Food sovereignty and nutrition in east and southern Africa: A synthesis of case study evidence

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Executive summary

In 2006, the Regional Network for Equity in Health in East and Southern Africa (EQUINET) and the Health Systems Research Unit of the Medical Research Council (MRC) of South Africa commissioned a series of country case studies on existing food security and nutrition programmes in East and Southern Africa that promote food sovereignty and equity.

What is meant by 'food sovereignty'? Food sovereignty includes the following criteria:

- prioritising local food production for domestic markets, based on peasant and family farmers;
- offering fair prices for farmers;
- ensuring access to land, water, forests, fishing areas and other productive resources;
- recognising and promoting the role of women in food production, equitable
- ensuring access to food and control over productive resources;
- giving communities control over their own productive resources;
- . protecting farmers' access to seeds; and
- providing public investment that supports the productive activities of families and communities, and that is geared toward empowerment, local control and the local production of food for domestic markets.

The case studies presented in this paper offer a country-level analysis of existing concrete policies and programmes, using secondary evidence to identify the role of health systems in food sovereignty. This paper synthesises the findings from these case studies, as well as additional background data, to outline the ways in which health systems can play a more pivotal role in promoting equity and food sovereignty in nutrition.

Attempts to improve the nutritional status of people in Eastern and Southern Africa (ESA) have been disappointing so far. In developing countries worldwide, there has been a decline in the number of undernourished people since 1990/92. However, in Africa, the number of undernourished people has *increased* since 1990/92 (mainly concentrated in Central Africa).

A recent analysis of nutritional data, partly funded by this project, examined all available large-scale nutritional survey data over the last ten years in Lesotho, Malawi, Mozambique, Swaziland, Zambia and Zimbabwe. The analysis found that populations with initially *better* nutrition may be those *most* affected. In other words, there is a higher rate of deterioration in a sub-group of the population. Three findings hint at this:

- Areas with initially better nutrition show *greater* increases in underweight prevalence.
- Higher socio-economic status (SES) is associated with higher levels of HIV prevalence, and when SES is controlled analytically, the association of HIV with deterioration is stronger. SES is masking the effect of HIV on child nutrition.
- The range of weight-for-age (standard deviation of the wt/age z-score) is *narrowing*, again in line with the initially higher wt/age groups of children being affected most.

This paper investigates the design and implementation of three important nutrition responses in ESA:

- **Food aid:** In Malawi, food aid may have played an important role so far in food security, but there is no explicit policy framework for food aid and a growing body of evidence that imported food aid impacts negatively on local production, usually resulting in unintended excess stocks of commercial maize. These excess stocks dampen current and future consumer prices, and may put additional pressure on government budgets if they have been financed through domestic borrowing.
- **HIV/AIDS-related nutrition interventions:** Studies show that the many small-scale HIV/AIDS-related nutrition programmes in ESA are limited in coverage, do not reach eligible people and are not regularly evaluated for their impact or effectiveness. Overall, the approach is not integrated, tending to deal with the short-term problems caused by HIV/AIDS, without addressing the long-term implications.
- **School feeding programmes:** School feeding programmes in Malawi and South Africa are informed by the policy outlined by the New Partnership for Africa's Development (NEPAD). School feeding programmes largely take the form of a vertical intervention programme, rather than a comprehensive nutritional programme, making any proposed impact on children's nutritional status unlikely.

These three nutritional responses are being influenced and shaped by dominant neo-liberal policies, which are inefficient and damaging to local economies. If ESA countries can adopt a more comprehensive approach to food sovereignty, they will reap the benefits. But, if a food sovereignty approach is to succeed in improving health systems, there must be improved co-ordination and communication between ministries. Ministries on their own are not in a position to provide comprehensive interventions – they need to work together.

Four recommendations are offered to governments to help them to implement a food sovereignty approach in their health systems:

- **Working with different stakeholders:** Governments will need to abandon quick-fix solutions, such as purchasing food commodities from large retailers or multinationals, and engage with a wider range of partners and role-players to promote local food production. This calls for a broader assessment of the institutional and macro- and micro-political situation within which service delivery is taking place, and building collaborative work with governments and their bureaucracies, civil society and local communities.
- **Giving a greater voice to local communities:** A significant benefit of a comprehensive food sovereignty approach is that it allows the people who are affected to take control of their own food security. Citizens are entitled to competent, responsive services, with a human rights approach. There are two channels of communication. The 'short route' ensures accountability between service providers and users, for example by involving local poor people in monitoring and providing services, by giving consumers the power to complain or by making the income of service providers dependent on their accountability to users. The 'long route' ensures accountability between governments and citizens, involving broader social and political change, for example by building relationships between local organisations, local community-based structures and personnel, and external state agents.
- **Strengthen service provision at community health worker level:** Intersectoral and community-focused responses call for increased strength and effectiveness of state actors within the communities they serve. A common feature of many successful

community-based health programmes is the presence of a cadre of workers who are trusted by and have access to households, and programmes that situate the right to health within the broader context of health equity.

- **Develop capacity for the management and monitoring of comprehensive interventions:** Involving other role-players, in particular those from vulnerable communities, in nutrition interventions calls for increased capacity in state agencies and non-governmental organisations (NGOs). These agencies and NGOs need to develop their capacity in order to be able to negotiate and monitor relationships between state and non-state providers, and to promote learning through action.

1. Introduction

In 2006, the Regional Network for Equity in Health in East and Southern Africa (EQUINET) and the Health Systems Research Unit of the Medical Research Council (MRC) of South Africa commissioned a series of country case studies on existing food security and nutrition programmes in the region that promote food sovereignty and equity.

What is meant by 'food sovereignty'? Food sovereignty includes the following criteria:

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- giving the community control over productive resources;
- . protecting access to seeds; and
- encouraging public investment that supports the productive activities of families and communities, and that is geared toward empowerment, local control and the local production of food for domestic markets.

The case studies presented in this paper offer a country-level analysis of existing concrete policies and programmes, using secondary evidence to identify the role of health systems in food sovereignty. This paper synthesises findings from these case studies, as well as additional background data, to outline the ways health systems can play a more pivotal role in promoting equity and food sovereignty in nutrition.

In developing countries, the number of undernourished people has declined to just three million people since 1990/2, incorporating an *increase* of 23 million between 2000 and 2003, and offsetting a decline of 26 million from 1990/92 to 1995/97. However, attempts to improve people's nutritional status in Southern and Eastern Africa have been disappointing, as indicated in *Table 1*. In Africa, the number of undernourished people has increased since 1990/92, mainly concentrated in Central Africa (FAO, 2006).

Table 1: Prevalence and number of undernourished people in developing countries, 1990/92 and 2001/03

FAO region	Prevalence of undernourished (%)		Number of undernourished (million)	
	1990/92	2001/03	1990/92	2001/03
Sub-Saharan Africa	35	32	169.0	206.2
Near East & North Africa	8	9	25.0	37.6
Asia	20	6	569.7	524.0
Latin America / Caribbean	13	10	59.6	52.4
All developing countries	20	17	823.1	820.2

(Source: (FAO, 2006)

Similarly, the proportion and number of stunted and underweight children in developing countries declined between 1980 and 2005 but, in Africa, these figures increased. Refer to *Table 2* for more details.

Table 2: Estimated prevalence and number of stunted and underweight children in developing countries, 1980–2005

UN region	Prevalence of stunting (%)		Number stunted (million)	
	1980	2005	1980	2005
Africa	40.5	33.8	34.78	49.40
Asia	52.2	29.9	173.37	110.19
Latin America / Caribbean	25.6	9.3	13.19	5.11
All developing countries	47.1	29.0	221.35	164.70
	Prevalence of underweight (%)		Number underweight (million)	
Africa	26.2	29.1	22.47	42.45
Asia	43.9	25.3	145.95	93.16
Latin America / Caribbean	14.2	4.3	7.32	2.35
All developing countries	37.4	24.3	175.74	137.95

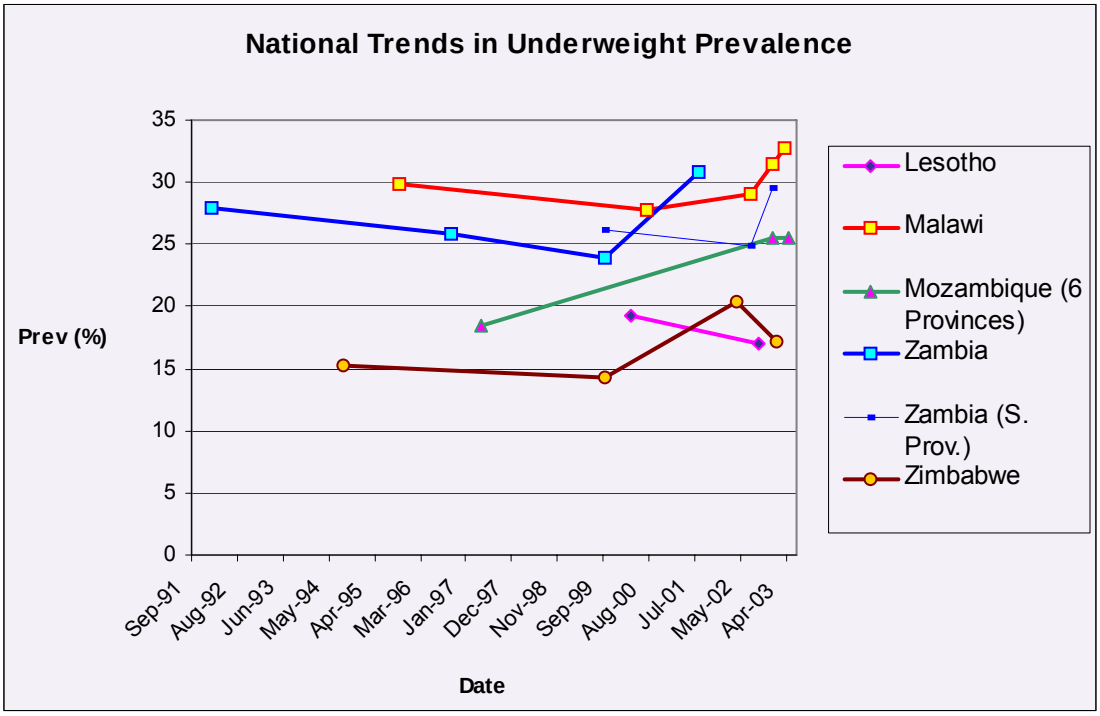
(Source: UN SCN, 2004)

Even more startling are the numbers for micronutrient deficiency, which better reflect the quality of the diet. For example, iron deficiency and anaemia affect more than 3.5 billion people in the developing world. More than 740 million people are affected by goitre (a result of iodine deficiency), and a further 2 billion are at risk for dietary iodine deficiency. In addition, between 78 and 254 million people are estimated to suffer from vitamin A deficiency and large numbers also suffer from zinc deficiency (UN SCN, 2004).
Eastern Africa is the sub-region experiencing the largest increase in numbers of underweight children – projected to increase by 36% from 1990 to 2005. A recent UNICEF study provides some important insights into the present situation regarding nutrition in the southern African region and its relationship to HIV and AIDS (UNICEF, 2003a). The study examined all available large-scale nutritional survey data over the last ten years in Lesotho, Malawi, Mozambique, Swaziland, Zambia and Zimbabwe. It found that the slow national trend for improvement in nutrition the 1990s ceased by the end of the decade. The latest data from Zimbabwe and Zambia show deterioration in the period 2001–2003. Levels of malnutrition remain shockingly high in Malawi and Mozambique, with more than 30% of children exhibiting stunted growth. Overall, 2.3 million children are underweight in the six countries mentioned above.

The surveillance of nutritional status is part of most Demographic Health Surveys (DHS) in the ESA region, and it is also measured by distinct national surveys. Data from these sources can be used to identify health inequalities and to monitor trends. Trends in the prevalence of underweight children (see *Figure 1* below) show that, until recently,

Malawi, Mozambique and Zambia had a prevalence of 25–30%, almost double that of Zimbabwe. Lesotho was also lower, below 20% (Mason et al, 2006). These levels stagnated throughout the 1990s, followed by a marked deterioration after the two droughts, with Malawi experiencing continuing deterioration due to persistent economic downturn. In contrast, the success of the food aid and supplementary feeding programme in Zimbabwe is reflected in the overall improvement seen after 2002 (which continued until 2004). There is little recent data to assess the effects of the recent deterioration in economic circumstances.

Figure 1: National trends in underweight prevalence



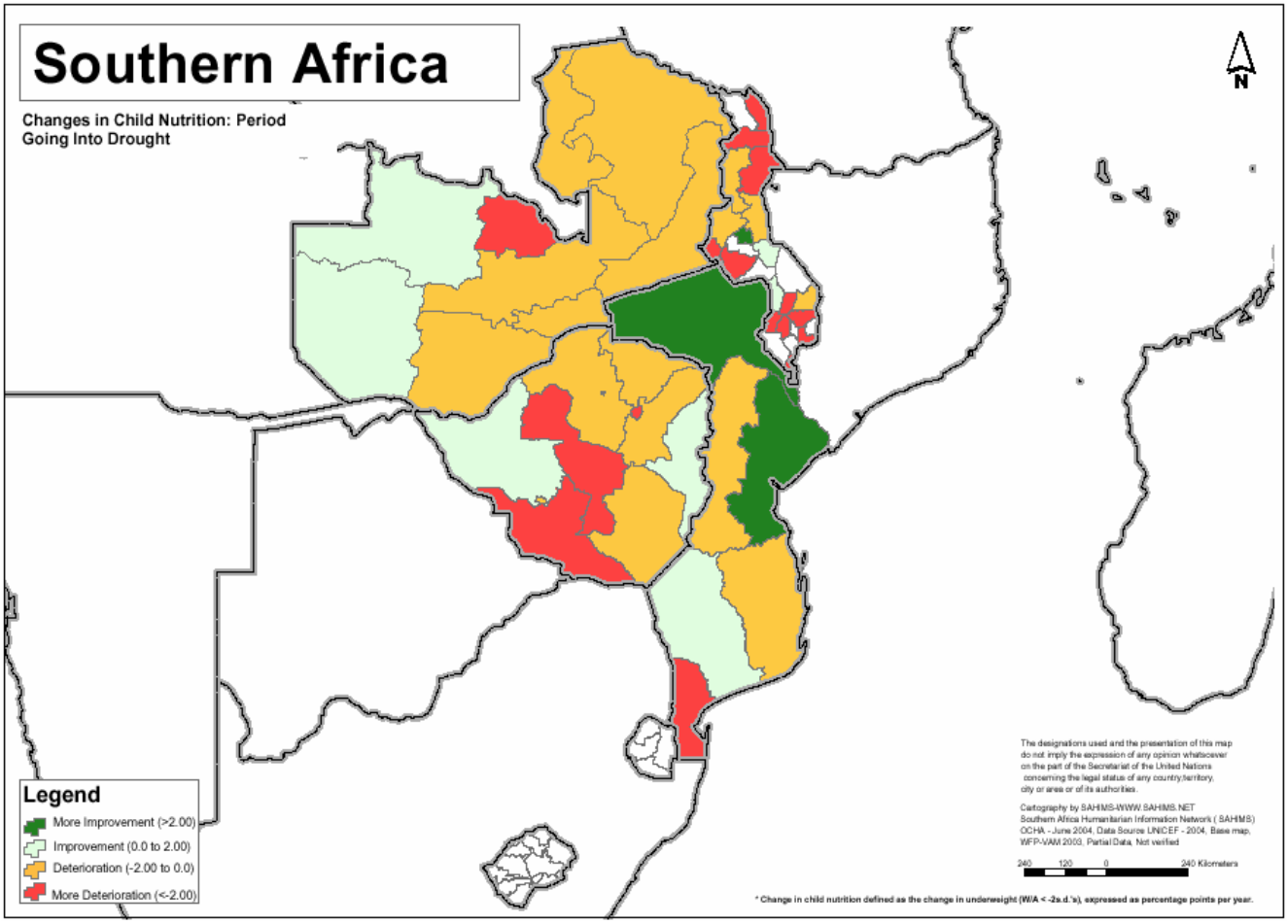
(Source: Mason et al, 2006)

Figure 2 and *Figure 3* are maps that illustrate trends in child nutrition in Malawi, Tanzania, Zimbabwe and Zambia during the drought in 1999–2000. Figure 2 shows changes in child nutrition *before* the drought, and Figure 3 shows changes in child nutrition *during* the drought. It is clear that child nutrition deteriorated during this period. An important finding from this analysis is that "the populations with initially *better* nutrition may be those *most* affected" (Mason et al, 2006).Three findings hint at this:

- Areas with initially better nutrition show *greater* increases in underweight prevalence.
- Higher socio-economic status (SES) is associated with higher levels of HIV prevalence, and when SES is controlled analytically the association of HIV with deterioration is stronger. SES is masking the effect of HIV on child nutrition.
- The range of weight-for-age (standard deviation of the wt/age z-score) is *narrowing*, again in line with the initially higher wt/age groups of children being affected most.

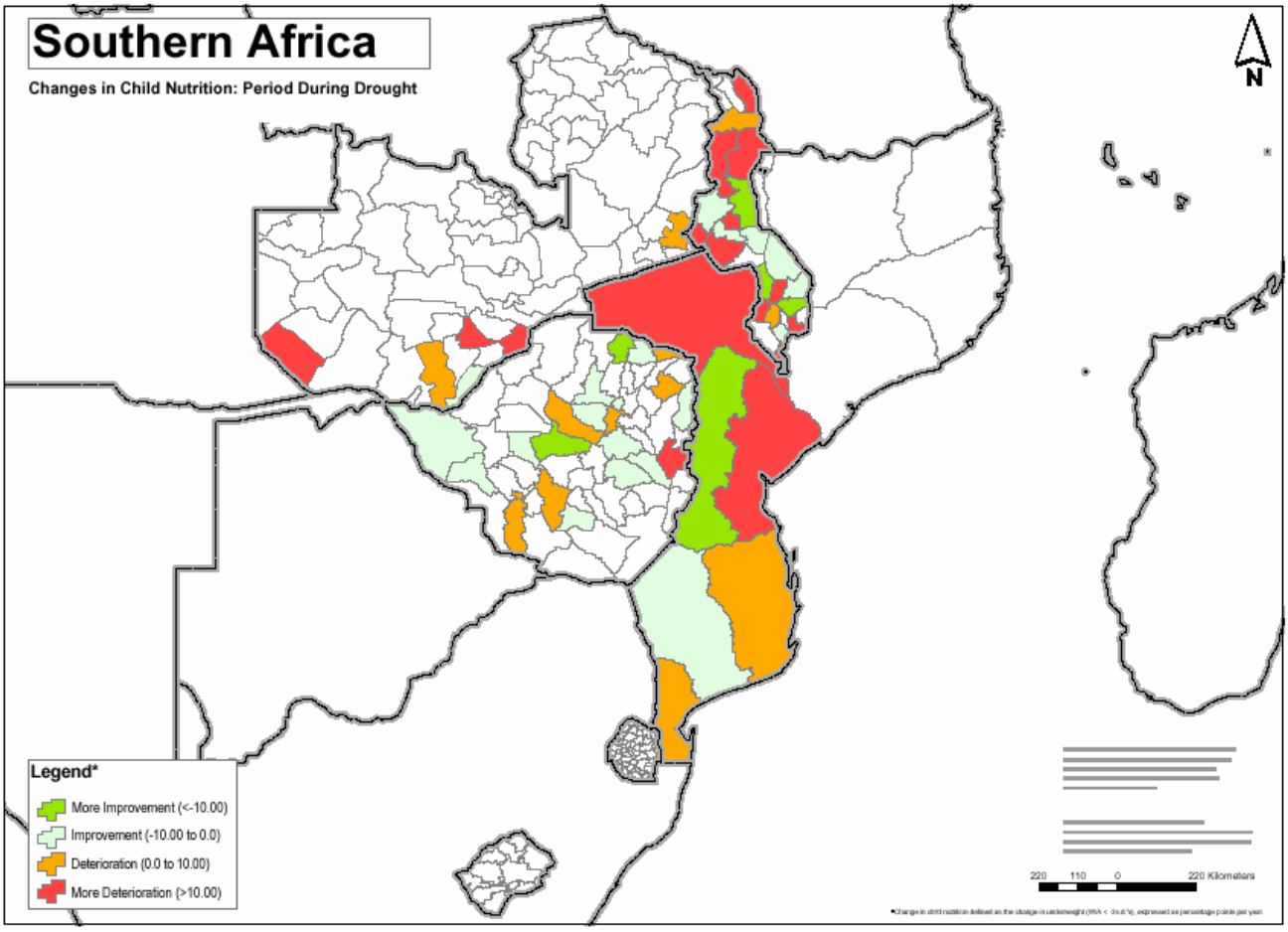
As a result, Mason (2006) concludes that "children in the hitherto less poor areas may be deteriorating faster than is apparent in the averaged data shown here" (page 33).

Figure 2: Southern Africa – Changes in child nutrition shortly before the drought of 1999–2000



(Source: Mason et al, 2006)

Figure 3: Southern Africa – Changes in child nutrition during the drought of 1999–2000



(Source: Mason et al, 2006)

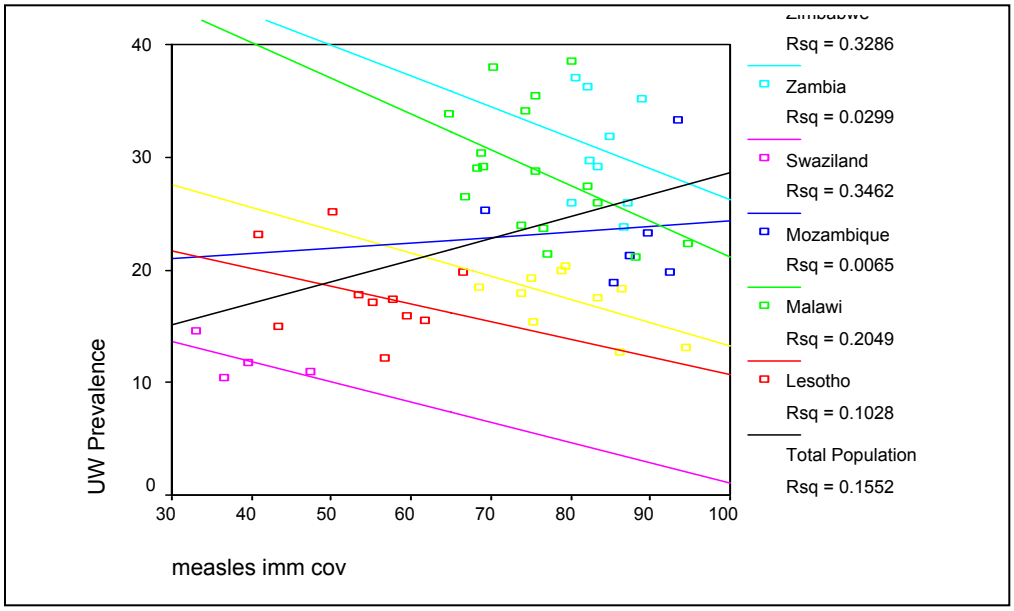
2. Nutritional status and equity

The close link between measures of the socio-economic status and nutritional status of children is well established from studies across a number of countries and regions. The pathways between these links are multiple and include better household food security, improved levels of care and better access to primary health care services. However, some of these pathways can be ameliorated even with relatively little change in basic income or wealth. For example, *Figure 4*, *Figure 5* and *Figure 6*, which follow, chart the relationships between issues such as the nutritional status of children, measles coverage, the level of education of the children's mothers, higher socio-economic status and HIV prevalence across all countries in the region. The relationships in nearly all cases are in the expected direction, but there are marked differences in the steepness of the slopes across the different countries.

Conducting comparative studies as to why maternal education is so much more important a determinant of childhood nutritional status in Swaziland than in Malawi may

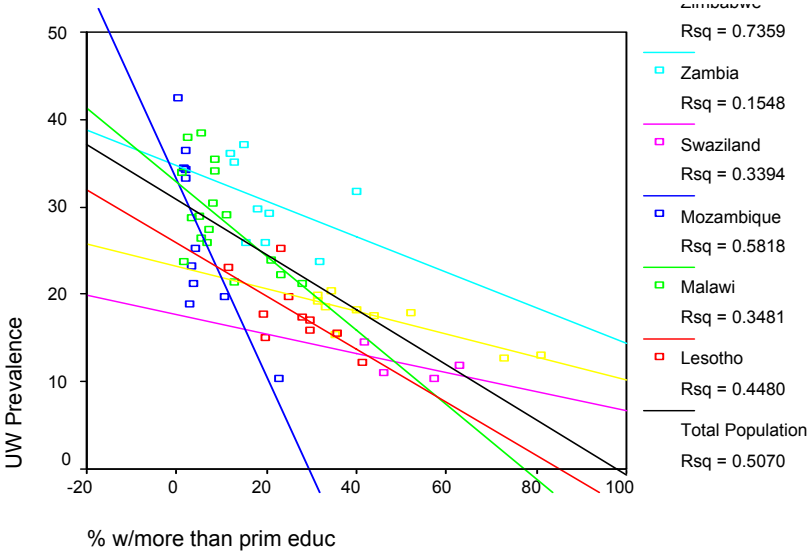
present some important policy options. for reducing the effects of inequality. Further analysis of datasets is continuing, which will hopefully explain these relationships better.

Figure 4: The relationship between underweight children and measles coverage



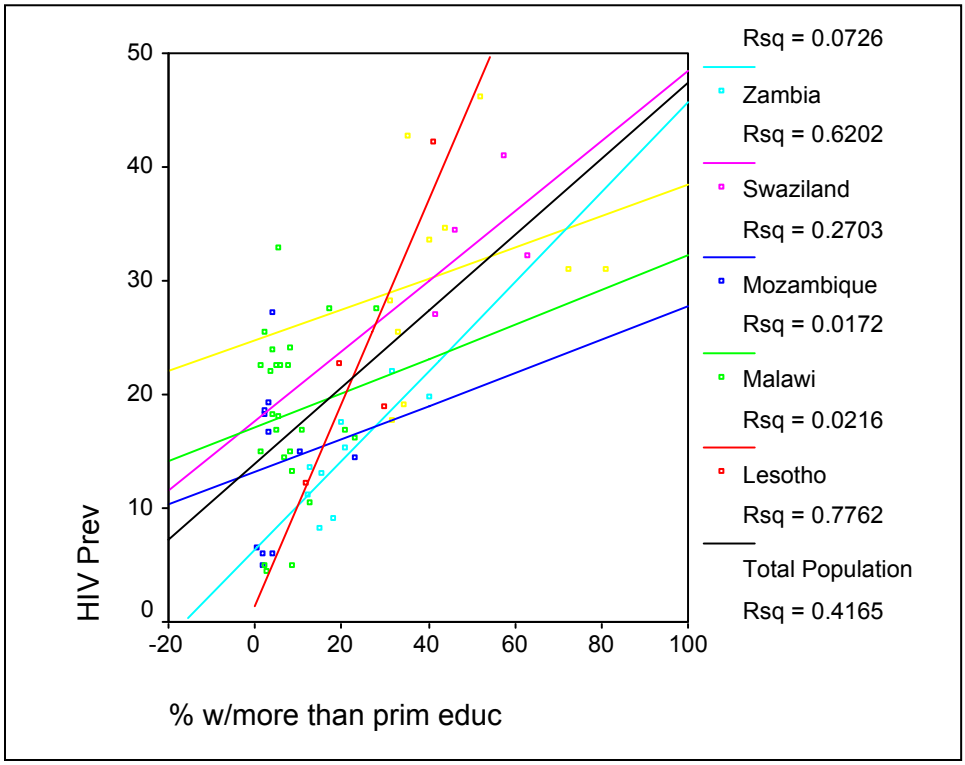
(Source: Mann et al, 2007)

Figure 5: The relationship between underweight children and levels of maternal education



(Source: Mann et al, 2007)

Figure 6: HIV prevalence vs education status of mothers with more than primary education



(Source: Mann et al, 2007)

3. What causes malnutrition?

While a lot of research has carefully evaluated many of the proximal causes of malnutrition such as breastfeeding and diet, there is very little rigorous evidence of more distal determinants, such as trade policy or agricultural practices. Only one change in agricultural policy – the shift towards commercial cash cropping – has been evaluated from a nutritional perspective. In the 1980s, the International Food Policy Research Institute conducted research into the nutritional impact of a series of cash cropping schemes in ten developing countries. The empirical results were mixed. Two of the schemes – potato production in Rwanda and a technological change to maize production in Zambia – lowered malnutrition among children aged five or under in participating households by providing higher incomes. But more than half the selected projects had no effect on nutrition, and some even had a negative effect. Studies in Kenya and the Philippines show that a doubling of income resulted in only a 4–7% increase in energy intake among preschoolers. In Sierra Leone, the children of commercial farmers were nutritionally worse off than subsistence farmers. These differences were attributed in part to the control of income within the household. Female-controlled incomes were related to higher levels of caloric intakes among children, as women are more likely than men to allocate resources towards food, thus highlighting the importance of gender in this area.

In conclusion, these studies indicate that cash cropping generally results in higher incomes and more spending on food, but has a relatively small impact on energy intake and, in most cases, little or no impact on childhood malnutrition (von Braun, 1995; von Braun and Kennedy, 1986; von Braun and Kennedy, 1994).

4. A food sovereignty approach to nutrition: Case studies

The findings outlined in section 3 above prompted EQUINET to commission a series of case studies to investigate the links between nutrition and food security interventions located within or closely linked with the health sector and health systems, and to provide a broader macro-level analysis of trade and agriculture. These case studies discuss the ways in which the design and implementation of feeding programmes are being influenced and shaped by dominant neo-liberal policies. They also promote an approach based on food sovereignty and equity, which will strengthen the design and implementation of food and nutrition policies and interventions, both generally and within the health system.

Within the context of building universal national health systems that protect rights to health, the health sector can play an important role in reinforcing a food sovereignty approach to nutrition and promoting equity-oriented goals. For example, child supplementary feeding and nutrition policies linked to primary health care also promote the local marketing of indigenous foods, women's productivity and their access to farm inputs, and public investments, such as fortifying locally milled grains. In these ways, the health system can reinforce a food sovereignty approach, even under conditions of food insecurity.

In the rest of this section, the following country case studies will be presented to investigate food sovereignty and equity in ESA:

- Food aid in Malawi: Jere (2007);
- HIV/AIDS and nutrition in East and Southern Africa: Atekyereza, Panagides, Graciano, Gerberg and Chopra (2007); and
- School feeding programmes in South Africa and Malawi: Tomlinson (2007).

4.1 Food aid in Malawi: Jere (2007)

Food aid is a relatively under-explored response to the nutrition and food crisis in Malawi. The EQUINET discussion paper entitled 'The impact of food aid on food markets and food security in Malawi', by Paul Jere, is a groundbreaking study of the effects on food aid on local food markets and food production in Malawi. Its findings are summarised below.

On closer inspection, it is clear that what is commonly referred to as the 'iron triangle of food aid' controls Malawi's food aid:

- **Agribusiness:** Just four companies and their subsidiaries, led by Archer Daniels Midland and Cargill, sold more than half the $700 million in food commodities provided through the United States Agency for International Development's food aid programme in 2004.
- **The shipping industry:** Only five shipping companies received over half the more than $300 million spent to ship that food (Stevens and Kennan, 2001).
- **Charitable organisations:** Non-profit aid organisations (NPOs) also have a vested interest in the current status quo. A number of large NPOs, such as Catholic Relief Services and CARE, depend on food aid for a quarter to half of their annual budgets.

> Their role in food distribution is widely recognised but they have also become grain traders, selling substantial amounts of the donated food on local markets in poor countries to generate tens of millions of US dollars for their antipoverty programmes (Madeley, 2003). Given that at least 50 cents of each dollar's worth of food aid is spent on transport, storage and administrative costs, selling food to raise money in, say, Africa, is an exceedingly inefficient way to finance long-term development. Would it not be better just to provide cash to stimulate local production?

The chief problem here is that imported food displaces local food production by increasing supply, lowering prices and reducing investment in local production. However, the analysis may be more complex than this, for three reasons:

- Food aid does not necessarily increase net domestic supply if there is an overall increase in consumption, or if food aid displaces commercial imports.
- It may be simplistic to assume that producer disincentives follow from product price changes. The seasonality of price effects – whether in the middle of the lean season or at harvest time – and absolute price levels are important modifiers.
- The impacts of food aid on other factors of production – including labour and credit – need further study.

Malawi has experienced persistent food deficits in the past five years, attributed to a reduction in maize production due to poor rains, a lack of inputs and infertile soils. The deficits have been bridged through a mixture of food aid, commercial imports and informal cross border trade. Unlike the 2002/03 food crisis, the 2005/06 crisis had more support from donors. Maize imports totalled 240,000 metric tons, of which 138,500 metric tons were mostly donor funded and 101,500 metric tons were imported by the government alone. Food aid has been one of the key approaches aimed at improving food security in Malawi. It has been inevitable in times of severe shocks such as drought, floods and market failure, and in lesser disasters, food aid resources have been linked to existing safety net programmes such as public works (food-for-work programmes) and targeted supplementary feeding.

There are three main categories of food aid that have been used in Malawi by different stakeholders:

- **Programme food aid** has been provided to the government as loans or grants, mainly for the purposes of improving the country's balance of payments and as budgetary support (a substitute for commercial food imports). In most cases, these loans or grants have conditions attached, which vary from donor to donor. Programme food aid is usually not targeted at specific beneficiary groups: it is normally destined for sale on local markets (at subsidised prices). It has also been used to build up Malawi's strategic food reserves.
- **Project food aid** may take the form of a grant in support of specific development objectives and beneficiary groups. Food is normally not provided directly to the government, but to the agency that is implementing the project (an NGO or government agency).
- **Relief food aid** is also provided as a grant, and is distributed to targeted beneficiaries to address critical food needs. If targeting requirements are not properly met, however, it has the potential to severely distort markets and create dependency.

Malawi has no explicit policy framework for food aid, even though a lot of food aid has been received over the past 10 years for relief and development activities. However, there are some key documents that are relevant to food aid in Malawi:

- the Malawi Economic Growth and Development Strategy (2006);
- the National Food Security Policy (2006);
- the Safety Nets Strategy (2000); and
- the Disaster Preparedness and Relief Act No. 27 of 1991.

Jere's paper outlines each of these pieces of legislation before turning to some of the impacts of food aid on local production, markets and dietary preferences. There is a growing evidence base that suggests that imported food aid has had a negative effect on local production. For example, the availability of free humanitarian food aid supplies through the World Food Programme reduced demand for commercial maize, which resulted in unintended excess stocks of commercial maize stocks, and dampened consumer prices, as well as producer prices for the next maize harvest. Unsold government commercial imports also put pressure on government budgets, as these were financed through domestic borrowing. Questions remain regarding the appropriate mix of commercial supplies and food aid to address food crises for Malawi.

Jere reports that there is evidence of an improvement in the government's responses to food crises. The 2005/06 food crisis saw a greater effort and achievement in the coordination of donor, government, UN and NGO response than the 2002/03 food crisis. In particular, the Food Security Joint Task Force that was established during 2002/03 food crisis and a Technical Secretariat in the Ministry of Agriculture (supported by the European Union and other donors) facilitated the coordination of the 2005/06 crisis. The performance of these structures was improved during the 2005/06 food crisis, as reflected by increased stakeholder participation and more frequent meetings of sub-committees and Plenary Sessions. More food aid was procured locally, too.

The paper concludes with some lessons learnt with respect to implementing good quality food aid programmes. The most relevant lesson here is perhaps the need to increase the capacity of the Malawi government to manage food aid processes. For example, in the 2005/06 food crisis, the government implemented two food pipelines to increase capacity. In addition to WFP free distributions, the government, with support from the British government's Department for International Development (DFID), also implemented a free food distribution programme in some districts, using a voucher scheme. This alternative was set up because the WFP's costs for food distribution were too high. Most of the stakeholders who were interviewed indicated that this was a bad practice, as it created unnecessary competition in the transport system and between implementing partners at local level. In addition, coordination and monitoring of the two programmes was difficult because of the different systems that were used. Ultimately, the government/DFID system lacked a proper monitoring and evaluation system, so that later on they had to adopt the WFP system after facing accountability problems.

4.2 HIV/AIDS and nutrition in ESA: Atekyereza et al (2007)

The spread and effects of HIV/AIDS in ESA has been well documented. Large-scale responses have also been implemented and are starting to have an effect on the health system, as well as the broader caring systems. Most of the attention has focused upon the scaling up of HIV treatment programmes but there has also been a significant

response to the epidemic with regards to nutrition interventions. The next paper in the EQUINET nutrition response series is 'A review of nutrition and food security approaches in HIV/AIDS programmes in Eastern and Southern Africa', by Peter Atekyereza, Dora Panagides et al. It combines two papers that audit the nutrition-led responses to HIV/AIDS across Eastern and Southern Africa and goes on to examine how these responses are in line with the lessons learnt from previous nutrition programmes. The nutrition-led responses to HIV/AIDS that are detailed in the Atekyereza and Panagides paper are all broad in scope and many of them have a multi-sectoral approach as one of their aims. They are summarised below.

In Uganda, a number of ministries have initiated an AIDS control programme that aims to strengthen AIDS education, promote nutritional standards for people living with HIV/AIDS (PLWHAs) and their families, and reduce poverty by establishing profitable agro-enterprises that save energy and time so that they are better equipped to cope with the epidemic. The World Food Programme (WFP) also operates in Uganda and provides relief food, rations, primary school education and feeding, supplementary and therapeutic feeding, and agricultural and market support to small scale farmers. TASO Uganda provides every HIV+ primary beneficiary with food for a maximum of five people in the household, including themselves. The Belgian Survival Fund provides micro credit to the poor in Uganda.

In Kenya, the COSAMO project of CARE's DAPII is designed to generate a sustainable increase in household access to savings and credit so that people can diversify their income-generating activities, thereby strengthening their livelihoods. The HIV/AIDS LIFE initiative project focuses on improving food, security and nutritional sufficiency through the distribution of food resources. The Food for Work project mitigates the effects of flooding by restoring canals, irrigation, dykes and other public infrastructures, de-silting canals and earth pans, rehabilitating village roads and small-scale irrigation schemes, and planting vegetation on restored physical structures in order to minimise soil and water erosion. The goal of the Nyanza Healthy Water project is to improve the quality of drinking water at household level. The Siaya-Busia Household Livelihood Security Project addresses the lack of clean safe water and sanitation, as well as poor nutritional intake due to low farm productivity of staple foods. The Livestock Marketing Enterprise (LIME) Project is a commercial model designed to address the challenges faced by pastoralists from the North Eastern part of Kenya by means of livestock marketing. The Millenium Water Alliance or 'Clean Living' has been designed to increase people's access to water and sanitation services.

In Tanzania, the Global Service Corps (GSC), through the Seeds of Sustenance Fellowship (SOS) Programme, provides skills and practical information to rural African communities affected by HIV/AIDS. GSC recruits, prepares, and trains pairs of local and visiting fellows to become qualified instructors in the technical areas of HIV/AIDS prevention and nutrition.

In Zimbabwe, ActionAid is giving food rations to HIV infected and affected households and to those with orphans and vulnerable children (OVC). The Red Cross targets home-based care clients who are HIV+, OVC and other affected households. The WFP has initiated a programme to provide nutritional support to pregnant and lactating women, while linking with programmes to help the prevention of mother-to-child transmission of AIDS. According to Atekyereza and Panagides, Zimbabwe seems to be the only country

with guidelines that recognise that food security activities should be introduced to mitigate the impact of HIV/AIDS.

In Mozambique, the government is planning to distribute multi-micronutrient supplements to all PLWHAs, using a clinic- and community-based approach. In addition, plans are under way to provide food support in the form of corn-soy blend (CSB) and an agreed-upon food basket to various target groups, including patients on ART and HIV+ patients with chronic illnesses. In response to the growing number of AIDS orphans, FAO founded the Junior Farmer Field and Life Schools for children and young people. The schools aim to share agricultural knowledge, business skills, and life skills with orphans and vulnerable children between 12 and 18 years of age.

In South Africa, the Integrated Nutrition Programme (INP) aims at fighting food insecurity for people living with TB and HIV by providing them with supplement meals and micronutrients.

Although there are numerous innovative programmes in East and Southern Africa that are responding to HIV/AIDS across the region, these programmes have limitations:

- Responses are limited in most cases.
- Aid does not reach many of the people who are eligible for it.
- Programmes are seldom evaluated to establish whether they are actually addressing the health and nutritional needs of PLWHAs.
- Hardly any evidence is available regarding the costs and effectiveness of responses in the region.
- There is a limited number of agencies on the ground to implement interventions.
- Overall, the approach is not integrated.

Responses to food shortages in the region tend to deal with the short-term problems caused by HIV/AIDS, without addressing the long-term implications. Zimbabwe is the only country with guidelines that recognise that food security activities should be introduced to mitigate the impact of HIV/AIDS. Nonetheless, its response still focuses on food security, rather than taking a more comprehensive approach that includes food sovereignty. The Junior Farmer Field and Life Schools in Mozambique appears to be the only programme that expands the notion of short term food security into areas of agricultural knowledge, in an attempt to feed increasing numbers of AIDS orphans.

4.3 School feeding programmes in South Africa and Malawi: Tomlinson (2007)

In his paper, 'School feeding in East and Southern Africa: Improving food sovereignty or photo opportunity?', Mark Tomlinson surveyed school feeding programmes in Malawi and South Africa, as well as the relevant policy outlined by the New Partnership for Africa's Development (NEPAD). His findings are summarised below.

Tomlinson notes that school feeding programmes can be divided in five categories, according to their objectives:

- school feeding as an emergency intervention;
- school feeding as a developmental intervention to aid recovery;
- school feeding as a nutritional intervention;
- school feeding to improve child cognitive development; and

- school feeding and short- and long-term food security.

In 1994, the South African government established the Primary School Nutrition Programme (PSNP), which attempted to redress the imbalances and inequities of the apartheid era. At its inception, the PSNP aimed to intervene at two crucial points seen as central to the future development of South Africa – nutrition and education. The purpose of the PSNP was to improve the health and nutritional status of South African primary school children, to improve levels of school attendance and to improve the learning capacity of children (which would in turn lead to an improvement in the quality of education). The PSNP intended to provide an early morning snack that would enhance levels of school attendance and increase children's learning capacity, improve their health through parasite control/eradication and micronutrient supplementation, and provide them with education on health and nutrition in order to improve their own health. It also aimed to bolster other government initiatives aimed at poverty alleviation.

Tomlinson outlines a number of problems with the school feeding programme in South Africa. For example, despite the broad aims of the PSNP (nutrition education and micronutrient supplementation), in practice, it has generally been a vertical school feeding programme (implemented by outside agencies and not linked to other aspects of school health, the school system or the health service) rather than a comprehensive nutritional programme. As a result, any proposed impact on nutritional status is unlikely to happen. School feeding in South Africa has also been beset by significant administrative difficulties and problems related to corruption, which are ultimately counter-productive. And coverage in South Africa has been poor and inconsistent.

In Malawi, the WFP organises the Food for Education (FFE) Programme. FFE includes a broader basket of interventions that aim to improve school enrolment, attendance, community-school links, and learning (WFP, 2006). Most of the WFP-provided food is either sourced locally (Malawi) or purchased within the Southern African region. Food is sourced elsewhere only if there is a local or regional food shortage. The FFE programme provides in-school meals or snacks to reduce short-term hunger and the associated cognitive impediments. In addition, the FFE programme provides take-home rations targeted at girls, orphans and other vulnerable children who attend school regularly. Finally, the FFE intervention uses a food-for-work scheme targeted at teachers and parents who are engaged in activities to improve schooling outcomes (Sibanda-Mulder, 2004).

The objectives of the Malawi school feeing programme are:
- to improve levels of school enrolment and attendance, especially with regard to girls and orphans;
- to ease short-term hunger, which will speed up the learning process, improve children's concentration and increase their assimilation of information; and
- to reduce disparities in enrolment and drop-out rates between boys and girls, especially in standards 5 to 8. (Fewer girls enrol at school than boys, and more of them drop out of school too.)

Malawi is at present developing a Nutrition and School Feeding Policy, and has proposed an institutional framework for a nation-wide school health and nutrition programme that is intended to operationalise school feeding activities supported and

implemented by the government and other stakeholders. The policy has not as yet been implemented.

NEPAD has developed the Comprehensive Africa Agriculture Development Programme (CAADP), which was endorsed in 2003. One aspect of this comprehensive plan is a flagship programme called the Home Grown School Feeding Programme (HGSFP). An important component of the NEPAD approach to school feeding is the emphasis on stimulating local food production. Many SFPs (including the WFP) may make use of food from the country in which they are working (although in many cases it comes from external sources), but in most cases it is not food produced within the vicinity of the schools. NEPAD aims to give local smallholder farmers the opportunity and assistance to provide schools with the necessary food products.

With school feeding, NEPAD aims to increase children's direct access to food through school feeding programmes and aims to reach 50 million children of school-going age by 2015. An important component of the NEPAD approach to school feeding is the emphasis on stimulating local food production. Many SFP's (including the WFP) may make use of food from the country within which they work (although in many cases it comes from external sources), but in most cases it is not food produced within the vicinity of the schools. NEPAD aims to give local smallholder farmers the opportunity and assistance to provide schools with the necessary food products. NEPAD's calculation is that, if 50 million children are fed for 220 days a year, this would amount to about 5 million tons of food per year for the programme, which would require at least 2 million poor farmers to produce it. In addition to creating a demand for basic crops like maize and bananas, demand will also be created for groundnuts (for their oil), sugarcane, various fruits and cassava, as well as for livestock, milk and eggs.

Both the school feeding and HIV case studies conclude that any comprehensive response needs to take into account the wider structural and systemic deficiencies that fuel the HIV pandemic and regional hunger: this conclusion is as true for responses to HIV/AIDS and nutrition as it is for school feeding.

5. Conclusion and recommendations

5.1 Conclusion

The increasing prevalence of under-nutrition and its debilitating effect on development for millions of children and adults across Africa is being increasingly recognised. This paper is a first step in helping us to identify some of the strengths and weaknesses of the responses to this unacceptable situation. The programmes considered here – food aid, school feeding and nutrition components of HIV/AIDS programmes – probably contribute more than US$ 1.5 billion in the Eastern and Southern African region alone. When implemented correctly, these interventions could have a crucial impact on people's nutrition, health and well-being in the region.

One over-riding message is the need for supportive pro-equity policies that can inform better programming. For example, in a comparison between Sri Lanka, Indonesia, the Philippines and Thailand, only Sri Lanka and Thailand showed rapid improvement in nutrition in the 1980s to 1990s (Drèze and Sen,1989). Indonesia showed slower but consistent improvement, and the Philippines little progress. Policies providing for female

education, social safety nets, affordable food and public health services were identified by the researchers to have contributed to this difference. The impact on child nutrition and survival by widespread female education in Sri Lanka is well documented, with 77% of married women in Sri Lanka now having schooling above primary school level. Drèze and Sen (1989) consider the establishment of social safety nets (especially the free or heavily subsidised distribution of rice, providing a minimum consumption floor for the poor) as the most important reason for the impressive performance of Sri Lanka. In a more recent review, Save the Children UK (2004) emphasises the provision of a universal, equitable and efficient public health system as an important reason for the low levels of maternal and child mortality in this country.

An interesting feature of the success in Thailand was the incorporation of nutrition as an important part of the National Economic and Social Development Plan (NESDP). This act led to the establishment of an extensive community-based network of village health communicators and volunteers, using existing village committees and leaders. The focus of these groups was the fulfilment of basic needs such as optimal nutrition (as measured by community-based growth monitoring and promotion) and education (Tontisirin and Winichagoon, 1997).

Comprehensive approaches like those mentioned above are sorely needed in East and Southern Africa. School feeding programmes in South Africa and Malawi lack a supportive policy and programmatic framework and are beset by considerable philosophical, financial, and logistical limitations and difficulties. They have no food sovereignty component, but are instead focused narrowly on food security. Of the programmes and interventions surveyed, only the NEPAD plan takes a food sovereignty approach. Unfortunately, its recommendations have not yet been implemented. Furthermore, its scope is ambitious and it is doubtful that governments in the region will be able to feed 50 million school children for 220 days a year.

The situation with regards to nutrition interventions for HIV is a little better, with examples of a more comprehensive approach. This may be related to the fact that many of the projects are run by NGOs, most of whom are locally situated, with skilled workers in communities. On the down side, there are very few programmes of substantial size, so coverage is patchy.

5.2 Recommendations

Atekyereza and Panagides (2007) point out that, historically, attempts to improve nutrition and food security have failed largely because of a lack of co-operation between the health and agricultural sectors. This is equally true for school feeding, where co-operation between the health and education sectors has often been poor. If countries in East and Southern Africa want to adopt a more comprehensive food sovereignty approach to nutrition and school feeding, their governments are going to have to significantly improve co-ordination and communication between their ministries. Ministries cannot work alone to provide comprehensive interventions – they need to work together.

The following four recommendations will help governments and other policy makers to develop progressive and effective nutrition interventions:

- Work with different stakeholders.
- Give greater voice to local communities.

- Strengthen service provision at community health worker level.
- Develop capacity to manage and monitor comprehensive interventions.

5.2.1 Work with different stakeholders

Governments will need to abandon quick-fix solutions, such as purchasing food commodities from large retailers or multi-nationals, and engage with a wider range of partners and role-players to promote local food production. This calls for a broader assessment of the institutional and macro- and micro-political situation within which service delivery is taking place, and building collaborative work with governments and their bureaucracies, civil society and local communities. In particular, it should analyse the politics involved in balancing work with governments and bureaucracies with work with civil society and local communities. School feeding and HIV/AIDS nutrition programmes need to be more community based.

5.2.2 Give greater voice to local communities

An integral part of a comprehensive food sovereignty approach is the strengthening of a human rights approach within the health system. Mobilisation and community involvement around nutritional issues, especially with respect to young children, has a rich history in the ESA region, for example, large-scale community based nutrition projects in Zimbabwe and Tanzania (Sanders & Werner 1997, Jonsson et al. 1998). In these examples, communities played an active role in the analysis of the problem and were give appropriate resources and capacity to plan and implement interventions.

The intersectoral nature of malnutrition also lends itself to involving different stakeholders. An important challenge in sustaining community participation is to develop the institutional framework for meaningful community participation. Consequently, recent policy shifts have focused more on the individual's rights for services such as health care. A significant benefit of a comprehensive food sovereignty approach is that it allows the people who are affected to take control of their own food security. Citizens are entitled to competent, responsive services, with a human rights approach. There are two channels of communication. The 'short route' ensures accountability between service providers and users (for example, by involving local poor people in monitoring and providing services, by giving consumers the power to complain or by making the income of service providers dependent on their accountability to users. The 'long route' ensures accountability between governments and citizens, involving broader social and political change (for example, by building relationships between local organisations, local community-based structures and personnel, and external state agents. These approaches have been criticised for undermining the concept of community participation as a fundamental part of the health system. What happens is that the approaches can be reduced a matter of the individual's consumption of the outputs of health systems that are managed and run by technicians and experts (Baez and Barron, 2006)

There are some examples of how food and nutrition programmes could be used to strengthen genuine community participation in health systems. Evans (1996) has previously outlined two important dimensions of mutually reinforcing relationships between state and non-governmental agents: complementarity and embeddedness. Complementariness is of relevance here (embeddedness will be discussed in the nest section).

Complementarity stresses the role of the state in establishing 'rule of law' (political will) to foster environments that allow local organisation to occur and is of interest here. An example of complementarity is the role of communities and activists to get nutrition concerns onto the HIV/AIDS agenda in ESA countries, thereby releasing resources for the provision of food as part of treatment and care. Activists, scientists and professionals are attempting to shift the bureaucratic supply systems of large donors that favour 'dumping' of excess food from developed countries towards more local sourcing (Jere, 2007). Their actions resonate with an analysis of various movements across South Africa that have coalesced different constituencies into civil society groupings that challenged the 'cultural nationalist / identity politics promoted by the new ruling elite' (Robins, 2004, page 664) that originally perceived HIV infected individuals as outsiders who were a threat. Instead, this mobilisation has articulated a new vision of citizenship in which recognising the political nature of the epidemic and pressing for antiretroviral treatment for HIV-positive persons is essential. Similar movements are now occurring around other basic rights such as access to clean water and sanitation.

Reviews of successful, scaled-up attempts to achieve this synergy have shown success depends crucially upon the relationship between local community-based structures and personnel, and external state agents (Tendler, 1997; Gillespie, 2003). A facilitatory environment, marked by actions such as advocacy, community mobilisation and capacity building, needs to infuse the system.

5.2.3 Strengthen service provision at community health worker level

The second dimension of Evans' mutually reinforcing relationships between state and non-governmental agents is embeddedness.

Embeddeness refers to the increased effectiveness of state actors when they are part of, or well acquainted with, the communities they are seeking to serve. A common feature of many successful community-based health programmes is the presence of a cadre of workers who are trusted by and have access to households. As fostering appropriate health care entails strengthening health care provision at the community health worker level, they provide the interface between users and the health system. Central to successful development is the building of trust and co-operation that will also facilitate the rapid scaling-up of similar community development efforts. An example is the Malawi government's improvement in managing of food aid during the two drought crises in Malawi over the last decade. The establishment of strong co-ordinating committees that are transparent and accountable to stakeholders has led to a more food sovereignty-based approach to food aid in Malawi.

5.2.4 Develop capacity to manage and monitor comprehensive interventions

Involving other role-players, in particular those from vulnerable communities, in nutrition interventions calls for increased capacity in state agencies and NGOs. These agencies and NGOs need to develop their capacity in order to be able to negotiate and monitor relationships between state and non-state providers. At present, these skills are very weak among managers. New approaches to learning, such as action learning and continuous learning, need to be introduced and nurtured.

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Equity in health *implies addressing differences in health status that are unnecessary, avoidable and unfair. In southern Africa, these typically relate to disparities across racial groups, rural/urban status, socio-economic status, gender, age and geographical region. EQUINET is primarily concerned with equity motivated interventions that seek to allocate resources preferentially to those with the worst health status (vertical equity). EQUINET seeks to understand and influence the redistribution of social and economic resources for equity oriented interventions, EQUINET also seeks to understand and inform the power and ability people (and social groups) have to make choices over health inputs and their capacity to use these choices towards health.*

EQUINET implements work in a number of areas identified as central to health equity in the region:

- Public health impacts of macroeconomic and trade policies
- Poverty, deprivation and health equity and household resources for health
- Health rights as a driving force for health equity
- Health financing and integration of deprivation into health resource allocation
- Public-private mix and subsidies in health systems
- Distribution and migration of health personnel
- Equity oriented health systems responses to HIV/AIDS and treatment access
- Governance and participation in health systems
- Monitoring health equity and supporting evidence led policy

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