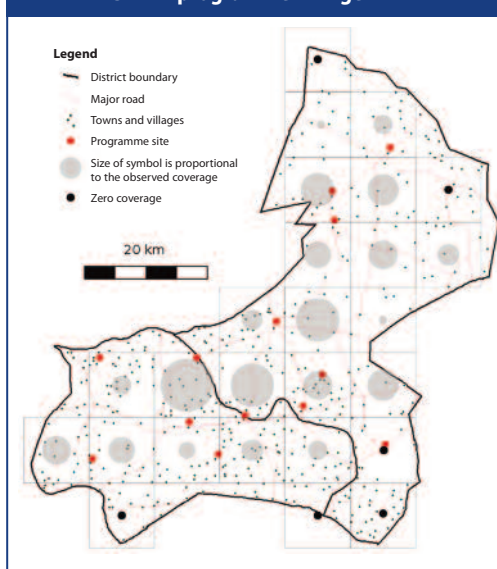


Figure 2: Coverage found by CSAS survey in a CMAM programme in Niger

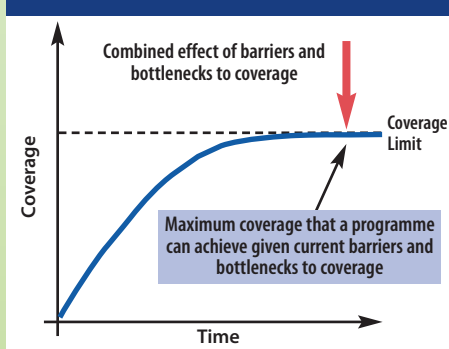


Data courtesy of Save the Children (UK)

Box 1: Coverage, coverage limits, and audit

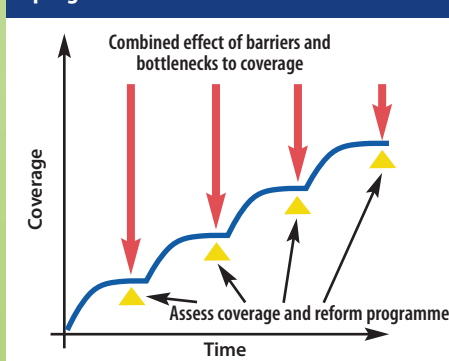
The pattern of coverage presented in Figure 3 may be interpreted as coverage increasing until it meets a limit that is imposed by the barriers and bottlenecks that act to limit coverage (Figure 5).

Figure 5: Coverage over time limited by barriers and bottlenecks



The process of audit using a coverage assessment technique such as SQUEAC aims to discover and address barriers and bottlenecks in order to improve coverage. The process is ongoing (either periodic, continuous, or a mixture of both) so that progress can be monitored and new barriers and bottlenecks (e.g. due to seasonality or unintended consequences of reform) identified and addressed. Coverage under audit will usually follow a bumpy trajectory (Figure 6).

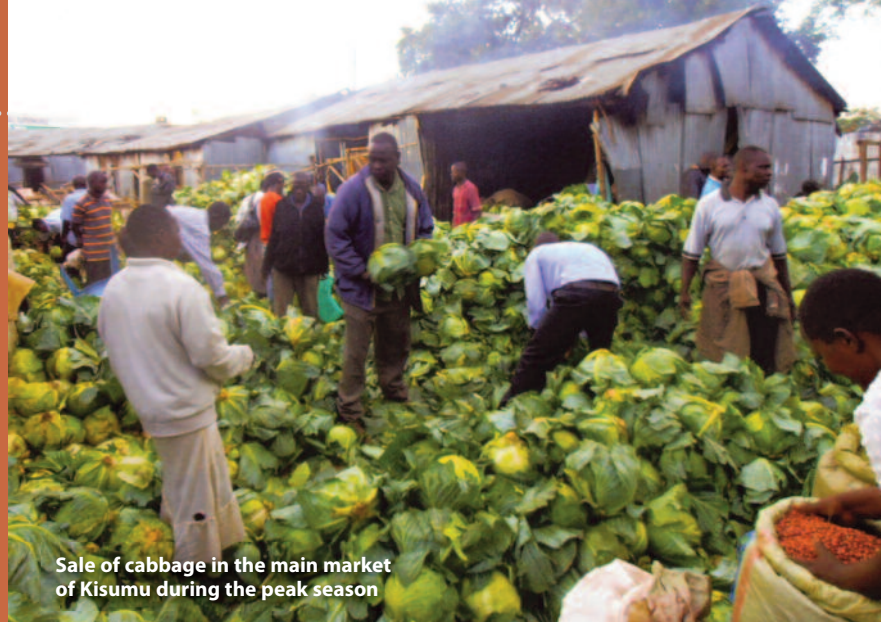
Figure 6: The pattern coverage over time in a programme under audit



It is important that audit continues after high coverage is achieved in order to confirm that good practice is being sustained and to identify and address new barriers and bottlenecks.

Understanding access to nutritious food by poor urban pregnant women and lactating mothers and their children in Kisumu, Kenya

By Albertien van der Veen, Rik Delnoye and Femke van der Lee



Sale of cabbage in the main market of Kisumu during the peak season



Albertien van der Veen is an experienced public health nutritionist/epidemiologist and team-leader of the urban nutrition theme group at the Royal Tropical Institute (KIT) in Amsterdam. She has worked for more than 25 years in Africa, Asia and the Middle East in food and nutrition security. Her current research focuses on food-based strategies to reduce malnutrition.



Rik Delnoye is an agricultural economist specialised in agricultural development. A former senior advisor at KIT, he is now coordinating a multi-donor funded food security and economic opportunities programme in Laos.



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Location: Urban slums, Kisumu, Kenya

What we know: In Kenya, 35% of the population is urban of whom nearly half lives in slums/informal settlements. Undernutrition is a major problem, particularly amongst the urban poor.

What this study adds: In this instance, there were adequate amounts of varied foods in urban slum markets but affordability limited access, especially in low season. Average results mask huge disparities in household expenditures and demographics within slums. A low Dietary Diversity Score amongst pregnant and lactating women correlated with a low per capita food expenditure and total expenditure, no bank account/savings, poor living conditions and lower education levels. Maternal dietary diversity was found to be a reliable predictor of child dietary diversity. Interventions to empower poor urban women in food supply chains are identified, including women's collectives and food processing.

Sub-Saharan Africa is rapidly urbanising and has the highest proportion of slum dwellers in the world. In Kenya, an estimated 35% of the population is urban of which nearly half lives in slums/informal settlements. The population of Kisumu, Kenya's third largest city and the capital of Nyanza Province, is approximately 440,000 of whom 60% lives in slums.

Undernutrition is a major problem in Kenya, 35% of all children under five are stunted (short for their age due to growth faltering), and more than half of all children suffer from mineral and/or vitamin deficiencies. Stunting among children living in urban poverty is around three times as high as among urban upper income children. Undernutrition among women of reproductive age, in particular pregnant and lactating women, is also common. At the same time, overweight and obesity in urban poor women and pre-school children is rapidly increasing, due to an unfavourable shift in consumption patterns (more fat and sugar, less polysaccharides and fibre).

The National Food Security and Nutrition Policy (FSNP) and the National Nutrition Action Plan (2012-2017) define Kenya's policy and programmes on malnutrition. Kenya's Nutrition Technical Forum plays an important role in the coordination of the implementation of nutrition programmes. One strategy that fits well with the strategic objectives of the Nutrition Technical Forum for urban nutrition is improving dietary intake through increasing dietary diversity. Promoting market-based solutions and their pro-poor positioning to secure good nutrition is one of the recommended strategies, but initiatives are few and limited in scale.

The Royal Tropical Institute (KIT), Netherlands, in close collaboration with Bondo University College (BUC), undertook research in Kisumu to design a model for gender and rights aware, cost-

effective and sustainable strategies to better match demand (address needs) for and supply of nutritious food in urban areas. The ultimate aim was to improve food and nutrition security of pregnant women, and lactating women with children under two years.

Methods

The objectives of this research were to:

- Profile the primary target group in terms of food access and consumption (intake) including underlying factors related to food habits, gender and other intra-household distribution factors.
- Identify if, what types and how strategies to better match demand and supply can contribute to improving food and nutrition security of the primary target group in a sustainable way.
- Identify opportunities for the development and/or improvement of local supply chains connecting the demand of the food and nutrition insecure to affordable and accessible supplies of nutritious food, in a need-responsive and sustainable way.
- Explore relevant public-private partnerships in the form of business propositions. This included defining the impact pathways, roles and investments and expected return on investments at target group and partner level.

A conceptual framework that focused on immediate, underlying and root causes of (in-) sufficient dietary intake was used to guide the research. The framework elaborated the three key food and nutrition security pillars (access, availability and utilisation), and for each considered demand, needs and supply.

¹ A slum is a settlement close to an urban centre (i.e. town or city) where inhabitants are characterised as having inadequate housing and basic services. A slum is often not recognised and addressed by the public as an integral or equal part of the city (UN Interagency Expert Group Meeting, Nairobi 2002). The term includes informal settlements. Both the term slum and informal settlement are used in this report.

The research consisted of two main parts. The first part focused on understanding underlying socio-cultural and economic factors influencing the demand for and access to nutritious food and ultimately food intake. The second part concentrated on understanding the functioning of the agri-food system, taking the results of the first part as an entry point. The overall set-up of the study was of quasi-experimental design involving both quantitative and qualitative research methods. Household characteristics and food consumption data were collected through a cross-sectional survey.

Field research was carried out in Kisumu in the last week of October and the first three weeks of November 2012 (in the high season of food availability). Within Kisumu, the urban slums of Manyatta and neighbouring Obunga were selected purposely for the food access and consumption survey. This choice was motivated by the fact that these areas are representative for urban slum dwellers in Kisumu according to key informants.

Background² data were collected from key informants and seven focus group discussions. The focus group discussions were held with one mixed group (men and women) and six groups of women. Participants were living in three different areas: Obunga, Manyatta and Nyalenda. The groups were divided over three age categories, each of the age categories focused either on food habits of pregnant and lactating women or child feeding practices.

The food access and consumption survey collected data from a randomly selected representative sample consisting of 295 women of reproductive age. The number of clusters per location was determined using probability proportional to size. The household was the primary sampling unit. Two stage cluster sampling was applied to determine the location of each household. Data were collected by nine local enumerators and ten students from BUC. Data collectors were supervised by staff from BUC and KIT. SPSS was used for the analysis of the data.

Prices of food commodities were collected at six retail outlets varying from the major Kibuye market to smaller outlets close to the targeted slum areas. Collection of data on the value chain was done through in-depth interviews with chain actors. A total of 50 retailers, eight wholesalers and six brokers were interviewed in a semi-structured manner. In-depth interviews were also conducted with some (poor) households to explore seasonal influence on food consumption and coping strategies.

A *nutritious food selection matrix* and a *chain selection matrix* were used to select food products that could potentially be looked into for value chain development options. Both matrixes were developed during the research. The value chains of each of the selected food items were mapped and analysed³.

Potential value chain interventions of selected food items were explored using a gender lens, in particular the concepts of 'agency' and 'structure'⁴. Potential strategic interventions for each selected food item were mapped in terms of economic feasibility, potential nutritious impact, agency and structure. An *opportunity matrix*, also designed during the research, was used to strategise these interventions

Main findings

Demographics

The total number of households interviewed for

the household survey was 295, of which 60 were in Obunga and 235 in Manyatta. The average household size was 4.5 persons per household in Manyatta and 4.4 in Obunga. Nearly one in eight (16%) of all households was a female headed household. In two out of three households (67%), the highest level of education was secondary school or higher. In 27% of the households, the highest level of education attained was college or university. Additional characteristics are summarised in Box 1.

Expenditure

Average per capita expenditure of all households was 3,800 KES per month or 127 KES per day. Differences between households were huge, with expenditure ranging from less than 20 KES per person per day to more than 1,150 KES per person per day. Most households spent about 100 KES per day. Households spent on average 2,100 KES per person per month on food, or 70 KES per person per day. Again this average masks large disparities. Nearly 10% of all households spent only 20 KES per person per day on food, while 5% of all households spent 150 KES person per day or more. Expenditure on food was on average 55% of the total household expenditure (in smaller as well as in larger families). The share varied hugely between individual households however, ranging from 5% to 92%. One out of four families spent more than 66% of its budget on food. Rent, costs of utilities (electricity, water etc.) and transport made up the bulk of the remaining expenditure.

Food consumption and diet diversity

Nearly half of the children under two years and one-quarter of the sample women consumed a diet of poor quality, lacking vitamins and minerals due to insufficient diet diversity (individual dietary diversity scores (DDS)⁵). Based on 24 hour recall, approximately 30% of the children and women didn't eat any fruits or vegetables and only half of the children consumed green leafy vegetables or other vitamin A rich vegetables such as tomatoes. Maternal diet diversity was found to be a reliable predictor of child diet diversity. Children aged 6 to 24 months whose mothers didn't eat sufficiently varied in the survey were nearly four times as likely to have a low DDS as children whose mothers had an adequately varied diet.

A higher DDS was significantly correlated to a higher per capita total expenditure in general and food expenditure in particular. Interestingly, half of the women whose per capita food expenditure was less than average had an adequate DDS (5 or higher). The only significant difference between those with and without an adequate DDS in the low expenditure groups was the household size. Women in larger households were twice as likely to have an adequate DDS as those in smaller households, possibly because their total daily budget for food was higher, enabling them to purchase more different types of food items.

A low maternal DDS (and children's DDS) was correlated with a low per capita food expenditure

² Using the snow-ball method for identifying consecutive key informants.

³ Matrixes available in full report once finalised. See author contact details.

⁴ 'Agency' refers to the capacity of an individual woman to act independently and to make her own free choices (Kabber 1999). 'Structure' refers to the socio-cultural environment such as rules, habits and customs.

⁵ Swahili word for field. These are mostly located in the (rural) outskirts of Kisumu.

⁶ Kennedy, G, Ballard, T and Dop, M. (2011). Guidelines for measuring household and individual diet diversity. FAO 2011. Available from: <http://www.fao.org/docrep/014/i1983e/i1983e00.pdf>

Box 1: Household profiles in Obunga and Manyatta

A little over half (54%) of the surveyed households lived in a permanent house (Manyatta, six out of ten households, in Obunga only one in four households). Nearly half (47%) of all households had a separate place for cooking – this was significantly higher in Manyatta than in Obunga. Three quarters (75%) of the sample households had their own pit-latrine. Over half (59%) were connected to the town electricity supply, 40% of the sample households had no electricity.

One out of five households (21%) in the survey owned productive animals, 90% of whom had chickens (on average 5 chickens per household). One out of three animal owners possessed other poultry; mainly ducks. Two households owned goats and six households owned other productive animals.

Only 7% of the sample households had a vegetable garden. Thirteen households (4%) had one or more fruit trees and 15 households (5%) had a shamba⁶. Shamba's were mainly used for growing maize. Despite its location at the edge of town bordering the country-side, Obunga households were not more likely to have a shamba or vegetable garden than households in Manyatta. The percentage of households having animals was also nearly the same.

In 96% of the households, at least one person had been working over the last six months.

In Manyatta, over half of the households was employed as business owner (defined as a person employing others) or doing skilled work for a regular wage during the last six months. In Obunga, only one out of three people working were similarly employed. In Obunga, 38% were working as an unskilled employee (for either a regular or irregular wage).



Sale of Sukuma Wiki in Kisumu

and total expenditure; not having a bank-account and/or savings; living in a house without electricity and/or a separate place to cook; not owning a shamba; and an education level of unfinished secondary school or less. Findings were inconclusive on intra-household distribution and decision making, e.g. prioritisation/availability of money for nutritious food, warranting further research.

Food availability

There was enough and sufficient varied nutritious food available at the local market(s) in Kisumu, but affordability (and therefore access) was a problem. Price was an important determinant of / reason for choosing where to buy food, but the possibility to buy on credit or in small quantities were factors of influence as well. Affordability, in particular in the off-season is a problem for local nutritious green leafy vegetables (sukuma, etc), fruits (oranges, mango) and other commonly consumed vegetables (cabbage, carrots, tomatoes), pulses and seeds (beans, peanuts) and fish (in particular big fish). In the off-season, the cost of a daily food basket is approximately 70% higher than in the peak season, and out of reach of the poor.

In both the high and low seasons, the cost of a nutritiously well balanced and less balanced diet is about the same. Interestingly, if a household spends 70 KES per person per day (the average found in the household survey), it is quite possible to consume a nutritious diet in the high season, but not in the low season (see Table 1). Households said they coped with the high prices by buying smaller quantities, lower quality and/or consuming substitutes (Omena (small fish)¹ instead of bigger fish, lemon instead of oranges). Vendors were found to accommodate these strategies. Insects, particularly termites, were consumed by over 40% of surveyed households in times of availability. However, outside the season, few traders/vendors offered insects and usually termites only. Supply was subsistence oriented and commercialised production hardly exists.

The local food markets are typical spot markets, characterised by loose, informal and often one-off trade relations, causing high levels of default and high transaction costs. Buying power is in the hands of wholesalers often working in cartels allowing them to influence pricing and determine other conditions (such as packaging, measurements) in the trade. The Nairobi wholesale cartels, in particular, are well known for their market power. Kisumu is strategically positioned along major trade routes for agricultural products.

Value chains

Four leading indicators were combined to select value chains that could improve availability of affordable nutritious food at the short/medium long term. These were: (i) the extent to which the food item responded to nutritional deficits, nutritional value and availability in periods of shortage, (ii) socio-cultural acceptance, preference and pricing, (iii) potential for chain interventions to extent the periods of availability and (iv) competitiveness at the consumer-end.

Analysis of the chain selection matrix revealed that mangoes, traditional green leafy vegetables, amaranth, groundnuts and edible insects could have high potential, particularly if the focus were on increased availability at affordable prices to the target group in the off-season. The following value chain intervention strategies serving this purpose were identified: (i) increasing efficiency in chain operation, for example through the establishment of preferred supplier relations to target groups and collective purchase of larger quantities (through Community Based Organisations (CBOs)) (ii) processing perishable foods to increase shelf life and periods of availability and (iii) focusing on the commercial production of ‘wild’ foods assuring year round supply.

Possible interventions

Since women are involved in both purchasing and producing food, the focus was on interventions that favoured building women’s capacity. Some potential intervention strategies linking poor urban women to selected food value chains include:

- Increasing purchasing power through collective action by consumers (women in particular).
- Processing perishables that are crucial in diets but are hardly available outside peak seasons.
- Identifying economic participation opportunities for women throughout the value chain.

Seasonal fruits (mango), groundnuts and vegetables (traditional green leafy vegetables) that are largely absent from diets during parts of the year can be easily processed at household or local industrial level and made available at affordable prices in low season. Opportunities for mango processing, with a focus on women’s leadership, collective purchase and women’s organisations, could be explored together with existing CBOs. Additionally, direct supply relations between producer groups and consumers (CBOs/specific women groups), which already exist for crops like amaranth, would facilitate improved chain coordination and more efficient supply to the target group.

The opportunity matrix used to strategise interventions set-out required investments (in terms of financial support, capacity building, awareness raising, and time-frames) of possible interventions against the expected impact on increased availability/affordability of nutritious food that responds to identified deficits in the current diet. Investing in commercialisation of edible insects would best increase the level of nutrient intake and address malnutrition in the target group, but would require significant investments and a longer term perspective. By contrast, interventions in, for example, the mango value chain would be relatively easy and fast to accomplish, yet have a lesser impact on nutritional intake and the reduction of malnutrition among the target group.

Next steps

The results of the research and the limitations were presented to a multi-stakeholders’ meeting in November 2012. Possible interventions were discussed with the aim to identify ways to enhance availability through increased production, processing, and/or collective purchase and potential stakeholders for the various options. In March 2013, KIT signed an agreement with Cordaid to collaborate in food and nutrition security interventions in Kisumu. In May 2013 potential stakeholders, including CBOs from Manyatta and Obunga, NGOs, local authorities and the private sector were interviewed. During a consecutive multi-stakeholder workshop, potential partners assessed the feasibility of increasing the availability at affordable prices of (processed or not) mangoes, green leafy vegetables (amaranth and sukuma wiki), insects, groundnuts and fish (included because of recent successful pilots and its high popularity and nutritious value). Workshop participants concluded that green-leafy vegetables and mango had the highest potential in terms of existing opportunities to increase availability, available resources and expertise and necessary activities. Omena and insects could be interesting but not at this stage, while (processed) peanuts were not considered an interesting opportunity given the current demand. KIT and Cordaid in close collaboration with implementing partners will translate the outcome of the workshop into fundable proposals to be submitted later this year.

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¹ Omena is consumed during the entire year and can be regarded as the protein safety net for poor households in Kisumu slums (located close to the lake).



Sale of Omena fish in Kisumu market

Table 1: Cost of a daily menu for a family of four including one child below 2 years (in KES)

	High season		Low season	
	Nutritious (DDS= 7)	Low diversity (DDS=4)	Nutritious (DDS= 7)	Low diversity (DDS=4)
Pumpkin (½)	20	none	30**	none
Cooking fat (60 ml)	20	20	30	30
Maize (1 kg/2 kg)	40	80	55	110
Onions (1 piece/3 piece)	13	40	20	60
Tomato (2 piece/4 piece)	7	15	20	45
Beans (1/4 kg)	20	none	25	none
Carrots (3)	10	none	15	none
Eggs (2)	20	none	25	none
Sukuma wiki (2 bunches)	20	20	60	60
Other greens	none	15	none	25
Bananas (1)	5	none	15	none
Milk (2 x 200 ml)	20	none	40	none
Sugar (in white/black tea)	5	10	5	10
Total/per person per day	200/50	200/50	340/85	340/85

Based on average prices. Prices in the off-season may be higher or lower, depending on supply.
**3 tomatoes or 2 small mangoes as substitute for pumpkin.



Obunga slum

Severe malnutrition in children presenting to health facilities in an urban slum in Bangladesh

Summary of research¹

Location: Urban slum, Bangladesh

What we know: Both severe acute malnutrition (wasting) and severe chronic malnutrition (stunting) are prevalent and co-exist in children. Routine screening and interventions offered at primary health care facilities typically prioritise identification and treatment of wasting.

What this study adds: Amongst children presenting to primary health care facilities in an urban slum, nearly one in 20 were severely wasted and one in 5 were severely stunted. Nearly half of the severely wasted children were also severely stunted. Routine screening for stunting as well as wasting, and adapted packages of care that consider socio-economic/food security as well as medical factors are needed to deal with this significant burden.

In order to generate crucial data on combined severe forms of malnutrition in the Bangladesh urban slum context, Médecins Sans Frontières (MSF) undertook a study to determine both the prevalence of severe acute malnutrition (SAM) and severe chronic malnutrition (SCM) among children aged 6–59 months presenting for medical care in the two MSF-supported primary health care facilities, and the extent of overlap between SAM and SCM in these children. This was a retrospective study using routinely collected facility-based programme data.

Dhaka, the capital city, is host to over 13 million people. The study focused on the sub-district, Kamrangirchar, to the west of Dhaka City, with a surface area of 3.68 km² on the bank of the Buriganga River and home to an estimated population of 400,000. The majority of the population are migrants. Kamrangirchar provides a temporary abode for this population, as the cost of living is cheaper than in the other slums of Dhaka. Kamrangirchar is divided into nine wards and 39 villages. In a population-based survey in Kamrangirchar in 2011, the prevalence of SCM was 22.7% (95% confidence interval [CI] 19.7–25.7) whereas that of SAM was 2.2% (95% CI 1.3–3.1; unpublished data, MSF Bangladesh).

The MSF project in Kamrangirchar started its activity in 2010, providing primary health care (PHC) services for children <5 years of age. The health services are provided free of charge through two clinics. Since the beginning of the project, over 1000 paediatric consultations per month have been conducted in these health facilities. All children attending the PHC clinics for curative or preventive care are screened for SAM by evaluation of height, weight and mid-upper arm circumference (MUAC). Anthropometric measurements and data on age and sex are recorded in a register. Children found to have SAM without complications and MAM with medical complications are admitted to the ambulatory therapeutic feeding centre. To address medical complications, children are admitted to an in-patient therapeutic feeding centre in an assigned private hospital. No routine screening for SCM is done at the PHC clinics.

Study method

All children aged 6–59 months who attended an

MSF PHC with any ailment for the first time from April to September 2011 were eligible for inclusion in the study. Weight for height and height for age Z-scores were calculated using the 2006 WHO growth standard charts. Children were classified by presence or absence of SAM and/or SCM. Prevalence of SAM and SCM was compared by age group and sex. The χ^2 test was used to compare differences in proportions. $P < 0.05$ was taken as statistically significant. Risk ratios (RR) and corresponding 95% CIs were calculated where differences were statistically significant.

Findings

During the study period, 7481 children meeting the inclusion criteria presented for care at the two MSF supported health facilities. All records were reviewed. Of these, 163 children (2%) were excluded as one or more anthropometric measurements were missing. Among the remaining 7318 patients, 52% were males, 25% were aged between 6 and 12 months, 27% were aged between 12 and 24 months and half were aged between 24 and 59 months of the children who sought care, 322 (4%) had SAM, 1698 (23%) had SCM and 176 (2%) had both SAM and SCM. There was no significant association of age or sex with SAM. The proportion of children with SCM was higher among males than females (RR 1.7, 95% CI 1.5–1.8) and the prevalence was significantly different between age groups, with the highest prevalence in those aged 13–24 months compared with those aged 6–12 months (RR 1.8, 95% CI 1.6–2.0).

Nearly half of the children with SAM (n=322) also had SCM, as compared with only one fifth of those without SAM (RR 3.4, 95% CI 2.7–4.1). The proportion of children with both SAM and SCM was higher among children aged \leq 24 months compared to those aged >24 months (RR 1.6, 95% CI 1.1–2.3). This overlap was not associated with sex.

Discussion and conclusions

This first report on the extent of overlap between SAM and SCM in children in an urban slum setting in Bangladesh indicates a high prevalence of SCM among children with SAM. These data confirm other findings. Among children attending a basic health unit situated in another Asian slum, in Pakistan, about 6.4% had SAM (severe wasting) and 43.6% had severe stunting. The extent of over-

lap in this study (nearly half of SAM children had SCM) is greater than observed in a study from a rural PHC in India, where 29% of children accompanied by their mothers presented with both wasting and stunting (<-2 Z scores). Similarly, in the Paediatric Department of the Civil Hospital of Pakistan, 42% of admitted SAM children were identified with SCM.

This study represents a first step in offering an adapted package of care to children suffering from SAM and SCM co-morbidity in a Bangladesh urban slum. The results of the study have a number of policy and management implications for slums and other similar settings.

First, large numbers of children in slum-based health facilities have SCM. Despite the acknowledged relatively high risk of having concurrent SAM, and its adverse consequences among these children, the presence of SCM is not routinely assessed in such health care services. The affected children had a treatable condition that, if undetected, would lead to chronic and irreversible health problems. The failure to identify and manage SCM at this stage represents a clearly missed opportunity for prevention of childhood morbidity and mortality.

Second, a large proportion of children with SAM require additional management for SCM. Management of these children under the current nutrition rehabilitation programme focuses predominantly on nutritional support of acute malnutrition, which urgently needs to be assessed for its adequacy in ensuring survival in these children in the long term.

Third, there appear to be substantial proportions of children with both SAM and SCM in this urban slum of Bangladesh, indicating a period of insecurity of quality food locally among these children. A joint survey in 2009 by UNICEF, the World Food Programme and the Institute of Public Health Nutrition also revealed that severe malnutrition in Bangladesh is associated with food insecurity due to increases in food prices. Management of SCM requires recognition and correction of both medical and other socio-economic problems. If these problems are not addressed, the child is unlikely to improve and may relapse.

In conclusion, this study shows that among children presenting to the health facilities in an urban slum in Bangladesh, nearly one in every 20 children had SAM and one in five had SCM; half of the children with SAM also had SCM. There is an urgent need to prioritise SCM in addition to SAM, and to develop effective interventions aiming to improve the overall nutritional status of children in such contexts in Bangladesh.

¹ Shams, Z et al (2012). Severe malnutrition in children presenting to health facilities in an urban slum in Bangladesh. *Health solutions for the poor*. Vol 2 No 4. Published 21 December 2012. <http://dx.doi.org/10.5588/pha.12.0039>

Gatekeepers in Mogadishu

Summary of research¹

Summary prepared by Dina Sinigallia.
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Christine Kamau (iDC)



Mogadishu

Location: Mogadishu, Somalia

What we know: Gatekeepers – people or structures that control access to something, such as information or services – are an important consideration in aid operations. In challenging environments such as urban Somalia, the nature and influence of gatekeepers on protecting internally displaced persons is complex.

What this article adds: The gatekeeper system is significant in Somalia and has grown in response to the need for large scale assistance but lack of access. Gatekeepers in Somalia may exert a positive (enabling access to services, land or security) or negative (e.g. diverting resources, taxing resources received, mis-targeting). Actions to minimise risks include continued movement away from remote management, expand the use of IDP feedback and complaints mechanisms, promote public recognition of well-performing gatekeepers, and more transparent operational procedures.

Tanya Copenhagen (a Danish based professional consultancy) and iDC (a Kenya based consultancy firm) were commissioned by the Cash Consortium – a group of four NGOs (ACF, Adeso, Danish Refugee Council (DRC) and Save the Children) who have been implementing large-scale unconditional cash transfers in South Central Somalia since 2011 – to carry out a study on gatekeepers in Mogadishu. The aim of the study was to identify possible strategies that aid agencies could use to mitigate the negative impact gatekeepers can have and improve their role in protecting internally displaced persons (IDPs).

The study team used a perception-based approach, triangulating information gleaned from a literature review and key informant interviews in Nairobi and Mogadishu. A total of 39 individuals from 24 different organisations working in Mogadishu and 52 other Mogadishu-based stakeholders (gatekeepers, IDPs and community leaders) were interviewed in December 2012. The investigation covered 11 IDP sites. Due to the complex nature and sensitivity of the subject matter, the study focused on qualitative data collection methods. While a number of limitations must be acknowledged (the timing of the study and the sensitivity of the topic), the findings are believed to be a good representation of the challenges presented by the gatekeeper system.

Interviews highlighted the fact that aid organisations use the term *gatekeeper* generically, to refer to various levels of actors or power structures involved in working with IDPs, or who have a vested interest in them. The team adapted the following definition of the term to the Mogadishu IDP context: a *gatekeeper* is 'a person or thing that

controls access to something, or that monitors, selects, and can withhold, information, etc.'²

Gatekeepers exist at various levels. In Mogadishu, with relation to IDPs, the most direct and obvious gatekeeper is that person that allows or denies access to IDPs. At district level, there are other gatekeepers in place who allow access, but only when certain conditions are met. Based on this study, gatekeepers at this level include:

- District Commissioners (DCs)
- Land owners
- Clan leaders
- Business people
- Some local agencies

For the sake of clarity, the team used the term *gatekeeper* to refer only to the overall IDP site leaders whom other camp structures report to. The other actors mentioned above are referred to as 'power holders'.

Gatekeepers are not new to the Somali context, and especially the urban environments of South Central Somalia. In 1992, when members of the population started fleeing to Mogadishu to escape the conflict (and subsequently became IDPs), some individuals stepped up or were selected as representatives of their IDP communities. When aid agencies and UNOSOM came to Mogadishu in '93-'94, they needed to engage with some form of IDP representation, and this is when the phenomenon of gatekeepers is said to have started to develop, especially as these representatives began to realise that they could use this system to bring in income for themselves. With the departure of UNOSOM in 1995 and the coming in of the Islamic Courts Union, the system weakened, reportedly leaving

the IDPs and IDP committees to arrange matters on their own. Gatekeeping, however, resurfaced with the return of aid agencies in March 2007 and the existing IDP leadership systems and committees were quickly taken over by these so called 'gatekeepers'. The large-scale arrival of IDPs between 2010 and 2011 (and to some extent in 2012), their critical need for assistance, and the continued approach of remote management, allowed the gatekeeper system to develop further in Mogadishu.

This study found that gatekeepers come into being in three main ways: (1) Inhabitants of Mogadishu who, on a speculative basis, search for and identify an empty plot of land and – through connections with influential personalities in the area – establish sites to attract IDPs to settle; (2) Existing land owners who set up sites to attract IDPs and aid; and (3) Individuals who are appointed to run the daily affairs of a site by the local leaders (most often the DC) of the area where the site is located. This third type is often drawn from the local host community, but occasionally, especially in the older sites, they are IDPs themselves.

What started as an attempt by gatekeepers to assist fellow countrymen in times of need, has evolved into a lucrative economic opportunity for individuals with equally limited avenues for making a living. Many respondents recognized that, given the significant gap in service delivery to the IDPs, gatekeepers can be seen as the 'private sector' stepping in to provide services. Consequently, the majority of the IDPs interviewed considered the gatekeepers as a positive phenomenon as they provide them with services (especially land, security and access to some basic services). However, the gatekeepers' significant power can also lead to abuse, and gatekeepers have also benefited from aid by diverting it before it reaches the intended beneficiaries. They do this in a number of ways: by force, by negotiating with humanitarian actors or by influencing the targeting of beneficiaries. Even when the aid safely reaches the designated beneficiaries, gatekeepers have been known to accrue benefits by 'taxing' following aid distributions, through demands/negotiations for a percen-

¹ Bryld, E., Kamau, C. and Sinigallia, D. (2013). Gatekeepers in Mogadishu. The Somalia Cash Consortium. 31st January 2013

² Oxford English Dictionary

³ More on this issue can be found in Human Rights Watch's recent report: Hostages of the Gatekeepers, released on 29th March 2013. Available at: <http://www.hrw.org/reports/2013/03/28/hostages-gatekeepers>

⁴ Even when institutions were set up to deal with IDPs, these lacked the resources, capacity and support needed to be effective.

tage payment from IDPs. Some gatekeepers were found to genuinely want to assist IDPs while others were seen to be purely exploitative. Interviews with NGO staff also indicated incidents of sexual abuse and human rights violations of IDPs, though these did not come out directly in the interviews with the IDPs.³

The report describes a number of factors, which contributed to the emergence of gatekeepers. These include:

The political and local governance context: the collapse of virtually all state structures in 1991, the protracted period of conflict and the split of leadership between informal institutions (such as clan leadership) and formal institutions (such as the Mayor and the DC).

The humanitarian context: fighting, compounded by natural disasters, led to massive displacement, with Mogadishu attracting large numbers of people, in addition to its resident urban poor.

The government's response: three important elements were out of the control of the state and fuelled the gatekeeper system: the local governance (the DCs) system, persistent insecurity and access to land. The general climate of impunity further facilitated the process. Furthermore, the absence of a credible national entity responsible for dealing with IDPs – and hence the absence of a clear and strong interlocutor for IDP issues – further complicated matters.

The humanitarian community's response: Somalia in general and Mogadishu in particular present a challenging operating environment. The decision to adopt remote management (i.e. withdrawing or drastically reducing international, and sometimes even national, personnel from the field and transferring greater programme responsibility to local staff or local partner organisations) had a number of serious implications (e.g. international staff losing familiarity with the field setting, difficulty of carrying out monitoring activities, limitations to providing guidance, technical support and capacity development of local staff and partners, and so on. Ninety six percent of the IDPs interviewed state having only an indirect relationship with humanitarian actors).

There are a number of actors who have an interest – humanitarian or otherwise – in the role played by gatekeepers. At district level, an IDP site is likely to have a variety of actors with some level of inter-

est. Accountabilities lie at different levels, with each level having a varying degree of influence.

Gatekeepers are first and foremost accountable to the landlord from whom they rent the land, or, if they are landowners, to those power holders supporting them to remain in the gatekeeper position, e.g. local clan leaders, the DC or business people. Apart from a handful of cases, this accountability goes upwards, to the DCs. DCs, for their part, answer to the Mayor. The influence of DCs varies and some are more powerful than others. Having a strong clan and militia backing plays a key part in the level of power they hold. However, downward accountability – to IDPs – is virtually non-existent. This is illustrated by IDPs' most frequent response to the question about what they would change within the camp. The most common response was, "That the gatekeeper would consult us more on issues that affect us."

In the short-term, the report asserts that gatekeepers will continue to remain a fixture of the IDP situation in Mogadishu. The new government has few resources or capacity to institute and enforce measures that would ensure greater protection of IDPs. It falls to humanitarian actors and the donor community to look for ways in which they can continue providing much needed assistance while still adhering to humanitarian principles and principles of good donorship.

The report identifies a number of strategies the Somali government and humanitarian agencies can put in place that could have a positive impact on the environment in which aid is delivered to IDPs in Mogadishu. Revised strategies should lead to a progressive phase-out of gatekeepers, however, they need to be applied progressively and with caution, to minimise the risk of rejection of the approach by gatekeepers, which would negatively impact the protection and security of IDPs. The team suggests the implementation of the following short-term measures:

- 1) Continue the move away from remote management. While security still remains an issue that affects access, the presence of NGO staff is a mitigating factor in the approach taken when dealing with the diversion of aid. Closer monitoring of activities and increased decision-making power of Mogadishu-based staff allows for immediate response and more context-appropriate approaches.
- 2) In collaboration with the Disaster Management Agency (DMA), humanitarian actors should engage all gatekeepers in awareness-raising and training on aspects of IDP protection, human rights, good leadership, transparency, accountability and management. This will require an identification exercise of all gatekeepers and IDP management structures. In addition, IDPs and the local community should go through awareness-raising sessions on their rights and obligations.
- 3) The camp committees should be reconstituted through a more transparent selection process as is, for example, applied by the Community-Driven Recovery and Development project (CDRD).⁵
- 4) Humanitarian organisations should expand the use of IDP feedback and complaints mechanisms, as is already underway. This should also involve the (reconstituted) camp committees. These committees could form the first level of dealing with complaints, with the implementing agency being the second level. The aim of this approach is to gradually increase the capacity of IDPs to effectively handle arising issues.

- 5) The humanitarian agencies and donors should assist the Government in developing the capacity of the DMA, clarifying its role vis-à-vis other government relief offices, and devising a framework to guide humanitarian aid delivery in Mogadishu.
- 6) Undertake public information meetings before each distribution and involve local authorities and the DMA in order to minimise the power exerted by gatekeepers and the degree of 'taxation', which is also exacerbated by a lack of clear information.
- 7) To encourage better uptake of good practices, and positive competition between gatekeepers in term of the services they offer to IDPs, humanitarian actors should promote public recognition of well-performing gatekeepers.
- 8) The different actors working with IDPs and gatekeepers should apply a harmonised and more transparent approach, specifically, develop and agree on minimum standards and operating principles. The next step would be to review existing and past initiatives, identifying those appropriate to the present context of Mogadishu. This necessitates having greater input from the field staff on what could work on the ground.
- 9) Promote open dialogue with the donor community to enable joint initiatives at policy and implementation level. For the above minimum operating standards to be fully taken up, there is need for transparent dialogue and a willingness to discuss these issues at donor level. The issue of gatekeepers will need to be addressed with the involvement of the National Government and Mogadishu administration. A joint effort on policy dialogue, combined with a revised implementation approach at local level is needed.

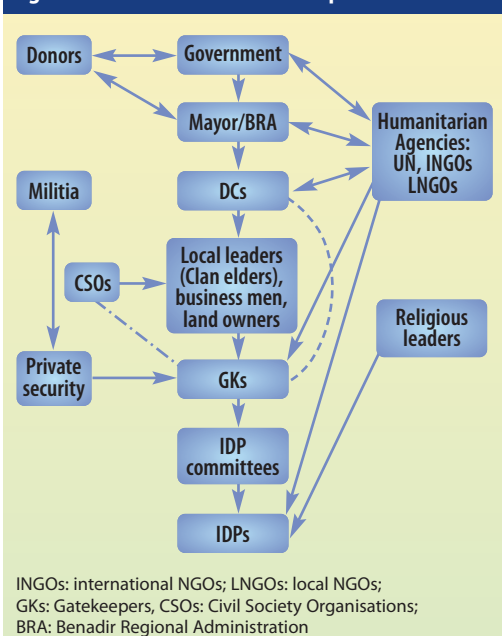
The team identified three specific recommendations for consideration in the long-term:

- Supporting the government in developing a land policy. The lack of a clear land policy continues to fuel the emergence of gatekeepers. The donor community should – in its policy dialogue – stress the need for the government to articulate an interim policy to guide land acquisition, settlement and ownership until a more long-term solution can be agreed upon. This should include guidance on management of public land occupied by IDPs.
- Start planning for longer-term durable solutions for the IDPs. The IDPs now form part of the urban poor in Mogadishu and alongside dealing with the issue of land, urban development strategies will need to be developed. This may include the development of youth skills to curb unemployment, as well as a general consideration of creating and strengthening more diverse livelihood opportunities.
- Involving the camp committees, the DCs, the Mayor's office, and the DMA in finding realistic longer-term solutions to IDP security – with support of the donor community and the UN. This strategy will ensure longer-term institutional anchoring. However, the humanitarian agencies must be careful to maintain their neutrality in this process.

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⁵ The CDRD programme relies on communities to drive development activities. It is a joint effort of United Nations Children's Fund (UNICEF), Danish International Development Agency (DANIDA), the Department for International Development (DFID), Danish Refugee Council (DRC), European Commission (EC) and Swedish International Development Cooperation Agency (SIDA).

Figure 1: District level relationships vis-à-vis IDPs



INGOs: international NGOs; LNGOs: local NGOs;
GKs: Gatekeepers, CSOs: Civil Society Organisations;
BRA: Benadir Regional Administration

Review of urban gardens programme for HIV-affected women and children

Summary of review¹



A caretaker participating in the urban gardens programme

DAI, Ethiopia, 2007

Food and livelihood insecurity is a long-term consequence of HIV, affecting the health, productivity, and asset stabilisation of families affected by the disease. Access to a reliable and safe food supply can be especially difficult for HIV-vulnerable populations in urban areas, where the means of food production are limited and where in many places food prices are increasing. Many interventions have been implemented to address this complex problem, but few have been well documented or evaluated.

Development Alternatives Inc. (DAI) has implemented a broad portfolio of economic-strengthening programmes designed to improve the health and livelihood outcomes of HIV-infected and -affected people, families, and communities, in terms of social, economic, nutritional, and household asset productivity. The Urban Gardens Programme for HIV-affected women and children (UGP) established 188 school gardens targeting a beneficiary group of orphans and vulnerable children (OVC) and 186 community group gardens targeting a beneficiary group of adult people living with HIV (PLHIV) in 23 urban centres across Ethiopia. The UGP was implemented in two phases: Phase I occurred from 2005 to the end of 2008, and Phase II from 2009 to the end of 2012.

More than 122,000 OVC and 10,000 PLHIV were directly affected by this programme and experienced improved food and income and a greater overall sense of well-being and empowerment. The programme also strengthened the capacity of local implementing partners (IPs) to deliver agronomic, nutrition, and marketing skills to these marginalised urban groups. The programme's success was tied to strong linkages with governmental and organisational health services and the sustainability of local partner organisations.

The U.S. Agency for International Development (USAID) commissioned the Food and Nutrition Technical Assistance III Project (FANTA) to conduct a review of UGP. This review was carried out in collaboration with USAID country

managers, former DAI/UGP area coordinators, local IPs and government counterparts, and the UGP project technical manager. It aimed to assess programme acceptability and ownership, evaluate outcomes (on economic, social, nutritional, behaviour, and health variables) and identify options for transitioning and sustaining the programme's successful activities.

Review findings

The UGP did excellent work in facilitating a dialogue on improved urban horticulture and its role in empowering PLHIV and improving food and economic security among vulnerable populations and key organisations in Ethiopia. A great many lessons have been learned through the creation of school and community group gardens, some of which are as follows.

The review indicates that, despite the results achieved during the programme's operation, some school gardens ceased to function once the programme ended and stopped providing technical support. Although the drip irrigation supplies remained on site, they were not being used, and garden beds were drying up and reverting back to virgin land. The review also revealed a number of other flaws in terms of sustainability. The drip irrigation technology, while state of the art for medium-sized producers, was too large, too costly, and too difficult to repair or even maintain by school and adult group gardeners. Agronomically, UGP training did not place a strong enough emphasis on soil health development, water conservation with mulching, deep digging, plant spacing, or local soil amendments.

For school gardens to continue, it will be important to create curriculum-oriented garden class-rooms, to focus on a new paradigm of 'grow more with less', to allocate a smaller land area for each student, and to provide adequate training in container gardening techniques. Furthermore, changing the time frame that students participate in the programme from September–June to January–December will allow them to be properly trained and mentored by outgoing participants,

will give teachers adequate time to select student gardeners and to provide support for the start-up of new student gardening groups and will allow students to carry on the gardening activity for a full half-year after the rainy period (June–September).

Community group gardens were well established by UGP and are likely to continue to operate successfully without further interventions. Broader agronomic training, using the *Urban Garden Dialogue* method² (UGP 2011b) and focusing on bio-intensive gardening, composting, and water conservation measures, would significantly enhance productivity outcomes. Drip irrigation systems are appropriate in some contexts and should be assessed on a garden-by-garden basis, with most gardens moving to simpler, more locally appropriate watering methods. The opportunity for further enhancement of economic and nutritional outcomes should be explored, with potential activities, including a more involved market assessment, training on improved post-harvest handling, and cooking skills training, delivered by trained implementing partner (IP) extension staff.

Follow-on programmes that include high-quality, hands-on, dialogue-based, neighbourhood network-oriented training with local IPs could achieve significant reductions in extreme poverty, food insecurity, and childhood stunting. Moving forward, the focus must be on locally appropriate, small-scale, high-yield agricultural techniques that are best suited to meet urban challenges while taking advantage of the many market and population outreach opportunities that these areas present.

The full report is available at: <http://www.fantaproject.org/publications/urban-gardens-review-2013.shtml>

¹ Jensen, Peter. 2013. *The Urban Gardens Programme for HIV-Affected Women and Children: A Review and Look to the Future*. Washington, DC: FHI 360/FANTA.

² UGP. 2011b. *Urban Garden Dialogue: Tools for Sustainable Urban Agriculture*. Second Edition. Bethesda, Maryland: DAI.

Review of food security and nutrition amongst urban poor

Summary of review¹

Location: Kenya, Niger, Bangladesh

What we know: A significant and increasing proportion of the world's population resides in urban slums. Achieving food security and adequate nutrition is a challenge amongst the urban poor.

What this study adds: The urban poor face unique challenges compared to the rural poor in the same country. They are particularly vulnerable to price rises and market shocks. Exposure to poor water and sanitation is compounded by high population density that impacts health. Urban specific strategies, approaches, tools and disaggregation of data are needed.

Save the Children UK commissioned NutritionWorks² to undertake a review of what is known about the mechanisms by which poor people attempt to achieve food security in urban slums. Part of the review involved examining if and how this is related to their nutritional status and where possible, how it compares to the rural poor in the same countries.

The aims were:

- To review the characteristics of the urban poor in terms of livelihoods and lifestyle, estimated numbers and growth in numbers, by regions of the world.
- To review current knowledge of food security among the urban poor.
- To review what is known about the nutritional status of the urban poor, and the likely causes of malnutrition in an urban environment.
- To compare data from the same country between the urban and rural poor, where available, to assess any relative disadvantage.
- To identify and review past or current programmes that have directly or indirectly addressed food security or undernutrition amongst the urban poor and to assess the factors that contributed to their success or failure.
- To identify donors that have an interest or history of funding programmes in urban food security and nutrition and the countries in which such work has been carried out, and to examine the potential opportunities for funding from major donors that have no known history of funding such programmes.

The review involved use of 'grey' and published research and literature and there was an emphasis on Kenya, Niger, Bangladesh and Myanmar. A summary of the case study in Bangladesh is included in Box 1.

Key findings

Urbanisation, the urban poor and their characteristics

The world's population is expected to grow from 6.7 billion to 9.2 billion between 2007 and 2050. Virtually all of the 2.5 billion increase will occur in the developing world's urban areas. Today, approximately 828 million urban residents are living in slum conditions, compared to 657 million in 1990. Sub-Saharan Africa is thought to have the highest number of urban slums with 62% of the urban population living in slums, followed by Southern Asia, with 35% (UN 2010).

Social networks in urban areas are based on political, religious, economic and ethnic connections. Social support systems are weaker for the most food insecure in urban areas, as they often do not have the same access to kin, political or religious groups to offer and provide support as in rural areas. All of which affects their social capital. Migration between rural and urban areas is two-way and often very context-specific depending on economic, social and political factors. It is essential to understand rural-urban linkages in analysis of the livelihoods and food security of the urban poor, as there is a high level of interdependency in many contexts and households may exploit opportunities for seasonal migration to mitigate risk.

Food security and nutrition among the urban poor (and causes of malnutrition)

The main determinants of food, livelihood and nutrition security are the same for urban and rural areas. However, there is a wide variation in the factors that affect these determinants. For example, urban households are more dependent on food purchase, which, if they have sufficient purchasing power, can lead to a more varied diet and higher reliance on 'ready-made' and fast foods, compared to rural households. Food access has a direct impact on dietary diversity and has been seriously affected by rising food and fuel prices, conflict, and the primary or secondary effects of natural disasters in urban areas across the globe.

Poor female-headed urban households or those with high dependency ratios tend to have a dietary diversity equal to that of the rural poor. However, existing tools for analysis, such as food consumption scores, tend to be misleading in urban areas where diets may appear diverse, but quantities of dairy products or meat consumed might be negligible. As the urban poor tend to be dependent on income from precarious informal sector jobs that rarely meets their consumption needs, they are more likely to employ risky coping mechanisms, including high levels of debt. Women are more likely than men to have less secure and irregular jobs that are not subject to labour laws and do not offer social or medical benefits. This affects breastfeeding, infant feeding and child care practices, especially for those without family support who must adapt their work patterns or use poor quality childcare.

Environmental issues (e.g. over-crowding, poor water and sanitation, pollution, open sewerage and

contamination) are most acute in cities and exacerbated in slums. They have a significant impact on child and household health. Where urban data has been disaggregated by wealth group or studies have focused on the urban poor, high rates of undernutrition (both acute and chronic malnutrition) have been recorded for children under 5 years of age, which are comparable with, or higher than, the rates in rural under-5s. Data that exists for urban poor women reveals both high rates of undernutrition, combined with rising levels of overweight or obesity in some cases, reflecting the 'double burden of malnutrition'(see excerpts from Bangladesh case study).

Urban food security and nutrition programming

Significant challenges are faced in urban food security and nutrition programming (by government, United Nations (UN) agencies and international non-governmental organisations (INGOs). First, there are assessment and targeting issues when faced with a highly mobile, densely packed population, where in- and out-migration is a constant feature. Although urban areas have traditionally been considered better served in terms of healthcare, education and sanitation, a closer look at the evidence reveals that proximity does not equate to access. Both cost of services and urban livelihood strategies, including long journeys to places of work and long working hours, limit access by the urban poor to healthcare, community nutrition services or improved water sources. Programmes have struggled to transplant rural approaches into the urban arena and are increasingly learning that there is a need to adapt, work with existing networks, organisations and systems, and conduct a thorough context-specific analysis prior to intervening. Social protection and cash transfer programmes are promising approaches in urban areas, with evidence to suggest that they improve dietary diversity, but as yet there remains a lack of evidence of their impact on the nutritional status of children under 5 years of age. The evidence clearly points to the need for multi-sectoral, integrated programming and an enhanced role for coordination between actors.

Funding urban food security and nutrition programmes

As far as this review could establish, no donors currently have an urban funding strategy, although the Swedish International Development Cooperation Agency (SIDA) are in the process of developing one, and DFID and ECHO are in the process of considering the way forward. This is a big gap in urban programming as, without funding, it will be difficult to develop the knowledge, skills, tools and experience to respond to needs arising in emergency, transition or long-term contexts.

Conclusions

The urban poor living in informal settlements and slums face a unique set of challenges compared to their rural counterparts. Almost exclusively dependent on the market for food and other necessary items, slum dwellers are very vulnerable to price increases and other market shocks. The population density of slums, in combination with poor sanitation and limited access to clean water, also translates into high transmission risk for communicable diseases. Despite the urban poor increasing

¹ Urban malnutrition: a review of food security and nutrition among the urban poor. Lili Mohiddin, Laura Phelps and Tamsin Walters. NutritionWorks. Report. 8 October 2012. Available at: <http://www.nutritionworks.org.uk>

² An International Public Nutrition Resource Group, <http://www.nutritionworks.org.uk/>

in proportion to the overall population there is little disaggregated data, available between both rural and urban contexts, and between slums / non-slums. Although this is changing with new research focusing on slum dwellers, the body of knowledge on basic indicators, particularly health, food security and nutrition, is still limited. It is clear that urban-specific skills are needed in a number of areas, including analysis (especially related to gender roles), governance, and programme design within INGO's, Governments, UN, the private sector and donors.

Recommendations emerging from this review include:

- Analysis of nutrition, food security, governance and gender is needed, along with baseline data collection in both established and emerging slums.
- The socio-economic, nutrition and food security status of poor urban households may vary considerably between and within urban areas and also between countries and continents.
- Urban areas are more complex than rural areas, at every level, from governance to nutrition and food security assessments, requiring strong urban platforms and coordination at all levels.
- There is a need to work more closely to improve the capacity of governments and national actors, as well as developing clearer ways of working with the private sector for service delivery and programme scale up.
- Early warning systems and the Integrated Phase Classification (IPC) need revisiting to ensure their appropriateness in defining and highlighting urban emergencies, especially in protracted crisis and slow onset emergencies
- More operational research on urban programmes and policy interventions is required to better understand urban contexts (both megacities and emerging urban slums), and how they differ, as well as evaluating the impact of adapted models applied from rural contexts.
- Resources are needed to support the development of best practice targeting methodologies for urban areas.
- Clear urban strategies are required by governments, UN agencies, and INGOs and these should influence the emerging thoughts of donors on the development of comprehensive urban funding strategies.
- Dedicated urban-specific skills are needed both sectorally and in terms of analysis and coordination, but also in typically weaker areas such as good governance and land tenure.
- Cash transfer programming and social protection are effective mechanisms for meeting both immediate and longer term food security objectives, and promising in terms of meeting nutrition objectives, in urban programme and policy work.

Box 1: Bangladesh case study summary

Bangladesh has an estimated urban population of more than 39 million (27% of its total population) made up of one third slums. Largely due to rural-urban migration, the slums are growing at a rate of 7% p.a., more than twice the overall urban growth rate (2.8%) and considerably higher than rural (0.4%). Urban population density is 200 times greater than the national figure.

The urban poor broadly belong to three occupational categories: self-employed (petty shopkeepers, beggars, vegetable vendors, tailors), day labourers (domestic help, rickshaw pullers, construction workers) and the working class (garment workers, car drivers, security guards, dairy farm workers) (Bangladesh Household Income and Expenditure Survey, 2005).

Slum landlords lack official ownership of their shanties, resulting in constant risk of eviction and lack of investment in sanitation infrastructure. More recently, distribution of the ownership of slum land has shifted heavily toward the private sector improving security of tenure. Only 72% of the urban population has access to the water supply while the sewerage system serves only 20% of its population.

Health indicators for the urban poor are worse than those for the rural poor due to the unavailability of urban primary health care and poor living conditions. In urban slums, minor diseases of children are usually treated by dispensaries/chemist shops or traditional healers and children are only taken to hospitals or clinics, usually with end-stage complications. Cost is a major barrier to accessing health care services. Street dwellers are not on the list of the local healthcare service providers, as they do not have any address and are not traceable.

A selection of studies over the past 10 years gives insight into the health and nutrition profile of the urban poor. They found that:

Adult (especially female) and child ill-health was common. A survey of 72% of female street dwellers had a current illness, of which only half sought treatment (often simply visiting drug sellers). All under-five children living in streets presented symptoms of acute respiratory infection, while 35% were suffering from diarrhoea (source: ICDDR'B³).

Overweight and obesity, chronic energy deficiency and underweight were prevalent amongst urban adults with variations between slum v non-slum dwellers. In a 2007 study⁴, overweight prevalence was found to be significant and increased among the urban poor (and rural women), (9.1% urban, 4.1% rural, 2000-2004 prevalence). The prevalence of Chronic Energy Deficiency (CED) was especially high (29.7% urban, 38.8% rural). Thinness (BMI < 18.5) was more common in the slums (27% of women and 35% of men) compared with the non-slums (13% of women and 19% of men). Obesity and overweight was more common in 2006 survey of the non-slum population (34% of women and 18% of men) but is also significant in slum dwellers (15% of women and 7% of men), especially in the wealthiest group (48% of women and 31% of men in the top fifth) (Bangladesh Urban Health Survey, 2006).

Urban/rural patterns of CED were similar. The high prevalence of CED in women of reproductive age (one quarter of women, with a seasonal peak) in urban areas mirrored the pattern in rural Bangladesh, where CED is even higher. (HKI/IPHN, 2006⁵).

Energy intake was inadequate. One quarter of households (24%) in a survey of a selection of Dhaka slums had an energy intake of less than 1805 kcal/person/day, classified as an indicator of 'extreme' poverty. (HKI, 2002).

Child mortality rate and low birth weight prevalence was high. UNICEF reports the under-5 mortality rate to be almost 50% higher in the urban poor areas in comparison with rural areas (2011)⁶. A study from 2000 in Dhaka slums found a prevalence of low birth weight of 46.4% among 1654 infants, attributed to intrauterine growth retardation.

The Bangladesh Urban Health Survey (UHS) of 2006 found that:

- In the four years pre-survey, childhood mortality rates in slums were 14 times that of the urban non-slums, and double that of the District Municipalities. The mortality decline observed in the 2006 survey was less rapid in slum areas.
- There was no clear relationship between the education of respondents, household wealth quintiles and mortality. However, the mortality rates in the highest education group and highest wealth quintiles were always lowest (as compared to the rates in other categories), except for neonatal mortality in the non-slums.
- The prevalence of stunting, wasting and underweight in slums was respectively 55.9% (36% in non-slums), 17.4% (9.8% in non-slums) and 45.6% (28.1% non-slums).
- Maternal height and BMI were strong predictors of *childhood stunting*; 68% of children born to short mothers and 61% born to thin mothers were stunted. Maternal education and household wealth had strong inverse relationships with stunting levels.
- Maternal BMI was a strong predictor of child-hood wasting, with thin mothers (BMI<18.5) three times more likely to have wasted children and almost eight times more likely to have severely wasted children
- In the slum areas, males had higher mortality during the neonatal period while females had higher mortality during the post-neonatal period and early childhood. In slum and non-slum areas, boys were thinner than girls.

A 2005 HKI survey found wasting in the urban poor mirrored the seasonal trends of rural Bangladesh. This study found minimal differences in stunting and underweight prevalence rates between urban poor and rural children aged 0-59 months (stunting: 39.2% urban, 39.2% rural; underweight: 45% urban, 45.7% rural).

Sub-optimal infant and young child feeding practices was common. A UNICEF Multiple Indicator Cluster Survey (MICS) 2009 reported that the percentage of women who started breastfeeding within one hour of birth increased nationally from 36% in 2006 to 50% in 2009. There was no difference between rural and urban areas in 2006 or 2009. Timely initiation of breastfeeding has improved substantially in all areas, with the exception of slums (39%).

In the HKI Nutritional Surveillance Project, 2005, exclusive breastfeeding practice was less common among the urban poor than in rural Bangladesh, with only 66% of infants exclusively breastfed in the first month of life, reducing to 16% at 4-5 months. Another study on breastfeeding practices found that urban working mothers in Dhaka slums found it difficult to breastfeed exclusively because they were away from their homes for long periods during the day. Strategies mothers employed to care for their infants included bringing adult family members from the village to feed and care for the baby during mother's absence, and breastfeeding when she returned home; employing people to care for the baby and to bring the baby to the workplace to breastfeed, or returning home to breastfeed during the working day; or taking the baby to work along with an older sibling who looked after the baby⁷.

This case study and a case study from Kenya are annexed in the full report.

³ International Centre for Diarrhoeal Disease Research, Bangladesh

⁴ Shafique S, Akhter N, Stallkamp G, de Pee S, Panagides D, Bloem M.W, 2007. Trends of under- and overweight among rural and urban poor women indicate the double burden of malnutrition in Bangladesh. *Int J Epidemiol.* 2007 Apr;36(2):449-57. Epub 2007 Jan 22.

⁵ http://www.hki.org/research/NSP_Ann_Report_FactsFigures_2005.pdf

⁶ http://www.unicef.org/bangladesh/media_7455.htm

Review of urban food security targeting methodology and emergency triggers

Summary of report¹



People queuing at an Oxfam feeding programme in Mbare, Harare

A recent report compiled by Oxfam GB, Concern Worldwide and Action Contre la Faim (ACF) aims to assist in capacity building and guidance during emergency responses in urban areas, focusing on food security, livelihoods, and nutrition. It covers emergency triggers and targeting emergency responses in urban areas.

Findings on triggers in urban areas

Triggers are events or indicators that precipitate the beginning or end of an emergency response. Existing frameworks provide a foundation for assessment and for gathering information in various sectors, but there are no urban-specific indicator cut-offs to trigger emergency responses in urban areas. There are a wide range of tools and frameworks used by non-governmental organisations (NGOs) and international organisations, but the most promising analysis framework for urban areas is the Integrated Food Security Phase Classification (IPC), incorporating elements of the HEA and 'Indicator Development for Surveillance of Urban Emergencies' (IDSUE), an attempt by Concern Worldwide to develop urban-specific indicators in Nairobi. In addition, Oxfam has been piloting a combined Household Economy Approach (HEA)/Participatory Capacity and Vulnerability Analysis (PCVA) approach which aims to combine risk mapping and identification of opportunities to strengthen protect and restore livelihoods.

The most common short-coming with these approaches is that they have not been piloted in or adapted to urban contexts. This lack of adaptation of tools in combination with the absence of baseline data (which has been disaggregated by informal settlements) means that it is currently very difficult to establish, with consensus, that an urban area has moved from a chronic to an acute crisis. This slows and confuses responses and blurs the distinction between emergency relief and development programming.

Recommendations on triggers

Key recommendations made in the report include:

1. Use existing coordination mechanisms such as the Food Security Cluster urban working group,²

and work with the WFP and FAO (who are tasked with taking forward the food security element of the Inter-Agency Standing Committee (IASC) urban strategy), to pilot and adapt the IPC tool for use in urban contexts.

2. Identify and agree with the Food Security Cluster urban working group the top five cities at risk of urban emergencies. Develop urban working groups in these cities, i.e. Port au Prince, Kathmandu, Manila, Dhaka, Nairobi, Harare, and Gaza.
3. Within 'at risk' cities, identify 'high risk' urban areas where emergencies are likely to occur (i.e. those vulnerable to natural disasters or price spikes), and develop geographical vulnerability mapping that supports contingency planning.
4. Through the Food Security Cluster urban working group, agree on an assessment approach and baseline mapping indicators, which can disaggregate different urban areas within one city, to ensure there is political consensus amongst key stakeholders and donors prior to an emergency.
5. Once there is consensus on IPC urban indicators, there will need to be a greater focus on urban data collection to feed into urban situation analysis. Although IPC indicators will need to be universally applied, there may be some locally specific adaptations for data collection. As an IPC chronic tool is being developed³, this is also a good opportunity to ensure that it represents urban contexts:
 - a. Some additional locally specific indicators may be required, and both quantitative and qualitative indicators are likely to be important.
 - b. The indicators used need to clearly identify when the acute phase is over.
 - c. The data analysis process and regular re-analysis must be very responsive to change given the pace of change in urban areas.
 - d. The system must be sensitive enough to identify emergency situations in small areas of the city.
6. Establish a clear baseline format for these areas prior to an emergency.
 - a. Baselines (which can be based on markets assessments such as EMMAs⁴) should include calculations of the cost of living including food, travel, fuel, rent, sanitation access, water purchase, education, health and market functionality so that the gap between 'normal times' and the shock can be quickly calculated.
 - b. Use this information to construct a baseline for the vulnerability, risk, coping situation and market access/availability, based on the system in 5 above.
 - c. Use this information to plan geographic and household targeting (see 7 below).
 - d. Utilise all primary and secondary data available, being aware that many other organisations are likely to have information available.
7. Explore the possibility of using technology to develop the information basis, using digital data gathering, and using smartphones, digital platforms and GPS to improve cost efficiency over the long-term. In areas prone to natural disasters (e.g. earthquakes), a low tech alternative should also be prepared.
8. Ensure that contingency planning incorporates building capacity in areas such as cash transfer logistics and finance, to ensure standard operating procedures on cash transfers are available to be applied during an emergency.
9. Ensure that emergency responses form part of an integrated 'One Programme Approach' linking humanitarian and development responses.

³ Review of urban food security targeting methodology and emergency triggers. Final Report. Ian MacAuslan and Maham Farhat. July 2013. See summary this issue of Field Exchange.

² See <http://foodsecuritycluster.net/working-group/urban-food-security-and-livelihoods>

³ <http://www.ipcinfo.org/ipcinfo-technical-development/ipc-chronic-scale/en/>

⁴ Emergency Market Mapping and Analysis. <http://emma-toolkit.org/>

Table 1: Suggested trigger indicator framework

Indicator area	Specific indicator	Threshold	Measurement	Challenges	Comments
Food security and socio-economic status	Household Hunger Score (HHS)	Severe (4-6)	Household hunger scale	Need to define the geographical area narrowly to focus on slums (and poorest areas within them if possible). May need to focus on particular population groups.	HHS shorter than Household Food Insecurity Access Scale (HFIAS) but seems to vary more. HHS is median of HHS of all households in sample.
	Household Dietary Diversity Score (HDDS)	>4 out of 12 food groups	Household Dietary Diversity Scale	High frequency reporting may be a challenge and need to consider frequency of surveys.	HDDS gives average of score of all households. May need to look at individuals as households usually contain one member who eats out, skewing the data.
	A local indicator of food insecurity, such as consumption of street food or food availability	Accelerated depletion/erosion strategies and assets leading to high food consumption gaps	HEA, EMMA		HEA should reveal survival deficit > 20%. EMMA will identify market opportunities.

Research

Table 1: Suggested trigger indicator framework (cont'd)

Indicator area	Specific indicator	Threshold	Measurement	Challenges	Comments
Food security and socio-economic status (cont'd)	Prevalence of negative coping strategies	Greater than usual, increasing crisis and distress strategies	HEA, surveys, key informants, focus group discussions (FGD), Coping Strategy Index (CSI)	Negative coping strategies are defined locally (e.g. reducing food consumption quantity or quality, prostitution, crime, dumpsite scavenging, selling productive assets, unseasonal migration)	
	Debt	Greater than usual, increasing To be determined locally,	HEA, surveys, key informants	Indicator specific to local areas (sometimes implies resilience, sometimes emergency). Changes in remittances, savings, loans, credit, rent arrears and debt should be captured.	Particularly important to understand the local context; for instance in Gaza, debt may indicate likely loss of social network, and therefore a critical situation.
	Credit access	> 20% reduction in access to informal credit mechanisms			
Displacement	Movement forced by disaster or destitution	Concentrated, increasing	Surveys, key informants, slum analysis, camp registrars, UNHCR data	Qualitative indicator meant to capture populations forced to move; threshold is where they are appearing in large numbers and changing the health and protection characteristics of the destination or forced displacement (e.g. earthquake, or slow onset droughts that lead to displacement).	Includes newly displaced or long term refugees or internally displaced population (IDP's)
Hazards & vulnerability	Increasing incidence disease outbreaks	Greater than usual, increasing			
Availability of assistance	Functioning of regular social protection systems	Poorly functioning, low coverage	Key informants, Government statistics	Qualitative indicator intended to capture changes in government provision for vulnerability	This can be a very important indicator where there are no other sources of assistance (as in Gaza, for example).
	Functioning of informal sharing mechanisms	Strained to non-functional	HEA, surveys, key informants	Reference to a baseline figure.	
Essential goods availability and prices	Price of main staple food	>20% seasonal reference, increasing	Consumer Price Index (CPI) from local statistics office, local price monitoring, EMMA, HEA	Need to account for wage inflation, subject to rapid change.	Also useful to assess drivers of prices such as agricultural production, exchange rate, import markets
	Price of fuel	>20% seasonal reference, increasing	CPI from local statistics office, local price monitoring, EMMA, HEA	Need to account for wage inflation, subject to rapid change.	Also useful to assess drivers of prices such as agricultural production, exchange rate, import markets
	Rent cost or loss/change of tenure	>20% seasonal reference, increasing, or forced eviction	CPI from local statistics office, local price monitoring, EMMA	Need to account for wage inflation, subject to rapid change - difficult to define standard unit, depends on size of house, number of rooms, neighbourhood, building materials, etc. Loss of housing should indicate if it is owner occupied, tenant owned, or if the tenant is squatting, living in makeshift housing or protection related issues.	Also useful to assess drivers of prices such as legislative changes, regularisation
	Access to water (litres per person per day (pppd))	4-7.5 litres pppd, or decreasing against a baseline	HEA, focus groups, surveys		SPHERE specifies <15 litres pppd and this may be an appropriate cut-off in urban areas where more water is needed for personal hygiene.
	Price of water / quality of water	>20% seasonal reference, increasing	CPI, local price monitoring, EMMA	Need to account for wage inflation, subject to rapid change.	
Health	Prevalence of illness in last two weeks	Greater than usual for season, increasing	DHS, surveillance systems such as NUHDSS in Nairobi, clinic reporting	Needs to be specific to different diseases to reflect public health risks.	WHO also use case fatality rates (of 1%). Can also have different thresholds for cases/week of specified diseases.
Security	Conflict	Widespread, high intensity	Key informants	Highly changeable.	Meant to cover violence such as post-election violence in Nairobi.
	Prevalence of insecurity (mugging, stabbing, rape, robbery)	Greater than usual, increasing	Surveys, key informants, crime records		
Area outcome: Nutrition	Global acute malnutrition	Greater than usual, increasing, exceeds the seasonal norm	Anthropometric measurements from household surveys such as DHS or MICS, clinic measurements, admissions, anthropometric surveys	Late indicator of crisis. Frequency of reporting is a challenge, and need to focus on specific area and groups.	IPC includes also >15% GAM but this is very difficult to measure accurately in urban areas because it requires high levels of data disaggregation e.g. by slums
	Capacity of nutrition clinics	Unable to cope with demand/ sharp increase in admissions	Clinic reporting	Does spare capacity indicate poor outreach or healthy population? Need to verify whether increases in demand are due to emergency or more health seeking behaviour.	The most vulnerable households do not always utilise clinics which they may associate with stigma or because of the transaction costs associated with choosing between attending clinic versus income generation.
Area outcome: Mortality	Crude mortality rate (deaths/10,000 people/day)	1-2, increasing, >2x reference rate	DHS, surveillance systems such as NUHDSS in Nairobi, local surveys	In many countries, these rates can be above 2 in 'normal' situations. Very difficult to measure frequently in an emergency.	May need to use the 'increasing' threshold.
	Under five mortality rate (deaths/10,000 U5s/day)	2-4, increasing	DHS, surveillance systems such as NUHDSS in Nairobi	In many countries, these rates can be above 2 in 'normal' situations. Very difficult to measure frequently in an emergency.	May need to use the 'increasing' threshold.

EMMA: Emergency Market Mapping and Analysis; HEA: Household Economy Analysis; DHS: Demographic Health Survey; NUHDSS: Nairobi Urban Health and Demographic Surveillance System; HHS: Household Hunger Score;

HDDS: Household Dietary Diversity Score; HFIAS: Household Food Insecurity Access Scale; CSI: Coping Strategy Index; CPI: Consumer Price Index



Nicole Johnston/Oxfam

Recommendations on targeting

Targeting should be approached as follows:

- Use urban coordination mechanisms to identify vulnerable geographic areas within cities and establish population numbers, key stakeholders’ capacity to respond and the gap between them. City-wide vulnerability mapping can reflect population numbers and concentration, livelihood and industrial activity zoning, service provision (both government and commercial), and infrastructure access (e.g. transport, communications, housing etc).
- Adapt integrated baseline HEX/PCVA assessments and analysis including power analysis to provide data on vulnerable groups and risks, as well as highlighting risky geographical zones. In the future, this may include markets assessment methodologies based on EMMA, as there are discussions underway about combining HEA and EMMA approaches.
- In high risk areas, baseline data can provide clear targeting indicators in advance of the emergency. These can be verified once the emergency has hit to ensure that they reflect all of the affected population groups. Joint baseline data collection and contingency planning can help to build consensus prior to the disaster on who is vulnerable and where, and what the community and states capacity to respond and recover is. Targeting in urban contexts needs to take particular care to ensure that vulnerable groups are not overlooked. These include slum dwellers, refugees, IDPs, and socially marginalised groups. The most effective way of tackling this is by breaking the city into grids or predefined areas, and then delineating these areas into sub-units, such as neighbourhoods or street groups to better facilitate analysis. Care must be taken because not all slums and informal settlements are marked on official city maps.
- Apply an adapted IPC framework to urban contexts to enable stakeholders to reach consensus on the level of emergency, and use the response analysis framework to decide on the type of response required and the subsequent targeting.
 - For many emergencies, starting with blanket provision is likely to be appropriate, but targeting will subsequently be required.
 - Base the decision on a calculation of the scale of need and the resources that are currently available or that will be available in the future.

Findings on targeting in urban areas

Good targeting in urban areas takes time, resources and good preparedness and contingency planning. This includes the development of risk and power analysis so that stakeholders, including the government, can identify their capacity to respond and identify where and how many people might be affected by various scenarios, as well as putting in place agreements and modalities for cash transfer mechanisms. NGOs have commonly applied community-based targeting (CBT) in urban areas, but this is very challenging in large cities as urban communities are hard to define. Furthermore, communities and leaders typically lack the coherence, power, confidence and knowledge of their neighbours to do this, given the densely populated and fluid nature of many urban areas.

A number of NGOs have experimented more recently with combinations of scorecards and community key informants instead of CBT. These can often be effective, but need careful tailoring to a specific context. For instance, programme evaluations in Port-au-Prince suggest that given the scale of disaster, blanket targeting, or targeting using an indicator that included isolation (e.g. geographic distance from markets) or displacement (e.g. whether the household has been forced to move by disaster), might have used resources more effectively.

Governments often prefer categorical targeting (e.g. ‘orphans’ or ‘older persons’) because this is simpler to explain and justify to their constituencies, and graduation is simpler (i.e. through no longer being a child, or through death of the older

person). However, these categories do not always overlap well with poverty or vulnerability, or crisis affectedness, so this approach will not always prioritise the most vulnerable in emergencies.

Advantages and disadvantages of different targeting methods are summarised in Table 2. Most methods will use variations of the following indicators:

- **Food security.** Household hunger score and dietary diversity are comparatively easy and fast to measure, though it can be hard to get reliable information.
- **Demographic indicators.** Often (but not always) relevant and quite easy to collect.
- **Livelihoods and income.** Income is critical in urban areas but hard to measure directly, hence the use of proxies. Questions on type of employment are more likely to succeed and are often useful. Questions on debt are important but can be unreliable and sometimes ambiguous.
- **Expenditure.** Highly relevant but hard and time-consuming to collect. Proxies are better.
- **Assets and housing.** Easy and reliable because can be verified by visiting targeting teams, but not always well correlated to poverty following an emergency (therefore weakening the usefulness of proxy means tests).
- **Nutritional status.** Reliable and highly relevant but can be expensive to collect.
- **Health status.** Relevant but not always reliable.
- **Receipt of assistance from formal or informal sources.** Usually highly relevant but can be difficult to interpret in contexts where informal sharing is very common.

Table 2: Summary of targeting methods

Targeting Method	Definition	Advantages	Disadvantages
Administrative targeting	Beneficiaries are selected from a population list; the criteria used for selection differ by programme. CBT is a type of administrative targeting, in which the list of population members is based on community leaders’ knowledge of their fellow villagers. This often uses categorical approaches to targeting.	<ul style="list-style-type: none"> • Simple to use when lists are available • Community engagement (if CBT is used) 	<ul style="list-style-type: none"> • Risk of exclusion if lists are incomplete or out of date • Prone to exclusion if community leaders favour one group
Community-based targeting (CBT)	Community leaders and members identify beneficiary households based on vulnerability criteria identified in FGD and is then triangulated and verified by the implementing agency.	<ul style="list-style-type: none"> • Community engagement • Not limited to small number of proxy criteria 	<ul style="list-style-type: none"> • Risk of exclusion of marginal social or political groups or new arrivals
Geographic targeting	Beneficiaries are selected on the basis of their geographic location (e.g. selecting the poorest and most food-insecure districts, and providing assistance to all households in district).	<ul style="list-style-type: none"> • Easy and quick 	<ul style="list-style-type: none"> • Low targeting accuracy if vulnerable households are widely dispersed
Institutional targeting	Beneficiaries are selected based on affiliation with a selected institution (e.g. enrolled at a selected school, lives in selected orphanage, or receives antenatal services at a selected clinic).	<ul style="list-style-type: none"> • Relatively easy – only institutions are selected and beneficiaries are those that attend the institution 	<ul style="list-style-type: none"> • Excludes people that would be eligible but who do who are not registered to receive services at targeted institutions e.g. IDPs
Means testing	Beneficiaries are selected on the basis of their income, expenditures, wealth or assets.	<ul style="list-style-type: none"> • High potential targeting accuracy 	<ul style="list-style-type: none"> • Time/resource intensive; requires census of all potential beneficiaries
Proxy targeting	Beneficiaries are selected on the basis of an observable characteristic or set of characteristics. Examples of single-proxy categorical targeting include: targeting by anthropometric status, by age and by physiological status (e.g. pregnancy/lactation).	<ul style="list-style-type: none"> • Easy to use if selection traits are obvious • Multi-proxy targeting increases targeting accuracy but may be costlier than single proxy 	<ul style="list-style-type: none"> • Risk of exclusion and inclusion error with single proxy targeting • Proxies may be difficult to observe directly and objectively
Self-targeting	Beneficiaries ‘self-select’ by deciding to participate. Incentives to participate, e.g. cash for work pay is set at a level just below or equal to daily labour rates, which acts as a self-selection mechanism. Aspects of programme design encourage the intended target group to participate and others not to participate.	<ul style="list-style-type: none"> • Avoids time and resource expenses of other targeting approaches 	<ul style="list-style-type: none"> • Risk of significant leakage unless programme is designed to maximise targeting accuracy

- Try to ensure that local government officials are involved in the decision from the outset, and utilise government mechanisms where possible. For example, use existing social protection programmes that can be scaled up in emergencies to deliver cash transfer programmes. Following this decision, begin planning for targeting immediately.
- Decide what geographical areas, vulnerable groups, households or individuals to target.
 - Most targeting criteria will specify both areas and types of households.
 - Understand and take account of local political issues to identify targeting criteria that make sense in the local politics.
 - Work closely with government representatives to ensure all targeting processes are integrated into government programmes.
 - The choice of targeting criteria will need to take into account the feasibility of identifying these areas and individuals.
 - The feasibility of targeting mechanism and indicators will to some extent depend on the information available.
- Specify a targeting methodology, including indicators to identify areas or households.
 - Existing targeting methods should be used or adapted where possible, and targeting must be time- and place-specific.
 - Urban targeting indicators need to be more responsive to change than rural indicators because the pace of change in urban areas is very high.
 - Agree where possible on targeting methodology in advance.

Each targeting method has limitations, outlined above. Targeting design and implementation will have significant impacts on the political credibility of the programme, which is vital in volatile urban areas. There is no perfect methodology that can be recommended in every case. In general, census-based scorecards are likely to be most effective if time and money permit, and if not, carefully implemented community based targeting (CBT) systems will be best (see Box 1).

Finally, when implementing any targeting approach:

- At least 10% of selected households should be visited for verification. If 30% of visited households do not meet the criteria, selection should be re-run.
- A computerised data entry and management system should be designed in advance to track, monitor and provide accountability around targeting.
- Local organisations will need to be involved in implementation, but the name of an international organisation can sometimes help with credibility.

British Red Cross urban learning scoping study

Summary of report¹

The British Red Cross has undertaken a scoping study to better understand the challenges posed by humanitarian action in urban areas, and how the Red Cross and partners might approach them more strategically. The findings are relevant to many others outside the Red Cross international division and partners (the primary target).

The study sets out what works in urban areas, what is relevant to British Red Cross ways of working and what is practical for staff.

It draws lessons from humanitarian programmes worldwide, but focuses principally on evidence from five British Red Cross operational contexts: Haiti (Port-au-Prince), Uganda (Kampala and other cities), Djibouti (Djibouti-ville), Mongolia (Ulaan-bataar) and Nepal (Kathmandu).

It looks at the evolving nature of risk and vulnerability in urban areas relating to natural hazards, urban violence and conflict, markets and livelihoods, health and water, sanitation and hygiene, and shelter, land and the built environment.

The study's observations include:

In urban areas people often have multiple livelihood strategies. The use of tools such as the British Red Cross' household economic security (HES) approach, which involves identifying (geographical) livelihoods zones for analysis, assessment and targeting is particularly challenging in urban areas.

On assessments, the use of the International Federation of Red Cross and Red Crescent Societies' (the Federation's) participatory approach for safe shelter awareness (PASSA) in Haiti was very successful, particularly in ensuring both a participatory and accountable approach.

The British Red Cross has built up experience in cash and livelihoods programmes in recent responses in China, Haiti, Pakistan and Bangladesh. However, there are particular challenges for cash transfer programmes in urban areas, especially in terms of identifying and targeting the most vulnerable, as, for example, seen in the British Red Cross' economic security programme in the peri-urban slums of Djibouti-ville.

The current situation inside Syria highlights the complexities of urban displacement and targeting, with people living with host families, in schools, public buildings, parks and mosques and often displaced more than once.

Investment in information management technology and capacity is often critical. In Haiti, for example, the Haiti Red Cross Society and the Federation, in partner-

³ Learning from the city. British Red Cross Urban Learning Project Scoping Study.

Box 1: Targeting design options

Census-based score cards

Census approaches using targeting scorecards or proxy means tests are usually the most effective methods in urban areas for identifying the poorest most fairly, and also generate a longer list of households for future scaling up of responses, but:

- Organisations may lack funding or time to develop proxy means tests, particularly in rapid onset emergencies. However, scorecards are more straightforward than proxy means tests and templates are available and can be adapted.
- Care needs to be taken adapting score cards or tests using knowledge of the local context and time to verify indicators.
- They must be implemented with the consent and participation of community members, but not with their full control.
- Surveyors should not be able to take final targeting decisions in households as this can undermine their credibility and cause resentment. Ideally, NGO staff should visit households directly to improve credibility.
- Decisions should be made at head office or with an algorithm in the field.
- Results should have some possibility of

'human over-ride' to correct obvious exclusions generated by the tests.

- Digital data gathering can improve the speed and reliability of the process.

Community based targeting (CBT) systems

CBT can identify the poorest households in urban areas and is comparatively fast and cheap to design and implement. If resources are limited, this may be the best option. However:

- Urban populations often do not know each other well and communities are hard to define, which usually results in greater reliance on community 'leaders', who do not always have the knowledge or incentives to target fairly.
- Targeting through community leaders can generate significant resentment, particularly in already fragmented or tense urban areas.
- Strong facilitation and great care are therefore required to ensure that community members and leaders have the knowledge and incentives to participate fairly, and to avoid putting too much pressure on community leaders. This can increase the cost of targeting.



Oxfam provided fertiliser and seeds as well as promotion of community nutrition gardens

ship with telecommunications firm Trilogy International, are creating an interactive communication platform using SMS and interactive voice response technology to enhance accountability to affected communities.

Getting shelter solutions right is a very important element of humanitarian response and recovery, without which successes in other areas such as livelihoods and health will be more limited. Building on its leadership of the global shelter cluster in disaster situations, the Federation has done much to highlight the need for more sustainable approaches to shelter reconstruction in urban areas.

The related issue of land tenure is often critical in urban areas, and navigating legal and political systems is important in ensuring the success of an urban shelter programme. Land tenure issues were among the biggest challenges faced by the British Red Cross team in Haiti. Under the leadership of the Federation's disaster law programme, Red Cross legal experts have been examining the legal barriers to shelter, the impact on vulnerable people and some potential solutions.

National disaster management authorities (NDMAs), have a particularly important role in urban disaster management and should be a key contact point.

A new, area-based method of coordination in urban settings (the integrated neighbourhood approach) is being discussed; this approach was taken by the British Red Cross in Haiti. A geographic approach linked to urban systems has challenges, e.g. where does humanitarian mandate end and that of development and government agencies begin. However, if well managed, such an approach provides a significant opportunity for a more joined-up response from government agencies (including civil defence, emergency services, line ministries and service providers), the private sector and civil society.

While agencies need to adapt to meet the challenge of humanitarian action in urban areas, urbanisation does not change everything. The fundamentals of good programmes, such as high quality contextual analysis and assessments, are common to both rural and urban areas. Yet, given the increasing scale of the humanitarian challenge in urban areas, there is a significant need for strategic planning and institutional adaptation.

The study highlights and elaborates five ways forward for the British Red Cross and partners:

- 1) sharpening context analysis and assessments
- 2) understanding cash and markets better
- 3) engaging and communicating with complex communities
- 4) adapting to the challenges of land and the built environment
- 5) engaging with urban systems and partnering with local groups and institutions.

Three case studies are included in the report (the experience from Djibouti is summarised in Box 1).

Practical tools for humanitarian action in urban areas and a framework for internal and external lesson learning steered by the British Red Cross urban working group is included in the annexes.

Case study

Djibouti: supporting peri-urban livelihoods and markets

In December 2008, following extensive regional assessments, the Federation launched an appeal for the Horn of Africa to address pressing needs in the region's drought-affected countries, whose plight was worsened by the impact of the global financial crisis and rising food prices. The appeal included Djibouti, Ethiopia, Kenya and Somalia, and was followed by a comprehensive plan of action drafted in June 2009. This plan encompassed a wide range of potential programmes including emergency food aid, health, water and sanitation and support for people's livelihoods.

The British Red Cross and the American Red Cross together identified specific components of the plan that they could jointly fund. Both National Societies agreed to fund a programme by the Red Crescent Society of Djibouti designed to protect and support the livelihoods of vulnerable groups affected by the economic and food security crisis in the country. The programme focused on providing vulnerable families living in peri-urban areas of Djibouti with one off microfinance loans to initiate small, yet viable income-generating activities. This was intended to improve the overall economic security of households and to increase their resilience in the face of future stresses.

The programme focused on an expansive squatter community, known as Balbala, with a population of around 250,000-300,000 including people from the Afar, Bedja and Somali tribes, all of whom were extremely poor. This peri-urban area, near the capital, Djibouti City, had very little access to basic services such as health, education and water and sanitation.

The aim of the programme was to help a minimum of 1,000 households, focusing mainly on women. The women received one-off reimbursable loans to initiate viable income-generating activities according to their wishes and capacities. Women who had been unable to access official micro-credit services were encouraged to apply. The long-term aim was that women, and the affected communities more broadly, would use this opportunity to improve their creditworthiness and would gain entry to existing microcredit schemes to pursue their own livelihoods further after the British Red Cross-funded programme came to an end. The reimbursed funds would then be used to finance a series of community-based projects to provide benefits to the targeted communities as a whole.

To ensure that the micro-credit project was accepted by all stakeholders and was implemented in a way that complemented the work of other groups, a step-by-step approach was taken that sought to avoid doing any unintended harm to the beneficiary communities themselves or to the existing microcredit system that served them. The approach was piloted from January 2010 with the disbursement of 100 micro-loans. It was hoped this approach would both benefit the community and establish the Red Crescent Society of Djibouti with a good reputation for this type of programme.

The project saw important successes in terms of delivery and impact, with the project providing 946 micro-loans, with a repayment level of around 93 per cent. Women used the loans to increase their base of productive assets and every beneficiary has now become a member of the micro-loan provider, while lending groups have applied for new loans after repaying their first loan.

Yet the programme encountered two central challenges relating to its urban setting. The first challenge was the identification and targeting of beneficiaries. Targeting the poorest people in an area where the British Red Cross had never worked took some time and a good deal of community sensitisation. Available socio-economic data was unreliable. Targeting was further hampered by security and access problems. Due to the unplanned nature of the settlements, the slum areas were very difficult to navigate and households were often hard to locate. Self-targeting through community meetings was deemed the best option but this proved time-consuming and demanded the support of an in-country programme manager.

A related challenge was the need to better understand household economies and existing debt burdens. Many people in the project lived day to day, barely earning enough to cover basic survival. Taking on debt in hard times is a coping mechanism, and no livelihoods approach can succeed without taking this into account. This point, again, highlights the need to better understand urban markets and financial systems and how they are both formed by and shape the communities that engage in them.



Port au Prince, Haiti

Global survey of the implementation of UNHCR's Policy on Refugee Protection and Solutions in Urban Areas

Summary of review¹

The advent of the 2009 Urban Refugee Policy (see Box 1) definitively changed UNHCR's approach to working with urban refugees and established clear protection objectives. In 2012, the UNHCR's Urban Refugee Steering Group commissioned a review of its largest urban refugee operations in 2012. This involved a detailed survey that was sent to UNHCR's 24 operations with urban refugee programmes that numbered more than 5,000 according to UNHCR's 2011 statistics. The survey sought to gauge the rate of implementation for each of the 24 UNHCR operations against the twelve protection strategies set forth in the policy. The aim was to provide a baseline for future implementation measurements and to identify good practices and specific challenges concerning urban refugees.

Despite the 2009 policy's radical departure from its predecessor, operations were reporting that

they were implementing the policy to a large extent. At the same time, they also highlight very real gaps, challenges and constraints in working with urban refugees. Although the plight of urban refugees is most deeply understood on the regional level, universal themes have emerged from this global analysis. All the themes point to the necessity of employing new methods with more innovative tools such as interactive websites and mobile messaging; engaging diverse actors such as neighbourhood chairmen and local merchants societies and advocating for urban refugees on the basis of their potential added value, as opposed to on the basis of human rights.

Key findings from the survey were as follows.

Documentation and status determination

Many urban refugees are often unable to formalise

their status and obtain documentation due to distances to government or UNHCR offices, related travel costs, fees, a lack of awareness of the registration process among urban refugees and fear of arrest. Because of these vulnerabilities, UNHCR operations should continue to explore methods that provide registration, documentation and status determination in a more efficient manner. This is especially critical in urban areas where the lack or non-recognition of documentation is linked to the provision of basic human services.

On-going good practices include the use of mobile teams, enhanced neighbourhood and municipal partnerships, the exploitation of appropriate communication technology, and, training of government officials involved in protection documentation. Across the board, it was found that the operations had insufficient space to receive refugees and asylum seekers and not enough staff who spoke their languages; it was recommended that operations invest to increase their use of communications technology, capacitate partners and streamline registration, documentation and status determination processes.

Constructive community relations and security

As the survey findings repeatedly flagged both the importance and difficulty of reaching out to urban refugees, new approaches could be tried to both foster effective refugee community structures and provide programmes that are mutually beneficial for refugees and host neighbourhoods. To date, there have been good results with the use of sms messaging, question & answer sessions, participatory assessments, partnerships with community-based organizations, recreational and cultural activities and educational programmes to help refugee communities come together. These good practices are consistent with the survey finding that it is the relationship with civil society at large, as opposed to a specific government entity, that is the key to expanding the protection space for urban refugees and asylum seekers. Pro-active outreach is essential for refugees to be aware of the protective mechanisms, services, livelihood opportunities and durable solutions available to them – through UNHCR, government or civil society – and to understand how to access them. New and non-traditional partners (mosques, churches, merchants associations, city social workers, etc.) could be enlisted to help promote integration and protection for refugees.

Survey findings also clearly reinforced the link between effective outreach and communication with refugees and prevention of security incidents. Paradoxically, survey findings indicated that many offices find that the defensive security protocols,

³ Learning from the city. British Red Cross Urban Learning Project Scoping Study.

Box 1: Targeting design options

UNHCR policy on refugee protection and solutions in urban areas (2009)

Until 2008, UNHCR continued to give primary attention to those refugees who were accommodated in camps, encouraged by UNHCR's 1997 policy statement on refugees in urban areas that assumed refugees were more the exception and less the norm. Recognising the need to address the issue of urban refugees in a more comprehensive manner, UNHCR replaced the 1997 policy statement with a 2009 policy.

This document set out a number of clear statements about urban refugees and the new policy including:

- 'Urban area' was defined as a built-up area that accommodates large numbers of people living in close proximity to each other, and where the majority of people sustain themselves by means of formal and informal employment and the provision of goods and services. *While refugee camps share some of the characteristics of an urban area, they are excluded from this definition.*
- The policy is based on UNHCR's mandate to protect the rights of refugees and to find solutions to their plight.
- The 2009 policy implementation will take account of the UNHCR and partner experiences and effective practices in urban contexts.
- In some countries, refugees have the option of living in a camp or organised settlement, whereas in others they do not. Some countries with urban refugee populations have signed the 1951 Refugee Convention and provide refugees with a legal status, residence rights and the right to work. In other countries such conditions do not prevail. In some countries where camps exist, refugees are officially obliged to stay there. In other countries, the movement of refugees from camps to urban areas is either permitted or tolerated.

The 2009 policy does not provide detailed operational guidelines, or deal with internally displaced persons or returnees in urban areas. It recognised the need adaptation to the specific circumstances of different countries and cities. It is primarily related to the situation of urban refugees in developing and middle-income countries where UNHCR has a presence and an operational role.

To achieve the policy objectives, an appropriate resource base would be required, coupled with effective cooperation and support from a wide range of other actors, especially those host governments and city authorities in the developing world that hosted the growing number of urban refugees.

The policy intended to apply to refugees in all urban areas, recognising that UNHCR would be constrained in its ability to attain this objective in countries where refugees were scattered across a large number of urban locations.

The policy paper deals with a number of key themes related to urban refugees:

- Securing the rights of urban refugees
- Expanding protection space
- Respecting key principles
- Implementing comprehensive protection strategies (e.g. providing reception facilities, undertaking registration and data collection, determining refugee status, reaching out to the community promoting livelihoods and self-reliance, ensuring access to healthcare, education and other services).

UN High Commissioner for Refugees, *UNHCR Policy on Refugee Protection and Solutions in Urban Areas*, September 2009. Available at: <http://www.refworld.org/docid/4ab8e7f2.html> [accessed 4 September 2013]



UNHCR/Global Survey Report 201

prescribed to help keep UNHCR property and staff safe, actually make it harder to be accessible and responsive to refugee needs and to build the rapport with refugee communities, which in turn helps to keep the office safe.

A safe and sustainable existence for urban refugees

Urban refugees' access to viable livelihoods is the key factor establishing their well-being or even just survival. If urban refugees can secure a livelihood and meet their basic material needs, they can better manage (and afford) to access services like education and health. Often this debate around livelihoods focuses on whether or not the host government provides refugees with the legal right to work per se. However, access to financial capital, credit and banking services is in fact more salient. Other factors – the socio-economic situation in the host country, refugees' skills relevant for the urban economy, freedom of movement, the status of refugees' documents and perceptions about resettlement – also significantly influence whether urban refugees can be self-reliant or not. UNHCR operations should explore other avenues when the advocacy for the right to work is blocked or detrimental to negotiations for safeguarding the larger protection space.

UNHCR should continue to invest in the ongoing efforts to support refugees' self-reliance beyond the advocacy for the right to work, such as targeted training programmes, support for small-scale informal market activities and collaboration with established civil society programmes. However, there is a sense among some staff that UNHCR does not possess adequate expertise internally or among traditional partners to creatively and holistically address livelihoods for urban refugees. Most survey respondents indicated that they would welcome the continued development of innovative livelihood programmes that link to cash transfers and durable solutions within the context of civil society partnerships.

Resettlement is the primary durable solution for urban refugees. By necessity, resettlement continues to be an important strategic tool used to leverage protection space in those countries that maintain restrictive legislation and practice regarding refugees. However, this clearly runs the risk of creating or exacerbating a pull factor into

these urban areas. Furthermore, UNHCR offices reported that refugees may be reticent to invest in livelihood activities in their country of displacement for fear that it might undermine their chances for resettlement. Finally, resettlement drives UNHCR registration and refugee status determination efforts, which are already stretched past capacity. When operations send clear messages to refugees about the actual likelihood of resettlement, it can motivate refugees to invest more in their livelihoods and education.

In several countries, patient advocacy and diplomacy has resulted in more progressive domestic legislation specific to refugees. In these countries, the possibility of local integration and permanent residence has been linked to livelihood programmes, which is a promising practice. However, it is important to recognise that some countries with restrictive refugee regimes are not likely to loosen their migration and refugee policies in the foreseeable future. In these cases, the best course may be to advocate for minor changes in policy and practice that can function as protective mechanisms rather than wholesale improvement of the legal framework.

Constructive engagement with host country governments and development of those governments' capacity to assist in addressing refugee issues are important tools.

Summary of recommendations

Urban areas are expansive and intricate environments in which to promote refugee protection. Refugees themselves live in marginal neighbourhoods with the urban poor, use the same (often underdeveloped) services and are linked with them through local economic activity. In many contexts, refugees (and the host communities) perceive that their stay is temporary pending resettlement, thus resettlement oriented refugees are less keen to invest in community structures, livelihood activities, learning the language and other integration efforts, which leaves them more reliant on UNHCR. On the other hand, there are untold numbers of refugees and asylum seekers who are trying to stay concealed from the government and UNHCR so that they may remain unnoticed for a long time. It is possible, this uncounted, unregistered population that has made greater strides toward integration. Thus, the survey results corroborate that effective refugee protection

in this complex context requires a multi-faceted, open approach.

Recommendations for a way forward for UNHCR include:

Multi-level, systemic and holistic engagement with key government actors

- Invest strategically in government partners responsible for immigration, refugees and security where it is likely to work, including the use of shared, online databases, biometric tools and standard operating procedures.
- Advocate for minor changes in policy and practices in countries with a very restrictive approach while supporting social capital within the refugee community and its immediate environs.
- Continue and expand advocacy and capacity development with line ministries responsible for key services, such as health, education and social welfare at the national, sub-national and municipal levels and local (neighbourhood level).

Innovative and extensive approaches to community outreach and development

- Professionalise outreach and invest in national, professional social workers.
- Engage with local legal aid societies to help refugees acquire documentation for businesses, bank accounts, rental properties and other business transactions.
- Use assessments, profiling or other tools to better understand and map refugee and asylum seeker populations and the nuances of the socio-economic and political positions of their neighbourhoods.
- Develop creative approaches, including expanded field outreach through non-traditional associations such as parent and teachers associations, sports clubs and religious groups combined with the use of modern communications technology.
- Develop innovative ways to empower refugee community groups so that they can take a more active role in socially and financially supporting their respective communities without creating ghettos.

Stronger linkages between material assistance, livelihoods/self-reliance, local integration and community development

- Develop new and more effective partnerships with civil society organizations that have expertise related to livelihoods, e.g., chambers of commerce, street vendors associations, neighbourhood groups.
- Use technology, including ATMs, M-Pesa, internet banking tech solutions etc. to support livelihood activities and access financial capital.

A review of how UNHCR uses durable solutions strategically to enhance protection

- Review the approach to durable solutions in urban contexts and critically consider, in particular, how refugee's perceptions about opportunities for resettlement and local integration may affect their efforts to be self-reliant.

A consultation with key actors on refugee protection in urban contexts

- Bring UNHCR staff with experience in urban contexts together with key government, UN, NGO and civil society actors to brainstorm and explore more effective and efficient ways to ensure refugee protection in urban areas.

Access the full report at:
<http://www.unhcr.org/516d658c9.html>

Malnutrition research in urban Africa: issues and opportunities

By Kelsey DJ Jones

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Kelsey Jones is a paediatrician doing clinical research on acute malnutrition between the KEMRI-Wellcome Trust Research Programme's laboratories in rural Kilifi and an outpatient therapeutic feeding programme run by the non-governmental organisation 'German Doctors' in Mathare Valley, Nairobi. He shares some of his observations on the challenges of conducting operational research amongst vulnerable urban populations.



Screening for acute malnutrition in a Kenyan slum

Kelsey Jones, Kenya, 2013

There is increasing recognition that addressing health and social problems faced by those living in urban slums will require adaptation rather than wholesale import of approaches developed in rural areas. For malnutrition, it is likely that the determinants and risk factors are completely different in an environment that is entirely cash-based, where even water is a daily expense, compared to places in which subsistence farming is the norm. Treatment or preventative strategies may need to be directed towards overcrowding, poor sanitation and stress just as much as acute or long-term food insecurity. Up to now, in Africa at least, urban settings have received nothing like the levels of research interest and investment as are directed towards rural areas. But for the work of a few pioneering groups like the African Population and Health Research Centre (APHRC), our current conception of the scale and types of problem that exist in urban slums is almost entirely at the anecdotal level: a situation that will need to change in order to reflect an Africa that is urbanising at a tremendous rate.

In Mathare, the process of establishing a research presence has been made easier by the fact that the 'German Doctors' clinic already has excellent community relations and outreach. Getting started is never totally straightforward, though, and has presented a number of themes and issues – opportunities as well as problems – that may be common to many urban areas. Perhaps the greatest challenge relates to the interconnected issues of frequent short-term migration, access and security. Stable communities grow and are bound together by a shared sense of belonging, but very few people live in Mathare by choice. 'Home' is often outside of the city, and trips back and forth as either is more able to meet immediate needs, are a fundamental part of many people's urban existence. Research often requires a constancy of setting and population that is difficult to reconcile with this. Whether it is being prepared to deal with an unstable population structure or having contingencies in place to trace participants who travel, factoring this in is essential. Personal mobility in and out of urban areas is not matched by freedom of movement with

the slum. Well-justified fear of crime and the maintenance of traditional village socio-political structures means that those who are considered 'outsiders' are spotted quickly and can be objects of suspicion. Working within existing local frameworks is critical to gaining community trust and consent. Community Health Workers (CHWs) are frequently underutilized and resourced, but the very fact of working in such a role, often unpaid, demonstrates vocation and commands the respect of the community. In Mathare, working with a group of committed CHWs has allowed us privileged access to a marginalised community, and has greatly increased the depth of my own understanding of the environment. The potential for engendering emotional conflict, by virtue of the fact that these are people who often live in the slum and so are to some extent both object and agent of the research, means that such relationships should be handled sensitively.

Ethical aspects of working with vulnerable populations will be familiar to all who work in areas where malnutrition is prevalent. In Mathare, I have found that balancing and establishing appropriate frameworks for fair compensation for research participants to be a particular challenge. When most mothers have to go out in the mornings to look for paid work (often washing clothes, for example) to pay for food/water/toileting for that day, the opportunity costs of attending research visits can seem enormous. The idea of 'paying' for involvement is not acceptable, because it generates disincentives to health and jeopardises community support, but providing fair expenses is very challenging, when participants live within walking distance. If most days' search for casual work is in vain, receiving expenses for a research visit might be very attractive – but isn't that the same as paying for involvement? Our approach has been to carefully think through how to maximize potential productive working hours via use of home and out-of-hours visits, streamlining less-essential research activities, and relying on provision of ancillary benefits to the whole community. As interest in urban research increases, synchronising approaches to these issues is critical. Different research

groups doing different things will cause huge problems, and I feel that this would be a productive area for further work and understanding.

Working in the city affords easy access to sophisticated laboratory facilities, to greater numbers of participants, and to the political decision-makers that turn research into policy. But though these are extremely important benefits, for me the most important difference to rural areas is the ubiquitous transparency of inequality. Nairobi houses many very poor people and a few very rich, and the distribution of health and wellbeing is intensely geographically defined. The parents I work with in Mathare want to work hard, and have a drive to improve their family's situation that I think is partly a consequence of the immense disparity in living standards in the city. Perhaps such feelings lie behind the great enthusiasm and generosity of spirit that I have encountered when initiating research – where aiming to improve on the current situation is also the guiding principal. It is certainly a great source of motivation for me. In fact, the immediacy of this inequality formed part of the inspiration for my current main project. The same child with a mid-upper arm circumference of 11cm, stunted, chronic diarrhoea and raised inflammatory indices is defined as suffering from 'severe acute malnutrition' in Mathare, but might be labelled inflammatory bowel disease (IBD) in one of the big private clinics over the road. Who is right?

There is a pressing need for more research in urban settings, great opportunities for partnership with communities and individuals, and no shortage of inspiration. We are performing a pilot randomised controlled trial to see whether simple, cheap medications that aid growth in paediatric IBD might be safe and useful in malnourished children (NCT01841099). I hope this article will help to encourage more people to think about getting involved.

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Debunking urban myths: access & coverage of SAM-treatment programmes in urban contexts

By Saul Guerrero, Koki Kyalo, Yacob Yishak, Samuel Kirichu, Uwimana Sebinwa and Allie Norris



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Introduction

Over the last decade, the treatment of SAM has been mainstreamed and rolled out around the world. Today, there are more SAM treatment services than ever before, covering a wider range of contexts. As part of that transition, SAM treatment has transcended from solely focusing on isolated, rural areas (often during/following a period of food insecurity and conflict), to urban areas in more stable, developmental contexts. This transition has exposed SAM treatment programmes to a number of variations in the causes (actual and perceived) of SAM and the way in which people respond to it, as well as variations in the way in which SAM treatment is delivered.

With the introduction of easy-to-use coverage assessment methodologies, and their application in a variety of urban contexts including Kenya, Liberia, Haiti, Democratic Republic of Congo (DRC), Afghanistan, Cameroon and Zambia, a growing body of evidence about SAM treatment in urban settings is emerging. What this evidence provides is a series of lessons about the challenges and opportunities presented by urban environments, and how, in reality, barriers and boosters to access are often dramatically different to how they were once perceived. As our understanding of urban programming grows, many of the underlying urban myths that have shaped SAM treatment programming have been exposed. This article draws from a range of experiences in different urban contexts to shed light on four of the most common myths influencing SAM programming.

Expectations & performance

There is a widespread consensus that urban contexts are unique, with specific sets of challenges and opportunities that affect access to primary health care programmes. In the case of SAM treatment, there are no universally agreed standards to evaluate how accessible SAM treatment programmes should be in urban environments. The only such available reference is the SPHERE Standards, which stipulate coverage rates of >50% for rural programmes, >70% for urban programmes and >90% for camp settings. These standards are clearly designed for humanitarian, emergency programmes and are therefore not always applicable to the developmental, urban environments in which SAM treatment is currently delivered. But there is a profound assumption underpinning SPHERE standards that has come to shape expectations of coverage in urban programmes; that SAM-treatment programmes in urban programmes should reach a higher proportion of the affected population than its rural counterparts.

This in turn implies that access is easier in urban environments, that barriers are somehow more easily surmountable. Part of this belief stems from the fact that access is (wrongly) equated with distance, something which is indeed significantly different compared to rural environments. But physical access is only a part of it; coverage is ultimately defined by the capacity of a programme to enrol a high proportion of the affected population (uptake) and the capacity to retain these cases until they are successfully cured (compliance). Coverage and defaulting data therefore provide the necessary evidence to determine whether these assumptions

about easier access in urban environments are justified.

Defaulting rates in urban contexts

Evaluating the comparative performance of urban programmes requires a baseline, a sense of what the average or expected defaulting rate is in a 'normal' SAM treatment programme. SPHERE stipulates that the default rate of a SAM treatment programme should be <15%. This threshold is corroborated by a recent analysis carried out by Action Contre la Faim (ACF) with publically available data from (urban, rural and camp) SAM treatment programmes (n =85 programmes) covering the period 2007-2013, which found a median defaulting rate of 13%.

Using these two figures as a reference, we find that defaulting is higher in urban SAM treatment programmes than in any other setting. Coverage assessments carried out in Lusaka (Zambia) in 2008 found defaulting of up to 69% of total exits in some facilities. Similar assessments carried out by the French Red Cross in urban Maroua (Cameroon) in 2013 found defaulting rates of 28%. Data previously published in Field Exchange (Issue 43) has shown the challenges faced by Concern-supported SAM treatment services in Nairobi (Table 1). Together this body of data suggests that compliance is actually lower (defaulting is higher) in urban environments.

Some of the most extensive and diverse information on defaulting in urban contexts has come from SAM treatment programmes in Port-au-Prince (Haiti). Inter-agency coverage assessments carried out in 2012 found a range of defaulting rates across different agencies (from 4% to 39%). What these assessments also found was that defaulting was more pronounced in programmes operating in urban slums. And this raises an important point: urban areas are not homogeneous but are a patchwork of different socio-economic groups facing different barriers to access. Designing and developing SAM treatment programmes for an 'average' urban population risks the marginalisation of some of these populations.

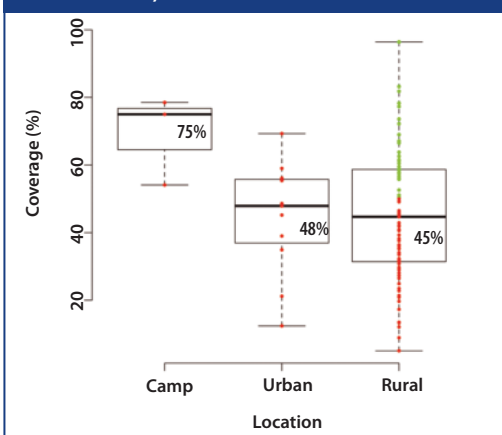
Coverage rates in urban contexts

There is additional evidence available to suggest that urban SAM treatment services are not more accessible than rural programmes. A sample of over 100 coverage assessments (including rural, urban and camp programmes) carried out between 2003 and 2013 shows that on average, urban programmes perform only marginally better than rural programmes. To date, however, no urban programme (in emergency or non-emergency context) has recorded coverage rates above or equal to those stipulated by SPHERE.

Table 1: Data from Nairobi SAM-treatment programme

Year	No. of Admissions	Cure Rate	Death rate	Default rate
2008	1,607	48.4%	2.4%	47.0%
2009	2,737	67.4%	3.1%	28.1%
2010	4,669	76.0%	2.0%	21.0%
2011	6,117	81.4%	1.8%	16.8%
2012	6,859	85.2%	1.0%	10.8%

Figure 1: Median coverage of outpatient SAM-treatment programmes (2003-2013, by context with highest & lowest recorded rates)



Coverage assessments, however, have done more than simply challenging the assumptions about access to urban programmes. More importantly, they have provided a wealth of data that sheds light on why access to urban programme is challenging, and the extent to which specific characteristics of urban environments affect coverage. The data are helping to provide the necessary evidence to debunk four of the most common urban myths about SAM-treatment services.

Urban myths about access to urban SAM-treatment services

Myth 1: Greater awareness about services and SAM in urban contexts leads to earlier presentation and improved health seeking behaviour

Access and coverage of SAM-treatment services is heavily influenced by health seeking behaviour (HSB). HSB in turn is influenced by a caretaker's understanding of the causes of SAM (aetiology) and the recognition and trust in health facilities where treatment can be found. One of the most common misconceptions about SAM treatment in urban environments is that traditional beliefs about aetiologies and corresponding HSB generally found in rural areas do not extend to urban environments. In other words, caretakers living in urban areas are thought to be able to recognise SAM as a health condition that can and should be treated in health facilities.

The experience of implementing SAM treatment programmes in urban environments, however, has helped uncover a more complex picture of HSB. In Monrovia (Liberia) and urban Maroua (Cameroon), for example, knowledge of SAM as a unique health condition has been found to be generally limited. Teenage pregnancies and the isolation of many households from the broader, inter-generational network commonly offered by rural communities were found to be compounding factors reducing awareness about the condition. Traditional Health Practitioners (THPs) are active in Monrovia, providing both preventative as well as curative services for malnutrition. There is evidence to suggest that they represent, in many cases, a first tier in HSB. Similarly, religious leaders (including Christian Pastors) also have a central role in HSB. In Kinshasa City Province (DRC), pastors are frequently consulted as a result of the stigma attached to malnutrition which discouraged cases from presenting openly at the health centre. In Kisumu (Kenya), coverage assessments have shown how cultural beliefs and practices have contributed to late presentation of SAM cases in treatment centres. Wasted and oedematous children are thought to have been bewitched and thus the services of a traditional

healer are often sought first. In Port au Prince (Haiti), malnutrition signs were clearly recognised by mothers, but they were generally understood as being the signs of a natural/mystic disease (djiok) caused by a curse or witchcraft associated with jealousy. The taboo associated with malnutrition led health staff to focus on the issue of 'low weight' instead of malnutrition to prevent defaulting. In spite of the large scale efforts to identify and treat malnutrition following the 2011 earthquake, continuing late presentation of SAM cases suggests limited changes to HSB. A similar lack of understanding of the causal factors and signs of malnutrition in Tadjourah town (Djibouti) meant that, although fever and diarrhoea were clearly seen as health conditions that could and should be treated in a health facility, the resulting wasting was not always perceived as needing treatment.

What these examples demonstrate is that the need to understand community perceptions, and invest in community sensitisation and active case-finding activities, is as pressing in urban environments as it is in rural areas. Many SAM treatment services, including those in Kisumu (Kenya), have recognised the need to identify and incorporate THPs into their community mobilisation activities. Programmes must recognise actual HSBs linked to SAM treatment and develop ways of adapting service delivery to reflect these.

Myth 2: Fewer facilities can deliver acceptable access and coverage in urban contexts

Geographical coverage, often defined as the proportion of health facilities in a given area offering a particular service, is key to ensuring optimal programme coverage. In rural settings, SAM treatment programmes generally aim to locate services in hard-to-reach areas, ensuring that travel times are as low as possible. In urban settings, however, higher population density and a comparatively smaller spatial area often leads to a programmatic assumption that fewer service delivery points (health centres, posts, clinics) can still deliver optimal programme coverage.

In Monrovia (Liberia), for example, a SAM treatment programme supported by ACF aimed to deliver services for the entire Greater Monrovia by using only eight out of the 250 health facilities in the city. When evaluated in 2011, the services were only reaching an estimated 24.8% of SAM cases. In Nairobi (Kenya), SAM treatment services supported by Concern Worldwide initially increased from 30 to 54 Outpatient Therapeutic Programme (OTP) sites in recognition of the need to increase service delivery points. Even then, coverage assessments showed that access was still limited, leading to a decision to double the number of sites. Today, SAM treatment services are delivered through 80 facilities.

Finding the right number of service delivery points requires a degree of advanced planning and testing. The right framework does not always involve incorporating SAM treatment services into all available facilities, and the costs associated with this may make it unfeasible. What experience has shown, however, is that successful urban SAM treatment services require networking and inter-connectedness between different facilities that can assist in the identification and referral of SAM to treatment sites. In Nairobi (Kenya), for example, the project has identified the need for children being treated by Outpatient Departments (OPD) and Comprehensive Care Centres (CCC) in urban areas to regularly screen children's mid-upper arm circumference (MUAC) and refer SAM cases to connected facilities offering SAM treatment services. Such partnerships require collaboration and coordination

between different stakeholders. In Port-au-Prince (Haiti), there were six organisations delivering SAM treatment services. A coverage assessment carried out in 2012 found poor linkages between the different non-governmental organisation's (NGO's) programmes, resulting in community volunteers referring SAM cases to the health facility supported by the NGOs they were working with, instead of referring to the nearest one. The multiplicity and high turn-over of the programmes/interventions from different NGOs in different fields was also identified to be a confusing factor for the population. Both of these factors had an impact on the collective coverage of these interventions.

Myth 3: Opportunity-costs for attending SAM-treatment services are lower in urban contexts

SAM treatment has traditionally been implemented in rural, mostly-agricultural environments in which seasonality and labour needs had a significant impact on treatment compliance and defaulting rates. It is often assumed that the absence of agricultural duties grants urban residents greater flexibility and lower opportunity costs for attending SA-treatment services.

In Nairobi and Kisumu (Kenya), however, SAM treatment services found that caregivers are time constrained, making weekly OTP follow up visits a significant challenge. Like many fellow caretakers of SAM children in Monrovia (Liberia) and Port-au-Prince (Haiti), most come from lower socio-economic strata and make their living as petty traders. Their ability to attend regular, day-long SAM treatment services can represent a loss of anywhere from 16% to 20% of their weekly income. Generally speaking, the risk is even greater for those formally employed; repeated absences can result in the loss of their (rare and difficult to obtain) employment. The high opportunity costs manifest in the high defaulting rates (see above) and low compliance with referrals that are commonly recorded by SAM treatment services in urban settings. Opportunity costs for caretakers in urban contexts are equal or higher than in rural areas. SAM treatment programmes can successfully deal with this by introducing operational measures designed to reduce attendance and opportunity costs. Potential measures can include bi-weekly visits (to replace weekly attendance) and extending opening times to evenings and weekends.

Myth 4: Urban populations are static with limited or no movement or migration

The fourth and last common urban myth is that migration (short or mid-term) and population movement somehow affects urban populations less than those in rural areas. Once again, the experiences from the field tell a different story.

The population of urban slums in Nairobi and Kisumu (Kenya), for example, have been found to be very mobile. The forces that shape their movement are many, and include short-term relocation to rural areas, accidental destruction of their homes (e.g. fires) and the need to identify new credit facilities after exhausting previous ones. In Monrovia (Liberia) and urban Maroua (Cameroon), change of address and short and mid-term relocation have also been found to be very common as land-ownership is even rarer than in rural areas, and residents relocate whenever employment or housing opportunities change. In Les Cayes City (Haiti), admission from certain neighbourhoods were subject to high defaulting rates due to the dynamic populations that often move from and to the capital and rural areas. In Tadjourah (Djibouti), the start of the school holidays and the peak of the hot season

result in frequent population movements from urban areas to cooler, upland, rural areas, contributing to defaulting. This migration between urban and rural areas has also been noted in other settings. In Bandundu and Kinshasa City provinces (DRC), peri-urban populations retain land for farming in rural areas or near their village of origin and family members often relocate to this land for extended periods, particularly during the planting and harvesting seasons. This mobility is vital in order for families to ensure a degree of self-sufficiency and thereby reduce expenditure on expensive food-stuffs sold in the town. In Kabul (Afghanistan), the size of the population living in informal settlements (KIS) varies depending on the season, with significant seasonal migration occurring during winter, when weather conditions deteriorate and employment opportunities decrease. During this period, families tend to migrate to the warmer eastern part of Afghanistan and to other big cities, leading to significant drops in attendance and increases in defaulting.

When migration and relocation occurs, caretakers seldom inform SAM-treatment service providers, thus preventing transfer to facilities closer to the new locations, and thus contributing to defaulting. Service providers must recognise that urban populations are not static; efforts must be made to constantly communicate to caretakers their right to be transferred to other facilities.

Conclusions

As SAM treatment services become more widely available in different contexts, new challenges will continue to emerge. The experiences of rolling out such services in urban contexts has shown that many of the underlying assumptions, or 'urban myths', that have traditionally shaped these interventions do not correspond to the more complex reality posed by urban populations. These urban features mean that some core elements of outpatient SAM treatment must not only be maintained (e.g. community sensitisation and case-finding), but also adapted to the specific challenges and opportunities of urban contexts. The experiences of many urban SAM treatment programmes are increasingly proving that improving access to services is not only a question of doing more (more service delivery sites, more information) but also of doing better. What is needed is the kind of participatory design that truly acknowledges the needs of the population it seeks to support. Changing attitudes about urban populations is only part of the challenge to improving access to SAM-treatment services. Gaining the political will to radically reshape treatment services to make them truly accessible to a complex, mobile, and often marginalised urban population remains the greatest task yet.

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Exchanging voucher for food

Use of cash vouchers in tropical storm emergency response in the Philippines

By Nashrudin Modin and Demosthenes Militante



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for the FSL in the Tropical Storm Washi emergency response project. Currently he is the deputy consortium coordinator of ACF in the emergency response to Typhoon Bopha.



Demosthenes Militante has worked in the Philippine mission of ACF International as FSL Coordinator since 2010. Prior to ACF, he had worked for six years in the

FSL programme of another international NGO in the Philippines.

ACF is working with three other international NGOs in this consortium - Plan International, Save the Children International and Care Netherlands. The authors gratefully acknowledge the contributions of Dr. Martin Parreno, Nutrition Coordinator, who contributed to the explanation about the therapeutic programme for the SAM children. This project was funded by ECHO, the Spanish Agency for International Cooperation for Development and Ajuntament de Barcelona.

Late afternoon of 16 December 2011, Tropical Storm (TS) Washi hit Mindanao, a major island in the southern part of the Philippines. It was felt in at least 13 provinces in seven regions in the Visayas and Mindanao islands. The most severely affected in terms of loss of lives and damage to properties was Cagayan de Oro City in Misamis Oriental province and Iligan City in Lanao del Norte province, both in Mindanao. The final casualty count almost reached 1,500 while an estimated 641,098 persons (or 92,964 families) were affected, 43,663 of whom were moved to evacuation centres. Some 9,193 households lost their homes while 18,873 others had homes partially damaged. Besides the loss of lives and destruction of thousands of homes, TS Washi also had a disastrous impact on people's livelihoods. The total cost of damage to agriculture and infrastructure was initially estimated at EUR17.5 million.

A three-month emergency intervention was implemented by Action Contre la Faim (ACF) and consortium partners, Plan International, Save the Children International and Care Netherlands. One of the intended results of the project was to reduce the vulnerability of the most affected households by improving their access to food. This was in response to rapid needs assessment findings that affected families, mostly in the evacuation centres, were highly dependent on food aid. The emergency intervention was implemented in the two cities of Cagayan de Oro and Iligan. The insights shared in this article are extracted from the post-activity analysis and post-distribution monitoring conducted by the ACF team.

Strategy

The initial strategy of ACF's Food Security and Livelihoods (FSL) team was to provide blanket food assistance to families in evacuation centres. However, the overwhelming response from various sectors (e.g. government agencies, international humanitarian agencies, local non-governmental organisations (NGOs), private groups and individuals, religious organisations, etc.) at the onset of the emergency resulted in a glut of food assistance. The aid provided was mostly dry items and canned goods, often of poor quality and low nutritional value.

As a result, ACF's FSL team shifted their strategy to targeting pregnant and lactating women (PLW) and children suffering from severe acute malnutrition (SAM). A cash voucher¹ programme was implemented to allow the target beneficiaries to purchase a variety of nutritious and fresh foods. This was viable as a rapid assessment by ACF showed that shops, public markets, groceries and supermarkets in the two cities were operating normally.

Cash vouchers were distributed to 3,035 beneficiaries, of whom 2,973 were PLW and 62 were SAM children and their families. To identify the target PLW and SAM beneficiaries, the FSL team worked with ACF's Nutrition team, who were then implementing care practice support to PLW and a treatment programme for SAM children among the TS Washi-affected families (UNICEF funded). The cash vouchers were distributed during February and March 2012.

The cash voucher intervention

Each PLW beneficiary received a set of cash vouchers with total value amounting to 30 euro or PhP 1,700². Beneficiaries received the vouchers in two equal instalments of PhP850 each separated by two weeks. Each voucher was expected to provide food to last for two weeks. The cash vouchers were used only in ACF-accredited partner shops, stores and vendors and beneficiaries were allowed to use the vouchers to buy specific items (see Box 1).

The supermarket and market vendors could not give change so purchases needed to amount to the denominations of the cash vouchers. The supermarket and market vendors were not entitled to any commissions or fees from ACF. Their only benefit in participating was the increased transactions coming from the target beneficiaries of ACF. The city governments were partners in the project



Figure 1: Cash voucher in Cagayan de Oro city

and monitored the food prices to ensure that nobody took advantage of the high demand for their food items.

The market situations in the two cities were different. In Cagayan de Oro, there were large supermarkets which allowed ACF to find a partner that could accommodate the volume of the food items that the PLW-beneficiaries would purchase. In Iligan, the only large supermarket declined to participate in the cash voucher scheme. As a result, ACF partnered with the federation of vendors in the main city public market. The design of the cash voucher schemes implemented in Cagayan de Oro and Iligan were therefore different as follows:

Cagayan de Oro: Each beneficiary received two vouchers in each installment, one valued at PhP500 and another PhP350. This allowed the beneficiary to shop for food items more than once at the supermarket using one voucher at a time. Figure 1 shows the front and reverse of the cash voucher.

Iligan: The beneficiaries received a set of vouchers in each installment with smaller denominations (PhP100, PhP 50, PhP 20, PhP10, PhP 5) amounting to a total value of PhP850. This allowed the

Figure 2: Cash voucher in Iligan city

beneficiary to make small purchases from different accredited vendors within the public market. Figure 2 shows a sample design of the cash vouchers used in Iligan City.

Insights from the cash voucher intervention

Post-distribution monitoring (PDM) activity was conducted by ACF one week after each distribution amongst a random selection of beneficiaries (n=350). This provided insights into how the assistance was received and used by the beneficiaries, and whether the distribution caused any protection issues, risks, or concerns. A Household Survey Questionnaire was the main tool used in data gathering and included sections on the beneficiaries' Food Consumption Score (FCS) and Individual Dietary Diversity Score (IDDS).

The ACF team visited evacuation centres, as well as the places of origin where former internally displaced persons (IDPs) had returned after their evacuation centres were closed. In total, about 19% of the total beneficiaries participated in this PDM.

A note on food item monitoring

The regular food items included in the FCS and IDDS monitoring tool were used include dairy products that were not purchasable using the vouchers. The questionnaire asks specifically for food items they purchased using the cash vouchers. However, respondents included their purchases of milk in monitoring feedback and this is reflected in Figures 1-3. It is possible that the data on the other food items could include purchases using other incomes. But the team still believes the responses on purchases fairly represent how they used the vouchers. This is due to the apparent behaviour of beneficiaries to fully use up the vouchers in one shopping and consume the purchased food items within a week.

Respondent profile

Of the total 350 respondents, 68.6% or 240 respondents came from Cagayan de Oro City, while 31.4% (110 respondents) were from Iligan City. There were 343 respondents from households of PLW, and seven (7) from households of SAM children (the SAM sample is the same in proportion (2%) to the total SAM beneficiaries out of the total 3,035 beneficiaries). The age of the majority of the respon-

Box 1: Allowable food items using cash vouchers

- Rice, flour, corn, oats and simple bread
- Meat (beef, pork, goat meat, and by-products)
- Poultry (dressed chicken, by-products and live poultry)
- Fish and seafood products (fresh and dried)
- Eggs and salted eggs
- Beans (monggo, red beans and white beans)
- Sugar (brown and white)
- Leafy vegetables (pechay, cabbage, camote tops, lettuce, etc.)
- Vegetables (carrots, squash, potatoes, chayote, tomatoes, eggplants, string beans, etc.)

- Spices (ginger, onion, garlic, etc.)
- Iodized salt
- Condiments (soy sauce, vinegar, fish sauce, catsup, etc.)
- Noodles (fresh miki, fresh canton, etc.)
- Fruits (bananas, orange, avocado, papaya, mango, pineapple, etc.)
- Oil margarine, butter, etc.

These food items were printed at the back of the cash vouchers and on the leaflets that accompanied the cash vouchers to provide the beneficiaries, the shops and vendors a convenient reference.



A mother and her baby with her voucher

¹ The FSL team referred to the voucher as a cash voucher, although it is restricted to food purchases, for the following reasons:
 (1) The vouchers carry a cash value
 (2) Beneficiaries are free to utilise the vouchers as if it is cash, meaning they can choose how much and how many of each food items to purchase and at what price.
 FSL team relates food vouchers to commodity vouchers where specific food items and quantities are indicated in the vouchers.
² This 30 euro was based on the budget pegged for a food kit that ACF originally intended to distribute to affected families. A typical ACF food kit contains rice (20kg), noodles (20 packs), canned sardines (20 cans), sugar (2 kg), salt (1 kg), and dried fish (2 kg). This food kit was estimated to provide food for a family of five for four weeks.

dents was between 18 to 29 years old and the household size of the majority of the respondents (88.2%) was between 4 – 7 members.

Household food access and dietary diversity

Food types consumed and food frequency immediately prior to the voucher distribution (“more than 7 days ago”) were investigated. This found that the majority (85%) of the respondents had received food assistance from government/private organisations/INGOs/NGOs and 24.6% had used livelihoods income to fund food purchases. Other food sources were cash assistance (1.4%), cash-for-work (2%), food-for-work (2.3%), vouchers (10%) and assistance from relatives/friends (3.7%). The most common pre-voucher foods consumed were cereals (staples) (99.7%, n=349) followed by vegetables (90%, n=315), meat and fish (84.3%, n=295), and condiments (70.3%, n=246). Fruit intake was 34.9 % (n=122) (Figure 1).

To investigate the impact of the voucher on food consumption, food type and frequency since the voucher distribution (“in the last 7 days”), was investigated. Using cash vouchers, the most common foods purchased were cereals (98.3%) followed by meat and fish (92.1%), vegetables (87.5%) and condiments (see Figure 2). Cereals were almost consumed everyday (6.33 days) followed by condiments (5.66 days), sugar (5.43 days) and oils (5.35 days). Vegetables, fruits and meat food groups were eaten on less than 3.67 days. See Figure 3.

With the exceptions of vegetables and cereals purchase and consumption which showed a marginal decrease, intakes of food groups generally increased with cash vouchers, significantly so for fruit consumption (from 122 respondents pre-voucher to 249 using vouchers).

Cereals and vegetables were the most common voucher-sourced foods prepared for SAM children (given daily), while meat and fish were prepared 5 out of 7 days. SAM children received no dairy or dairy products in the previous 7 days (these foods were not allowable in the voucher scheme).

For both PLW and SAM children, the most common food groups consumed in the previous 24 hours were grains, roots or tubers (94%), meat, poultry, fish, seafood (76.3%) and eggs (70.9%).

Overall, 57 % of the respondents had acceptable Food Consumption Score (FCS) results, 18% were borderline and 25% had a poor score.

Effectiveness of the cash voucher intervention

Most of the respondents (92.3%, n=323) indicated that the items lasted for one week and never longer than two weeks. Without voucher support, only 17.1% of respondents would have bought the same foods in the same amount. Reported benefits of the vouchers were reduced food expenses (93.7%, n=328), greater access to food (88.9%, n=311), and improved quality and quantity of food consumed (76.9%, n=26). More than half of the respondents (52.9%, n=185) shared the food purchased.

All the respondents were satisfied with the distribution process (well organised, accessible, convenient), the range of food items available in stores and the assistance provided.

Analysis

Close to 25% of the respondents were still able to earn income which they used to buy food. One explanation for this is that Cagayan de Oro and Iligan cities have large areas that were untouched

by the flood and where normal economic and business sectors of the cities were still functioning. In addition, the PDM was conducted in March 2012, (two and half months after the disaster) by which time, the general economy and the business sectors of the two cities were starting to normalize.

Our findings show that prior to receiving the cash vouchers, the respondents already had access to fresh food items such as vegetables, meat, fruits and other fresh foods. This is contrary to the findings of the needs assessment done immediately after the disaster which found that respondents were fully dependent on food kits being distributed to them. Respondents were found to have other sources of cash, e.g. cash-for-work and relatives. Many cash-based interventions, specifically cash-for-work, had been implemented before the voucher programme. The ACF team now recognized that another assessment should have been implemented prior to the actual cash intervention to establish the precise situation of the target beneficiaries.

The respondents maintained their preference for five food items when using the cash vouchers: cereals (staples), vegetables, meat, condiments and oils/fats. The cash voucher distribution increased the access of IDPs to more nutritious foods with an increase in purchase of almost all food items, significantly in fruit consumption.

One possible explanation for food items generally lasting only one week is that the beneficiaries did not have adequate storage facilities. Another possible explanation is that the monetary value of the cash voucher was not adequate. The high level of sharing with other households (52.9%) is also likely a factor and in itself, should be examined further in order to inform future cash transfer/voucher schemes and food aid interventions by ACF.

Overall, the PDM results indicate that the respondents were satisfied with the cash voucher intervention but suggested that hygiene items should be included among the items covered in future programmes.

It is interesting to note that although the design of the cash vouchers used and the type of markets (supermarket vs public market) were different between the two cities, there was no difference in the behaviour of beneficiaries in using the cash vouchers. Almost 100% of the beneficiaries made a single visit to the market (supermarket or public market) to purchase their food items despite Iligan city’s design allowing multiple market visits/purchases. A common reason was to save on transportation costs. This has a bearing on future cash voucher interventions, particularly if the objective is to encourage beneficiaries to spread their purchases of fresh food over a longer time period.

Conclusions

The PDM results indicate that the cash voucher intervention of ACF achieved its objective of improving the access of the target beneficiaries to food and made a significant contribution to the objective of improving the nutritional value of the food consumed. As reported by the population, the cash received from cash-for-work and the cash voucher interventions allowed them to buy fresh and nutritious foods such as vegetables, meats and fruits.

The high satisfaction expressed by the respondents indicates that the processes and systems being employed by ACF in its CTP projects are broadly adequate. However, there are insights from

the PDM that merit further examination and should be considered in future CTPs, in particular, the monetary value of the vouchers, low FCS and the high level of sharing food.

The time between assessment and intervention can see considerable change in circumstances of the affected population; this remains a challenge in acute emergency response and perhaps especially in urban contexts that are an emerging context under scrutiny.

For more information, contact: Demosthenes Militante, email: dmilitante@ph.acfspain.org

Figure 1: Kind of foods the household consumed pre voucher distribution (% total respondents)

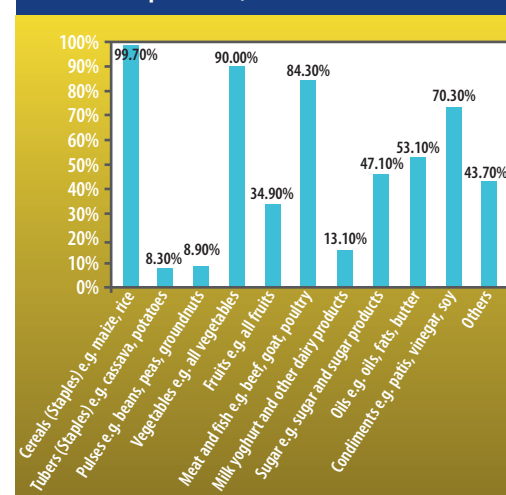


Figure 2: The food items bought and consumed by households using the cash vouchers (% of total respondents)

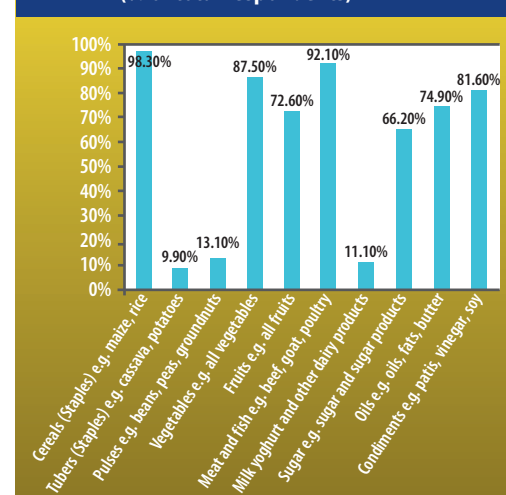
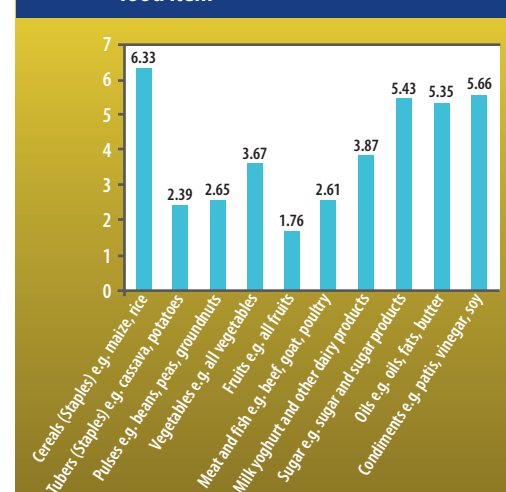


Figure 3: Number of days in last 7 days the respondents household ate a particular food item



Coverage Monitoring Network Profile



COVERAGE MONITORING NETWORK

Since the start of operations in August 2012, the Coverage Monitoring Network (CMN) has supported a total of 50 coverage assessments, with nine implementing organisations (including non-governmental organisations (NGOs), Red Cross societies and governments) in 21 different countries. The table below gives the coverage rate and main barriers to accessing CMAM services identified in the assessments:

As part of the first phase of the project, the CMN conducted five regional trainings in Pakistan, Kenya, Burkina Faso, Democratic Republic of the Congo (DRC) and Nepal. In these locations, trained professionals are now conducting coverage assessment independently and/or with remote support from the CMN and other peers in-country.

The implementation of project activities in a wide range of contexts has highlighted the need for a deeper understanding of the broader issues and factors influencing nutrition programmes. These include (but are not limited to): access to urban programmes, implementing assessments in large geographical areas, the challenges and opportunities in identifying key community figures, working with local media, the emerging need for evaluating the coverage of treatment programmes for moderate acute malnutrition, operating remotely in insecure or inaccessible areas, and the widely acknowledged (but not always understood) goals of capacity building. The experiences of the CMN team with these issues are increasingly being documented and can be found in the blog-section of the CMN website.

In its efforts to increase access to technical support, the CMN is currently finalising the French translation of the SQUEAC/SLEAC technical documents, originally published by the Food and Nutrition Technical Assistance (FANTA), Valid International, Brixton Health and their partners. The French translation is scheduled to be released in November 2013, and will be a valuable resource for the increasing number of francophone nutrition practitioners seeking to implement coverage assessments.

The CMN remains committed to helping nutrition stakeholders understand the context-specific factors influencing their performance and to take the experiences gathered so far to new locations. Over the next few months, the CMN will be launching new activities and publications designed to stimulate further debate about the challenges and opportunities faced by nutrition programmes around the world.

For further information, contact: Jose Luis Alvarez, CMN Project Coordinator, email: cmnproject@actionagainsthunger.org.uk

All reports and data are available in the CMN website: www.coverage-monitoring.org

Country	Region	Coverage rate	Main barrier identified
Senegal	Matam	17%	Community awareness
Sudan	Mornei, Darfur	59%	Insufficient screening and case finding
Ethiopia	Dolo Ado	79%	Insufficient screening and case finding
Haiti	Port-au-Prince	45%	Stigma
Ivory Coast	Danane	25%	RUTF stockouts
Rwanda	Gisagara	30%	Distance
South Sudan	Kapoeta	40%	Distance
Yemen	Sana'a	34%	Lack of follow-up of defaulters
Burkina Faso	Diapaga	N/A	Lack of awareness about the programme
Burkina Faso	Yako	31%	Lack of awareness about malnutrition
Niger	Keita	28%	RUTF stockouts
Niger	Mayahi	31%	Interface with the programme
Chad	Batha	20%	Lack of awareness about the malnutrition
DRC	Bafwasende	40%	Insufficient screening and case finding
DRC	Opala	N/A	N/A
Cameroon	Maroua	35%	Lack of awareness about malnutrition
Pakistan	TMK	63%	Lack of awareness about the programme
Philippines	Cotabato	63%	Lack of awareness about the programme
Nigeria	Katsina	53%	Interface with programme
Senegal	Matam	15%	Community awareness
Mali	Kita	25%	High defaulting linked to poor quality care
Somaliland	Sanaag	N/A	Conflict in the area and stigmatisation
Chad	Kanem	37%	Distance
Chad	Bahr-el-Gazel	27%	Distance & population movement
Kenya	Laikipia	42%	Lack of awareness about the programme
Ivory Coast	Toulepleu	42%	Lack of awareness about malnutrition
Ivory Coast	Zouan Hounien	21%	Lack of awareness about malnutrition
Chad	Iriba	36%	Lack of awareness about the programme
Chad	Amdam	N/A	N/A
Afghanistan	Kabul	36%	Lack of awareness about the programme
Chad	Kanem	37%	Lack of awareness about the programme
Kenya	Garbatulla	50%	Insufficient screening and case finding
Angola	Huambo	N/A	Lack of Awareness about malnutrition
Burkina Faso	Mani	26%	Lack of Awareness about malnutrition
Burkina Faso	Bogandé	30%	Distance
Niger	Gaya	30%	RUTF stockouts
Niger	Zinder	51%	Distance
Niger	Tera	60%	RUTF stockouts
Kenya	Dagoretti	61%	Stigma
Kenya	Embakasi	31%	Stigma
Kenya	Kasarani	52%	Long waiting for treatment
Kenya	Njiru	26%	Migration
Somalia	Garowe	85%	Alternative Health practitioners
Somalia	Bosaso	86%	Alternative Health practitioners
Sudan	South Darfur	51%	Wrong admission criteria
Sierra Leone	Freetown	52%	Lack of awareness about the programme
Mauritania	Guidimaka	35%	Lack of Awareness about malnutrition
DRC	Kandakanda	31%	Lack of awareness about the programme
Pakistan	Badin	63%	Lack of Awareness about malnutrition





Profiling methodology for displaced people in urban areas

Through a period of study and engagement with United Nations (UN) agencies and non-governmental organisations (NGOs), Feinstein International Centre (Tufts University) developed in 2012 a methodology to obtain profiling information about the population of refugees in an urban setting and how their experience compares to other groups amongst whom they live.

In seeking to develop effective programmatic interventions, it is important to understand whether displaced people in urban areas are worse off than the urban poor and other migrants amongst whom they live. However, it is difficult to identify and distinguish refugees and the internally displaced population (IDPs) from the existing urban poor. In the towns and cities of Africa, the Middle East and Asia, refugees live in low-income areas, experiencing the same problems of poverty, poor services, crime and lack of employment, and often even sharing housing with the urban poor. While the government and/or UNHCR can register refugees who present themselves to the relevant office, many refugees, including some of the most vulnerable, are often not reached or even known about by agencies. Refugees may remain deliberately 'hidden' to avoid contact with authorities or may be unaware of/afraid to access services.

A *profiling approach* can help address these programming issues by:

- **Distinguishing refugees from other types of migrants**
A profiling study provides a clear definition of who the agency includes and does not include in the refugee group in a particular setting, and how refugees are defined differently from other migrant groups. The report explains whether, how, and why refugees are more vulnerable than other migrants and the local population in urban contexts.
- **Mapping where and how refugees are distributed in the urban setting**
Profiling data reveal where refugees (or the target population) are located, whether they are living interspersed throughout the city or concentrated in a specific neighbourhood, and whether they live near hazardous areas (like industrial areas or garbage dumps).
- **Determining locally specific factors that influence the vulnerability of poor households**

This considers their ability to respond to economic shocks, disasters, etc., and how refugees differ from other urban groups with regard to these factors.

As well as vulnerabilities, profiling can also reveal (relative) strengths, i.e. skills and other livelihood assets possessed by refugees and whether and how these differ from their neighbours.

Knowing the whereabouts, strengths and weaknesses of the target population can provide entry points for programming. Profiling can be used for political/advocacy purposes, as it is a relatively technical exercise that produces straightforward and verifiable data. Both the profiling exercise and the data can be used to engage with host governments to promote the rights of refugees. Profiling data can even potentially be used to show that refugees contribute to the economy.

The study's outcomes include:

- Final report
 - conceptual framework
 - research summary
 - recommendations on good profiling practices (to inform donors) and on programming (for implementing agencies)
 - research methods (including methods, mapping tools)
- Three case studies (Aden, Yemen; Mae Sot, Thailand; and Polokwane, South Africa) that detail how the method was adapted and the tools used in each case. The database is available to other researchers on request.
- Toolkit that includes revised profiling tools and a training module, all designed to be easily used by field organisations. The profiling tools include:
 - the survey questionnaire
 - survey data entry template
 - survey sampling strategies
 - urban mapping instructions
 - qualitative interview schedules
 - outline of a two-day training workshop.

Requests for either data or tools should be directed to Karen Jacobsen, email:

Karen.Jacobsen@tufts.edu

Access the content online at: <http://sites.tufts.edu/feinstein/2012/developing-a-profiling-methodology-for-displaced-people-in-urban-areas>

Nutrition Exchange flyer – pass it on

The third edition of the ENN's relatively new publication, Nutrition Exchange, has been produced in English, French and Arabic. Nutrition Exchange differs from Field Exchange in terms of length of article (shorter), technical detail (lighter), and contributors (aiming for a greater proportion of contributors from national, district and community levels).

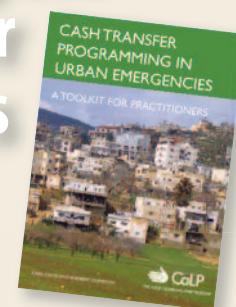
Enclosed in this edition of Field Exchange is a Nutrition Exchange flyer to encourage contributions. We would appreciate it if you

would have a read and then pass on the flyer to a national colleague or counterpart whom you think would like to receive a copy and/or contribute their experiences. As with Field Exchange, the Nutrition Exchange editorial team will provide editorial support to write an article.

For more information, visit:

www.ennonline.net/nutritionexchange and to share article ideas, contact the editors: Carmel Dolan carmel@ennonline.net and Valerie Gatchell valerie@ennonline.net

Tools to support cash transfer programmes



The Cash Learning Project (CaLP) is composed of a steering committee of Oxfam GB, the British Red Cross, Save the Children, the Norwegian Refugee Council and Action Against Hunger/ACF International. These organisations have come together to support capacity building, research and information-sharing on cash transfer programming as an effective tool to help deliver aid in times of crisis.

Cash transfer programming in urban emergencies: A toolkit for practitioners

The Cash Learning Partnership (CaLP) undertook a study of the current status and impact of urban emergency response programmes that utilise cash transfer programming. Informed by this study, the Cash Transfer Programming in Urban Emergencies toolkit was produced in 2010. It brings together the collective knowledge of best practices, key issues in programming, and adaptations of cash transfer programme methodologies for urban settings.

The flow of the toolkit follows the logical order of a project cycle and contains both guidance and examples of tools. It provides generic tools and guidance that can be quickly adapted for different urban settings. All tools described in this toolkit are adapted from and based upon real urban project experiences involving a variety of organisations and contexts.

Tools described in this toolkit can be downloaded from the CaLP website in MS Word, MS Excel, and MS PowerPoint format. Additional manuals and documents listed in the bibliography provide detailed discussions on how to choose which type of cash programming, and general guidance on cash transfer implementation.

Interactive mapping tool for cash transfer programmes

The CaLP has developed a cash mapping tool aiming to visually represent the usage of cash transfer programmes (CTP) at a global level. It is a tool to support advocacy and learning exchange.

Key features of the tool include:

- Interactive map representing the number of projects at several levels of information and zoom
- Extractable data at any level allowing users to save and use it
- Contact database
- Graph generation module allowing users to analyse trends (TBC)
- Restricted access to respect confidentiality in security-sensitive areas
- Available in English, French and Spanish

Key information displayed include:

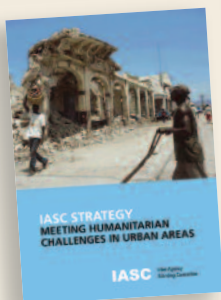
- Name of the implementing agency and contact details
- Location, budget and timeline of the project
- Donors
- Sectors and objectives
- Modality, distribution mechanisms and delivery agents

You can enter data about your projects so they appear on the map

For both tools and other resources, visit:

www.cashlearning.org or contact: communications@cashlearning.org

IASC strategy on meeting humanitarian challenges in urban areas



In 2010, the Inter-Agency Standing Committee (IASC) produced a strategy on meeting humanitarian challenges in urban areas. The IASC Urban Strategy includes a recommended Two-Year

Action Plan of priority actions to be implemented by IASC agencies and other interested partners.

The aim of the IASC Urban Strategy is to recommend actions that humanitarian actors can take to make their responses to humanitarian crises in urban areas more effective and thus save more lives and accelerate early recovery. The strategy is built around six key objectives: i) Improving multi-stakeholder partnerships, ii) Building technical surge capacity and urban expertise, iii) Developing and adapting tools to urban contexts, iv) Promoting the protection of vulnerable urban populations, v) Strengthening livelihoods and vi) Enhancing preparedness among national and local authorities in urban areas. It details issues, gaps and proposed actions for each objective.

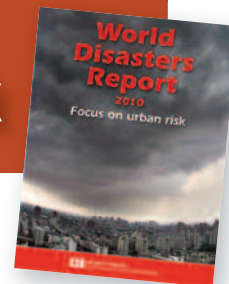
Working under the direction of the IASC Working Group, the Strategy and Action Plan were developed by the IASC Task Force on Meeting Humanitarian Challenges in Urban Areas, chaired by UN-HABITAT, with active participation of United Nations agencies, International Organisation for Migration (IOM), international non-governmental organisations consortia and the Red Cross/Red Crescent Movement. The Strategy and Action Plan are evidence-based and reflect experiences and good practices from stakeholders throughout the international humanitarian system.

The IASC Reference Group on Meeting Humanitarian Challenges in Urban Areas is a subsidiary body of the IASC Working Group that emerged from the original task force. The group acts to maintain profile and to bring related policy issues to the IASC Working Group's Agenda.

Access the strategy and view activities of the Urban Reference Group online: <http://www.humanitarianinfo.org/iasc> and choose 'Subsidiary bodies' in the menu.

¹ <http://www.humanitarianinfo.org>

World Disasters Report: Urban risk



The 2010 edition of the International Federation of Red Cross and Red Crescent Societies (IFRC) World Disasters Report focused on urban risk. Produced shortly after two large 'urban' disasters; an earthquake in Chile (death toll in hundreds) and in Haiti (death toll in hundreds of thousands), the report is built on the premise that the urban context presents both problems and opportunities for disaster risk reduction and humanitarian assistance.

It provides a comprehensive review of urban risk that includes discussion on urbanisation and disaster risk, urban myths, disaster impacts in urban and rural areas, housing issues, and strengthening and supporting local action.

Following a review of urban disaster trends, the report describes some of the challenges and different approaches used to identify 'urban disasters' and their impact. One of these approaches is the DesInventar¹, a conceptual and methodological tool for the generation of National Disaster Inventories and the construction of databases of damage, losses and in general the effects of disasters. The report mentions the potential of the DesInventar database, to achieve a more sophisticated

understanding risk at urban district level, if it were more widely adopted.

Topics covered in subsequent chapters include:

- Risks and vulnerability in urban contexts
- Experiences with community-driven and led responses to disasters and disaster risk reduction
- The need for 'flexible' money for affected households and communities
- Urban violence, risk factors and strategies to address it
- Urban risks to health, with particular consideration of children, pandemic disease, nutrition and diet, mental health
- Climate change effects on patterns of urban risk and reducing effects
- Financing, urban governance, disaster risk reduction and urban development

The full report is available at:

<http://www.ifrc.org/en/publications-and-reports/world-disasters-report/wdr2010/>

¹ <http://www.desinventar.net>

The Food Security and Livelihoods in Urban Settings Working Group

The Food Security and Livelihoods in Urban Settings Working Group of the Global Food Security Cluster (gFSC Working Group) is composed of approximately 20 organisations including cluster lead agencies, WFP and FAO, academic institutions and non-governmental organisations (NGOs).

The overall aim of the gFSC Urban WG is to be a specialist resource within the gFSC to help strengthen the capacity of partners to shape urban food insecurity response at the global and national levels.

The work of the gFSC Urban WG is framed within the Terms of Reference agreed with the Inter-Agency Standing Committee (IASC), as described on the gFSC website and outlined below.

To achieve its objectives, the gFSC Urban WG researches and helps develop food security tools and systems, encourages roll out of gFSC partner's technical resources, and looks for gaps in available data and urban food security guidance. WG partners help develop tools and guidelines through collection of case studies and best practices, analysis of indicators, and review of assessment and targeting methods. Linked with this is the WG's interactive geographical mapping of partners' urban activities design, aimed at making the information available at field level.

The gFSC Urban WG participates in other reference groups within the United Nations system, while also linking with and assisting other international groups that have similar interests, including the IASC Meeting Humanitarian Challenges in Urban Areas (MHCUA) Reference Group, the International Federation of the Red Cross, Concern Kenya and others. The individual core members of the WG are also called on as individual experts by gFSC major global partners and academic institutions as they seek to define their urban strategy.

Since a core of gFSC work is to support the growth of food clusters at national level, the gFSC Urban WG encourage outreach to the country-level through country clusters and local partners, and supports the creation of country level urban hubs and working groups. Because key members of the working group are field based, they are able to play an active part in encouraging both international and local organisations to gather together and support each other on urban food security issues.

For information on the gFSC Urban Working Group, visit: <http://foodsecuritycluster.net/working-group/urban-food-security-and-livelihoods> or contact: Marina Angeloni, Focal Support Officer, email: marina.angeloni@wfp.org

Food for Cities discussion forum

The 'Food for Cities' discussion list was set up by FAO in 2002 as an online platform to bring individuals and organisations together in the international development community with an interest in food system approaches relevant to cities.

Contributors include those working in the public sector (national and local governments, municipalities, and international organisations), private sector, academics, NGOs and civil society.

Themes include right to food, nutrition, emergency operations, production and marketing, natural resources management and land tenure, local governance, and rural-urban linkages.

To join the network, connect to <http://dgroups.org/fao/food-for-cities> or contact Francesca Gianfelici and Julien Custot, email: food-for-cities@dgroups.org

Children in an urban world

Summary of report¹

The experience of childhood is increasingly urban. Over half the world's people – including more than a billion children – now live in cities and towns. The UNICEF *State of the World's Children* reference guide presents the most recent key statistics on child survival, development and protection for the world's countries, territories and regions in a single volume on an annual basis. The 2012 edition has sought to shed light on the experience of children and young people in urban areas, especially the poorest and most marginalised. This report focuses mainly on those children in urban settings all over the world who face a particularly complex set of challenges to their development and the fulfilment of their rights.

In 2011, for the first time, *The State of the World's Children 2011* included tables on Adolescents and Equity, the latter focusing on disparities by household wealth. *The State of the World's Children 2012* adds a second table on Equity, focusing on urban-rural disparities. This new table (Table 12 of the report) provides urban, rural and urban:rural ratio data for the following indicators – birth registration, skilled attendant at birth, underweight prevalence in children under 5 years, under-fives with diarrhoea receiving oral rehydration solution (ORS) and continued feeding, primary school net attendance ratio, comprehensive knowledge of HIV (females 15-24y), and % population using improved sanitation facilities. Table 6 of the report includes % population urbanised and average annual growth rate of the urban population.

The report highlights a key challenge to assessing children's wellbeing in urban settings is the lack of disaggregated data. In rural v urban comparisons, urban results tend to be better, whether in terms of the proportion of children reaching their first or fifth birthday, going to school or gaining access to improved sanitation. But these comparisons rest on aggregate figures in which the hardships endured by poorer urban children are obscured by the wealth of communities elsewhere in the city. Where detailed urban data are available, they reveal wide disparities in children's rates of survival, nutritional status and education resulting from unequal access to services. Gathering accessible, accurate and disaggregated data is an essential step in the process of recognising and improving the situation of children in urban areas.

The report considers in particular the rights of children to shelter, health, nutrition, water, sanitation and hygiene, education and protection. Issues raised include:

Inadequate living conditions are among the most pervasive violations of children's rights. The lack of decent and secure housing and such infrastructure as water and sanitation systems makes it so much more difficult for children to survive and thrive. Yet, the attention devoted to improving living conditions has not matched the scope and severity of the problem. Evidence suggests that more children want for shelter and sanitation than are

deprived of food, education and health care, and that the poor sanitation, lack of ventilation, overcrowding and inadequate natural light common in the homes of the urban poor are responsible for chronic ailments among their children.

The locus of poverty and undernutrition among children appears to be gradually shifting from rural to urban areas, as the number of the poor and undernourished increases more quickly in urban than in rural areas. However, even the apparently well fed – those who receive sufficient calories to fuel their daily activities – can suffer the 'hidden hunger' of micronutrient malnutrition: deficiencies of such essentials as vitamin A, iron or zinc from fruits, vegetables, fish or meat. In a number of countries, stunting is equally prevalent, or more so, among the poorest children in urban areas as among comparably disadvantaged children in the countryside.



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Nearly 8 million children died in 2010 before reaching the age of 5, largely due to pneumonia, diarrhoea and birth complications. Some studies show that children living in informal urban settlements are particularly vulnerable. High urban child mortality rates tend to be seen in places where significant concentrations of extreme poverty combine with inadequate services, as in slums. For example, around two thirds of the population of Nairobi, Kenya, lives in crowded informal settlements, with an alarming under-five mortality rate of 151 per thousand live births. Pneumonia and diarrhoeal disease are among the leading causes of death. Poor water supply and sanitation, the use of hazardous cooking fuels in badly ventilated spaces, overcrowding and the need to pay for health services – which effectively puts them out of reach for the poor – are among the major underlying causes of these under-five deaths.

Urban settings provide proximity to maternity and obstetric emergency services but, yet again, access and use are lower in poorer quarters – not least because health facilities and skilled birth attendants are in shorter supply. The report includes a case study of good practice around maternal and child health services for the urban poor from Nairobi, Kenya.

There is some evidence that urban mothers are less likely than rural ones to breastfeed and more likely to wean their children early if they do begin.

An analysis of Demographic and Health Survey (DHS) data from 35 countries found that the percentage of children who were breastfed was lower in urban areas. Low rates of breastfeeding may be attributed in part to a lack of knowledge about the importance of the practice and to the reality that poor women in urban settings who work outside the home are often unable to breast-feed.

Around 2.5 million under-five deaths are averted annually by immunisation against diphtheria, pertussis and tetanus (DPT) and measles. Global vaccination coverage is improving but more needs to be done. Lower levels of immunisation contribute to more frequent outbreaks of vaccine-preventable diseases in urban communities that are already vulnerable owing to high population density and a continuous influx of new infectious agents. Poor service delivery, parents who have low levels of education, and lack of information about immunisation are major reasons for low coverage among children in slums as diverse as those of western Uttar Pradesh, India, and Nairobi, Kenya.

Urban life can also have a negative effect on the mental health of children and adolescents, particularly if they live in poor areas and are exposed to the dangers of violence and substance abuse. Disrupted and poor access to education by children, protection issues (risk of trafficking, child labour, and living and working on the streets) add to risks. Migrant children are often on the periphery of service access and 1 in 5 moves to an urban settlement without a parent.

When emergencies occur in marginalised urban areas, children are among the most susceptible to injury and death. Over three quarters of casualties in recent decades have been children in sub-Saharan Africa or South Asia. Droughts, flooding and post-disaster conditions all intensify pre-existing risks. Information on slum communities is often inadequate, outdated or non-existent, making it difficult to locate the most vulnerable and those in greatest need. There are examples of successful practices in community identification from Nairobi and the Philippines.

In poor urban areas, failures in development contribute to disasters, and disasters, in turn, undo or undermine development gains – deepening poverty and further widening the social and health gaps separating poor from rich. Routine, small-scale calamities in many settlements result from poor governance, planning and management, and often indicate vulnerability to much larger disasters. Existing poor health and nutrition can increase disaster risk for children, hamper recovery and, if not addressed in the emergency response, leave children more vulnerable to future shocks. When disaster strikes, supportive environments critical to children's well-being may break down. Families may remain in emergency camps for extended periods, and these dysfunctional environments can become the only home children know during their formative years.

Access the full report, associated video content and individual statistic tables at:
<http://www.unicef.org/sowc2012>

¹ The State of the World's Children 2012. Children in an Urban World

Ensuring Access to Health Care: Operational Guidance on Refugee Protection and Solutions in Urban Areas



In 2011, the Public Health and HIV (PHHV) section of UNHCR produced an operational guidance for public health programming in urban settings for refugees and asylum seekers (henceforth referred to as refugees). It provides practical guidance for UNHCR country programmes to advocate for and facilitate access to (and when necessary provide and/or support) quality public health services for refugees equivalent to those available to the national population. It draws on best practices and illustrative examples from cities and towns from UNHCR operations and can be adapted according to differing contexts. 'Public health' concerns both preventive and curative health and nutrition services.

The operational guidance recognises that the public health role of UNHCR is more complex and less well defined in non-camp settings, where there are multiple health service providers in cities including state, private and local and international non-governmental organisations (NGOs). It states that UNHCR staff also engage in multi-sector, multi-agency mechanisms that address the underlying causes of vulnerability and ill health of the urban poor including refugees. Specific safety nets may need to be supported by UNHCR to support refugees most in need and to improve their economic potential.

The guidance elaborates a three pronged approach – advocacy, support, and monitoring & evaluation. UNHCR advocates on behalf of refugees to ensure that authorities make public services including health services available at similar or lower costs to that of nationals. UNHCR supports and facilitates integration into, and strengthening of, the national public health system. This may include direct funding or indirect support via partners. UNHCR assesses, monitors, and evaluates the health, nutritional, educational and economic status of refugees, ensuring needs are met in line with accepted standards and that quality services are available and accessible.

Nine key principles underlie the strategy: access, integration, equity, prioritisation, rationalisation, partnerships, participation, communication and evidence based decision-making.

UN High Commissioner for Refugees (UNHCR), Ensuring Access to Health Care: Operational Guidance on Refugee Protection and Solutions in Urban Areas, 2011, available at: <http://www.refworld.org/docid/4e27d862.html> [accessed 16 September 2013]. Available in English, French and Spanish.

ALNAP review of lesson learned from responding to urban disasters



In November 2012, ALNAP produced a review paper that outlines key lessons related to the design and implementation of urban disaster-response programmes. It focuses particularly on the response and early recovery phases of an urban emergency, and on natural disasters such as earthquakes and flooding. It is a field resource for people planning and implementing relief and early recovery operations in urban areas. It is specifically targeted at people working for international agencies but is also applicable to programmes implemented by local and national civil society organisations and by municipal and national government agencies.

Information is organised into nine lessons on topics such as programme design, needs assessment, and covers five sectoral interventions (rubble, debris and solid waste; water, sanitation and hygiene

(WASH); food; health and protection) Many of the lessons – such as those around programme design and coordination – are applicable across all sectors.

The lessons in this paper derive from a literature review that considered evaluations, reviews, reports, lessons papers and existing best practice guidelines relating to urban humanitarian action. Most of these documents relate to urban disasters in lower-income countries, as this is where international humanitarian actors are most likely to be involved in disaster response. However, the review also covered documentation relating to disasters in G20 countries.

Access the report at: <http://www.alnap.org/pool/files/alnap-lessons-urban-2012.pdf>

ALNAP urban resources

In July 2013, ALNAP launched the Urban Response Community of Practice (CoP). The CoP is a place to share learning, ask questions, spread the word about new initiatives, highlight new documents and events, and identify others working on or in urban humanitarian response. The CoP already has over 115 members from over 33 countries across the globe and more join every day. As the CoP grows, it will be a place to identify new webinar topics, as well as be an ongoing forum to keep discussion moving forward. It aims to provide a platform to be used by anybody working in or on urban environments. Everyone is welcome to join (see link below) and share their thoughts, experiences, questions and projects.

Complementing the CoP, the Urban Humanitarian Response Portal contains almost 1400 resources, from guidelines to evaluations, on a wide range of topics including cash programming in urban areas, targeting and assessment, conflict and violence, food aid and nutrition. The Portal welcomes submissions of relevant documents and also hosts a

webinar series. Upcoming topics for 2013 include lessons working in urban violence, how urban planners and those involved in humanitarian responses can work together, cash and voucher programming in urban areas, and how World Vision has changed urban policy and urban practice.

Finally, urban publications by ALNAP includes a lessons paper for working in urban response in 2012 and a second lessons paper on urban violence due out in October 2013. Both are found at <http://www.alnap.org/ourwork/urban.aspx>

For more information, contact: Leah Campbell, Research and Programme Assistant, l.campbell@alnap.org, www.alnap.org

Urban Response Community of Practice: <https://partnerplatform.org/urban-response/>

Urban Humanitarian Response Portal: <http://www.urban-response.org/>

Urban Humanitarian Response Portal webinar series: <http://www.alnap.org/ourwork/urban/webinars.aspx>

ACF guide to identification of vulnerable people in urban environments



A methodological guide has been developed by ACF to identify vulnerable people in urban environments. It is designed for use by field practitioners for assessment of sustainable livelihoods and urban vulnerabilities. It was developed in response to several problems experienced through ACF programming including proliferation of food crises in urban environments, difficulty targeting the most vulnerable population among all those affected by urban poverty, breakdown of social structures and official betrayal or non-recognition of marginalised neighbourhoods.

It focuses on cities and urban settlements in developing countries where life is precarious, however the guide is applicable for urban settings in general.

The guidelines provide information on methodology and several tools of analysis, e.g. to organise second-hand documents, to create a vulnerability and/or livelihood mapping across the conurbation (a

region combining several cities, towns, or other urban areas that, through growth, have merged to form one continuous urban area), or to complete a low-level analysis in one or several districts.

The guide recognises it cannot comprehensively address the diversity of urban contexts and humanitarian situations. It is a first version that will be tested and validated during field work by practitioners from diverse backgrounds. The authors welcome suggestions and recommendations.

ACF, 2010. Identification of vulnerable people in urban environments: assessment of sustainable livelihoods and urban vulnerabilities.

Available from: <http://www.actionagainsthunger.org> and select 'Publications'

Za'atri refugee
camp, Jordan

Syria: an 'urban' humanitarian crisis

By Jeremy Shoham, ENN editor

Events in Syria have arguably led to the largest humanitarian crisis for the past 20 years. The number of displaced within Syria are estimated to be over 4 million with a further 2 million plus seeking refugee status in surrounding countries. There are an estimated 776,902 refugees in Lebanon, 534,418 in Jordan, 500,237 in Turkey, 127,411 in Egypt and 194,644 in northern Iraq¹. The majority of these refugees live out of camps in towns and cities, whilst the size and density of some of the refugee camps that have been necessary effectively mean that these have become urban conurbations. Za'atri camp in Jordan hosts 120,000 Syrian refugees and is currently the second largest refugee camp in the world. It would therefore have been remiss of the Field Exchange team not to highlight this largely urban crisis in this special urban issue of Field Exchange. However, given the complexity of this crisis and enormous challenges posed by it, as well as the substantial learning already taking place through the response, the ENN have decided to devote a special issue of Field Exchange to the Syria crisis which will be published mid-2014. This short article therefore is intended mainly to inform readers of our plans and to encourage you and your colleagues working in the region to consider writing up programme experiences over the coming months for this special issue.

Initial discussions with Caroline Wilkinson and Marian Schilperoord from UNHCR and access to the UNHCR portal on unfolding events in the region indicate that there is much learning that is taking place by those agencies involved in the response and that a great deal of this is new. At this early stage there appear to be at least seven broad areas related to nutrition where lesson capture in Field Exchange could help support the sector. These are as follows:

i) The **nature of nutritional problems** amongst this refugee population is not typical of many refugee crises. While there are problems of micronutrient deficiency (particularly anaemia) and infant feeding challenges (partly related to how to assess and manage non-breastfed and artificially fed infants), prevalence of global acute malnutrition (GAM) is low. Yet, there has arguably been an overemphasis on dealing with acute malnutrition given the limited scale of the problem and lack of attention to other key areas especially prevention of

malnutrition in all its forms. What is different about this refugee crisis may be the chronic health and nutrition related problems that were endemic amongst this population before the crisis, e.g. diabetes, obesity and coronary heart disease, and providing support services to address these health issues. It will also be of interest to document how the general ration and cash/voucher programmes have managed to accommodate the needs of this vulnerable sub-group of the refugee population.

ii) There may be considerable learning with respect to how the **various nutrition and food security assessments** that have been conducted have supported the response. There appear to be emerging learning around the need for standardising assessments across the region, the need to include certain types of information that may not typically be included in nutrition or food security assessments, and the demographic focus of the surveys. Furthermore, given the enormous complexity of targeting often scarce resources amongst a large displaced population living in a dense urban area alongside non-refugees, the assessments have been challenged to define and refine vulnerability criteria.

iii) The **food ration, cash and voucher programmes** in the region have evolved over time in order to meet the emerging needs of the refugee population. Perhaps the greatest challenge for these programmes has been targeting in a context of scarce resources. There have also been challenges and learning around monitoring, i.e. of multiple retail outlets, and the need for flexibility in relation to events like Ramadan. Given the socio-economic, age demographic and health profile of this population, it will also be interesting to determine what has been learnt about optimal programme design.

iv) Providing **access to health care** has been, and remains, particularly challenging for humanitarian actors working with this displaced population. There are substantial differences between the refugee host countries. For example, health care in Lebanon is provided within a highly privatised health care system, so that agencies have had to find ways of subsidising and increasing access for refugees, e.g. mobile clinics, targeting particularly vulnerable areas. Access to health care in Jordan has been far more straightforward, although the vast numbers of refugees have put an enormous strain on

the government system and there remain differences between registered and unregistered refugees. In Iraq and Turkey, the respective Ministries of Health are greatly involved.

v) **Livelihoods programming** in the different country contexts has also been enormously challenging. The need for, and capacity of, refugees to pursue livelihoods and generate income has depended on the amount of humanitarian aid received, legality of working in the host country and the type of livelihood programming support from international and national agencies. The coping strategies employed by refugees both in the camps and out of camp have provided a good indicator of the success of these programmes.

vi) **Provision of shelter**, although not usually perceived as relevant to nutrition, becomes more pertinent where there are seasonal extremes of temperature. There are lessons from this emergency around the successes and challenges of the shelter programme in a context of such rapid and large-scale refugee influx.

vii) The importance of adequate **water, sanitation and hygiene (WASH)** to nutrition and health is recognised. There are lessons about providing services in large camps as well as enabling access to safe water and sanitation for out of camp populations.

viii) The **funding environment and reliability of the food and resource pipelines** have been a major challenge for this population. At this point in time, approximately 40% of funding needs have been met. This has resulted in projected and realised pipeline breaks, as well as the need to target existing resources more stringently. The funding environment has consistently been insecure. The reasons behind the resource shortfalls and how these have been addressed are of considerable interest to the humanitarian sector.

In order to maximise learning from this crisis, time is of the essence. We want to capture the detail of programming and the decision-making happening now behind the scenes before these are lost with turn-over of staff and the start of new project cycles. Over the coming months, the ENN will be making contact with UN and NGO HQ, regional and country programmes and plan to undertake some field trips to support a more 'real time' lesson capture. We welcome any suggestions and contributions – these can take the form of an email, telephone call or sharing a report and of course, newly written material. As needed, we will treat information sensitively and in confidence.

Contact the Field Exchange team at:
marie@ennonline.net or call +44 (0)1865 249745

¹ Source: data.unhcr.org/syrianrefugees/Syria.php accessed on 4th October 2013

Urban refugees debate forum

The urban refugees debate forum is an independent forum for practitioners, policy makers, researchers, urban refugees and the internally displaced themselves, as well as the public at large, to debate key issues, share information and disseminate new ideas. Urban refugees and IDPs throughout the world are especially encouraged to participate in these debates and to raise issues of concern.

Two main categories of issues are debated on this debate forum:

- Thematic issues that raise in depth questions related to urban displacement
- Topical issues that provide an immediate reactions to the latest news

Debates are launched by contributors. Once a debate is launched, any individual can participate. You do not need to be registered to leave comments. However, comments will be moderated prior to their publication. A summary of a recent debate ("Why do we still have refugee camps?") is included in this edition of Field Exchange.

The debate forum is operated by the organisation Urban Refugees, whose mission is to advance the rights of urban refugees and IDPs worldwide. Interested debate contributors should contact: debate@urban-refugees.org

Visit the debate forum at: www.urban-refugees.org

UNHCR operational guidance for promoting livelihoods and self-reliance for urban refugees



In 2011, the UNHCR produced operational guidance for promoting livelihoods and self-reliance in urban areas. It aims to provide guidance for UNHCR country programmes to advocate for and facilitate access to (and when necessary provide and/or support) quality livelihood services for refugees equivalent to those available to the national population.

It was developed since protection and livelihoods are interlinked for urban refugees (e.g. illegal to work or own businesses, harassment and higher rental rates, are just some of the common features of urban refugee experiences). Furthermore, support to livelihoods promotes and preserves use of skills and assets, increases the capacity of refugees to return home when safe to do so, enables contribution to the host community and government, and supports dignity and self-reliance.

The guidance is elaborated according to nine underlying key principles: access, integration, assessment, targeting, self-reliance, partnerships, participation, monitoring and evaluation, handing over.

It is aimed primarily at UNHCR field operations and at government counterparts, operational and implementing partners, including potential new partners that may include microfinance institutions, the private sector, foundations and academic institutions. Regional representations and decision-makers in headquarters are also addressed.

The guidelines address all urban persons of concern currently under UNHCR's mandated and designated responsibility, including refugees, asylum seekers, internally displaced persons (IDPs), stateless persons and returnees. The guidelines specify where and how approaches to different groups vary. While UNHCR is not mandated to support the local population, it is generally acknowledged that they should be included in activities that are planned in areas with a high concentration of refugees.

This operational guidance is based on lessons learnt and good practices gathered across urban operations since 2008. This guidance is complemented by general guidance on livelihoods, on assessment, microfinance and advocacy for the right to work.

UN High Commissioner for Refugees (UNHCR), *Livelihood Programming in UNHCR: Operational Guidelines, 2012*, available at: <http://www.refworld.org/docid/512611392.html> [accessed 16 September 2013]. Available in English and Spanish.

Time to think urban....Kenya

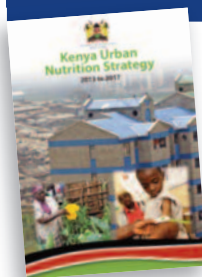
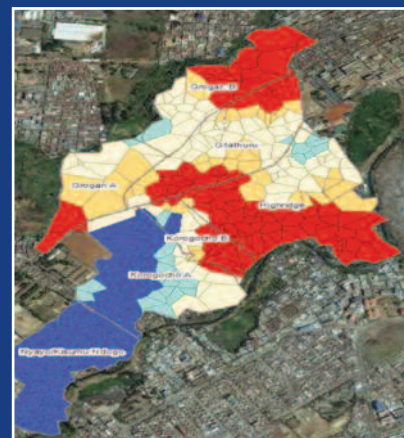
By Linda Beyer, Valerie Wambani and Koki Kyalo

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The authors acknowledge the support of Terry Wefwafwa, Head of the Nutrition Division, Ministry of Public Health and Sanitation, Kenya.



This article shares the approach and vision for urban nutrition programming in Kenya from the national perspective. It reflects collaborative work by the Ministry of Public Health and Sanitation, UNICEF Kenya, Concern Worldwide and other stakeholders.

Understanding the challenges of urban nutrition and food security in Kenya

In Kenya, close to 1 in 3 children live in urban areas (5.2 million) with 1.7 million of these children living in poverty. Households spend up to 75% of their income on staple foods, with price shocks and over reliance on markets resulting in negative coping mechanisms and heavy reliance on street foods. Malnutrition and anaemia rank 4th out of the top 10 causes of mortality for children under 5 years in Nairobi and account for 8.4% years of life lost¹. Stunting affects more than one in two children in urban slums (see Figure 1). Emerging issues are rickets, severe stunting in young children (severe stunting in children under one year of age has doubled over the past six years²), co-morbidities (diarrhoea and HIV/AIDS)

and challenges for care practices in early childhood care settings. The difference in child malnutrition between the wealthiest and poorest households is twice as great in urban areas compared to rural locations, highlighting a number of inequities.

Policy framework

There is a strong policy framework for urban nutrition action in Kenya. Recent innovations in urban policy and strategy guidance are:

- Urban Areas and Cities Act (2011) guiding urban governance.
- Urban Policy (Draft 2012) addressing urban guidance.
- Urban Nutrition Strategy (2013-2017) providing urban sector strategies (due out October 2013).

Kenyan government priorities

A key area of action is strengthening information systems and analysis in urban areas, to identify who and where are the most vulnerable. Table 1 outlines the target vulnerable groups and severe acute malnutrition (SAM) caseload faced in informal urban settlements in Nairobi, Kisumu and Mombasa. Since 2008, the Ministry of Health Kenya (MoH) with support from UNICEF and Concern Worldwide has accelerated nutrition interventions in urban contexts, addressing barriers to vulnerable populations, strengthening health systems and ensuring a package of evidence based high impact nutrition interventions (HINI) reach children and mothers.

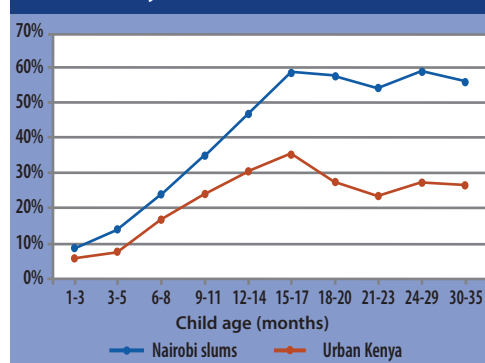
Assessing coverage for HINI has involved strengthening Health Information Systems (HIS) indicators and Community Based Indicators. Further strengthening of analysis of urban vulnerability has involved:

- *Sentinel Site Surveillance* for urban areas – Nairobi Urban Health and Demographic Surveillance System (NUHDSS) (APHRC)
- *Assessing coverage for urban areas* (SQUEAC³) which highlight barriers and areas for strengthening response
- Innovations in *mapping urban vulnerability*

Table 1: Urban population, target groups and acute malnutrition caseloads

	Nairobi (100% urban)	Kisumu (52% urban)	Mombasa (100% urban)
Total population of informal settlements	1,992,237	300,672	563,622
Children under five years	258,996	64,173	44,102
Pregnant and lactating women	119,534	18,040	33,817
Severe acute malnutrition caseload	8,701	2,875	917

Figure 1: Stunting in Children < 3 years in Urban Kenya (APHRC, KDHS)



¹ APHRC, 2008. <http://www.aphrc.org/>

² APHRC, 2013. <http://www.aphrc.org/>

³ Semi-quantitative Evaluation of Access and Coverage

Views

Nutrition and the urban consumer



The 'Pusha Love' campaign in Lesotho is about preventing HIV which uses positive dialogue about the future to talk about how to change the epidemic. About 20 'live' mannequins were deployed en masse in various parts of town. They would stand in random positions for 5-10 minutes and attracted lots of attention. Their mouths are taped and their t-shirts say, "It's time we start talking" in Sesotho.

By Jennifer Christian and Abel Irena

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Abel Irena is currently the Nutrition and Neonatal Health Technical Advisor with PSI. Previous experiences include as technical advisor/researcher with Valid International for five years and as a nutritionist with Save the Children (US) in Ethiopia.

Do you know what a flash mob is or how it might be applied to a public health or nutrition message? Have a look at this short PSI youtube clip from Burundi to promote condom use in 18-24 year olds. Link at: <http://youtu.be/RtSGJ2KcEEM>

Funding for nutrition programmes has long focused on acute emergency situations and highly vulnerable, targeted populations, such as people living with HIV/AIDS. However, there is now growing recognition of the widespread nutrition gap in many communities living in chronic situations of need and affecting multiple population groups. This has brought a renewed focus on the need for general population-based campaigns, as well as easily accessible services and in some instances, nutrition products. In particular, there is recognition of the need to include the urban poor as a key population, often equally at risk of malnutrition to their rural counterparts due to poor diet choices, limited accessibility to fresh varied produce and poor living conditions. Innovative communication techniques common in the commercial sector for selling products, are increasingly used to help 'sell' health messages and associated services to populations. These look on the beneficiary as a 'consumer' of information, products and services. There are many lessons from the commercial sector and their successes in

- are helping to map vulnerable/at risk populations⁴
- Food Security mapping (see map in header)
- Hourly income
- Personal security
- Coping strategies

A second key area of action is acceleration of systems/coverage of HINIs to address disparities in malnutrition in urban informal settlements/slums of Nairobi. Progress in health system strengthening is reflected in improved coverage for Nairobi and Kisumu facilities where HINIs implementation has increased from 26 facilities in 2008 to 102 facilities in 2012, reaching 89% of target health services in urban slums. Coverage for outpatient treatment for acute malnutrition has also improved, with coverage reaching 40 to 50% of target (see Table 2) and achieving global Sphere standards (defaulter rate, recovery rate and mortality rate). Coverage assessments have highlighted barriers to future programming that will inform efforts.

The area of Infant and Young Child Nutrition (IYCN) has seen improved strategies and focus on community level support⁵. Results included improvement in complementary feeding practices (see Table 2). Main strategies have included Trials for Improved Practices (TIPs) which used formative assessment for improved complementary feeding of young children, Mother to Mother Support Groups (MtMSG) and Community Capacity Enhancement (CCE); these approaches have been integrated together to mobilise communities and empower caregivers with knowledge and skills for better practices.

Challenges and constraints

Challenges and constraints to urban nutrition programme support in Kenya include:

- Inadequate resources for health and nutrition programmes at all levels
- Fewer partners supporting urban nutrition
- Transient populations with intra-slum migration

- Limited quality maternity services in informal settlements
- Market level influence: price shocks, infant formula use and sub-optimal complementary foods
- Challenges for working mothers and un-regulated day care settings
- Social challenges and insecurity (HIV/AIDS, substance use and violence)
- Need for strengthened analysis for disparities and interventions

In order to take urban programming to the next level and strengthen nutrition responses in vulnerable urban areas, Kenyan government priorities are:

- To identify gaps to expand urban priorities, identify disparities and strengthen analysis of vulnerabilities including the impact of rising food prices and inequities.
- To undertake further analysis and develop multisectoral responses to address underlying causes of early child care (day care settings) including child protection concerns, lack of clean water and proper sanitation. One action is to develop guide lines for minimum standards for day care settings.
- To improve sectoral responses to address disparities in neonatal mortality through investments in maternal newborn care.
- To prevent deaths in children under five years through improved access to health services, improved water and sanitation and prevention strategies for HIV.
- To strengthen the local resource base for urban nutrition response through advocacy for government funding from the devolved governments, include community interventions to improve coverage of HINI and social transfer programmes addressing nutrition security (food/cash vouchers).

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⁴ APHRC and Concern Worldwide, 2009
⁵ Concern Worldwide, UNICEF, MoH, 2010

Table 2: High Impact Nutrition Interventions, national targets and achievements in Nairobi and Kisumu (2010-2012)

Focus of Nutrition Programme Support	High Impact Nutrition Intervention	National Target	Nairobi 2010	Nairobi 2012	Kisumu 2010	Kisumu 2012
Infant and Young Child Nutrition	Early initiation of breastfeeding	> 70 %	56 %	71 %	61 %	66 %
	Exclusive Breastfeeding	> 80 %	46%	59 %	46 %	44 %
	Dietary Diversity	> 70 %	38 %	74 %	42 %	73 %
	Feeding Frequency	> 80 %	4 %	46 %	5 %	81 %
Micronutrient Deficiency Control	Vitamin A supplementation	> 80 %	76 %	73 %	N/A-	86 %
	Zinc treatment	> 50 %	14.6 %	40 %	N/A-	43 %
	Deworming	> 80 %	48.6 %	52 %	30.6 %	53 %
	Iron/Folate	> 50 %	3.6 %	N/A	5.1 %	N/A
IMAM	SAM coverage	> 70 %	32%	39 %	50%	46%



Government of the Republic of Kenya Ministry of Health



marketing and advertising commercial products (with the ultimate aim of profit), that we can apply to marketing and advertising services and products that have a public health goal.

This new approach is especially pertinent for the urban 'consumer'. This adds an additional layer of complexity to the marketing strategy. How does today's urban 'consumer' in developing countries differ from a rural audience? What is their significance in the adoption and uptake of new behaviours, products and services? To use marketing speak, how do we "sell" to them more effectively, even if we are talking about feeding behaviours or uptake of free products, such as micronutrient powders or bednets?

First, programmers need to begin treating developing markets as just that, developing, and very quickly. In addition to massive construction booms in many African and Asian countries, consumer choice, including health products, has also grown significantly. Twenty-five years ago, Chinese consumers were lucky to find a condom, and if they did it was an unattractive, government-distributed free option. Today there are over 1,000 brands in the country. Increased options make markets healthier by injecting competition that has a role to drive down prices and enables consumers find a product of their preference. Along with such options comes an increase in the overall level of advertising that people are exposed to. In urban slums, the chaos of daily life in densely populated areas, the plethora of independent vendors promoting a wide variety of goods, the new ways in which many companies are marketing to the 'bottom of the pyramid' (SMS, wall paintings, over-branded kiosks, branded vehicles, etc.) and the rapid increase in TV ownership and satellite TV, means that being seen by an urban consumer requires breaking through the clutter. Whether your campaign is for a product, service or behaviour, getting noticed and remembered in such an environment requires a different kind of marketing than the traditional, functionally-driven public health communication. It requires emotionally driven, relevant concepts and it requires 'surround sound' campaigns that incorporate new and innovative marketing techniques. This will be critical for uptake whether your product is freely distributed, socially marketed or commercial.

Commercial market research tells us that people react emotionally before they process rationally, even if they don't always realize it. This means if communication does not resonate personally with a consumer, they will never take the time to process the actual message being delivered. Creating that personal connection requires two steps: gaining an in-depth understanding of your audience that goes beyond demographics, including their lifestyle, aspirations, fears and values, and creating an emotional benefit of the desired behaviour that is relevant, compelling and credible to your audience. This emotional connection is what can make an ad stand out on TV, be remembered and talked about; just as lack thereof can make it forgettable no matter how many times it is aired. Recent marketing research shows that while rationale might create a short-term shift in behaviour, an emotional approach can create a much larger, long-term change in profits (or in our case, behaviour!).

Even with a good concept, good execution of the campaign will still be the ultimate driver of success. This means complementing traditional media (TV, radio, outdoor, interpersonal communication, in-store) with newer media that are likely to reach an urban poor population (SMS, guerilla marketing

like flash mobs¹, over-branding of people or of vehicles (e.g. taxis, buses), CCTVs in public transport) while ensuring it all ties together as a campaign. While traditional media can serve to increase awareness and knowledge, guerilla techniques can often create buzz and word-of-mouth around your campaign – helping to address attitudes or social norms. In Burundi, Population Services International (PSI) just organized the country's first ever flash mob in the capital to promote their condom brand and then posted it on YouTube so that people could share it with friends (see link at beginning of this article). Even in densely populated areas, guerilla marketing such as flash mobs can create buzz in busy informal markets where entertainment options are otherwise limited. In Kenya, PSI is working with GAIN and the Kenyan Ministry of Health to use TV to create broad-scale awareness of a new umbrella brand that signifies food which has been fortified. Another communications campaign by PSI and the Government of Kenya addresses the issue of HIV and concurrent partnerships head-on² while a regional social marketing platform for condoms has unified a number of brand images to help increase uptake³. When it comes to creating broad brand connection and awareness, market research studies show that TV is still the most powerful medium.

However, internet and mobile phone usage is skyrocketing. Social media can be used to reward loyal fans with special offers (thus improving the chances of word-of-mouth recommendations) as well as serving as a platform for dialogue, experience sharing, questions or suggestions. In Zimbabwe, social media is being used to let men share their stories about why they chose to get circumcised and what their experience was like. SMS technologies can help with targeting and timely messages as well as product distribution, particularly among poor populations. In Papua New Guinea, subscribers to PSI's 'Haus Lain' can receive weekly health messages on their phone. USAID and Johnson & Johnson have collaborated to create the Mobile Alliance for Maternal Action (MAMA), which targets pregnant women and new mothers with health information and advice via SMS which evolves in line with their exact stage of pregnancy. In Mozambique, PSI is piloting the Movercado programme where unique codes received via SMS serve as vouchers to be redeemed for free products in a nearby shop. This can, for example, allow pregnant women who go to the clinic to be sent a voucher for fortified food. By

tracking their pregnancy, they can also be sent reminders about breastfeeding or complementary feeding advice. Vendors who honor the vouchers can potentially also be reimbursed for the product on their mobile phone, saving admin time and costs. Recently this has also been used to create access to water treatment products during a cholera epidemic, rewarding local businesses and avoiding the typical logistical difficulties of delivering emergency supplies. These newer media platforms for marketing campaigns can provide significant opportunities.

There are a large number of urban poor who are often malnourished due to the limited affordability and availability of fresh and nutritious food, increased availability of unhealthy, processed foods, and low awareness of appropriate infant and young child feeding practices. However, just as important is the role that the urban consumer plays in setting trends and disseminating new ideas, behavioural trends and products to rural areas. Rural consumers often aspire to what they see their urban relatives using, wearing, eating and drinking. In addition, urban consumers often bring goods back to their rural relatives during holiday periods. The urban population itself may include temporary rural residents, attracted/driven to the urban centre for work opportunities. In Namibia, PSI's malaria programme made a point of encouraging people in urban areas to buy mosquito nets and bring them out to rural relatives during the holidays. In addition, uptake of something new may decline if rural consumers find out their city-dwelling relatives have never heard of it. Kenya's fortified food brand awareness campaign has targeted urban consumers in its first phase for all of these reasons.

Urban markets are thus a critical one for building up awareness and changing behaviour that will improve nutritional outcomes amongst the entire population. However, it will require a change in mindset and a lot of learning from the private sector for organisations working in the field to make better nutrition into the latest trend.

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¹ A flash mob is a group of people who assemble suddenly in a public place, perform an unusual act for a brief time, then quickly disperse, often for the purposes of entertainment, satire, artistic expression or messaging.

² See video at: <http://www.psi.org/multimedia/video/hiv-and-concurrent-partnerships>

³ See video at: <http://www.psi.org/multimedia/video/psi-southern-africa-regional-platform-condom-social-marketing>

A flash mob in Roma, outside the national university in Lesotho. This marketing was done to create awareness as a "teaser" right before the launch of the campaign, 'Pusha Love'.



Why do we still have refugee camps?

By Michael Kagan

Michael Kagan is Associate Professor of Law at the University of Nevada, Las Vegas. He maintains the independent blog rsdwatch.org about the challenges of refugee status determination by UNHCR and in collecting basic data about where and how UNHCR does so.

Summary of online blog¹



The Champs Elysees street in Za'atri camp, Jordan - the main market street created by the Syrian refugees

UNHCR/J. Kohler, Jordan, Sept. 2013

Below is a summary of a contribution by Michael Kagan on the Urban Refugees Debate Forum² that scrutinises UNHCR policy and practice around urban refugees, posted 10th August 2013. It is followed by a short postscript (again summary of online comment) by Jeff Crisp (former UNHCR staff).

Four years ago, UNHCR issued its Policy on Refugee Protection and Solutions in Urban Areas³, perhaps the UN's most important 21st century statement of protection strategy. In UNHCR's words, the new policy "marks the beginning of a new approach." Refugees are now to be reconceived as people with autonomy. The focus is to be on their rights, their legal status, their ability to support themselves and to raise their families in dignity. But as always, the situation on the ground is more complicated. Four years on, the world is still littered with refugee camps imposed on refugees. In East Africa, on the Thai border with Burma, and in dozens of other places, refugees are directly or indirectly forced to live in remote camps.

This gap between policy and practice is the background for several new critiques of UNHCR's urban refugee policy⁴. The gist of the critiques, with varying degrees of nuance, is that old habits die hard, and while the new policy sounds good, UNHCR's commitment to urban refugees in practice is not always clear. Camps are still abundant, and they are still central to UNHCR's work.

The critiques warrant a response, and in the process we might be able to bring the rhetoric about rights-based refugee policy closer to realities on the ground.

UNHCR's urban refugee policy has long been entangled with a great deal of symbolism beyond the scope of any specific text. On paper, the 1997 urban policy was actually a bit of a mixed bag, with at least grudging acknowledgement that refugees have rights. UNHCR explains the new urban policy as an adaptation to new circumstances. UNHCR says that with increased rural-to-urban migration, it makes sense to embrace urban refugees in 2009, whereas in 1997, refugees were reasonably assumed to be rural. To its great credit, the 2009 urban refugee policy is quite self-critical about the "negative attitude of some UNHCR staff" that contributes to tension with urban refugee communities. We should also not forget that the new policy grew out of nearly a decade of critical reports and studies, many of which were sponsored by UNHCR

itself (especially by the Policy Development and Evaluation Service).

In 2009, I heard high ranking UNHCR officials speak eloquently about what was misguided in the old policy and about the importance of adopting a new approach to urban refugees. I heard UNHCR officials talk about the evils of forced encampment, the degradation of forced isolation, the importance of refugee rights.

Results-based accounting doesn't always work with UNHCR

When UNHCR publishes a document that does not quite match facts on the ground, it is tempting to question UNHCR's motivations. In the sharpest terms, Simone Haysom⁵ of the Humanitarian Policy Group wrote: "UNHCR's own commitment to its landmark 2009 urban refugee policy should be called into question." Tim Morris and Sonia Ben Ali⁶ ask if UNHCR is reviewing its own work in implementing its new policy with "an air of complacency?" (question mark original).

The hint of hypocrisy is a seductive hook for criticism. But it's analytically limited. It is certainly fair to compare UNHCR policy and UNHCR practice. In fact, if we want UNHCR to fulfil its mission, it is essential. As Verdirame and Pobjoy⁷ write: *If the 2009 Urban Policy had been adopted by the department of a national government in a free country, its implementation would be subject to various checks and balances.... These checks and balances are not in place in the case of UNHCR and international institutions in general.*

The only way to try to fill this gap is for those on the outside to ask tough questions of UNHCR, and to offer tough critique when UNHCR is not doing what it should be. When a matter of refugee policy is fully within UNHCR's authority, it's especially fair to hold UNHCR's feet to the fire.

But not everything that affects refugees is within UNHCR's control. The mere fact that many refugees are still warehoused in camps does not on its own mean UNHCR is to blame. The 2009 Urban Refugee Policy is, for the most part, a statement of what UNHCR *wants* to happen, not about what

UNHCR will actually be able to do. Since the policy aspires to far more than UNHCR can deliver on its own, one has to be cautious about measuring UNHCR by the results.

It is always possible to find gaps in UNHCR practice. It is a big, complicated, human institution being pulled in competing directions, working under severe constraints in dozens of countries to try to do essential things that, quite often, no one else will do. Its staff do amazing things, and also make mistakes. On any given day with UNHCR, you can find heroism, innovation, competence, mediocrity, indifference, and occasional cruelty. Sometimes you can find all of that in one field office.

It is often difficult to discern whether a UNHCR failure is merely an exception, or the tip of an iceberg. Moreover, while UNHCR tries hard to speak with one voice in public documents, it is always churning with internal divisions and debates. These internal contradictions can lead to accusations of hypocrisy and insincerity, since some people who work for UNHCR really are not committed to the official policy. But it also simply reflects the complexity and difficulty of the subject matter.

That doesn't mean that UNHCR should not face tough questions about its activities. It is important to ask, as Verdirame and Pobjoy do, why urban refugee programmes still seem to be getting the short end of the stick in the UNHCR budget. And it is reasonable to ask if UNHCR is being assertive enough in telling governments that urban refugees exist, and that they have rights. Take, as an example, Tanzania, where legislation restricts refugees to camps and largely prohibits refugees from living in the city. It is reasonable to ask UNHCR if it is doing all it can to convince the government that refugees have a right to be in the city, and to provide them assistance.

¹ <http://urban-refugees.org/debate/>

² See news piece about the debate forum in this issue of Field Exchange, <http://urban-refugees.org>

³ UN High Commissioner for Refugees, UNHCR Policy on Refugee Protection and Solutions in Urban Areas, September 2009, available at: <http://www.refworld.org/docid/4ab8e7f72.html> [accessed 3 September 2013]. A short summary of the UNHCR 2009 policy is included on page X.

⁴ The End of Refugee Camps? Guglielmo Verdirame & Jason M Pobjoy. August 2013. Legal Studies Research paper Series. PAPER NO. 29/2013. Access at: http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2297741

⁵ <http://www.odi.org.uk/opinion/7538-world-refugee-day-kenya-nairobi-refugee>

⁶ <http://urban-refugees.org/debate/unhcr-reviews-urban-policy-air-complacency/#more-75>

⁷ See footnote 1

These are legitimate questions. But they should not necessarily be understood as criticisms. Rather, they are an effort to prevent hard choices from being covered over by soothing diplomatic verbiage. The world is complicated, and responsibility is often diffuse. UNHCR needs to be held accountable, but its critics also need to be modest in not exaggerating UNHCR's flaws.

Interpreting UNHCR silence

For Haysom, Morris and Ben Ali, and Verdirame and Pobjoy, a primary basis for questioning UNHCR's commitment to the new urban policy is the fact that UNHCR has not always publicly criticized governments for forcing refugees into camps.

Morris and Ben Ali's essay is in many ways a critique of the way UN agencies talk. They give the example of how Human Rights Watch reported that it was "impossible" for refugees in Nairobi to get ID cards, but UNHCR would only say it was "challenging." Anyone who has worked in this field has learned to engage in some semantic softening like this. Don't say you are outraged. Say you are concerned. Don't say you had an argument. Say you had a dialogue. And if you don't have anything nice to say, maybe don't say anything at all. Let's call this Geneva-speak.

There's some force to this critique – and not just about urban refugees. UNHCR wants to be, and largely is, the primary global authority on refugee issues. But can UNHCR credibly play this role and still be selective about revealing what it knows about what certain governments are doing?

What are we to make of the fact that earlier this year the High Commissioner applauded the United Arab Emirates for its "very generous commitment" to Syrian refugees (i.e. as a donor and logistics hub), despite the UAE's atrocious record on migrant rights generally, including reports of torturing Syrian refugees?

In the future, I would suggest that UNHCR avoid the appearance that its compliments (or its silence) can be bought. But even if UNHCR avoids that pitfall in the future, Morris and Ben Ali are pointing to a more ambiguous problem. What about UNHCR's general hesitation about criticizing governments? Consider Haysom's criticism⁸ of UNHCR in Kenya, when the Kenyan Government was planning to force all refugees into the camps:

While the UN Refugee Agency (UNHCR) has said it will not support forcible relocation to the camps and has urged the government to abandon the directive, it has committed assistance to refugees who wish to voluntarily return to camps. UNHCR has joined a government-run taskforce to oversee the implementation of the directive to ensure it is done humanely.

Essentially, UNHCR was engaged in a balancing act. It opposed forced encampment. But if it were to happen, UNHCR wanted to be involved so as to make it as humane as possible. This is a morally debatable strategy, certainly. UNHCR's involvement will lend legitimacy to an oppressive policy. But it will also probably relieve immediate suffering.

The fact of the matter is that UNHCR is not Human Rights Watch. Putting out public statements is not its main work. UNHCR has millions of people on the ground depending on it. Every day, UNHCR staff are trying to get refugees out of detention, trying to get deputy ministers of the interior on the phone, trying to stop deportations. It is important for refugees that the deputy ministers return UNHCR's phone calls (and they often don't). But the danger is that by staying engaged, UNHCR will implicitly legitimize policies that violate

refugee rights, when the offending government says, "We did this in consultation with the UN."

The question is where to draw the red line, a question that has followed the humanitarian movement since the founding of the International Committee of the Red Cross (ICRC). Although UNHCR does not have a doctrine of neutrality quite as developed as the ICRC, UNHCR's approach owes much to the ICRC heritage. And so before criticizing UNHCR it is worth considering the ICRC's "principles under fire":

Neutrality should not be confused with confidentiality. The ICRC's neutrality has a very specific purpose, namely to enable the organisation to gain the trust of all the parties to a conflict, whatever their stance, and thus to come to the aid of all the victims.... This is not the same thing as silence, or cowardice, or compromise. It is more difficult to say to a security minister that a country's prisons are unsanitary, overcrowded and run by staff that torture inmates than to publish an article denouncing these facts in the press....

Confidentiality, however, has limits.... In other words, the ICRC is fully aware that there are limits to persuasion and that public denunciation – the means of action favoured by organisations like Human Rights Watch or Amnesty International – can sometimes, albeit not always, be more effective. When the ICRC decides to take a public stand on violations of humanitarian law because its efforts at persuasion have been to no avail, it is not departing from the principle of neutrality but from the practice of confidentiality.

I have always had reservations about this, chiefly because I think that in a crisis, human beings working in large organisations will usually take the lowest risk path. That is, they will usually do what seems safest for the aid organization, not for the people who are in danger, and that usually means staying quiet too long.

But I must acknowledge that it does take a special kind of strength to try to work with a government that means to do wrong, and to try to soften the blow. While it can feel more morally satisfying for activists to put out principled press releases, it is important that someone keeps channels of communication open. For refugees, that someone is typically UNHCR, and looking back at the 10 years I spent working with refugees in the Middle East, I cannot imagine what we would have done if UNHCR had not played this role. I tend to agree with the critics that UNHCR is sometimes more cautious than it needs to be. UNHCR should see that many governments do seek out its praise and are angered by its criticism, when it comes. That's good. It means that UNHCR has at least a little bit of power, and it should learn to use this. But these are tough calls to make, and critics should acknowledge as much. UNHCR's public silence should not be automatically construed as endorsement.

The challenge is bigger than camps

I wish that the 2009 policy had dispensed with the term "urban refugee" altogether, because it promotes a distracting focus on geographic location rather than human rights. The assumption is that there is a dichotomy between refugees who are forced *en masse* into refugee camps in rural areas, and those who live more independently in cities. But even the 1997 urban policy acknowledged that a refugee should have the same rights regardless of where that refugee chooses to live.

There is something extreme about refugee camps. As Verdirame and Pobjoy write, "The essence of a

refugee camp is separation'. When refugee camps are the assumed foundation of refugee policy, operational energy shifts toward logistics. How do we supply X amount of calories and Y quantity of shelter to Z location? But when one thinks about refugees outside of camps, living on their own, the focus shifts toward what refugees can do for themselves, and that highlights the importance of legal status and rights.

Verdirame is the scholarly authority on the ways in which refugee camps are anomalies¹⁰ in international law, places where whole pieces of territory are *de facto* governed by international aid agencies instead of sovereign governments.

Legal separation is especially visible when refugees are confined in remote places. But not all refugee camps are isolated geographically. Many Palestinian camps in the Middle East are in the middle of cities. Not all refugees who are in camps are confined. Nor does leaving a camp ensure integration.

Legal separation can occur even when refugees are free to live wherever they want, if they are denied the right to work, if their kids cannot go to school, if local authorities will not recognize their marriages and divorces, or provide them routine police protection. It's usually host governments, not UNHCR, that impose this separation on refugees.

As I have explained more extensively elsewhere¹¹ (borrowing heavily from the work of Jeff Crisp of UNHCR's Policy Development and Evaluation Service), host governments in the global south have strong incentives to marginalize refugees. Sometimes they do this geographically, by confining refugees to camps (see: East Africa). Sometimes they tend to do this through more invisible legal restrictions (see: Middle East). But what happens in both scenarios is similar. The refugees are rendered more vulnerable and more dependent, while UNHCR becomes a "surrogate state."

Critics of UNHCR often gloss over the power of local politics in promoting refugee separation. For instance, Verdirame and Pobjoy state broadly that host governments don't like UNHCR offering parallel services to refugees rather than integrating refugees with locals. Maybe that is true of some countries. But I have my doubts. If a host government didn't want UNHCR to run parallel services for refugees, why did they let UNHCR do it? There are many governments that insist on separate services for refugees that refuse to let refugee kids enroll in local schools, that will not discuss including refugees in national development plans, and that will not allow refugees to seek employment. (Examples: Tanzania, Egypt, Lebanon). One of the main goals of the 2009 policy is to re-focus on host state responsibility. But why should we think that local governments will be willing to open their schools, their medical clinics, their employment markets, and their housing supply to refugees, especially in a climate of xenophobia or economic distress? Isn't it easier for a host government to say, "Refugees are an international responsibility?"

It would indeed be easier if all of the blame for refugee separation belonged to UNHCR. Then UNHCR could fix it. But in reality UNHCR must

⁸ See footnote 3

⁹ <http://www.icrc.org/eng/resources/documents/misc/5vveea.htm>

¹⁰ The UN and Human Rights. Who Guards the Guardians? Guglielmo Verdirame. August 2013

¹¹ New issues in refugee research. "We live in a country of UNHCR". The UN surrogate state and refugee policy in the Middle East. Michael Kagan. Research Paper No. 201. August 2011. <http://www.unhcr.org/4d5a8cde9.html>

adapt to the political realities in countries where host governments are simply unwilling to take responsibility for refugee protection or to let refugees integrate with their citizens. The new urban policy doesn't clearly tell a UNHCR office what to do if a host government refuses to take responsibility for refugee rights, and that is a major weakness.

UNHCR's greatest immediate potential is to expand refugee autonomy and dignity without dismantling the UNHCR surrogate state, finding new ways to deliver aid and focusing new attention on legal status and individualised services. With many countries denying refugees the right to work and impeding their access to government services, UNHCR is focusing more on developing its own referral networks and experimenting with more creative ways to enhance refugee livelihoods. But such efforts will always represent a compromise with reality, because they still depend on UNHCR and continue a kind of refugee separation.

Half full, half empty, or has the water just started pouring?

So, are we really at the beginning of a new era for refugee policy? Consider the case of Kenya again, where Haysom¹² criticized UNHCR for its willingness to participate in proposed refugee relocation. Just last month, a Kenyan court blocked a plan¹³ to force tens of thousands of refugees in Nairobi into camps. It is disturbing that in 2013 a government would want to do this, and that does not bode well for the goals of the new urban policy. But it is also encouraging that a court said no. That could just be a fleeting victory. Or it could be a foundation for the future. *UNHCR's amicus curiae submission¹⁴ in the Kenyan case is also an important development; it advances an analysis of freedom of movement that is far closer to Verdirame and Pobjoy's position than to the 2009 Policy (italicised added in subsequent online comment).*

What struck me most in UNHCR's 2012 Global Survey of the implementation of its new urban policy¹⁵ is that it kept returning to the issue of legal barriers and legal status. I cannot recall a UNHCR report that places such a strong emphasis on law in the global south. Such concerns have always been a focus of UNHCR's work in Europe, North America and Australia. But in the global south, in the past at least, UNHCR tended to talk in more operational terms. It may be tedious, but there are literally dozens of references to legal issues throughout the report – the challenges of legal barriers, the difficulties of determining legal status, the importance of legal aid and legal networking. This focus on law is new.

Yes, there are grounds for criticism. We do not know if UNHCR's growing attention to legal obstacles to refugee livelihoods will translate into expanded refugee rights in practice. We do not know if UNHCR will focus as clearly on legal issues when reviewing its own policies. I can't help but note that on refugee status determination by UNHCR, the 2012 Global Survey stressed backlogs and resources. In other words, the report stressed the logistical side of mandate RSD. But the report made little mention of the unfinished work of bringing greater fairness to the process – the legal rights at stake.

But UNHCR decided in 2009 to endorse an essentially rights-based approach to refugee assistance. It decided that good refugee protection takes refugees where you find them, rather than telling them where they have to go. UNHCR decided to put this document out in a high profile way knowing full well that the situation on the ground wouldn't measure up. It is not yet a success. But it is a very good start.

¹² See footnote 3

¹³ See full text of case at: [http://www.hrw.org/sites/default/files/related_material/PETITION%20115%20AND%2019%20OF%202013%20JUDGMENT\(FINAL\).pdf](http://www.hrw.org/sites/default/files/related_material/PETITION%20115%20AND%2019%20OF%202013%20JUDGMENT(FINAL).pdf)

¹⁴ UN High Commissioner for Refugees, Brief of the United Nations High Commissioner for Refugees (1st Amicus Curiae), in the matter of the contravention of fundamental rights and freedoms under Articles 2, 3, 10, 20, 21, 27, 28, 29, 36, 39 and 259, of the Constitution of the Republic of Kenya 2010, and in the matter of Articles 22, 23 and 258 of the Constitution of the Republic of Kenya 2010 and in the matter of the Refugees Act and in the matter of the intention of the Government of Kenya to move all refugees residing in urban areas to the Dadaab and Kakuma Refugee Camps with effect from 21.01.2013, in the High Court of Kenya at Nairobi, Constitutional and Human Rights Division, Petition No. 115 of 2013, 12 March 2013, available at: <http://www.refworld.org/docid/5151b5962.html> [accessed 3 September 2013]

¹⁵ The Implementation of UNHCR's Policy on Refugee Protection and Solutions in Urban Areas – Global Survey – 2012. Available at: <http://www.unhcr.org/516d658c9.pdf> and summarised in this edition of Field Exchange (46).

Postscript

By Jeff Crisp

Jeff Crisp is former Head of Policy Development and Evaluation, UNHCR, and has been recently appointed as Senior Director for Policy and Advocacy, Refugees International.

Posted whilst on UNHCR staff in response to the online blog (14th August, 2013)

As principal drafter of UNHCR's 2009 urban refugee policy, I was pleased to see Mike Kagan's essay on this subject, which provides a welcome corrective to the simplistic critiques offered by the other authors cited in his article.

The full story of the way in which UNHCR's urban refugee policy has been formulated and implemented is told in a PowerPoint presentation which I gave in Oxford last December. I am happy to send a copy to anyone who wants to see it.

With respect to another issue raised by Mike, UNHCR is very much aware of the need to develop a broader policy on "out of camp" refugees, rather than focusing solely on urban contexts. This re-thinking process started with the Ivoirian influx into Liberia in 2011 (when many refugees preferred to stay with host communities rather than moving to a camp) and has of course been strengthened by the current Syrian refugee crisis. See our recent evaluation of UNHCR's Syrian emergency operation which includes the paragraphs cited below.

"While international attention and resources have been largely directed at camps in Jordan and Northern Iraq, over 60 per cent of the Syrian refugee population in the region live outside camps. Their locations are diverse, spanning major cities, provincial towns, peri-urban and rural settings. The out-of-camp refugees are also confronted with a range of shelter conditions and differing access to services and livelihoods opportunities. Most live in precarious conditions and are vulnerable to a number of protection risks and socio-economic pressures. Ensuring timely registration, outreach and access to services for such a vast and geographically dispersed refugee population has been particularly challenging.

While there have been mounting efforts by UNHCR and its partners to support refugees living outside camps, there is a need to significantly boost the humanitarian community's outreach to non-camp refugees, to strengthen mass information activities, to ensure refugee access to public services and to expand international support to public services in host countries. Many interviewees recognized that there remains a need to develop appropriate tools and capacity, both within UNHCR and the broader humanitarian community, to respond to emergencies in urban and out-of-camp settings."

The online exchange has continued online and can be viewed at: <http://urban-refugees.org/debate/>

Plans for a special edition of Field Exchange on the Syria crisis are outlined by ENN in this edition (see page 48).



Spotting the invisible crisis: early warning indicators in urban slums of Nairobi, Kenya

By Lilly Schofield, Shukri F Mohamed, Elizabeth Wambui Kimani-Murage, Frederick Murunga Wekesah, Blessing Mberu, Thaddaeus Egondi, Catherine Kyobutungi and Remare Ettarh



Lilly Schofield has worked in many countries in Africa and Asia as a nutrition consultant. Until June 2012 she was the Evaluation and Research Support Advisor for Concern Worldwide Kenya. She has recently joined Save the Children UK as a Nutrition Advisor.



Shukri F Mohamed works at the African Population and Health Research Centre (APHRC) as a Research Officer. She coordinated, managed and led the activities of the Indicator Development for Surveillance of Urban Emergencies (IDSUE) project, described here. She led the project analysis write-up and APHRC's input into this article.



Elizabeth Wambui Kimani-Murage is an Associate Research Scientist at APHRC and a Wellcome Trust Fellow. She has about 10 years of experience of research in environmental health and public health issues in sub-Saharan Africa. She was the project manager in the project overseeing the operations of the project, including data collection and management.



Frederick Murunga Wekesah is a Research Officer at the APHRC with research interests in epidemiology, MCH and HIV in the context of urbanisation. Frederick trained the data collection team, supervised data collection and participated in data management, analysis and the actual writing of the report.



Blessing Mberu works on policy relevant research on migration, urbanisation, adolescent reproductive behaviour and poverty in sub-Saharan Africa under the Urbanisation and Wellbeing Research Programme at APHRC.



Thaddaeus Egondi is a data analyst working under Health Challenges and Systems programme at APHRC. He was the data analyst for the IDSUE project responsible for data management and indicator generation.



Catherine Kyobutungi heads the Health Challenges and Systems Research Programme at ADHC Her research interests are in the epidemiology of non-communicable diseases in the African region and in health systems strengthening.



Remare Ettarh was associate research scientist at APHRC between 2009 and 2012.

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This article shares experiences and findings of operational research in Kenya¹ to identify indicators that can help detect the 'tipping point' from chronic need to crisis in vulnerable urban populations.

Despite the recognised risk and growing international commitment to address urban crises, urban environments and actors working in them are still often plagued with a dearth of information. Until recently, urban areas were often excluded from national and sub-national surveys under the assumption they would skew data and obscure negative trends in rural areas. Even when they are included, data are rarely disaggregated between wealthier urban neighbourhoods and slums, leading to a homogenisation that hides the true situation in both areas. Furthermore, high levels of food insecurity and unstable livelihoods that typify urban poverty are often thought of in terms of chronic development challenges. While sustainable improvements in these indicators for many of the world's urban poor will certainly require long-term investment in development and poverty alleviation by government, civil society, non-governmental organisations (NGOs) and other key stakeholders, there is growing recognition that urban areas also face significant risk for both rapid and slow onset disasters.

The key characteristic of urban vulnerability is its multi-dimensional nature and the fact that both chronic and acute vulnerabilities co-exist and overlap in the same populations, with hazards coming from both the local environment (fire, flood, localised violence, etc.) and global forces (price shocks, for example). These vulnerabilities also interact to exacerbate the effects of one another. Because of this, even moderate shocks can precipitate a crisis among many of the urban poor. Understanding the tipping points at which vulnerability transforms into acute need is therefore critical.

The urban poor are exposed to multiple interconnected vulnerabilities and risks from the environment in which they live and the livelihoods which they pursue. Most slum dwellers lack secure tenure to their land and housing, making them vulnerable to sudden eviction and destruction or loss

of property. The overcrowding and non-durable nature of most slum housing coupled with inadequate sanitation and water services means that disease transmission is high. Health service provision is limited also affecting health status of the population.

Urban centres are characterised by a highly monetised economy meaning that even the extreme poor must access all or almost all of their basic needs through the market; this means access to an income is essential for household well-being. Wage labour is a centrepiece of urban economies as the informal economy is a key employer of the urban poor. The urban poor can also face higher per unit costs for key goods and services and limited access to these services compared to their wealthier urban counterparts because of the inability to buy in bulk/larger quantities. Slum dwellers in Nairobi pay 11 times² as much for water as residents in better off neighbourhoods because, while non-slum dwellers pay monthly bills to the City Council, slum residents obtain water piecemeal from exploitative vendors within the community; Dhaka slum dwellers pay 25 times as much³. Many urban poor rely on low quality, casual, insecure and low paying jobs, some of which are also subject to seasonal slow-downs. A review of employment data from five countries found that employment rates were not largely different between urban poor and non-poor but uncertainty of employment was higher among the poor. The uncertainty of livelihoods coupled with need for cash to meet basic needs also translated into greater adoption of dangerous and undesirable livelihoods such as commercial sex work, crime, scavenging and working on garbage dumps, and child labour. These livelihood strategies expose those who practice them to greater risk of ill

¹ Indicator Development for Surveillance of Urban Emergencies Research Report for Year 1. Concern Worldwide and APHRC.

² Beall, J, and Fox, S (2006). Urban Poverty and Development in the 21st Century: Towards an Inclusive and Sustainable World, 2006, Oxfam GB, Development Studies Institute, London School of Economics

³ Beall et al (2006). See footnote 2

health and physical harm, reinforcing and deepening the poor health of the community.

On top of these mutually reinforcing poverty domains come additional shocks or stressors. These can be both external, such as a broad economic downturn, conflict, drought, floods or extreme weather in food producing regions, or increases in global food prices. They can also be more localised, such as escalating gang violence, localised water shortages, or an infectious disease outbreak. These shocks interact with the underlying vulnerabilities limiting household's ability to meet their basic needs. When the combination of shocks and underlying vulnerabilities overwhelm the coping capacity of the community, the tipping point is reached and excess morbidity and mortality result.

Prediction of this tipping point is the key focus of a project on Indicators of Urban Emergency, nested on the Nairobi Urban Health and Demographic Surveillance System (NUHDSS). Specifically, the project has focused on identifying key indicators that can be routinely monitored to detect when an urban poor community is approaching the tipping point. This article describes the preliminary steps employed to identify and define these indicators and lessons learned. To inform indicator development, the project involved a number of studies and analyses that are outlined below.

Study methods

Phase 1

The first phase of the study involved a qualitative study and retrospective data analysis.

Qualitative study

A qualitative study was conducted in two slum settlements in Nairobi Kenya, Korogocho and Viwandani, where APHRC runs a longitudinal health and demographic surveillance system, the NUHDSS, with about 71,000 individuals living in about 28,500 households in these two areas. Both slums are located on the outskirts of Nairobi city about 10 km from the city centre. The two communities are informal settlements characterised by poor housing, lack of clean water, poor sanitation, unemployment, poverty and overcrowding. Viwandani slum is located very close to the city's industrial area and it is home to many low income young people who are predominantly male and have migrated from rural areas to work in the industries. As a result, a high proportion of married men in Viwandani do not live with their spouses who have been left behind to farm and take care of the children. Korogocho, by contrast, is a more established slum settlement with a high proportion of married men living with their spouses and children.

The target study population was residents of the two slum communities. The key eligibility criterion for participating was based on residency as defined by the NUHDSS. A resident must be registered in the NUHDSS with a minimum stay of four months. The NUHDSS captures particulars of location of household and its members (composition). Participation in the project was voluntary and all participants who consented to participate confirmed this by signing a pre-written consent form.

The main aim of this study was to capture the perspective of the urban poor and their own understanding of humanitarian crisis. Both focus group discussions (FGDs) and key informant interviews (KIIs) were conducted. The focus groups were conducted among four distinct groups: younger



Life in Korogocho slums, Nairobi, Kenya

Lama Kabbani, Concern, Kenya, 2013

men (15-24 years), older men (25+ years), female household heads, and married women and unmarried girls (15+ years) with participants selected using purposive sampling. There were 10 FGDs with each group consisting of 8-10 people and 12 KIIs. The KIIs were conducted among the community leaders including teachers, religious leaders, community based organisation (CBO) leaders, women group leaders, youth group representatives, village leaders, administrative leaders and health professionals. All data collected were recorded, transcribed, translated, coded and analysed in MAX QDA using the constant comparison method.

Retrospective analysis

At the same time as the qualitative study, the study team conducted a retrospective analysis of data from the NUHDSS and nested studies collected from the two slum communities over a four year period (2007 to 2010). Though not collected for the purpose of exploring urban humanitarian crisis, the data from NUHDSS and nested studies includes vital information on household size and dynamics, health, nutrition, crime and household assets. Additionally, the period of time studied (early 2007 to late 2010) encompassed a period of political upheaval and price increases that severely affected Kenya's urban slum dwellers. Following the disputed 2007 elections, violence erupted across many areas of the country and the slums became the main areas of unrest in urban centres. This period of upheaval was followed closely by global food price increases that saw the price of staple food rise, severely affecting poor urban dwellers ability to meet their basic needs. The aim of this analysis was to explore trends in the demographic data to identify how key demographic and health variables reflected the changing situation on the ground and if any of these variables were early warning signs for the substantial increases in negative coping and food insecurity that were seen. Bivariate, graphical and regression analysis was used to compare the level of variables between the different time periods.

Phase 2

Phase 1 generated an initial list of indicators, identified by combining and comparing results from the qualitative and retrospective analysis and informed by a review of relevant literature. The second phase of the study involved prospective monitoring of these indicators on a quarterly basis, beginning initially in the same two slums and later expanding in a phased manner across multiple informal settlements of Nairobi and Kisumu. The indicator tool was continually refined and revised throughout this phase in an iterative manner as new data and learning were added from each round and study site. In the initial three rounds, 500 households were randomly sampled from each

study site. In round four, the sample size was reduced to 400 per site after post-hoc power calculation on previous rounds showed that this sample size had adequate power.

The full results of these first phases are available elsewhere⁴. Below is a summary of some of the key findings and implications of these findings for future work on urban emergency monitoring.

Results

Qualitative study

Respondents were first asked to describe the normal or every-day conditions of their lives and then to think of crises times and describe what made those periods crises and how they coped with such times.

Normal situation

The 'normal' non-crisis situation described by respondents was still one characterised by extreme poverty, food insecurity, high level of insecurity and tenuous livelihoods. Jobs were hard to come by, mostly casual and irregular. To get and/or maintain a job, men often bribe while women told of how they have to give their bodies to men.

"If your husband works at the construction sites, when it rains nobody gets out his cement and so at that time you don't get anything..." (FGD, Married women, Korogocho)

"If you don't know anyone, stay in the house....The people who suffer a lot are young women because for a young woman, you have to undress to get a job...So the job goes to the boys who have the money because they will give it (bribe)" (FGD, Unmarried girls, Viwandani)

Even in non-crisis times, many households faced conditions of food insecurity and often reduced meal size and frequency to get by (Table 1).

...And I can tell you there are many people here who sleep on porridge only. You find that they drank porridge in the morning, never had anything at lunch time and then in the evening they make the same porridge. (FGD, Older Men, Korogocho)

Crisis times

Given that slum residents typically live 'on the edge', a small disturbance of the normal situation tends to lead to an acute crisis. When asked to describe times of crisis, respondents identified a wide variety of crisis types. The most commonly mentioned was the post-election violence that racked Nairobi's slums in 2008. However other crises mentioned were economic (food price crisis in 2008/2009), social (increased drunkenness and drug abuse in youth), health related (recurrent cholera outbreaks) and security (inter-ethnic fighting in 1997 and

⁴ See footnote 1

Figure 1: Household food security at the beginning of the intervention

Normal situation	Crisis situation
Changing dietary patterns: <ul style="list-style-type: none"> Changing food source (street foods vs. cooking at home) Changing food types (grains and legumes vs. meat) Reduce amount of food consumed 	Changing dietary patterns: <ul style="list-style-type: none"> Changing food source (street foods vs. cooking at home) Changing food types Reduce amount of food consumed
Augmenting income: <ul style="list-style-type: none"> Find legal employment (casual labour) Illegal activities (prostitution) Undesirable/looked down upon livelihoods (emptying toilets, scavenging) 	Augmenting income: <ul style="list-style-type: none"> Illegal activities (prostitution, crime) Undesirable/looked down upon livelihoods (emptying toilets, scavenging)
Use social networks: <ul style="list-style-type: none"> Borrowing Credit Young girls maintain multiple boyfriends 	Use social networks: <ul style="list-style-type: none"> Increased/Reduced sharing of food Go to boyfriend/partners for money Sending children to relative/friends to eat

Table 2: Measures of household food security for pre-emergency, emergency and post-emergency phases

	Pre-Emergency		Emergency		Post-Emergency		Total	
	N	%	N	%	N	%	N	%
If had extra Kshs 2,000, can HH change food								
Yes	1,503	90.1	6,406	93.3	6,684	94.7	14,593	93.6
No	165	9.9	463	6.7	374	5.3	1,002	6.4
<i>Person chi2(2) = 49.3710; p = 0.000</i>								
Food changes that can be made if HH received additional Kshs 2,000 each month								
Add more usual food	346	23.1	1,749	27.3	2,146	32.1	4,241	29.1
Buy foods containing a variety of vitamins/minerals	793	52.8	3,356	52.4	3,749	56.1	7,898	54.1
Buy variety of foods	362	24.1	1,301	20.3	787	11.8	2,450	16.8
<i>Person chi2(4) = 250.9740; p = 0.000</i>								
Food security index classification								
Poorest	622	31.6	2,753	34.2	2,731	35.1	6,106	34.3
Poor	739	37.6	2,899	36.0	2,779	35.7	6,417	36.1
Least poor	607	30.8	2,391	29.7	2,267	29.2	5,265	29.6
<i>Person chi2(4) = 8.7262; p = 0.068</i>								

Table 3: Household income and expenditure patterns, wealth status, general living conditions and dwelling structures for pre-emergency, emergency and post-emergency phases

	Pre-Emergency		Emergency		Post-Emergency		Total	
	N	Mean (SD)	N	Mean (SD)	N	Mean (SD)	N	Mean (SD)
Subjective household wealth ranking (Scale of 1-10 (very poor to very rich))	1,680	4.16 (1.39)	6,878	3.95 (1.35)	7,059	4.01 (1.27)	15,617	4.00 (1.32)
<i>F value=16.07 p=0.000</i>								
Average HH income in last one month (Kshs)	1,681	6,641 (4303)	6,883	8,479 (5430)	7,066	9,082 (5904)	15,630	8,554 (5590)
<i>F value=132.75 p=0.000</i>								
Average HH expenditure in last one month (Kshs)	1,681	7,451 (3170)	6,883	8,354 (3442)	7,066	8,566 (3546)	15,630	8,353 (3477)
<i>F value=70.54 p=0.000</i>								
Average monthly food expenditure (Kshs)	1,681	4,293 (1963)	6,883	4,796 (1952)	7,066	4,900 (2036)	15,630	4,789 (2000)
<i>F value=63.04 p=0.000</i>								
Average weekly energy expenditure (Kshs)	1,681	91.89 (155.96)	6,883	161.19 (177.89)	7,066	145.29 (169.19)	15,630	146.55 (172.93)
<i>F value=110.36 p=0.000</i>								
Average weekly water expenditure (Kshs)	1,681	50.03 (58.80)	6,883	68.12 (59.44)	7,066	89.60 (71.25)	15,630	75.88 (66.38)
<i>F value=339.61 p=0.000</i>								
Average weekly health care expenditure (Kshs)	1,681	107.59 (383.83)	6,883	78.03 (396.65)	7,066	81.70 (392.23)	15,630	82.87 (393.36)
<i>F value=3.87 p=0.0208</i>								
Dwelling index classification								
Poorest	851	43.1%	3,484	43.3%	3,624	46.5%	7,959	44.7%
Poor	645	32.7%	2,770	34.4%	2,306	29.6%	5,721	32.1%
Least Poor	477	24.2%	1,792	22.3%	1,859	23.9%	4,128	23.2%
<i>Pearson chi squared(4) = 44.58 p=0.000</i>								
Asset index classification								
Poorest	688	35%	2787	34.7%	2838	36.5%	6313	35.5%
Poor	708	36%	2665	33.2%	2657	34%	6030	33.9%
Least Poor	572	29.1%	2588	32.2%	2290	29.4%	5450	30.6%
<i>Pearson chi-squared (4)=19.41; p=0.001</i>								

HH: Household

1999). Increased insecurity was mentioned as both a warning sign of crisis and as a key defining feature of crisis periods.

Food security, both in terms of availability and access, was negatively impacted in crisis periods. A security crisis caused many traders and shop keepers to pull out of the slums or close their shops temporarily. Simultaneously, household purchasing power was eroded due to worsening employment conditions and increasing prices.<

Coping strategies

Table 1 summarises the coping strategies employed by the urban poor in both normal and crisis situations. It shows that there was not a distinct set of 'crisis coping strategies' but rather the same coping mechanisms were used in crisis and non-crisis times, though they may be used more often or to a more marked degree during a crisis. Food related coping strategies (reducing meals size, frequency, switching to cheaper foods, scavenging food from dumpsites) were common and used in both crisis and non-crisis times.

Retrospective data analysis

The final composite dataset for the retrospective data analysis contained 18,371 records from 4,286 households over a four year period from Jan 2007 to October 2010. Three time periods were defined based on when post-election violence occurred, and when maize prices (the main staple food) peaked and began to fall.

The *pre-emergency period* was defined as January 2007-December 2007.

The *emergency period* ran from January 2008-June 2009. This covered both the post-election violence period and the period when food price inflation was rampant, with the maize price peak occurring in May 2009.

Post emergency was defined as July 2009-October 2010.

A number of key variables were selected to assess the effects of the post-election violence and subsequent food price increases on urban slum dwellers. The variables were grouped into four main domains, including food security, personal security, water and sanitation and health outcomes⁵. Household food security was measured using a food security composite index⁶ and Table 2 presents these results. During the emergency and post-emergency periods, a significantly higher proportion of households reported that they would use extra money if this were available to make dietary changes to acquire increases in quantity or mineral/vitamin content of foods. Using the food security index, more households were classified in the poorest category during the emergency (34.2%) and post-emergency (35.1%) phases than pre-emergency (31.6%), though the increase was not significant. This trend may reflect a long term poverty impact of the emergency, where households employed negative coping strategies to protect consumption in the emergency period that compromised long term well-being and thus were not able to

⁵ There were no specific livelihood measures included in the DSS data hence no livelihood domain included in analysis.

⁶ The components that were used for computing the food security index included the following questions: how often do you purchase the following staple foods (maize meal, githeri and kales); how many meals were served to the household members during the last two days; during the last seven days, for how many days were the following foods served in a main meal eaten by the household (chapati, meat and bread); whether the household had enough money to buy food, whether the children slept without eating in the past 30 days, and whether the adults slept without eating in the past 30 days. Two questions on sanitation were also included.

recover once prices reduced. Data on coping strategies are not collected in these datasets so it was not possible to test this hypothesis.

The household income and expenditure patterns, wealth status, general living conditions and dwelling structure features were also examined. As highlighted in Table 3, in the emergency period, slum households ranked themselves lower on a scale of 1 (very poor) to 10 (very rich) compared to pre-emergency and post-emergency phases. Both household average monthly incomes and expenditures significantly increased in the emergency and post-emergency phases compared to pre-emergency. This may be at least partly explained by increased remittances and donations in time of need/crisis. Absolute expenditures on different goods varied across the three time-periods depending on the type of good, for example, energy expenditures were highest during the emergency period, while water expenditures were highest in the post emergency period and health expenditures highest in the pre-emergency period.

The results on households general living conditions and dwelling structure characteristics (as measured by the dwelling index), showed that a similar proportion of households (43%) were in the poorest category during the pre-emergency and emergency periods, however, the proportion increased slightly (47%) in the post-emergency phase.

Prospective indicator monitoring

Results from the retrospective and qualitative investigations were combined with information from the existing literature to develop an initial list of indicators to test prospectively.

The first four rounds of data collection covering one year from April 2011 to April 2012 were

collected at 3-month intervals (Table 4). The aggregate figures showed stable levels for most key indicators and largely agreed with the qualitative results depicting a chronically poor but stable state of food and livelihood insecurity. There was heavy reliance on negative coping strategies with over 70% of households in all rounds using at least one negative coping behaviour in the last month.

These figures masked local level variation however. When each site was analysed separately for changes in food security and employment, a more complex picture emerged. The percentage of severely food insecure in both sites varied from round to round (Figure 1) though the variation occurred in different directions, i.e. rounds with higher food insecurity in Korogocho corresponded with rounds of lower food insecurity in Viwandani and vice versa. The fluctuation may also be reflecting seasonal variations in food security, though why these fluctuations would be opposite in the two study sites remains a question for further study.

A similar pattern holds when employment of main breadwinners is considered (Figure 2). Breadwinners in Viwandani worked more hours on average in round 3 compared to rounds 1 and 2 and a lower percentage was unemployed (1.3% in round 3 compared with 2.5% and 3.9% in Rounds 1 and 2). Korogocho breadwinners faced differing conditions; they worked fewer hours and a higher percentage had no work at all in round 3 compared with the preceding two rounds. Round 4 saw a fall in unemployment in Korogocho and a slight increase in Viwandani.

Given the reliance of slum dwellers in Korogocho and Viwandani on market purchased food, the fluctuations in breadwinner employment may be the underlying cause, at least partially, of the fluctuations in food security. A further analysis

of what distinguishes the employment patterns in these two slums is required to understand why employment opportunities should improve in one when they worsen in another. One hypothesis is that while breadwinners in both areas are predominantly engaged in casual labour (44% and 54% in Viwandani and Korogocho respectively), Viwandani's location adjacent to the industrial quarter means that more of these casual labourers are working in the formal sector as daily labourers at factories and construction sites. However, Korogocho residents' casual labour is more often tied to the informal waste management industries that derive from the main city dump to which it is adjacent.

Lessons learned

The preliminary findings of this project highlight several key lessons learned and some of the unique challenges of monitoring and identifying crisis in urban poor environments.

There are high levels of chronic vulnerability and poverty in these populations and therefore a thin line between normal and crises situations. Some experts insist that lives in such slum settings are in perpetual emergency. Slum dwellers often described the same types of coping strategies employed to meet everyday challenges and shortfalls as those used during crises. Even in periods of relative stability, a large proportion of slum dwellers suffer from food insecurity and utilise negative coping strategies such as removing a child from school, reducing food intake, stealing, sending family members away or begging to make ends meet.

The change in food insecurity indicators over time in the two study sites showed significant conflicting patterns with one area improving at the same time the other worsened. Local conditions

Table 4: A selection of data collected (3 monthly intervals), April 2011 to April 2012

Indicator	Round 1	Round 2	Round 3	Round 4
Food Security				
Severely food insecure (%)	50.6	49.4	50.5	50.2
Dietary diversity >4 food groups (%)	63.2	73.1	59.6	63.9
Use of street foods (%)	41.7	43	51.1	41.1
Average no. of meals per day (adults)	2.1	2.1	2.3	2.6
Markets				
Common consumption basket* - price (Ksh)	1620	1813	1730	1890
Water				
Proportion of HH with <15 litres/person/day (%)	27	30.2	29.9	47.7
Health				
Morbidity rates	0.16	0.13	0.19	0.1
Interpersonal relationships				
Prevalence of intra-household disputes (%)	10.7	10.3	14.3	16.3
Prevalence of inter-household disputes (%)	12.2	7	7.7	6.6
Household food sharing (%):				
Gave			34.55	33.1
Received			32.95	32.1
Security				
Prevalence of shocks (%)	17.1	10.6	15.1	11.9
Perceived security situation: proportion respondents who rated security as bad or very bad (%)	50.5	44.2	54.1	68.8
Use of security coping strategies (%)	54.8	54.4	53	58.6
Employment and socio-economic status				
Dependency ratio (HH member: income earners)	1.8	1.7	1.8	2.1
Median monthly income of breadwinner (Ksh)	6,600	6,600	7,900	6,600
Coping strategies				
Use of at least one negative coping strategy (%)	74.9	77.1	77.8	78.9

* Composite price for standard basket of basic commodities including maize flour, sukuma wiki (kale), water, cooking fat, cooking fuel (paraffin).

Figure 1: The proportion (%) of severely food insecure households in both slums at each round of data collection, April 2011 – April 2012

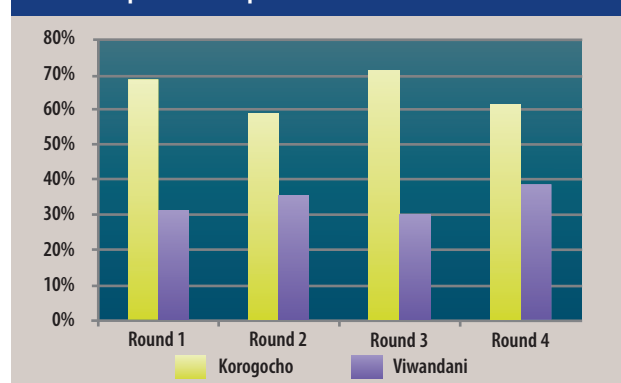
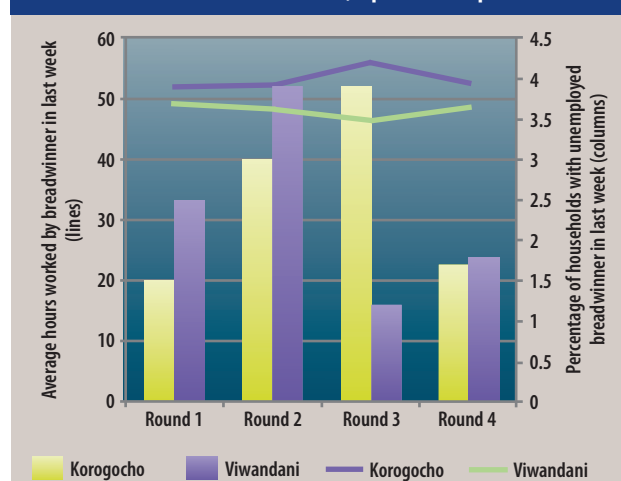


Figure 2: Employment of breadwinners (average hours worked and % unemployed) in both slums at each round of data collection, April 2011-April 2012



can vary significantly between slums in the same urban area and worsening conditions in one slum can accompany improvements in another slum. In this study, this may have been partly explained by the different locations and associated employment opportunities. This raises the important question of what level of disaggregation is necessary and appropriate when monitoring urban poor populations. The quantitative data presented here highlight the risk of aggregating different slums together and masking changes at a slum level. Further investigation is needed to understand what is driving the changes in food and livelihood security in these slums and why they are responding differently to the same city level conditions.

A key question that arises is whether we can define common characteristics of urban poor communities that dictate how they will be affected by municipal level changes in prices, food availability etc. Can we identify zones within larger urban areas that while not geographically continuous, behave in the same way to external and internal stresses or shocks? Or is each slum community different? The implications of this issue are important for any early warning work in urban areas because it determines at what level indicators must be monitored to detect crisis and what information can be extrapolated from one slum community to another.

Way forward

The on-going work on urban early warning indicators in Kenya is resulting in expansion to more sites both within Nairobi and other urban centres in Kenya. This will allow for testing of indicators and validation across a wider range of contexts. It is also facilitating further exploration of the spatial heterogeneity of urban slums to address questions around what factors drive the inter-slum differences as discussed above.

Further prospective monitoring of the draft indicators and revision is also required to distinguish those that are sensitive to change early in a developing crisis.

Feedback from key stakeholders after the first year results led to expansion of the data collection to include detailed income and expenditure information. The aim of this information is to develop a 'survival basket' analysis to define a minimum level of consumption needed to meet basic needs and subsequently validate the draft indicators against this threshold to identify those that show strong agreement.

Further work will involve development of a refined indicator list for surveillance of urban emergencies and development of thresholds/cut-offs/decision algorithms for indicators to define an urban emergency.

In sum, through the development and preliminary testing of an indicator framework, several key lessons have been learned and baseline values established for the indicators. Further development and use of this tool will allow for better understanding of the spatial variations within urban poor communities in Nairobi and other urban areas in Kenya.

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Nutrition security emergency programming in diverse urban contexts

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The past decade has witnessed an increased volume of humanitarian programme implementation in urban environments, and Action Contre la Faim (ACF), has been a key player adapting to this trend. Since 2004, ACF has launched an increasing number of urban programmes globally, including nutrition prevention and treatment, food security and livelihoods (FSL), water, sanitation and hygiene (WASH), and care practices components with an overarching goal of nutrition security¹. The question for humanitarian actors is no longer *whether* we should intervene in urban contexts, but how we can do it better.

By 2050, 66% of the population in developing countries will live in urban areas. According to the Population Division of the UN DESA (Department of Economic and Social Affairs), the majority of the urban population live in slums². Here, people live in hazardous and volatile environments that are likely to degenerate and become full scale disasters as a result of additional complex environmental and political events³. ACF and other humanitarian actors have encountered new challenges in humanitarian emergencies in urban contexts that require further analysis in order to improve the pertinence and

the quality of response, and ACF has developed a specific guide for identifying vulnerable people in urban settings⁴. The underlying vulnerabilities in urban contexts and the persistent nature of malnutrition, food insecurity and public health hazards can often constitute a 'perfect storm' that goes beyond humanitarian agencies' operational capacity in an emergency response setting, touching on structural and policy issues of urban planning, public health infrastructure, urban migration and national politics.

Urbanisation increasingly shapes vulnerabilities, risks, and potential responses. Indeed, urban humanitarian emergencies are commonly seen as the result of a trigger event such as an earthquake or a violence outbreak, combined with the population's underlying vulnerability to that event. Because of population density, chronic poverty and proximity to economic centres, urban settings may experience greater scale of disaster than rural areas in terms of public health and livelihoods consequences.

According to ALNAP, there are "a number of elements that would appear to be specific to urban disasters, most of which are related to the nature of cities and the nature of urban vulnerability. These fall into three broad categories of

¹ Nutrition security exists when all people/household members, at all times, have physical, social and economic access to sufficient, safe and nutritious food that meets their dietary needs and food preferences, combined with a sanitary environment, adequate health services, and proper care and feeding practices to ensure an active and healthy life for all people/household members. ACF has carried out or currently implements urban programmes in Kabul, Afghanistan (since 2004); Monrovia, Liberia (2005); Gonaïves (2005) and Port au Prince, Haïti; San Pedro (2007) and Abidjan, Ivory Coast; and since then also in Bangui, Central African Republic; Ouagadougou, Burkina Faso; Conakry, Guinea; Freetown, Sierra Leone; Gaza, oPt; Djibouti; Nakuru,

Kenya; Mogadishu, Somalia; Cotabato City, Philippines; Bamako, Mali; Ulaanbaatar, Mongolia; Kinshasa, Democratic Republic of Congo.

² World Urbanisation Prospects: The 2009 Revision, Highlights; ESA/P/WP/215, United Nations Department of Economics and Social Affairs/Population Division 3, March 2010.

³ Humanitarian Action in Urban contexts, HPN N° 35, November 2006.

⁴ See news pieces in this edition of Field Exchange, The guidance is available at: http://www.actionagainsthunger.org/sites/default/files/publications/2010_acf_identification_of_vulnerable_people_in_urban_environments_guideline_en.pdf

density, diversity and dynamics.”⁵ In its lessons for urban contexts, ALNAP has specifically highlighted the use of cash-based interventions and working with local private sector and market actors as key to the design and implementation of urban emergency response⁶. ACF case studies demonstrate that for humanitarian emergency response in urban areas, cash-based interventions (CBIs), encompassing a wide range of activities and delivery mechanisms, are highly relevant for immediate improvements in nutrition security. They also demonstrate that a greater density of population, civil society, private sector and humanitarian actors, along with greater proximity to government power brokers, can provide both increased opportunities and challenges for emergency response compared to rural contexts.

This paper will describe the challenges ACF has faced in four urban areas, with crises ranging from large-scale disaster to complex emergency to prolonged emergency levels of malnutrition. These food and nutrition security programmes took place in the Philippines, Ivory Coast, Haiti, and the Democratic Republic of Congo (DRC). The examples point to the relevance of CBIs, including debit cards, mobile phone transfers and cash vouchers in urban contexts, where flexibility and market linkages are key to improving food security and nutritional status and contributing to early recovery.

ACF urban programmes

Fresh food vouchers to prevent malnutrition in a rapid onset disaster in Port au Prince, Haiti (2010-2011)

In response to the January 2010 devastating earthquake in Haiti, ACF implemented a range of emergency activities in Port-au-Prince⁷ and Gonaïves including a pilot fresh food vouchers project to complement other food assistance and nutrition interventions.

ACF conducted a rapid market assessment in its area of operation, which indicated that staple and fresh products were locally available but inaccessible to the most vulnerable populations due to high food prices. ACF found that the use of vouchers, rather than an in-kind distribution of imported food, was the most appropriate response to improve vulnerable households' access to a nutritious diet while supporting local vendors. Physical access to markets and a surfeit of payment institutions were also key factors in the decision to provide voucher-based assistance.

Two years following the earthquake, households in Port-au-Prince had not fully recovered. Their resilience to shocks and their food and nutrition situation was still severely eroded and food prices remained high. ACF began a voucher programme, in the form of a safety net, first in the north of the country, then in Port-au-Prince, aimed at restoring food security for vulnerable households and improving their nutritional status. By ensuring access to fresh and staple food through local markets, ACF supported the local economy to strengthen livelihoods recovery and to improve households' access to a diversified diet. Overall, 4,500 families and 300 small traders benefited from the project. The possibility for families to purchase food with the vouchers allowed them to reimburse an average of 25% of their debt and to pay for school fees. Ninety per cent of traders assert that they had more benefits than before the programme. However, despite a temporary partnership with Sogexpress bank to reimburse traders and short-term benefits in improving diet diversity, the lack of long-term work with local civil society partners prevented the programme from having a long-term impact.

Nutrition and food security support for people living with HIV/AIDS in Kinshasa, DRC (2009-2013)

ACF used a similar approach of delivering vouchers for fresh food to improve dietary diversity and nutritional status and support local markets in Kinshasa, DRC beginning in 2009. In urban Kinshasa, chronic poverty and hunger persists far from the conflict-affected Eastern provinces but stemming from the same state failure to provide essential services and safety nets to the population. This crisis disproportionately affects the most vulnerable, including people living with HIV/AIDS (PLWHA) and their family members. The first evaluation of the programme in 2009-10 highlighted the fact that HIV/AIDS was a growing public health issue in Kinshasa due to the inadequate nature of health facilities, increasing prostitution levels and an already fragile socio-economic urban backdrop⁸.

In urban areas, households may have less opportunity to depend on the solidarity of family or other social networks as they might in villages. One of the major coping strategies identified amongst PLWHA households was a reduction in food consumption of up to 40%, according to WFP⁹. Malnutrition is one of the main causes of global mortality amongst PLWHA, as it renders the immune system more susceptible to opportunistic diseases that can be fatal. Appropriate nutrition is essential to strengthen the immune system and to reinforce the efficacy of anti-retroviral treatment (ART), in order to prolong the lives of PLWHA and to prevent mother-to-child transmission of HIV/AIDS.

ACF thus initiated and continues to support a programme on nutrition, food security and livelihoods in Kinshasa since 2009, which includes the following key components:

- Treatment for severely acutely malnourished (SAM) children and adults, with ready-to-use therapeutic foods (RUTF).
- Treatment for moderately acutely malnourished (MAM) children and adults through fresh food vouchers supporting PLWHA as both clients and vendors. The voucher values were developed based on an analysis of nutritional value and cost of a locally-appropriate food basket.
- Income generation activities for households of PLWHA whose members are discharged from MAM treatment, who host orphans and vulnerable children, and/or the income-poor who lack requisite purchasing power for a complete, nutritious food basket in urban markets.
- Provision of water filters to households receiving nutritional treatment, with priority given to households with infants and SAM cases.

Similar to the Port-au-Prince voucher scheme that was eventually integrated into a safety nets approach, the Kinshasa programme seeks to provide a continuum of care from treatment to self-sufficiency, whereby PLWHA and their families can maintain their health after malnutrition treatment has ended. The fresh food voucher approach led to weight gain

in PLWHA, showing the relevance of this delivery mechanism in an urban setting. Income generation activities supported PLWHA both as clients and vendors, contributing simultaneously to the food security and livelihoods of this vulnerable group.

Vouchers for flood relief and pilot debit card intervention in Cotabato city and Sultan Kudarat, ARMM (Mindanao), the Philippines (2011)

In response to rapid-onset floods from the Rio Grande de Mindanao in the Philippines, ACF implemented a cash-based intervention in Cotabato City¹⁰ and Sultan Kudarat, in the region of Mindanao in June 2011. As in Haiti and DRC, ACF decided to use vouchers in order to focus its assistance to flood-affected households on both food and non-food items with light conditionality¹¹. In this case, local supermarkets served as vendors. The programme also piloted the first humanitarian use of electronic debit cards in the Philippines for 305 of the families.

ACF's rapid assessments from June 2011 showed that overcrowding at Evacuation Centres (ECs) had caused a rapid deterioration in conditions. Early assessments showed that in-kind food aid from the government was insufficient in quality and quantity, and internally displaced persons' (IDPs) purchasing power had been negatively affected by the floods. Many IDPs were selling assets they had salvaged during evacuation in order to buy supplementary foods. The state of local markets presented opportunities that supported the use of a CBI to respond to people's immediate needs. Market assessments found that prices of staple commodities were relatively stable. Supermarkets were still conducting business as their supply chains had not been interrupted and their locations were unaffected by floods. Of the 35 ECs in Cotabato City, 25 were located within 1-2 kilometres of these markets and were accessible by public transportation or by walking.

Overall, beneficiaries found CBI to be a more effective mechanism than in-kind interventions due to the flexibility it gave them to cover their needs. There were advantages to the use of debit cards for both staff and beneficiaries: distribution only occurred once as card 'reloading' happened electronically, and beneficiaries could shop multiple times at their discretion. Implementing a CBI also alleviated local cultural apprehensions about the use of cash and demonstrated that vouchers or cash were an appropriate response, despite high local political tensions between the national government and the Moro Islamic Liberation Front in the area.

See field article in this issue of Field Exchange that elaborates further on the experiences from the Philippines.

Unconditional Cash Transfer (UCT) by mobile phone to increase food security and protect livelihoods in a post conflict context in Abidjan, Ivory Coast (2011)

A similar approach using new technologies was

⁵ Ramalingam, Ben and Paul Knox-Clarke. Meeting the Urban Challenge: Adapting Humanitarian Efforts to an Urban World, ALNAP, July 2012.

⁶ Sanderson, David and Paul Knox-Clarke. Responding To Urban Disasters: Learning From Previous Relief And Recovery Operations, November 2012. See news piece in this issue of Field Exchange.

⁷ The population of Port au Prince was 704,776 in 2003, and was officially projected to have reached 897,859 in 2009. Unofficial estimates, however, put the city and its surrounding areas' at two million inhabitants in the late 1990s, reaching 3.6 million inhabitants in 2010.

⁸ Evaluation report on the impact of the income generation

component of the HIV project, ACF 2009.

⁹ Feasibility study for HIV/AIDS project, ACF 2010.

¹⁰ Cotabato's population was about 271,786 in the 2010 census; it is bounded by the municipality of Sultan Kudarat to the north, which has a population of about 94,861 people.

¹¹ Vouchers may only be exchanged with vendors identified by and linked to ACF for the purposes of a project, and in some cases they may only be valid for the purchase of a specific range of items at those vendors. This means that beneficiaries have less flexibility on their purchases than they would with an unconditional cash grant, but a great deal more flexibility than through an in-kind kit distribution.

used in 2011 in Ivory Coast, where ACF piloted the first humanitarian use of transfers via mobile phones in the country, in Abidjan, following the violence that erupted after the November 2010 elections. Insecurity and violence led to an increase in staple food prices and worsened already high food insecurity levels. Combined with the reduced availability of health services, the people of Ivory Coast were facing a rapid decline in nutritional status¹².

In this context, the project established a cash transfer programme via mobile phones, to provide poorest households in two of the most affected neighbourhoods with essential food items. By June 2011, WFP decided to pursue this type of intervention because civil security had improved in the highly impacted neighbourhood of Abobo and Yopougon in Abidjan. Markets then had adequate supplies of basic commodities and stable prices but many people had lost their source of income and lacked purchasing power. WFP selected ACF as its operational partner and the mobile phone service provider MTN as a partner for distributing the cash.

A total of 10,800 households received assistance via mobile phone SIM cards. Households headed

activities can contribute to food security and nutrition outcomes early on in emergency response, while also contributing to longer term recovery and maintenance of health and livelihoods.

In all four cases highlighted in this paper, and in urban contexts more generally, people access food through purchase in their local markets. Cash-based rather than in-kind assistance is thus particularly relevant for urban contexts, and can be prioritised as long as markets are functioning and other important criteria are met¹⁴. In the Kinshasa programme, nutritionally at-risk households were both clients and vendors, and food vouchers as well as income generation support were able to contribute to both food security and longer-term livelihoods recovery. Similarly in the Abidjan programme, four categories of spending accounted for 80% of total reported spending and contributed to both immediate food security and longer-term activities (41% reported spending on food, 23% on income generation activities, 8% on education and 7% on health)¹⁵.

Urban areas are physically dense and socially dynamic, which can sometimes pose a challenge for targeting and partnering, but they also provide

The challenge of urban density, however, is often linked to its diversity and dynamics¹⁷. Urban populations are often more diverse than rural populations within fairly small geographical areas. A challenge that arose, particularly in Port au Prince, Abidjan and Kinshasa, was to target the 'right' beneficiaries¹⁸. ACF has developed vulnerability identification guidelines for urban settings¹⁹ and these were used and improved upon in Abidjan and Port au Prince.

In Abidjan, after geographical targeting, ACF conducted a house-to-house survey using standard food security indicators. A large survey team was able to go through 10 neighbourhoods in 2.5 weeks, registering everyone they could find and completing a list of beneficiaries three weeks from the start, with rolling data entry. This was as quick a method as community-based targeting mechanisms, yet better fitted to the political complexity of the situation. Surveyors would not make targeting decisions in the field, partly to avoid bias and partly for their own safety. They covered around 25,000 households and subsequently selected 10,800.

In Port-au-Prince, ACF developed a scorecard that would be used for practical targeting by collecting data on socio-economic status measured by income, and running regressions to identify simple and easily collected and verifiable indicators that correlated with income. The methodology used to create the score-cards revealed issues specific to urban targeting; people were in general less worried about their absolute level of income than about the reliability and regularity of that income. This makes sense in areas where households rely on the market for all essential items. Households differentiated between regular and occasional small business for the same reason. Commonly-used indicators, such as the dependency-ratio, turned out not to be relevant, while specific indicators, such as not eating chicken on a Sunday, were very relevant. The implication is that more generic poverty scorecard measures would not have been sufficient; the Port-au-Prince scorecard was highly context specific. In general, the scorecard was felt to be effective and was used by other organisations as well.

The urban environment offers greater proximity to national policymakers. In the DRC, ACF contributed to the development of a HIV/AIDS nutritional treatment protocol to address the lack



ACF/DRC, J. Asenbrennerova

by women, with children under 5 years, dependent on community assistance, with a nursing and/or pregnant woman, with disabled and/or elderly person(s), or affected by HIV/AIDS were prioritised in targeting. Each household received 33,000 CFA franc once a month for three months. The advantages of transfer via a SIM card were found to be: rapid and secure transfers; capacity for multiple withdrawals in varying amounts; the mobile phones could be used directly to pay for commodities and services; and the aid agency could send SMS messages to beneficiaries to spread information and increase awareness about the programme and other initiatives (e.g. health/nutrition information).

Improving nutrition security in emergencies: opportunities and challenges of the urban context

In the examples presented above, and in urban contexts in general, the complexity of the response is exacerbated by two main features: population density and the complexity of the environment (physical, social, political, economic) as laid out in a 2009 ALNAP paper¹³. In these contexts, cash-based interventions in various forms proved to be timely, appropriate, and flexible. The density, diversity and dynamics of urban areas may vary, but ACF's work in the Caribbean, Latin America, Africa and Asia has shown that CBI such as fresh food vouchers, mobile transfers and SMS messaging, debit card transfers, and income generation

relatively easy physical access to markets and a greater access to financial service providers and payment institutions than a village might. Hundreds of thousands or even millions of people may be affected by a shock, but density can also broaden the opportunity to reach more people faster after an emergency. This is particularly true, as ACF found in the Philippines and Ivory Coast, when remote payment and communication mechanisms such as text messaging, electronic transfers and mobile phone banking are used. Population density also provides incentives for mobile and internet companies to scale up network access, and crowdsourcing¹⁶ for new electronic and mobile products and services. Crowdsourcing can also be used to spread nutrition and public-health awareness messaging and to improve financial literacy.

CBIs in urban areas can also contribute to livelihoods recovery rather quickly. This is quite different from experiences in rural areas in general and agro-pastoralist zones in particular, where livelihoods recovery may take years or be impossible, e.g. due to environmental change. Typically, urban cash-based livelihoods activities can get a quick boost from CBIs. CBIs and support for local markets can help provide a continuum of care, moving from immediate nutrition and food security assistance to livelihoods recovery and resilience within the same programmes, sometimes within an emergency timeframe.

¹² In the capital, this turmoil was taking place in the second largest city in West Africa. According to the national census, there were 5,068,858 inhabitants in the metropolitan area of Abidjan in 2006, and 3,796,677 in the municipality per se. UN world Urbanisation Prospects estimate for 2007, UN 2011 (Archived from the original on 27 April 2011).

¹³ O'Donnell, Ian and Kristin Smart with Ben Ramalingam. Responding to urban disasters: Learning from previous relief and recovery operations. ALNAP Lessons Learnt, July 2009.

¹⁴ See the CaLP toolkit on Cash Transfer Programming in Urban Emergencies, among others: <http://www.cashlearning.org/resources/library/251-cash-transfer-programming-in-urban-emergencies-a-toolkit-for-practitioners?keywords=Tools>

¹⁵ WFP/ACF Unconditional Mobile Cash Transfer in Abidjan, Ivory Coast. External Evaluation. March 2012

¹⁶ Crowdsourcing is the practice of obtaining needed services, ideas, or content by soliciting contributions from a large group of people, especially common with online communities.

¹⁷ O'Donnell, Ian and Kristin Smart with Ben Ramalingam. Responding to urban disasters: Learning from previous relief and recovery operations. ALNAP Lessons Learnt, July 2009.

¹⁸ There is no single approach to targeting criteria in urban areas and no best practice on whether to select the most affected by a disaster, poorest, most vulnerable to a future disaster, or households in certain categories. This is highly context-specific.

¹⁹ Identification of Vulnerable People in Urban Environments: Assessments of Sustainable Livelihoods and Urban Vulnerabilities. ACF, 2010. See news piece in this issue of Field Exchange.

of policy framework on HIV/AIDS and public health. ACF also works in collaboration with the DRC health sector and partners who provide ARVs and psychosocial support to PLWHA and their families. Integration of CBIs into social policies may prove more challenging, considering government buy in and financing challenges. In Kinshasa, coordination was very positive with other partners supporting interventions for PLWHA, yet more challenging with health authorities than in rural areas. Nonetheless, proximity and access to high-level decision-makers may prove an opportunity to work towards increased government capacity to deliver social protection schemes and implement better policies for nutrition and food security.

Civil society can be more established than in rural areas, giving humanitarian actors the opportunity to work through existing structures to respond and hand over to communities more quickly. ACF has worked closely with civil society partners in Kinshasa since 2009, training them to identify malnourished PLWHA and refer them for treatment. As the programme continued over two years, more emphasis was placed on the responsibility of existing national structures to take over and manage rather than simply engage in the referral and treatment activities. Civil society can also, however, conceal entrenched power structures and figures that may resist humanitarian selection criteria and even retaliate against humanitarian actors who do not provide support to their constituents. ACF staff had to deal firmly yet diplomatically with various non-state actors in Port-au-Prince.

There may be a higher number of partners in an urban rather than a rural emergency. This can result in a setting of coordinated interventions addressing food, health and nutrition issues to contribute to nutrition security, but it can also add to confusion and duplication. In Port au Prince and Abidjan, which were large-scale emergency responses, coordination with other local or international humanitarian actors and partners proved challenging. There, the multiplicity of government actors, and the often weak accountability processes that bind them, complicated coordination mechanisms. In Haiti, for instance, efforts to set up a decentralised disaster-risk-reduction committee to prepare for further disasters were hampered by this complexity and by lack of capacity. In Abidjan, on the other hand, laudable efforts at coordination with other agencies, as well as with the Préfecture and Mairie, proved that we could avoid duplication through agreed geographic targeting, beneficiary-list-sharing, and harmonisation of rates.

An analysis of these four programmes, therefore, demonstrates that urban diversity, dynamics, and population density often create a challenging context for emergency programme implementation, especially with regards to coordination (with the government, with civil society, among agencies), and to targeting. They can also, however, provide increased opportunities for emergency response. In contexts such as those described above, where urbanisation increasingly shapes vulnerabilities, risks, and potential responses, the four programmes demonstrate that thanks to their flexibility, CBIs appear most relevant to respond to the diversity of people's needs. Where flexibility and market linkages are crucial to improving food security and nutritional status, they can indeed contribute to food security and nutrition outcomes rapidly and at scale in emergency response, while also contributing to longer term recovery and maintenance of health and livelihoods.

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Evaluation

Impact evaluation of cash, food vouchers, and food transfers among Colombian refugees and poor Ecuadorians in urban Ecuador

Summary of evaluation¹

Evaluation headlines: Levels of food insecurity and associated anaemia are high amongst Colombian refugees and poor Ecuadorians in the northern provinces of Ecuador. Following an assessment in 2010, WFP established food, food voucher and cash transfer programmes through a number of implementing NGOs in two adjacent provinces in the north of the country. An evaluation by WFP and IFPRI was undertaken to compare the impact of the three interventions. Key findings were that cash allows for savings that help households smooth their food and non-food consumption. However, if the objective is to increase calories or dietary diversity, vouchers are the most cost-effective means of doing so, followed by cash, although food vouchers is the modality least preferred by beneficiaries

Despite substantial research into the impact of food assistance and the impact of conditional cash transfers (CCTs), in many contexts there is almost no evidence from a rigorous evaluation directly comparing the impact and cost-effectiveness of cash transfers and food transfers in the same setting. A recently published evaluation in Ecuador is one of several impact evaluations being undertaken in different countries by the World Food Programme (WFP) and the International Food Policy Research Institute (IFPRI) in which various forms of transfers will be compared to learn which modalities are most effective in different contexts. The other countries are Yemen, Niger and Uganda.

Ecuador has the largest refugee population in Latin America and the vast majority of refugees are Colombians. In 2010 there were approximately 121,000 refugees and 50,000 asylum seekers living in Ecuador. As a result of constitutional changes on immigration and refugee issues in 2008, as well as the Enhanced Registration Programme in 2009, Ecuador has provided documentation to thousands of Colombian refugees in need of international protection. However, despite programmatic action and international support, refugees remain excluded from many government services and programmes, as well as discriminated against in the job market.

In order better to understand the refugee situation in Ecuador and how to respond to it, the WFP in collaboration with UNHCR conducted a study on the food security and nutrition situation of this population. They found that 27.9% of the Colombian refugee population is food insecure and suffers from low dietary diversity. The incidence of food insecurity is higher in northern border provinces, reaching 55% in Sucumbíos and 44% in Carchi and Imbabura. In addition, 48% of children are anaemic.

Responding to the study's findings and to a request from the Government of Ecuador (GoE) in April 2011, WFP expanded its assistance to address the food security needs of refugees and support their integration into Ecuadorian society. The new programme, partially funded by the Spanish Government, used cash, food vouchers, and food transfers to support the most vulnerable refugees as well as poor Ecuadorians in urban centres of Carchi and Sucumbíos. Both Carchi and Sucumbíos are northern border provinces that receive high influxes of Colombian refugees.

¹ WFP/IFPRI (2012). Impact Evaluation of Cash, Food Vouchers, and Food Transfers among Colombian Refugees and Poor Ecuadorians in Carchi and Sucumbíos. Final Report. International Food Policy Research Institute Poverty, Health, and Nutrition Division October 17th, 2012

Method

The evaluation study set out to estimate the relative impact and cost-effectiveness of cash, food vouchers and food transfers on household food security indicators, as well as complementary indicators such as household expenditure and anaemia. It also investigated the gender effects of the programme and the impacts on reducing tensions and discrimination between Colombian refugees and the host Ecuadorian population. In addition to the quantitative impact evaluation, a qualitative study was conducted in order to learn more about the efficacy of nutrition trainings that accompanied the distribution of the different transfer types.

Despite sharing administrative borders, the two intervention provinces of Carchi and Sucumbíos have markedly different geographic, agro-ecological, and economic characteristics. Carchi is located in the northern highlands at high altitude, characterized by an industrial and agricultural-based economy including production of tobacco, dairy, floriculture, and staple crops such as potatoes and maize. Sucumbíos is located in the Amazonian lowlands and its economy is driven by natural resource extraction, primarily oil, making it one of the most important economic areas in Ecuador.

Carchi and Sucumbíos were selected by WFP for the transfer programme because of the high

collaboration with local partners as areas that have large numbers of Colombian refugees and relatively high levels of poverty. In November and December of 2010, the Centro de Estudios de Población y Desarrollo Social (CEPAR) implemented a household census in these barrios. Every household in the selected barrios was visited, mapped, and administered a one-page questionnaire that consisted of basic demographic and socioeconomic questions. A proxy means test was then developed to target beneficiaries based on indicators of household demographics, nationality, labour force participation, food security, and asset ownership. Based on point scores by nationality, the decision was made to include automatically all Colombian and Colombian-Ecuadorian households as “qualifying.” In addition, since WFP wanted to reach households that were not already being covered by GoE grants, the decision was made to exclude all households who reported receiving the government’s social safety net transfer programme, the Bono de Desarrollo Humano (BDH). Households residing in the selected barrios with low socioeconomic status that met the criteria described above formed the original sample eligible for the intervention.

Intervention

The intervention consisted of six monthly transfers of food, food vouchers, or cash to Colombian refugees and poor Ecuadorian households in

ATM cards for all cash transfer beneficiaries. Cash transfer households could retrieve their cash at any time (i.e. they could keep cash in the bank for longer than one month), however, it had to be taken out in bundles of \$10. The food vouchers were also valued at \$40 and were given in denominations of \$20, redeemable for a list of nutritionally-approved foods at central supermarkets in each urban centre. The list of approved foods was composed of cereals, tubers, fruits, vegetables, legumes, meats, fish, milk products, and eggs. The food vouchers could be used over a series of two visits per month and had to be redeemed within 30 days of initial receipt of the voucher. The vouchers were serialised, printed centrally and were non-transferable. The food basket was valued according to regional market prices at \$40 and included rice (24 kg), vegetable oil (4 litres), lentils (8 kg), and canned sardines (8 cans of 0.425 kg). The food basket was stored and distributed by local partners. The transfer size for all modalities was set to be roughly comparable to the national cash transfer scheme, the BDH, which, at the time of programme design, was \$35 per household.

Nutrition sensitisation was a key component of the programme, aimed at influencing behaviour change and increasing knowledge of recipient households, especially in regard to dietary diversity. To ensure a consistent approach to knowledge transfer, a set of curricula was developed by WFP to be covered at each monthly distribution and transfers were conditional on attendance at the nutrition trainings. These topics included (1) programme sensitisation and information, (2) family nutrition, (3) food and nutrition for pregnant and lactating women, (4) nutrition for children aged 0–<12 months, and (5) nutrition for children aged 12–24 months. Nutritional recipes were also distributed throughout the six months. During the last monthly meeting, an overview and review of lessons learned was implemented, including nutritional bingo in which participants were asked questions about previous training sessions in game format. In addition to monthly meetings, posters and flyers were developed and posted at distribution sites, including supermarkets, banks, and community centres, further to expose participants to knowledge messaging. These topics included, among others, recommended consumption of food groups, daily nutritional requirements, proper sanitation and food preparation.

The strategy for estimating the impacts of the cash, food voucher, and food transfer was built into the design of the programme. Sample clusters were randomly assigned to one of four treatment arms: the cash transfer group, the food voucher transfer group, the food transfer group, and the comparison group (which received no transfers). Due to the distinct socioeconomic and geographic characteristics of Sucumbíos and Carchi, the randomisation of cluster centres was stratified at the province level.

Randomisation was conducted in two stages: first, barrios were randomised to either treatment or comparison arms and second, all treatment clusters (geographical units within barrios) were randomised to cash, food voucher, or food transfer. Before conducting the randomisation, consultations were undertaken with WFP and CEPAR to ensure that there was a sufficient number of qualifying households in each cluster and there was sufficient geographical distinction between clusters. This process led to 63 barrios and 128 clusters in the four urban areas over which to randomize. The number of clusters per barrio varied from one to six, with an average of approximately two per barrio. The barrios and clusters were randomised



WFP/Sebastien Paque

concentration of refugees and poor Ecuadorians as identified by the 2010 Emergency Food Security Assessment (EFSA). In addition, both provinces have the presence of implementing partner non-governmental organizations (NGOs) for food transfers, financial institutions including ATM branches, supermarkets and functioning central markets. The urban centres chosen for the study were Tulcán and San Gabriel in Carchi, and Lago Agrio and Shushufindi in Sucumbíos. Tulcán and Lago Agrio are the capital cities of Carchi and Sucumbíos, respectively, and represent the largest urban areas within the provinces. Both cities are in close proximity to the Colombian border (for example, Tulcán is approximately seven kilometres from the border). In addition to these four primary urban areas, three additional smaller urban areas were included in the programme target population: General Farfán, Huaca, and Pacayacu. These additional areas are suburbs close to the four primary urban areas and share the same transfer distribution centres, financial institutions, and supermarkets.

Barrios (or ‘neighbourhoods’) within these urban centres were then pre-chosen by WFP in

selected urban centres. The transfers were distributed in coordination with local partners and the assistance of the president of each barrio. An enrolment meeting was held in March before the first transfer was distributed to issue photo ID cards, as well as to sensitize beneficiaries to the programme objectives and logistics. The coordination of the intervention was managed by the WFP Country Office (CO) through regional sub-offices in each province and was backstopped by staff at headquarters in Quito. In the initial enrolment and sensitisation, the programme was described as a poverty and food security transfer targeted toward women and therefore, the majority of the entitlement (programme identification) cardholders were expected to be women. However, based on household demographics, men could also be entitlement holders and participate in all programme activities. Overall, approximately 79% of cardholders in Carchi and 73% of cardholders in Sucumbíos were women.

The value of the monthly transfer was standardised across all treatment arms. The total value of the cash transfer was \$40 per month per household. This amount was transferred onto pre-programmed

into the four treatment arms using percentages of 20/20 for comparison and food, and 30/30 for cash and food voucher. These percentages were established in consultation with WFP to meet both beneficiary target sizes by transfer type, as well as sample size requirements for the evaluation design.

Evaluation

In order to conduct an evaluation of the cash, voucher, and food transfer programme, baseline and follow-up surveys were conducted. The baseline survey was conducted in March-April 2011 before the first transfers were distributed. The follow-up survey was conducted approximately six months later (October-November 2011) after the last of the six distributions. The sampling for the baseline survey was conducted by CEPAR and IFPRI after receiving the beneficiary lists. Based on the distribution of clusters in the treatment arms and the required sample sizes, 27 households per comparison and food clusters and 20 households per food voucher and cash clusters were randomly selected to be interviewed in the baseline survey. In addition, since one of the main objectives of the evaluation was to compare differences across nationalities, the Colombian and Colombian-Ecuadorian households were oversampled to ensure a sufficient sample for comparative analysis. In total, 3,331 households were surveyed at baseline. However, approximately 30% were too rich and subsequently excluded from the programme, and so the evaluation focuses only on 2,357 households that were included after the retargeting period and could be matched with monitoring data. Of these households, 2,122 were re-surveyed at follow-up.

Results

Food security

The cash transfer incurred the lowest costs to participants in terms of waiting times and transportation costs. A higher percentage of participants preferred to receive all the transfer in cash as opposed to all in food and vouchers. Across all three modalities, the transfers were reported to be mainly used for consumption of food items; however, voucher recipients in comparison to cash recipients spent a larger percentage on food. Almost none of the food transfer or voucher was sold to buy other items. Besides food consumption, food recipients tended to share their transfer with friends or family, or save their transfer for later use. Cash recipients also reported saving a small share of their cash for later use and spending a small portion on non-food items. Nutrition knowledge increased from baseline to follow-up with the largest knowledge gains occurring on food items that are rich sources of iron and vitamin A, and on feeding practices for infants.

Overall, programme participation led to large and significant increases across a range of food security measures, with the value of per capita food consumption increasing by 13%, per capita caloric intake increasing by 10%, Household Dietary Diversity Score (HDDS) improving by 5.1%, Dietary Diversity Index (DDI) by 14.4%, and Food Consumption Score (FCS) by 12.6%. All three modalities significantly increased the value of food consumption, caloric intake, and dietary diversity as measured by the HDDS, DDI and the FCS. However, the increase in dietary diversity measures was significantly larger for the voucher modality and the increase in caloric intake was significantly larger for the food modality. The food modality led to significant increases in the number of days a household consumed five out of 12 food groups: cereals, roots and tubers, meat and chicken, fish

and seafood, and pulses, legumes, and nuts. The cash transfer led to significant increases in seven food groups: roots and tubers, vegetables, meat and poultry, eggs, fish and seafood, pulses, legumes, and nuts, and milk and dairy. Finally, the voucher led to significant increases in nine food groups: cereals, roots and tubers, vegetables, fruits, meat and poultry, eggs, fish and seafood, pulses, legumes, and nuts, and milk and dairy. The impact of vouchers on the frequency of consumption was significantly different to that of food transfers for vegetables, eggs, and milk and dairy.

Colombians in the food and cash group experienced significantly greater gains in dietary diversity measures than Ecuadorians. With the exception of small increases in expenditure on toys, the combined transfer programme did not lead to increases in non-food expenditures.

Anaemia

Taken together, the results for anaemia can be summarised in the following way. First, although levels of anaemia were high, particularly for the younger age group, the intervention did not have a positive impact on anaemia reduction for either children aged 6-59 months or for adolescent girls aged 10-16 years. This result can be explained by the relatively short intervention period. In addition, the focus of the intervention was on food security and nutrition in general and not focused specifically on anaemia reduction. Based on the results, it is possible (and is corroborated by household food group caloric results) that for young children, consumption moved away from more diverse diets and towards consumption of staples that were part of the food transfer for that treatment group.

Household decision-making and behaviours

Overall, transfers led to a significant decrease in intimate partner violence, however, there was no impact on decision-making indicators. The food treatment arm led to a significant impact on experience of disagreements regarding child health. Otherwise, there were no significant impacts by treatment arm for women's decision-making. While all three treatment arms led to significant decreases in physical/sexual violence, only cash and food led to significant decreases in controlling behaviours. However, there were no significant differences across modalities in the size of the impact for any of the intimate partner violence indicators. There were no significant differential impacts with respect to being Colombian on any of the household decision-making indicators or intimate partner violence indicators.

The food modality was the most costly and the cash and voucher least costly. In terms of cost-effectiveness across food security outcomes, vouchers were the least costly means to improve these outcomes while food was the most costly means to improve these outcomes.

Although vouchers had the largest impact in terms of food security, voucher participants reported having the most difficulties with the programme, with 79% of voucher beneficiaries reporting at least one complaint with their transfer, compared to 40% in the cash group and 37% in the food group. Common difficulties experienced by the voucher recipient households included high food prices and lack of food in supermarkets, as well as problems at cashiers and understanding rules or use of vouchers. In general, cash was the preferred modality among participants. In terms of opportunity costs and transportation costs, cash was the least costly, which is consistent with partic-

ipants' revealed preferences. Despite modality-specific complaints, overall, beneficiaries reported overwhelming satisfaction with the programme, including nutrition trainings and interactions with programme staff.

The most costly modality to implement from the institutional perspective for WFP was the food transfer, while cash and vouchers had similar costs. In particular, as measured on a per transfer basis using modality-specific costs, it cost \$3.03 to transfer \$40 in cash to a beneficiary, \$3.30 to provide them with a \$40 voucher, and \$11.50 to transfer \$40 worth of food. The difference in cost between the food ration and the other modalities was primarily due to added storage, distribution, and contracting. In contrast to the other transfers, food rations require a degree of manipulation, in that they must be packaged (thus requiring labour), transported (human resource and transport cost), and stored in warehouses (rental and upkeep costs). Combining impacts with costs to compare the cost-effectiveness across modalities for food security measures, we found that food vouchers are the most cost-effective means for improving food security and food is the least cost-effective means of improving these outcomes.

Beneficiary opinions of the nutrition trainings were positive, and there seemed to be some evidence of behaviour change, particularly in the testing and use of recipes, as well as food purchase patterns. However, it is not clear whether this effect would persist without the added benefit of the transfer. In addition, the inclusion or involvement of spouses in the nutrition training and behaviour change process may have led to more favourable overall outcomes.

It is important to emphasize that the results from this evaluation represent a nutrition knowledge and transfer 'bundled' intervention and are specific to the population studied: poor urban households in Northern Ecuador. Although large overall programme impacts were found, these findings may not hold in rural areas where supermarkets are more likely to have less variety of foods and may also lack the capacity to implement such a programme properly. While these results cannot be generalised to rural areas, they do provide insight for a large, vulnerable segment of the population, the urban poor, and demonstrate how transfer programmes have a short-term positive impact on food security and social relations within households and communities. In the context considered here, choosing the 'winner' among the different modalities depends on the objectives of the policymakers. If the objective of these transfers is simply to improve welfare, cash is preferable. Cash is the modality that beneficiaries are most satisfied with, and it is the cheapest means of making transfers. Given the budget available to WFP for this project, shifting from food to cash could have increased beneficiary numbers by 12%.

Moreover, cash allows for savings that help households smooth their food and non-food consumption. If the objective is to increase calories or dietary diversity, vouchers are the most cost-effective means of doing so, followed by cash. Although, vouchers are the most cost-effective means of increasing caloric availability and diet quality, it is the modality least preferred by beneficiaries. Thus policymakers are faced with the trade-off of improving overall welfare or improving specific outcomes. The former gives aid recipients' autonomy, while the latter restricts their choices in order to achieve specific objectives.

Evaluation of post 2007 election violence recovery programme in Kenya

Summary of report¹



The Safaricom vehicle at Kinyach Police Post – the distribution point for the cash transfer project

Paul Welsh, Concern, Kenya, 2008

Evaluation headlines: The NGO, Concern Worldwide, was involved in immediate and recovery responses to the post-election violence in Kenya. The evaluation finds the response was effective in linking relief and recovery and the intervention design (cash transfers delivered by mobile phone and indexed to household size and market prices, and combining food and livelihood support) appropriate, appreciated by beneficiaries and successful. Targeting was valid but transparency and fairness can improve. Trade-offs in this type of approach include promoting business versus supporting the most vulnerable and empowering through cash transfers versus supporting the most needy.

The announcement of the closely contested 2007 presidential election results on 30th December 2007 sparked off violence never witnessed before in the history of independent Kenya. Over 1,500 people died and between 400,000 and 600,000 were internally displaced. Effects of the violence and displacement were particularly severe in Western Kenya, the Rift Valley, and amongst business owners in major cities including Nairobi, Kisumu, Eldoret, Nakuru and Naivasha.

The crisis had various immediate humanitarian implications and high economic costs. Many of those displaced were destitute. Malnutrition was exacerbated by rocketing food and petrol prices in Nyanza (particularly), or by lack of access to farms in the north Rift Valley. Low cereal production as a result of both poor rains and poor access to farms had knock-on effects on food availability elsewhere in the country, including Nairobi. Health systems and care-seeking behaviour were disrupted. In terms of the economy, people lost jobs and were excluded from their livelihoods, and suffered secondary effects of economic slowdown. One estimate puts these costs at Ksh100 billion (USD1.5 billion), focused on western regions that were already amongst the country's poorest. Livelihoods were affected not only by the displacement but also by violence that directly or indirectly damaged businesses.

The Kenyan government's response to the crisis was led by the Ministry of Special Programmes, which coordinated with the Kenyan Red Cross and implemented in partnership with a range of civil society organisations including non-governmental organisations (NGOs) and faith based organisations (FBOs). The response initially provided basic needs to displaced persons in camps, focusing on protection, food, education, health, water and sanitation. However, while basic needs in camps appear to have been met, there remained substantial concerns about the situation of displaced persons outside camps. Furthermore, conditions within camps deteriorated with the onset of the rainy

season, the duration of the crisis and pressures on support networks and resources.

Concern's response

The NGO, Concern, was involved in both the initial response to the crisis (providing initial emergency relief), and in a further recovery programme. This combined approach sought to link relief and development and to help recipients of aid to not only regain basic needs but to participate actively in development processes. The first element of the response was the provision of emergency relief (food distribution, emergency water, sanitation and hygiene (WASH), Nutrition support and psychosocial support). Concern, in partnership with FBOs and NGOs, provided support to the internally displaced persons (IDPs) living in the formal and informal camps, host communities, and IDPs in transit. Concern's responses to the emergency were divided into two phases:

- *Phase I:* Early January to end February 2008: a total of 165,144 beneficiaries received relief support – 23,448 in Nairobi, 87,456 in Rift Valley and 87,456 in Nyanza. A total of 78 children were treated for severe acute malnutrition (SAM) in Nairobi and Kisumu slums, and staff from seven health facilities were trained in prevention and management of SAM.
- *Phase II:* Early March to end June 2008: a total of 279,343 beneficiaries were provided relief support – 18,890 in Nairobi, 31,178 in Rift Valley and 29,246 in Nyanza. A total of 29 severely malnourished children were treated in Nairobi while an estimated 200,000 acutely malnourished children have benefited indirectly from the intervention in Nairobi, Nyanza and Western province.

The two emergency relief phases were followed by two recovery phases. These used cash transfers to support the recovery of affected households in terms of regained food security and livelihoods:

- In phase I of the recovery, Concern piloted the use of mobile phone cash transfer technology (M-PESA) for bulk cash transfers in early 2008 in the Kerio Valley, one of the most remote

parts of Kenya. This pilot was externally evaluated and a range of recommendations for expansion were made².

- In phase II, the Post Election Violence Recovery (PEVR) Programme was designed in-line with the National Peace Accord signed by the two political parties, the Early Recovery Strategic Framework for Kenya and lessons from Concern's M-PESA cash transfer pilot. A wider cash transfer programme was rolled out, in partnership with NGOs and FBOs, from August 2008 to 6,522 households in Nairobi slums, Kisumu slums, rural Nyanza, Kitale and Eldoret. With an average of six members per household, this represented about 39,132 vulnerable people who were still experiencing the consequences of the post election violence.

PEVR programme

The PEVR programme focused on immediate humanitarian assistance and livelihood support to victims of violence with special attention to food insecure households.

The principle objective of the PEVR programme was to enable severely affected rural and urban populations in Nyanza, Nairobi and North Rift Valley to mitigate the negative impact of the post election violence and resume productive roles in the national development process. The specific objective was to meet short-term food security needs of IDPs and returnee/resettled households, thorough the provision of targeted food aid.

Evaluation findings

An evaluation of the PEVR highlighted a number of key findings regarding the programme³. One key finding was that the PEVR was highly relevant to the effects of the violence, not only for linking relief and recovery, but also because its design was particularly appropriate in two ways.

First, following recommendations made from the pilot and in several other cash transfer evaluations, transfers were indexed to household size and local market prices, and were sent to families through their mobile phones. This was intended to address potential inflationary concerns and to meet household food entitlements for households of varying sizes. The food support element was calculated to provide a food basket comprising of basic food items like maize, beans, sugar, salt and oil designed to meet 50% of the calorific requirements of household members. On average Ksh 600 per household member was sent monthly through M-PESA for a period of 3-6 months to enable households to buy food.

¹ Evaluation of Concern's post election violence recovery (PEVR) programme. Final Report. Ian MacAuslan, Oxford Policy Management (OPM) 2010. Full report available at: <http://www.opml.co.uk/projects/evaluation-post-election-recovery-programme-kenya>

² Evaluation of Concern Kenya's Korogocho Emergency and Food Security Cash Transfer Initiative. Ian MacAuslan and Lilly Schofield. OPM and Concern Worldwide. Final Report. January 2011

Second, the PEVR combined food and livelihood support. The monthly food security grant was combined with a one off 'business grant' of between Ksh 3000 and 6000 given to households who had lost livelihoods. This business grant was designed to restore households' on and off-farm income generating activities affected by the violence and to therefore assist in Kenya's economic recovery, while ensuring humanitarian needs were met.

Overall, the programme was viewed very positively by the majority of partners and recipients. Partners felt the programme assisted those who received the transfer, either through a temporary support to basic needs at a time when people were still struggling with high prices and fragile livelihoods, and with more lasting impact as recipients invested in businesses or were able to absorb medicines and nutrients and start working. Recipients were uniformly delighted and often reported boosts in self-confidence as a result of receiving the transfer. Negative impacts were rare and were related to poor communication, uncertainties in Concern's budget and the speed with which the programme was implemented.

Combining food and livelihoods grants was highly effective where it was implemented well. Although recipients did not spend the entire food transfer on food, they were better able to meet their household food needs and also pay school fees and rebuild their livelihoods. The evaluation did not find evidence of misuse or disincentives to work.

More specifically, the indexing of the transfer to household size and market prices was effective and useful and should be repeated in further transfers. However, recipients were sometimes confused by the variation in the amount they received and this made them, on some occasions, less confident to challenge programme staff when they thought they had received insufficient amounts. For longer-term transfers, the fiscal implications of indexing the value to local prices will need to be considered.

The M-PESA delivery system was effective and highly valued by recipients, and should be repeated. The M-PESA distribution system was universally considered to be the best method of distribution, delivering direct to recipients and allowing them to keep their transfers secret. However, careful thought needs to be given to the most appropriate programme for those unable to use mobile phones or collect the transfer themselves, who had in the PEVR to choose nominees to collect on their behalf. The nominee system was open to abuse and recipients valued this far less.

The targeting process selected vulnerable households affected by the violence, as intended. However, because the targeting process was largely outsourced to community members and partner staff with limited time, often those selected were not the most vulnerable and were in many cases known personally to those doing the targeting. While the targeting criteria remain valid, further consideration could be given to the specification of the targeting mechanism to improve its fairness and organisation.

The evaluation suggested that this programme model could be usefully repeated, with small adjustments, in post-emergency and normal situations in Kenya and elsewhere.

The evaluation identified a number of trade-offs that need to be considered moving forward:

1. Promoting businesses vs. supporting the very vulnerable. Business development implies focusing on the dynamic and entrepreneurial.

Very vulnerable households are typically neither. The business development model needs to be reconsidered for these (bed-ridden, very elderly) individuals and households.

2. Empowering recipients through M-PESA based cash transfers vs. caring for the needy. A similar problem, the neediest struggle to collect cash and are reliant on caregivers to provide for them (including collecting their cash, and buying their food and medicines). M-PESA-based cash transfers have been reviewed very positively in this programme. But are M-PESA cash transfers the right approach for individuals in full-time care, who are not aware of what they are receiving?
3. Calibrated transfers vs. simplicity. Varying the transfer sizes by price and household size is sensible, particularly in long-term programmes where price changes are likely to be a significant concern. But this makes it much more difficult for recipients to understand their entitlements. A possible solution is to have annual adjustments or inflation rather than monthly adjustments, and intensive publication of the changes.
4. Timeliness vs. clarity of communication. The programme needed to begin in order to address very real food insecurity concerns, but the speed at which it was implemented caused problems of communication impacting on the quality of implementation. Future programmes could take more time if possible, but preparations could be made for clear communication briefs in emergency programming.
5. Transparency vs secrecy. While transparency in targeting and programme design is highly desirable from the point of view of accountability and community acceptance, particularly around targeting, being entirely open about the transfer can create security problems for recipients seeking to hide their transfers from others.
6. Independent targeting vs. community acceptance. Involving community leaders in targeting risks selecting the same recipients time and time again, but not involving them may put the entire programme at risk should they reject it. Requiring a house-to-house approach seems crucial to capture the poorest, and community leaders could be involved in a supervised validation stage.

The evaluation recommended a number of modifications for further exploration in future programmes including:

- Consider greater oversight of targeting process and tighter geographical targeting.
- Retain varying amount of transfer by household size and for inflation but consider the fiscal implications of indexing the transfer to inflation over a long period. Also consider the most appropriate time period for indexing given rapid changes to market prices but administrative costs of regular monitoring.
- Ensure that recipients clearly understand that transfer values may vary.
- Ensure that all recipients have a registered sim card and/or phone prior to starting payments.
- Where possible, couple food transfers with a livelihood package.
- Consider not using cash transfer for those who cannot use M-PESA even after training and sim card distribution – food support or alternative care support should be considered.

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³ The evaluation methodology revolved around in-depth interviews and focus group discussions conducted in Nairobi and Nyanza. Focus groups and in-depth interviews were conducted with recipients, non-recipients, and recipients through nominees, and in-depth interviews were also conducted with partner staff.



Nancy Locuhulia Paul, aged 46 from Loywat in Pokot East District, single mother of seven children and a grandmother of three. At the first distribution, Nancy was the first person to receive the text message that her money had come through. She used the money to buy food and treatment for her livestock. At a meeting held by Concern before the second distribution, Nancy told us how they all appreciated the support saying "Thank you very much; before you came we were very restricted. Now we have phones, we have money – as women, we are empowered".



Samuel Chesubet is the Peace and Reconciliation Initiative Chairperson for Pokot East. Apart from the obvious financial support benefits of the cash transfer project, an additional outcome has been successful peace-building between the three ethnic groups involved.

Mr Chesubet explained "We have been trying to bring the Pokots and Turgen together, and have held a number of sensitisation meetings to discuss issues. Since Concern came in with the M-Pesa support, we have experienced some peace. People attend meetings and thus can discuss reconciliation initiatives. Thanks to Concern, we are also attending to our farms and livestock – our livelihood".



Maria Kipketer receiving her cash. She is 38 years old and is married with 8 children, and lives in Kinyach. She is a cluster leader – so responsible for helping the other 9 people in her cluster to get their money.

Donor lessons on linking emergency and development funding in urban programming

Summary of article¹



Food Insecurity
Lessons in Kenya

Location: Urban Kenya

What we know: The urban population in Kenya is disproportionately affected by food insecurity and malnutrition, that has been exacerbated by the global food crisis.

What this article adds: It shares a bilateral donor's experience. Cash for work and urban agriculture projects in informal settlements in Kenya had short term impact. Donors need to link humanitarian and development funding to extend gains of 'emergency' projects. Stronger communication between development and humanitarian officers within donor country teams and around pooled funding is needed.

The urban population in Kenya is disproportionately affected by food insecurity and malnutrition with almost half the total food poor in Kenya (43% or over 4 million people) living in informal settlements. With food insecurity exacerbated by the global food crisis, the Emergency Response Fund (ERF) called for proposals to address this problem in Nairobi's informal settlements. The Swedish International Development Cooperation Agency (Sida) is one of two donors to this fund, contributing US\$1.7 million since June 2009. An evaluation of Sida's humanitarian assistance (2010-14) by Development Initiatives generated a 'lesson learning' article summarised here.

Project overview

Cooperazione Internazionale (COOPI) responded to the ERF call with a proposal to provide emergency livelihood assistance in Mathare and Huruma settlements (Nairobi). This project was subsequently evaluated by Development Initiatives. The project had two components: Cash for Work (CFW) and urban agriculture.

COOPI targeted the project at particularly vulnerable households using the following criteria:

- Households with members receiving HIV or TB treatment.
- Households with malnourished children (identified by collaborating with another ERF project run by Concern International).
- Households headed by single members or elderly people (over 55 years old).
- Households with disabled family members.

The CFW scheme selected vulnerable households to receive 720 Ksh (approximately US\$10) in exchange for working two days per month to clear garbage (with people taking turns to work each week so that the project assisted around 1,400 households). The money increased their food purchasing power and benefited the local economy (particularly food kiosks), while the work improved the hygiene situation in the settlements.

Due to the extreme shortage of land, the urban agriculture component involved the innovative approach of assisting people to grow vegetables in sacks. It provided 1,000 households with a sack, high quality soil mix (to ensure successful harvests) and 43 seedlings of kale (sukuma wiki), spinach, spring onion and capsicum. The spring onion and capsicum act as natural pest control. It also provided farming tools and materials to fence off plots of land where the beneficiaries kept their

sacks, to prevent goats and other animals that forage in the settlements from eating the plants. The participating households could harvest vegetables twice a week.

Limitations

The project was a pilot with humanitarian assistance from the ERF, which provides funding for 6 months, after which COOPI hoped to secure longer-term funding to continue its activities. However the main challenge proved to be failure of a donor or the government to provide longer term development funding. Thus the project ended in January 2010, when the food market was still very volatile.

As a result, the project impact was very short-term. For example, a woman started a small business selling porridge with the cash that she earned. As long as others were earning money as well, they were able to buy the porridge but once the project ended, they could not afford it anymore and her business failed. Although the CFW approach was intended to meet basic needs, COOPI had hoped that people would also be able to start saving money. However, project beneficiaries used the money they earned for essentials such as food, uniforms and school fees and had no money left once the project ended. As a result, when interviewed, they were desperately hoping that it would resume. Finally, although a few people occasionally used the boots, gloves and other equipment that COOPI provided to clear garbage, these efforts were ad hoc and garbage once again piled up in the settlements.

Lessons learned: a donor's perspective

Without the ERF's willingness to fund projects that address the chronic problem of food insecurity in Nairobi's informal settlements, the COOPI project would never have been implemented. In this respect, the Kenya ERF is different to ERFs in other countries (which take a much more limited approach to what constitutes 'humanitarian' aid), and is in line with Sida's goal (stated in its humanitarian strategy) to support longer-term approaches.

The project itself was successful and a focus group discussion with project beneficiaries showed that it made an important contribution to their lives since they receive little or no other form of assistance. By the end of the project, 1,400 households had earned US\$50 each to meet their immediate basic needs. COOPI worked with the Cooperative Bank of Kenya to help 1,000 of these households to open bank accounts and obtain ATM cards to withdraw their cash as needed. For most,

this was their first opportunity to access banking services, including savings and micro-loans. The rest were unable to do so often because they did not have suitable identification documents and, in these cases, the bank allowed COOPI to make payments at their branch on Saturday so that beneficiaries faced less risk of being robbed.

COOPI's efforts to provide good quality soil and protect the farming sacks from animals, ensured success for the 1,000 households involved in the agriculture component and enabled them to continue producing vegetables after the end of the project.

In addition to tangible benefits, the project helped unemployed and vulnerable people feel that they could have a job and earn money, which boosted their self-esteem and also made use of their latent social capital. The project involved the community more widely and many thousands more than the direct beneficiaries were made aware of the link between their nutrition and the unsanitary conditions in which they live.

Although urban development and addressing the problems of urban informal settlements in Kenya is a priority in Sida's country strategy for development assistance, and Sida funded the COOPI project through the ERF, the agency missed the opportunity to link its humanitarian and development funding by using its development budget to continue to support a project that was already underway and benefiting participants. There are 'good practice' examples of Sida making such links (e.g. in Democratic Republic of Congo (DRC)) that should be shared.

Other ways in which Sida can avoid similar missed opportunities in future include:

- Better communication within country teams about projects that are likely to require longer-term development funding. This should be systematic when Sida funds humanitarian projects in areas that are priorities in the country strategy (e.g. health in DRC, urban development in Kenya). This would help to ensure that activities started with humanitarian funding receive the longer-term support that they require and that short-term activities do not undermine longer-term solutions.
- When Sida contributes to country-level pooled funds (whether Common Humanitarian Funds or ERFs), humanitarian officers should engage in Advisory Boards or other mechanisms to ensure that they know what they are funding through these mechanisms. This will help them to inform development colleagues in the country team about how these projects relate to priorities in the country strategy and to identify opportunities for ensuring continued funding for key activities.

¹ This is a summary of a 'Learning from Experience' article written by Development Initiatives as part of the evaluation of Sida's humanitarian assistance (2010:4). www.devinit.org

² An independent organisation focused on analysis and use of data for the elimination of extreme poverty. See <http://www.devinit.org/>

A mother with her baby being assessed at an ATFC

Early results from urban SAM treatment programme in Chad

By Aimé Tamberi Makiméré, Emilienne Soubeiga, Deo Katsuva Sibongwere and Geza Harczi



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This article shares the early results of a new urban programme to treat severe acute malnutrition in the city of N'djamena, Chad. It was submitted by ALIMA, an international NGO that aims to support and work with national efforts to respond to medical catastrophes that include acute malnutrition, and by Alerte Santé, a medical NGO from Chad.

N'djamena is located in the Sahel region of Chad, close to the border of Cameroon and has over one million inhabitants. Nutritional surveys recently conducted by the Chadian Ministry of Health (MoH) and UNICEF in 2012 and early 2013¹ showed a nutritional crisis in nine of the 11 regions of the Chadian Sahel (GAM (global acute malnutrition) >15%). In comparison, the situation in N'djamena seems relatively better off. Acute malnutrition rates for children under 5 years indicate a 'serious' situation in 2012 (13% GAM and 1.8% severe acute malnutrition (SAM)), and a 'precarious' one in 2013 (6.7% of GAM and SAM 1.2%).

However, the challenge here is not prevalence, but caseload – a phenomenon common to many urban settings in the Sahel and largely overlooked. Indeed among all the regions in Chad surveyed in 2012, N'djamena had the highest caseload of children affected by GAM per region – estimated at 22,000 children at the time of the survey. It is hard to assess accurately the annual incidence of SAM in N'djamena due to the absence of community based management of acute malnutrition (CMAM) services and limited data. However, based on the most recent prevalence estimation (1.2%) among a population of about 200,000 under-five children and using a specific programming tool², the SAM annual caseload in N'djamena could be as high as 5,200 cases.

In 2010, Médecins Sans Frontières (MSF) implemented a short-term nutritional programme addressing SAM in the context of a measles epidemic that provided treatment to over 5,000 children. Since then, only two relatively small ATFCs (ambulatory therapeutic feeding programmes) have been in operation: one implemented by the Notre Dame des Apôtres health centre with little international support and another by a new and small local non-governmental organisation (NGO) APCEM-PVT (Association pour la Prise en Charge des Enfants malnutris et Personnes Vulnérables au Tchad – Association for the Treatment of Malnourished Children and Vulnerable Persons in Chad). Clearly, up until recently, children with SAM in the capital have had very minimal access to medico-nutritional care despite renewed efforts by the MoH, exemplified by the recent commitment of Chad to the SUN movement (May 2013).

In April 2013, the Chadian medical NGO, Alerte Santé, and the international NGO, ALIMA (The Alliance for International Medical Action), started providing support to the MoH to treat SAM in the capital city of N'djamena, Chad. The programme is funded by ECHO and receives in-kind support from UNICEF. The programme covers two of the four health districts in the N'djamena Health Region. The objective is to increase access to nutritional rehabilitation in the capital, to reduce morbidity and mortality due to

malnutrition among children under 5 years, and to understand better SAM in urban settings in the Sahel. The programme provides support to four ATFCs integrated in MoH health centres and an ITFC (Inpatient Therapeutic Feeding Centre) run by ALIMA/Alerte Santé in partnership with Notre Dame des Apôtres.

There were a large number of new admissions from the start of the programme even without any active case finding strategies. After only three months, 3,133 children were admitted to the four ATFCs supported by ALIMA, while the two other ATFC run by other NGOs had admitted more than 1000 new SAM cases for the same period. The rate of admissions has reached 300 new admissions per week. A notable feature of the programme is that children are brought to the centres without any information campaign.

Early programme results

While it is too early to draw firm conclusions, first results from the field team are as follows.

Ninety per cent of admissions are children aged 6 to 23 months old; this confirms that nutrition vulnerability is highly concentrated in young children as observed in the 2012 survey³.

Programme indicators are satisfactory and improving: the recovery rate is 85.9%, death rate is 3.2% (and decreasing), defaulter rate is 5.1%, and transfer rate (for medical cases needing specialised care or those cases that are transferred to another ATFC) is 5.8%. These rates are improving every week. It appears that good geographic accessibility and free, available and quality health care are contributing factors to good attendance and ownership of the programme by parents. Many parents are really amazed seeing how their children get better in a short period of time.

Over the same period, 463 children were admitted to the ITFC, i.e. a hospitalisation rate of 14.7%. About one third of admissions are referred from other medical structures. Most of them are very sick and in urgent need of intensive care. The hospital mortality rate in the ITFC is still relatively high at 11.8%, but has significantly decreased over time. As often occurs when beginning nutritional programmes, the first weeks of a programme draw very severe cases that have been without care for a long period. Many have acute complications such as sepsis, acute diarrhoea, severe respiratory infections, malaria, and severe anaemia. HIV and TB prevalence seem to be higher than in other nutritional programmes in

¹ See: http://foodsecuritycluster.net/sites/default/files/Rapport_Final_SMART_Sahel_Tchad_2012_VF_0.pdf and <http://www.cmamforum.org/Pool/Resources/RAPPORT-FINAL-SMART-SAHEL-FEVRIER-2013.pdf>

² Mark Myatt, [www.cmamforum.org/Pool/Resources/caseloadCMAM-June-2012\(1\).pdf](http://www.cmamforum.org/Pool/Resources/caseloadCMAM-June-2012(1).pdf)

³ GAM prevalences among children 6-29 months and 30-59 month of age were estimated at 20.1% and 6.6% respectively, meaning that a 6-29 month old child was more than 3 times at risk of being malnourished ('relative risk').

the region, although data are still to be analysed. According to MoH data, N'Djamena town has one of the highest prevalence rates of HIV (7 to 8%) and TB (566/100,000 inhabitants) while the national prevalence is 3.5% for HIV. The national incidence rate for TB is 399/100,000.

Health conditions appear to be similar or worse in the town to those in rural areas. This has also been reflected in the mortality rates observed in previous surveys, i.e. in N'djamena an under-five's mortality rate (U5MR) of 1.05 [0.48-2.3] deaths /10,000 /day was observed in 2012, the third highest rate in the 11 regions surveyed, behind Guera and Salamat (see Table 1). The same type of survey indicated an even higher U5MR of 1.24 [0.59-2.63] at the beginning of 2013. ALIMA and Alerte Sante are considering investigating further the genesis of malnutrition in N'Djamena and other related consequences on children's health.

Early conclusions

This programme has already made us consider that urban SAM is common in the Sahel and largely overlooked. We don't know what future admission trends for the programme are likely to be or its current coverage. While we initially planned sensitization activities, we have put these on hold for fear of being overwhelmed, especially on the ITFC side, even though we are now planning to treat over 7,000 SAM cases this year. Among this intake there will be many medical complications requiring more beds and staff. We are facing a problem of high bed occupancy rate. Despite a gradual increase from 20 to 35 beds, this is still insufficient. According to current data, the required bed capacity for this urban ITFC would be between 75 and 100. We hope that the positive support provided from MoH authorities will help us to solve this problem in the coming weeks.

Finding medical human resources in Chad is also a challenge. While being in the capital city does help, it does not compensate for the lack of qualified and trained staff for a country facing nutritional crisis. Our plan for 2014 would be to set up a referral ITFC with the MoH that could also be the training centre for health professionals in management of malnutrition.

In conclusion, the findings of our work in N'Djamena suggest the need to scale up CMAM treatment availability in large Sahelian cities, to integrate these services into routine health care and to develop programme capacity to host and treat complicated cases of acute malnutrition in need of hospitalisation.

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Table 1: Mortality rate in the general population and children less than 5 years, Sahel region of Chad, May-June 2012

Region	General population		Children less than 5 years	
	Sample	Death per 10,000/day	Sample	Death per 10,000/day
N'Djamena	4804	0.54 [0.32-0.89]	848	1.05 [0.48-2.30]
Lac	2993	0.21 [0.11-0.41]	570	0.63 [0.23-1.68]
Kanem	2968	0.24 [0.11-0.50]	603	0.30 [0.07-1.20]
Hadjer Lamis	2954	0.39 [0.19-0.79]	681	0.79 [0.32-1.90]
Barh El Ghazal	2994	0.27 [0.11-0.64]	755	0.35 [0.12-1.07]
Batha	3408	0.94 [0.66-1.34]	759	1.76 [1.03-3.00]
Guéra	3517	0.96 [0.69-1.35]	783	2.17* [1.40-3.35]
Ouaddai	2636	0.37 [0.19-0.74]	591	0.45 [0.15-1.37]
Wadi Fira	3179	0.28 [0.13-0.59]	763	0.47 [0.14-1.58]
Salamat	3328	0.51 [0.30-0.87]	756	1.18 [0.54-2.57]
Sila	3084	0.55 [0.39-0.78]	729	0.49 [0.19-1.28]

Under 5 years mortality rate greater than the alert level of 2/10,000 children under 5 years/day



Living conditions in Korogocho slums, Nairobi

The roll out of IMAM in Kenya's urban slums

By Koki Kyalo, Claire Orengo, Regine Kopplow



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Claire Orengo is the Health and Nutrition Coordinator for Concern Worldwide Kenya and sits on the National Nutritional Technical Forum of the Ministry of Health, Department of Nutrition. Previously, she worked with International Medical Corps in Ethiopia and Sierra Leone and Medair in Somaliland and South Central Somalia.



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The authors acknowledge the contributions of the Ministry of Health Kenya and UNICEF Kenya.

The face of poverty in Kenya is changing and the country is facing a new urban crisis. The rate of urbanisation in Kenya is one of the highest in the world. The urban population growth is estimated at 5% annually over the last decade compared to an estimated average 2.3% population growth of sub-Saharan Africa. Over 60% of the urban population in Kenya lives in slums¹; the slum dwellers in Nairobi reside on only 5% of the land. Urban poverty is characterised by lack of employment, lower wages and returns from informal employment, and extremely poor levels of basic services such as housing, sanitation, health care and education. There are increasing numbers of 'food poor', those unable to meet all nutritional needs due to expenditure on other basic non-food essentials, and 'hard-core poor', who cannot meet their minimum food requirements even if they allocate all their income to food². The poorest urban-dwellers spend up to 75% of their income on staple foods alone.

Urban settings have increasingly become unequal settings. Indicators for infant mortality rates (IMR) in Kenya's slums are significantly worse than the

national average; 60 and 95 per 1,000 live births in Nairobi and Kisumu respectively, compared to a national average of 52 per 1,000 live births. However, these figures are severely misleading in relation to the urban poor, given that they are city-wide and include all socioeconomic groups, including those from Nairobi's leafy suburbs and better off area as well as areas of great deprivation. Without disaggregated data, equitable and timely targeting of responses to the need remains difficult. The IMR for the urban poor is much higher; a longitudinal study conducted by the African Population and Health Research Centre (APHRC) between 2003 and 2005 in two slums in Nairobi revealed that the infant mortality rate was 40% higher (96 per 1,000 live births) than that of Nairobi (67 per 1,000 live births) as a whole.

The Child Survival and Development Strategy indicates that 50% of all under-five mortalities in Kenya are associated with malnutrition³. Malnutrition in urban loca-

¹ Nairobi Urban Sector Profile, 2006

² OXFAM, 2009. Urban Poverty and Vulnerability in Kenya.

³ Republic of Kenya, 2008. Child Survival and Development Strategy 2008-2015.

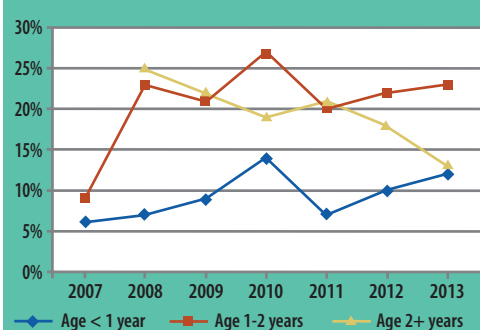
tions can take a number of forms, i.e. stunting, wasting, and micronutrient deficiency. In many instances, different types of malnutrition overlap. Stunting is the predominant form of malnutrition found in urban areas in Kenya. An APHRC surveillance system established in two Nairobi slums found that one in two children was stunted⁴. Further, an APHRC (2013) comparative analysis of stunting trends over the past 6 years indicates a doubling of stunting rates (see Figure 1). The SAM (Severe Acute Malnutrition) rates based on Concern Worldwide (2009) survey results are 1.9% for Nairobi and 4.1% for Kisumu, which together translates to more than 7,000 SAM children. This high prevalence of SAM (>1%) indicates comorbidity among the SAM cases and in particular, high prevalence of diarrhoeal diseases and HIV related conditions that have further exacerbated malnutrition.

The right to good nutrition is enshrined in the Kenyan constitution (Article 42c) and the National Food and Nutrition Policy. Greater accountability is required to the urban poor and to addressing underlying determinants that contribute to malnutrition. Addressing urban slum conditions such as poor water, sanitation and housing, access to health and education services, health and dignity are apparently a low priority in most government departments. However the MoH with support from Concern Worldwide and UNICEF has developed an Urban Nutrition Strategy⁵ that is currently going through an approval process for publication.

Strategy to increase access of IMAM services in urban slum setting

Prior to the integrated management of acute malnutrition (IMAM) implementation in 2008, the only available nutritional services for SAM were provided through the traditional inpatient care units that existed in the main referral hospitals in urban slums. MoH (Ministry of Health) started to roll-out IMAM and to build the long-term capacity of health staff so that the programme could be sustained and replicated across the big cities of Nairobi and Kisumu. All the activities were planned and implemented by provincial and district level MoH staff with support from partners, most notably Concern Worldwide. Concern Worldwide's support to MoH consisted mainly of technical assistance, which aimed at improving the technical knowledge in curative and preventative nutritional services within the existing health system. The entry point for urban IMAM was paediatric clinics based in the informal settlements (slums) of Nairobi, supported by a local non-governmental organisation (NGO) Lea Toto, which focused on provision of HIV/AIDS services. Further scale up of IMAM in urban slums was triggered by poor health indicators, as well as socio-economic factors experienced by the urban poor.

Figure 1: Severe stunting (height for age z score <-3) in Korogocho and Viwandani (urban Nairobi slums)



Source: APHRC

The roll out of IMAM in urban slums focused on three of the four IMAM components: inpatient care, Outpatient Therapeutic Programme (OTP) and community mobilisation. Health workers from the Maternal Child Health (MCH) and Out-Patient Department (OPD) were targeted for the IMAM trainings. Until recently, the OTP was viewed by many health staff as a vertical programme and thus there was a perception that it was extra work that needed additional staff for implementation. However, there has been a gradual positive change which has seen OTP almost fully integrated into the routine work of most health facilities. Health workers in the MCH and OPD departments screen children using mid upper arm circumference (MUAC) tapes, in addition to the weight-for-age (WFA) measurements traditionally used.

Currently OTP services are being offered in eight districts in Nairobi and one in Kisumu through MoH and private facilities supported by NGOs (e.g. Concern Worldwide) and Faith Based Organisations (FBOs). There has been remarkable decentralisation of IMAM services, from 30 in 2008 to 107 in 2013. Private health facilities⁶ have been fundamental to the increased geographical coverage of the services. Currently up to 55% of the IMAM services are provided through private health facilities in the urban slums of Nairobi and Kisumu. Between January and June 2013, private health facilities have admitted up to 60% of the SAM admissions. However, coverage assessments of OTP services conducted by Concern (using SQUEAC⁷ methodology) have indicated poor access and coverage despite increased geographical coverage. More importantly, the assessments have provided a wealth of data that sheds light on why access to the urban nutrition programme is challenging, and the extent to which specific characteristics of urban environments affect coverage. Factors affecting coverage include poor health seeking behaviour influenced by both culture and stigma, caregivers are time constrained making weekly OTP follow up visits a significant challenge, a highly mobile community as they seek job opportunities, short term relocation to the rural areas and accidental destruction (like fires) of their homes.

On-the-job training

During the initial roll-out of IMAM, Concern supported the MoH to design and offer flexible theoretical training based at the facility followed by 8 to 12 weeks of on-the-job training. The theory classes were flexible depending on the schedule of the facility and the trainings scheduled on less busy days. The short trainings (one and a half days) were followed by weekly on-the-job training which takes a minimum of three consecutive weekly visits. This was later scaled down to twice a month and eventually to monthly supportive supervision visits once the facility was well versed with the treatment protocols. A standard supervision checklist is used for on-job training and support supervision.

Community mobilisation

The Kenya Community Health Strategy has promoted the use of community health workers

(CHWs) to support implementation of IMAM. This is a critical intervention aimed at reducing health inequities, improving the effectiveness of service delivery, and enhancing community access to nutrition services by promoting community ownership and control through the community strategy. Over time, a community strategy has been refined to increase early detection and home follow-ups. Each health facility is served by community units that have assigned a number of CHWs for respective households. The CHWs conduct community sensitisation, screening in the community, referrals of SAM/ MAM cases, home follow-up of absentees and defaulters, and follow-up of inpatient referrals back to OTP. The retention of CHWs is a major challenge due to their 'volunteer' status as they are not paid for services rendered but receive a monthly incentive of 2000 Ksh (£15) per month⁸. The MoH has advocated for the flat rate to regularise the CHW pay. The MoH relies heavily on partners to cover these costs as they are yet to be entrenched in the MoH budgets.

Linkages with other health/nutrition interventions

Currently most OTPs are situated at the MCH which has considerably helped strengthen the linkages for both the caregiver and the child to other MCH services such as immunisation, ante-natal and post-natal consultations and therefore also to primary health care delivery services. In addition, children responding poorly to SAM treatment are referred for HIV and TB screening. Further MUAC screening and referral links to MCH have been established with Comprehensive Care Clinics (CCC), OPD and TB clinics. In addition to IMAM, Concern Worldwide supported the MoH to integrate promotion of breastfeeding and optimal complementary feeding. Referrals of MAM cases and OTP discharges to Supplementary Feeding Programme (SFP) has remained weak. The urban areas are yet to secure long term support for SFP. Currently MoH support is not regular, thus clinics go for months without supplementary foods.

Further, Concern Worldwide has scaled up support to the MoH to increase coverage and quality of twelve high impact nutrition interventions (HINI) in the health facilities. In July 2010, Kenya adopted the HINI package which comprises of breastfeeding, complementary feeding, hand washing, Vitamin A supplementation, zinc supplementation, multiple-micronutrients, deworming for children, iron-folic for pregnant women, salt iodisation, iron fortification of staple foods, prevention and treatment of moderate acute malnutrition, and treatment of severe acute malnutrition.

Health system strengthening: towards sustainable nutrition gains

Concern Worldwide worked with health facilities providing technical support to health facility staff who in turn provided quality nutrition services. However, this approach was not considered to be sustainable (limited engagement with District Health Management Teams - DHMTs) and thus the shift was made towards health systems strengthen-

⁴ See article in this issue on urban challenges in Kenya that included stunting data (page 49).

⁵ The Urban Nutrition Strategy is intended to provide a mechanism through which government will facilitate, in a coordinated manner, the implementation of strategic actions to improve and ensure the nutrition of urban populations.

⁶ Private health facilities include those run by NGOs, FBOs and individuals. Beneficiaries are increasingly using these services as they charge subsidised treatment fees, are accessible (often situated inside the slums unlike MoH) and offer quicker services (MoH health facilities experience long queues). Recently, the MoH has begun opening facilities in the slums.

⁷ Semi Quantitative Evaluation of Access and Coverage (SQUEAC) Concern Worldwide has monitored the access and coverage of the urban nutrition programme since February 2010. Initially, the SLEAC methodology was used to determine access and coverage at the facility catchment but later changed to SQUEAC methodology that has the capacity to determine the access and coverage levels at district level. In addition, the SQUEAC requires low resources as compared to the SLEAC. Since 2010, annual coverage has ranged between 30%-49% (against 70% Sphere indicator) in both Nairobi and Kisumu.

⁸ MoH salaries generally start at over 10,000 Ksh per month.



Source: Concern Worldwide

ing, to build the capacity of the DHMTs to support and sustain the skills within the health facilities. Concern Worldwide’s approach to health system strengthening focuses on five key areas: technical, managerial, human resource, finance, and supplies and logistics. This has seen Concern Worldwide increase the scope of support to the DHMT from technical to the other four components of the health system. Although it is a slow and long term investment, it is more sustainable and effective in building nutrition capacity within the MoH. The MoH role in provision of health services to the poor urban population is critical to closing the inequality gap. In recognition of this, Concern Worldwide is now embracing building the capacity of the DHMT through Health System Strengthening to own the process.

Operational issues – training, supplies, logistics, supervision, reporting

In addition to training health workers in health facilities, DHMTs also organise on-the-job trainings and supportive supervision to reinforce health workers skills. The county nutrition office coordinates with the districts to develop supply requests for RUTF (Ready to Use Therapeutic Food) and anthropometric tools that are channelled through UNICEF for support. Though Concern Worldwide has lobbied with the districts to include RUTF and anthropometric supplies in the Districts’ annual plans, this component is not yet fully funded. Further, logistical management of supplies at health facilities remains a challenge. Reporting through the District Health Information System (DHIS) has improved the timeliness and quality of nutrition data (including IMAM indicators).

Successes, key challenges and lessons learned of IMAM urban roll-out

There has been an expansion of services (from 30 to 107 health facilities), with increased admissions and steadily improving performance of the

Table 1: IMAM programme performance indicators

Year	No. of Admissions	Cure Rate	Death rate	Default rate
2008	1,607	48.4%	2.4%	47.0%
2009	2,737	67.4%	3.1%	28.1%
2010	4,669	76.0%	2.0%	21.0%
2011	6,117	81.4%	1.8%	16.8%

programme. Both cure and death rates are within Sphere Standards recommendations, although default rates (while decreasing) remain high (see Table 1).

Management of acute malnutrition has been included in the district ‘Annual Operational Plans (AOP)’ since 2008 in Nairobi and Kisumu districts. This has ensured that IMAM becomes part of the routine health service delivery in these districts. However, IMAM supplies, such as RUTF, are yet to be funded under the AOP.

The work has mobilised and used existing human resources; CHWs and community leaders. Community linkage has been strengthened between the health facilities, inpatient referral centre and community, thus increasing referrals and home follow-ups of acutely malnourished children.

A number of challenges encountered by the programme are:

Poor staff and capacity retention:

High staff turnover at health facilities continues to be one of the main challenges since the inception of the programme. The Kenya Nutrition Action Plan 2012-2017 outlines integration of IMAM in nurses and medical pre-service training. This important component is yet to get funding.

CHW motivation/remuneration:

The Kenya Community Health Strategy embraces working with CHWs however retention of CHWs is a major challenge due to their ‘volunteer’ status with the low incentive that is also not provided by MoH.

High defaulter rates (above the recommended Sphere standards):

While the default rate is slowly declining, it remains high. Main reasons include migration as families move due to fires, high rents, or for work opportunities and frequent absenteeism as caregivers often prioritise casual work over attendance at health facilities.

Coverage:

Although coverage has improved, it still remains well below Sphere standards. Close location of

services in the urban context (seen in the high geographical coverage) is not enough to ensure service coverage. Facility operating hours and the time poor profile of urban slum dwellers contribute to this.

Funding:

Regular and consistent funding for urban poverty alleviation, including addressing chronic malnutrition, remains a challenge. Donors generally look at urban slums as governance and policy issues for national governments and not necessarily areas suitable for sustainable development. Lack of humanitarian indicators for urban settings also excludes humanitarian donors from engaging. Urban areas are highly market dependent. Droughts in rural areas or global food price spikes, for example, can translate into high food prices in urban markets. Economic downturn can affect access to paid employment particularly for the low paid, affecting household incomes. The combined effects of price increases and reduced income can tip those living in chronic poverty into a crisis situation. While the numbers of malnourished children increase substantially, the percentage malnutrition rates remain below internationally recognised emergency indicator levels. However, even low prevalence rates can translate into very large caseloads due to the high population density of urban slums. This makes it difficult to mobilise resources, both in terms of funding from donor agencies and in terms of the motivation of government and key stakeholders to respond. Sphere standards do not address the complexity of urban settings. Concern Worldwide has begun to develop specific humanitarian indicators for slow onset emergencies in urban areas (see field article in this issue of Field Exchange).

A number of key lessons learned include:

- Though slow, working through the MoH system is a more effective and sustainable approach to delivery of IMAM.
- Partnerships with private health facilities in provision of IMAM services are critical in increasing access and increased use of protocols by all health providers.
- In the urban slums, absolute caseloads of malnutrition are often high, even when the prevalence of malnutrition is low. It is important to sensitise stakeholders, especially donor agencies and health staff, on the complex health and nutrition needs affecting urban populations and differences with rural populations who until recently, have largely been the recipients of humanitarian programming.

For more information, contact: Koki Kyalo, email: koki.kyalo@concern.net

Jacqueline Mwende who has brought her 12 month old son, Fanwual, to the Concern-supported Mukuru Reuben health clinic in the heart of Nairobi’s Korogocho slums.

The clinic is an oasis amongst the mud, rubbish and noise of the tightly-packed slums, and offers free services to mothers. Fanwual is checked for malnutrition using a MUAC (mid upper-arm

circumference) which indicates severe malnutrition. He is given RUTF and Jacqueline is given a supply to take home with her.

Home is a cramped tenement flat on the 5th floor of a rundown block, with no electricity and shared latrines which tenants must pay to use. Jacqueline lives here with her husband and five children, who sleep either on or under two tiny settees.

“My husband cannot find work and I make a little money selling onions, but the rent is very expensive and we can only afford to eat once a day.” Her other children should be at school but have been refused because she cannot pay the school fees. “I want a good future for my children” she says, “a good education and that they should eat like other children.”



Gideon Mendel, Concern, Kenya, 2012

Agency Profile



Christian Jepsen, Mogadishu, Somalia

Name:	Norwegian Refugee Council
Address:	Grensen 17, 0130 Oslo, Norway
Phone:	+47 23 10 98 00
Email:	nrc@nrc.no
Website:	http://www.nrc.no/
Year founded:	1953
Secretary General:	Jan Egeland
No. of staff (HQ):	170
No of staff worldwide:	3,000

NORWEGIAN REFUGEE COUNCIL **NRC**

This profile of the Norwegian Refugee Council (NRC) has been written by three members of NRC's staff in response to a set of written questions. Vibeke Risa is the Head of the Thematic Technical Support Section, which is located in NRC's International Programme Department. This section is composed of advisors on thematic and cross-cutting issues, such as gender, youth, environment and urban displacement. The work in these areas is undertaken in close collaboration with the Technical Advisors in charge of NRC's Core Competencies. Prior to her position as Head Section, Vibeke was the Gender Advisor in NRC. Thomas Ølholm has been NRC's Food Security Advisor since August 2013. He previously worked as a Project Coordinator on food security in NRC's Country Office in South Sudan. Jake Zarins has been a Shelter Advisor with NRC since October 2011. He has been a Shelter Programme Manager in several of NRC's Country Offices, most recently in Afghanistan and Sri Lanka. Jake has contributed to the development of several urban shelter programmes in NRC, most recently in Lebanon and Jordan, but also in Afghanistan.

Brief history of NRC

The Norwegian Refugee Council (NRC) is an independent, humanitarian, non-profit, non-governmental organisation (NGO) which provides assistance, protection and durable solutions to refugees and internally displaced persons worldwide. NRC was established in 1946 originally to supply food and clothing to the starving millions in a Europe devastated by war. 'Aid to Europe' was a stand-alone fund raising initiative which quickly developed into a broader organisation. Four million kilos of food were collected, packed and shipped to the countries in Europe with greatest need. In 1953 'Aid to Europe' was transformed into the Norwegian Refugee Council which continued the fund raising.

In the decade 1956-65, NRC switched its focus to outside Europe and started raising funds for displaced people in Africa, Asia and the Middle East. On the home front, NRC was responsible for the reception of refugees and the running of recep-

tion centres for refugees in Norway until 1982, when the Norwegian government took over their management. This marked a shift in NRC's focus to international work. The conflict in the Balkans in the 1990s was a key event in defining NRC as an international humanitarian organisation and NRC increasingly became an operational agency implementing projects in the field. In 1997, NRC changed status from being an umbrella organisation for NGOs to being an independent private foundation. Today, NRC works in approximately 22 countries providing protection and assistance to people forced to flee. It centres its activities around five core competencies – education; information, counselling and legal assistance (ICLA); food security; shelter and WASH (water, sanitation and hygiene). In addition, NRC is developing its capacity in prevention of and response to gender-based violence (GBV) as this has proved to be a key issue in the contexts where NRC works. In recent years, providing assistance to displaced people in urban settings has become more important and NRC is thus working to build its capacity to better understand how to identify and target the urban displaced and how to provide appropriate assistance to this group

What is the role of NRC in food security (and nutrition) programming?

The Food Security core competency in its current form is relatively new in NRC. In 2008, a policy change was initiated, changing NRC's approach from direct distribution of food and non-food

items (NFIs) towards food security and livelihood related programmes, with a larger focus on agricultural production and income generation.

The policy focuses on addressing the problems of food accessibility/affordability, utilisation and long-term stability of the food system. Internally displaced people (IDPs), refugees and returnees face different constraints and have different opportunities and capacities depending on the context in which they live (rural/urban, high/low security risk areas, etc.).

As of today, NRC implements food security and livelihoods programmes in nine countries (Somalia, Yemen, Kenya, South Sudan, DRC, Liberia, Ivory Coast, Zimbabwe & Pakistan) with potentially three additional country programs to be added in 2014 (Ethiopia, Iran and Djibouti). The programmes cover a broad scale of interventions, ranging from emergency response to broad based livelihoods responses that include the most important components needed for re-establishing of peoples livelihoods. As of 2011, NRC initiated food security responses in urban settings and is a member of the Urban Global Food Security Cluster working group.

How is NRC funded?

NRC is funded by a series of institutional donors, the largest being the Norwegian Ministry of Foreign Affairs, which has traditionally been NRC's most important donor. NRC has, however, in the last 10 years significantly broadened its donor base



Christian Jepsen, Mogadishu, Somalia



and ECHO, UNHCR, SIDA and DFID are now also strategically important donors to NRC. Smaller donors include UNICEF, UNDP, WFP, USAID and CIDA. Additionally, NRC receives funds from individual sponsors and some private companies.

What is NRC's involvement and interest in urban programming?

NRC recognises that the profile of its beneficiaries is changing and that traditional refugee camps are no longer necessarily the norm. We are in the process of shifting the focus of our interventions into urban contexts where the issues are very different. Providing assistance in urban settings requires a different understanding of what the issues are, how to identify and target beneficiaries, and how best to design and implement the assistance. NRC has in the last couple of years become involved in programming – mostly within shelter – for displaced in urban settings, particular examples include Afghanistan (Kabul), Iraq (Baghdad), Mali (Bamako), Jordan and Lebanon, and is learning through this process. As the issue of urban displacement has gained momentum in the international community, NRC wants to be one of the organisations at the forefront in terms of learning and developing urban responses. We are therefore investing in this learning process and an Urban Displacement Advisor (Laura Phelps) will join us in October to lead the process of developing NRC's thinking and vision for the future in terms of programming for displaced populations in urban settings.

Is there an NRC urban policy or strategy?

There is currently no NRC urban policy or strategy, however NRC has developed Urban Shelter Guidelines, which is a tool for humanitarian actors implementing shelter interventions in urban settings. NRC will spend the next 2-3 years developing better targeting and needs assessment tools, including increased understanding of markets in urban settings and aims to have a strategy or a set of guidelines for urban programming at the end of this period.

What types of food security or nutrition sensitive programming have NRC been involved in in urban contexts?

NRC's involvement with urban food security is still in its early stages. We have started the implementation of food security and livelihoods programmes in urban areas in Somalia, Cote d'Ivoire, South Sudan and DR Congo using cash and voucher transfers, since this is considered one of the most

appropriate approaches for urban based food security programmes, using existing market linkages. So far projects related to urban food security have had a focus on promoting alternative or new livelihoods, including the creation and improvement of skills for increased income opportunities and access to food for households. In addition and to a more limited extent, programmes are working with urban food production, especially vegetable gardens.

What has NRC learnt through these experiences?

There is a further need to focus and integrate cash and voucher responses, within market based urban programming and to recognise the need for improving and scaling up food security responses in urban and peri-urban settings. NRC has also recognised the importance of better beneficiary involvement from the beginning to ensure that responses suit the immediate needs of the people assisted and enable NRC to work together with affected people towards their recovery and sustainable solutions.

Are there particular urban specific food security/nutrition issues that the NRC grapples with?

The urban food security projects of NRC are relatively new and have not yet been evaluated. As we continue developing and testing new tools and approaches, such issues will be identified and addressed.

Has there been a specific food security/nutrition post within NRC in the past and how will this post contribute to the new urban work to be developed by Laura Phelps?

NRC has had a Technical Advisor on Food Security based at Head Office since 2008. The Food Security Advisor has had the responsibility to develop NRC's food security approach and has also worked closely with the Cash and Voucher Advisor, a post that has existed in NRC since 2011. Since NRC's urban work will be undertaken through our Core Competencies, Laura Phelps will work very closely with the technical advisors who are responsible for NRC's Core Competencies. The knowledge and experience of the Food Security, Cash and Voucher, and Shelter Advisors in particular, will be vital for Laura as she develops NRC's urban strategy and Laura's expertise on urban displacement will be key to improving our food security and shelter programming. We very much

regard these skills and competences as complementary and look forward to seeing higher quality services being delivered to our beneficiaries in urban settings.

What are the short and medium term plans for food security programming and in particular nutrition/nutrition sensitive programming in urban contexts?

The approach taken by the Food Security Core Competency will depend on the relevant context. These range from direct support to IDPs, refugees and host communities to market-based analysis and livelihoods interventions. One of the most common types of support is provided through cash-transfer programming, linked with skills development and access to income as a means to access food. NRC is planning to expand this into larger programmes starting with interventions in the Horn of Africa. NRC does not address food insecurity through direct nutrition programmes. Instead, the food security programmes address the underlying causes of food insecurity and malnutrition.

How would you describe or distinguish NRC from other international NGOs, e.g. mandate, culture, approach, etc?

NRC is a Norway-based international NGO that places great emphasis on its core values of dedication, inclusiveness, innovation and accountability. Our vision is 'Rights Respected, People Protected'. NRC aims to provide relevant assistance on the ground and be flexible to try new approaches and adapt interventions to need and context. We also aim to be a learning organisation, always striving to integrate lessons learnt and good practices into our programmes. NRC considers its staff, both national and international, as its key resource and aims to continuously develop their capacity as well as to value and build on their knowledge, expertise and dedication. NRC has, in the last five years, grown to become a significant international humanitarian actor providing protection and assistance to refugees and IDPs and is now investing to make sure that we are able to deliver programmes in all displacement settings, including urban contexts.

Finally, could you elaborate on the IDMC and the Perspective magazine that NRC is involved in?

In 1998, NRC established the Internal Displacement Monitoring Centre (IDMC), located in Geneva. IDMC is today a leading international body monitoring internal displacement in approximately 50 countries. Their database is continuously updated and is accessible to the public. Based on its monitoring and data collection activities, the Centre advocates for durable solutions to the plight of the internally displaced in line with international standards. You can access it at:

ICDC: <http://www.internal-displacement.org/>

Together with UNHCR, NRC publishes a foreign affairs magazine, Perspective, which is issued quarterly and addresses humanitarian assistance and international politics. It aims to set the focus both on current conflicts, but also on wars and conflicts that no longer appear in the headlines. An objective is to spark and inform debate on the plight of displaced people and others suffering from humanitarian crisis. Each issue features an in-depth story on a selected topic, the latest one being the aftermath of the Arab Spring. The magazine can be downloaded from NRC's website <https://www.nrc.no/?aid=9555102>.

Invite to submit material to Field Exchange

Many people underestimate the value of their individual field experiences and how sharing them can benefit others working in the field. At ENN, we are keen to broaden the scope of individuals and agencies that contribute material for publication and to continue to reflect current field activities and experiences in emergency nutrition.

Many of the articles you see in Field Exchange begin as a few lines in an email or an idea shared with us. Sometimes they exist as an internal report that hasn't been shared outside an agency.

The editorial team at Field Exchange can support you in write-up and help shape your article for publication.

To get started, just drop us a line. Ideally, send us (in less than 500 words) your ideas for an article for Field Exchange, and any supporting material, e.g. an agency report. Tell us why you think your field article would be of particular interest to Field Exchange readers. If you know of others who you think should contribute, pass this on – especially to government staff and local NGOs who are underrepresented in our coverage.

Send this and your contact details to:

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The opinions reflected in Field Exchange articles are those of the authors and do not necessarily reflect those of their agency (where applicable).



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just one world



International Federation
of Red Cross and Red Crescent



World Vision



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 ENN enables nutrition networking and learning to build the evidence base for nutrition programming. Our focus is communities in crisis and where undernutrition is a chronic problem. Our work is guided by what practitioners need to work effectively.

- We capture and exchange experiences of practitioners through our publications and online forum
- We undertake research and reviews where evidence is weak
- We broker technical discussion where agreement is lacking
- We support global level leadership and stewardship in nutrition

Field Exchange is one of the ENN's core projects. It is produced in print and online three times a year. It 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 ENNs updated strategy (following mid-term review in 2013) is available at www.ennonline.net

The Team



Jeremy Shoham is Field Exchange Editor and Marie McGrath is Field Exchange sub-editor. Jeremy Shoham, Marie McGrath, Carmel Dolan and Emily Mates are Technical Directors.



Thom Banks is the ENN's Desk Operations Officer and provides logistical and project support to the ENN team.



Chloe Angood is a nutritionist working part-time with ENN on a number of projects and supporting Human Resources.



Matt Todd is the ENN financial manager, overseeing the ENN accounting systems, budgeting and financial reporting.



Charlotte Roberts is the ENN's Operations and Mailing Assistant, based at the ENN's office in Oxford.



Welcome to Clara Ramsay as part-time Finance Assistant. Clara has many years of experience working in finance in the charity sector.



We bid adieu to Michele Toler who has secured a full time job with a local charity. We will miss her extreme organisational skills and look forward to luring her back when we need extra hands on deck.



Orna O'Reilly designs and produces all of ENN's publications.



Phil Wilks (www.fruitsolutions.com) manages ENN's website.

The Emergency Nutrition Network (ENN) is a registered charity in the UK (charity registration no: 1115156) and a company limited by guarantee and not having a share capital in the UK (company registration no: 4889844). Registered address: 32, Leopold Street, Oxford, OX4 1TW, UK. ENN Directors/Trustees: Marie McGrath, Jeremy Shoham, Bruce Laurence, Nigel Milway, Victoria Lack, Arabella Duffield





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