

Basic Principles for Food-Assisted Programs in the Context of HIV/AIDS

FINAL DRAFT

The following set of principles have been developed by a working group composed of representatives of the USAID Food for Peace, Global Health, Office of HIV/AIDS and Africa Bureau. The purpose of this set of principles is to guide partner organizations who are preparing to include an HIV/AIDS component in an ongoing or proposed program using PL480 resources.

- 1. Ensure that a thorough analysis of food security and HIV/AIDS has been conducted prior to the design and initiation of food-assisted HIV/AIDS programs.***

Although HIV/AIDS is an important vulnerability factor in many countries in sub-Saharan Africa, there is limited evidence that food insecurity patterns closely match HIV/AIDS prevalence patterns. Geographic areas with the highest HIV/AIDS prevalence within a country do not necessarily correspond to areas of greatest food insecurity. In Ethiopia, for example, HIV prevalence is much higher in urban areas than in rural areas whereas food insecurity is greater in rural areas. Urban and rural communities are likely to differ greatly in their susceptibility and vulnerability to the disease; consequently, a separate livelihood analysis should be performed for each. In addition, it is important to note that the level of food insecurity and underlying factors differ by country and region within countries, and the food security situation evolves over time.

Food-assisted food security programs implemented in high HIV/AIDS prevalence contexts need to conduct an analysis of, and account for, how HIV/AIDS will influence program design, implementation and outcomes. In some circumstances, such as the Southern Africa Food Security Crisis of 2001-2003, the objective of preventing malnutrition and associated mortality among the general population involved programming in communities with high HIV prevalence and/or significant food-security impacts due to the HIV/AIDS pandemic. In such cases, HIV/AIDS needs to be factored into assessments of vulnerability to food insecurity and resilience (ability of households and communities to cope with food security stresses and shocks) and the outcomes of these assessments should be reflected in program designs. Examples of responsive program designs include the provision of adult and child care services that permit adults with many dependents (sick adults or children) to participate in the food for work activities, and the establishment of closer distribution points and provisions to allow home-

DRAFT

based care volunteers to retrieve family rations so that food is more accessible to compromised households.

Where sufficient data and technical and cash resources are available, a thorough analysis of food security and HIV/AIDS should include:

- a) Maps of food insecurity and the prevalence of HIV/AIDS, identifying areas of overlap where these basic principles should be applied;
- b) Major factors contributing to food insecurity (e.g., HIV/AIDS, agro-climatic, socio-economic, political);
- c) Major factors putting individuals at risk of HIV infection;
- d) Household and community livelihood and coping strategies;
- e) Current and potential local capacity to address food insecurity and HIV/AIDS.

Because the analysis could require significant cash and technical resources, the broader development community should be called upon to provide technical guidance and to make financial contributions. Collaboration at the analysis stage can facilitate cooperation and program integration at the design and implementation stage.

2. *Ensure effective collaboration between food, food security and HIV/AIDS practitioners.*

The HIV/AIDS pandemic has serious consequences on individual, household and community food security. Those working on food security are increasingly finding it necessary to alter their program designs and underlying conceptual frameworks to accommodate or account for the pandemic. Similarly, food insecurity compromises an HIV-infected individual's ability to access and adhere to adequate treatment and care. HIV/AIDS practitioners are increasingly finding that food is a critical complement to treatment and care focused interventions; yet, it is also noted that PLWHA frequently have inadequate access to food.

In recognition of the multi-sectoral nature of the HIV/AIDS pandemic and the relative scarcity of resources available to respond, development practitioners are exploring how to improve collaboration and better link existing and future HIV/AIDS and food security programs to achieve improved program performance and knowledge sharing. The achievement of effective collaboration or program integration requires that, in contexts characterized by food insecurity and a high prevalence of HIV/AIDS, practitioners with different technical expertise and backgrounds rely on each other for key complementary skills and knowledge and work closely together. Collaboration should extend to designing and conducting needs assessments, developing program designs, establishing targeting mechanisms and creating meaningful monitoring and evaluation plans.

3. ***Ensure that the objective of meeting existing and future acute humanitarian needs is met before obligating food resources for non-emergency HIV/AIDS related programs.***

Food-assisted HIV/AIDS program designs should take into account reasonable expectations for potential natural and man-made disasters; and hence, should incorporate flexibility to be able to redirect food resources to meet acute humanitarian needs if a disaster arises. If there are reliable indications that food security is deteriorating due to drought, conflict or other factors, and the situation is threatening to cause large-scale acute malnutrition and associated mortality, the objective of saving lives through the distribution of food should supercede other non-emergency objectives. This implies that the pipeline for emergency response (including the HIV/AIDS-affected) must be secure before food aid is used for other purposes such as addressing non-emergency HIV/AIDS needs.

4. ***Ensure that food-assisted HIV/AIDS programs are providing assistance to food-insecure HIV/AIDS affected populations.***

The 1990 US Farm Bill mandates that food aid resources (both food commodities and local currencies generated through monetization) be used to enhance food security. Total food resources are scarce relative to the needs of food insecure populations throughout the world. Commodities are more expensive and require additional technical capacity than cash resources. For these reasons, food resources should be prioritized to meet the needs of food insecure populations, which include those adversely affected by HIV/AIDS.

An appropriate targeting criteria for both food-assisted programs in high HIV/AIDS prevalence contexts and HIV/AIDS-related programs that use food aid resources would capture individuals and households that are both food insecure and HIV/AIDS affected. Only in situations where the intervention is designed specifically for People Living with HIV/AIDS (PLWHA) would it be necessary to know or proxy a beneficiary's serostatus. Standard indicators exist for identifying PLWHA (e.g., serostatus, chronic illness), HIV/AIDS affected populations (e.g., households with several Orphans and Vulnerable Children (OVC) or someone who is chronically ill or households that experienced a premature death of a young adult) and food insecure populations (e.g., size of household, female-headed households, households with high dependency ratios). The appropriate set of indicators to include in the targeting criteria ought to reflect the objective of the program or subcomponent of the program.

Targeting individuals or households is often problematic because the number of individuals or households requiring assistance often exceeds the available supply of food aid. Field experience suggests that community-based targeting can be effective where there are significant differences in vulnerability within a

community and communities are relatively stable in structure. The HIV/AIDS pandemic may be altering this common scenario by spreading vulnerability widely across a community or set of communities (e.g., orphans being sent to live with relatives) and by changing historic definitions of vulnerable groups – striking predominately people between the ages of 15 and 49 years and their families. In addition, humanitarian assistance providers are continuing to grapple with how to establish meaningful and effective targeting criteria that can capture both vulnerability to food insecurity and vulnerability to HIV/AIDS within this new and evolving environment. Community-based targeting allows more flexibility than a more rigid criteria-based system for characterizing and identifying individuals and households in need of assistance and thus continues to hold promise in this context.

5. *Ensure that the objectives of food-assisted programs and their component interventions (e.g., home-based care or food-for-training activities) are clear and explicit such as providing HIV/AIDS affected population with:*
- a) *nutritional care and support,*
 - b) *incentives to participate in program activities, and*
 - c) *safety nets and/or income transfers.*

USAID encourages its partners to integrate food-assisted food security programs with HIV/AIDS programs; however, in doing so, the primary reason for using food resources (or the added value of food resources) must be clearly articulated and explicit. Food resources may be used to:

- a) prevent malnutrition and mortality in the *general population* stemming from a rapid and significant deterioration in food security, where HIV/AIDS may be one of the factors contributing to the deterioration (therapeutic feeding, safety nets, food-for-education);
- b) protect and enhance livelihoods of HIV/AIDS affected populations (safety nets, food-for-education (FFE), food-for-work (FFW) and food-for-training (FFT) in life and livelihood skills, AIDS awareness and care giving);
- c) encourage guardianship of orphans and vulnerable children;
- d) reduce physical deterioration and delay the progression of the disease in PLWHA.
- e) improve treatment adherence and efficacy by helping patients manage side effects of Anti-retroviral drugs (ARVs) and treatment of Tuberculosis (TB) and other opportunistic infections;
- f) encourage enrollment and increase participation in Voluntary Counseling and Testing (VCT), Prevention of Mother to Child Transmission (PMTCT), Prevention of Mother to Child Transmission Plus (PMTCT+), other prevention programs and HIV/AIDS services; and

- g) compensate volunteers who provide care and support to PLWHA or who participate in community works that build the community's capacity to address HIV/AIDS and its impacts..

6. *Ensure that ration size and composition corresponds to the objective of the food-assisted program and gives adequate attention to associated logistical and financial costs.*

While HIV/AIDS, nutrition and food security are clearly linked, many questions remain concerning the relationship between pre-existing malnutrition and the susceptibility to HIV and the progression of the disease. World Health Organization (WHO) guidelines indicate that both asymptomatic and symptomatic individuals have additional energy requirements, which suggests a possible adjustment to standard rations when working with HIV/AIDS affected populations. To date there is insufficient evidence for specific recommendations on increased protein or micronutrient intake. Still, many individuals are malnourished prior to becoming infected and rehabilitation is required for proper treatment, care and support.

Food in food security and HIV/AIDS programming can serve a number of functions other than therapeutic feeding of PLWHA or improving the diet of populations with sub-clinical nutrient deficiencies and a high prevalence of HIV/AIDS. While in emergencies general distribution programs establish rations that cover nearly all of an individual's needs, FFW rations cover as little as 20 percent and, in other instances, rations serve as one-off incentives to participate in AIDS awareness sessions. For logistical, practical and moral reasons, rations are often designed for the entire household even when the ultimate target is an individual (e.g., children under five, the chronically ill).

Decisions regarding the size and composition of rations must also take into consideration commodity management capacities, local policies (e.g., genetically modified food), costs (e.g., higher cost blended or fortified foods versus unprocessed basic grains, commodity management and oversight costs) desired or required shelf life, local culture and taboos, and preparation constraints such as the labor required for processing (hand milling) or fuel required for cooking.

7. *Ensure that important cash-based activities complement and reinforce food-assisted activities.*

Food alone can not adequately address food insecurity or the HIV/AIDS pandemic. Effective home-based care requires the provision of care and support to complement food rations. Effective development of alternative livelihoods strategies requires training and oftentimes inputs and credit to complement the temporary income transfer of the food-for-work rations. Food can address short-

term needs while cash-based program components can support longer-term food security. Food-assisted programs, which can and often do include program components supported by cash grants or monetization of commodities, should not be seen as the only mechanism for addressing food insecurity and HIV/AIDS. Wherever possible, agricultural, health, and water and sanitation programs that have complementary food-security objectives and/or are located in the same geographic area should be integrated or linked to food-assisted programs.

8. *Ensure that food-assisted food security and HIV/AIDS programs do no harm.*

Food is a visible commodity that allows community members to readily identify PLWHA. With the advent of effective AIDS awareness campaigns and large-scale treatment programs, HIV/AIDS-associated stigma may be reduced, but it is still a concern in many parts of the world that can result in discrimination, rejection and occasionally violence. Program designs and implementation should minimize the potential for creating stigma and monitor its occurrence.

Food distribution, especially large-scale food distribution, can create a number of unintended negative socio-economic effects. Some common effects include:

- a) dependency,
- b) markets and local production disincentives,
- c) disruption of traditional safety nets and support systems, and
- d) stigma and community resentment.

Food-assisted programs should support existing community coping mechanisms and not exacerbate divisions within the community. Food-assisted programs should prevent undesirable outcomes and incorporate a monitoring system as an insurance mechanism to guard against such unwanted outcomes.

9. *Ensure that graduation criteria and exit strategies are clear, realistic and explicit so that desired outcomes are sustainable.*

Feeding people is a short-term, limited response. Food aid resources are relatively limited both in quantity and scope of practical and effective application to address the needs of food insecure HIV/AIDS affected populations. Improving individuals', households' and communities' food security, livelihoods strategies and resilience to HIV/AIDS is a medium- to longer-term effort. In acknowledgment of this reality, many food-assisted HIV/AIDS programs include behavior change, knowledge transfer and training components. These programs tend to rely heavily upon community volunteers to provide services and expect communities to assume responsibility for continued implementation once the program has ended. But, the HIV/AIDS pandemic is a long-wave phenomenon whereby communities will be experiencing its impacts for many years to come

DRAFT

and the community needs to address issues of sustainability early in program implementation.

10. Ensure that monitoring and evaluation and documentation of lessons learned are given adequate attention.

Scientific links between nutrition, food security and HIV/AIDS are well established, but the evidence base that would help identify effective programming to address these linkages is still limited. The number of activities to address food insecurity in high HIV/AIDS prevalence settings through food-assisted interventions has increased in recent years, but there is little empirical evidence regarding intervention effectiveness. Examples of effective programming need to be documented and disseminated so that lessons can be replicated and/or brought to scale.

Establishing effective monitoring and evaluation (M&E) systems that assess the coverage, progress, and outcomes of food aid interventions is an essential component of successful programming and enables identification and potential expansion of effective approaches. In addition, a strong reflective M&E system can provide important input into the development of improved assessment and targeting methods as well as the definition of priorities for operations research and other more rigorous studies. Adequate human and financial resources should be allocated for the purposes of monitoring, evaluation and dissemination.