Working Document

CRS KENYA DROUGHT EMERGENCY RESPONSE: RAPID ASSISTANCE PROGRAM (RAP)[1]

1.0 Background

In 2005, Kenya faced the worst drought in 50 years. Twenty seven out of 72 districts in arid and semiarid lands (ASAL) were affected and are still facing significant humanitarian and livelihood threats. According to the FEWSNET food security update of January 2006, the failure of the 2005 October to December short-rains season followed three to six successive poor seasons.[2] Kenya experiences mild cyclical drought conditions approximately every three to five years, with more severe dry periods on a roughly ten-year cycle.[3] Since 2003, successive poor rainy seasons have limited the ability of households in the ASAL - especially the poorest – to recover lost assets and expand coping mechanisms. This has increased vulnerability across a vast area of Kenya from the pastoral North to the Southern rangelands, and from the marginal agricultural areas of Eastern Province and parts of Coast Province. This situation prompted the President of the Republic of Kenya to make an appeal in December 2005 for both local and international support for people living in the drought affected districts.

In December 2005, WFP predicted up to 2.5 million people (ten percent of the Kenyan population) would be under serious stress with global acute child malnutrition ranging from 18 to 30 percent in the arid north and eastern areas of the country. On the other hand, the Government of Kenya (GoK) estimated the number of people requiring food aid to be 3.5 million including 500,000 school children. The food aid pipeline was severely stretched, and the GoK required support[4]. Nonetheless, an assessment of national commodity balance sheets for staple foods in Kenya demonstrated that food security problems largely resulted from problems in food access, as opposed to availability. In fact, the 2005 maize crop yield data presents an increase over previous years, indicating that the food insecurity problem being experienced was one of access rather than availability.

In response to the GoK appeal, CRS/Kenya undertook a series of firsthand Drought Rapid Assessments in nine districts of the country namely; Kilifi, Tana River, Marsabit, Kitui, Mwingi, Makueni, Machakos, Mbeere and Tharaka. These assessments were

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[2] "Kenya Food Security Update" FEWSNET, 4 Jan 2006

[3] "Kenya Long Rains Assessment Report 2005", Kenya Food Security Steering Group, Aug 2005

[4] "Kenya Monthly Food Security Updates" Kenya Metrological Department and WFP press releases

conducted through desk review, discussions with the GoK and other actors, and CRS partners in the affected districts. According to CRS/Kenya emergency assessments in the marginal agricultural areas, the crops planted in October 2005 wilted at knee height or suffered severe moisture stress leading to near total crop failure.[5] Results of a Rapid Market Assessment at the same time showed that prices for beans, rice and maize were increasing. Compared to the same time in 2005, prices had increased by an average of 35 percent for some commodities. In all the districts, over 90 percent of the households reported depleted food stocks from the previous season's harvest.

The CRS/Kenya rapid emergency assessments found that over 90 percent of households in all the assessed districts reduced consumption from two to three meals per day to one small meal per day as a copping mechanism.[4] Meals were mainly comprised of boiled maize, and thus did not provide adequate nutrients required for supporting daily normal body caloric and nutrient needs. With the increasing food deficits at the household level, vulnerable groups including women and children fail to meet their additional caloric and nutrient needs. Women reported that when their households run out of food, children are given priority to eat, then the sick, elderly, fathers and mothers last.[4]

Despite a lack of adequate operational nutrition surveillance systems for the affected districts, available data and field visits indicated an increasing number of underweight and wasting children. In the more severely drought affected communities, malnutrition levels ranged between 30 and 49 percent,[6] while the moderately affected areas had levels ranging between 15 and 21 percent.[7] These malnutrition levels are well above the WHO Global Acute malnutrition threshold of 15 percent. [8] Ministry of Health (MoH) health records data indicated that incidence of acute upper respiratory infections in children was increasing[9] while women in rural health facilities were experiencing more complications both in pregnancy and in delivery.[10] In addition, anemia was reported to be highly prevalent in lactating and pregnant women.

In response to persistent drought conditions across much of Kenya, CRS/Kenya developed the Kenya Drought Emergency Response (K-DER) with the goal of protecting and enhancing livelihoods in drought-affected communities. K-DER long-term relief and recovery interventions focuses on Food and Nutrition (SO1), Water and Sanitation (Watsan) (SO2) and Livelihoods and Agriculture (SO3). Through KDER, CRS/Kenya supports the restoration of livelihoods and increased resiliency in drought-affected communities. Demand subsidies for seeds and other agricultural inputs along with technical assistance regarding appropriate seed selection for drought-prone areas

[5] "Kenya Drought Emergency Rapid Assessment Report - Machakos, Makueni, Mwingi and Kitui districts" CRS/Kenya, January 2006

[6] "Growth Monitoring Records - Maikona Child Health Project" Christian Children's Fund

[7] "CHANIS Summary Sheets" Makueni and Mwingi Districts, 2005 and "Child Survival Growth Monitoring Records" Plan International - Kilifi district

[8] "CHANIS Records" Kargi and Maikona dispensaries

[9] "Kenya Drought Emergency Rapid Assessment Report - Marsabit District" CRS/Kenya, January 2006

[10] Nurse-In charge Kargi Dispensary (interview with the authors)

are in the pipeline for the most important planting season (October 2006). This activity targets four divisions in Kitui and Makueni districts of Eastern province. As an interim measure, CRS supported communities in developing community investment plans (CIPs) for improving natural resource management through the construction of soil and water conservation structures. CRS will facilitate the communities in implementing the CIPs through voucher for work schemes to extend support during this interim period (June – October 2006).

As stated earlier, the 2005 short rains season crop failed in the marginal agricultural areas of eastern Kenya including Kitui and Makueni districts and this led to a rapid onset of acute food insecurity. Consequently, CRS/Kenya decided to augment the K-DER program with a Rapid Assistance Program (RAP). The RAP component of K-DER program was designed to meet immediate needs of targeted droughts-affected communities in Kitui and Makueni. The RAP also provided contingency planning for support to general populations over the critical four-month period following the failure of the short rains harvest in March 2006. This program supports K-DER SO I on food and nutrition that states - "Nutritional status of populations in targeted drought affected communities is improved." It commenced in June 2006 after a delay of about three months and implemented for a period of five months from start-up.

1.2 RAP Design

The RAP addresses the food security problem through local purchase (LPC) of commodities according to a simple decision tree for food aid responses[11] (Figure1).

1. Are markets functioning well?

YES → Provide cash transfers (or vouchers) to targeted recipients, not food aid.

NO

↓

2. Is there sufficient food available nearby to fill the gap?

YES → Provide food aid sourced through local purchase/triangular transactions.

NO → Provide food aid through transoceanic shipments.

Source: "Food Aid after Fifty Years: Recasting its Role."

Figure1. Decision Tree for Food Aid Responses

As stated earlier, an assessment of national commodity balance sheets for staple foods in Kenya demonstrates that the food security problem in Eastern Kenya largely results from problems in food access, as opposed to availability. In fact, the national 2005 maize crop actually presents an increase over previous years. When used appropriately in these situations, the LPC modality can dramatically reduce response time and

[11] Maxwell, Dan, and Barrett, Chris "Food Aid After Fifty Years: Recasting its Role" Rout ledge, May 2005

improve cost efficiency of relief activities, in comparison to in-kind trans-oceanic shipments of food aid. In this case, LPC enhanced the timeliness of the RAP.[10]

In addition, recent initiatives have demonstrated that LPC, as a demand-side subsidy, can stimulate local production and marketing - a key concern for long-term recovery.[12] By delivering demand-side interventions at the extreme end of the market chain i.e. directly to beneficiaries/consumers via fungible resource transfers (vouchers or cash) the impact of LPC can reach the entire range of actors on the commodity supply chain. Furthermore, because fungible transfers can be reimbursed for a range of available foods, according to beneficiary-defined economic strategies, the potential inflationary impact of LPC is mitigated.

2.0 RAP DESCRIPTION, INTERMEDIATE RESULT AND OUTPUTS

RAP is a five month pilot program that increased access to food by vulnerable pregnant and lactating women and households with malnourished children less than 5 years of age through a food voucher system using existing market channels. It is a demand-side subsidy from a Supplemental Support Fund (SSF) where target beneficiaries were identified through health centers, and given food vouchers redeemable at local retail outlets. This type of resource transfer to targeted beneficiaries has been effective in similar (or more challenging) situations in the region.[13] Issuance of vouchers was accompanied by training in how to use the value of the transfer to meet nutritional requirements, given existing market conditions. The use of a voucher system provided invaluable data on the use of the transfer, enabling a management information system (MIS) that allowed an unprecedented level of management control, and monitoring and evaluation (M&E). CRS in East Africa has a great deal of experience in logistics of implementing voucher programs through seed vouchers and fairs programs, which was used to support the implementation of RAP. The RAP activities achieved K-DER Intermediate Result 1.1 – "During the critical short-term period, targeted families supplement their diets with additional nutritious foods". RAP immediate outputs included;

Output 1: Access to food in the market by targeted families is improved
By delivering food through the LPC modality, the RAP provided support that enhanced local marketing activities.

Output2: Family knowledge of nutrition is improved.
Before starting the distribution of food vouchers, targeted vulnerable groups received information and education for 20-30 minutes on dietary requirements and basic nutrition. The training sessions aimed at supporting the beneficiaries in making informed choices of food items that would improve their nutritional status. Vouchers themselves contained educational information. Children with severe malnutrition (<70

[12] Walker, David J., Jonathan Coulter and Rick Hodges "Policy Implications Arising from the Development Impact of Local and Regional Procurement of Food Aid" Position Paper Prepared for UK DFID EC-PREP Programme, Natural Resources Institute, University of Greenwich, UK, December 2005
[13] Ali, Degan et al "Cash Relief in a Contested Area: Lessons from Somalia" Humanitarian Practice Network (HPN), March 2005

percent of the median weight for height) were referred by participating clinics for therapeutic feeding programs, in addition to being provided with the voucher for the family.

3.0 RAP TARGET AREAS AND BENEFICIARIES

As noted, in January 2006, CRS/Kenya and partners undertook a nine-district multi-sectoral emergency assessment of the drought impact. The assessment covered four geographical areas selected according to current operational areas and needs.[14] From the areas assessed, CRS/Kenya identified 4 divisions within the 2 districts of Kitui and Makueni where RAP was implemented. The criteria used were based on:

- The scale and magnitude of affected populations
- Existing relief coverage
- Current CRS/Kenya and diocesan staff capacity
- Availability cash resources

The total population of the targeted divisions in the two districts is approximately 193,291 persons, of whom approximately 125,008 were affected by the drought. RAP targeted vulnerable groups for supplemental feeding including lactating and pregnant women and families of malnourished children under five.

The WHO estimates that lactating and pregnant women represent five percent of the general population. Children under five account for 18 percent of the population and of these WFP estimates that 15.5 are malnourished.

Furthermore, CRS/Kenya estimates that the program would reach 95 percent of eligible beneficiaries. This is higher than the 70 percent estimated by the SPHERE project for targeted food aid programs because CRS/Kenya estimates that the voucher program would attract a greater number of those eligible. Based on these calculations, RAP target beneficiary numbers were as shown in Table 1:

- Lactating and pregnant mothers: 2,503
- Malnourished children under five: 3,502

Table 1: K-DER RAP Target Areas and Beneficiaries

District	Affected Divisions	Population	Affected Population	Targeted Population	
				L &PW	MCU5
Kitui	Mutha	43,704	30,593	765	1,158
	Mutomo	51,123	35,786	448	678
Total		94,827	66,379	1,213	1,836
Makueni	Nguu	22,303	13,382	390	591
	Kathonzweni	76,161	45,697	900	1075
Total		98,464	59,079	1,290	1,666
Grand Total		**193,291**	**125,458**	**2,503**	**3,502**

[14] "Drought Emergency Rapid Assessment Reports" CRS/Kenya January 2006

P&LW = Pregnant and lactating mothers, MCU5 = Families with malnourished children under 5 years

4.0 SUPPLEMENTAL SUPPORT TO VULNERABLE FAMILIES

To provide additional caloric and protein intake as a supplement to relief food for the most vulnerable, CRS and implementing partners carried out a targeted resource transfer from a Supplemental Support Fund (SSF) to support households with malnourished children and pregnant or lactating women.

The RAP delivered supplemental assistance through 11 existing health centers registered with the program, five in Makueni and six in Kitui. During the start-up period, as pregnant or lactating women and mothers with malnourished children under the age of five attended health centers, the staff registered the targeted beneficiaries in beneficiary registration forms and the information recorded was entered into a computerized database and beneficiary registers generated. A register of retailers (*Duka* owners) in the program areas who agreed to supply supplemental food resources through the voucher system was also generated.

On specified days, beneficiaries identified by health centers received transfers from CRS partner staff in the form of food vouchers drawn from the SSF, and redeemable through registered local retailers. The value of the transfer reflected the cost of monthly basic food rations as defined by SPHERE:

1. Pregnant and lactating women: One Individual Ration consisting of cereal (12.5 kilos) and beans (six kilos) estimated at Ksh 540.
2. Malnourished children under five: One Family Ration (equivalent to four half rations) consisting of cereals (25 kilos) and beans (12 kilos) estimated at Ksh 1,080.

In order to register as an implementing retailer, RAP required that retailers hold a bank account through which to receive reimbursement in order to avoid security risks associated with transporting large quantities of cash to the market sites. Retailers were required to fill in purchase data on the back of vouchers at time of sale in order to track their use by beneficiaries. In order to minimize value discounting, vouchers were being collected from the traders for reimbursement on a bi-weekly basis (at the time of Market Assessments). Throughout the RAP, CRS/Kenya and the Partners monitored markets on a weekly basis and informed the *Duka* owners about the prevailing market prices.

In addition to increased access to food, families were not restricted on the food and other basic items such as soap but were expected to make informed choices as a result of increased family knowledge of appropriate nutrition and hygiene.

5.0 IMPLEMENTATION

Immediately following the approval of the RAP in May 2006, CRS/Kenya engaged Ben Watkins of Kimetrica Ltd as the M&E systems and emergency programs Database consultant who in consultation with the CRS RAP staff designed and finalized the RAP M&E plan and database an Access VBA MIS.[15] In June 2006 the consultant also developed the vouchers and the Market and Nutrition Assessment forms and CRS RAP staff finalized the detailed implementation plan. Subsequently RAP was carried out in three phases:

5.1 Start-Up (30-45 days)

RAP sensitization meetings were held in May 2006 at the district level to inform the district steering groups (DSG) who are the emergency coordinating units about the program and how it fits into the existing GOK/WFP Emergency Operations Program (EMOP). The meetings were also aimed at sensitizing the traders and the health centers about the program so that they would prepare and those interested express interest to participate in RAP. Rapid market assessments were also carried out with the aim of understanding the food supply chains in the respective areas. The clinic, *Duka* (food stores) and beneficiary registration also commenced. Training of RAP Implementing Partners staff took place in Machakos from June 7th - 9th 2006. This was followed by household and community baseline surveys that were completed in June 2006. The beneficiary and *Duka* registration data were entered into the computer database, the beneficiary and *Duka* registers were developed and vouchers generated and printed in July 2006. The values of vouchers (Ksh 1,080 for family Ration and Ksh 540 for individual ration) were pegged on the maize (ksh 20) and bean (Ksh 45) prices one week before voucher distribution commenced.

5.2. Implementation (three months)

The distribution of vouchers to beneficiaries through the health centers on a rolling basis with one fourth of the beneficiaries receiving vouchers each week started on 18th July 2006. The vouchers were distributed in three rounds;
Round 1: 18th July 2006 – 11th August 2006
Round 2: 15th August – 8th September 2006 and;
Round 3: 12th - September 30th.
The vouchers were distributed four days in a week with one day for reconciling the number of vouchers distributed weekly. This timing moderated the flow of demand into the markets and reduced the potential for inflation. During the three months of implementation, the RAP staff undertook weekly assessment of markets through the participating retailers, and reimbursed vouchers. In addition, the RAP staff liaised with *Duka* owners to adjust commodity prices when they started to fall in August. The downward price adjustment benefited the targeted beneficiaries as they redeemed more food with vouchers. Before voucher distribution the health workers gave a 20-30 minutes health and nutrition education to the beneficiaries within the health centers. This was done using participatory approaches. RAP staff supported on-going nutritional

[15] The RAP Database will support the proposed program "Enhanced Tools for Allocating Food Assistance" with Tulane University - Center for Disaster Management and Humanitarian Assistance

training by providing training materials for use by community health workers and health centers staff and also undertook weekly monitoring of clinics.

5.3. Mid- term Review (30 days):

Mid-term review was conducted from 7th – 21st August 2006, two weeks after the first voucher distribution. The same household and community surveys questionnaire administered during the baseline was used but questions on RAP were asked during the interviews.

5.4. The Final Evaluation

The final evaluation will be conducted in October/November 2006. The Final Evaluation will be undertaken by an external consultant who will draw conclusions on the effectiveness of the RAP in meeting K-DER SO1: *"Nutritional status of populations in targeted drought affected communities is improved*" and IR 1.1: "*During the critical short-term period, targeted families supplement their diets with additional nutritious foods"*. It will also include an evaluation of the market impact of the RAP activities. Thirty days is required to ensure that lessons learned are documented. The K-DER RAP Phases/Activities Timelines are summarized in Table 2.

Table 2. K-DER RAP Phases/Activities Timeline

PHASE ONE: Start-Up 30 - 45 days	**PHASE TWO: Implementation Three months**	**PHASE THREE: Final Evaluation 30 days**
• M&E system finalized • Set-up RAP Database • Set-up voucher system • Set-up Assessment systems • Training of RAP staff • Market and Nutrition baselines	• Weekly assessment of markets • Weekly reimbursement of vouchers • On-going sales into deficit markets • On-going health and nutritional training • Weekly nutritional assessments • Mid-term review	• Preparation of Final Evaluation • Final Financial Report

6.0 MANAGEMENT AND ADMINISTRATION

An Emergency Program Manager (PMI) with experience in emergency relief operations, including distribution logistics, and agricultural marketing was responsible for K-DER throughout the life of the program. The full-time K-DER RAP staff received technical support from the CRS Agro-enterprise & Monetization Adviser Mr. David Rinck, and administrative support from the CRS/Kenya Director of the Basic Needs Division Ms Hanna Dagnachew. The Emergency PM at CRS Level was assisted a TDY Johan Razafiarison of CRS Madagascar in finalizing the M&E system, sensitization and training of partners and collaborators at start up and implementation phases. The Emergency PM at CRS Level was assisted by a M&E manager, a Nutritionist/Health Educator and four Enumerators at partner level led by an Emergency coordinator temporarily recruited for this project by each diocesan partner.

Additional part-time staff included an Accountant, Finance Officer, four data clerks and two Drivers. Kimetrica Ltd a consulting firm was hired to develop the RAP M&E plan including data collection formats and data base RAP will hire an external consultant for the Final Evaluation scheduled to take place in October 2006. The external consultant will have specialized economics experience, including statistics and econometric modeling. The K-DER RAP Titles and Responsibilities for CRS and Partner Staff are summarized in Table 3.

Table3: K-DER RAP Titles and Responsibilities for CRS and Partner Staff

Title	Primary Responsibilities
Emergency Program Manager	• Overall K-DER and RAP management • Analysis of Market Assessments • Analysis of Nutrition Assessment • Management of General Population Access sales • Supervision of voucher distribution and reimbursement • Supervision of Nutritional Training
Johan Razafiarison: TDY	• Assist in finalizing the M&E system • Assist RAP management at start-up and initial implementation • Assist in training of partners and collaborators.
M & E Officer /Market Analyst	• Supervise Market Assessments • Supervise Nutrition Assessment • Supervise enumerator team
Enumerator Team Leader Enumerators (4)	• Weekly data collection in target areas • On-going data entry
Nutritionist Emergency Coordinators (2)	• On-going Technical Support • Management of targeted sales and receipts
Accountant Finance Manager	• Bookkeeping • Financial Reporting
Drivers (2)	• Local Transport
Final Evaluation consultant	• Lead and produce Final Evaluation
M&E Plan and Database Developer	• Development of RAP Database
Agro-enterprise & Monetization Adviser	• On-going technical support
Director Basic Needs Div.	• On-going administrative support

7.0 MONITORING AND EVALUATION

CRS/Kenya invested significantly in monitoring and evaluation of this program, especially with respect to IR 1.1. This investment was necessary in order to have an effective and responsive program and had the added benefit of contributing to CRS'

learning on local purchase interventions. The M&E system consisted of three components:

7.1. Market Survey Forms

At the time of start-up, RAP staff used Market Survey Forms (checklists) to undertake a baseline market assessment. Subsequently, RAP staff undertook Market Surveys on a weekly basis.
The Market survey Form was used to collect data on the following topics:

- Commodity price per unit
- Volume and sources brought to market
- Volumes and types of food aid distribution within the immediate market
- Consumer behavior

The Market Survey Forms generated price information which determined the price and hence quantities of the commodities the beneficiaries redeemed voucher for and therefore subsequent voucher values, and program strategies. Secondly, the Market Survey Forms supported weekly Market Assessments. Finally, the Market Surveys helped in determining the level of support RAP provided to the local marketing activities.

7.2. Baseline and Mid-Term Household and Community Questionnaires

Baseline and mid-term household and community questionnaires were used to collect data at household level on a 30x30 cluster sampling method for household survey and one community per cluster. The same questionnaires were administered two weeks after first voucher distribution in a mid-term review which included questions on RAP. The data once analyzed will be used to measure the impact of RAP at household and community level.

7.3. Vouchers

Throughout Implementation, RAP staff issued vouchers once a month per beneficiary on a weekly basis through health centers. To reimburse vouchers, retailers provided data (on the back of the voucher) regarding commodities purchased, and quantity and price per unit cost.

Voucher data was meant to support weekly Market Assessments and Nutrition Assessments. Once analyzed the voucher data will also measure the level of support RAP provided to domestic production and local marketing activities.

7.4. Nutrition Survey Forms

At the time of start-up, RAP staff used Nutrition Survey Forms to undertake a Baseline Nutrition Assessment. Throughout Implementation, RAP staff undertook Nutrition Surveys on a weekly basis. The Nutrition Survey Form collected data regarding consumer behavior in order to understand beneficiary use of resource transfers.

Once analyzed the nutrition data will provide feedback on the impact of Information, Education and Communication on Nutrition. Exit interviews with beneficiaries augmented this process. The Nutrition Survey Forms supported weekly Nutrition Assessments.

7.5 Final Evaluation

A Final Evaluation will be conducted by an external consultant in October/November 2006.

The K-DER RAP Monitoring and Evaluation plan is as shown in Table 4.

Table 4: K-DER RAP Monitoring and Evaluation

Report	Source	Frequency	Timing
Baseline Market Assessment	Retailers (Market Form)	Once	Start-Up
Baseline Nutrition Assessment	Health Centers (Nutrition Form)	Once	Start-up
Baseline household and community surveys	Household and community questionnaires	Once	Start-up
Market Assessment	Retailers (vouchers and Market Form)	Weekly	Implementation
Nutrition Assessments	Health Centers and beneficiaries (vouchers and Nutrition Form)	Weekly	Implementation
Mid-term Review	Household and community questionnaires	Once	2 weeks after first voucher distribution
Final Evaluation	Final Evaluation Team Leader	Once	Final Evaluation

8.0 FINANCIAL RESOURCES

RAP program was privately funded using CRS private resources to the tune of US$ 400,065.

9.0 RAP ACHIEVEMENTS

Since RAP started in June 2006 it has registered a number of achievements as shown in the present report.

9.1 RAP M&E Plan and Database

The RAP computerized M&E system and an Access VBA MIS database was developed through a consultant, Kimetrica Ltd. The database has a report generating mechanism and that has helped RAP staff compile monthly progress reports promptly.

9. 2 Baseline and Mid-Term Surveys

The data from Household and Community baseline and mid-term surveys was entered into the RAP database. Analysis of the data is being completed and the survey reports

will be ready soon. The delays were as a result of the slow data entry occasioned by hitches experienced with the computer software which was ideally being test run concurrently with data entry. According to the RAP software Developer Kimetrica Ltd, development and test running of the software required about 3 months but they had only one month to develop the RAP Database. However, the RAP M&E system and data base developed by Kimetrica were a valuable tool to CRS in keeping track with the RAP progress and controls in voucher distribution, redemption and reimbursement to traders.

9.3 Beneficiaries Registered and Eligible Beneficiaries

The registration of beneficiaries was initiated in May 2006 and continued through June 2006. This was followed by Beneficiary data entry into the RAP database. A total of 5,537 beneficiaries were registered at registered health facilities (Table 5). This was 92% of the 6,005 targeted beneficiaries. Of the total number registered 43% were lactating or pregnant women and 57% were families with malnourished children under five.

Table 5: The number of beneficiaries registered for food vouchers program in Kitui and Makueni districts.

District	Division	P&LW	MCU5	Total
Kitui	Mutha	609	1,165	1,774
	Mutomo	406	696	1,102
Makueni	Nguu	343	431	774
	Kathozweni	1,041	846	1,887
Total		2,399	3,138	5,537

P&LW = Pregnant and lactating mothers, MCU5 = Families with malnourished children under 5 years

Out of 5,537 registered 4,943 were eligible as RAP beneficiaries (Table 6). Of the total number eligible 41% were pregnant or lactating mother and 59% were families with malnourished children under five years old.

Table 6: # of food vouchers printed and distributed to implementing partners for one round of voucher distribution.

District	Division	P&L W	MCU5	Total
Kitui	Mutha	561	1065	1,626
	Mutomo	266	664	930
Makueni	Nguu	340	343	683
	Kathozweni	834	870	1,704
Total		**2,001**	**2,942**	**4,943**

P&LW = Pregnant and lactating mothers, MCU5 = Families with malnourished children under 5 years

9.4. Vouchers Distributed

The food vouchers were distributed in three rounds and the vouchers distributed per round are shown Table 7. The number of vouchers distributed to beneficiaries was 96.8% of the vouchers distributed to partners and only a negligible 3.2 % were not yet claimed by beneficiaries at the end of voucher distribution. The 96.8% of the vouchers distributed was more than 95% targeted eligible beneficiaries and above the 70% estimated by the SPHERE project for targeted food aid programs.

Table 7: Actual number of food vouchers distributed each month

District	Division	Food Voucher Type		Total	Unclaimed
		P&LW (Individual)	MCU5 (Family)		
Kitui	Mutha	550	1,045	1,595	**31**
	Mutomo	246	644	890	**40**
Makueni	Nguu	332	332	664	**19**
	Kathozweni	801	835	1,636	**68**
Total		**1,929**	**2,856**	**4,785**	**158**

P&LW = Pregnant and lactating mothers, MCU5 = Families with malnourished children under 5 years

9.5 Vouchers Redemption

The beneficiaries normally used to assess their household needs before redemption of the food vouchers at the *dukas*. The vouchers were being redeemed basically for maize, beans, and small quantities of cooking fat, margarine, wheat flour and Uji (local CSB blend) mix among others. There was no restriction on what beneficiaries could redeem but the shop keepers were recording whatever was being purchased by the vouchers on the backside of the voucher. This was for audit purposes as well as determining the quantity of different food items bought by the targeted beneficiaries. Based on Market surveys conducted as a component of the RAP program, it was evident that prices of food items reduced slightly in August/September from Ksh 22-25 per kg of maize and Ksh 55 per kg of beans to Ksh 18-20 per kg of maize and Ksh 40-45 per kg of beans in both districts. Prices were higher in Kitui compared to Makueni. However, duka owners interviewed during regular M&E visits indicated that prices would start rising in October as the planting season starts.

9.6 Health and Nutrition Education

Community health workers effectively used training materials distributed by CRS prior to voucher distribution. These education sessions lasted up to 20 minutes, with question and answer sessions and discussions following for an additional 30 minutes. The level of beneficiary interest in the health and nutrition education was high based on their active participation. The topics covered ranged from appropriate nutrition for children less than 5 years of age, management of diarrhea, and importance of good health and nutrition during pregnancy and lactation. In addition, HIV/AIDS messages were also passed during these training sessions.

9.7 Impact of RAP on Missed Opportunities

The participating clinics have recorded increased number of fully immunized children since RAP started and especially from mid-July to September during RAP voucher distribution as shown in Figure 2. The use rate of the health facilities has also increased. For example attendance rate at Kisayani dispensary increased by 54%.

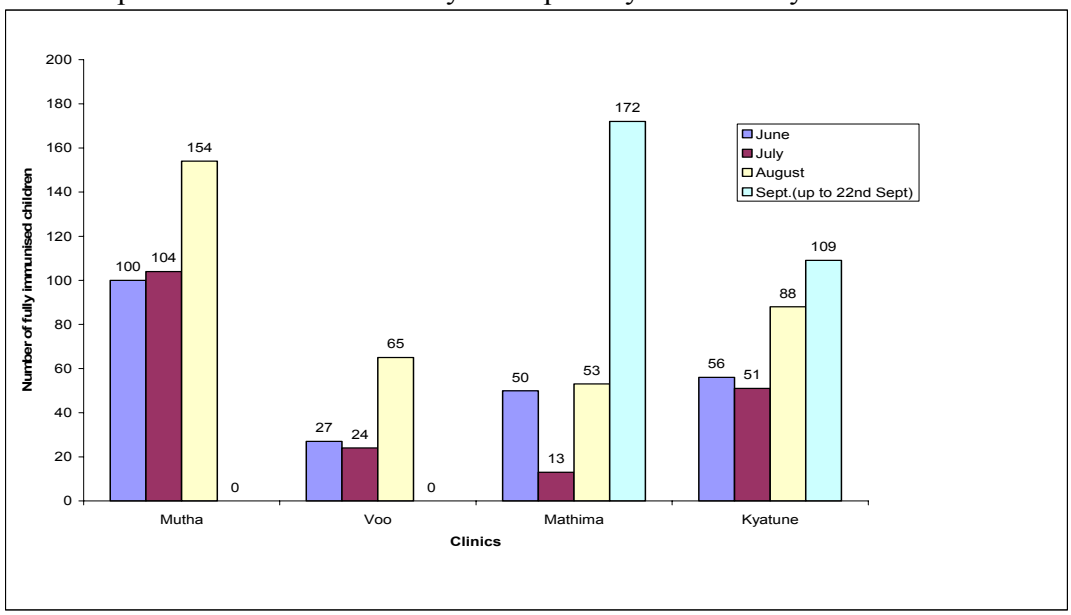

Figure 2: Number of Fully Immunized Children from June to Third Week of September in some RAP Participating Clinics.

9.8 Collaboration and Networking Initiatives

RAP generated a lot of interest with Donors, Government and Private Voluntary Organizations (PVOs) implementing similar programs in Kenya. This was mainly due to its computerized M&E systems and database with inbuilt controls and risk management systems. Among the donor staff we held discussions with were Leigh Stubblefield, Senior Advisor for Livelihood Programs, of DFID Kenya, Joanne Raisin- Team Leader, Africa Hunger Task Team- DFID-UK and Michael Samson- Director of Research Economic policy Research Institute, Cape Town South Africa (DFID Consultant on Cash Transfers Program). DFID was very much impressed with the positive effect that RAP was having in stimulating the local market by engaging the local *dukas* in the program. In addition, there was particular interest on the positive results that the RAP was having in addressing the "gaps" in health education and increasing important services (immunization and Ante Natal Clinics attendance) at health facility level. The M&E system established with inbuilt control mechanisms ensured that the project was well managed. Other discussions focused on targeting and the important step in the RAP program of engaging other key stakeholders in the program (including the Government and other PVOs) to ensure that those targeted are the most needy and emergency support efforts were not duplicated e.g. WFP/GOK - EMOP. Joint field visits with the GOK staff and DFID were made to lobby for the use of the RAP model in situations where food insecurity is an issue of lack of access as opposed to availability. RAP has also been instrumental with OXFAM in forming a

consortium of PVOs interested in biding and implementing cash transfer programs like one being developed by DFID on social protection. OXFAM, CARE, CRS and WVI are in the process of forming the consortium with OXFAM taking the leading role.

David Rinck of the CRS/EARO presented the Kenya RAP at the International Labor Organization as an innovative cash transfer program for emergency programming. There was a great deal of interest and discussion the Kenya RAP. A write-up on the RAP can be viewed in the ILO BDS Knowledge website.

10.0 CHALLENGES/CONSTRAINTS

- Donors were not willing to fund RAP due to fear of risks.
- Time used in developing the M&E system, database and data entry though worth it delayed actual voucher distribution in an emergency response situation.
- Two weeks spent on baseline data collection using a sampling method that required many respondents most of whom were not even beneficiaries. This again delayed the voucher distribution exercise aimed at saving lives.
- Slow pace of beneficiary registration by the clinics. The health facilities staffs were inadequate and were more engaged in treating patients.
- A big number of mothers did not have Identity cards (IDs) during registration and used their spouses and relatives IDs who were sometimes not available during voucher distribution
- Slow pace of Duka registration due to fear by duka owners who had not participated in vouchers system before.
- The expansive catchment areas of the clinics in sparsely populated areas made tracing of some registered beneficiaries difficult. A few vouchers were not claimed by the registered beneficiaries.
- High demand for vouchers by many vulnerable groups. There were a large number of vulnerable community members who were left out of the program but kept on turning up during voucher distribution hoping that they would be recruited.
- Unwillingness of some duka owners to adjust the prices downwards since they thought they had exclusive rights to supply the goods and redeem vouchers.

11.0 LESSONS LEARNT

- Early preparation is required for a fully computerized emergency program to allow for beneficiary screening, data entry, voucher generation and printing.
- Effective risk control mechanisms are necessary to avoid cheating during beneficiary, *duka* and clinic registration as well as during voucher distribution. Investment in an effective M&E system and database is necessary when implementing a RAP kind of program.
- Local food purchase programs are effective where food access as opposed to availability is the problem. Food store (*Dukas*) owners who participated in RAP were able to mobilize large amounts of cash resources to replenish their stock at short notice (no stock credit was given before the start of the program).

- RAP type of programs helps health facilities get children who have not been immunized and other missed opportunities including immunization defaulters as their mothers are attracted to the clinics by the vouchers.
- Targeting of vulnerable pregnant or lactating women and malnourished children under five through health facilities in remote areas enables the health facilities reach out to a large number of clients. The clinics which were participating in RAP were able to meet the Ministry of health (MOH) Rapid Response Initiative (RRI) monthly targets of fully immunized children.
- The non-restriction on what the beneficiaries would redeem the vouchers for made them appreciate the food voucher system using local *dukas* of their own choice since they were getting a variety of food items from a known source thus minimizing suspicion of contamination and were able to balance their diets. Letting beneficiaries make their own choice of the food items they purchased through vouchers make them feel dignified and appreciated.
- Local food purchase programs like RAP energizes the local market activities and helps in building the local economies in marginal areas where the purchasing power of the communities is limited.
- RAP type of emergency programs help vulnerable groups rebuild their assets like poultry from the little savings made during the food voucher distribution period.
- Adequate time is required to build the capacity of implementing partners especially in financial management to avoid delays in paying of the *duka* owners.
- The RAP tie to a long-term conditional cash transfer (CCT) program would offer a sustainable future for the RAP targeted beneficiaries.

12.0 CONCLUSIONS

- RAP was successful and should be scaled-up due to the high demand as a result of the large number of eligible beneficiaries left out due to financial constraints.
- RAP energized the local market activities and most traders increased their food stocks and could replenish stocks without seeking for credit.
- The M&E system and database developed and used in RAP eased its management. The RAP M&E systems and database could be adapted to other programs within CRS especially when we build our own capacity.
- RAP was cost effective and enough controls were put in place and logistical costs were met by the traders in areas where the target beneficiaries resided.
- Local food purchase emergency programs like RAP should be encouraged in areas where markets are working and food insecurity is mainly due to lack of access as opposed to availability.