Overseas Development Institute

HPG Background Paper

The Southern Africa crisis

A critical review of needs assessment practice and its influence on resource allocation

James Darcy, Andre Griekspoor,
Adele Harmer and Fiona Watson

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About the research team

The study team was led by James Darcy, Research Fellow in the Humanitarian Policy Group (HPG) at ODI. Food and nutrition sectors were covered by Fiona Watson of NutritionWorks in London. The health sector was covered by Andre Griekspoor, seconded to the study from the Department of Emergency and Humanitarian Action in WHO, Geneva. The fourth team member, HPG Research Officer Adele Harmer, focused on agency and donor decision-making. Adele also edited the study report.

About the research

This study of the Southern Africa crisis is part of a research project by HPG into the assessment of humanitarian needs. The study does not attempt to evaluate the performance or impact of humanitarian programming in Southern Africa. The study team is conscious of the demands placed on those charged with responding to a crisis of this magnitude and complexity. Where conclusions are drawn in this study about best practice in assessment, the intention is that these should reflect the real-world constraints involved in assessing and responding to such crises. As practitioners as well as researchers, the team members understand those constraints in general terms, but perhaps not the specific constraints faced here. The team would appreciate feedback as to whether the right balance has been struck between the ideal and the practical. More generally, thoughts and comments on the report, both its factual content and its findings, are welcome.

HPG's research project on the assessment of humanitarian needs is one of four commissioned by the Montreux Group of donors as part of a review of global humanitarian financing. The other three studies are examining donor behaviour; global humanitarian assistance; and the implications of changes in global humanitarian financing for the UN system. The study on assessment of humanitarian needs is due to be completed in April 2003. The research is funded by the UK Department for International Development (DFID), the European Community Humanitarian Office (ECHO) and the Australian Agency for International Development (AusAID).

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Vulnerability Assessment Committee (VAC) in Harare, particularly Phumzile Mdladla, for arranging our discussion with the VAC; and to the Oxfam GB regional office in Pretoria for its help in organising flights.

A note on terminology

In this report, unless otherwise specified, 'agency' refers to any international organisation directly involved in implementing humanitarian programmes, including the UN specialised agencies and international NGOs. The term 'donor' refers to any body (governmental or inter-governmental) concerned with the administration of official funding for humanitarian or development purposes. At certain points, the report distinguishes between agencies, for example between international NGOs and UN agencies, when it is useful to highlight aspects of their independent contractual relations or differing organisational dynamics.

List of acronyms

CAP	Consolidated Appeals Process
CHAP	Common Humanitarian Action Plan
CHAD	Conflict and Humanitarian Aid Department
CFSAM	Crop and Food Supply Assessment Missions
DFID	Department for International Development
ECHO	European Community Humanitarian Aid Office
EU	European Union
FANR	SADC Food, Agriculture and Natural Resources Sector
FAO	Food and Agriculture Organisation
FEWSNET	Famine Early Warnings Systems Network
IFI	International Financial Institutions
IFRC	International Federation of the Red Cross and Red Crescent
INGO	International non-governmental organisation
NVAC	National Vulnerability Assessment Committee
OCHA	UN Office for the Coordination for Humanitarian Affairs
OFDA	Office of US Foreign Disaster Assistance
REWU	Regional Early Warning Unit
RRSU	Regional Remote Sensing Unit
RVAC	Regional Vulnerability Assessment Committee
SADC	Southern Africa Development Community
SC-UK	Save the Children UK
UNHCR	UN High Commissioner for Refugees
UNICEF	UN Children's Fund
USAID	US Agency for International Development
WFP	World Food Programme
WFP-VAM	World Food Programme Vulnerability Assessment and Mapping Unit
WHO	World Health Organisation
VAC	Vulnerability Assessment Committee

Executive summary

This case study, one of five, is part of a research project by the Humanitarian Policy Group (HPG) on the assessment of humanitarian needs. The focus of the study is the international system, exploring the link between needs assessment and decision-making (by agencies and donors) about response and resource allocation, with a specific focus on the food and health sectors. The underlying concern is with global funding disparities: levels of funding do not seem to correlate with levels of need, and the most urgent cases are not consistently prioritised. Yet the humanitarian 'system' lacks a consistent and objective basis for deciding which those cases are, and the means to decide about the allocation of resources between competing priorities.

This case study explores the relationship between humanitarian needs assessment and decision-making in a slow-onset emergency. It is concerned principally with the international humanitarian system and its criteria for response, with a focus on the food and health sectors. It does not attempt to analyse the Southern Africa crisis *per se*, nor to evaluate the response to it. It focuses on three thematic areas: conceptual issues, the practice of needs assessment, and the link to decision-making processes in agencies and donors.

Conceptual issues

The nature of the crisis

Although it is widely agreed that there *is* a crisis in Southern Africa, it is characterised in a variety of ways, from 'food crisis' through to 'complex emergency' to 'development crisis' to 'governance crisis' or 'HIV/AIDS crisis'. Arguably, each describes a different facet of a complex problem, the most obvious symptoms of which are lack of access to food and the devastating (and growing) impact of AIDS. None of those interviewed described the current situation as a 'famine', though the potential for famine and the need for preventive interventions is the rationale for most of the humanitarian response.

One factor that hinders a shared understanding of the nature of the crisis is the lack of international definitions of levels of food insecurity. This study highlights the urgent need for agreement on a simple classification of different levels of food insecurity, and suggests as a minimum that a distinction be made between chronic or periodic food insecurity; acute food crisis; long-term food crisis; and famine. Without agreement on such basic distinctions, situations are subject to misrepresentation, comparisons within and across contexts become

difficult, and the nature of commensurate and appropriate response, and the distinction between prevention and treatment (or even whether a response is required at all) becomes hard to assess.

This study considers the question why the HIV/AIDS pandemic is not *itself* classified as a humanitarian crisis by the humanitarian sector. In terms of excess mortality and morbidity, it dwarfs the effect of the food crisis, though it is related to it. The apparent failure to address HIV/AIDS effectively in its own right can only partly be ascribed to the problems inherent in devising effective preventive, curative and palliative responses. It is also partly because this more intractable issue has no classification in the normal humanitarian lexicon – and it is one for which there is weak political and institutional responsibility. Certainly, the scale and nature of the problems concerned are such as to demand interventions across a range of sectors – public health, social welfare – that go beyond the capacity and resources of the humanitarian system, and beyond the humanitarian agenda as it is understood in the present study.

One crisis or many?

There appears to be broad consensus that 'the crisis' is a regional one, though its severity varies considerably across the region. Such an approach makes sense for planning and resource mobilisation, and highlights both the economic inter-connectedness of the region and the various common factors, such as food insecurity and HIV/AIDS. However, this approach also obscures those features that are particular to the various country-level crises, each of which has its own distinct features. It also fails to account for the significant variations at the micro level. As a result, there is a danger that approaches will fail to adapt to local circumstances, and that there will be insufficient focus on those areas and sectors of greatest need. Instead, the 'crisis' is better seen as a number of distinct crises, which have a number of causal and symptomatic features in common.

Crisis or new normality?

A common theme during discussions was the problem of distinguishing normal situations from those that were so abnormal as to demand a distinct (humanitarian) approach – as opposed to an extension or modification of existing development approaches. When does a situation become 'critical', and when does it cease to be so? No consensus was found on these questions, though judgements about them are inherent in the decision-making process. Arguably, such distinctions are not useful in situations where either the situation remains critical for so long that it becomes the norm, or where (as for example in Malawi) the crisis represents a point on a steadily-deteriorating development curve. Crises are not always signalled by step changes in external

variables, a fact that would tend to support the argument for a more consistent use of benchmarks and 'trigger' indicators for humanitarian response. A combination of indicators and a range of data, socio-economic as well as physiological, qualitative as well as quantitative, is essential for this purpose.

Strategic planning and conceptual models

There is a gap between the generally-accepted understanding of the situation in Southern Africa and the planning for response. The majority of agencies and donors agree that the crisis is long-term in nature, and that the need for sustained welfare support is likely to continue into the medium term. Yet the short-, medium- and long-term planning for the impacts of the crisis seems poorly informed by any broad strategic analysis. Few respondents were able to outline solutions that went beyond the normal six- to nine-month 'risk horizon' for humanitarian response. Discussions about humanitarian food aid and social welfare (safety-net) provision are conducted in separate fora. More generally, there appears to be a lack of 'system-wide' strategic thinking about how to reduce vulnerabilities and increase capacities. This apparent lack of strategic planning reflects a familiar institutional and conceptual divide between relief and development approaches that urgently needs to be resolved in Southern Africa.

There was an evident lack of conceptual models adequate for analysing the multiplicity of factors involved (political, socio-economic, climatic and environmental, demographic and epidemiological) at micro and macro levels, and establishing the links between them. This cannot be explained entirely by the peculiar nature of the crisis itself, but again reflects the lack of coherence between relief and development models.

Needs assessment practice

Assessment and analysis

While the primary purpose of formal needs assessments may be to inform an organisation's decisions about whether and how to respond, assessments may also aim to force a decision by others, to influence the nature of others' decisions, or to justify decisions already taken. The study team found that decisions to launch assessments were not always based on clear or consistent criteria, and that the objectives of assessments may be as much about justifying an agency's request for funding (the decision to intervene having already been taken) as about establishing an objective picture to inform an appropriate response. For some organisations, the decision to assess at all was strikingly haphazard; one of the first assessments that identified a

potential food crisis in Malawi, for example, was undertaken not as an end in itself, but as part of a staff training programme.

If assessments are to be objective and balanced, the analysis of needs (or, better, of risks) should be clearly distinguished from the design of responses and requests for funding – with the latter explicitly justified in relation to the analysis of needs, risks and capacities. This requires that needs assessments are adequately resourced, and that they are not premised on the assumption of any particular form of intervention. Donors should be prepared to fund assessment as an essential activity in its own right.

The balance between 'snapshot' surveys and continuous surveillance needs to be ensured – the balance in this case weighed far too heavily in favour of surveys. The series of repeated surveys undertaken by the VAC was an attempt to combine breadth/depth of analysis with the monitoring of trends and critical changes. The method adopted was not well suited to this task, and was arguably over-elaborate (and costly) for the purpose it actually served. Over the longer term, investment in permanent surveillance systems as part of the development effort to prevent crises and increase preparedness is essential.

The type and scope of assessments

Formal assessments of need in Southern Africa varied in their type, scope, timing and impact. Assessments ranged from those done by a single agency focused on a single sector in specific geographic areas, to multi-agency and multi-sectoral assessments operating at the national and regional level. There was a range of methodological approaches to assessments in food and health, and some combined a number of methodologies. Overall, food-aid oriented assessments predominated, in particular the findings of the Food and Agriculture Organisation (FAO), the World Food Programme (WFP) and the Vulnerability Assessment Committee (VAC) in the six worst-affected countries. At the district and sub-district levels, small food security and nutrition assessments were undertaken by international NGOs which, though limited in scope, played an important role in drawing attention to the food crisis. Assessments examining the health sector were undertaken by both NGOs and UN agencies, in particular the World Health Organisation (WHO) and the UN Children's Fund (UNICEF). However, these had a limited impact in putting health and other non-food sectors on the agenda.

In the absence of any overarching strategy for coordinating macro- and micro-level assessments within and between countries, it proved impossible to develop an overall picture of needs and to

make comparison between contexts. Even the best coordinated process, the VAC, was subject to significant local variation. Nor was there any capacity for piecing together the findings from the various assessments undertaken at the macro and micro levels to create a picture of overall need based on shared and comparative analysis.

Figures and indicators

The study found that the use of indicators such as mortality rates, morbidity patterns and the prevalence of acute malnutrition was inconsistent and generally very limited. The various country-level crises have not been defined on the basis of such indicators, but rather on the basis of food-security indicators.

The total number of people in need of assistance calculated for the interagency Consolidated Appeals Process (CAP) was originally set at 12.8 million, and later increased to 14.4m. This figure is based on an analysis of (potential) food deficits rather than a broader problem analysis; a figure of this magnitude is hard to interpret without understanding the specific categories of risk involved. The assumption that this was a food crisis meant that there was limited critical analysis of other needs. Measuring the extent to which the eventual scale of response was proportionate and appropriate to needs in Southern Africa (and compared to situations elsewhere) is thus highly problematic.

Multi-agency versus single-agency assessments

The VAC Emergency Food Security Assessments were the clearest example of a multi-agency assessment process. There was general agreement that the multi-agency approach was of collective benefit, but there were a number of challenges in the process, including agency disagreements regarding the best methodology, the validity and reliability of the data, and the limited analysis of that data.

The study notes that a multi-agency approach goes some way towards mitigating the institutional biases that can prevail in undertaking assessments. Multi-agency assessments may be more likely to produce credible, reliable and objective results. The study questions, however, the degree to which agencies are able and encouraged to challenge the analysis of findings in a consensus-driven environment. It is essential that the system remains open to independent and potentially challenging analysis, that conclusions are revisited when situations change, and that agencies are prepared to question their own and others' assumptions.

Multi-sectoral versus mono-sectoral assessments

The merits of conducting assessments using multi-sectoral teams have been much debated. The fundamental question is whether such an approach enables a more integrated analysis than is possible if such assessments are conducted separately. The study team concluded that, rather than trying to formulate a single methodology to assess all aspects of a given situation, what was important was that sectoral assessments were coordinated closely enough in terms of their geographic and temporal focus that the results could be correlated and analysed in relation to each other, and that conclusions could be drawn from the corresponding data sets.

The coordination of assessments

This case study highlights the absence of a strategic framework to guide agencies in achieving geographic and sectoral balance. There were nonetheless many positive examples of effective coordination. Although the data produced may not have been fully utilised, the VAC assessments represented a coordinated and collaborative process, both within and between countries. Agencies made efforts to coordinate in the nutrition and health sectors, within each affected country. However, the linkage between the effective coordination of assessments and the coordination of decision-making was limited in all sectors other than food aid.

Unassessed needs

The challenging political situation in Zimbabwe presented significant obstacles for agencies in gaining access to certain rural areas to undertake needs assessments. There was also a very limited understanding of urban needs; the VAC did not undertake assessments in urban centres. It was not clear how (if at all) the needs of inaccessible populations were taken into account by either the VAC or agencies or donors. In addition, in Zimbabwe, there was limited understanding of nutritional needs as a national nutrition survey carried out in May 2002 was not repeated and nutrition data gathered as part of the VAC was of variable quality.

Information and decision-making

Assessing factors other than need

Decisions to respond were shaped by a number of external considerations in addition to formal assessments of need, including the capacity of the humanitarian community to mount a response; the political context and issues of humanitarian access in Zimbabwe; concerns about accountability and good governance in Malawi; the competing demands on humanitarian finances; the commitment and leadership of key stakeholders; and the tension between the humanitarian and development streams within organisations. Trust in an agency's capacity to

deliver was a key variable for donors, and the pursuit of individual agency mandates, was also important.

The study noted that the decision-making process in agencies and donors alike lacks transparency. The criteria for intervention are unclear – neither articulated explicitly in policy, nor guided by specific triggers or indicators. Until decision-making is made more transparent, the relative weight given to needs assessments within this process remains uncertain.

Triggers for response

There was no single, commonly-agreed trigger in Southern Africa which led to a response from the humanitarian community. Most donors and agencies based their decision to respond on a gradual accumulation of evidence from informal and formal sources, including early-warning systems, civil society, UN and NGO assessments, lobbying, media profile and in-country reporting.

Information systems

The study found that there was no one source of information which donors or agencies relied on extensively. Although donors noted the need for a single system that would deliver accurate and credible data, it was less clear what such a system might look like. The intended key tool for information management – the Southern African Humanitarian Information Management System (SAHIMS) – was not (at the time the study was conducted) fulfilling the role donors and agencies expected of it, primarily because of its late arrival, the lack of clarity around its purpose and outputs and poor financial and personnel resourcing.

The study highlights the importance of establishing information-management systems in a timely manner, to provide accurate and objective information upon which to plan and coordinate the response and allocate resources in a consistent and proportionate way.

The coordination of decision-making

The coordination of decision-making at the regional level was weak, particularly in sectors other than food. The UN Office for the Coordination of Humanitarian Assistance (OCHA) does not have a lead role in coordination in the region and instead supports the lead agency, WFP. There has been a particular focus on logistics for food aid coordination, with less emphasis on other forms of assistance. Attempts by donors to coordinate independently of the UN system have been limited. Coordination at the national level formally lies with the UN Development

Programme (UNDP) Resident Representative, with OCHA in support. This respects the structures in place for the coordination of development assistance, and it recognises the need for a long-term approach to addressing the underlying structural problems in the region. However, it assumes and relies on the capacity of individuals who are arguably more attuned to development issues than matters of a humanitarian nature.

Resource allocation

The UN Consolidated Appeals Process (CAP) is the primary mechanism for resource mobilisation in the region. Neither the CAP nor any other system in the region provides a total picture of resource requirements, nor of how resources are allocated. That said, the study team note that OCHA has attempted to trace the humanitarian resources flowing outside of the CAP in Southern Africa. At the time the study was conducted, over $117m had been expended in Southern Africa external to the CAP. This is in comparison to the $349m spent within the framework of the CAP. In other words, around one-third of the total funds were flowing outside of the CAP.

The 2002 CAP for Southern Africa does not reflect a comprehensive process of assessment or analysis of need. The food aid requirements stated in the Appeal largely overshadowed needs in other sectors. In addition, donors are not funding the CA consistently; and the under-representation of health and other sectors in the Appeal is further affected by donor preferences to fund food aid over any other sector.

Future programming

Decisions about future programming in Southern Africa seem to be informed as much by concerns about sustainability as by any analysis of needs. What was strikingly absent, as far as the study team could determine, was any concerted joint planning by those concerned with humanitarian assistance on the one hand, and those concerned with the medium term, such as the provision of social-welfare (safety-net) assistance. This gap reflects the more general institutional division between humanitarian and development planning, a gap which requires urgent attention in Southern Africa if future programming is to be effective.

Chapter 1
Introduction

This case study on Southern Africa forms one element of a broader research project on measuring humanitarian needs. The dominant theme of the study is the question of what constitutes a humanitarian crisis, where it begins and where it ends, and what characterises it. The concern is with the international humanitarian system and its criteria for response, with a focus on the food and health sectors. The purpose is not to analyse the Southern Africa crisis *per se*, or to evaluate the response to it. Rather, the study identifies those features that shed light on broader research questions: how 'humanitarian need' and 'crisis' are conceived; how needs are assessed and prioritised; and the extent to which an objective assessment of needs informs decisions about response and resource allocation.

The focus of the study is on the international system, exploring the link between needs assessment and decisions (by agencies and donors) governing responses and resource allocation, with a specific focus on the food and health sectors. The underlying concern is with global funding disparities: levels of funding do not seem to correlate with levels of need, and the most urgent cases are not consistently prioritised. Yet the humanitarian 'system' lacks a consistent and objective basis for deciding which those cases are, and the means to decide about the allocation of resources between competing priorities.

1.1 Rationale and methodology

This study was designed to allow an exploration in 'real time' of the process of humanitarian needs assessment and decision-making in a slow-onset crisis. It complements other case studies being undertaken as part of the overall study, which ask similar questions in relation to rapid-onset natural disasters and to a variety of conflict-related situations (South Sudan, Somalia, Afghanistan and Serbia).

While the response to the crisis by the national authorities in the countries affected is clearly crucial – and their responsibility central – the subject of analysis here as throughout the overall study is on the practice of the international humanitarian 'system' of agencies and donors. In order to provide a reasonable degree of focus, it was decided to concentrate on two of the most severely affected countries, Malawi and Zimbabwe, and to focus specifically on the food and health sectors. Research was conducted in November and December 2002. A review of primary

and secondary literature is complemented with over 50 interviews with representatives from UN agencies, official donors and specialist staff from international NGOs.

The questions explored here are clustered around three themes: concepts and definitions; needs assessment practice; and the information basis for decision-making. Following a preliminary sketch of conditions in the two countries under review, Chapter 2 deals with the conceptual issues, highlights the lack of agreed definitions and response thresholds and considers whether and how this is problematic. The guiding question here is whether the ways in which 'humanitarian crisis' is conceived and articulated foster appropriate responses. The models of analysis currently in use (including typical relief and development paradigms) are considered, and some ways are suggested of introducing greater conceptual clarity to the analysis of such contexts. Chapter 3 looks at the practice of needs assessment: why it is done; the forms it takes in Southern Africa, the processes and mechanisms involved, and the types of information generated. The concern here is to examine the extent to which the goal of objective needs assessment is served by current assessment practice, and whether this is providing the information necessary for appropriate decision-making. The use of indicators is considered in this context, and a suggested minimum 'package' of data for such contexts is proposed – along with the methodology by which such a package might be assembled. Chapter 4 explores the relationship between information and decision-making in Southern Africa. In particular, it looks at the extent to which formal needs assessments in a slow-onset crisis influenced decision-making, and how far other information, external to needs assessment, informed decisions regarding the allocation and prioritisation of resources. In examining this, the study attempts to understand what sort of information is privileged and trusted in the decision-making process, by whom, and why. The study ends with a summary of conclusions and recommendations for action.

1.2 Recent history and current context in Malawi and Zimbabwe

Southern Africa has experienced significant declines in economic and social development over the past decade, resulting in an increased number of people living below the poverty line.[1] The high degree of economic integration within the region has meant that the downward trend in production and economic opportunities and changing policy prescriptions of the stronger nations, in particular Zimbabwe, have had knock-on effects throughout. Ultimately, climatic changes, cumulative declines in GDP, international economic and aid policies, poor governance, the debilitating impacts of entrenched, structural poverty and HIV/AIDS have combined to increase vulnerability in the region in terms of food security and access to basic social services.

The situation affecting Southern Africa, and six countries in particular, has since the early months of 2002 been construed as a regional crisis, though in fact the extent and nature of the crisis varies considerably from country to country.[2] Food insecurity is the most obvious unifying feature, and it is here that the humanitarian response is predominantly focused. At the time this study was conducted (November 2002), countries in the region were preparing to enter the lean period running up to the harvest in March 2003. Although nutrition levels as measured by a series of surveys seemed relatively normal, there were high levels of food insecurity as measured against a range of indicators, and there were said to have been famine deaths in Malawi in the early months of 2002. Given the analysis of food availability and food access, it was widely believed that, without continued food aid, famine was a real possibility, at least in the two countries the team visited, Malawi and Zimbabwe.

1.2.1 Malawi

Malawi is a landlocked country, with a predominantly rural population of approximately 11.4m people. Poverty is chronic, with more than 65% of the population living below the poverty line. In 2000, Malawi fell into the bottom 7% of countries on UNDP's Human Poverty and Human Development indices. Malawi depends on international assistance from its development partners. Total development expenditure was expected to be approximately $0.14 billion in 2002. As a Highly Indebted Poor Country (HIPC), it also qualifies for debt relief. Malawi's economy is primarily agricultural, accounting for 85% of the national labour force and the great majority of exports (tobacco alone accounts for some 60%). The majority of rural households comprise small-holder farmers largely reliant for consumption on a single harvest of maize.[3] Major cash crops include tobacco and groundnuts, pulses, cotton and vegetables. In the 1990s, Malawi experienced 3–4% annual economic growth in response to agricultural growth levels of 5–7%. Despite this growth, approximately 40% of the population do not achieve self-sufficiency from their own production in 'normal' years, and depend upon seasonal agricultural labour or share-cropping. There are also seasonal variations in food security with a 'hungry period' between January and March/April.

After independence from the UK in 1964, the Malawian government provided a range of subsidies to small-holder maize producers. It also attempted to control maize movement and prices by means of a parastatal grain agency, the Agriculture Development and Marketing Corporation (ADMARC). ADMARC sold grain at controlled prices, in particular during the hungry season before the next harvest.[4] This was a major factor in Malawi's food security.

Political changes and the structural-adjustment policies supported by donors in the late 1980s aimed to replace the subsidies governing the agricultural market and introduce a greater private-sector element.[5] However, the commercial operators that were supposed to fill this gap were discouraged from investing by the state's continued, albeit diminished, involvement in the market. Structural reform also resulted in heavy cuts to the social sector – in particular health programmes – which were not adequately sustained in the shift towards community-based programmes.

According to UNAIDS/WHO statistics, at the end of 2001 850,000 people in Malawi were living with HIV/AIDS, of whom 7.5% were children. Adults with HIV/AIDS are estimated to comprise 16.4% of the population between the ages of 15 and 49.[6] There were an estimated 80,000 HIV/AIDS-related deaths in 2001, and an estimated 500,000 children have lost one or both parents to HIV/AIDS.

Against this backdrop, a number of immediate factors contributed to Malawi's maize shortages. Excess rains caused extensive flooding and water-logging, damaging consecutive harvests in 2000 and 2001.[7] In addition, the bulk of the government's Strategic Grain Reserve was exported in late 2000 and early 2001 in order to pay back credit owing to commercial institutions. The government delayed importing grain and, as a result, only half of the 150,000 tonnes of maize required had arrived by the end of May 2002. Combined, these factors led to critical shortages of food in markets and record maize prices, surpassing the average family's daily purchasing power by over three times.

1.2.2 Zimbabwe

The background to the humanitarian situation in Zimbabwe is more complex than in any other country in the region. Zimbabwe faces similar challenges to Malawi, such as chronic poverty, a history of difficult structural adjustment and a severe HIV/AIDS pandemic. However, the situation in Zimbabwe has been exacerbated by an extended period of instability and political uncertainty.

Landlocked Zimbabwe has an estimated population of 13.7m people, about a third of whom are urban. Poverty is chronic. The economy has contracted by 35% since the late 1990s; inflation was predicted to top 500% in 2003, and unemployment was widespread.[8] Parallel markets have flourished as the price and availability of basic commodities have risen beyond the ability of ordinary households to pay.

The decline in Zimbabwe's economy has primarily been driven by macroeconomic policies, such as price and foreign-exchange controls and rapid agrarian reform, in particular a fast-track resettlement programme. The contraction in the economy has been further exacerbated by the closure of factories and business due to dwindling investor confidence. While the reform process did not overly affect maize production by smallholders, the commercial production of maize and other cereals has been reduced by approximately 70%, or 500,000 tonnes. Meanwhile, concerns about poor governance and the human rights situation have prompted donors to suspend most bilateral development assistance.

As in Malawi, these long-term causes of food insecurity combined with more immediate factors, as drought in two consecutive seasons, and reduced planting of most cereals, resulted in a sharply-reduced cereal harvest in 2002.[9] Meanwhile, health service provision has come under increasing pressure. A lack of foreign exchange means that there are severe shortages of essential medicines in some 73% of peripheral health centres, while national stocks of drugs and vaccines are critically low. Over 30% of 15–49-year-olds have HIV/AIDS, and there are 600,000 AIDS orphans.

Chapter 2
Conceptual issues

This chapter deals with the conceptual questions around defining humanitarian crises. It highlights the lack of agreed definitions and response thresholds, and considers whether and how this is problematic. The guiding question is whether the ways in which humanitarian crisis is conceived and articulated foster appropriate responses. A number of specific questions are addressed:

- What constitutes a humanitarian crisis? When does it begin and when does it end? What characterises the current situation in Southern Africa? What kind of crisis is it?
- What distinguishes a food crisis from chronic food insecurity? What constitutes a famine? Is there famine in Southern Africa?
- What is the humanitarian agenda in this situation, and how does it relate to development?
- What conceptual models are used to analyse the humanitarian context and its relationship to political, socio-economic and other structural factors?
- How are the concepts of need, vulnerability and risk used in this context? To what extent is a 'deficit' model implied by the use of these terms? To what extent are needs defined in terms of required inputs?

2.1 Definitions and categories

2.1.1 Defining 'crisis'

There is no single, agreed definition within the humanitarian community of 'humanitarian crisis' and 'emergency'. While many organisations have their own, none provides a basis for deciding what level of threat to life (let alone the more nebulous concept of 'well-being') would constitute such a crisis; nor do they suggest a means of measuring this.

The situation in Malawi and Zimbabwe was variously described to the research team as: a humanitarian crisis; an HIV/AIDS crisis; a long-term crisis; a livelihood crisis; a developmental crisis; a governance crisis; a manufactured crisis; and a food security crisis. Clearly, these descriptions are not mutually exclusive, and could describe different facets of the same situation seen from different perspectives. It is arguable that some of these descriptions, for example

'long-term crisis', are contradictions in terms. Some are more symptomatic descriptions, others relate more to causes.

Which aspects of 'the crisis' are emphasised depends on the perspective of the observer – and usually on the perspective of the organisation. At the outset, there was general consensus that the situation in Southern Africa was primarily a food crisis, caused by external climatic factors coming on top of economic and governance problems. Thus, in November 2001 the newsletter of the Famine Early Warnings Systems Network (FEWSNET) claimed that 'The current food deficit is the result of two consecutive poor production seasons due to drought, flooding and disruption in the commercial farming sector'.[10] More recently, analysis has tended to emphasise the structural and underlying factors, in particular HIV/AIDS. According to the Consolidated Appeal Process (CAP) mid-term review in 2003, for example, 'There is a growing belief that the emergency in Southern Africa is driven by the HIV/AIDS pandemic and that the food crisis is the immediate and most visible manifestation of this more deep-rooted problem'.[11]

This shift in understanding has implications for the response. The original emphasis on external factors suggests that the problem is relatively straightforward, and can be relatively quickly and simply remedied. For example, the humanitarian crisis sparked by the 1991–92 drought ended as a 'natural termination' when the harvest came in March 1993.[12] In contrast, an emphasis on internal structural problems implies the need for a sustained, long-term approach to tackling the underlying factors which cause the 'symptom' of food insecurity. This approach is reflected in the thinking of some agencies and donors, including USAID, which was planning different uses of food aid. Interventions might include Food For Work to compensate for lack of 'ganyu', linked with community-based nutrition surveillance and supplementary feeding.[13]

The characterisation of a crisis primarily in terms of supervening climatic factors can be a convenient fiction, one that allows both host government and the international aid community to avoid direct reference to more intractable and politically sensitive issues. There are many examples in history of man-made disasters, the result of failed or abusive policies, which have been portrayed as natural calamities. North Korea comes to mind as a recent example, where a food crisis was attributed predominantly to natural causes (in this case flooding), a face-saving explanation that allowed the government to request international assistance. There is good reason to believe that, in Zimbabwe, the welfare of a large proportion of the population has been subordinated to the pursuit of the government's political interests. Any adequate causal explanation of the crisis must take account of this political element.

It is important to ask why the HIV/AIDS situation itself is not classified as a humanitarian crisis. Certainly in terms of excess mortality and morbidity it dwarfs the impact of the food crisis, though it is related to it both as cause and effect. At the household level, increased levels of dependency and the impact on productivity can both be said to be important causal elements of the crisis of food access. But what of the direct symptoms of AIDS? The lack of obvious 'remedies' might be the determining factor here – though if the humanitarian agenda is conceived in terms of reducing suffering, the HIV/AIDS crisis surely merits greater attention in its own right.[14] The provision of food aid, while potentially crucial to the welfare of those with HIV/AIDS and their families, cannot in itself be said to constitute an adequate humanitarian response. At the same time, the scale and nature of the problems concerned are such as to demand interventions across a range of sectors – public health, social welfare – that go beyond the capacity and resources of the humanitarian system, and beyond the humanitarian agenda as it is understood in the present study.

The study team sought to determine whether any more precise and quantifiable measures might be used to help define this particular 'humanitarian crisis'. Two factors in particular are necessary: an agreed scale of measurement, and an ability to measure situations against that scale in a consistent way. A definitional approach based on such measurement involves defining significant points ('benchmarks') on that scale, indicating levels of severity. A few definitional benchmarks – for example, based on crude mortality rates (CMRs) – offer the prospect of a more precise categorisation (see Annex 2). The benchmarks set may be arbitrary, but are nevertheless useful as a common basis for describing severity. However, the indicators involved are typically hard to measure accurately over a wide area. Moreover, they tend to provide a historical picture – they are not necessarily useful predictors unless trends can be established and the data extrapolated, taking account of relevant variables. The use of such indicators and benchmarks as triggers for response is therefore problematic: a CMR measured at 2/10,000/day represents a situation that is already out of control, and demands intervention. Unless there is a way of establishing trends in CMR through frequent monitoring, action to prevent catastrophic declines must logically be triggered by other indicators.[15] Moreover, given the inherent humanitarian concern with factors like well-being and dignity, the concept of 'humanitarian crisis' or 'humanitarian need' cannot be reduced to quantitative definitions. While quantitative thresholds may not constitute the only grounds for humanitarian action, they may provide an agreed basis (and sufficient grounds) for such action – and indicate where such action is imperative to safeguard life.

2.1.2 Defining humanitarian need

'Humanitarian need' is in one sense a construct derived from the perceptions, assumptions and values of those making the assessment. No universal shared definition exists, and the responses of donors and agencies alike reflects a wide diversity of interpretation. The practice of assessment is equally variable. The unit of analysis may be populations, communities, social groups, families or individuals. The validity of the picture that is built up depends in part on the validity of the assessment techniques employed, the way in which they are employed, and the skill and objectivity with which results are analysed and interpreted in the light of other available information.

Typically, a 'deficit' model is used to describe need: the affected population is said to lack some essential commodity and/or service, or to lack the conditions necessary for their well-being or survival. In some cases, this approach seems natural and appropriate; where, for example, a community has lost its assets in a flood, and where the deficit is obvious, for example lack of shelter. In other cases, it makes less sense; if, for instance, the baseline is so low that measuring 'deficits' becomes meaningless, or if the need – for protection, for example – is unquantifiable in these terms.

In such cases, concepts of threat, risk and vulnerability seem appropriate in addition to the deficit model. Even in situations where a deficit model might seem appropriate it can be misleading. Thus, in Southern Africa the response is geared towards providing food aid to make up for a food deficit. This is not to say that food aid *per se* is inappropriate – indeed, it may be essential. But analysing situations such as this simply as 'food deficits', to which the appropriate response is to provide food aid, ignores the factors that determine access to food, and obscures other critical 'deficits' like access to health services. Even though the case for food aid may be strong, its impact (including market effects) cannot be understood if other factors are not incorporated into the analysis.

2.1.3 Defining food crisis and famine

There is a broadly-accepted definition of food security: 'Food security exists when all people, at all times, have physical and economic access to sufficient, safe and nutritious food for a healthy and active life'.[16] There is less clarity about when situations of food *insecurity* become food *crises* or famines. Thus, the situation in Malawi in early 2002 has been described as 'the worst famine in living memory'.[17] By contrast, interviewees for this study judged the word famine to be too extreme to describe the regional situation; according to a senior WFP representative, 'There

hasn't been a famine, and there isn't one now'. The existence of high malnutrition rates and accompanying mortality rates, as a result of chronic food insecurity and poor health, is not always described as a famine. The word famine is not used to describe malnutrition rates above 15% in the drought-prone Red Sea State of Sudan, or in the south,[18] or rates above 20% in Mandera, Kenya.[19] Cases where there is agreement that a famine has occurred have usually been characterised by extreme increases in excess mortality. The famine in Bahr el Ghazal, Sudan, in 1998 resulted in about 70,000 excess deaths. Conversely, many of the largest emergency food aid programmes have been in areas with low malnutrition and related mortality rates: in Bosnia in 1992–95, Kosovo in 1999 and Afghanistan in 2001–2002, for instance. Elsewhere, clear signs of impending famine, as in South Sudan in 1998, have been ignored and food aid has come too late to save lives.

Box: The 1991/92 humanitarian crisis in Malawi

There are a number of similarities between the 1991–92 crisis and the present crisis. Both were apparently precipitated by drought exacerbating existing difficulties, including chronic poverty and poor governance. The scale of the 1991–92 crisis appears at first glance to be greater. Crop production was affected far more severely, and a total of 4.7m people were estimated to be in need of food aid in 1992,[20] compared to only 3.2m in July 2002.[21] Despite this, and despite the fact that the food aid response was limited to less than a year, widespread food shortages, starvation and migration were prevented during 1991–92. In contrast, predictions for the current crisis are much gloomier, with talk of impending famine and the erosion of coping strategies to the point of destitution. One of the major differences between the two crises is the impact of HIV/AIDS. Whereas 20 years ago poor, rural small-holders may have been able to recover from a particularly bad year with the help of food aid, a population plagued by HIV/AIDS cannot recover.[22] This emphasises the increased need for non-food aid in the present crisis, and the importance of linking emergency and development programmes in order to combat the underlying problems. It also has implications for needs assessments. Where these have a narrow focus, the response is going to be limited – in this case largely to food aid. This may have been enough in 1991–92, but is unlikely to 'solve' the present crisis.

Although far more resources have been invested in emergency food security assessments in the present crisis than 20 years ago, the response has been similar, with a mono-sectoral focus on food aid. Ninety-two per cent of the 1991–92 UN/SADC appeal was for food, compared to 94% in the July 2002 CAP appeal for Malawi. While the VAC can potentially provide in-depth data about household livelihoods, vulnerabilities and coping strategies, this information has had a limited influence on the response.

The term ‘famine’ implies a particularly severe level of suffering affecting large numbers as an outcome of extreme food insecurity. It carries an emotive power that is often used to elicit a response. In Malawi, for example, the suggestion that famine was about to occur provided a major impetus for the initial humanitarian response. The threat of famine is not always distinguished from the reality, nor is famine always distinguished from the outcomes associated with lower degrees of food insecurity. Elements of this confusion were found in the southern Africa context. The lack of agreed symptomatic definitions in this area represents a significant obstacle to achieving common understanding.

A number of different ways have been proposed to classify situations of food insecurity, and new classifications are being developed.[23] This study proposes a simple classification, outlined in Table 1. The overall purpose would be to provide a universal classification which allows comparisons to be made between different contexts. The specific objectives would include:

- to increase the accountability of national governments, donors and humanitarian agencies;
- to increase understanding and reduce the misuse of emotive terms;
- to improve response; and
- to improve the quality and usefulness of needs assessments by clarifying the types of information which will aid decision-making.

The proposed classification highlights the basic features associated with different types of food insecurity, including changes in behaviour and in mortality and health indicators. It identifies four types which cover both chronic and acute situations: chronic or periodic food insecurity; acute food crisis; long-term food crisis; and famine. This is put forward not as a definitive typology, but as an illustration of the type of distinction on which it would be useful to reach consensus at the operational level. Each category could usefully be broken down further. The associated thresholds for crude mortality and malnutrition are to some extent arbitrary, but are consistent with general usage in the humanitarian sphere. Clearly they are not stand-alone indicators, but have to be analysed in conjunction with food security indicators. These indicators are neither exhaustive nor appropriate for all situations. Rather, they provide some indications of the process of deterioration. This classification is based solely on typical symptoms and associated responses, bringing together typical food insecurity and health symptoms. It makes no attempt to categorise by causal features: the point is simply to try to achieve greater consistency of description. Nor does it deal with questions of scale or timeframe, though the assumption

here is that (as with any humanitarian crisis), the notion of extensiveness – temporal, geographic, demographic – is inherent. It is important to recognise that the characterisation of a situation as a food crisis does not mean that it could not, with equal validity, be seen as, for example, a health crisis; or that food aid is the only indicated response. Recent advances in famine theory suggest that such an approach is inadequate; and that famine must be seen as a process with various stages, which must be properly understood if appropriate and timely interventions are to be made.

Box: Theories of famine

Until the 1980s, conceptions of famine – both its causes and symptoms – were for the most part variants of the model proposed by Thomas Malthus in the late eighteenth century: famine was characterised by starvation deaths, triggered when the productive capacity of the land was inadequate to support the existing population. Famine, on this view, was a largely natural phenomenon resulting from a combination of inadequate food supply, bad weather, inappropriate agricultural practices, and population growth. Still today, despite considerable advances in famine theory, 'the idea of drought-induced production failures and/or overpopulation continue to exert strong influence over institutional understanding of famines' (Lautze et al., 2003).

This view of famine as resulting from food-supply shocks precipitated by natural disasters was challenged by Amartya Sen in his work *Poverty and Famine* (1981). For Sen, 'starvation is the characteristic of some people not having enough to eat. It is not the characteristic of there not being enough to eat' (ibid). Sen's theory highlights the inability of particular groups to access foods, regardless the overall availability of food. Famines are not always triggered by a decline in food availability; they are likely to occur when individuals are not able to afford whatever food is available. Sen's approach has been criticised for neglecting the political dimension of famine. In his later work with Drèze, *Hunger and Public Action* (1989) Sen emphasises the role of the state, arguing that the likelihood of famine is greatly increased in states lacking democratic forms of government or a free press. The 'democracy prevents famine' hypothesis has been contested by several authors (Devreux, 2000, 2001; Keen 1994; de Waal, 2000).

Alex de Waal in his book *Famine that Kills* (1989) demonstrated, through his work in Sudan in the 1980's, that in most famines, deaths are due to disease rather than outright starvation. Famine should be understood to mean the disruption of a way of life, involving hunger and destitution (including loss of assets) and sometimes but not always involving death: there are 'famines' and 'famines that kill' (ibid.). De Waal showed how households elect to forego food consumption in order to protect essential assets in times of stress, thus challenging the assumption that distressed household's first priority is always to obtain food. De Waal's analysis suggests that

emergency relief priorities in situations of famine should include not only food aid, but water, sanitation and health care.

Based on these new theoretical models, epidemiologists and nutritionists have further analyzed the complex relationship between nutritional status, health, food security and the risk of famine deaths. These models see famine as a *process*, and distinguish different phases of famine, including changes in adaptive behaviour (coping and survival strategies). In the earlier phase, increasing prevalence of acute malnutrition may be an indicator of declining food insecurity, without massively increased risk of mortality. If the situation fails to improve, or worsens, households may suffer a complete entitlement collapse, leading to destitution, distress migration and associated health crises. In the late stages where both exposure and susceptibility to disease is increased, the risks of dying associated with malnutrition are much higher. So the same prevalence of malnutrition carries very different risks depending on the background morbidity patterns resulting from the health environment.

Earlier models tended to neglect the political aspects of famine. In the 1990's, there was a growing understanding of the political dimension of famines, especially in complex political emergencies (Keen, 1994; Duffield, 1994; de Waal, 2000). David Keen in *The Benefits of Famine* (1994) has highlighted that famine may confer economic benefits on some parties. In other words, famine may have (non-Malthusian) functions as well as causes, and can be used as a weapon of war or politics, through the diversion or denial of food aid, or biased distribution favouring particular groups. The current situation in Zimbabwe demonstrates that such practice is not limited to armed conflicts.

Table 1: A classification of food insecurity

Level	Mortality and Malnutrition Indicators	Food Security Indicators	Responses
1. **Chronic (or periodic) food insecurity** Access to food limited, often seasonally, and diet inadequate for good health. High prevalence of chronic malnutrition (stunting) and likely to be some seasonal increase in mortality, morbidity and acute malnutrition (wasting).	CMR 0.2 - 1/10,000/day Wasting 2.3 - 10% Stunting › 40%	*Production:* Poor yields leading to pre-harvest 'hungry season'; Low prices for cash crops etc. *Income and employment:* High unemployment and low wages leading to poverty. Dependence on casual labour and the informal economy etc. *Markets:* Price instability of staple foods and other key commodities; Shortages of key commodities and foods (often seasonal); Lack of market integration. *Assets:* Low asset base; High reciprocity (e.g. dependence on loans, kinship/family ties, seasonal labour). *Coping strategies:* **Adaptive** or **insurance** strategies periodically employed (e.g. changes in cropping patterns; sale of non-productive assets; borrowing small loans; seasonal labour migration; collection of wild foods etc.)	*Typical indicated responses:* **Longer-term strategies** Support to livelihoods, food security, existing public health system; Social safety nets. *Information systems required*: Early warning systems; Health and nutrition surveillance.
2. **Acute food crisis** A crisis of food access precipitated by a shock but may be compounded by longer-term vulnerabilities (e.g. poverty, HIV/AIDS etc.). National capacity (and willingness) to respond exceeded (e.g. lack of strategic food reserves). CMR and wasting levels remain normal initially but rise as crisis persists.	CMR 0.2 - 2/10,000/day Wasting 2.3 - 15% **or** increases in wasting rates (e.g. doubling over a few months)	*Production:* Precipitating events such as drought or war lead to loss of crops and/or livestock; Dramatic decline in overall food availability. *Income and employment:* Loss of jobs; Fall in wages; Increased dependence on the informal economy. *Markets:* Dramatic rises in price of food and other basic items. *Coping strategies:* Normal coping mechanisms start to break down under stress. Increase in unsustainable **crisis** strategies (e.g. changes in consumption patterns; disposal of key productive assets.)	*Typical indicated response*: **Emergency responses and 'stepping up' of longer-term strategies** Targeted general ration; Possibly targeted supplementary and therapeutic feeding; Increased health care provision; Targeted agricultural production inputs; Livelihood and food security support. *Information systems required*: Early warning systems (food availability and prices); Health and nutrition surveillance; Multi-sectoral assessments (including household food security, livelihoods, health and nutrition status, access to water and sanitation); Mortality and nutrition surveys.
3. **Long-term food crisis** A long-term crisis of food access often associated with	CMR 1 - 2/10,000/day	*Production:* Low crop and livestock production over long time period	*Typical indicated response*: **Longer-term strategies together with some emergency**

poverty, lack of investment, erosion of livelihoods and political marginalisation. Wasting levels remain chronically high and fluctuate depending on season and level of humanitarian aid (if provided).	Wasting 15 – 30%	*Income and employment:* Poverty and destitution high; High unemployment; Low wages; High dependence on welfare and low return activities (e.g. petty trading). *Markets:* Prices of food and other basic items unaffordable for the poor. *Coping strategies:* Unsustainable **crisis** strategies relied upon during specific seasons.	**responses** Strengthening civil organisations (especially of marginalized groups); Sustainable livelihood support; Targeted general ration; Supplementary and therapeutic feeding. *Information systems required*: Health and nutrition surveillance; Multi-sectoral assessments (including household food security, livelihoods, health and nutrition status, access to water and sanitation); Mortality and nutrition surveys.
4. **Famine** A food crisis that results in major excess mortality and very high levels of severe acute malnutrition (both children & adults).	CMR › 2/10,000/day Wasting › 25 % Or dramatic increases in wasting rates (e.g. trebling over a few months)	Characterised by catastrophic lack of access to food including market collapse; mass destitution; social breakdown; breakdown of formal and informal social systems *Coping strategies*: Coping and crisis strategies exhausted or extreme **survival** strategies (e.g. distress migration, high risk activities).	*Typical indicated response:* **Major and immediate emergency response** Blanket general ration distribution; Extensive supplementary and therapeutic feeding; Health service support. *Information systems required:* Health and nutrition surveillance; Repeated multi-sectoral assessments; Repeated mortality and nutrition surveys.

CMR = Crude Mortality Rate
Wasting. = Acute malnutrition in children ‹ 5 years based on weight for height ‹ 2 Z score or 80%.

2.2 Conceptual models and frameworks of analysis

The study team found that a number of different conceptual models were in use in Southern Africa. Some were explicit (Save the Children's Household Economy Approach, for example), but most were not so clearly articulated. Most of the conceptual models in use were constructed around food security, combining macro-economic and other elements with factors relating to household food access. Nutrition elements were partially incorporated, though with different weight as to their significance and associations; for example, the implications of low measured prevalence of acute malnutrition are described in various ways. Health factors seemed to feature little. The prevalence of HIV/AIDS figured more as a factor affecting production, and as a general cause of vulnerability, than as an issue in its own right.

Conceptual models can serve an explanatory and a predictive purpose: they can help to explain observed phenomena, predict likely changes and assess the likely impact of a given intervention. There is reason to think that the models on which much of the prevailing analysis of the Southern Africa crisis is based are inadequate either to explain, or predict. These limitations were particularly notable when examining the nature of the crisis with regard to health; in this situation a simple 'food crisis' model is evidently inadequate.

If a number of factors combine to cause a particular outcome, then interventions are likely to have to tackle a number of those factors simultaneously in order to be effective. Intervention in any one sphere must take account of other relevant factors, or risk having only marginal effects. The study team concluded that the lack of clearly articulated and shared models, adequate to the task of cross-sectoral analysis in this context, has hampered effective communication and collaboration in designing appropriate response strategies. New models attempt to address some of these gaps.[24]

2.3 Relief and development

One of the recurrent themes of this research has been the problem of reconciling relief and development discourses, so as to formulate responses that accounted for the intractable and extended nature of the crisis. Some of these problems arose from management and funding divisions within and between organisations, which treat humanitarian and development programmes as distinct categories. While this may recognise the peculiar demands of emergency response, where speed and flexibility are at a premium, it also tends to introduce conceptual and practical schisms, where an understanding of the medium and longer-term factors at work is essential to constructing appropriate responses. As one international NGO

worker noted, 'the system does not require me to work with my development colleagues'.[25] Likewise, it appeared the reverse was true in that development workers had limited incentives for responding to situations perceived as the responsibility of their humanitarian partners.

These divisions have a direct bearing on how a situation is interpreted and needs are assessed. For an agency or donor operating in 'emergency' mode which has short-term symptomatic relief to offer (such as food aid), it is perhaps inevitable that the assessment will be of symptoms rather than causes. If the situation were a time-limited deviation from an acceptable norm – caused by freak flooding, for example –such an approach might be adequate. However, none of those interviewed by the study team described the situation in Southern Africa in these terms, and most were at pains to emphasise the long-term and structural nature of the problems involved. Yet few were able to outline solutions that went beyond the normal six- to nine-month 'risk horizon' for humanitarian response. Although many of these same organisations have country or regional strategic plans that extend three years into the future, there was little evidence of analysis or scenario planning further than a year ahead. At the same time, both donors and agencies were markedly reluctant to contemplate continuing current relief strategies over such extended time frames.

Clearly, agencies cannot predict in detail inherently uncertain futures. At the same time, current response plans in Southern Africa are not adequately informed by knowledge of those long-term factors and trends that are in effect givens for the future, such as the continued spread of HIV/AIDS and its demographic, health, social and economic impacts and the decline of the region's rural economies. The study team found that the identified needs in health and nutrition were largely interpreted as developmental responsibilities – including strengthening health services, and a range of interventions to reduce the HIV/AIDS burden. At the same time, the development community appeared to place boundaries around the types of assistance it would provide, with a particular emphasis on the sustainability and cost-effectiveness of services, rather than a sustained capacity to treat the longer-term needs of the crisis, such as the provision of anti-retroviral drugs.

2.4 Needs or rights?

Rights featured remarkably little in the discussions held by the study team. Given the emphasis many agencies and donors place on rights, specifically human rights, as a governing principle of their work, this is particularly striking. Some of those interviewed hinted at reasons why this might be so. A DFID representative in Malawi noted that 'among the rural community, the

idea that they might have a right to demand services is completely foreign' – a reflection of a local political history that is mirrored in other parts of the region. Mechanisms such as democratic institutions and a free press assume a political environment that cannot be taken for granted in the region.[26] At the level of international responsibility, rights-based arguments have also not featured significantly, and ideas about rights appeared to have little policy or programming impact.[27] Where arguments based on rights and related responsibilities have been most used (in Zimbabwe), they have focused on discrimination and the abuse of these rights. Issues of social and distributive justice have been less prominent. At a more practical level, the Sphere standards were referred to very little in discussions about assessments and decision-making, and the rights rationale underlying Sphere was not invoked at all by interviewees.

Recommendations

1. Further develop a classification of food insecurity, food crisis and famine that combines process indicators (food security and coping strategies) with outcome indicators (mortality and malnutrition). A process to achieve this is in currently under discussion, and will be advanced in consultation with WFP.

2. Seek consensus on the proposed classification among international humanitarian agencies and donors. A consultation process to achieve this should be established, with the aim of producing a consensus statement within an agreed timeframe.

3. In parallel with the above, initiate a discussion process on the appropriate analytical models for the situation currently faced in Southern Africa, taking full account of the HIV/AIDS pandemic, with a view to informing strategies that can bridge the relief–development divide. Specifically, identify strategies that effectively combine social welfare ('safety net') approaches with food aid and other relief strategies in the short and medium term.

Chapter 3
The practice of needs assessment

This chapter is concerned with the formal process of needs assessment, typically involving sector specialists following defined methodologies, rather than the more general forms of assessment used in decision-making. Formal assessments involve the use of recognised methodologies to obtain data and undertake an analysis on which to base a calculation of need. There are various elements to this process: fact-finding/data collection; analysis of data to reveal patterns and trends; and the attempt to establish causes for observed phenomena, and predict likely outcomes.

This chapter explores a number of questions in relation to the practice of needs assessment in the South African crisis response:

- What is the rationale for needs assessment? How are the concepts of need, risk, vulnerability and capacity understood and assessed in practice? What determines the desired minimal levels of access to commodities and services? On what basis are inputs targeted?
- What is the process by which needs are formally assessed by individual organisations and collectively? What mechanisms are involved?
- To what extent have assessment and surveillance efforts been coordinated? What is the balance between individual and collective agency assessments? What are the respective benefits of each approach? To what extent have assessments been multi-sectoral? What efforts have been made to find unifying methodologies across sectors? To what extent have results been aggregated? How complete a picture do they provide?
- What is the balance between the use of 'snapshot' assessments and the use of surveillance or monitoring? Is this the right balance for this situation?
- What needs assessment methodologies are practised? What are the strengths and limitations of each? How consistent are they?
- What kinds of information do these formal assessments and surveillance mechanisms generate? Is this information descriptive, quantitative, qualitative or analytical?
- What indicators are used in formal assessment and surveillance practice? Which indicators are essential, and which desirable?

- What is the minimum 'package' of data and analysis that should be expected to inform decisions in contexts like the Southern Africa crisis? What assessment processes would be needed to generate this package?

3.1 Needs assessment rationale

The common reason for conducting a humanitarian needs assessment is to inform an organisational decision about what to do in a given situation. This implies recognition that there is a decision to be taken. But how does an organisation come to that conclusion, especially where, as in Southern Africa, the situation is a slow-onset or chronic one? Who decides to mount a formal assessment, and at what point? How is it decided who is on the assessment team, and who sets its terms of reference? The nature of the eventual decision, the organisation that is making it and the range of likely options for response, all have a direct bearing on the type of assessment conducted and on the assumptions on which the analysis is based. This is rarely explicit, but anyone trying to determine the significance and validity of the results of a given assessment has to bear these factors in mind.

Needs assessments inform decision-making in four main areas:

- whether to intervene;
- the nature and scale of the intervention;
- the prioritisation and allocation of resources; and
- programme design and planning.

While the primary purpose of a formal assessment may be to inform an organisation's decisions about its response, assessments may also force a decision by others, influence the nature of others' decisions, or justify decisions already taken. By far the most evident rationale for needs assessment in Southern Africa was to inform lower-level decisions about resource allocation at the district level. The Vulnerability Assessment Committee (VAC) process in particular seemed to be designed with this aim in mind. The decision to assess, in slow-onset emergencies such as in Southern Africa, appeared at times to be haphazard – one of the first assessments that identified a potential food crisis in Malawi, for example, was undertaken as part of a training programme for Save the Children staff. In other circumstances, it was evident that assessments were driven by the resource-allocation process. To this extent, decisions to intervene were made concurrently with decisions to launch an assessment, and seemed to have been decided on the basis of limited 'formal' data.

3.2 The subject of analysis: needs, capacities, risks and vulnerabilities

As a minimum, assessments typically include an analysis of capacity (individual, family, community, government) as a basis for judging what level and type of support is required. Capacity in this sense can be described as 'the resources of individuals, households, communities, institutions and nations to resist the impact of a hazard', including coping strategies.[28] It can also involve an understanding of the services people have access to, and the standards of service provision.

Commonly, an assessment will also make an analysis of the need for certain forms of intervention. This implies a scale against which needs can be measured. The idea of 'measuring' needs involves two elements: the application of relevant norms (usually a minimum requirement or a pre-existing 'normal' situation); and an assessment of how the reality differs. In this sense, needs assessment may be concerned with identifying and measuring deficits – actual or predicted. The extent of variation from the norm (the deficit or need) will depend in part on what norms are applied, and in part on the degree to which people are able to satisfy their requirements without external assistance.

Analysis of vulnerability is also a factor. Vulnerability might be understood as potential future need, but it can also be understood in relation to risk. Vulnerability refers to the degree of exposure to factors that threaten well-being and the extent to which individuals, households and other social groups can cope with these factors. Vulnerability thus has two sides: an external side (exposure to shocks and stresses) and an internal side (ability to cope). The concept of vulnerability can be applied to a wide range of issues under the general heading of 'well-being'.

In Southern Africa, the study team found that in relation to the food sector, some assessments focused on current and predicted food needs, for example the FAO/WFP crop and food supply assessments. Other assessments focussed more broadly on food security which not only measured needs in terms of deficits, but also incorporated a broader analysis of vulnerability and risks, for example the Food Economy Assessments carried out in Malawi and Zimbabwe by SC-UK.[29]

For the VAC, in the context of household food security, vulnerability refers to the degree of exposure to factors that threaten household food security and the extent to which people can cope with these factors.[30] The VAC was set up with a mandate to 'promote coordinated

development in the field of vulnerability and livelihoods assessment in the SADC region'. Before the onset of the crisis, the VAC was in the process of developing a regional vulnerability/livelihoods database with an associated analytical framework, including long-term plans to support the Southern Africa Development Community (SADC) countries in undertaking comprehensive national-level livelihood baseline studies, using a household food economy analysis framework. The VAC's original conceptual framework, drafted in 2001, was designed as a mechanism for promoting vulnerability and livelihood assessment.[31] However, once the crisis began this broader analysis of vulnerability was superseded by a focus on food aid alone. Although some in-depth information on coping strategies was collected, most of this data remained unanalysed.[32] [33]

In the health sector, an analysis of risks and/or vulnerabilities to health adds an extra dimension to an analysis of needs and capacities. It is harder to understand this sector in terms of deficits below a certain norm, although the availability (or lack thereof) of health care facilities and access to them, or a lack of drugs, may be described in these terms. Assessment-wise, it is common practice to identify the main causes of morbidity and mortality, and to analyse what causes or influences these. In Southern Africa, for example, food insecurity would lead to malnutrition, which by itself can be seen as a status of ill health and a direct cause for mortality, but also as a factor that makes people more susceptible to other diseases, for example diarrhoea, measles, or malaria. The quality of health services is more difficult to describe in relation to a norm. Should the norm be the quality and coverage of services as existed before? In the case of Malawi, access to services was less than 50%, and the health system was unable to cope with the increasing burden of disease due to the HIV/AIDS epidemic.

A life-threatening communicable disease is as much a threat to survival as a shortage of food. In this sense, the need for adequate treatment of such a disease is clear. When the disease burden is increased above normal levels, the need for additional humanitarian services and the need to provide access to such services on a different basis (ie non-charging) seems straightforward. In a slow-onset situation such as the situation in Southern Africa, where there is a close relationship between food insecurity, HIV/AIDS and reduced life expectancy, there is a significantly increased burden of disease over what is considered the norm. However, assessments focused on determining health status, together with risks to health; the interpretation of these assessments and their development into programmed responses did not address access to health services or measures to control HIV/AIDS.[34]

A diagrammatic approach to understanding the concept of deficit in the health sector is attached in Annex 1. The significant point that this diagram attempts to highlight is that it is impossible to address 'excess morbidity' without addressing the already existing and increasing deficit in coverage/access to health care services.

3.3 Assessment processes and mechanisms

A variety of processes and mechanisms informed the assessments in Southern Africa: there were multi-agency and single-agency assessments; multi-sectoral and mono-sectoral approaches; and one-off assessments and longer-term surveillance mechanisms.

3.3.1 Multi-agency versus single-agency assessments

The clearest example of a multi-agency assessment was the VAC Emergency Food Security Assessments. As far as the study team is aware, these are a unique example of collaboration in that a number of agencies (UN, IFRC, international and national NGOs) plus national governments came together to coordinate a series of assessments across a whole region. There was general agreement that the multi-agency approach was of collective benefit[35] – allowing for broad geographic coverage; drawing a picture at the national and regional level; ensuring the adoption of a common methodology; and engaging agencies collaboratively.

A multi-agency approach goes some way towards mitigating the familiar institutional biases that can prevail in undertaking assessments, and so may have greater potential to produce credible, reliable and objective results. However, there were disagreements between agencies regarding the best methodological approach, in particular whether the assessments should be questionnaire-based or based on more qualitative data-collection techniques. As a result, the methodology reportedly contained a series of compromises,[36] leaving open questions as to the validity and reliability of the results. Moreover, agencies may find it difficult to challenge the analysis of findings in such a consensus-driven environment. It is essential that the system remains open to independent and potentially challenging analysis, and that agencies are prepared to question their own and others' assumptions.

Single-agency assessments are generally conducted over a limited geographic area and cover relatively small samples, and so should not be assumed to be representative of conditions in other areas – although taken together with other evidence, they may point to a more widespread problem. They can be carried out quickly, and usually focus on specific objectives. These assessments are an essential complement to macro-level evidence or more general

survey techniques. They can, as in the case of Malawi, serve as an essential corrective to interpretations drawn from macro-level evidence.

3.3.2 Multi-sectoral versus mono-sectoral assessments

The merits of trying to conduct assessments using multi-sectoral teams have been much debated. There are logistical and other practical considerations, not least cost, but the more fundamental question is whether such an approach enables a more integrated analysis than is possible if assessments are conducted separately.

In Southern Africa, there was significant debate as to whether the VAC assessments should be more multi-sectoral, extending the data collection to cover areas such as health and HIV/AIDS. There were specific concerns that the mandate of the VAC was limited and that current staff were inexperienced in collecting other kinds of data. There were more general concerns that an expanded VAC might lose focus and become too unwieldy. In addition, it was noted that there were other ways in addition to simultaneous assessment of 'matching' data to achieve a holistic view. The study team concluded that assessment processes need not be multi-sectoral, but that sectoral assessments needed to be coordinated closely enough so that the results could be correlated and analysed in relation to each other.

3.3.3 One-off assessments and surveillance

One-off assessments such as those undertaken by the VAC, UN agencies and NGOs provide a 'snap-shot' in time. In order to establish a trend or change, these assessments have to be repeated, and this is a resource-intensive process. While surveillance provides real-time monitoring with no time-lag between assessments, these systems usually only cover sentinel sites, leaving open the possibility that there is deterioration in a pocket not covered by the surveillance system. Indicators usually only monitor symptoms, so there is still a need for in-depth assessments which allow causes to be better explored, and an assessment of how people are coping with the changes occurring. And systems need to be maintained and supported; many founder after a few months without continuing inputs.

In Southern Africa, most respondents noted that the surveillance systems responsible for collecting and analysing data were weak. WHO and UNICEF have been trying to establish health and nutrition surveillance, but progress has been limited and poorly coordinated with the food security agenda. The study team concluded that the balance between 'snapshot' assessments (surveys) and surveillance needs to be ensured – the balance in Southern Africa

was weighted far too heavily in favour of assessments.[37] In principle, if there are proper surveillance and reporting systems in place, there is less need for such an elaborate, costly and time-consuming survey process. The results from surveillance can inform the targeting of surveys.

3.3.4 Coordinating assessments

This study is particularly concerned with two aspects of coordination: the extent to which assessments were coordinated at a strategic level to ensure balanced geographic and sectoral coverage; and the extent to which results of assessments were shared and analysed comparatively. There was no strategic framework to guide agencies in achieving geographic and sectoral balance. That said, there are many positive examples of effective coordination, in the VAC for example. Agencies also sought to coordinate in the nutrition and health sectors within each country. However, the linkage between the effective coordination of assessments and the coordination of decision-making was limited in all sectors other than food aid, where WFP played a strong role from the onset of the crisis.

3.4 Assessments methodologies: food security and nutrition

Assessments of food security/livelihoods fell into three broad categories: general assessments of need; assessments of food availability; and assessments of food accessibility (household food security/livelihoods analysis). In addition, a number of national and sub-national nutrition surveys were carried out. Some, such as the FAO/WFP crop and food-supply assessments, focused on current and predicted food needs. Others, such as the Food Economy Assessments carried out in Malawi and Zimbabwe by Save the Children-UK, incorporated a broader analysis of vulnerability and risks.

3.4.1 General assessments of need

Agencies frequently conduct their own needs assessments. Their primary aim is usually to assess whether the agency should intervene, the feasibility of the intervention, and how the agency should respond. These assessments may be multi-sectoral. Usually, they are based on secondary data and interviews with key personnel from the region. Examples from Southern Africa include:

- Action Against Hunger, Needs Assessment Mission, Zimbabwe, 5–20 May 2002.
- Christian Aid, Emergency Food Assessment, Malawi, 12–20 March 2002.
- Oxfam, Humanitarian Needs Assessment, Zimbabwe, 22 April–3 May 2002.

Information generated through this type of assessment does not necessarily provide a balanced overview of needs, but rather informs and directs the agency.

3.4.2 Assessments of food availability

The two main assessment tools for analysing overall food availability in Southern Africa have been USAID's Famine Early Warning System (FEWS NET) and the FAO/WFP Crop and Food Supply Assessment Missions in April–May 2002. While FEWS NET provides information on a regular basis, the FAO/WFP missions were carried out in response to the growing food crisis, with the aim of estimating crop production and forecasting future shortfalls, and reviewing the overall food situation and determining food import requirements, including food assistance needs. These types of assessment generally rely on secondary data sources (often government estimates), although the FAO/WFP missions also carried out field interviews. Overall food availability is assessed, though access to food may be dealt with through, for example, an assessment of patterns of food prices.

3.4.3 Assessment of food accessibility (household food security/livelihoods analysis)

There are some seven identifiable agency approaches to carrying out food security assessments (sometimes referred to as livelihood assessments).[38] These approaches have been developed for different purposes and in the context of different agency mandates; agencies tend to be protective of their own approaches and promote them as the best method. Despite these distinctions, the various approaches share many common elements. There is often agreement on the causal framework for food security, which leads to many of the same indicators being collected. Many approaches also emphasise the non-food aspects of household economies and the importance of protecting livelihoods. The differences are generally in data-collection methods (secondary data versus primary data; qualitative techniques such as participatory rural appraisal versus quantitative questionnaire-based approaches), sampling procedures (economy zones versus livelihood groupings versus representative sampling), and the depth and complexity of the techniques used (implemented by highly skilled individuals collecting in-depth information or less skilled interviewers collecting more superficial data).

3.4.4 The VAC Emergency Food Security and Nutrition Assessments

The VAC was established in early 1999 by the SADC Food, Agriculture and Natural Resources Sector (FANR). There is a regional VAC, and national VACs in each of the region's six affected countries. Members of the regional VAC include most FANR technical units, WFP-VAM, CARE,

FEWS NET, SC-UK, FAO, and IFRC. The national VACs are a consortium of government, NGO and UN agencies.

At the onset of the crisis, the VAC planned a series of Emergency Food Security Assessments from August 2002 to May 2003 in each of the six countries affected. WFP took the lead in designing these assessments, which aimed to provide practical information for programming based on a consistent methodology across the region. The objectives were:

- to refine geographic and temporal targeting in time for the step-up of assistance in September 2002;
- to characterise social groups for the purposes of targeting; and
- to identify key monitoring indicators.

Assessments focused primarily on current and predicted food needs. The VAC assessments combined different methodological approaches. The assessments aimed to combine three sets of data:

1. Household Livelihood Analysis: primary data was collected through district-level and household interviews.
2. Macro Processes/Indicators: reliant on secondary data sources.
3. Nutrition data.

The emphasis was on Household Livelihood Analysis. Each country developed its own method of collecting data, but most combined the Household Economy Approach with a questionnaire approach.[39] It was broadly understood that the amalgamation of these two approaches was not wholly successful, and that the methodology suffered as a result. The questionnaire was lengthy, which resulted in a large amount of data with little time for quality control or analysis, and inquiry sites were not randomly selected. Different countries used slightly different methodologies, which made comparisons more difficult.

3.4.5 Criteria for effective food security assessments

The study team concluded that criteria for effective food security assessments would include the following:

1. Assessments need to meet the Sphere Standard for Food Security Assessment and Analysis
2. Methodologies need to be transparent
3. Samples need to be representative
4. Nutrition data needs to be linked with food security data; data does not need to be collected simultaneously, but does need to be available for the same population for around the same period in time
5. Methodologies may vary, but should be suitable to the capacity and resources available, and should be simple enough to be carried out by national staff with minimal training

Recommendations

1. Develop criteria for assessing food security that can serve as a common basis for existing methodologies, and provide a stronger basis for objective comparison.[40] In addition to basic criteria, all assessments should aim to generate a common minimum data set, regardless of the way data is then processed and interpreted. These criteria should be read in conjunction with the proposed general criteria for assessment to be elaborated in the report of the overall ODI study.

2. Building on this, promote understanding of the comparative advantages, constraints and appropriate uses of existing methods of assessing food security.

3.5 Assessment methodologies: health

In the health sector, assessments focused on three areas: mortality surveys, morbidity surveys and survey's of health care capacity.

3.5.1 Mortality surveys

There are several methods to estimate mortality, but all are problematic. There are generally accepted cut-off points indicating an emergency situation, given in Annex 2.

Malawi's Ministry of Health and Population, supported by UNFPA, UNICEF, UNAIDS and WHO, undertook mortality surveys in April 2002. These were repeated in September 2002, as part of a rapid health assessment. The two surveys identified mortality rates of approximately 1.9 per 10,000 per day. These are almost at a level defined as 'emergency out of control' (above 2/10,000/day). However, various features of the methodology make it impossible to

produce a more general picture of mortality rates, and figures were taken out of context. The sampling employed was not random; instead, a selection was made of those districts expected to be worst affected, within which the worst villages were chosen. This makes it impossible to extrapolate the findings beyond the sample population of 25,000 people. The second assessment in September 2002 used the same methodology for purposes of comparison. It found the same CMR (1.96/10.000/day) in what was the 'good' as opposed to the 'hungry' season. This would seem to indicate a worsening situation over this period.

UNICEF led country-wide nutrition surveys in Malawi at the district level, combined with a mortality survey, in August and September. Under-five mortality rates were included, and maternal mortality rates were taken from national data sources. These used a standardised two-stage cluster sampling methodology, thus providing comparable district mortality rates.[41] The rates found were mostly within normal ranges.

In both Malawi and Zimbabwe, there were calculations of hospital-based mortality rates. In Zimbabwe, this was part of the needs assessment in the health sector, coordinated by WHO in collaboration with the Ministry of Health and other partners in the Humanitarian Assistance and Recovery Programme (HARP). Other sources of mortality-related information include life expectancy estimates from secondary sources, WHO reports and UNICEF's Multiple Indicator Cluster Survey (MICS). Data is based partly on assumptions and partly on extrapolations from the past, or from neighbouring countries; it should thus be interpreted with caution.

3.5.2 Morbidity surveys

There are no universal cut-off points for morbidity rates that would indicate an emergency. A level of more than 1.5 times the normal morbidity rate is often taken as the threshold. There are specific thresholds for various potentially epidemic diseases, which in certain cases is just one case.

Morbidity data is collected from health facilities and records, and so only includes people who seek health care. The trends in incidence can therefore only be interpreted together with knowledge of access to health care. In both Malawi and Zimbabwe, the trend was a reduction in incidence, but an increase in the fatality rates of patients admitted to hospital. The combination of food insecurity and the high prevalence of HIV/AIDS suggests that there would be increases in morbidity. There is a strong indication that access to services is

decreasing, and that people wait longer before seeking assistance or do not seek it at all. In Malawi, attendance had dropped by as much as 25% compared to the previous year.

The prevalence rate of HIV is collected at sentinel public maternal care clinics. This requires the consent of the women who come to these clinics, and selects only women of productive age (15–49 years old). Although this data cannot be extrapolated to the general population, this method is the only one available and is followed in most countries. It is also used to compare the situation between countries, but this is problematic given differences in access to public health.

3.5.3 Health care surveys

Health care surveys attempt to measure the performance of health care in terms of access, availability and quality. The only place where access to services can be measured is at the household level. There are standardised methods for doing this, sometimes combined with nutrition surveys. No specific surveys were undertaken in Malawi or Zimbabwe for this purpose. However, all indications were that access was unacceptably low and decreasing. Although ill health and premature mortality were identified as important vulnerability factors for the food insecure, there were no urgent measures to increase access to services and raise the quality of care.

Assessing the availability of health facilities requires a calculation of the numbers and levels of health facilities available to the target population, and their respective capacity, for example number of beds or consultations per person per year. In Malawi, analysis concluded that capacity was sufficient to treat only 10–20% of severely malnourished children, even when severe malnutrition was estimated to be as low as 1%. To the knowledge of the study team, no assessment was carried out on the quality of diagnosis and treatment, nor on the financial aspects of health care, such as the cost of services and patients' ability to pay, or on the use of appropriate protocols.

3.5.4 Criteria for effective health assessments

The study team concluded that criteria for effective health assessments would include the following:

1. Methodologies need to be transparent
2. Sampling need to be representative, particularly for household surveys
3. Methodologies may vary, for example in the level of detail, but they should be suitable for the time, capacity and resources available
4. All data sets should be collected in a similar time period to allow for analysis of causes and influences between different sectors
5. Methods need to be consistently applied over time to allow for trend analysis, and to provide baselines for comparison
6. The costs of assessment should be in realistic proportion with the costs of service provision
7. Findings need to be produced in a timely fashion

Recommendations

1. Develop consensus on a minimum health information 'package' in situations like that in Southern Africa, related to health status, threats to health, vulnerabilities and the capacity of health services. Agreement on information requirements should be reached between the relevant actors (government, agencies) at an early stage. This should then inform the use of information and surveillance mechanisms, and new or strengthened mechanisms where necessary. The aim should be to provide a reliable common basis for decision-making about health-related responses.

2. Assessment data, together with a related rationale for the programme decisions made, should be placed in the public domain. When publishing data, the methodology followed should be made clear, and confidence intervals for the data specified wherever possible.

3.6 The use of indicators and the limits of interpretation

Mortality, morbidity and malnutrition indicators were used in Southern Africa to bolster the case for food aid. The results were, however, not always used in a way that could be justified on the basis of the methodology followed, and very little hard data appeared to be available on which to base decisions.

3.6.1 Nutrition

Nutrition data presented an inconsistent picture. In Malawi, for example, there was a wealth of anecdotal information about increases in attendance at Nutrition Rehabilitation Units; attendance rates 'among the 89 nutritional units in Malawi are known to have increased dramatically in the first quarter of 2002'. However, results from nutrition surveys did not confirm these apparent increases in severe malnutrition.

Baseline data is available from the 2000 Malawi Demographic and Health Survey, which found an average acute malnutrition rate (<-2Z score weight for height) for the whole country of 7% (excluding oedema). The actual rate may, therefore, have been higher. Nutrition surveys (30x30 cluster samples) were carried out by SC-UK and Oxfam in four of Malawi's 27 districts in March 2002. A significant increase in moderate malnutrition was found in only one district (Salima), and there was evidence to suggest that this may have been as much to do with a rise in diarrhoeal disease as a lack of food. Other nutrition surveys did not show the same dramatic rise. Rates of global malnutrition remained similar to the national average of 7%, though severe malnutrition was surprisingly high in some districts, such as Thyolo.

Despite this ambiguous picture, the data from Salima was used as evidence for a national crisis. This may have been justified on the basis that other districts, where data was not collected, could have been following the same trend. However, subsequent surveys have not seen a sustained rise in malnutrition rates; nonetheless, the nutritional situation for children under five has been described as 'extremely precarious'.

In Zimbabwe, there has equally been no evidence of a rise in malnutrition rates, but the ability to conduct surveys has been restricted by the government.

3.7 Vulnerability and targeting

An important objective of needs assessments is to identify vulnerable groups to help inform targeting strategies. The causes of vulnerability are frequently not distinguished from its consequences, and different groups may be described as vulnerable for different reasons. In terms of vulnerability to food insecurity and malnutrition, causes include the following:

- Physiological vulnerability (certain individuals are vulnerable because they are physiologically 'weaker', young children, the elderly, people with HIV/AIDS, pregnant and lactating women, for example)

- Economic vulnerability ('poorer' individuals and households are vulnerable because they have fewer socio-economic resources/assets or less access to food and services)
- Social vulnerability (some cultures discriminate against certain groups so that they have less access to resources, female headed households, widows for example)
- Geographic vulnerability (areas differ in poverty levels, or are more or less prone to drought or flooding, for example)
- Political vulnerability (groups can be discriminated against on the grounds of political or kinship affiliation)

A vulnerable group is not necessarily a target group. Targeting decisions may be based on a hierarchy of vulnerable groups, with some receiving higher priority than others. The practical issues surrounding targeting will also inform decision-making. For example, geographic targeting may be favoured above household targeting because it is more acceptable to give something to all households within a community and ignore other communities completely, than to give to only some households in all communities.

One of the explicit aims of the VAC assessments was to refine geographic and temporal targeting, and to characterise social groups for the purposes of targeting. In practice, the assessments concentrated on calculating food aid needs for each district (geographic targeting). The description of vulnerable socio-economic groups was more vague. For example, the VAC assessment report for Malawi states:

As expected the poorest in a population are most vulnerable. Households with no more than just a hoe or axe are very vulnerable. Households owning assets such as bed, chair, table, bicycle, radio are likely not to need assistance, except when there has been illness or death of a productive member. Every community that was assessed by the VAC teams named the elderly, sick and disabled as the most vulnerable in the community. Other socio-economic targeting indicators are female headship, heavy reliance on labour for food or income, large number of dependents, low dietary diversity and meal consumption reduced to only one time a day.

This description would cover most people within a community, and is not of great practical use in determining which vulnerable groups should be prioritised and how they can be identified. In fact, WFP used a system of community targeting to distribute food aid. This involved speaking directly with communities and asking them to select households based on criteria developed by WFP. Families living with HIV/AIDS were not explicitly identified as a

vulnerable group in the Malawi VAC assessment, though in practice these families have been targeted for food aid.

The VAC example highlights a number of problems with assessing vulnerable groups. First, there can be a lack of clarity about how vulnerability is understood (by cause or consequence) and at what level (geographic, household, individual). Second, assessing geographic vulnerability is easier than assessing household vulnerability. Third, targeting decisions are based on determinants other than vulnerability alone.

In practice, despite efforts to establish vulnerability criteria and distribute food according to those criteria, it was evident that much of the food aid was in fact redistributed at the village level by the communities themselves. This is not necessarily of concern unless the result is that the most vulnerable do not receive the assistance they need.

Chapter 4
Information and decision-making

This chapter explores the relationship between information and decision-making in Southern Africa, in particular the extent to which formal needs assessments in a slow-onset crisis influenced decision-making, and the extent to which other sources of information affected the allocation and prioritisation of resources. There is much to suggest that how an organisation comes to a decision to intervene, with certain resources, prioritising certain sectors, within a particular geographic scope, especially when the crisis is slow-onset in nature, is only partially based on an assessment of needs.

This chapter explores a number of questions in relation to information and decision-making in the South African crisis response:

- How did the evidence from the various assessments influence the decisions of agencies and donors? To what extent did other factors, including political and institutional priorities, override the information generated from needs assessment?
- To what extent was the humanitarian response prompted by single triggers, or by a gradual accumulation of evidence? Within what planning and analytical timeframes were decisions taken? Did agencies and donors make decisions on the basis of predictive analysis, or on the basis of current or historical analysis?
- What role did formal information systems play? Did the information generated allow conclusions to be drawn about relative priorities?
- To what extent was analysis shared, and decisions about response (by agencies and donors) made in a coordinated way? Taken together, did decisions by individual organisations result in a set of responses that matched priority needs?
- How effective is the CAP as a mechanism for prioritising needs in slow-onset crises?

This chapter suggests the following basic requirements of good decision-making:

- decisions should be timely in relation to the relevant objectives;
- they should be transparent;

- they should be informed by needs assessment, or at least demonstrably based on reasoned judgements about likely needs and capacities;
- they should be proportionate and appropriate to the scale and nature of needs; and
- as far as possible, decisions should be made in coordination with other relevant agencies, donors and host governments, so as to ensure effective prioritisation of efforts.

This involves ensuring that:

- needs assessments are adequately resourced;
- those undertaking needs assessments are appropriately trained/skilled;
- the analysis of need is clearly distinguished from (but linked to) the design of responses and requests for funding;
- those responsible for decision-making have reasonable capacity to interpret the results of needs assessments and make reasoned judgements about the appropriate response;
- OCHA is adequately resourced to play an active role in coordination and prioritisation;
- the humanitarian community has access to an information system which provides an up-to-date and complete picture of resource allocation by sector; and
- the sum of assessments undertaken provides a balanced and total picture of humanitarian need.

This chapter explores the extent to which these requirements have been met in Southern Africa.

4.1 Factors influencing decision-making

Anecdotal evidence suggests that the factors that influence decision-making in humanitarian crises often have a very limited correlation to the information generated from formal needs assessments. Decisions to respond can be shaped by a number of external considerations, such as political interest, the capacity of the humanitarian community to mount a response, competing demands on humanitarian finances, political commitment and leadership and the organisational dynamics within donor and agency institutions.

Evidence from Southern Africa suggested that certain external factors were critical in informing decision-making. Some influenced the timing of decision-making. For example, many interviewees maintained that donor concerns regarding corruption and poor governance in Malawi delayed humanitarian action. Other factors influenced the scale of the response; the

high level of interest from certain donor governments, for instance, was key to eventually ensuring a significant commitment of resources. Other factors – namely the early characterisation of the situation as a food crisis – influenced the nature of decision-making and response; crudely put, classifying the crisis as a food crisis provided the basis for donors and agencies to follow a relatively straightforward and familiar decision-making process for a food-aid response.

The decision by key donors to respond, or not, had much to do with the political context. Much of the information regarding the humanitarian crisis was filtered at donor headquarters through a set of policy concerns regarding good governance and accountability. In the case of Malawi, there was extensive discussion in the latter half of 2001 and early 2002 regarding the sale of the country's Strategic Grain Reserve, and donors were concerned about assisting a government which in other forums was being accused of mismanagement and corruption. At the same time, donors noted that they were unable to respond until the government made an official request for assistance.[42] Political considerations also played a part in some agency thinking. For example, in determining the level of resources required for the CAP appeal, some agency decisions were informed by a concern that they risked simply filling a void left by a host government's failure to discharge its responsibilities to its own people.

The capacity of the international humanitarian community to respond was also a key determinant in the decision-making process. Trust in an agency's capacity to deliver was an important element in securing resources from donors.[43] One donor noted that initial discussions with WFP in Malawi led them to believe that the agency was incapable of putting together the necessary emergency programmes. Donor pressure placed on the agency at headquarters resulted in a significant increase in the number of experienced staff deployed, and resources allocated. UN agencies and NGOs, in turn, examined their own capacity to mount a response, and/or to manage their partners.[44] Both donors and UN agencies noted that they had concerns around the capacity of NGOs relatively inexperienced in the humanitarian sector to manage a large and ongoing food distribution exercise.[45]

Access was also a key concern for the international community, particularly in Zimbabwe, where there was limited scope for bilateral dialogue between donor governments and Harare. Donors had to be confident that the humanitarian agencies could negotiate access to vulnerable populations in such a politically sensitive environment.

The organisational dynamics within donors and between agencies also had a bearing on decision-making. A number of donors cited tension between the development and humanitarian streams in the interpretation of the severity of the situation in Southern Africa, and in where the responsibility for managing it lay. One donor representative from the humanitarian stream noted that, even though the programming environment shifted into areas that development colleagues had no previous experience in, such as therapeutic feeding, the country programme staff remained resistant to interpreting the situation as one of humanitarian concern.[46]

High-level political commitment from certain donor governments was key to capturing resources. Such factors are arguably arbitrary in nature, based on individuals' judgements rather than an understanding of comparative need. In the sense that Southern Africa as a whole is not of significant geopolitical interest, this high-level political commitment ran counter to the general trend in humanitarian funding, where the absence of such interest makes it more difficult to secure resources. It can only be assumed that significant political pressure ensured that competing funding priorities at a global level did not markedly dent support for the situation in Southern Africa. This has been primarily due to the commitment of the larger donors – USAID, ECHO and DFID – and the ongoing work of two high-profile special envoys to the region whose job is to keep the region on the humanitarian map.

4.2 Indicators, triggers and the status of information

As is perhaps typical in a slow-onset emergency, there was no single, commonly-agreed trigger which led to a response from the humanitarian community. Rather, most donors based their decision to respond on a gradual accumulation of evidence from a range of informal and formal sources, including early-warning systems, civil society (church and other), UN and NGO assessments, lobbying, media profiling and advice from in-country representatives. Most informants agreed that there was no 'watershed moment' when chronic food insecurity suddenly became a food crisis; the switch from food insecurity to food crisis was a matter of 'degree, scale and magnitude'.[47]

For the most part, key indicators such as mortality and morbidity rates and malnutrition levels were not utilised as triggers for intervention, not least because such data was on the whole absent, and generalisations from what existed were difficult. To a large degree, climatic factors provided the 'entry point' into the region, and deeper examination on the part of the humanitarian community of the underlying causes of the crisis came about only after they were on the ground. Early-warning information in the form of declining crop production and increasing prices triggered assessments in late 2001 and early 2002, which prompted a limited response from donors; the EU initiated a supplementary feeding programme, and USAID began discussions with WFP on general food distributions. In April 2002, continued surveillance of the formal early warning systems triggered the large-scale FAO/WFP food and crop assessment. This determined production at the national level, provided a food balance sheet, formed the basis of WFP's EMOP and to a large extent informed prioritisation within the CAP.

UN agencies based their decision to undertake assessments on a 'threshold' dividing 'poverty in general and seasonal hunger in particular' from 'food crisis'. This threshold was deemed to have been crossed during the first three months of 2002.[48] International NGOs, less dependent on formal early warning systems for their information, responded to a varied set of triggers including independent observations on the ground, findings from their own or partner assessments, UN agency and VAC assessments, and anecdotal information from field representatives, local markets and churches. No systematic process was involved, and the approach appears to have been largely haphazard.

For donor governments, trust in an organisation's information seems to have been as important as the reliability of the data or the process of assessing need. Donors attached significant weight to the WFP/FAO assessments in comparison to others undertaken in the region, partly because of the credibility of the data (in comparison to national figures), and because of a tendency to gravitate towards straightforward, quantitative estimates. At the same time, donors interviewed for this study admitted doubts about the figures put forward in the EMOP. For the most part, donors placed less emphasis on individual NGO assessments or anecdotal information than they did on the VAC or FAO/WFP assessment. In keeping with trends elsewhere, donors noted that they were increasingly investing in their own operational capacity to interpret and verify the data and analysis provided by independent sources.[49]

There were mixed views on the role of the media in decision-making for Southern Africa. Some informants argued that the media played a critical role in drawing attention to the situation in Malawi. Stephen Devereux suggests that it was only after 'civil society and the media disseminated information about the severity of the food crisis that stakeholders were prompted into action'.[50] Some felt that the media over-simplified and distorted the crisis, presenting a one-dimensional and sensationalist picture of events. UN agencies such as UNICEF noted that they used the media less as a trigger and more as a longer-term mechanism to maintain the profile of the crisis.[51]

The question of what might trigger a withdrawal of humanitarian services remained unclear ('When the funding runs out' was a common response). Malnutrition figures do not serve this purpose, since overall malnutrition levels have remained relatively low throughout. While some thought had been given to exit strategies at the time of this study in November 2002, for most agencies the 'risk horizon' was the point of the next harvest (March/April 2003). The implication was that only then could a judgement be made about the continuing need for food aid or other forms of input. While this appears logical, on most models of analysis the need for targeted support to poor rural populations (and in Zimbabwe urban populations as well) was foreseeable into the medium term. The effects of the HIV/AIDS pandemic in particular indicate that a radical rethink of relief and welfare/development strategies is required across the region, but this had not been developed at the time the study was conducted.

4.3 Decision-making in the longer term

There is general consensus among donors, UN agencies and some NGOs that the response to Southern Africa's food crisis has been preventive in nature – and successful in its effect.[52] Such a claim is based on the assumption that millions across the region faced the threat of starvation in the 2002/03 agricultural year, and that the international response averted this outcome.[53] The analysis overlooks claims that there was a severe food crisis in 2001/02 to which the international community failed to respond. The claim is equally limited to the food crisis/food aid nexus. Few would claim that the collective intervention had a major impact in other areas such as health. The effect in protecting livelihoods is uncertain, given the continuing and growing impact of general economic decline and of the HIV/AIDS pandemic.

The rationale for intervention revealed a complex trade-off between the nature of the crisis and the nature of the response. Most informants recognised that the crisis required an extended/prolonged multi-sectoral response.[54] Most informants were also aware that it was of

a type that had not been dealt with before – 'challenging the humanitarian paradigm'.[55] Yet the programming responses appeared to be short-term and primarily single-sector in response. The longer-term decision making regarding needs, including potential contingency and scenario planning was not being grappled with. To a certain extent this was explained by the boundaries set around the primary funding mechanism, the CAP, which put pressure on donors and organisations to design projects and corresponding resources for the short term (up until July 2003). However, it was also a reflection of the failure of the humanitarian and development actors in the region to develop common strategies which addressed the need for long-term development financing to provide and maintain social safety nets.

Future programming appeared to be concerned as much with issues of sustainability as with an analysis of need. Many of those interviewed noted the uncertainty surrounding donors' willingness to fund continued inputs of food aid. However, this was based less on predictive analysis of need than on a belief that the policy approach (and perhaps the political commitment) was unsustainable. At the same time, it was recognised that, in the absence of changes in government policy, the region might need the same type of intervention for years to come.[56]

4.4 Formal information systems

A mix of formal and informal systems of information influenced decision-making in Southern Africa:

- early-warning sources such as the Famine and Early Warning Project;
- national governments' data, and statistics such as SADC FANR national and regional information sources;
- NGOs – both anecdotal information and needs assessments;
- UN agency data and assessments; and
- donor government sources, bilateral and multilateral dialogue, in-country modes of analysis and verification.

It was commonly noted by donors that there was a need for 'a single system' to –deliver accurate and credible data, both region-wide and country-specific.[57] Less clear was what such a system might look like, whether there was any consistency in the type of information agencies, donors and NGOs required and at what point it was imperative for decision-making in the programming cycle for resource allocation.

The only independent formal early-warning system in Southern Africa is FEWS NET, which relies almost exclusively on secondary data, analysing and collating information into concise one-page briefings.[58] This means that its assessments can only be as good as the data available, which is primarily sourced from national government statistics, for example on crop production, prices, imports and exports.

The key tool for information management in the region was intended to be the Southern African Humanitarian Information Management System (SAHIMS), housed in the OCHA regional office in Johannesburg. SAHIMS was portrayed as an interagency information and data clearing-house, which would provide data-management support to UN humanitarian coordinators responsible for planning for the region. It would liaise and support existing information systems such as FEWS NET, as well as those of the SADC and other technical bodies in the region. It was also intended that UNICEF and WHO would provide key staff to support the facility in their areas of expertise, specifically in health and nutrition surveillance. Donors interviewed for this study noted the slow pace at which SAHIMS was established (it was not launched until October 2002) and its inadequate staffing levels. At the time of writing, SAHIMS had provided only limited information to support decision-making and planning in the region. SAHIMS also appears to have a more comprehensive and longer-term vision than that which normally characterises humanitarian information-management tools. This vision was not shared by all interviewees, some of whom argued that it should have a strictly humanitarian agenda. Key staff responsible for SAHIMS noted that a lack of donor funds for the project had limited progress. Ultimately, the late arrival of SAHIMS, the lack of clarity around its purpose and outputs and poor financial and personnel resources suggest that it will find it difficult to fulfil the role that agencies and donors expect of it.

4.5 Coordination

Regional coordination for the crisis is undertaken outside the affected countries, in Johannesburg. The UN has established the Regional Inter-Agency Coordination Support Office (RIASCO), and a number of donors and some NGOs have also set up regional hubs. Responsibility for the coordination of assistance operations throughout the region is assigned to WFP's Regional Director for East and Southern Africa.

OCHA does not play its usual (mandated) role in the region, and instead provides support to WFP as the lead agency. OCHA also plays a very low-key role at the country level – where

humanitarian coordination is led by the UNDP Resident Representatives – and regionally. WFP, with support from OCHA, is tasked to assist the UN country teams to manage and coordinate the humanitarian response in collaboration with governments, donors and NGOs. A more integrated approach to assessment might have been achieved had OCHA played a more decisive part early on in coordinating the efforts of UN agencies. This might have prevented the evident schism that developed between the food and health sectors, and led to a more balanced set of responses from the outset.

Representatives from RIASCO felt that a light coordination structure was paramount to ensuring that the Resident Representatives retained primary responsibility for country coordination and implementation of the emergency response. The rationale for this was to minimise unnecessary disruption to development programmes.[59] This respects the structures already in place for the coordination of development assistance, and it also recognises the need for a long-term approach to addressing some of the underlying structural problems that contributed to the region's humanitarian crisis. However, it is also problematic in that it assumes and relies on the capacity of individuals who are arguably more attuned to development issues than to managing and coordinating a humanitarian response. This can ultimately result in variable standards and inconsistency of coordination at the country level.

Donors also expressed the view that a light coordination structure at regional level had a number of drawbacks, especially in the initial phases of a humanitarian response. In particular, donors were looking for regional leadership from the UN, in order to enable a more coherent understanding of the scale and severity of the crisis.[60] It appears that, in the early months of the response, there was a particular focus on logistics coordination for food aid, and very little emphasis on providing information and/or coordinating the response for other forms of assistance, including health interventions. Attempts by donors to coordinate independently of the UN system have been limited, partly because the larger donors actively engaged in the region, such as USAID and DFID, tend towards bilateral decision-making for resource allocation. There have, however, been moves to establish a Stakeholders Group, comprising donors, UN agencies and NGOs.[61]

In Zimbabwe, the coordination of the international humanitarian response is relatively strong at the macro level – between agencies and donors – under the leadership of UNDP. This is partly due to the longer preparation time; a Humanitarian Assistance and Recovery Plan (HARP) was in place from October 2001. In comparison, coordination at the

community/local level is limited; according to one NGO worker, 'apart from food aid and nutrition, there is no coordination in Zimbabwe'.[62] In Malawi, the coordination of the initial phase in the humanitarian response has been shared between the government, UN agencies, donors and NGOs. The majority of stakeholders note that each has a voice in the decision-making process. However, as in Zimbabwe, the emphasis is on coordinating the distribution of food aid. Coordinating a single-sector priority area for response is arguably less challenging than coordination between multi-priority sectors, or the effective translation of a coordinated humanitarian response into a coherent longer-term recovery strategy.

Donors and WFP in particular were keen to establish a coordinated approach for working with NGOs in food distribution. It was recognised that the majority of WFP's potential implementing partners were small and predominantly involved in longer-term development projects, and that they had little emergency experience, let alone experience in managing and coordinating large-scale food distributions. Such concerns led to the development of a unique model of NGO coordination in Malawi: the NGO consortium, comprising 12 international and national NGOs, all of which hold individual memoranda of understanding with WFP as implementing partners in food distribution. The consortium is chaired by CARE International. NGOs are responsible for:

- implementing the Joint Emergency Food Aid Programme (JEFAP) at district level;
- coordinating with government district authorities to establish coordination structures;
- assisting in the selection of beneficiaries; and
- providing for the transportation of commodities for distribution from extended delivery points to food delivery points (only SC-UK and Oxfam were doing this).

The government, donors, NGOs and WFP were all positive about the consortium as a mechanism for coordination. The consortium has enabled information-sharing – both between donors and NGOs and among NGOs themselves. Donors noted that they preferred a system where they held fewer contracts with NGOs, and believed that the benefits of devolved decision-making outweighed the risks; one donor representative noted that 'Imperfect decision-making at the local level is better than imperfect decision-making in Lilongwe'.[63] NGO representatives noted that the consortium lessened the competition between them for donor funding. One UN agency voiced some concern, noting that the leadership of the consortium was 'very democratic, and prey to being weak, with no single institution taking the necessary strategic or budgetary control'. Some of the concerns expressed above in relation

to the VAC process, to do with creating false consensus and discouraging dissent, may also apply here.

4.6 The CAP and prioritising needs

The CAP, launched on 18 July 2002, has been the primary mechanism for resource mobilisation in the region. UN agencies requested a total of $611m, targeting 12.8m people, for the period July 2002–June 2003 for six affected countries.[64] The CAP relies primarily on the WFP/FAO food and crop assessment, and as such is an imperfect reflection of needs. It is heavily skewed towards food aid – of the $611m requested, $507m (over 80%) was for food commodities. In comparison, health needs were set at just over $48m (7%). WFP is one of the few agencies to have secured over three-quarters of its appeal. In comparison, UNICEF and WHO had, at the time of writing, secured 33% and 11% respectively. As a whole, requirements for health and sectors other than food have been severely under-funded, at a mere 21%.[65] This is reflected at country level in Malawi and Zimbabwe. In Malawi, UN agencies appealed for $144m – over 90% for food commodities. The total under the CAP for the emergency interventions of the other appealing organisations – FAO, UNICEF, UNDP and WHO – was $9m.

Donors' preference for supporting food over other essential requirements has been broadly consistent with past CAPs. According to the external review of the CAP in 2002, approximately 60% of all global contributions have consisted of support to the food sector.[66] This does not necessarily imply that the needs of beneficiaries in, for example, the health sector are not being addressed, as donors may be funding this outside of the CAP. The critical point is that neither the CAP nor any other system in the region provides donors, and the rest of the humanitarian community, with a complete picture of sectoral resource allocation. The arbitrariness of resource allocation within the CAP was striking. One respondent noted, when asked how the figure of £18.6m was arrived at for WFP's EMOP, answered that this was 'how much was available'.[67] Similarly, UNICEF allocated 7% of its discretionary budget to the region for vulnerable children with no correlation to an assessment of need.

Donors with a strong engagement in the region acknowledged that, to some extent, their funding was predetermined – either towards specific UN agencies or by sector. One noted a 'vested interest' in funding agencies with which the donor had 'long-term strategic partnerships'.[68] Another donor official reported a predetermined sectoral bias, in that the objective was to meet 50% of food aid needs in each country.[69] Generally, the CAP served only

as a rough guide for donors in how they prioritised their resources, and was considered at best as a short-term planning tool for region-wide response.[70] One donor official noted that the CAP played almost no role in decision-making.[71]

Interviewees from UN agencies suggested that the CAP appeal was pitched significantly lower than projected levels of need in an effort to match what the 'market' was expected to bear, and so elicit a positive response from donors. Other criteria appeared to be dictated by capacity; WFP in Zimbabwe, for instance, aimed to attract 'as much food as we are able to distribute'.[72] While donors did not seem to share the view that the CAP appeal was set too low, a significant amount of resources were channelled outside of the CAP framework: over $117m has been expended in Southern Africa external to the CAP, compared with $349m within the framework of the CAP.

Conclusion

The dominant theme of this case study was the question of what constitutes a humanitarian crisis, where it begins and where it ends, and what characterises it. While the situation affecting Southern Africa was generally construed as a regional crisis, the nature of this crisis – its symptoms and causes – was (and remains) a matter of some debate. Food insecurity was the most obvious unifying feature, and it was here that the humanitarian response focused. Based on the analysis of both food availability and food access, it was widely believed that, without continued food aid, famine was a real possibility. A limited body of evidence lent credibility to this claim. Interestingly, key indicators such as mortality and morbidity rates and malnutrition levels did not act as triggers for response.

Of the other symptoms that lead the situation in Southern Africa to be characterised as a crisis, those associated with HIV/AIDS were the most striking. The humanitarian and social consequences of the pandemic are incalculable. In terms of excess mortality and morbidity, it dwarfs the effect of the food crisis. Yet the effects of HIV/AIDS were treated less as a humanitarian issue in their own right than as a contributory factor to food insecurity – in other words, as a cause of crisis, and a vulnerability factor, rather than a crisis *per se*.

The picture of formal assessment of needs in Southern Africa was a mixed one. Decisions to launch assessments in were not always based on clear or consistent criteria, and objectives of assessments were not solely designed to establish a picture of need. On occasion, assessments were as much about justifying an agency's request for funding (with the decision to intervene having already been taken). For some organisations, the decision to assess at all was strikingly haphazard.

Formal assessments varied in their type, scope, timing and impact. There was a range of methodological approaches and some combined a number of methodologies. Critically, there was no overarching strategy for the variety of assessments within and between countries. In the absence of this framework, there was no way of developing a balanced and total picture of needs in Southern Africa, or a drawing of comparisons between contexts.

The multi-agency assessment process approach of the VAC Emergency Food Security Assessments was an innovative step forward in the evolution of assessment practice. The study

team concluded that such collaborative processes can produce relatively consistent and credible results, and can help counter organisational biases. In this case, the process was heavily oriented towards the calculation of food aid requirements, shutting down other possible options for response to food insecurity. It is essential that such approaches remains open to independent and potentially challenging analysis, that conclusions are revisited, and that agencies question their own and others' assumptions. Attempts to conduct multi-*sectoral* assessments took too little account of the specific requirements of sector-specific methodologies. The study team concluded that rather than attempting to combine sectoral assessments in a single process, sectoral assessments should be coordinated closely enough in terms of their geographic and temporal focus that the results can be correlated and analysed in relation to each other.

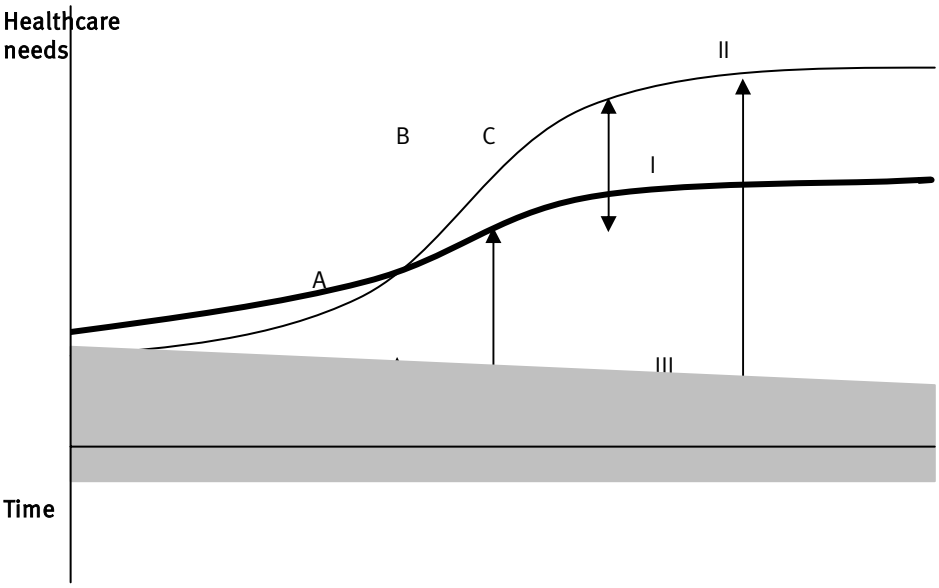
The balance between 'snapshot' surveys and continuous surveillance needs to be ensured – the balance in this case weighed far too heavily in favour of surveys. The series of repeated surveys undertaken by the VAC was an attempt to combine breadth/depth of analysis with the monitoring of trends and critical changes. The method adopted was not well suited to this task, and was arguably over-elaborate (and costly) for the purpose it actually served. .Over the longer term, investment in permanent surveillance systems as part of the development effort to prevent crises and increase preparedness is essential.

Decisions to respond to the situation in Southern Africa were shaped by a number of external considerations in addition to formal assessments of need. The study concludes that the decision-making process in agencies and donors alike lacks transparency. The criteria for intervention are unclear – neither articulated explicitly in policy, nor guided by specific triggers or indicators. Until decision-making is made more transparent, the relative weight given to needs assessments within this process remains uncertain.

The light footprint approach of OCHA in the region allowed the lead agency, WFP to effectively prioritise logistics for food aid coordination, with less emphasis on other forms of assistance in the early stages of the crisis. The study concludes that OCHA needs to be adequately resourced and mandated in such contexts to play an active role in coordination so as to ensure effective prioritisation of efforts, proportionate and appropriate to the scale and nature of the crisis.

Decisions about future programming in Southern Africa seem to be informed as much by concerns about sustainability as by any analysis of needs. What was absent, as far as the study team could determine, was any forum between humanitarian and development actors that analysed and planned jointly for a longer-term response. This gap reflects the familiar institutional and conceptual division between humanitarian and development approaches, a divide which requires urgent attention in Southern Africa if future programming is to succeed.

Annex 1: Understanding deficit in the health sector



I Baseline, increasing healthcare needs (increasing morbidity among others due to HIV pandemic)

II Additional increased healthcare needs caused by food insecurity (which increases normal and HIV-related morbidity)

III Access to services to cover healthcare needs (grey area represents percentage of total morbidity, baseline and excess, covered by healthcare services)

A Existing gap in access to basic services (deficit of access to health services)

B Difference between I and II = excess morbidity caused by food insecurity, or what could be defined as the 'humanitarian' need caused by the food-security crisis

C Difference between II and III = total healthcare deficit/increasing gap in access to services

Annex 2: Mortality and morbidity indicators

Mortality indicators: an *outcome* or health status indicator, expressed as a rate. In humanitarian contexts, the following are most commonly used:

- Crude Mortality Rate – defines the number of deaths per 10,000 per day
- Under-five Mortality Rate – defines the number of deaths among children under five years of age, per 10,000 per day
- Maternal mortality rate: maternal deaths per 1,000 live births
- Cause-specific mortality rates: disaggregation of crude rate, identify top five causes of death

Emergency benchmarks: *excess mortality*, understood as a major deviation from the norm for the context, or a more general norm (defined as doubling the baseline rate, e.g. >1/10,000/day CMR for most Sub-Saharan African countries).

Measurement: death registers, surveillance of burials, surveys.

Morbidity indicators: an *outcome* indicator; also *risk* factor for mortality and malnutrition. The methodology is well-established, based on agreed case definitions.

- *Prevalence rate* of a given disease: total number of persons sick or portraying a certain condition in a stated population at a particular time (point prevalence) or during a stated period of time (period prevalence), regardless of when that illness began, divided by the population at risk of having the disease at the point in time, or midway through the period in which it occurred expressed as a proportion of a given population affected, or number of cases in a given population.
- *Incidence rate* of a given disease: number of new cases of a specified disease reported or diagnosed during a defined period of time, divided by the number of persons in a stated population in which the cases occurred.
- *Attack rate:* proportion measuring cumulative incidence, often used for particular groups, observed over a limited period and under special circumstances, as in epidemics, expressed as a percentage.

Emergency benchmarks: no international cut-off points for morbidity that would indicate an emergency, though for some potentially epidemic diseases there are thresholds. Most

thresholds are based on a doubling of the baseline over two measured periods, or exceeding expected seasonal trends.

Measurement: *Incidence* – health facility-based surveillance. *Prevalence* – household survey.

Malnutrition indicators: *outcome* indicator; also *risk* factor for morbidity and mortality. The methodology of collecting nutrition indicators is well-established. There are internationally recognised cut-off points to indicate malnutrition in an individual, and to indicate a serious situation at a population level. During emergencies, the nutrition indicator which is universally used is wasting (or acute malnutrition) measured through weight for height in children and Body Mass Index (weight/height^2) in adults. Measures of stunting (or chronic malnutrition) are generally not used in emergencies.

Emergency benchmarks: a *worrying nutritional situation* is indicated by a prevalence of acute malnutrition in under-fives between 5% and 8%, and a *serious nutrition situation* indicated at >10%.

Measurement: 30x30 cluster surveys of under-fives.

Food-security indicators: In contrast to health indicators, experience of food security indicators is still relatively limited. There are no universal indicators of food insecurity, and many are based on subjective judgements from potential beneficiaries who may have preconceived views of the assessment procedure. Furthermore, the information may not always be presented in a manner which is useful to agencies.

It is unlikely that universal food-security indicators can be identified because the differences in the food economies of different contexts are so wide as to make comparison impossible. However, it may be possible to identify core indicators for a particular situation, which can be monitored and their trends observed over time. One example of such an initiative is the Coping Strategies Index (CSI), which is being developed by WFP and CARE International in Kenya. The CSI enumerates the frequency and severity of coping strategies of households faced with a short-term insufficiency of food. Four general categories of coping are measured, with individual strategies defined according to location and culture:

1) Dietary change

2) Increasing short-term food access (borrowing, gifts, wild foods)
3) Decreasing number of people to feed (short-term migration)
4) Rationing strategies (mothers prioritising children/men, limiting portion size)

List of interviewees

Johannesburg/Pretoria, South Africa

Michael Drinkwater, Regional Programme Coordinator, CARE Southern and West Africa Regional Management Unit, 18 November 2002

Jerry Dyer, Head of Office, UNICEF, 18 November 2002

Rob Holden, Head of Office, Southern Africa Humanitarian Crisis Unit, DFID, 18 November 2002

Chris Kaye, Head, OCHA Regional Support Office for Southern Africa, 18 November 2002

Christine Mitchell, Database Manager, OCHA Regional Support Office for Southern Africa, 18 November 2002

Joyce Luma, Regional VAC Representative, World Food Programme, 2 December 2002

Judith Lewis, Coordinator, Regional Director for East and Southern Africa, World Food Programme, 2 December 2002

Jeff Bryan, Disaster Response Co-ordinator for Southern Africa, Office of Foreign Disaster Assistance, USAID, 3 December 2002

Maren Lieberum, Regional Food Security & Nutrition Advisor, Oxfam, 3 December 2002

Malawi

Patricia Zimpata, Liaison Officer, Department of Disaster Preparedness, 20 November 2002

William Aldis, WHO Special Representative for Malawi, 20 November 2002

Francis Battall, Emergency Relief Manager, World Vision, 20 November 2002

Zahra Nuru, Resident Representative, UNDP, 21 November 2002

Ann Conroy, Adviser to Vice-President, Vice-President's Office, 21 November 2002

Paul McKee, Technical Advisor, American Red Cross Malawi, 21 November 2002

Dr Harry Potter, Livelihoods Adviser, DFID, 21 November 2002

Philip Upson, Consultant, Southern Africa Humanitarian Crisis Unit, DFID, 21 November 2002

Peter Hailey, Nutrition Programme Officer, UNICEF, 21 November 2002

Erasmus Morah, Country Programme Adviser, UNAIDS, 21 November 2002

Fred Mwathengere, Programme Analyst (HIV/AIDS), UNDP, 21 November 2002

Yuki Nosé, Program Officer (Public Health Specialist), UNDP, 21 November 2002

Eric Eider, Humanitarian Officer, OCHA, 21 November 2002

Cindy Holleman, Food Security Adviser, Save the Children UK, 22 November 2002

Nick Osborne, Head of CARE, CARE USA, 22 November 2002

Larry Rubey, Chief, Agriculture and Natural Resources, USAID, 22 November 2002
Eric Kenefick, VAM Officer, World Food Programme, 22 November 2002
Gerard Van Dijk, Representative, World Food Programme, 22 November 2002
Jonathan Campbell, Consultant, World Food Programme, 23 November, 2002
Lola Castro, Head of Programme, World Food Programme, 23 November, 2002
Georgia Paiella, Nutritionist, World Health Organisation, 23 November 2002
Valid International/Concern, community therapeutic feeding programme, Dowa, 23 November 2002
Theresa de la Torre, Epidemiologist, World Health Organisation, 24 November 2002
John Borton, Director, Learning Support Office, 24 November 2002

A meeting was hosted by the Learning Support Office, Malawi, on 20 November 2002. Attendees:

Francis Battal (World Vision), William Aldis (WHO), Philip Upson (DFID), Wilma Roswe (Ministry of Agriculture), Jonathan Campbell (WFP), Anne Conroy (Adviser, Vice President's Office), Yuki Nose (UNDP), Cindy Holleman (SC-UK), Peter Hailey (UNICEF), Patricia O'Loughlen (Department of Disaster Preparedness), Chigomezgo Mtegha (DFID), Chisomo Gunda (Ministry of Agriculture), McBain Kanongodza (Red Cross), Monica Djupvik (UNAIDS), John Borton (LSO)

Zimbabwe

Michael O'Donnell, Emergency Food Security Adviser, Save the Children (UK), 25 November 2002
Dr. E.K.Njelesani, Representative for Zimbabwe, World Health Organisation, 26 November 2002
Dr Shadreck Khupe, World Health Organisation, EHA focal point, 26 November 2002
Dr George Tembo, Country Programme Adviser, UNAIDS, 26 November 2002
Kevin Farrell, Representative, World Food Programme, 27 November 2002
Nicholas Haan, Regional Programme Advisor, Vulnerability Analysis and Mapping, World Food Programme, 27 November 2002
Isaac Tarakidzwa, VAM Officer, World Food Programme, 27 November 2002
Dr Festo P. Kavishe, Representative, UNICEF, 26 November 2002
Judith Mutamba, Consultant, UNICEF, 26 November 2002
Elliot Vhurumuku, FEWSNET Representative, 26 November 2002

John Hansell, Regional Food Security Adviser, Central and Southern Africa, DFID, 27 November 2002
Glyn Taylor, Consultant, Southern Africa Humanitarian Crisis Unit, DFID, 27 November 2002
Mark McGuire, Food Systems Economist, Food and Agriculture Organisation, 27 November 2002
Graham Farmer, Regional Emergency Coordinator, Food and Agriculture Organisation, 27 November 2002
Victor Angelo, Resident Representative and UN Resident Coordinator, UNDP, 28 November 2002
Andi Kendle, ACF, 29 November 2002
Sophie Battas and Christophe Legrande, Oxfam, 29 November 2002

A meeting was hosted by the Regional Vulnerability Assessment Committee, Zimbabwe, on 27 November 2002. Attendees:

Phumzile Mdladla (Regional VAC Chair, SADC REWU), Mark McGuire (FAO), Leila Oliveira (RVAC/FEWSNET), Judith Mutamba (UNICEF), Bruce Isaacson (FEWSNET), Faith Chikomo (FEWSNET), Douglas Magunda (SADC Database), Dorothy Nyamhanza (SADC-RRSU), Bentry Chaura (SADC REWU), Nick Haan (WFP)

London

Gary Sawdon, Food Security and Livelihoods Advisor, SC-UK, 7 November 2002
Sarah King, Emergency Capacity Building Officer, Christian Aid, 7 November 2002
Neil Garvey, Emergency Response Officer, Christian Aid, 7 November 2002

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Notes

[1] In 1996, the average percentage of people living below the poverty line was approximately 59%. In 2001, this figure had climbed to 68%. *UNDP Poverty Report 2000*, *UNDP Human Development Report 2001*.

[2] The six countries are Malawi, Zimbabwe, Zambia, Mozambique, Swaziland and Lesotho.

[3] Other cereals (rice, sorghum and millet) are grown in smaller quantities. Cassava is grown widely in the north, while cultivation of sweet potato is increasing in central and southern regions. Most small-holder farmers also produce groundnuts and other legumes during the year. *Malawi: Emergency Food Security Assessment Report*, Malawi National Vulnerability Assessment Committee, September 2002.

[4] That is, from December or earlier depending on the size of the previous harvest.

[5] The subsidy on fertilisers was reduced and replaced with loans for purchases at full import parity prices. ADMARC was increasingly expected to operate in market conditions – both in its purchase and sale of grain.

[6] UN Consolidated Inter-Agency Appeal in Response to the Humanitarian Crisis in Southern Africa, Malawi, July 2002–June 2003.

[7] The excess rains were reported to have affected over half a million people, and more than 40,000 hectares of maize, rice, millet, cassava, tobacco and cotton fields.

[8] See DFID (July 2002) *An Assessment of the Humanitarian Situation in Zimbabwe*; RIASCO (20 December 2002) *Southern African Humanitarian Crisis Update*.

[9] The extent of the drought in Zimbabwe from January to March 2002 – the primary growing season – was completely unforeseen. While there would have been a significant decrease in cereal production due to other factors, the lack of rain severely affected small-holders' production of maize, by an estimated 790,000 MTs.

[10] The 16 November 2001 FEWSNET newsletter warned that the Zimbabwean population was either highly food insecure, or was about to become so.

[11] CAP midterm review, 2003 – Regional Overview.

[12] SADC Food Security Technical and Administrative Unit (July 1993) *Assessment of the Response to the 1991/92 Drought in the SADC Region*.

[13] Some 40% of the rural population of Malawi do not achieve self-sufficiency from their own production in 'normal' years, and depend upon seasonal agricultural labour or share-cropping ('ganyu') during the lean period. When times are bad there is less work. Food for Work programmes could substitute for traditional 'ganyu'.

[14] One explanation given for limited requests for funding to respond to the HIV/AIDS crisis was that countries expected additional resources through the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM).

[15] The demonstration of raised mortality rates can sometimes trigger a response, especially a change of response where a situation runs 'out of control' of an existing assistance programme. Equally, a reduction in mortality rates may trigger a reduction or withdrawal of assistance.

[16] World Food Summit Plan of Action, 1996, paragraph 1. This definition is widely used, including in the new Sphere Standards on Food Security.

[17] Devereux, S. (May 2002) *The Malawi Famine of 2002: Causes, Consequences and Policy Lessons*. Brighton: IDS.

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[18] Nseluke-Hambayi, M. (April 2002) *A Fragile Situation in Sudan*. ENN, Issue 15, April. RNIS (2002) *Report on the Nutrition Situation of Refugees and Displaced Populations.* UN Sub-Committee on Nutrition, October

[19] ENN (1999) *Chronic Malnutrition: A Problem Not Addressed by SFPs*. ENN, Issue 7, July.

[20] UN/SADC joint appeal for Malawi, June 1992.

[21] CAP appeal for Malawi, July 2002.

[22] See de Waal, A. (2002) *'New Variant Famine' in Southern Africa*, presentation for SADC VAC meeting, Victoria Falls, 17–18 October.

[23] A research project at the Institute of Development Studies (IDS) in the UK is examining the experience of famine over the last 50 years. One aim of the project is to develop an operational definition of famine.

[24] See, for example, de Waal (2002).

[25] Interview, international NGO, Pretoria.

[26] It was suggested by one of those interviewed that some politicians took the view that, if they did nothing, they could not be accused of mistakes.

[27] A powerful case can be made under the UN Charter and the Covenant on Economic, Social and Political Rights of 1966 (articles 1.3, 11 and 12 in particular).

[28] IFRCS (2002) *Guide to Vulnerability and Capacity Assessment*, June.

[29] These assessments were carried out in Binga District, Zimbabwe, April–May 2002; Nyaminyami District, Zimbabwe, July 2001; Mutorashanga Informal Mining Communities, Harare, 2001; Salima District, Malawi, October 2001; Mchinji District, Malawi, October 2001.

[30] See 'Food Security and Vulnerability to Shocks: The SADC FANR VAC Conceptual Framework', draft, 19 June 2001.

[31] Chambers and Conway (2002) gives this definition of livelihood: 'a livelihood comprises the capabilities, assets (including both material and social assets) and activities required for a means of living. A livelihood is sustainable when it can cope with and recover from stress and shocks, maintain or enhance its capabilities and assets, while not undermining the natural resource base'.

[32] VAC Strategy and Operational Plan for Emergency Food Security Assessment and Monitoring in Southern Africa, June 2002.

[33] The only significant concession to people suffering from or otherwise affected by HIV/AIDS is to target those families living with AIDS with food aid. Other forms of aid which could have been considered include livelihood support to prevent asset depletion, emergency microfinance schemes, cash aid (to cover extra costs such as funerals, for instance), and agricultural inputs to small-holders.

[34] This was primarily because the excess morbidity and mortality that could be attributed to the food insecurity came on top of an already-increased disease burden due to HIV/AIDS. It thus became difficult to understand how to respond to the 'excess top 10%' of the disease load, while the current capacity to treat the pre-existing disease load was around 40% and declining. The only sensible response was to strengthen the entire health system, a prospect considered beyond the scope of the humanitarian agencies.

[35] Interview, Emergency Food Security Adviser, international NGO.

[36] Interview, Nutrition Adviser, UNICEF.

[37] Regular assessments, for example the UNICEF MICS, also act as a surveillance mechanism, but with long intervals.

[38] These are described in detail in Jaspars, S. and J.Shoham (October 2002), *A Critical Review of Approaches to Assessing and Monitoring Livelihoods in Situations of Chronic Conflict and Political Instability*. London: ODI.

[39] In Zimbabwe, for example, the assessment was conducted in all of the country's 57 using Food Economy Zones (FEZs) as the main sample strata. Specific wards were identified to be most representative of the FEZs (this process did not involve random selection) and interviews were conducted at a district and community level. In addition, 12 to 16 households were randomly selected and a questionnaire administered. The first round of assessments was completed in August 2002. The assessments provided a figure giving the percentage of people in need of food aid for each district within each affected country.

[40] A WFP technical workshop on emergency needs assessment in Rome in March 2003 went some way to identifying such common criteria, and also provided suggestions for coordinated action aimed at producing assessments that are 'sound, credible and comparable'.

[41] Two-stage cluster sampling methodology refers to a random selection of 30 clusters, and within each cluster the random selection of a number of households. Total sample size is based on calculations taking into account the expected prevalence or rate, the desired precision, a p-value of less then 0.05, and the design effect of the method.

[42] The official request for assistance from the Malawian government came on 22nd March 2002.

[43] This was noted by a senior official from USAID.

[44] Many international NGOs, for example Christian Aid, were not operational in Southern Africa, and worked only through local partners.

[45] Such concerns led to the development of a unique consortium model of NGO coordination in Malawi. The consortium was chaired by CARE International, and consisted of 12 international and national NGOs, including SC-UK, SC-US, CRS, WVI, Emmanuel International, Concern Universal, Africare, Salvation Army, GOAL Malawi, MRCS and Oxfam.

[46] Interview, humanitarian adviser, donor government.

[47] Senior donor official, USAID. Interview, senior UN agency representative.

[48] OCHA (2002) *United Nations Regional Humanitarian Assistance Strategy in Response to the Crisis in Southern Africa*, July.

[49] Interview, humanitarian adviser, donor government.

[50] Dexereux (May 2002), p. 5.

[51] Interview, senior UN agency representative.

[52] The Secretary-General's Special Envoy for Humanitarian Needs stated in January 2003 that a 'serious food crisis has been averted through good partnership between SADC, donors, NGOs and the UN'. *Southern Africa Humanitarian Crisis Update*, 10 February 2003. In January 2003, WFP announced its '$500 million emergency food relief operation in southern Africa had averted widespread starvation in the coming months'.

[53] According to the 2002 CAP: 'Almost 13 million people in Southern Africa are on the very edge of survival as the region struggles with shortages of food'

[54] Interview, humanitarian adviser, donor government.

[55] WFP (2002) *Report of the First Mission of the Special Envoy to Lesotho, Malawi, Mozambique, Swaziland, Zimbabwe and Zambia*, 3–15 September.

[56] Interview, food security Adviser, international NGO.

[57] Interview, humanitarian adviser, donor government/senior donor official, USAID.

[58] Buchanan-Smith, M. and S. Davies (1995) *Famine Early Warning and Response: The Missing Link*. London: Intermediate Technology Publications, p. 40.

[59] Interview, humanitarian adviser, DFID.

[60] Interview, humanitarian adviser, DFID.

[61] Interview, senior donor official, USAID.

[62] Interview, food security adviser, international NGO.

[63] Senior donor official, USAID.

[64] The population figure subsequently grew to 14.4 million. According to the mid-term review of 2003, it was likely to increase further based on the findings of the latest vulnerability assessment.

[65] Mid-term Review 2003.

[66] Porter, T. (2002) *An External Review of the CAP*. Commissioned by Evaluation and Studies Unit, OCHA, p. 3.

[67] Interview, senior donor official.

[68] Interview, humanitarian adviser, discussing DFID's Institutional Partnership Agreements.

[69] Interview, senior donor official, USAID.

[70] Interview, humanitarian adviser, DFID.

[71] Interview, senior donor official, USAID.

[72] Interview, senior UN agency representative, WFP.