

FOOD AND  
NUTRITION  
TECHNICAL  
ASSISTANCE



**HIV/AIDS and Food Aid:  
Assessment for Regional  
Programs and Resource  
Integration**

**Workshop Report**

**Entebbe, Uganda November 2-5,  
2004**

Food and Nutrition Technical  
Assistance (FANTA) Project

Regional Centre for Quality of Health  
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## 1. SUMMARY

The Food and Nutrition Technical Assistance (FANTA) Project and the Regional Centre for Quality of Health Care (RCQHC) convened an **HIV/AIDS and Food Aid: Assessment for Regional Programs and Resource Integration workshop** in Entebbe, Uganda November 2-5, 2004. The workshop was funded by USAID's Regional Economic Development Services Office for East and Southern Africa's (REDSO). The objectives of the workshop were to improve understanding of food aid programming in the context of HIV/AIDS, strengthen capacity to assess the need for food aid interventions in HIV/AIDS-affected communities, and plan assessment activities that might identify opportunities for integrating food aid interventions into REDSO's Transport Corridor Initiative (TCI). In addition, the workshop sought to assess partner needs for regional technical or other assistance to strengthen food aid programming addressing HIV/AIDS, including identifying and sharing lessons and promising practices.

There were 51 participants at the workshop. (See Appendix 1 for the participant list.) Participants included PVOs implementing food aid programs in east or central Africa; REDSO HIV/AIDS implementing partners that seek to integrate or coordinate with food-based interventions in the transport corridor; World Food Program (WFP) regional and country office representatives; USAID Washington, regional and country Mission representatives from Offices of HIV/AIDS, Food for Peace and Poverty Analysis and Social Safety Net; Famine Early Warning System Network (FEWS NET); FANTA and RCQHC.

The workshop combined technical presentations with presentations on current programming experience, group work and plenary discussions. (See Appendix 2 for the workshop agenda.) The workshop themes included:

1. REDSO HIV/AIDS and Title II and WFP food aid programs in the region
2. Food interventions in the context of HIV/AIDS
3. Sources of resources for food interventions for HIV/AIDS programming
4. Technical issues in food aid, such as targeting, rations, and distribution mechanisms
5. Integration of food and HIV/AIDS programming
6. Assessment of vulnerability to food insecurity and the appropriateness of food aid as a response
7. Coordination of food security assessments with the broader TCI site assessments and design strategy

Participants identified technical information and assistance needs and provided suggestions for improved sharing of experiences. The technical assistance areas identified were:

1. Integration of nutrition into ART
2. Micronutrient requirements
3. Use of locally available foods in the Africa region
4. Specialized food products
5. Replacement feeding options for HIV+ positive mothers
6. Increasing access to home-based care

Next steps that participants may choose to be involved with include:

1. Participation in the TCI partners meeting November 17-18, 2004 in Nairobi
2. Provision of feedback on and involvement with local adaptation of the RCQHC Nutrition care and support counseling materials
3. Contributing to the FANTA/RCQHC Best Practices compendium

This workshop report summarizes the presentations and the main issues raised during the discussions and presents the next steps agreed upon by the participants.

## **2. WELCOME AND DESCRIPTION OF THE USAID/KAMPALA BASIC CARE PACKAGE**

The Director of USAID/Kampala's Office of Population, Health and Nutrition welcomed participants to the workshop, and described an important new program funded by USAID/Kampala. The goal of this program is to make widely available a package of basic services designed to help keep people living with HIV and AIDS (PLWHA) healthy. The package currently includes simple technologies for safe water to decrease the incidence of diarrhea, daily antibiotic as a prophylactic to decrease the opportunistic infections, insecticide treated bed nets and on-going social support. The basic care package program is implemented at the community and household level; the Uganda Mission is optimistic that they will be able to extend coverage from urban to rural areas. One of the biggest challenges is to create and maintain reliable, sustainable supply systems for the required supplies for the package. USAID/Kampala would like to include Title II food commodities as part of the basic package, but the limited availability of Title II resources is a constraint. They also need good advice on how to mainstream nutrition, such as nutrition counseling, into the basic care package. USAID/Kampala is also considering including micronutrients in the program, specifically vitamins B, C and E, possibly through a social marketing approach. A key research need is whether access to food rations enhances adherence to Anti-Retroviral Therapy (ART).

## **3. PRESENTATIONS**

### **3.1. REDSO HIV/AIDS Vision and Strategy and Current USAID HIV/AIDS Programming on or near the Transport Corridor**

The presentation on the REDSO HIV/AIDS program described the strategy and activities implemented by REDSO to achieve their five goals: 1) Sound analysis of the regional epidemic; 2) Technical assistance to bilateral Missions and The President's Plan for AIDS Relief focus countries; 3) Implementation of regional programs; 4) Support to non/limited presence countries; and 5) Donor partnerships. (See Appendix 3.1 for the PowerPoint presentation.) The REDSO HIV/AIDS program covers five President's Plan Focus countries (Ethiopia, Kenya, Uganda, Tanzania and Rwanda) in addition to 4 non-focus countries and 3 limited presence countries. The presentation also introduced the Transport Corridor Initiative (TCI), which is a new, multisectoral integrated program aimed at high risk sites and high risk populations. The Mission

sees the TCI as an opportunity to: 1) contribute to The President's Plan goals; 2) gather and disseminate lessons learned; and 3) showcase multi-sectoral efforts to address HIV/AIDS.

In the discussion, participants raised the need for information on the characteristics of the population covered by the TCI, both mobile and resident, including "residents" who in reality are often transient. One study in a truck stop town found that after three years approximately half of the population of the town had moved on.

Much more information is needed on the numbers of orphans and vulnerable children (OVC) and street kids, where they are coming from or whether they have been left behind in the truck stop towns by the death of parents or parents being sick and returning to their home community. The need for more information on the population in the TCI sites, especially regarding the level of food insecurity, was a recurring theme during the workshop, and is a central focus on the upcoming TCI site assessment and design strategy. This information is critical to define the programming area around each truck stop site, and the at-risk and vulnerable population being targeted.

Another issue that was raised in the discussion and recurred throughout the workshop was whether and how food aid might be targeted at food insecure households and individuals that live dispersed in largely food secure areas. One example is urban areas, which may be relatively food secure on average but have large numbers of food insecure households. Related to this issue is the question of targeting food by HIV status rather than food insecurity status, especially in areas of high prevalence of HIV/AIDS but relatively low prevalence of food insecurity. This issue becomes particularly important when discussing Title II or WFP food aid as the source of food assistance for PLWHA and people affected by AIDS (PABA), given that the objective of the food aid resource is to measurably reduce food insecurity among vulnerable populations and the poorest of the poor. A related concern reiterated throughout the workshop was how easy it could be to lose focus on the larger food insecure population that is the primary objective of the food aid programs when incorporating an HIV/AIDS objective, especially due to the emotional and political pressure to respond to HIV/AIDS.

### **3.2. Conceptual Construct for Transport Corridor Initiative (TCI) programming**

The TCI will target high-risk mobile populations with prevention activities and services while identifying vulnerable people living with and affected by HIV/AIDS for community-based support in key communities. The presentation highlighted some of the central themes of the TCI that were important to the discussion over the course of the workshop (See Appendix 3.2 for the PowerPoint presentation):

1. TCI is a multi-sectoral approach
2. The critical importance of linkages and coordination: the TCI aims to identify, link with, build on and strengthen what already exists through improved collaboration and coordination, supplemented by limited additional or new activities to fill in critical gaps.
3. There are two main target population groups and types of activities:
  - a. high-risk and mobile populations targeted with prevention activities
  - b. vulnerable PLWHA and PABA targeted with community-based support
4. The development of a branded concept, both as a model and the "Safe T Stops" themselves, which can then be disseminated across the region.

The TCI proposes to initially focus on sites along the Mombasa-Nairobi-Kampala-Yei portion of the Northern Transport Corridor. The first five sites for the TCI have been identified in collaboration with the USAID Missions in the respective countries. These are Mari Ya Kani, the site of a weigh bridge about 40 km from Mombasa in Kenya; Busia and Malabi, towns on the Kenya/Uganda border, and Kaya and Yei, Southern Sudanese towns approximately 100 and 200 km from the Uganda/Sudan border (see Figure 1.) At present the definition of the “community” to be targeted in each of the TCI sites has not been determined. The site assessments will help to determine the geographic reach of the activities around the truck stop focal point.

**Figure 1. Pilot Sites for the Transport Corridor Initiative**



In one of the first of many questions raised during the workshop on how to target activities at mobile populations such as truckers, the issue was raised of how to ensure continuity in prevention education or adult education such as literacy courses that are being planning for the “Safe T Stops”. How will a trucker get the multiple sessions necessary to cover a curriculum? In the discussion on adult education programs, REDSO clarified that HIV/AIDS resources would not be used to implement the adult education programs, rather that the TCI would link with existing adult education programs.

The question of the relationship between the TCI and the private sector was raised in the discussion. The central key TCI approach of building on and not duplicating what is already available, the importance of integrating the private sector into the TCI activities, and ensuring that the TCI does not inadvertently create unfair competition was stressed.

The importance of focusing advocacy efforts on higher level policy makers in addition to generating demand for appropriate policy and programs from the ground up through strengthening the capacity of the “grassroots” was emphasized.

In addition, a move away from defining “risk groups” to targeting risky behaviors was suggested by workshop participants. By defining the problem in terms of high-risk groups (e.g. truck

drivers) rather than risky behaviors (e.g., multiple sex partners), there is a danger of fostering the perception that a person who is a member of one of these high-risk groups is HIV+ and/or an HIV/AIDS transmitter. However, it is still useful to recognize the characteristics of groups where there is a high prevalence of certain risky behaviors, so that appropriate behavior change messages and other interventions (e.g. poverty programs to address economic factors that influence risky behaviors in a certain group) can be designed.

In response to a question about the criteria REDSO will use to determine partner capacity and participation in the TCI, REDSO clarified that Family Health International (FHI) is the primary implementing partner, and requested any PVO interested in talking about expanded partnerships to contact FHI.

### **3.3. Current Food Aid programming on and near the Transport Corridor – Title II**

The session focused on the location of current Title II programming in Kenya, Southern Sudan, and Uganda. (See Appendix 3.3 for the PowerPoint presentation.) There currently is very limited non-emergency food aid programming and HIV/AIDS programming in Southern Sudan. The HIV/AIDS prevalence rate is estimated at 2-3% in Southern Sudan near the Uganda border. The assumption is that the conflict there has kept the rates low, but with the decrease in conflict and improvement in the roads (traffic has tripled), there is a potential for a rapid increase in HIV transmission.

The Uganda map highlighted Title II HIV/AIDS-related programming along a major transport corridor in Uganda; most of this programming is not in areas of high food insecurity. The maps presented served to again highlight one of the central discussion themes of the workshop - - Do we concentrate on areas that are food insecure or populations that are food insecure in relatively food secure areas? It was clear from the presentation that the geographic overlap between high HIV/AIDS prevalence and high food insecurity prevalence is not very high. However, unconfirmed data indicate that up to 90% of the families of the 1 million HIV/AIDS-infected in Uganda may fall below the poverty line, and that HIV/AIDS is currently hitting hardest in the more rural, impoverished areas where HIV/AIDS services have not yet reached. If these data prove to be accurate, this would indicate that there would likely be growing overlap between areas of geographic focus for food insecurity and those for HIV/AIDS in Uganda. In addition, it is believed that HIV/AIDS prevalence rates in the conflict-affected regions in northern Uganda may be double the current estimates; estimates are that 10-15% of the internally displaced persons (IDP) receiving food aid in IDP camps are HIV+.

### **3.4. Current Food Aid programming on and near the Transport Corridor – World Food Program (WFP)**

The session began with a general description of the WFP HIV/AIDS Initiative in 12 countries in Eastern and Southern Africa, followed by details of the program in Djibouti, Eritrea, Ethiopia, Kenya, Rwanda, Tanzania and Uganda. (See Appendix 3.4 for the PowerPoint presentation.) The \$69 million Initiative is targeting almost 900,000 people affected and infected by HIV/AIDS, and uses household food insecurity, not individual HIV status, as the first-level targeting criteria.

A WFP participant briefed the group on a WFP HIV/AIDS training initiative implemented for both staff members and WFP contract workers (truck drivers and their assistants, porters, and dock workers). Of relevance to the design of the TCI, WFP found that most truckers and dock workers do not attend the trainings because they fear losing a day's pay. It was stated later in the workshop that there is also not much motivation for the trucking companies to support voluntary counselling and testing (VCT) or care and support because the pool of potential drivers is so vast that a sick driver can be replaced immediately.

### **3.5. Food Interventions in the Context of HIV/AIDS**

Using the framework of The President's Plan for AIDS Relief and the Global Funds Initiative, the presenter discussed food and nutrition interventions that can potentially support treatment, prevention and care and support. (See Appendix 3.5 for the PowerPoint presentation.) These interventions include nutrition counseling and education, supplementary and therapeutic feeding, institutional support (e.g., orphanages, hospices) and using food as an incentive for participation in activities, such as school education, training and HIV/AIDS prevention behavioral change counseling sessions. It was emphasized that these interventions are not just limited to the use of food aid; they include the use of food generally. The interventions covered in the presentation were not prioritized in any way. Individual programs need to determine which of these interventions would help meet their program objectives and target their most vulnerable populations. It is important to keep in mind that more capacity is generally required to implement interventions involving individual food rations compared with household food ration transfers.

The discussion highlighted three groups with food and nutrition needs that were not included in the presentation. The first group was infants who have been weaned early by HIV+ mothers. There clearly is a need for additional guidance on how to address the needs of these infants, particularly in the context of prevention of mother-to-child transmission (PMTCT).

The second group was children at risk of malnutrition. Here the recommendation is that all children under two in populations with a high prevalence of undernutrition be targeted; this recommendation is standard for food aid programming in areas with a high prevalence of chronic malnutrition (usually greater than 30%) among children. The issue of targeting orphans versus vulnerable children in HIV-affected households was also raised. It was pointed out children from affected households often become stunted before their parent(s) die, which supports an argument for earlier targeting.

The third group was elderly caregivers. The expectation, however, is that they would be targeted as vulnerable households for receipt of safety net rations. The participants were asked whether there has been much experience in adapting the Food For Work distribution mechanism to account for the constraints faced by households with elderly caregivers, loss of working-aged adults and high dependency ratios. There has not been much experience to date in this kind of adaptation; it is likely that other types of distribution mechanisms will be more appropriate for these types of households.

A workshop participant asked whether there is evidence that food aid prolongs life in PLWHA. It is widely acknowledged that PLWHA consider the food their highest priority. Unfortunately,

not a lot of evidence exists. Part of challenge is that science indicates that earlier interventions are better but programs usually are not targeting PLWHA early in the disease progression. The common phenomenon of sharing of rations among all household members also means that the PLWHA often doesn't receive the full supplement needed, especially if the size of the ration doesn't take household sharing into account.

In order to increase the evidence base, USAID and other donors should consider funding the research. Individual programs are unlikely to undertake this research; they may lack both resources and capacity. In addition, rigorous documentation requires research protocols that include a range of programs and intervention approaches, and cover multiple countries. The community can not wait, however, for a fully established evidence base before attempting to address the problems. There is a need to move forward with what is believed to be the best practices and to document experience to compile the evidence needed during implementation. However, it is important not to generalize too much from the findings of individual, usually cross-sectional studies. There are relatively few panel studies that follow households over time. This highlights the importance of situation-specific vulnerability assessments and program design.

### **3.6. Basic Principles for Food-Assisted Programs in the Context of HIV/AIDS**

USAID has drafted ten principles to guide food-assisted programming in the HIV/AIDS context. (See Appendix 3.6 for the PowerPoint presentation.) These principles were drafted to provide guidance to food aid organizations developing program proposals to address the impacts of HIV/AIDS. The principles address the importance of such actions as: thorough analysis of food insecurity, targeting of food insecure populations, clarity of graduation and exit strategies, doing no harm with food-assisted programs and sharing the lessons learned through monitoring and evaluation.

### **3.7. Title II Food Aid Programming Guidance and Resource Availability**

An overview of the current thinking at Food for Peace (FFP) about the use of Title II resources for HIV/AIDS programming and resource availability projections for the next few years were presented. (See Appendix 3.7 for the PowerPoint presentation.) HIV/AIDS programming funding has increased substantially, while Title II resources are becoming increasingly constrained. This points towards the need for integration of programming and demonstration of the effectiveness of food aid programming in the HIV/AIDS context. New non-emergency Title II Development Activity Proposals are more likely to be funded in FY 2007 than in FY 2006, because there are a number of programs ending in FY 2006, which should result in a relatively larger amount of resources available for new programming.

The discussion highlighted policy and operational realities that are important to keep in mind when discussing Title II food aid programming. These include the decreasing flexibility of monetization as a way of obtaining the cash resources necessary for programming; and pressures to limit the length and proportion of multiyear programs in the Title II portfolio, to reduce the proportion of resources that are committed and therefore not available to respond to emergencies where loss of life would be imminent in the absence of a response.

Some participants expressed concerns about the issue of motivating volunteers if food aid is used as an incentive, and the real potential for undermining the spirit of volunteerism. Programmers should be sensitive to what is being considered a “volunteer”. Programs sometimes may be asking for more hours of work from volunteers than might be feasible without some sort of remuneration.

### **3.8. WFP Food Aid Programming Guidance and Resource Availability**

The presentation focused on WFP intervention approaches and the purposes of food aid in HIV/AIDS programming; the importance of vulnerability analysis; and a range of implementation issues, including geographic targeting, beneficiary selection, the food basket provided, the duration of support, distribution modalities, partnerships and monitoring and evaluation. (See Appendix 3.8 for the PowerPoint presentation.) WFP’s flexibility for adding new programming through regular programming channels is relatively restricted, but new approaches, such as government and international partnerships, may offer expanded opportunities. Integration of WFP food aid into the TCI initiative would need to be addressed within the context of existing programs if it fits, or addressed when the programs come up for renewal.

### **3.9. Targeting Food Aid in the HIV/AIDS Context Overview**

The session examined the importance of targeting groups that are truly food insecure and targeting the most food insecure among these groups through a discussion of targeting requirements and rationale at different levels (geographic, group/community, household, individual), targeting criteria and targeting mechanisms. (See Appendix 3.9 for the PowerPoint presentation.) The importance of using multiple demographic targeting criteria or the inclusion of food insecurity criteria with demographic criteria when targeting was emphasized. The presenter also discussed the need to continually link targeting to program objectives and some of the challenges faced when targeting (e.g., stigma, specificity of proxy indicators, reaching beneficiaries early in the disease progression, fluidity of household composition).

Targeting mechanisms also need to be implemented so that stigma and associated discrimination against PLWHA is not increased. In general, increased access to treatment and other services, not only food, will ultimately reduce stigma. One example is where the provision of food rations has acted as such a strong incentive to bring people into services, that it not only has helped overcome stigma, people are actually presenting themselves as HIV+ when in fact they are not in order to receive food.

One challenge faced at the geographic targeting level is the difficulty of getting good, disaggregated data at the local level that will permit detailed overlay mapping of HIV/AIDS with food insecurity prevalence. Programmers often find themselves using old data at a higher level of aggregation than ideal, and even more reliant on proxy rather than direct indicators.

### **3.10. Targeting Food Aid in the HIV/AIDS Context in Practice: WFP Community-based Targeting in Kenya**

Using the Busia District in Kenya as an example, the session focused on the methods, advantages and challenges of doing community-based targeting for HIV/AIDS food-based care and support. (See Appendix 3.10 for the PowerPoint presentation.) WFP applied multiple targeting criteria to identify program beneficiaries in Busia, with community involvement in defining the food insecurity criteria used. Special efforts were made to ensure that women were involved in the community-based targeting efforts. Advantages of community-based targeting include being able to tap into local knowledge and understanding of vulnerability and empowering the communities to mitigate the impacts of HIV/AIDS. Challenges include the need for training and information sharing across several levels, the special efforts needed to ensure that women are involved, and ensuring sufficient time for defining the criteria and implementing the targeting.

Another challenge to community-based targeting is that really vulnerable individuals are often excluded from community processes (this social exclusion is often an important determinant of their vulnerability) so special efforts are needed to ensure not only that they are appropriately targeted but that they are also included in community committees responsible for targeting and distribution.

The community-based targeting systems may include mechanisms to penalize beneficiaries who do not conform to agreed-upon conditions for ration receipt. Methods to ensure fairness in the application of penalties and way to ensure an appeal process and recourse for beneficiaries were discussed. It is important that the national government support and be involved in the community-based targeting and distribution systems, to avoid local level abuse, leakage and corruption.

Lessons learned in urban programming highlight the need to work with strong community-based organizations or other organizations that can bring together target households that may be dispersed across a wide geographic area. However, WFP has found that community-based targeting and distribution systems are more effective in rural areas than in urban centers, because it can be difficult to find community-based organizations in urban centers that have detailed information about the situation of specific families in the area.

### **3.11. Food Aid Rations in the HIV/AIDS Context**

This presentation focused on the factors that need to be considered in determination of ration size and mix in the HIV/AIDS context, such as increased energy needs of PLWHA, limitations on the ability to process and prepare food, changes to household size and changes to traditional coping capacities. (See Appendix 3.11 for the PowerPoint presentation.) While noted that a number of these factors argue for increased ration packages or the use of blended, fortified products such as corn-soy blend (CSB), commodity costs and commodity management capacity are significant constraints that need to also be factored into the equation. There is a need to address underlying micronutrient deficiencies in the population (vitamin A, iron) and the fact that ration changes often involve trade-offs with reaching more beneficiaries or reaching households for longer periods.

One point stressed in the presentation is that, although there may be increased energy requirements for PLWHA, given that the ration is designed to be a supplement to the household's existing diet, increasing the household ration size does not ensure that the extra energy will be consumed by the PLWHA in the household. However, it may be useful to address other special needs of PLWHA, for example, problems with food consumption and digestion, by including commodities that are more easily consumed and digested

Furthermore, while the WHO recommendations do not include a recommendation for an increase in protein requirements for PLWHA, protein needs should be reflected in the ration composition as a proportion of energy needs. Therefore programmers need to maintain the energy/protein balance as they look at different ration compositions.

A participant questioned the rationale for and appropriateness of calculating ration size based on average household size in the target population, based on concerns that an average ration going to a larger than average household would impact the achievement of program results. Participants discussed approaches for adjusting the ration to account for differences in household size, while acknowledging the logistical challenges of doing so. One practical consideration in determining different ration sizes is minimizing the necessity to scoop and repackage the commodities, and adjusting ration size calculations so they equal whole packing units.

WFP is struggling with determining which commodities to include in a household ration in Southern Africa. To serve effectively as a safety net transfer, it is important to understand how different commodities contribute to the existing family food basket, what opportunities households have to access different types of commodities and how these opportunities may be compromised. For example, households can not produce oil, so they need cash to obtain it. High quality, animal protein sources are often expensive and not accessible. If the ability to access pulses is compromised within the households, they are left with very few other options to meet protein requirements. The array of options for accessing carbohydrates, in comparison, is usually much larger, so it may make sense to place greater priority of protein sources and oil in the ration.

Beneficiary preference is also a factor when determining which commodities to include in a food ration. Participants shared their experiences: in some programs beneficiaries preferred sugar and milk; other programmers found that if beneficiaries were only getting CSB and oil, they would ask for beans. Another program had to show beneficiaries how to use pulses when they were introduced, and now finds them preferred to beans because of cooking time. If porridge is a preferred food, then beneficiaries tend to like CSB and similar cereal blends. The importance of developing locally-appropriate recipes that incorporate both the ration commodities and local foods was emphasized.

### **3.12. Food Aid Distribution Mechanisms**

The topic of the session was the multiple and complicated operational issues involved in implementing a food aid distribution program. (See Appendix 3.12 for the PowerPoint presentations.) The presentations highlighted issues to consider when determining the process for beneficiary selection, including the trade-offs involved in deciding whether to provide food rations directly through the HIV/AIDS service provider or through a referral system. The fact

that the HIV latency period is long was raised and the question of how programmers can account for the stage of the disease was discussed. An HIV+ individual will likely be healthy and productive in the early stages, so the fact that they are HIV+ should not be a sole criteria for food ration receipt. The entry point for food aid programs must be food insecurity. However, it was also acknowledged that most PLWHA enter programs fairly late in disease progression, so their need may already be acute and special related to ARV medications.

The discussion covered the impact of distance and remoteness on the cost and quantity of food that can be delivered, as well as the implications of decisions about distribution modalities such as frequency, size of the ration and distance to the distribution point. Participants stressed the importance of a critical mass for cost-effective programming; small beneficiary populations mean a loss of economies of scale that translates to increased per beneficiary costs. In addition, many dispersed distribution points rather than a single centralized one also results in less economies of scale and higher cost per beneficiary.

The integration of food aid into HIV/AIDS and other programming is constrained by a lack of cash resources, for both WFP and FFP. WFP only integrates food where programs already exist; however, the food component still requires extensive logistics and handling.

Differing food distribution capacity among partners is another challenge. It is not reasonable to expect that every HIV/AIDS service delivery agency will develop high quality food logistics and delivery systems, so it is critical to develop strong linkages between HIV/AIDS service delivery and food delivery systems. When designing integrated food aid and HIV/AIDS activities, agencies must ask whether it makes sense to distribute food through all HIV/AIDS service delivery centers or if it make more sense to deliver food through a central location that beneficiaries can access by referral from the HIV/AIDS service provider.

Common to discussions about food aid programming are the issues of dependence and the “do no harm” principle. Experiences in designing food aid programs to strengthen community resiliency and initiative were shared. One example was the use of local procurement rather than importation of food commodities for the rations. However, it can not be assumed that local procurement will automatically reduce dependency. If effective purchasing power of the population is not increased, local procurement may simply create a false market that collapses once the program ends. The discussion concluded by emphasizing the importance of incorporating livelihood and income generating activities in HIV/AIDS-related food insecurity programming.

### **3.13. Food Insecurity and Vulnerability Overview**

The overview began with a conceptual framework for food security and its components, followed by the determinants of vulnerability to food insecurity, including sources of risk and types of coping capacities. (See Appendix 3.13 for the PowerPoint presentation.) The presenter stressed the importance of both tangible and intangible assets to the capacity to manage risk and cope with shocks. Participants discussed a number of scenarios of the degree of overlap between populations affected by HIV/AIDS and populations affected by food insecurity, where the different scenarios might be found and possible implications for resource allocation and priorities.

One participant noted that in typical situations household will manage risks by working together. But there is a real problem when the risk affects everyone. Another participant noted that in countries like Lesotho and Swaziland that HIV/AIDS has become a co-variate shock – the impact has gone beyond the household level and now there are fears that the whole government system is falling apart because of HIV/AIDS.

The group agreed that food insecurity is a risk factor for HIV/AIDS, as is high mobility. However, huge programs may never be able to meet the needs of these various at-risk groups. “Boutique” approaches may be needed to focus in on the specific needs of different groups.

### **3.14. Food Insecurity and Vulnerability in Practice: WFP’s Vulnerability Assessment Mapping System**

The session began with a presentation on the components of WFP’s Food Security Information and Analysis System (FSIAS) and their role in the system. (See Appendix 3.14 for the PowerPoint presentation.) The components include baseline studies and vulnerability analyses, an early warning system, a system of food security and needs assessments, and a system of monitoring and evaluation. The presenter emphasized the central importance of institutional dynamics and partnerships. Governments must take a leadership role in the FSIAS for the information that is generated to be accepted and acted upon, and not considered as just a technical exercise. The challenges faced by WFP in implementing the FSIAS in the Eastern and Southern Africa region include the quality and availability of data in conflict/post-conflict situations and the relative importance placed on emergency-related information versus the baseline studies necessary for longer-term programming, the wide disparities in capacity and collaborative frameworks among food security partners in the different countries; and the fact that the information generated does not always result in an appropriate response.

WFP noted that vulnerability assessment is an area where they are still building their capacity. There is still a great need to identify vulnerability assessment tools for urban areas. A participant reminded the group that when developing tools to assess coping capacity, there is a need to separate coping strategies that can be done again and again (e.g. eating less) versus those that can only be done once (e.g. selling a goat).

### **3.15. Food Insecurity and Vulnerability - Data for the Proposed Sites along the Transport Corridor**

The session opened with a presentation detailing information on the prevalence of food insecurity and HIV/AIDS, and livelihood systems in the proposed TCI sites. (See Appendix 3.15 for the PowerPoint presentation.) A few Title II programs already operating fairly close to the TCI sites were identified. These include a World Vision LIFE initiative and MSF-Spain/WFP program in Busia (which is distributing food with ART) and CRS LIFE program in Mari Ya Kani.

### **3.16. Assessing the Potential for Food Aid Interventions in High HIV/AIDS Prevalence Contexts Overview**

A description of the information that needs to be included in a Title II food aid proposal opened the session. The presentation then focused on information and indicators that can be collected during a needs assessment to determine the level of food insecurity in the program area, what aspect of food security is problematic, who is food insecure and vulnerable and whether food aid is an appropriate response to food insecurity in the population. (See Appendix 3.16 for the PowerPoint presentation.)

Traditionally indicators of children's nutritional status are used as an indicator that a household is food insecure, because children tend to be the most protected in terms of having their food needs met in food insecure situations. Indicators of children's nutritional status will not be as effective in the HIV/AIDS context, because deterioration in their status may come too late to address the problems of a chronically ill household member. The participants were reminded that this workshop was focused on trying to bring together two different types of expertise – food aid programming and HIV/AIDS programming. Depending on the area being targeted, the appropriate response to the HIV/AIDS problem might be food aid, food or neither.

### **3.17. Assessing the Potential for Food Aid Interventions in High HIV/AIDS Prevalence Contexts in Practice: FHI and CRS Kenya Experiences**

The topic of the session was the assessment process and program design of FHI and CRS food aid programs that address food needs of OVC and PLWHA in Kenya. (See Appendix 3.17 for the PowerPoint presentation.) FHI Kenya used a two phase process of targeting. First, FHI Kenya determined criteria for selection of the geographic areas and communities, then identified criteria to target specific vulnerable households.

### **3.18. TCI Site Assessment and Design Strategy**

The TCI site assessment and design activities will be conducted in January and February 2005 with the goal of launching the first TCI programs in March 2005. (See Appendix 3.18 for the PowerPoint presentation.) The purpose of the assessment is to collect essential data for guiding the design of the intervention, identify key community leaders and other potential program partners and involve the community to maximize relevance and ownership. The assessment, which will cover both situation analysis and an assessment of existing capacity to respond, will be carried out by multisectoral teams that will collect information in the areas of health, education and social services and needs, economic issues including customs and trade, psychosocial needs and support, and policy issues. The exact mechanisms for collecting primary information have not been defined; defining this is one objective of the TCI Partners' Meeting scheduled for November 17-18, 2004 in Nairobi, Kenya.

## 4. GROUP WORK AND DISCUSSIONS

### 4.1. Incorporation of Food Components into HIV/AIDS Service Delivery Programs / Incorporation of HIV/AIDS Components into Food Security Programs

Participants divided into two groups (one for each type of integration: 1. food components into HIV/AIDS programs and 2. HIV/AIDS components into food security programs) to discuss the design of the integrated program, including objectives, target groups, targeting criteria, type and mechanisms for food distribution. The groups then discussed issues and challenges presented for each type of integration and identified options for addressing them.

Both groups identified overburdening of volunteers and staff as one of the key challenges with program integration. Suggested solutions included increasing the numbers of volunteers, providing incentives and including family members. Challenges in measuring food insecurity and targeting vulnerable individuals within context of community needs (how to include the most vulnerable without excluding other community members) might be addressed through capacity building and the definition of proxy indicators. Other challenges identified included integrating the public sector and integrating services for clients in a multi sectoral or ‘non-sectoral’ manner while insuring quality control and an emphasis on the programs’ comparative advantage, logistic issues, donor-driven prioritization of activities and legal issues such as land ownership and inheritance rights.

### 4.2. Assessing the Potential for Food Aid Interventions in the TCI sites

Participants formed four groups to discuss how to assess the potential for food aid interventions in each of the proposed TCI sites (Malaba and Busia were combined because their characteristics are similar). Each group identified the information needed to 1) describe the TCI program sites in general, 2) identify other existing programs and services in the area, including services addressing components of food insecurity; 3) understand the characteristics of the target groups of HIV services and the overall population in the catchment area of the program sites and 4) define the TCI catchment area. Table 1 presents the results of the group work.

**Table 1. Recommendations for assessing the potential for food aid interventions in the TCI sites**

<u>Information needed about the TCI sites generally</u>	
<ul style="list-style-type: none"> <li>• Location of the site</li> <li>• Degree of urbanization</li> <li>• Size of catchment area / neighboring areas</li> <li>• Road network</li> <li>• Presence of army barracks</li> <li>• Total population</li> <li>• Population structure / demographic profile / ethnicity</li> <li>• Population movement</li> <li>• HIV/AIDS prevalence</li> <li>• Education level</li> </ul>	<ul style="list-style-type: none"> <li>• Main economic activities</li> <li>• Level and type of activity at truck stop                             <ul style="list-style-type: none"> <li>• # of trucks per day</li> <li>• general traffic volume and type</li> <li>• volume of trade</li> <li>• main commodities traded</li> </ul> </li> <li>• Services provided at the truck stop</li> <li>• Market days                             <ul style="list-style-type: none"> <li>• Market hours</li> </ul> </li> <li>• Social activities</li> </ul>

Information needed about existing programs and services in the area,  
including services addressing components of food insecurity

- |   |   |
|---|---|
| <ul style="list-style-type: none"> <li>• Institution analysis: what are the roles of the existing institutions?</li> <li>• Types of programs that exist</li> <li>• Types of services provided</li> <li>• Location and coverage of services</li> <li>• Provider of services</li> <li>• Area covered</li> <li>• Target groups</li> <li>• Number of beneficiaries</li> <li>• Sources of funding and types</li> <li>• Government participation</li> </ul> | <ul style="list-style-type: none"> <li>• Formal/informal collaboration and linkages                             <ul style="list-style-type: none"> <li>• Other service providers</li> <li>• Existing CBOs and activities</li> <li>• Associations</li> </ul> </li> <li>• Private sector capacity</li> <li>• Plans or scope for project extension/expansion</li> <li>• Organizations' needs for program extension</li> <li>• Existing gaps in services</li> <li>• Organizations' perception of problems</li> <li>• Labor dynamics</li> <li>• Transportation infrastructure</li> </ul> |
|---|---|

Information needed about characteristics of the target groups of HIV/AIDS services  
and the overall population in the catchment area of the program sites

- |   |   |
|---|---|
| <ul style="list-style-type: none"> <li>• Definition of different target groups</li> <li>• Mobility (Where do the people in the different target groups come from? Where do they go when they leave?)</li> <li>• Interaction with surrounding communities</li> <li>• Food security issues (utilization, access, availability)                             <ul style="list-style-type: none"> <li>• Sources of livelihood and livelihood patterns</li> <li>• Assets (disposing or accumulating; types)</li> <li>• Household type (number of room, material of roof, walls)</li> <li>• Income levels especially youth</li> <li>• Unemployment rate</li> <li>• Production</li> <li>• Purchasing power</li> <li>• Market supplies / prices</li> <li>• Sources of food</li> <li>• Health                                     <ul style="list-style-type: none"> <li>• Mortality rates   <ul style="list-style-type: none"> <li>• Changes seen over 5-10, 15 years in mortality</li> </ul> </li> <li>• Morbidity</li> <li>• Diarrhea</li> </ul> </li> <li>• Water and sanitation infrastructure and access</li> <li>• Nutrition</li> </ul> </li> <li>• Vulnerability – risks, coping capacity</li> </ul> | <ul style="list-style-type: none"> <li>• Demographic information                             <ul style="list-style-type: none"> <li>• Household size</li> <li>• Age groups</li> <li>• Dependency ratios</li> <li>• Female headed households</li> <li>• Pregnant women</li> <li>• Enrollment rates, school abandonment,</li> </ul> </li> <li>• Social networks                             <ul style="list-style-type: none"> <li>• Organized in groups</li> <li>• Group dynamics</li> </ul> </li> <li>• Kinship support</li> <li>• Gender considerations</li> <li>• HIV/AIDS prevalence levels                             <ul style="list-style-type: none"> <li>• # of PLWHA</li> <li>• # of people under ART</li> </ul> </li> <li>• General HIV/AIDS knowledge survey                             <ul style="list-style-type: none"> <li>• HIV/AIDS perceptions (causes and transmission)</li> </ul> </li> <li>• Community mapping by age groups and by sex for high-risk groups</li> <li>• Cultural norms and behaviors that may facilitate of impede risk behaviors</li> <li>• Traditional associations or practices                             <ul style="list-style-type: none"> <li>• Marriage, death, birth, coming of age</li> <li>• Credit associations, funeral associations, women's associations</li> </ul> </li> <li>• Needs of OVC, street children</li> </ul> |
|---|---|

<u>Defining the TCI catchment area</u>	
<ul style="list-style-type: none"> <li>• Furthest point the majority comes from regularly to trade, purchase or seek services</li> <li>• 40 – 50 km</li> <li>• Primary target truck stop urban area with secondary target in the surrounding communities</li> </ul>	<ul style="list-style-type: none"> <li>• Kinship/clan catchment area</li> <li>• Involve existing community to define catchment area</li> <li>• Depends on resource availability</li> </ul>

### **4.3. Latitude and Limitations to Food Aid and HIV/AIDS programming along the Transport Corridor**

Participants held a wide-ranging discussion on the latitude and limitations of linking Title II food aid programs with TCI. Areas of discussion included:

#### **4.3.a. Resource availability**

If additional Title II resources were available, and food aid was warranted based on food insecurity status in the TCI program sites, implementing partners would consider incorporating new activities related to the TCI. However, this would be difficult to do in the absence of new resources because existing programs have reached the limit of coverage given the resources currently available. There is no problem with Title II implementing partner capacity; lack of resources is what would constrain expansion.

If HIV/AIDS-related Title programming were expanded, it would be necessary to ensure that there would be resources from other sources available for the services that the food aid would complement. This would include both direct HIV/AIDS-related services and other food security interventions, for example in water and sanitation or agriculture, which are necessary to address food insecurity and livelihoods of vulnerable households.

In order to respond to the impacts of HIV/AIDS, partners may be asked to redirect resources from the traditional target groups for food aid that reflect the objectives of both the organizations and the resource (e.g. reaching the poorest of the poor where the risk of HIV/AIDS may be lower (WFP) and measurable reductions in food insecurity (Title II)) to places with less poverty but where opportunity exists to hold back the spread of the disease. When and how is it appropriate to compromise on one objective to address another? And how does the source of the resources (e.g. Title II) influence these decisions?

#### **4.3.b. Role of food aid**

For Title II partners a key component of potential food aid programming in the TCI sites would be the focus on mitigation and care for the HIV-infected, within towns and surrounding areas. Factors that increase vulnerability are different in urban centers. Food aid is likely to be appropriate in communities around the transportation corridor, not in the towns on the corridor.

Food aid is more likely to play a useful role for some target groups compared with others (i.e. OVC compared with truckers.) The TCI needs to be clear on the target groups and the nature of resources available for programming.

There appeared to be a general consensus that truck drivers should not be the target for food aid interventions. However, while the truck driver moves on, the CSW stays in the town, and people from the town and surrounding towns interact with static population in TCI sites.

An important focus for HIV/AIDS prevention is to identify women and young girls at risk who are not CSWs but may end up as CSWs for lack of other opportunities. To do this, however, programs need to understand where the CSWs are coming from and why. Why do CSWs do what they do and can food play a role to help reduce transmission and support alternative livelihood activities?

Food aid programs targeting most food insecure areas might keep the young girls and vulnerable women from having to migrate down to truck stops in search of economic opportunities. It is important to consider, however, that food insecurity may not be the reason for going into commercial sex work; women may want or need cash to purchase things other than food, so a transfer may need to be cash rather than food to be effective.

Along a transport corridor, it is more likely that street children rather than CSW would be food insecure and therefore the target for food aid interventions. What are the opportunities and resources to attack root causes of issues that force boys and girls on to the streets?

The group noted that food can be a resource to achieve a clinical outcome and an input into livelihoods. These are two different populations being targeted and this needs to be taken into consideration. There is a need to look beyond ART when thinking about solutions to the problems presented by HIV/AIDS, but, on the other hand, there is a need to make the link between food and ART in order to support the objectives of The President's Plan and increase the use of The President's Plan resources for food and nutrition interventions.

There are multiple factors that can have an impact on food access. This is a very broad area and it is difficult to create a program that addresses all of these factors. Programs also need to address why there are recurrent shocks; this will not be accomplished by just addressing households that have chronically ill members. This aspect of recurrent shocks is not currently being addressed by the REDSO regional approach.

Title II and other development responses still are not addressing the root causes of food insecurity. Food aid has been provided for years, but there does not appear to be a lot of improvement to be shown for these efforts.

Some of the current Title II programs that address HIV in urban centers along the main transport corridor in Uganda also reach clients up to 40 km off of the road. Program examples include The Aids Support Organization (TASO) and Africare.

Experience in working in sites similar to the proposed TCI sites has shown:

- The migratory nature of beneficiaries is greater in urban areas which presents a challenge for food aid and other types of programming.
- It is important to focus on behavior change when addressing with risky behaviors

#### **4.3.c. TCI assumptions and design**

Now that the epidemic is generalized, has the dynamics of HIV transmission been studied to make sure truck drivers and CSW are still major contributors to transmission of the disease? Evidence does exist that it is still necessary to target the most mobile and those with the most partners and partner mixing. Targeting transport corridors is not a new concept; transport corridors have already been identified as an important route for transmission and where a concentration of the more heavily HIV/AIDS afflicted are found.

The TCI design should take into consideration different prevalence rates and how they have moved and changed along the corridor. Efforts are needed to identify what has been working in these communities to reduce prevalence and transmission.

While the “Safe T Stop” is a centralizing point for services, the TCI focus includes activities around the truck stop and activities in surrounding towns.

Participants recommended that mass media approaches be included in the TCI, since they have been shown to be very effective in behavior change strategies. The TCI will build on what is going on in countries, but will also build messages that will travel along the corridor with the trucker, so mass media will clearly play a key role.

#### **4.3.d. Site Assessment**

Participants stressed that concerted efforts to identify possible purposes and uses of food aid/assistance/support within the TCI should wait until after the site assessment is completed and the need demonstrated. It was also stressed that, by participating in this workshop, the organizations are not committed to participate in the TCI.

The assessment process will bring in multisectoral expertise to develop appropriate responses based on both a needs assessment and a response assessment. The TCI program may include food and nutritional aspects, customs procedures, non-formal education for girls, in addition to prevention, care and support, etc.

Are the assessment criteria to determine food aid in HIV context applicable to truck drivers? Are truck drivers food insecure? If they are not likely to be, they would not be the target of food interventions. But HIV+ truck drivers should be targeted for nutrition counseling, in order to help them maintain their health.

Participants asked where the resources for the assessment would come from. This will be determined at the TCI Partners Meeting on November 17-18, 2004.

#### **4.4. Moving Forward: Coordination of the Site Assessment Process**

The goal of the TCI assessment and design strategy is to be able to target high risk populations, identify vulnerable PLWHA and PABA and gaps in existing services. The plan is to do the TCI over 6-7 years, with the first three years being seen as the pilot phase.

FHI was asked to provide an example of what a TCI partnership might look like, and define what the advantages are for both parties - - the value added for partners to continue what they are

doing and count towards TCI. A key assumption of the TCI is that the partners on the ground know best what is working well and what is not. The assessment will help identify what aspects of programming partners might need to improve or strengthen or what pieces are missing. The TCI would also like to encourage new groups or partners, but first priority is to build on what already exists.

The participants asked whether guidelines on how to access resources would be available to partners that participate in the TCI site assessment and design strategy. The response clarified that participation in the assessment does not necessarily mean an organization would receive extra funding. Even without extra funding, there are many ways that existing programming can and should be improved. However, REDSO will share information with the bilateral USAID Missions on the priority gaps and needs identified to encourage additional funding that could be added to existing agreements to address identified gaps or programmed through small grants to community-based organizations. If new elements are coming into the TCI, USAID hopes to get them funded by the time of the TCI launch in March 2005.

The participants asked whether Title II food aid is going to be available for integration with the TCI. The first step is to do the food insecurity assessment. Even if a need is identified, a lot of conceptual work is still needed on how food aid could be used in the TCI. Partners should explore possibilities for innovative approaches, and explore in communities around the TCI sites to assess what the needs are. If partners feel that, based on the results of the assessment, a case can be made for Title II resources, FFP will consider it (although it was made clear in the earlier presentation that Title II resources are very constrained.) In this context, it is important to emphasize that the partners are doing more than just food aid. There is a clear need for USAID and the partners to make the case to The President's Plan that food and nutrition are a critical part of treatment strategy.

Even if additional Title II resources were made available, there are continuing restrictions on cash resources to be used in conjunction with HIV/AIDS activities. FFP is still struggling with identifying how to integrate HIV/AIDS as part of the food insecurity strategy. Very integrated programs and integrated resources are necessary to address the problem. A challenge that USAID needs to address is that different resources (e.g. Title II and The President's Plan) have different funding cycles and procurement mechanisms. Intra- and inter-agency mechanisms are necessary to coordinate resources and funding. Because of the timing of funding cycles, any integration of food aid into the TCI may be lagged.

In addition to defining whether there is a role for food aid, the assessment should help information decisions on what the potential role of food might be in different activities – how do programs target it for different sexes, age groups, and different setups in the communities? Examples include those who are directly hungry, youth who not prepared for life (use food rations while educating in life skills), people without shelter (does food has a role?)

Private sector needs to be incorporated into the TCI. The approach should work not just with a coalition of public good service providers, but should also leverage the private sector to provide services and link with the concept. For example, if TCI helps a private sector business improve his services to truckers that draws in more truckers, this will result in a larger audience for

behavior change messages. TCI will work with private sector associations, and will look into working with activities funded through the World Bank

There is a need to understand literacy rates of target groups because this affects the ability to change behavior and adhere to therapy. This provides an opportunity to involve the education sector and the Ministry of Health, since the education of health workers (including midwives) to understand complexities of ART administration and to standardize advice and assistance for mobile populations should be a priority.

The site assessment and strategy design process will engage government and line ministries, not only for policy reasons, but for the data and knowledge they have. The process will also include truck drivers' and other types of associations. The site assessment will mainly focus on rapid assessment to collect qualitative data that gives a sense of whether there is a problem. Baseline data will be collected after the program begins to get the quantitative data needed.

The detailed data collection plans have not been defined yet. Teams will be defined at the TCI Partner's meeting on November 17-18, 2004. Since the assessment will include various sectoral analyses, the group will work with experts to figure out how to get the data necessary. Consideration will be given to having a multi-phase assessment for food insecurity. One possibility is to project from HIV/AIDS prevalence data to estimate needs, for example, as ART is expanded. If food needs to be incorporated with the ART, the TCI partners can project what the food needs might be.

FHI asked the workshop participants to continue being a resource for the assessment team. An email working group will be created to keep people up to date on with progress and to ask for data that may be missing. If any organization is interested in being added to list, or participating in the TCI more directly, they should contact Gail Goodridge at FHI ([ggoodridge@fhi.or.ke](mailto:ggoodridge@fhi.or.ke)).

#### 4.5. Technical Assistance Needs

The participants identified a range of topics where technical information and assistance is needed. These included:

1. How to **integrate nutrition into ART**
  - On-site feeding versus take-home ration
2. **Micronutrient** requirements
  - Continue to update and disseminate
3. How to **use locally available foods** in the Africa region
  - Nutritional values
  - How to integrate into ART and home- based care
  - Identify organizations to assist programs to develop local products
    - Part of REDSO program – ASORECA regional agricultural association source of possible support for working with producers, developing products
4. **Specialized food products**
  - Link technical knowledge in nutrition with food processing, particularly private sector

- Standard testing protocol / quality control
    - Bureau of Standards can only verify whether composition is as said; can not verify efficacy of product
  - WFP has established TAG that clears new food products
    - TAG doesn't recommend whether WFP should buy, just whether the product meets standards
    - Producers submit request for review to TAG, TAG looks at recipe, nutritional composition, and technological process including quality assurance mechanisms
    - TAG works with producers to improve product if they wish
    - Products on USAID commodities list still go through TAG before WFP agrees to purchase
  - Tremendous pressure from manufacturers
    - A lot of health claims are being made that are not substantiated by any evidence
  - Alternatives are already available in many countries
    - Porridges that are a grain/soy mix plus micronutrients are cheaper and just as good as more expensive, specialized food products
  - Information about what foods are being produced where
    - Available regionally? At a country level?
    - Add information on whether product has been certified by WFP
5. Information on **replacement feeding options** for HIV+ positive mothers
- Exclusive breastfeeding recommendation is unrealistic because rates are very low
6. Increasing access to **home-based care**
- Getting to the people living with HIV/AIDS
    - Programs know what services to offer once they reach people, but don't know well how to identify and reach beneficiaries.
    - Methods for mapping in districts where key care centers are; obtaining knowledge of where the affected people are from the centers.

In addition to the technical topics, there is a general need for improved **knowledge management**. Opportunities to improve knowledge management and the sharing of experiences include:

- Network through people one meets at workshops such as this
- Tap into current experience of who is doing what; look to other PVOs and implementing partners first for best practices and technical assistance before looking to USAID for technical assistance
- USAID's comparative advantage is identifying best practices and disseminate
- Establish communities of practice that are internet- or email-based
  - Examples include ProNut ([www.pronutrition.org/discgroups-hiv.php](http://www.pronutrition.org/discgroups-hiv.php))
- REDSO should consider how to regularly get people together to share information
- FANTA and RCQHC have received funding to gather best practices in nutrition care and support – documenting in 5 countries (Uganda, Kenya, Zambia, Tanzania, TBD) in much more detail
- Plan how to fund the dissemination of new or updated guidelines

## 5. NEXT STEPS

Key next steps include:

1. **TCI partners meeting** November 17-18, 2004 in Nairobi, Kenya.
  - Organizations are encouraged to contact Gail Goodridge at FHI ([ggoodridge@fhi.or.ke](mailto:ggoodridge@fhi.or.ke)) if they interested in attending or being kept in the loop as planning for the TCI site assessment and design strategy progresses.
2. **Workshop report**
  - The workshop report will be distributed before the TCI partners meeting on November 17-18, 2004.
3. RCQHC **Nutrition care and support counseling materials**
  - Contact the Regional Centre (Sarah Naikoba [snaikoba@rcqhc.org](mailto:snaikoba@rcqhc.org)) and FANTA (Robert Mwadime [rmwadime@rcqhc.org](mailto:rmwadime@rcqhc.org)) with any questions or follow-up about the materials.
  - Materials being adapted in Kenya, Rwanda, Swaziland, Zambia. Contact the USAID Mission or FANTA (Robert Mwadime [rmwadime@rcqhc.org](mailto:rmwadime@rcqhc.org)) if interested in more information
4. RCQHC **Best Practices compendium**
  - Contact Regional Centre (Sarah Naikoba [snaikoba@rcqhc.org](mailto:snaikoba@rcqhc.org)) if you have any best practices to contribute
5. **Technical assistance needs**
  - Take advantage of the contacts you have made – network to share with and learn from each other!
  - FANTA will provide the list of technical topics to REDSO for their consideration

**HIV/AIDS and Food Aid: Assessment for Regional Programs and Resource Integration**  
**2<sup>nd</sup> -5<sup>th</sup> November 2004**  
**Imperial Botanical Beach Hotel, Entebbe, Uganda**

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**HIV/AIDS and Food Aid: Assessment for Regional Programs and Resource Integration**  
**2<sup>nd</sup> -5<sup>th</sup> November 2004**  
**Imperial Botanical Beach Hotel, Entebbe, Uganda**

**Draft Participants List**

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**Regional Economic Development Services Office for East and Southern Africa (REDSO)**

**REDSO HIV/AIDS Program**




Dr. Jeffrey Ashley  
Regional Office of HIV/AIDS



**REDSO HIV/AIDS Program**

Providing Quality Technical Support to Client Missions and Non-presence Countries



**REDSO/ESA HIV/AIDS PROGRAM COUNTRIES**



**PEPFAR Focus Countries**  
Ethiopia, Kenya, Uganda, Tanzania, Rwanda

**PEPFAR Non-focus Countries**  
Madagascar, DRC, Eritrea, Sudan

**Limited Presence Countries**  
Burundi, Somalia, Djibouti

Legend:  
 PEPFAR Focus  
 PEPFAR Non-focus  
 Limited Presence

**Goals of Regional Office of HIV/AIDS – USAID/REDSO**

1. Sound analysis of the regional epidemic
2. Technical assistance to bilateral Missions and PEPFAR focus countries
3. Implementation of regional programs
4. Support to non/limited presence countries
5. Donor partnerships

**REDSO HIV/AIDS SO 8: Strengthened Programs for HIV/AIDS in the Region**

**Indicators**

- Number of people served with prevention, treatment, care and support services.
- Percent of programs that have adopted at least one of the better practices advocated by REDSO.
- Percent of REDSO funded programs that meet annual planned results.

**IR1: Strengthened USAID Mission technical and strategic leadership**

**IR1.1: State of the art programs designed and monitored in the region**

**IR1.2: Critical approaches, responses and skills promoted**

**Indicator**

- Percent of bilateral country programs that can provide specific examples of the role that REDSO has played in strengthening their programs.

### Technical assistance to Missions

- All Missions:
  - contribute to design teams and strategy development
  - conduct analysis of emerging issues in the region and work proactively with bilaterals to integrate new approaches and elements in their programming
- PEPFAR Focus Countries:
  - facilitate the coordination of information on approaches and best practices across and within countries to facilitate achievement of rapid results
- PEPFAR Non-focus Countries:
  - support bilateral programs to maintain and further decrease prevalence levels
- Non-presence or Limited Presence Countries:
  - support and management oversight

### IR2: Enhanced human and organizational ability to respond to the epidemic

IR2.1: Skills enhanced

IR2.2: Policy and legislative change advocated

IR2.3: Systems to deliver quality prevention, treatment, care and support enhanced

#### Indicators

- Number of sector-specific interventions implemented
- Percent of trainees that achieve 75% or higher on training post-tests.

### IR3: Information exchanged, lessons learned and best practices disseminated

IR3.1: Key regional issues identified and researched

IR3.2: Improved collection, analysis and dissemination of information in the region

#### Indicator

- Number of key regional issues promoted effectively

### IR4: Effective programs implemented in target populations

IR4.1: Multisectoral activities initiated

IR4.2: Cross-border activities initiated

#### Indicators

- Number of service outlets/programs providing HIV prevention, care, treatment and support services
- Condom use with non-regular sexual partners

### Multisectoral Approach

- A synergistic HIV/AIDS program which focuses primarily on people-level impact
- Offer package of services to people infected with or affected by HIV
- Example: Food for Peace Office & Food Security Office together with partners to define a program focused on provision of food, prevention & care services along transport corridor.

### Selected REDSO Activities

- Support to African Behavior Change Communication Network
- Support to the African Network on Care of Children Affected by HIV/AIDS
- Meta-analysis on the impact of HIV across sectors
- Workplace HIV programs with partners of REDSO SO teams (multi-sector)
- Technical assistance to PEPFAR focus countries

### **Selected REDSO Activities (cont.)**

- Strengthening Faith-Based and Community Responses to HIV/AIDS
- Integrate food & nutrition into multi-sectoral HIV/AIDS program to assure comprehensive service delivery to PLWHA
- Support the Regional Pharmaceutical Forum (CRHCS and RPM+) to improve drug/commodity supply systems and management

### **Transport Corridor Program**

- **New multi-sectoral & integrated program**
  - Sectors: transport, trade, education, health, gender, etc.
- **Regional & Holistic**– ‘HIV pandemic knows no borders’
- **‘Risk sites’ and ‘risk populations’**
  - Transport routes, stop-overs, surrounding communities
  - Transport drivers, assistants, sex workers, OVCs
  - People level impact

### **Transport Corridor Project (cont.)**

- Public-private - sustainability: government, civil society, business sector
- Negotiate regional/multi-national private sector leveraging of resources & implementation commitments
- Foster regional policy harmonization
- Identify & rapidly disseminate lessons & best practices throughout region

### **Safe-T-Stops**

- Create & support a ‘branded franchise’ – Safe-T-Stops - immediately identifiable to beneficiaries
  - Services: secure over-night parking, food & lodging, streamlined customs clearance; HIV/AIDS education & counseling; STI services; VCT; low-risk entertainment; faith-based programs, etc.
  - Direct beneficiaries: drivers, partners, families, PLWHA & transport companies
  - Community-owned with spin-offs of poverty reduction, education, HIV/AIDS & STI information and services
  - Five or six ‘showcase’ sites during Phase One of REDSO program: e.g., Malaba, Arua, Yei, Rumbek...

### **Results: Strengthened Programs for HIV/AIDS in the Region**

- Major contribution to PEPFAR goals
- Reinforce/complement bilateral HIV/AIDS programs
- Added value of lessons learned, best practices
- Showcase example of multi-sectoral, integrated HIV/AIDS programming
- A *minimum* of potential beneficiaries reached in only four countries would be 275,000 people

### **Food & Nutrition for PLWHA**

- REDSO’S contributions include:
  - Pre-service Training in nutrition & HIV/AIDS for Medical Schools, Nursing Schools, Nutrition & Public Health Departments
  - Country Nutrition Guidelines for PLWHA
  - Guidance on nutrition and ART
  - Training materials & tools for ART providers on integrating nutritional components into ART

### **Food & Nutrition for PLWHA (cont.)**

- Technical guidance on the use of specialized food products for the HIV/AIDS context
- Counseling & community health worker's Materials for HIV nutrition
- Working towards a food fortification regulation & control network
- Development of nutrition coalitions in Kenya, Tanzania and Uganda



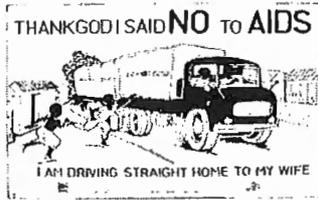
**THE OFFICE OF HIV/AIDS,  
USAID/REDSO WELCOMES YOUR  
REQUESTS FOR SERVICES**



**THANK YOU FOR YOUR  
ATTENTION!**

312

## Regional Transport Worker Initiative



REDSO/ESA



Illustration for HIV/AIDS

## Presentation Objectives

- **Epidemiological rationale and what we know**
  - Stop Over Towns
  - What we know about truck drivers
- **Proposed program and status**
- **Next steps**



Illustration for HIV/AIDS

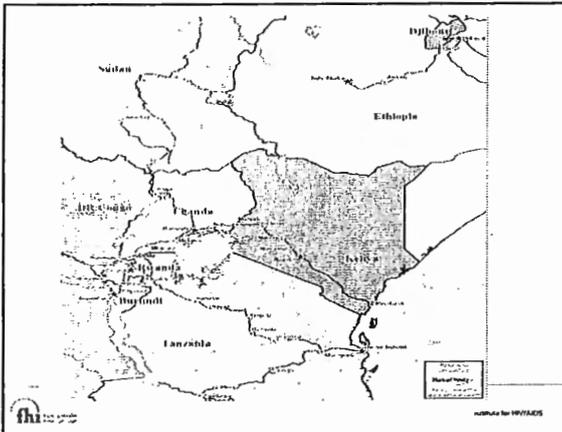


Illustration for HIV/AIDS

## Truck Drivers -- Demographics

- **Most truck drivers are:**
  - married (67-84%) – (low condom use with wives)
  - between 30-40 years of age
  - average of two trips per month for long distance drivers
  - have primary school education



Illustration for HIV/AIDS

## Truck Drivers and HIV/AIDS

- **HIV prevalence among truck drivers is two to three times national average**
- **Knowledge is high....**
- **Nearly half obtain commercial sex along the route; condom use moderate (30-45%)**
- **Approximately 40% did NOT visit a sex worker in the past year** (Rwanda, 2002)
- **BC requires sustained, strong programming!**



Illustration for HIV/AIDS

## Stop Over Towns - Ethnography

- **Not just truckers and sexworkers:**
  - Farmers delivering their goods, townsfolk, and regionally mobile truckers
  - Disproportionate number of young women (traders, sex work, lodges)
  - Intersection of men with money and women without money or power
  - Transient populations – truckers, sex workers and residents!
  - Higher prevalence rates than surrounding areas & national averages



Illustration for HIV/AIDS

## Proposed Program – Goal



“to target high-risk mobile populations with prevention activities and services while identifying vulnerable PLWHA and PABA for community-based support in key sites”



included for HIV/AIDS

## Proposed Program (1/3)

- **Dual Approach:** Men reached in worksites and stop-over towns; women reached in stop-over border towns
- **Communication:** Peer education as a core strategy with possible mass media support
- **Condoms:** Linkages with social marketing programs and national free condom distribution, as well as *partner reduction/being faithful*



included for HIV/AIDS

## Proposed Program (2/3)

- **STD services:**
  - private providers
  - referrals to public services supported by USAID Country Missions.
- **Referrals for other services:**
  - VCT, clinical care, home care, legal support, ART, PMTCT etc.



included for HIV/AIDS

## Proposed Program (3/3)

**..plus** a multisectoral response:

- **Community-based mitigation** (food/nutrition support)
- **Policy change/advocacy** (customs, trade, free movement of people)
- **Education/training opportunities**
- **Small enterprise development**



included for HIV/AIDS

## Safe-T-Stop

**A comprehensive,  
community response**



included for HIV/AIDS

## Program elements...

- **Transport services for truckers**
- **Petrol**
- **Truck repair**
- **Internet/Email connection with trucking companies**
- **Secure overnight parking**
- **Food**
- **Lodging**
- **Streamlined customs clearance**



included for HIV/AIDS

### more services...

- **Health services for truckers & community**
- **General health**
- **Emergency first aid (accidents)**
- **HIV/AIDS education and counselling**
- **STI and other clinical services**
- **Voluntary testing and counseling**



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### ...and more

- **Social services for truckers & community**
- **Low-risk entertainment/game rooms**
- **Sports facilities (e.g. soccer fields)**
- **Faith-based programming**
  
- **Education services for truckers & community**
- **Adult learning programs**
- **Skills training**
- **Literacy programs**
- **Nutrition literacy**



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### ...strengthening the community

- **Food security and livelihood support**
- **Community-ownership/Involvement/ alternative employment opportunities**
- **Addressing food Insecurity for vulnerable communities**
- **Care and support for AIDS-affected households Including OVC**
- **Food security as care, treatment and prevention strategies**



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### Special food security issues

- **How to address increased energy intake needs of PLHA**
- **Strategies for improving household livelihoods given the reduced availability of household labor**
- **How to avoid increasing stigma for PLHA**
- **Meeting the particular needs of families with adopted orphans, child-headed households**
- **Targetting by HIV status vs non-HIV related food insecurity**



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## Yei Safe-T-Stop

**24-hour Full Service Center  
and Diesel**

**Just 100 km ahead!**



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## Yei Safe-T-Stop

**Budget accommodations!  
Clean rooms and showers**

**90 kms ahead!**



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**Yei Safe-T-Stop**

***Entertainment!***  
**Wide Screen Sport & Football**

***Only 80 kms ahead!***



intended for PWV/ADS

**Yei Safe-T-Stop**

***Hot, fresh food in the***  
***community kitchen!***

**Just 70 kms down the road!**



intended for PWV/ADS

**Yei Safe-T-Stop**

**Evening Prayer Services**

**Just 60 kms further...**



intended for PWV/ADS

**Yei Safe-T-Stop**

**Learn to read!**  
***Adult Basic Literacy Classes***  
**7-9 pm**

**50 kms ahead....**



intended for PWV/ADS

**Yei Safe-T-Stop**

**Health Clinic Open**  
**Evenings 6-8 pm**

**Just 40 kms up the road...**



intended for PWV/ADS

**Yei Safe-T-Stop**

**Truckers Union**  
**Discount Cards Accepted!**

**30 kms ahead.**



intended for PWV/ADS

**Yei Safe-T-Stop**

**Counseling and  
social services open  
6-8 pm**

**-- only 20 kms --**




**Yei Safe-T-Stop**

**Evening Skills Training  
Classes!!**

**-- just 10 kms --**




**Welcome to Yei!**

**Safe-T-Stop**

**Community Services Center**




**Proposed Program  
Status**

- Regional meeting Sept 1-3 to refine strategy and identify initial USAID partners
- Negotiations ongoing between USAID/REDSO and USAID Country Missions to finalize Year 1 countries




**USAID Partners**

**Key stakeholders:**  
Governments, private sector

**Regional organizations:**  
ASARECA, CAFS, COMESA, CRHCS, NCCK, RCQHC, TTCA, MTT

**USAID CAs:**  
CRS, FHI, JSI, MSH, PATH, PSI, Pop Council

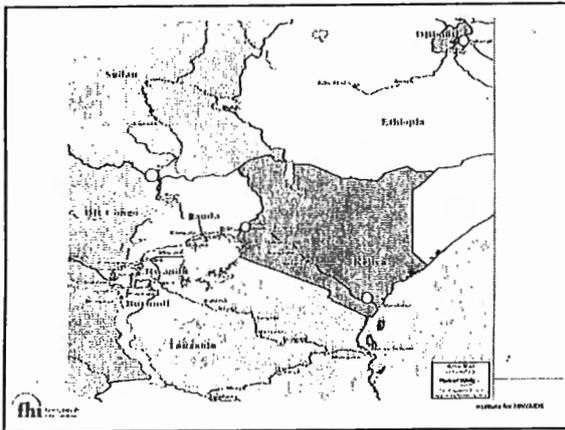
**USAID Initiatives**  
Core Initiative, FFP, FANTA, GLIA, HAI, HCP, HUB, Policy Project, IMPACT




**Current status of sites:**

Port of Djibouti to Ethiopia border	✓ Djibouti on board
Kenya	✓ Kenya on board
Sudan	✓ Southern Sudan on board
Rwanda and Uganda	✓ Discussions with Missions



## Next steps

1. Finalize launch countries
2. Partners meeting - action planning (mid-Nov)
3. Key stakeholder meetings
4. Rapid needs assessments
5. Recruit expanded partners (private sector, multisectoral, GFATM, bilateral donors)
6. Country programs developed/launched
7. Regional overlay activated (BCC, BP, LL)



Initiated by UNICEF

3.5

FOOD AND NUTRITION TECHNICAL ASSISTANCE

## Food Interventions in the Context of HIV/AIDS

HIV and Food Aid: Assessment for Regional Programs and Resource Integration Workshop  
Entebbe, Uganda

Sandra Remancus  
FANTA Project  
November 3, 2004

## Global Goals

- President's Plan for Emergency AIDS Relief Goals
  - 2 million HIV-infected on treatment
  - 7 million infections prevented
  - 10 million provided with care & support
- WHO and UNAIDS
  - 3 X 5 Initiative - 3 million HIV+ on ART by 2005



### Treatment

Intervention	Nutrition education and counseling for ART clients
Objective	To support client adherence, improve drug efficacy, and manage side effects of ART
Programming Issues	<ul style="list-style-type: none"> <li>Materials exist:</li> <li>• RCQHC counseling materials (forthcoming)</li> <li>• RCQHC Training Manual on HIV/AIDS and Nutrition</li> <li>• National guidelines</li> </ul>

### Treatment

Intervention	Supplementary food for ART clients
Objective	To improve client nutritional status, promote client adherence, improve drug efficacy, and manage side effects of ART
Programming Issues	<ul style="list-style-type: none"> <li>• Take-home rations</li> <li>• Need links with clinic, pharmacy or lists of ART clients for targeting</li> <li>• Experience with this will scale up as ART delivery scales up</li> </ul>

### Treatment

Intervention	Supplementary food for PLWHA who do not yet qualify for ART
Objective	To provide an incentive for follow-up until eligible for ART
Programming Issues	<ul style="list-style-type: none"> <li>• Take-home rations</li> <li>• Any experience?</li> </ul>

### Prevention

Intervention	Supplementary food to HIV infected and affected
Objective	To provide a safety net and income transfer to prevent adoption of risky livelihood strategies
Programming Issues	<ul style="list-style-type: none"> <li>• Take-home rations</li> <li>• Already a secondary objective of many food aid programs</li> </ul>

*stop women + girls from involvement in sex trade*  
*stop migration in search of work.*

<u>Prevention</u>	
Intervention	Supplementary food for vulnerable populations
Objective	To provide an incentive to participate in HIV/AIDS awareness, behavior change, or counseling services
Programming Issues	<ul style="list-style-type: none"> <li>• Take-home rations</li> <li>• Similar to use of food as an incentive in MCHN activities</li> </ul>

<u>Care &amp; Support</u>	
Intervention	Nutrition education and counseling for PLWHA <i>people living with AIDS</i>
Objective	To help PLWHA manage symptoms, meet nutritional needs, and maintain healthy weight
Programming Issues	Materials exist: <ul style="list-style-type: none"> <li>• RCQHC counseling materials</li> <li>• RCQHC Training Manual on HIV/AIDS and Nutrition</li> <li>• National guidelines</li> <li>• FAO Living Well with HIV/AIDS</li> <li>• FANTA Guide on Nut Care &amp; Support</li> <li>• SAfAIDS Fact Sheets</li> </ul>

- for people who are not food insecure
- for organizations not handing out food.

<u>Care &amp; Support</u>	
Intervention	Supplementary food for moderately malnourished children and adults living with HIV/AIDS
Objective	To support nutritional rehabilitation of moderately malnourished PLWHA
Programming Issues	<ul style="list-style-type: none"> <li>• Take-home rations or on-site feeding</li> <li>• Delivered through community-based programs, home-based care, palliative care, or other services</li> <li>• Targeting through anthropometric measurement</li> </ul>

<u>Care &amp; Support</u>	
Intervention	Therapeutic food for severely malnourished infected and affected children & adults
Objective	To rehabilitate severely malnourished infected and affected children & adults
Programming Issues	<ul style="list-style-type: none"> <li>• On-site feeding</li> <li>• Use of specific foods, such as BP-100, F-100, F-75, Plumpynut, local versions of Plumpynut</li> <li>• Targeting through anthropometric measurements &amp; clinical signs</li> <li>• Malawi study to assess effectiveness of CTC approach - results in Feb 2005</li> </ul>

<u>Care &amp; Support</u>	
Intervention	Supplementary food to HIV-affected households <i>death, female HH</i>
Objective	To provide a safety net and income transfer to increase access to food and to help meet nutritional needs
Programming Issues	<ul style="list-style-type: none"> <li>• Take-home rations</li> <li>• Can be used to support OVCs and HH caring for them</li> </ul>

<u>Care &amp; Support</u>	
Intervention	School feeding
Objective	To increase school attendance and retention, improve student concentration and educational attainment, increase access to food for OVCs, & income transfer to host families
Programming Issues	<ul style="list-style-type: none"> <li>• On-site feeding and/or take-home rations</li> <li>• Target schools in areas with high concentration of OVCs</li> <li>• Includes day care feeding</li> <li>• Schools may be best source of psychosocial support</li> </ul>

*best way to keep kids in school minimize stigma amongst OVC*

*Can we completely rehabilitate someone in the Final stages of AIDS? Rehab before they die?*

<u>Care &amp; Support</u>	
Intervention	Supplementary food for OVCs and/or other HIV affected individuals through Food-for-Training
Objective	To provide an incentive for participation in vocational or other skill training
Programming Issues	<ul style="list-style-type: none"> <li>• On-site feeding or take-home ration</li> <li>• Usually targeted at older OVCs or widows</li> </ul>

• targeted to older children widows

<u>Care &amp; Support</u>	
Intervention	Food commodities for institutions caring for OVCs or providing services for OVCs - including street children
Objective	To increase access to food that can help meet nutritional needs of OVCs, act as an incentive for services and reduce institution's costs
Programming Issues	<ul style="list-style-type: none"> <li>• More likely in urban areas</li> <li>• Experience with this intervention - WFP/Uganda, God's Golden Acre/South Africa,</li> </ul>

• urban areas where institutions exist

<u>Care &amp; Support</u>	
Intervention	Food commodities for institutions caring for PLWHA for use in services provided to PLWHA
Objective	To increase PLWHA's access to food, help meet nutritional needs and reduce institutional costs.
Programming Issues	<ul style="list-style-type: none"> <li>• Food to hospitals, hospices, etc.</li> </ul>

<u>Care &amp; Support</u>	
Intervention	Micronutrient supplementation for PLWHA
Objective	To correct the existing nutritional deficiencies of PLWHA
Programming Issues	<ul style="list-style-type: none"> <li>• Micronutrient requirements over RDA for PLWHA are not known</li> <li>• Concern that high doses of some nutrients may cause adverse outcomes, e.g., vitamin A, iron, zinc</li> </ul>

low intake of micronutrients leads to more rapid advances of AIDS communities supporting HIV/AIDS families. Where are they?

→ don't know what effect of high volume of micronutrients will be.

purchase food locally to deal with infants: PEPFAR funding - maybe

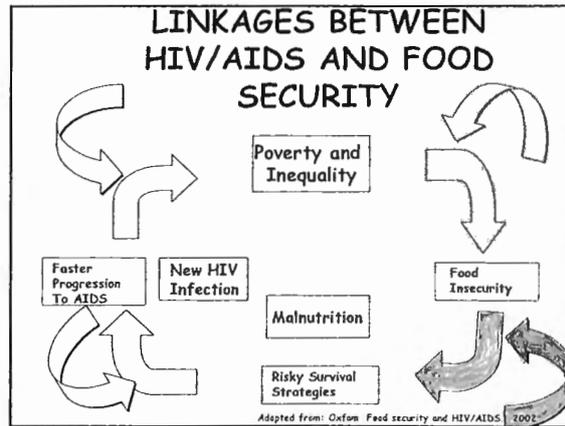
<u>PEPFAR Support</u>	
Nutrition counseling & education	<input checked="" type="checkbox"/> Yes
Food (locally purchased)	<input checked="" type="checkbox"/> Maybe
Micronutrient supplements	<input checked="" type="checkbox"/> Unclear



**Basic Principles for Food Assisted Programs in the context of HIV/AIDS**

USAID  
FOOD AND NUTRITION TECHNICAL ASSISTANCE  
FFP

Judy Canhuati, FFP  
Kampala, Uganda  
November 1, 2004



Where, what and how to intervene

What are the basic principles for programming food aid programs in an HIV/AIDS context?

What are the basic principles of Food Aid programming in the Context of HIV/AIDS  
DRAFT

**Principal #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.

Questions:

- Overlap between food insecurity & HIV;
- Urban vs. Rural food insecurity?
- How to mobilize resources for joint assessments (HIV/economic development/FS)

**What should be included in the assessment**

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

### **Principle #2**

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

- Program design and underlying conceptual frameworks can be altered to accommodate the pandemic.
- Develop understanding of how food insecurity compromises an HIV-infected individual's ability to access and adhere to adequate treatment and care.
- Food is critical, but PLWHAs frequently have inadequate access to food.

### **Collaboration issues**

- Explore how to improve collaboration and better link existing and future HIV/AIDS and food security programs to achieve improved program performance
- Collaboration should extend to designing and conducting needs assessments, developing program designs, establishing targeting mechanisms and creating meaningful monitoring and evaluation plans.

### **Principle #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:

- Take into account potential natural and man-made disasters;
- Incorporate flexibility to be able to redirect food resources to meet acute humanitarian needs if a disaster arises.

### **Humanitarian issues**

- Deteriorating FS due to drought, conflict or other factors, threatening large-scale acute malnutrition and associated mortality, will make the objective of saving lives through the distribution of food supercede other non-emergency objectives.
- 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.

### **Principle #4**

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

- Food resources should be prioritized to meet the needs of food insecure populations, including HIV/AIDS affected.
- Targeting criteria should capture individuals and households where food insecurity and HIV/AIDS overlap.

### **Targeting issues**

- Indicators should 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

### Principle #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:

- nutritional care and support,
- incentives to participate in program activities, and
- safety nets and/or income transfers.

### Integration issues

- 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:
  - 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);

### Integration issues

- 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);
- encourage guardianship of orphans and vulnerable children;
- reduce physical deterioration and delay the progression of the disease in PLWHA.

### Integration issues

- 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;
- 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
- 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..

### Principle #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.

- World Health Organization (WHO) guidelines indicate that both asymptomatic and symptomatic individuals have additional energy requirements,
- An adjustment to standard rations when working with HIV/AIDS affected populations may be necessary.

### Ration and food issues

- To date there is insufficient evidence for specific recommendations on increased protein or micronutrient intake.
- 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,

### Ration and food issues

- FFW rations cover as little as 20 % requirements
- one-off incentives to participate in AIDS awareness sessions.
- 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
  - costs
  - desired or required shelf life,
  - local culture and taboos, and
  - preparation constraints

### Principle #7

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

- Effective HBC requires the provision of care and support to complement food rations.
- Alternative livelihoods strategies require training 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.

### Complementary intervention issues

- Food-assisted programs, including 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 with complementary food-security objectives or overlapping geographic areas should be integrated or linked to food-assisted programs.

### Principle #8

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

- Food is visible and allows community members to readily identify PLWHA.
- There may be less HIV/AIDS-associated stigma, but it can result in discrimination, rejection and occasionally violence.
- Program designs and implementation should minimize the potential for creating stigma and monitor its occurrence.

### Do No Harm issues

- Some common negative effects of food distribution include:
  - dependency,
  - markets and local production disincentives,
  - disruption of traditional safety nets and support systems, and
  - 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.

### Principle #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 with limited quantities 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.

### Exit strategy issues

- With this reality, many food-assisted HIV/AIDS programs include behavior change, knowledge transfer and training components.
- Programs tend to rely heavily upon community volunteers to provide services and expect communities to sustain the program.
- Communities will experience its impacts for many years to come and the community needs to address issues of sustainability early in program implementation

### Principle #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.
- Limited evidence base to identify effective programming to address these linkages.
- Many activities addressing food insecurity in high HIV/AIDS with food-assisted interventions, but there is little empirical evidence regarding intervention effectiveness.

### M & E issues

- 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.

### M & E issues

- Strong M & E will assist in identifying programs that can be scaled up.
- Strong M&E system provides important input into improved assessment and targeting methods and 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.

Thank you



Photos: FAO, CARE, USA



## **Title II and HIV/AIDS**

**HIV/AIDS and Food Aid: Assessment  
for Regional Programs and  
Resource Integration  
2-5 November 2004**

- HIV lens gaining strength within FFP
- Partners are focusing more on HIV
- HIV resources have increased and Title II have constraints
- Key is integrated programming and weight is on PVOs and missions to achieve

- Leveraging funds would allow us to direct more resources
- To enhance support need to demonstrate
- Provision of food not generally seen as part of development
- Need to reexamine components of our work

- How can AERs help us to document?
- How can HIV and FS inform design of new DAPS?
- Next year off-cycle

### HIV/AIDS & Food Aid Programming

Guidance & Resource Availability

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HIV/AIDS and Food Aid:  
Assessment for Regional Programs and Resource Integration  
Entebbe, 2-5 November 2004

Francesca Erdelmann  
WFP – HIV/AIDS Unit



### WFP & HIV/AIDS

- ↘ WFP consideration of food security, food aid & HIV/AIDS since early 2001
- ↘ WFP policy paper on 'Food aid programming in the era of HIV/AIDS' – Febr 2003
- ↘ WFP HIV/AIDS unit since mid 2003
- ↘ WFP cosponsor in UNAIDS since Oct 2003

HIV/AIDS - Food & nutrition insecurity!

### HIV/AIDS & Food Aid

- ↘ Programming - guiding principles
  - Intervention approaches
  - Vulnerability analysis
  - Purpose of food aid
  - Implementation
- ↘ Resources

### Intervention approaches

- ↘ Prevention
  - Awareness & prevention education
  - Prevention of risk behavior
  - Protection
- ↘ Care & support
  - Nutrition care & support for PLWHA & chronically ill
  - Nutrition care for vulnerable groups – <5s, OVC, elderly
- ↘ Mitigation
  - Alternative livelihood strategies
  - OVC education & skills building

Do No Harm

VCT?

### Vulnerability analysis

- ↘ Multisectoral needs assessment – intersectoral cross analysis
  - demographic characteristics
  - health indicators
  - appropriate nutrition indicators
  - morbidity & mortality
- ↘ Infection spread risk factors (mobility, violence, etc.)
- ↘ Hotspot identification – overlay mapping
- ↘ Urban food and nutrition insecurity & HIV/AIDS

Proxy – indicators

### Purpose & role of food aid

- ↘ Physical/biochemical
  - Nutritional well being
  - Treatment efficacy
- ↘ Food security/income
  - Household food security
  - Income transfer
- ↘ Programme participation
  - Attendance, enrolment
  - Treatment adherence

Problem analysis  
 ↓  
 Purpose  
 ↓  
 Role of food aid  
 ↓  
 Programme design

## Implementation

- ↘ Geographic targeting
  - High food insecurity – High HIV prevalence
  - Rural - urbanized areas
- ↘ Beneficiary selection
  - Infected - Affected
  - Clinical & Nutritional needs
  - Food security needs
- ↘ Food Basket
  - Quality – Quantity
  - Food = supplement/complement

Food aid =  
Food need =  
Food insecurity

## Implementation [2]

- ↘ Duration of support
  - Short term - Exit strategy - Dependence
- ↘ Distribution modalities
  - Appropriate channels
- ↘ Partnerships
  - Multi partner arrangements
  - Unconventional partners
- ↘ Monitoring & Evaluation
  - Measuring effect/impact
  - Building evidence - effectiveness

Integrated services:  
food = complement  
to other services

## HIV/AIDS resources

- ↘ Regular programme channels
  - EMOP, PRRO, CP, Dev
- ↘ Government partnerships
  - GFATM, WB-MAP/TAP etc.
- ↘ International partnerships
  - Clinton Foundation HIV/AIDS Initiative

Thank you.



FOOD AND NUTRITION TECHNICAL ASSISTANCE

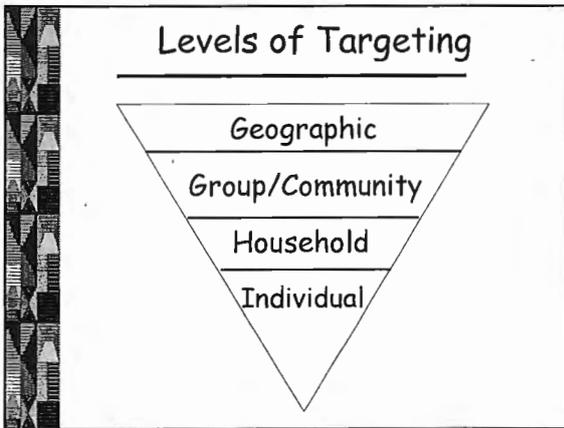
## Targeting Food Aid in the HIV/AIDS Context

HIV and Food Aid: Assessment for Regional Programs and Resource Integration Workshop  
Entebbe, Uganda

Sandra Remancus  
FANTA Project  
November 3, 2004

## Objectives

- Provide an overview of food aid targeting in the HIV/AIDS context
- Discuss a practical case of community-based targeting (WFP)



## Steps in Targeting Food Aid in the HIV Context

1. Define the program objectives  
*reducing food security amongst HIV/AIDS households*
2. Determine targeting criteria to use
3. Identify the targeting mechanisms  
*how to operationalize criteria*
4. Allocate resources & monitor  
*is food going to the right people*

## Potential Targeting Criteria in the HIV Context

Demographic	<ul style="list-style-type: none"> <li>• Elderly headed household</li> <li>• Child headed household</li> <li>• Female/widow headed household</li> <li>• Household with recent death of productive adult</li> <li>• Household with high dependency ratio</li> <li>• OVC</li> <li>• Street children</li> </ul>
Physiological	<ul style="list-style-type: none"> <li>• HIV + (status known)</li> <li>• Chronically ill</li> <li>• Malnourished adult/child</li> </ul>
Medical	<ul style="list-style-type: none"> <li>• ART client</li> <li>• TB patient</li> </ul>

## Use of Multiple Criteria

Demographic criteria  
+ Demographic criteria  
= Targeting of most vulnerable in each group

Example:  
Female headed household  
+ Presence of OVCs  
= Targeting of most vulnerable households

### Use of Multiple Criteria

Demographic criteria  
 + Food insecurity/vulnerability criteria  
 = Targeting of most vulnerable in each group

Example:  
 Household with chronically ill member  
 + Assessment of household food stocks  
 = Targeting of most vulnerable households

*this might interfere with social capital*

### C-SAFE Zambia Food Security Criteria

- Employment: formal, informal, temporary & part time
- Cattle/livestock ownership
- Amount of land cultivated
- Amount of food harvested vs. household requirements (both consumption and income generation are considered)
- Household items owned, i.e. farming implements, etc.
- Presence of productive adults in the household and number of dependants

Source: Targeted Food Assistance in the Context of HIV/AIDS, C-SAFE, September 2004

*TASO verifies family assistance*

### Targeting Mechanisms

- Self-selection
  - Recipient determines costs/benefits
- Outside (Administrative)
  - Targeting criteria pre-defined & objective
- Community-based
  - HBC networks, Community committees, village leaders

*comm stable, large variation in household welfare status*

### Challenges

- Stigma
- Early targeting - before downward spiral
- Targeting by proxy or "broad brush" indicators can pick up unintended groups or those who aren't food insecure
  - chronically ill = elderly
  - Female headed household ≠ food insecure household
  - Sensitivity vs. specificity
- Fluidity of vulnerable HH composition

*targeting takes time - may be when recipient is dying*  
*excluding those not eligible - avoiding the exclusion of eligible people*

### Challenges

- Outsider targeting
  - Dependent on selection of the correct indicators
  - Risk of corruption, bias, etc.
  - Administratively costly
- Community targeting
  - Risk of corruption, bias, etc.
  - Community may not agree with targeting principles
  - Difficult to standardize targeting/compare
  - Difficult to do in urban areas
  - Women often not included in group doing targeting

### Other Sources of Information

- Targeted Food Assistance in the Context of HIV/AIDS: Better Practices in C-SAFE Targeted Food Programming in Malawi, Zambia, and Zimbabwe, C-SAFE, Sept 2004, <http://www.c-safe.org/downloads/TFAFinal.pdf>
  - Descriptions of using Village Action Committees, Color Coded Verification Systems, Social Mapping, and criteria for graduation.

**FOOD AND NUTRITION TECHNICAL ASSISTANCE**

## Food Aid Ration

HIV and Food Aid: Assessment for Regional Programs and Resource Integration  
Workshop  
Entebbe, Uganda

Sandra Remancus  
FANTA Project  
November 3, 2004

### Factors that need to be considered in determination of ration size and mix in the HIV/AIDS context

1. PLWHA's increased need for energy
2. Difficulties with food intake by PLWHA
3. Limitations on ability to process & prepare food
4. Changes to household size
5. Decreased food availability & accessibility
6. Household coping capacity altered

### Energy Requirement Increases for PLWHA

Population Group	HIV phase	Energy requirement
Adults	Asymptomatic	10% increase
	Symptomatic	20-30 % increase
Pregnant/lactating women*	Asymptomatic	10% increase
	Symptomatic	20-30% increase
Children	Asymptomatic	10% increase
	Symptomatic (with no weight loss)	20-30% increase
	Symptomatic (with weight loss)	50-100% increase

\* This is in addition to extra energy, protein and micronutrients required by pregnancy or lactation.  
Source: WHO, 2003

### PLWHA's increased need for energy

Are increased energy needs of PLWHA a reason to change the ration size?

Probably not

- Household ration usually given
- Not intended to meet 100% of needs
- Status often not known anyway

### Difficulties with food intake by PLWHA

- Symptoms and illnesses associated with HIV/AIDS
  - Oral thrush
  - Loss of appetite
  - Taste changes
  - Fever
  - Constipation/diarrhea

### Difficulties with food intake by PLWHA

How does this affect the ration choice?

Consider commodities that can be used as a porridge or gruel (corn-soy blend and wheat-soy blend)

- Texture makes it easier to swallow
- Processing makes it easier to digest



### Limitations on ability to process & prepare food

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- Illness and time spent on caregiving limits time allocated to fuel & water gathering and food preparation
- Food processing (milling) too costly for affected households
- Children in charge of food preparation



### Limitations on ability to process & prepare food

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How do limitations on ability to process & prepare food affect ration choice?

Consider commodities that are processed and/or partially precooked

- No further milling is necessary
- Cooks in a minimal amount of time ( $\approx 10$  min)
- Requires minimal fuel for cooking
- More easily prepared by children



### Changes to household size

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- Households experiencing adult mortality tend to become permanently smaller
- Households taking in OVCs will become bigger



### Changes to household size

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How do changes to household size affect the ration size?

When household size increases:

Consider a ration package that meets a higher percentage of nutritional needs or has a higher income transfer value

- Based on vulnerability analysis



### Decreased food availability & accessibility

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- Reduced crop production during illness and after death (both cereal and cash crops)
  - Due to loss of labor – both ill person and caregiver – and reallocation of capital to cover medical expenses.
- Impact varies by:
  - Male or female household head illness/death
  - Head-of-household vs. non-head death
  - Socio-economic status of household
  - Timing of illness/death
- Declines in household income



### Decreased food availability & accessibility

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How does decreased food availability and accessibility to HIV-affected households change ration determination?

Consider a ration package that meets a higher percentage of nutritional needs or has a higher income transfer value

- Based on vulnerability analysis



## Household coping capacity altered

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- Traditional coping mechanisms may be overwhelmed
- Normal reciprocity arrangements and informal mechanisms affected



## Household coping capacity altered

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How do changes to a household's coping capacity affect ration determination?

Consider a ration package that meets a higher percentage of nutritional needs or has a higher income transfer value

- Based on vulnerability analysis



## Other Considerations/Challenges

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- Program objectives
- Existing underlying nutritional deficiencies in the population, e.g., iron, Vitamin A
- Commodity costs
- Commodity management capacity
- Trade-off between increasing the size of the food basket vs. the number of beneficiaries reached



## Other Sources of Information

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- Title II Commodity Reference Guide:  
[http://www.usaid.gov/our\\_work/humanitarian\\_assistance/fp/crg](http://www.usaid.gov/our_work/humanitarian_assistance/fp/crg)
- Title II Commodity Fact Sheets:  
[http://www.usaid.gov/our\\_work/humanitarian\\_assistance/fp/crg/sec2.htm](http://www.usaid.gov/our_work/humanitarian_assistance/fp/crg/sec2.htm)
- NutVal: Spreadsheet based program to plan rations. For information contact the nutrition section at WFP at [nutrition@wfp.org](mailto:nutrition@wfp.org).
- HIV/AIDS: A Guide for Nutritional Care and Support, FANTA, Module 6: Food Basket Calculations

**Food insecurity and vulnerability**  
Anne Swindale, Ph.D.

**HIV and Food Aid: Assessment for  
Regional Programs and  
Resource Integration Workshop**

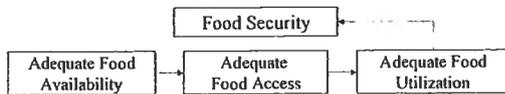
Entebbe, Uganda  
2 – 5 Nov 2004

Food and Nutrition Technical Assistance (FANTA) Project  
Academy for Educational Development  
1825 Connecticut Avenue, NW Washington, D.C. 20009-5721  
Email: fanta@aed.org Website: www.fantaproject.org

**USAID Definition of Food Security**

When all people at all times have both  
physical and economic access to  
sufficient food to meet their dietary  
needs for a productive and healthy life

**Food Security conceptual framework**



**Components of food security**

- **Availability** – Sufficient quantities of appropriate, necessary types of food from domestic production, commercial imports, or donors are **consistently available to the individuals or are in reasonable proximity** to them or are within reach
- **Access** - Individuals have **adequate incomes or other resources** to purchase or barter to **obtain** levels of appropriate foods needed to maintain consumption of an adequate diet and nutritional level

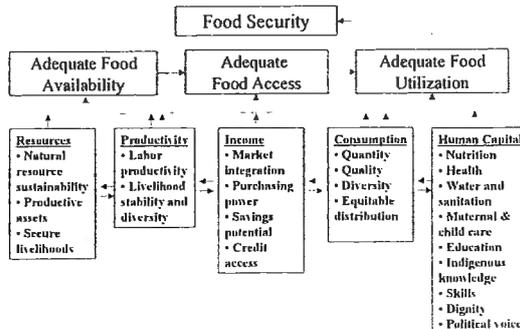
*flow*  
*national aggregates*  
*household access prod + procured*

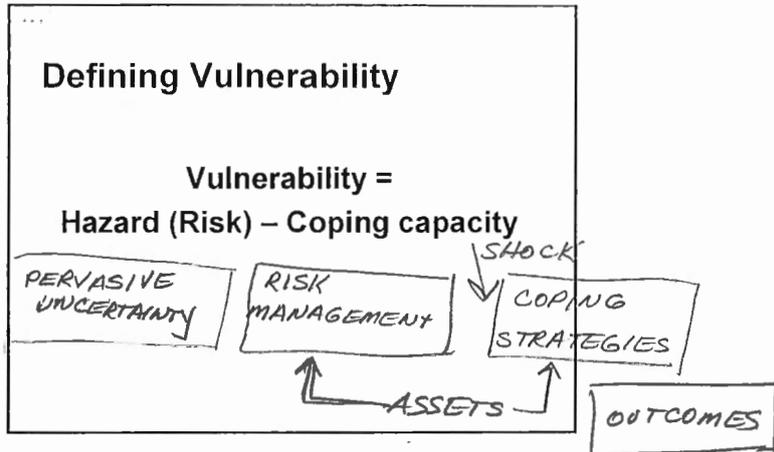
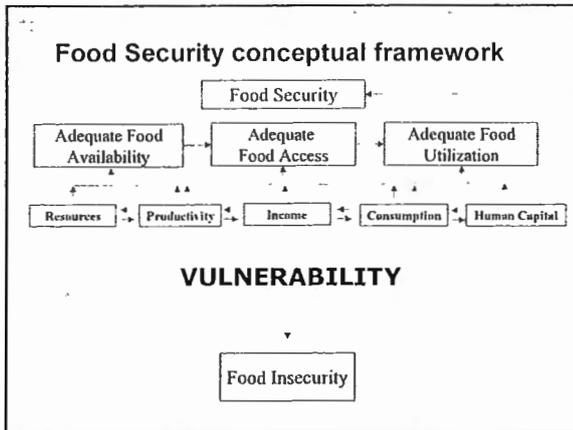
**Components of food security**

- **Utilization** - Food is properly used, proper food **processing and storage**, adequate **knowledge and application of nutrition and child care**, and adequate **health and sanitation services** exist

*household use*

**Food Security conceptual framework**





- ### Reason for vulnerability
- Physiological
  - Economic
  - Social
  - Political

- ### Physiologically vulnerable
- age groups vulnerable to malnutrition (children and the elderly)
  - pregnant and lactating women
  - sick and convalescent individuals

- ### Economically vulnerable
- poor areas / groups / households / individuals
    - facing livelihood threat or loss
    - facing covariate shocks
    - facing idiosyncratic shocks
  - households with high dependency ratios/loss of productive members
  - groups / households / individuals who live in environmentally marginal regions.

- ### Socially vulnerable
- unsupported old people, widows, orphans, and people with disabilities
  - socially excluded individuals or households (including PLWHA and HIV/AIDS survivors)
  - female-headed households (in some contexts)

• AIDS in high prevalence areas starts as a idiosyncratic shock which becomes covariant shock as all households get infected.

## Politically vulnerable

- refugees, IDPs or communities exposed to **violence or conflict**
- groups or households exposed to **discrimination** (e.g. exclusion from relief distributions or government services)
- ethnic, religious or caste **affiliation** (in many cases, it may be unacceptable or dangerous to apply this criteria)

## Types of Risk

- Natural
- Social
- Political
- Economic
- Health

## Types of Risk

- **Natural**
  - Heavy rainfall, flooding, landslides, volcanic eruptions, earthquakes, hurricanes, drought, natural resource base degradation and depletion
- **Social**
  - Crime, violence, terrorism, gangs, ethnic strife, civil war, breakdowns in traditional commitments of trust and reciprocity, discrimination, STIGMA

## Types of Risk

- **Political**
  - Riots, coup d'état, temporary/permanent confiscation of assets or labor, forced relocation, poor governance, lack of legal recourse, inadequate representation, corruption, lack of accountability, inadequate provision of services and creation of public goods, ineffective institutions, adverse regulation, lack of recognition of human rights
- **Economic**
  - Unemployment, income fluctuation, employment insecurity, savings depletion, price volatility, inflation, high transaction costs, collapsed terms of trade, lack of liquidity, loss of value of assets, information asymmetry

## Types of Risk

- **Health**
  - Epidemics; endemic disease; widespread malnutrition; inadequate availability of and access to health services, water, sanitation; lack of knowledge/poor practices

## Coping capacity determinants

TANGIBLE / INTANGIBLE

- Physical Capital
  - Natural Capital
  - Financial Capital
  - Human Capital
  - Social Capital → pooled social capital
  - Political Capital → bridging social capital
- LEARNED SKILLS (CUMULATIVE FORMAL / INFORMAL KNOWLEDGE)
- PRODUCTIVITY (LEARNED SKILLS APPLIED)
- ABILITY TO LEARN (NUTRITION, HEALTH STATUS)

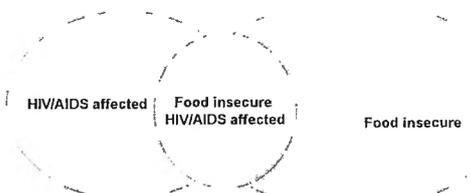
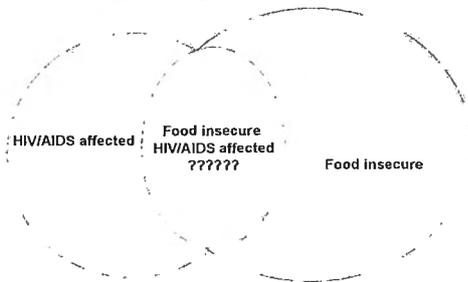
### Coping capacity determinants

- **Physical capital** – production equipment, livestock
- **Natural Capital** - natural resource stocks e.g. land, water, wildlife, biodiversity; owned land, access to common property resources
- **Financial Capital** - cash and other liquid resources, e.g. savings, credit, remittances, pensions

### Coping capacity determinants

- **Human Capital** - skills, knowledge, ability to labor and good health
- **Social Capital** - quantity and quality of social resources (e.g. networks, membership in groups, social relations, and access to wider institutions in society)
- **Political Capital** - relationships of power and access to and influence on the political system and governmental processes at the local and higher levels

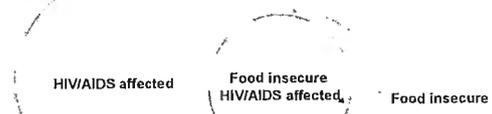
### What situation are we facing? Defining the problem...



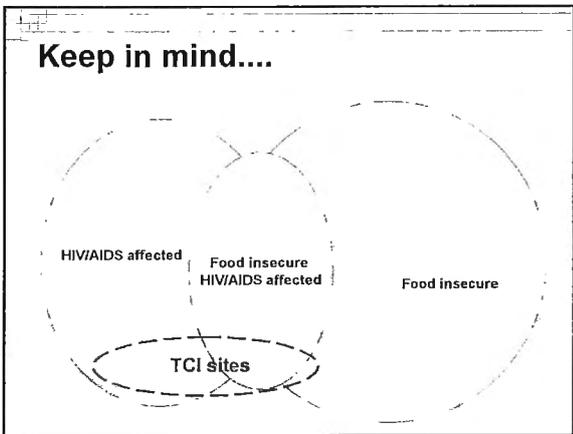
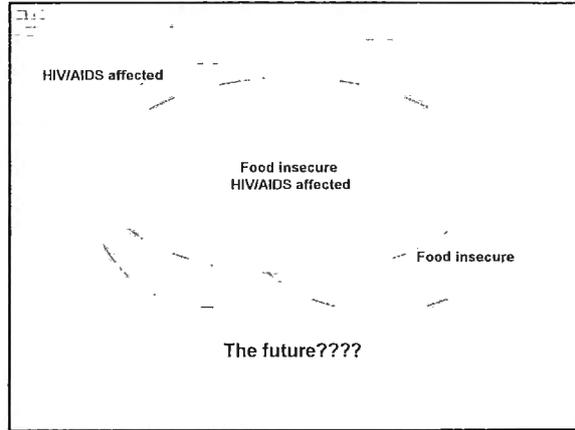
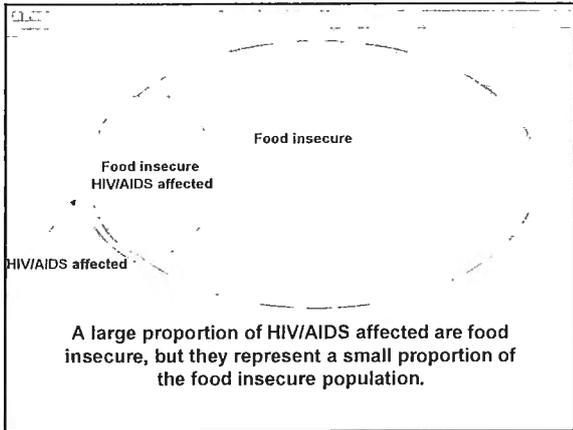
Some of the HIV/AIDS affected are food insecure, and some of the food insecure are HIV/AIDS affected, but there is a sizeable proportion of the food insecure for whom HIV/AIDS is not a factor and a sizeable proportion of HIV/AIDS affected who are not food insecure (e.g. because HIV/AIDS affected are still concentrated in urban areas and food insecurity is largely a rural problem)



A large food insecure population, but because HIV/AIDS prevalence is not high, a small proportion of the food insecure are HIV/AIDS affected and given the distribution of HIV/AIDS (e.g. mainly urban professionals), a small proportion of HIV/AIDS affected are food insecure



A large proportion of the food insecure are HIV/AIDS affected, but food insecurity is not a significant problem for this population, thus the relatively small food insecure population and the relatively large proportion of HIV/AIDS affected who are not food insecure



### Assessing the potential for food aid interventions in high HIV prevalence contexts

Anne Swindale, Ph.D.

#### HIV and Food Aid: Assessment for Regional Programs and Resource Integration Workshop

Entebbe, Uganda  
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Academy for Educational Development  
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#### Requirements for a Title II non-emergency (development) food aid proposal include...

- Needs assessment
  - What are nature and dimensions of the problem?
  - How long is it going to last?
  - Who are the most vulnerable groups?
  - What and how much is needed; what is the best response?
  - To what extent is local coping capacity and provision of services overwhelmed?
  - What are major logistical and resource considerations?

#### Requirements for a Title II non-emergency (development) food aid proposal include...

- Data on the geographic distribution of food insecurity in the country
  - Justify choice of geographic area(s) targeted
  - Define criteria for selection of specific communities
  - Identify and quantify the target group(s)
  - Preliminary sense of the level of resources (and type) needed

#### Requirements for a Title II non-emergency (development) food aid proposal include...

- Problem assessment
  - Diagnostic baseline assessments used for the design of an intervention
    - Identify priority technical areas and interventions
  - Early warning and vulnerability assessments used to understand the nature and determinants of an imminent food emergency

#### Requirements for a Title II non-emergency (development) food aid proposal include...

- Unmet needs
  - Extent to which problems in these priority areas are addressed by other programs
  - Which unmet development needs remain
- Institutional assessment
  - Capacity and relative strengths of CS and local partners
    - Technically
    - Geographically

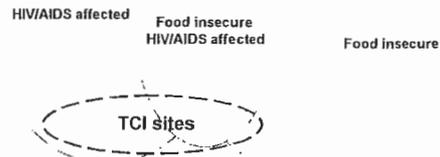
#### Focus on Needs Assessments

- Food Security Profiles / Poverty Maps
  - Constructed from secondary data sources
  - Enable better targeting of scarce resources
  - Prioritize interventions within a country and across countries
- This group has essentially skipped this step
  - TCI sites are the program sites

However .....

Still important to justify any proposed food aid interventions in the TCI site, on the basis of absolute level of food insecurity and relative level compared with other food insecure areas in the countries

Keep in mind....



### What do we need to know?

- What is the level of food insecurity in the program area?
- What **aspect** of food security is problematic?
- **Who** is food insecure and vulnerable? How do we **identify and count** them?
- Is food aid an **appropriate response** to food insecurity in this population?

### Indicators of food insecurity

- Assume that availability is not an issue for this population

Access	Utilization
<ul style="list-style-type: none"><li>■ Food insecurity measurement tool</li><li>■ Dietary diversity</li><li>■ Assets/Asset divestment</li></ul>	<ul style="list-style-type: none"><li>■ Nutritional status</li><li>■ Prevalence of diarrhea</li></ul>

### Experiential household food insecurity scale

- Food insecurity is a measurable experience that can be described and analyzed to categorize households by level of food insecurity
- Draws on the U.S. Household Food Security Scale approach
- Studies have shown that the US approach to developing an experiential food insecurity scale can be applied successfully in a different developing country contexts

### Experiential household food insecurity scale

- Some aspects of the experience of food insecurity appear to be universal
  - Fear/anxiety/worry about running out of food
    - Actual household food depletion
  - Insufficient food intake/rationing (quantity)
    - Physical effects
  - Decreased dietary quality
    - Nutritional
    - Taste and appeal
    - Social acceptability
  - Coping strategies to increase household resources

### Household Food Insecurity Measurement Instrument

Over the past 12 months....

1. Have you worried that your household would not have enough food?
2. Has your family not been able to eat the way you think you should because of lack of resources?
3. Did you or any adult in your household ... because there was not enough food?
  - Have to limit the amount of food eaten in a day
  - Eat fewer meals in a day
  - Go a whole day without eating
  - Go to sleep at night hungry

### Household Food Insecurity measurement instrument

Over the past 12 months....

4. Did any child in your household ... because there was not enough food?
  - Have to limit the amount of food eaten in a day
  - Eat fewer meals in a day
  - Go a whole day without eating
  - Go to sleep at night hungry
5. Did you get to the point where you had to eat foods that are not acceptable to your culture/community because of lack of resources?

### Household Food Insecurity measurement instrument

Over the past 12 months....

6. Was there a time when you completely ran out of food and didn't have any good/acceptable/appropriate ways of getting more?
7. In order to meet your household food needs, did you have to:
  - Do something that you disliked?
  - Compromise your future food needs?
  - Compromise needs other than food?
  - Do something that you are ashamed of?

### Household Dietary Diversity

- Changes in dietary diversity (number of different foods or food groups consumed) are a **good indicator of changes in average per capita consumption and caloric availability**
- A 10% increase in dietary diversity is associated with a:
  - 6.5% - 11% increase in consumption (per capita expenditures)
  - 3.7% - 7.3% increase in caloric availability
- Lower estimates are more appropriate in populations with relatively low levels of caloric availability (more food insecure)

### Household Asset Index

- Specific to local conditions - list of assets must be **context specific**
- Appropriate assets to track include
  - Productive assets (e.g., oxen, farm or handcraft implements)
  - Assets **easily acquired and liquidated**
    - Assets of domestic utility (e.g., kitchen utensils)
  - **Luxury** items (e.g. jewelry or radios)
- Asset sales can be classified on a **severity scale**
  - Sale of productive assets = more severe response = higher short and long-term vulnerability

### Nutritional status of children

- Child growth at all ages reflects the overall health and welfare of individuals and populations.
  - Used to predict performance, health and survival.
- **Anthropometry** is a widely used, inexpensive and non-invasive measure for assessing the general nutritional status of an individual or a population group

### Three commonly used anthropometric indices

- Stunting (length or height-for-age)
- Wasting (weight-for-height)
- Underweight (weight-for-age)

### Stunting

- Reflected by **low height-for-age** (or length-for-age)
- Stemming from a **slowing in the growth of the child** and resulting in a **failure to achieve expected height (length)** as compared to a child of the same age
- Stunting is an indicator of **past growth failure – cumulative**
- Associated with a number of long-term factors:
  - Chronic insufficient **protein and energy intake**
  - **Frequent infection**
  - Sustained **incorrect feeding practices**
  - **Low socioeconomic family status**

### Wasting

- Reflected by **low weight-for-height**
- Indicates **current acute malnutrition** resulting from failure to gain weight or actual weight loss
- Causes include:
  - **Inadequate food intake**
  - **Incorrect feeding practices**
  - **Disease or infection**
  - Or, more usually, a combination of these factors
- **Subject to rapid change** - individual children and population groups
- **Marked seasonal patterns** - changes in food availability or disease prevalence to which it is very sensitive

### Underweight

- Reflected by **low weight-for-age**
- A **composite measure** of stunting and wasting
- Useful for **defining the overall magnitude** of the extent of malnutrition and its changes over time
- Measures either **past (chronic)** or **present (acute)** undernutrition
  - Although it is unable to distinguish between the two

### Children < 24 mo with diarrhea in last two weeks

- Useful as a proxy indicator for overall environmental health
- Causes include:
  - **Inadequate quantity and/or quality of water**
  - **Inadequate sanitation infrastructure**
  - **Incorrect hygiene practices**
  - **Disease or infection**
- **Marked seasonal patterns**
- These same factors likely to significantly impact PLWHA as well

### Demographic indicators likely to impact both access and utilization – important measures of vulnerability

- **High dependency ratio**
- **Death or chronic illness of working aged adult**
- **Death or chronic illness of mother of young children**
- **Age of household head = very old or very young**
- **Female-headed household**
- **School enrollment rate**

**Is food aid an appropriate intervention in a given HIV context?**

- Do a significant proportion of individuals/households in the program **lack access** to sufficient food?
- Is providing **food** likely to improve their situation as well or **better than other interventions**, e.g. cash transfers?

**Is food aid an appropriate intervention in a given HIV context?**

- Do beneficiaries need an **incentive** to participate in activities?
  - Would providing food sufficiently mitigate constraints that prevent participation?
  - Compared to other incentives that could be offered?

**Is food aid an appropriate intervention in a given HIV context?**

- Are there **enough potential beneficiaries** in the program area to merit procurement of food resources?
- Are **activities implemented regularly and systematically** enough that commodities can be planned and delivered in an organized manner?

**Is food aid an appropriate intervention in a given HIV context?**

**Treatment**

- Is lack of food affecting **ART therapy effectiveness**?

**Prevention**

- Is poor access to food contributing to **risky behaviors**?
  - How widespread is this dynamic?

**Is food aid an appropriate intervention in a given HIV context?**

**Care and Support**

- Is lack of food one of the **principal causes of malnutrition** among PLWHA (rather than e.g. frequent infections, loss of appetite)?
- Are there **enough severely malnourished** to merit a therapeutic feeding intervention?
  - Is effective nutritional rehabilitation **already available**?

**Is food aid an appropriate intervention in a given HIV context?**

**Care and Support**

- Is **absence from school** among OVCs a significant problem?
- Would food **mitigate constraints** preventing attendance?
  - Compared to other incentives that could be feasibly offered (e.g., books, school uniforms, waiving of school fees, cash)?

**Is food aid an appropriate intervention  
in a given HIV context?**

**Care and Support**

- Do OVCs/PLWA at **institutions** receive **enough food** to meet their nutritional needs?
- How would food allow the institution to **improve other services**?

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## HIV/AIDS and FOOD AID

### Assessing the Potential for Food Aid Interventions in High HIV Prevalence Contexts

FANTA and RCOHC — HIV/AIDS & FOOD AID Workshop (English)

1

## Introduction

- HIV/AIDS:
  - A health issue but also a major threat to development and human security
  - Kills most productive members of society → reduces productivity and increases dependency ratios
  - Reduces caring capacity → strains traditional kinship mechanism of social support through networks within extend families.
    - increases vulnerability of dependants to food insecurity and impairs intergenerational transfer of knowledge.
- HIV/AIDS is socially invisible
  - Silence, denial, stigma and discrimination
  - Long incubation period → increased chances of transmission
  - Effective prevention and mitigation difficult
- HIV/AIDS has rural and urban dimensions
  - Death of income earner → urban migration for survivors in search of work
  - Infected urban dwellers return to rural homes for care and to die
- HIV/AIDS is not gender-neutral
  - Women more susceptible, marginalized, powerless & at higher risk of exposure

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2

## Pillars of HIV/AIDS Response

- Prevention
  - Aimed at reducing HIV infection through behavioral change (abstinence, faithfulness, promotion of condom use and enhancing life skills)
- Treatment
  - Aimed at counseling, nutrition education and food supplements to promote compliance, improve drug efficacy and manage side effects of ART.
- Care and Support
  - Aimed at nutritional care and support to prevent nutritional depletion in addition to appropriate treatment of opportunistic infections, etc.
- Mitigation
  - Aimed at reducing the severity of HIV/AIDS impacts on households, communities and other institutions.

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3

## Why Nutrition Support?

- Access to adequate food and palliative nutritional care and support can prolong life, has the potential to significantly postpone HIV/AIDS related illness and keep a person healthy and productive for a longer period of time for their own benefit and for the benefit of those who are dependent on them for care (e.g., young children), thus, in a sense, postpone and reduce vulnerability to the impact of the infection.

FANTA and RCOHC — HIV/AIDS & FOOD AID Workshop (English)

4

## Goals of nutritional intervention

1. Preservation of lean body mass
2. Nutritional repletion during infection
3. Provision of adequate level of nutrients
4. Minimization of symptoms of mal-absorption
5. Maintain optimal health in patients with HIV/AIDS
6. Enhancement of quality of life.

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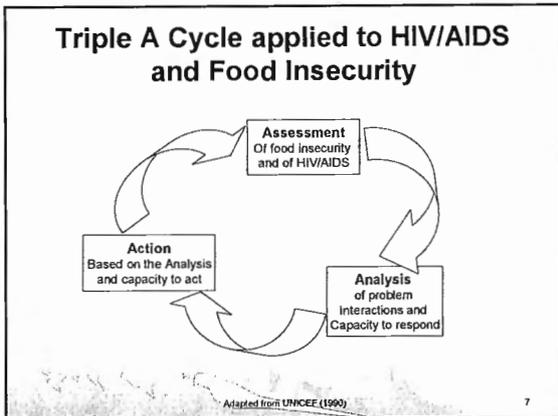
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## Potential for Food Aid Interventions

- Supplements current intakes of calories and other nutrients
  - reduces likelihood of HH experiencing malnutrition.
- Offsets the need and practice of inappropriate coping strategies
  - Reducing food consumption, prostitution, begging, etc.
- Reduces productive asset divestment
- Can increase the capacity of a CBO to provide assistance to affected HHS
- Can serve as a motivating factor for a community to mobilize itself and develop sustainable support systems.

FANTA and RCOHC — HIV/AIDS & FOOD AID Workshop (English)

6



### Life Initiative Project: the FHI (Kenya) Experience

- Target
  - HIV/AIDS OVCs in several areas.
- Assessment
  - Used quantitative & qualitative data collection methods
  - Covered 800 HHs, 32 KIs & 16 FGDs in 4 areas (Districts)

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### Life Initiative Project: the FHI (Kenya) Experience continued..

- Implementation
  - Objective – provide over 5,000 children (→ 21,000 beneficiaries) with food resources to supplement the daily caloric intakes.
  - Criteria for area selection for initial phase
    - Highest number of vulnerable HHs (female/child headed)
    - Highest proportion of single-parent HHs.
    - Availability of legal functional CBOs – current operations, leadership and capacity to manage food resources.
  - Criteria for specific HH identification (one or more)
    - With a moderately or severely malnourished U5 child using accepted anthropometric indicator
    - With a child whose growth continues to falter
    - Single parent HH with an U5 child.
    - Other locally (community) selected indicators.

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### Life Initiative Project: the FHI (Kenya) Experience continued..

- PIP developed
  - Justification for the intervention
  - Program design
  - Implementation strategy
    - Definition of eligibility criteria
    - Commodities & ratio size
    - Logistics
    - Reporting accounting
    - Nature of partnership and collaboration with CBOs (MOUs)
- Project started 2002 with 2,500 and now has 6,500 OVCs. Project expanded to Nairobi slums and expected coverage will be nearly 10,000 OVCs

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### Life Initiative Project: the FHI (Kenya) Experience continued..

- Monitoring
  - Field monitors to look into food distribution
  - Organization
    - Regular assessment food distribution
    - Assessment of other indicators
      - Education (attendance and class performance)
      - Health & nutritional status
    - Capacity building
      - Pastoral care and counseling
      - Nutrition and HIV/AIDS
      - Advocacy for community support of child-headed homes
        - Micro-financing for support groups
      - Medical camps

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