Food Assistance Programming In the Context of HIV

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List of Acronyms and Abbreviations

ADL	activities for daily living
AFASS	acceptable, feasible, affordable, sustainable and safe
AIDS	acquired immunodeficiency syndrome
ART	antiretroviral therapy
ARV	antiretroviral
BMI	body mass index
BCC	behavior change communication
C-SAFE	Consortium for Southern Africa Food Security Emergency
CBO	community-based organization
CBCC	community-based child center
CBT	community-based targeting
CCA	Common Country Assessment
CCM	Country Coordinating Mechanism
CD4	helper T-cell of the human immune system
CDD	community-driven development
CHBC	community home-based care center
CHS	Community and Household Surveillance
CHW	community health worker
CIDA	Canadian International Development Agency
CRS	Catholic Relief Services
CS	Cooperating Sponsor
CSB	corn soy blend
CSI	coping strategies index
CMAM	community-based management of acute malnutrition
DA	Development Assistance
DAC	district AIDS committee
DFID	UK Department of International Development
DHS	Demographic and Health Surveys
EC	European Commission
ECHO	European Commission – Humanitarian Aid Department
ECOG	Eastern Cooperative Oncology Group
EDP	extended delivery point
EU	European Union
EUM	end-use monitoring
FANTA	Food and Nutrition Technical Assistance Project
FAO	United Nations Food and Agriculture Organization
FBO	faith-based organization
FCS	food consumption score
FDP	final distribution point
FFA	food for assets
FFE	food for education
FFP	USAID's Office of Food for Peace
FFT	food for training
FFW	food for work
FH	Food for the Hungry
FHI	Family Health International
FLA	field-level agreement

GFD	general food distribution
GIPA	greater involvement of people with HIV and AIDS
GMO	genetically modified organisms
GMP	growth monitoring and promotion
GTZ	German Society for Technical Cooperation
H/A	height-for-age
HAART	highly active antiretroviral therapy
HACI OVC	Hope for African Children Initiative, Mozambique
HBC	home-based care
HDDS	household dietary diversity score
HEPS	high energy protein supplement
HFIAS	household food insecurity access scale
HHS	US Department of Health and Human Services
HIV	human immunodeficiency virus
HRQOL	health-related quality of life
IASC	United Nations Interagency Standing Committee
IDP	internally displaced person
IMCI	Integrated Management of Childhood Illness
IEC	information, education and communication
IFPRI	International Food Policy Research Institute
ILO	United Nations International Labour Organization
IMCI	Integrated Management of Childhood Illness
LANFE	Lesotho Association of Non-Formal Education
LBW	low birth weight
LLPPA	local level participatory planning approach
M&E	monitoring and evaluation
MAP	multi-country HIV/AIDS program
MAHFP	months of adequate household food provisioning
MCH	maternal and child health
MCHN	maternal and child health and nutrition
MDG	Millennium Development Goal
MERET	Managing Environmental Resources to Enable Transitions
MICS	multiple indicator cluster surveys
MOE	Ministry of Education
MOU	Memorandum of Understanding
MUAC	mid-upper arm circumference
NAC	National AIDS Commission
NASCOP	National HIV/AIDS and STD Control Program, Kenya
NEC	nutrition education and counseling
NGO	non-governmental organization
O/GAC	Office of the U.S. Global AIDS Coordinator
ORS	oral rehydration solution
OVC	orphans and vulnerable children
PCI	Project Concern International
PDM	post-distribution monitoring
PEPFAR	United States President's Emergency Plan for AIDS Relief
PL	positive living
PLHIV	people living with HIV
PMTCT	preventing mother-to-child transmission
PRA	participatory rural appraisal
PRRO	protracted relief and recovery operation

PRSP	Poverty Reduction Strategy Paper
PSI	Population Services International
QOL	quality of life
RC	Relief Committees
RDA	recommended daily allowance
RH	reproductive health
RHM	rural health motivator
RUTF	ready-to-use therapeutic food
SCN	United Nations Standing Committee on Nutrition
SES	socioeconomic status
SFP	supplemental feeding program
SGBV	sexual and gender-based violence
STEPs	Scaling up HIV Interventions through Expanded Partnerships
STI	sexually transmitted infection
TASO	The AIDS Support Organization, Uganda
TB	tuberculosis
TB-DOTS	tuberculosis treatment (directly observed treatment, short-course)
TFP	therapeutic feeding program
THRs	take-home rations
Title II	United States Public Law 480 Title II development food aid program
TOT	training of trainers
TSA	The Salvation Army
UN	United Nations
UNAIDS	The Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNODC	United Nations Office on Drugs and Crime
USG	United States Government
USAID	United States Agency for International Development
USDA	United States Department of Agriculture
VAC	village AIDS committee
VAM	vulnerability analysis and mapping
VCT	voluntary counseling and testing
W/A	weight-for-age
WFP	United Nations World Food Programme
WFS	World Food Summit
W/H	weight-for-height
WHO	United Nations World Health Organization
WIC	USDA's Special Supplemental Nutrition Program for Women, Infants, and Children (US-based)
WSB	wheat soy blend
WV	World Vision

Foreword

There is increased acknowledgment in the development community of the links between food insecurity and HIV, and the corresponding need to integrate food and nutritional support into a comprehensive response to the epidemic. In areas of high HIV prevalence,[A] many food assistance agencies have recognized the need to adjust conventional food assistance interventions to respond to vulnerabilities related to HIV's impact on individuals, households and communities.

Efforts to effectively respond to food insecurity and HIV are hindered by the lack of both documented, sector-based promising approaches and field-level evidence on appropriate food assistance interventions in the context of HIV. To address these challenges, the Food and Nutrition Technical Assistance (FANTA) Project, working with Technical Assistance to NGOs (TANGO) and funded by the United States Agency for International Development (USAID) and the World Food Programme (WFP), has developed this guide on Food Assistance Programming in the Context of HIV.

Why Was the Guide Developed?

The goal of the guide is to improve capacity to design and implement food assistance programs in the context of HIV by providing a set of tools, promising practices and key considerations that enhance the flexibility and appropriateness of program design and implementation modalities. The guide strives to answer these core questions:

1. How can food aid-supported food security programs modify their design and implementation to account for the constraints and needs faced by people living with HIV (PLHIV) and HIV-affected households and help achieve food security outcomes in a high-prevalence context?

2. How can HIV prevention, treatment, and care and support programs better utilize food and food-related resources to help achieve their HIV-related outcomes?

3. How can food security and HIV programs integrate their activities in areas of high food insecurity and high HIV prevalence to maximize complementarities and synergy without compromising the core objectives of either program?

Who Is the Guide for?

The principal audience for Food Assistance Programming in the Context of HIV includes WFP regional and country offices, WFP implementing partners, USAID regional and country Mission Offices of HIV and Food for Peace (FFP), as well as Title II Cooperating Sponsors (CSs), and other governmental and non-governmental organizations that use food assistance to save lives, provide nutrition care and support and enhance resilience and adaptive capacity among food-insecure households and those affected by HIV. The guide is written for program directors, program advisors and senior program managers who are directly involved in the analysis and formulation of food assistance strategies and country program activities at HQ and in regional and field offices.

A The term "high prevalence" is used throughout this guide. It is analogous to the concept of a ***generalized epidemic*** of HIV. HIV is commonly understood to reach the status of a generalized epidemic where over five percent of high-risk groups and over one percent of pregnant women are HIV-positive.

Particularly in areas where food insecurity and HIV prevalence are high, the guide will help these decision makers respond to the challenges posed by the epidemic through design and implementation of food assistance strategies that are appropriate for managing the interactions among HIV, food security, livelihoods and nutrition.

How Should the Guide Be Used?

The guide is intended to help decision makers ask the right questions about the relevance, appropriateness, effectiveness and impact of food security programs in an HIV context, as well as help them integrate food and nutrition interventions into HIV programs. The guide addresses food security vulnerability assessments, targeting, activity design, program implementation and operational challenges associated with food assistance in the context of HIV.

The guide builds upon what has been learned through WFP and USAID Title II experience with food security and food assistance programs in areas affected by HIV. It discusses complex programmatic and operational strategies, and presents examples of sector-specific approaches that have shown positive results among the most vulnerable individuals, households and communities.

How Is the Guide Organized?

Part I. HIV and Food Security: Conceptual and Institutional Framework

Part I describes the food security conceptual framework, which should be used as the basis for all food assistance interventions. Part I outlines currently known and accepted linkages between food security, livelihoods and HIV; explains food assistance's potential role in addressing related vulnerabilities; and discusses international and national food security and nutrition policies, goals and program resources and mechanisms relevant to food assistance and HIV programs.

Part II. Program Design Steps

Part II provides guidance on the full range of conventional project design steps, with a focus on the specific implications of food assistance programming in HIV-affected areas and populations.

Part III. Sector-Specific Program Design Considerations

Part III reviews the design and implementation of interventions for key sectoral categories, identifies tools and promising practices, and provides key considerations for addressing specific challenges in the context of HIV.

Introduction

Since its onset, the HIV epidemic has magnified the already significant problems caused by poverty, food insecurity, gender inequality and weak governance in developing countries. During this same period, social services in the worst-affected countries have withered or become less affordable, incomes and formal employment levels have plunged, and wars and large-scale population migration have disrupted social stability. Meanwhile, life-threatening diseases other than HIV, such as tuberculosis and malaria, have been on the rise, directly affecting institutions' ability to provide quality health care. Meanwhile, amid these multiple threats to human security, HIV has contributed to the continued deterioration of living conditions, especially among the poor.[1]

The past two decades have revealed a complex, bi-directional relationship between food security and HIV. Illness and death resulting from the disease have an immediate impact on food security by limiting household income and food production. At the same time, food insecurity and poverty fuel the further spread of HIV when people are driven to adopt immediate survival strategies that make them more vulnerable to HIV infection. Food security is also compromised by HIV because of the specific nutritional requirements of those infected by the disease. Not only do people living with HIV (PLHIV) require greater energy intake from foods, they often experience difficulty in digesting it. Access to adequate nutrition is critical to the health of infected individuals, including those receiving antiretroviral therapy (ART). Finally, the combined impacts of food insecurity and HIV place further strain on already limited household resources as affected family members struggle to meet household food needs while paying for care, treatment and support of infected members.

The enormity of these impacts and the complexity of the bi-directional relationship between food security and HIV are highlighted by these statistics:

- Since the emergence of the virus, more than 60 million people worldwide have been infected and over 20 million have died.[2]
- The Joint United Nations Programme on HIV/AIDS (UNAIDS) estimates that as of 2005, there were between 33 million and 46 million individuals living with HIV and that the vast majority of those infected live in developing countries.[3]
- It has been estimated that each case of HIV directly affects about four other people, meaning the HIV epidemic is affecting millions of people beyond those who are infected.[4]
- As of 2003, 32 percent of the population of sub-Saharan Africa (206 million individuals) is undernourished, representing nearly one-quarter of all the undernourished people in the world.[5]
- Sub-Saharan Africa is home to 11 percent of the world's population but faces the burden of caring for nearly two-thirds of global HIV cases.
- Nearly 14 million Africans have already died as a direct result of the epidemic; by 2020 most of the 25 million people living with HIV will have died as well.[6]
- Current estimates by UNAIDS suggest that 5.7 million people are living with HIV in India and as many as one million individuals are infected in China.[7]
- Asia will overtake sub-Saharan Africa in absolute numbers of people infected with HIV before 2010 and will be the HIV epicenter by 2020.[8]

Still, it is important to note that this bi-directional relationship can be positive as well as negative. While it often accelerates a downward spiral into further poverty and deprivation for poor households, it may also present opportunities to help arrest and reverse this descent. For example, food assistance plays a vital role as a safety net for protecting productive assets of HIV-affected households and has helped increase adherence to ART among infected individuals.[9-13]

Primarily perceived as a public health crisis in the early stages of its evolution, the HIV epidemic is now widely acknowledged as having contributed to the deterioration of human, financial, social, political and cultural resources at the household, community, regional and national levels throughout much of Africa. For this reason, growing emphasis is being placed on developing multisectoral responses to food insecurity and HIV that incorporate both short- and long-term perspectives on increasing resiliency. This approach requires effective coordination of multiple interventions that provide for the immediate needs of HIV-infected individuals and affected households while ensuring that they have the skills and assets needed to achieve long-term food security. Specific steps in designing effective, multisector food assistance programs for implementation in high-prevalence settings are presented throughout this guide.

The challenges in designing effective food assistance programs in the context of HIV arise from the fact that the impacts of the disease are pervasive, systemic and dynamic.[14, 15]

Endnotes

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Chapter I: Conceptual Framework

HIV and Food Security: Conceptual and Institutional Framework

Chapter 1: Conceptual Framework

HIV and Food Security: Conceptual and Institutional Framework

Key Concepts

1.1 Basic Concepts: HIV, Food Security, Vulnerability and Livelihood Security

1.2 Understanding the Relationship Between HIV and Food Insecurity

1.3 Implications for Food Assistance Programming in Response to HIV

In This Chapter

This introductory chapter focuses first on the basic concepts underlying the human immunodeficiency virus (HIV), food security, vulnerability, and livelihoods. These concepts include definitions of food availability, food access and food utilization, which are critical to achieving food security. The chapter also discusses vulnerability, risk and resilience, which are critical to understanding the dynamic relationship between food insecurity and HIV. A major factor in the conceptual understanding of HIV is the disease's impact on livelihoods, which is in turn a key determinant of the level of food security that communities, households and individuals achieve.

The chapter then further explains the relationship between food insecurity and HIV, emphasizing the vicious cycle that often is created when HIV infection leads to deterioration of nutritional status and immune function among food-insecure individuals.

Chapter 1 concludes with a discussion of the implications of the relationship between food insecurity and HIV for the development of integrated food assistance and HIV programs, including a clarification of program objectives and targets.

1.1 Key Concept

Basic Concepts: HIV, Food Security, Vulnerability and Livelihood Security

A number of basic definitions are important for a good conceptual understanding of the dynamic relationship between food security and HIV.

HIV and AIDS[A]

HIV attacks the immune system. It is spread through sexual contact, direct inoculation with contaminated needles or blood transfusion. It can also be spread from mother to child during pregnancy, birth or breastfeeding. Left untreated, HIV compromises immune system function, leaving the infected person susceptible to a variety of opportunistic infections. Acquired immunodeficiency syndrome (AIDS) is an advanced stage of HIV, clinically defined by the presence of HIV infection and a low level of white blood cells or T-cells.[1]

Food Security

Food security occurs when "all people, at all times, have physical and economic access to sufficient, safe and nutritious food to meet their dietary needs and food preference for an active and healthy life." [2, 3, 4]

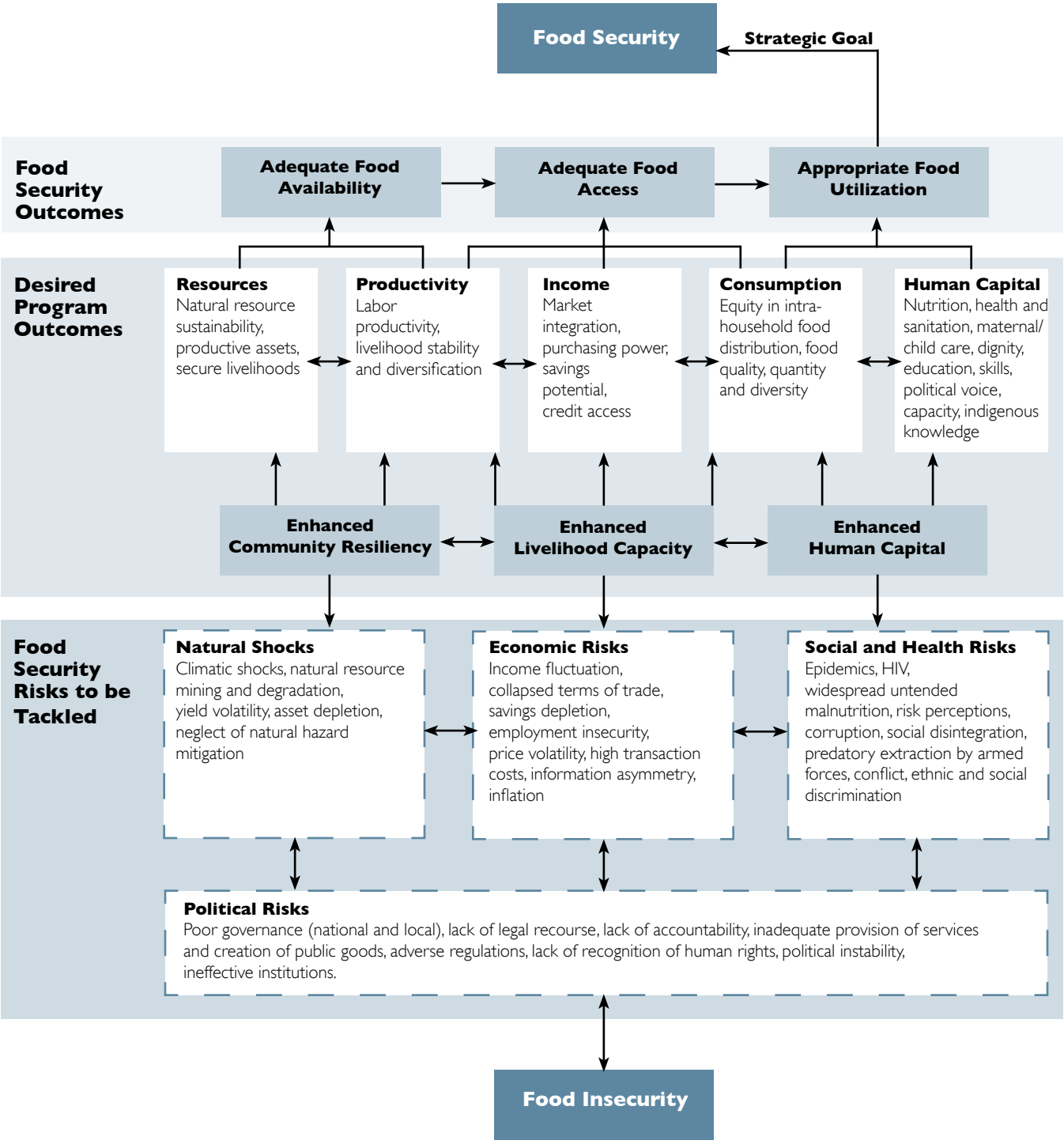
A food-secure household is one in which all household members are well-nourished.

This definition of food security is founded on three fundamental elements: adequate food **availability**, adequate **access** to food and appropriate food **utilization**. Figure 1 depicts critical linkages between food security outcomes, program outcomes and potential risks. The framework suggests a hierarchical relationship where food security results from adequate food availability and access, as well as proper food utilization.

- Food ***availability*** is derived from domestic agricultural output and net food imports at the national level. In the context of HIV, food availability tends to be impaired by production failures related to labor constraints, gender inequality in land tenure and loss of productive assets needed to sustain household food production.
- Food ***access*** refers to the household's ability to get food in the marketplace or from other sources (transfers, gifts, etc.). Food ***access*** depends largely on household purchasing power, which varies in relation to market integration, price policies and temporal market conditions. In the context of HIV, affected households and infected individuals may be too ill or overburdened to earn money to buy food, and they may have limited access to community networks, markets and trade associations because of stigmatization.
- Food ***utilization*** is determined by food safety and quality, how much a person eats and how well a person converts food to energy, all of which affect proper biological use of food, nutritional status and growth. Adequate food utilization requires a diet providing sufficient energy and essential nutrients, potable water, adequate sanitation, access to health services and proper feeding practices and illness management. (See Figure 2 for a commonly used conceptual framework expanding the relationship among food

A Except in the case of proper nouns, this document has adopted the recommended terminology in the UNAIDS Editors' Notes for Authors (August 2006). In place of HIV/AIDS, HIV is used to refer to the virus and its impacts and AIDS to the clinical diagnosis or cause of death. PLHIV is the preferred terminology rather than other variants PLHA or PLWHA.

Figure 1: An Expanded Conceptual Framework for Understanding Food Insecurity



Source: Webb and Rogers, *Addressing the "In" in Food Insecurity*, 2003.

access, utilization and nutrition.) In the context of HIV, food utilization among members of affected households is impaired by insecure access to a good quality diet, difficulties in accessing health services, lack of knowledge about appropriate child feeding and care practices and lack of time to provide proper child care, inability to breastfeed and lack of resources for appropriate replacement feeding, and discrimination against women in controlling resources. Food utilization is often further compromised among people living with HIV (PLHIV) due to higher energy requirements, increased susceptibility to food- and water-borne infections and the effects of opportunistic infections.

It is also important to distinguish between **chronic** and **transitory** food insecurity. Chronic food insecurity is a long-term or persistent inability to meet minimum food consumption requirements, while transitory food insecurity is a short-term or temporary food deficit.[5]

Vulnerability to Food Insecurity

Strategies to reduce food insecurity have been largely aimed at improving food availability, access and utilization among those who are already food-insecure, largely because of the obvious need to prioritize food assistance provided through emergency and relief interventions to those with the most immediate need. It may be a significant challenge to address the needs of households that are food-secure now but are using coping strategies that may compromise their food security later. Such scenarios point to factors that are often missing in analyses of food and livelihood security: **vulnerability** and **resilience**.

Hazards can be natural, as in the case of earthquakes and illness, or man-made, as in the case of unemployment, degradation, policy changes and war.

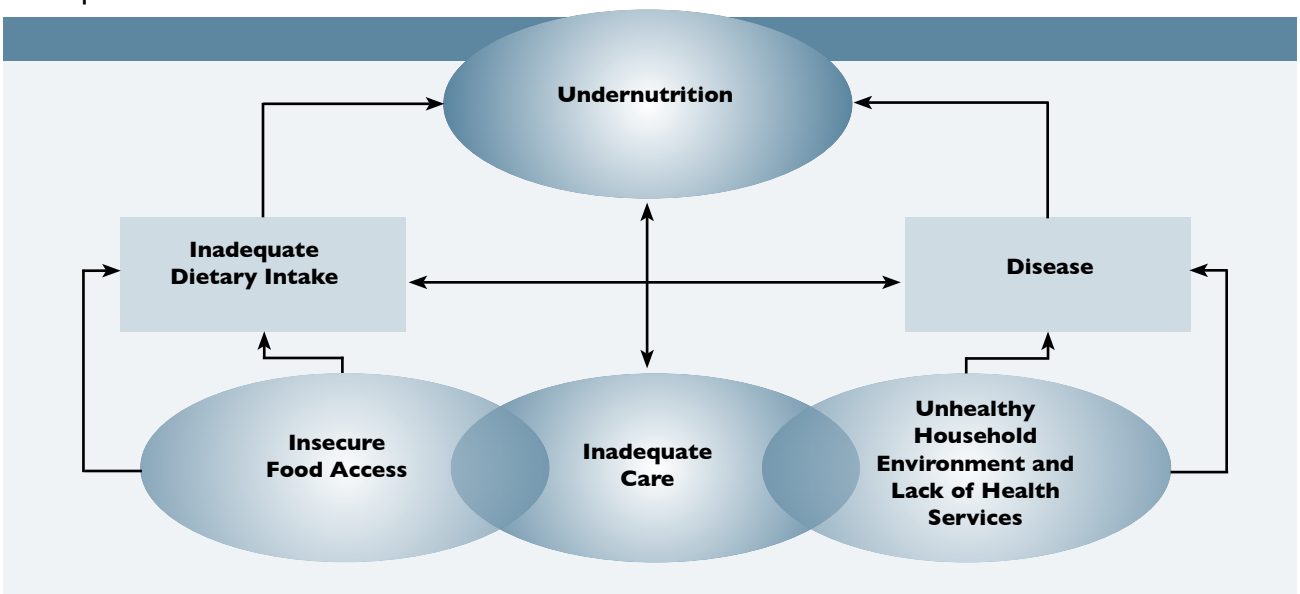
Vulnerability can be defined as the exposure and sensitivity to livelihood shocks, a concept that begins with the notion of **risk**.[6] Individuals, households, communities and even nations face multiple hazards from different sources. Risks are the combination of the probability or frequency of occurrence of a defined hazard and the magnitude of the consequences.[7] Hazards often cannot be prevented, and if they materialize, can generate a shock that hurts individuals, households and communities in both predictable and unpredictable ways.[8]

The degree of vulnerability depends on the nature of the risk and a household's **resilience**, or "ability to bounce back or recover after adversity or hard times, to be capable of building positively on these adversities."[9] A household's resilience often is related to:

- The magnitude of the shock that a household or community can absorb and remain viable
- How well a household or community can self-organize after the exposure to the hazard to maintain an acceptable level of functioning and structure
- How well a household or community can learn from these difficult circumstances and adapt
- The household's characteristics, notably its assets and livelihood strategies

Vulnerability can be lessened by 1) reducing exposure to risks of shocks that affect many people (e.g., frequent droughts) or shocks that affect individuals or households (e.g., the death of the household head) and/or 2) increasing the ability to manage shocks.[10] However, chronically food-insecure households often are not resilient to shocks and are continuously vulnerable. While food security interventions often seek to build resilience in food-insecure communities, this is even more challenging in the context of HIV because of the disease's progressive nature. In the context of HIV, food assistance programming should strive to

Figure 2: Availability, Access and Utilization—The Relationship Between Inadequate Food Access at the Household Level and Undernutrition



Adapted from UNICEF, *Strategy for Improved Nutrition of Children and Women in Developing Countries*, 1990.

enhance the resilience of affected communities, households and individuals. The information throughout this guide can give food assistance program managers ideas on how to enhance community and household resilience.

The conceptual framework presented in Figure 1 adds the dimension of vulnerability and risk to the three elements of food security. This framework shows the risks that constrain or threaten food availability, access and utilization. The basic food security framework is presented in the upper part of the diagram, with the desired food security outcomes leading to the goal of improved food security. The major risks that must be tackled to achieve food security and their links to the desired program and food security outcomes are at the bottom of the framework. [11]

HIV-induced food security shocks differ from other shocks and cannot be addressed the same way droughts and other natural disasters can. HIV significantly undermines a household's ability to provide for basic needs because HIV-infected adults may be unable to work, reducing food production and/or earnings. Healthy family members, particularly women, are often forced to stop working to care for sick relatives, further reducing income for food and other basic needs. The households may have trouble paying costs associated with heath care and nutritional support. They also may be severely restricted in participating in community activities. Children may be withdrawn from school because families cannot afford school fees because of the need for the children to care for ill relatives. This affects the opportunities for future generations. [12]

The framework in Figure 1 has a strong link to livelihood frameworks that many development agencies use (see the Livelihood Security section and Figure 3 later in this chapter). The impact of HIV on all aspects of people's livelihoods calls for integrated approaches to address the epidemic.

Vulnerability to HIV

In the past, the public health understanding of HIV has been dominated by the notion of individual risk—a confluence of cognitive, attitudinal and behavioral factors that operate at the individual level.[13] Efforts to control the transmission of HIV focused on individual behavioral change. More recently there has been a shift from this approach to an awareness of how broader contextual factors converge to shape the complex environment in which individual behavior takes place. It is now recognized that socio-cultural, economic and political realities fundamentally shape individual risk, significantly limiting individual choices and options for risk reduction. Public health officials now recognize that broadening the scope of HIV interventions requires new collaboration across multiple sectors and disciplines.

In southern Africa overall, the marginal probability of dying from disease and AIDS-related causes rises steeply from age 15, peaking at 30 to 34 for females, and 50 to 54 for males.[14]

Urban Versus Rural Vulnerability to HIV

At its onset, the HIV epidemic was generally understood to be a predominantly urban concern. It was also initially observed that the disease affected more men than women and was more common among those with relatively high incomes. However, there is growing concern over HIV's rural impacts due to dynamic patterns of migration and trade, the movement of refugees and other rural-urban linkages.

Recent experience suggests that the epidemic likely has a disproportionate impact on rural agricultural communities given the generally fragile state of smallholder farming and the difficulties rural households face when they lose productive laborers. The burden of the epidemic also affects rural areas when HIV-affected urban adults send children back to their villages of origin or return themselves when they become seriously ill. In many such cases, the costs of long-term care and support for the extended family are increasingly borne by rural communities.[15]

Urban areas in countries highly affected by HIV maintain relatively higher rates of prevalence than rural areas, by most estimates.[19]

The differences in urban and rural livelihood strategies also have important implications for households vulnerable to food insecurity and HIV. In urban wage-based economies, poor households often borrow from informal sources or draw down savings to cope with a shock to livelihoods. When these fail, they may use riskier ways to generate income. Men may turn to migrant labor or long-distance transportation work, while women may engage in transactional sex to provide for the household. [16, 17, 18] In rural areas, households often try to meet growing expenses for food, HIV treatment or funerals by selling their assets, encouraging members to migrate to urban areas to find work or relying on child labor, often at the expense of school. In both urban and rural settings, household vulnerability to HIV is increased, setting up a dynamic in which responses to immediate needs compromise the prospect of long-term food and livelihood security.

Gender Issues

To understand the challenges of addressing food insecurity in the context of HIV, it is critical to note that women, especially young women, are more susceptible to acquiring HIV than men for several reasons:

- Immature genital tracts and high rates of asymptomatic untreated sexually transmitted infections (STIs) make young women more susceptible to acquiring HIV.

- Women are more likely to receive blood transfusions than men because of higher rates of anemia and complications during childbirth.
- Women may resort to transactional sex to provide for their families during acute food shortages.
- During civil unrest and violent conflict, women and girls could be sexually exploited by soldiers and/or militants.
- Many cultural practices allow men to have multiple sexual partners and make it difficult for a woman to insist on safe sexual practices, including asking a man to wear a condom.

On average, women are infected with the virus six to 10 years younger than men. A recent Zambian study showed that more than 60 percent of the prime-age deaths observed in a nationally representative rural sample between 2001 and 2004 were among women.[20]

Women often suffer heightened impacts of HIV and food insecurity due to specific nutritional issues:

- Women who are pregnant or breastfeeding have increased nutritional needs, which often go unmet in food-insecure environments and can be even more challenging to address in the context of HIV.[21, 22]
- Malnutrition increases the viral load in the blood stream which increases the possibility of HIV-positive pregnant women passing the virus on to their infants. [23, 24]
- In agricultural communities, the death of a household adult male often leaves women without the labor and knowledge needed to maintain the family livelihood.[25] Many such communities bar women from owning land, livestock and other assets, putting widows in jeopardy of losing critical resources they helped develop and maintain.

The fact that women now form the majority of those living with HIV has an enormous social and economic impact on affected households and communities, particularly in low- and middle-income countries. Within such environments, women and girls perform the lion's share of socially valued work, raising and nurturing children, performing domestic labor and caring for the sick. Women are also generally more knowledgeable and adept at gathering famine foods and nurturing social networks that may provide vital support in periods of acute food insecurity. When a woman dies, much of the burden typically shifts to younger and older women who step in to foster the children.[28]

In South Africa, almost three-quarters of HIV-affected households were female-headed, one survey has found. A significant proportion of these women were battling HIV-related illnesses themselves. In Manicaland, Zimbabwe, when a woman died from AIDS, households dissolved in two out of three cases. [26, 27]

For heterosexual men, cultural beliefs and practices related to masculinity can influence their vulnerability to HIV.[29] Societies where men are encouraged to have multiple sex partners to demonstrate their manhood could be more vulnerable to rapid transmission. For this reason it is important to take local values, customs and people's knowledge into account when designing interventions.

Coping Strategies in the Context of HIV

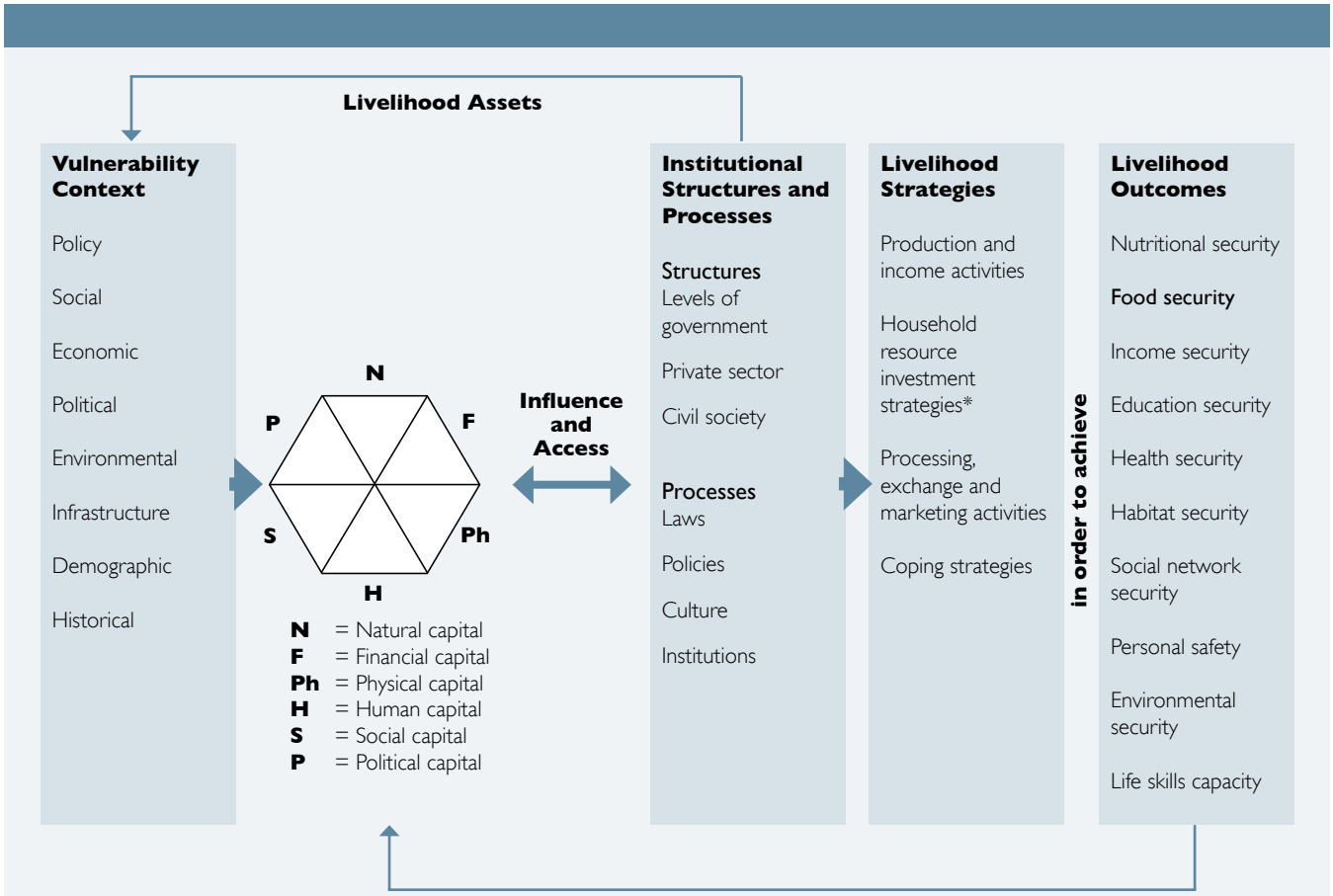
Persistent hunger, the responsibility of caring for chronically ill family members and the death of productive heads of household can lead poor families to adopt irreversible coping strategies that permanently alter resiliency to future shocks. Coping strategies with particularly negative consequences include eating less or substituting less-nutritious foods, selling assets, using savings and investments to pay for basic needs and medical care, and withdrawing children from school. While such strategies may help families avoid dissolution and meet immediate needs, they threaten the human, financial and social capital that affected households will need to maintain food security over the long term. [30, 31, 32]

Seasonal and permanent labor migration is another common coping strategy HIV-affected households use. While this strategy often helps to diversify livelihood strategies and diffuses the shock of the disease over a wider geographical area, it also can undermine the health status, and food and livelihood security of individuals and households. Families left behind face greater responsibility for caring for chronically ill household members and lower crop yields as available workers leave home. Meanwhile, as HIV continues to expand at the societal level, there are fewer employment options for migrant laborers. Many are driven into relatively high-risk income-earning strategies (transport, petty trading, commercial sex, etc.), further increasing vulnerability to HIV infection.

Livelihood Security

Household livelihood security has been defined as ***"adequate and sustainable access to income and resources to meet basic needs (including adequate access to food, potable water, health facilities, educational opportunities, housing and time for community participation and social integration)."*** A sustainable livelihood is one that can help a household cope with, recover from and adapt to stress and shocks; maintain or enhance its capabilities and assets; and provide sustainable livelihood opportunities for the next generation.[33, 34]

Figure 3: Livelihood Security Framework



* Decisions regarding use of tangible and intangible household assets (consumption needs, health needs, education, shelter)

Adapted from DFID Sustainable Livelihoods Framework (1999) and CARE Household Livelihood Security Framework (2002).

A full understanding of livelihoods requires a thorough comprehension of:

- The context in which the households and communities are living (economic, social, political, environmental, cultural)
- The tangible and intangible assets to which households have access (natural, financial, physical, human, social, political)
- The institutional structures and processes that influence livelihood opportunities within the community (government, civil society, private sector)
- The various livelihood strategies that people pursue to make a living or to cope with shocks, and the livelihood outcomes that are achieved by households and communities

Food security is one of several outcomes that households are trying to achieve (see Figure 3).

HIV Impacts on Assets [35, 36]

HIV has multiple impacts on livelihood security, increasing vulnerability, and through impacts on assets, institutions and livelihood strategies.[37, 38]

Human capital. HIV decreases household productivity due to sickness and AIDS-related opportunistic infections; infected individuals eventually will die while still in their productive years. Productivity is further diminished as healthy individuals care for the sick and attend funerals. Children are forced to leave school early, thus achieving lower levels of education. In addition, there is less sharing of indigenous knowledge between generations because of the premature deaths of adult workers.

Financial capital. Medical costs and funerals are a major financial burden, while the inability to work reduces household income. Affected households are often forced to sell assets or borrow. Thus, these households risk facing difficulties in getting loans from banks. The poor usually rely on informal lenders—often at very high interest rates—or on group-based microfinance initiatives. However, both of these types of services tend to be vulnerable to aggregate shocks, such as in the late stage of the HIV epidemic. Even at the early stages of the epidemic, an affected family is less able to avoid default and is less attractive to group-based lending schemes.

Natural and physical capital. Land is often sold to pay medical and funeral expenses. Land inheritance customs and laws can make widows in certain patrilineal systems more vulnerable and at risk of losing their land rights. Families with surviving members who cannot cultivate their land might also be at risk of losing their land rights. Affected households often adopt less labor-intensive ways to farm and may also be forced to sell productive assets and livestock, which further reduces agricultural productivity. Access to water and energy sources (such as wood to be used or sold as fuel) also becomes more difficult, as women might be sick or need to spend more time caring for the ill, often leaving the responsibility to collect water and wood to children. HIV also might undermine the ability of communities to pool risk and work together to sustainably manage common property including rangeland, cropland and river basins.

Social capital. Social networks within communities deteriorate with the spread of HIV, as more households and individuals become affected and cannot help other families. Social capital may also be weakened as affected households and individuals are shunned because of the stigma attached to HIV. Institutions that contribute to social capital, such as local non-governmental organizations (NGOs) and faith-based organizations (FBOs), are likely to weaken as members die. At the national level, the capacity of government and social institutions to provide formal safety nets and support to HIV-affected people decreases as

the epidemic progresses because of increasing costs, diminishing revenues as a significant number of productive-age people become ill or die, and the deterioration of human resources to implement and manage the provision of social safety nets and services.

HIV Impacts on Institutions

HIV can have a significant effect on the institutions that provide social services that are critical to the livelihoods of households. These impacts are both demand and supply related. For example, HIV influences the demand side of all service institutions by reducing financial resources available to pay for services. The demand side of education is also affected as fewer children attend school due to death or illness of a family member or to stigma.[39] HIV influences the supply side of education by reducing the supply of educators. Agricultural services are diminished as the number of extension workers declines. Market and transportation systems are impaired as the number of traders and drivers falls.

HIV's impact on health services in high prevalence areas is also significant. Demands for HIV treatment can place burdens on health care institutions that result in shifting infrastructure, personnel and financial resources away from meeting other basic health care needs.[40] Shifting resources away from investing in basic-needs infrastructure (e.g., potable water, sewage services, child vaccination programs) could have profound effects on the larger population's health.

HIV Impacts on Livelihood Strategies

The likelihood that individuals will be exposed to HIV will depend in part on their livelihood strategies. As noted earlier, strategies such as migrating to earn additional income or engaging in transactional sex to get food can increase exposure. Once a household is exposed, its livelihood strategies can change significantly because of shortages of labor, the sale of productive assets and the need for cash to pay medical costs.

The impact of HIV on assets, institutions and strategies will also influence the strategic responses of communities and households. These responses in turn will have outcomes—on availability, access and utilization of food—that will themselves affect future susceptibility and vulnerability. [41]

1.2 Key Concept
Understanding the Relationship Between HIV and Food Insecurity

The cyclical nature of the relationship between food insecurity and HIV has been shown to depend on a number of factors including: [42]

- Household's demographic structure
- Gender of household head
- Timing of illness and/or death (e.g., agricultural season)
- Number of people infected
- Length of time the household has to cope with the impacts of the disease
- Household's resources
- Level of expendable household income
- Level of community reciprocity and nature of social networks

By 2010, AIDS could leave as many as 25 million children in Africa under the age of 15 without one or both parents, studies suggest. [44]

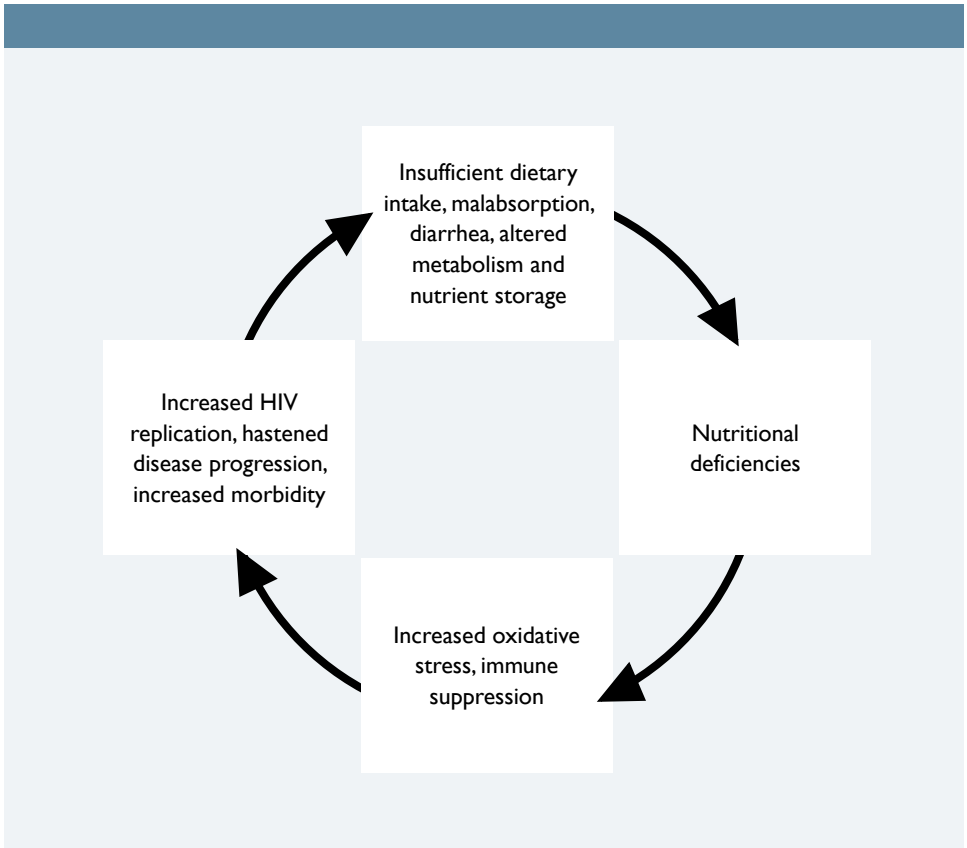
The HIV epidemic can be seen as a shock deeply affecting all components of livelihood systems and their outcomes. The term "new variant famine" has been widely used to describe food insecurity that results in regions with high HIV prevalence.[43] The term conveys the concept that pervasive food shortages or famine in regions with high HIV prevalence are fundamentally different than acute food insecurity in other contexts. Previously, a drought, civil conflict or other shock would temporarily alter food production and livelihood systems, requiring households to cope as best they could until the situation returned to normal. However, in the case of HIV, households and communities face a shock to food and livelihood security from which no quick return to normalcy is possible.

In contrast to more traditional shocks, the convergence of food insecurity and HIV often leads to the establishment of an increasingly vicious cycle, with food insecurity heightening ***susceptibility*** to HIV exposure and infection, and HIV in turn heightening ***vulnerability*** to food insecurity.[45, 46, 47] These factors often contribute to and reinforce this cycle:[48]

- Unlike many short-term shocks HIV tends to have a continual and cumulative effect on household food security.[49]
- HIV disproportionately affects prime-age adults, killing the most productive members of society. It therefore increases household dependency ratios, reduces agricultural productivity, income generation and caring capacity, and impairs knowledge transfer between generations.[50]
- HIV typically has a more pervasive impact on household food security than other shocks because the disease ***increases*** the nutritional requirements of infected individuals, widening gaps between food needs and food access.
- Efforts to address the impacts and prevent the spread of HIV are hindered by affected individuals' reluctance to seek assistance due to the stigma surrounding the disease. [51]
- The scale of the HIV epidemic is larger than that of most other shocks to food security, in that it has impacted entire countries and regions with high prevalence rates.

- As it intensifies, the epidemic decreases the capacity of key institutions, creates a huge burden on inadequate health services and contributes to increasing household dependency ratios in affected communities, impacting the ability to provide adequate care for children, pregnant women and PLHIV.
- The progression from initial infection to presentation of symptoms may take several years, facilitating the further spread of HIV in the interim. At the national and community level, the scale and impact of HIV may not be recognized until prevalence is already high, limiting and delaying the establishment of coping strategies to deal with food security impacts. [52]
- Food insecurity exacerbates gender inequality and can lead women to engage in exploitative sexual relationships that place them at greater risk of contracting HIV. [53]
- Food insecurity can promote migratory labor and marketing arrangements that place individuals at greater risk of being exposed to HIV. [54]
- Food insecurity can increase susceptibility to HIV in that the risk of infection and the disease's rate of progression are influenced by an individual's nutritional status. For instance, micronutrient deficiencies have been shown to increase the likelihood of mother-to-child transmission.[55, 56]

Figure 4: The Vicious Cycle of Malnutrition and HIV



Source: Semba and Tang, "Micronutrients and the Pathogenesis of Human Immunodeficiency Virus Infection," ***British Journal of Nutrition*** (1999), 81.

Just as the relationship between food insecurity and HIV can be distinguished from other types of shocks, the interaction between the disease and malnutrition is considerably more complex and dynamic than many other threats to individual health (see Figure 4).

It has long been recognized that synergistic interactions between infection, nutritional status and immune function undermine individual health by reducing dietary intake and nutrient absorption while increasing utilization and excretion of proteins and micronutrients. However, HIV is considerably more damaging than most other types of infections because it directly attacks and destroys the cells of the immune system. Likewise, HIV also affects the production of hormones involved in the metabolism of carbohydrates, proteins and fats, contributing to the dramatic weight loss observed in most adult AIDS patients. In advanced stages of the disease, severe malnutrition is typically reflected by continual decreases in weight from the loss of muscle tissue and subcutaneous fat, as well as fever, nausea, vomiting, diarrhea and susceptibility to opportunistic infections. [57–64]

In addition to compromising the health of PLHIV, HIV undermines the nutrition of other members of affected households. For instance, the weight loss, fatigue and decreased productivity among infected individuals, many of whom are heads of household and/or mothers, have a direct and negative impact on the household's ability to get, prepare and eat nutritionally adequate food, including appropriate replacement feeding. Good infant and child feeding and care suffer as mothers sicken and die, and children are cared for by fathers, grandparents, foster parents or siblings who may not have the knowledge, resources or time to provide adequate care. In this way, children, whether they are HIV positive or not, suffer nutritional consequences as a result of HIV.

1.3 Key Concept
Implications for Food Assistance Programming in Response to HIV

Because the impacts of HIV and food insecurity are highly correlated and the epidemic is very different than other common shocks, vulnerability to HIV and food insecurity cannot be reduced by providing food or health care alone. Rather, it must be recognized that multiple processes influence vulnerability, shape the outcomes of responses, and in many cases, spread the effects of infectious disease and malnutrition.[65]

Ultimately, assessment of the interrelated effects of HIV and food insecurity should be guided by conceptual frameworks for food security and livelihoods. Factors such as the timing of illness or death, the duration of illness, gender and age of the person infected, household size and wealth status, as well as marriage systems and social support, can also ease or worsen the disease's impact on food security. [66]

Before resorting to food assistance, food assistance program managers should carefully assess the root causes of hunger and malnutrition. Often, poverty or the inability to earn income is the underlying cause of chronic hunger, which in turn is compounded by the effects of HIV. While food assistance can play an important short-term role in such instances, it is not likely to help those affected over the long term unless it also provides support for improving livelihoods.[67]

Food Assistance Objectives

Food assistance programs are in-kind or cash transfers to address hunger and malnutrition (e.g., food stamps, Women, Infants and Children [WIC] programs, food subsidies, food price stabilization). This guide's main focus is food assistance programming that provides food transfers. Food aid is any international concessional flow in the form of food, cash or credit to purchase food in support of food assistance programs. The flexibility of food aid, including the ability of implementing partners to monetize food aid to fund program interventions, has allowed it to be used for relief assistance as well as a wide range of development interventions.

In the context of HIV, food assistance has considerable potential for reducing individuals' susceptibility to HIV by preventing them from adopting high-risk livelihood strategies to feed themselves and their families. Food assistance also can ease the impacts of HIV by enhancing the diet of PLHIV, which in turn can benefit other household members, including orphans and vulnerable children (OVC).[B] In this way, food assistance facilitates a greater productive and caring capacity. [68]

Defining the objectives of food assistance within the food security and livelihood frameworks is essential to designing an effective response to a target population's food security needs. Combined use of both the food and livelihood security frameworks is also helpful for identifying strategic partnerships throughout the continuum of needs of PLHIV. For instance, food can be used in several ways to protect and enhance human capital, such as saving lives in the aftermath of a natural disaster, reducing chronic malnutrition among young children, improving women's nutrition, improving education levels and helping to support the prevention and treatment of HIV. Such interventions can have a direct impact on food utilization. In the case of supplementary feeding and therapeutic care of PLHIV or OVC, food assistance may be used in the short term to help the household with immediate food needs and may increase adherence to treatment regimens.

Planners of food assistance interventions should aim to use food resources to build the coping capacities of communities and households, in addition to meeting short-term needs for food.

Food assistance also can help protect livelihoods when provided in the form of direct transfers to households after a shock such as the death of a household head. It may also serve as a safety net until new or reestablished livelihoods become productive. Household and community assets can be created through food for assets (FFA) projects such as building or repairing roads, water reservoirs, irrigation systems and soil conservation structures. Food assistance is also commonly provided to help offset the opportunity cost for participating in skills training and technical assistance programs. Such transfers can have a positive impact on food access. Food provided through public works programs to build community infrastructure can also help communities protect and enhance their resiliency. Building cyclone shelters, flood embankments and other soil and water conservation structures can help communities manage future shocks and maintain food availability. In all cases, non-food resources are necessary to ensure the completion of these interventions.[69]

Targeting Food Assistance

Food assistance should support positive coping strategies among HIV-affected households. To do this, food assistance programs must be appropriately targeted. Targeting identifies the groups in need of assistance, where such groups are, the specific type of assistance

B Definitions of OVC can vary from country to country and between various implementing agencies and donors. National definitions of OVC should take precedence in the country in which programs are being implemented.

appropriate for the particular context, as well as how and when to get the assistance to them. Food assistance programs that do not accurately define and effectively reach target groups will not help improve food security. Meanwhile, providing food to relatively food-secure groups may have unintended negative consequences such as displacing trade or diminishing incentives to produce food. In addition, care should be taken to avoid targeting food assistance exclusively to food-insecure households that are HIV-affected. Excluding food-insecure households that are not HIV-positive could be perceived as discrimination, creating disharmony in the community.

Despite considerable improvement in food assistance targeting over the years, much progress must be made in developing information systems that can identify and locate factors that contribute to food insecurity resulting from HIV, as well as determine households and communities most at risk (see **Chapter 5: Targeting**).

While food assistance can be used to support a number of program areas, it may not be appropriate in circumstances where a lack of food is not a problem, where risk of creating dependency is high or where food-based employment schemes are likely to disrupt market functions.[70] To guard against such negative effects, NGOs and the World Food Programme (WFP) should address these questions:

- Are PLHIV and affected households food-insecure?
- Is food insecurity due to lack of availability of food or access to food?
- Are food transfers an appropriate response to food insecurity?
- At what point and for how long would food assistance be most critical for PLHIV and affected households?
- When would the provision of food assistance be most useful to prevent negative coping strategies?
- When would food assistance be least likely to have negative repercussions?
- What is the role and purpose of food assistance in the prevention of HIV?
- What is the role and purpose of food assistance in HIV treatment programs?
- What is the role and purpose of food assistance in HIV care and support?

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Chapter 2: Policy and Program Environment

HIV and Food Security: Conceptual and Institutional Framework

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HIV and Food Security: Conceptual and Institutional Framework

Key Concepts

2.1 International Food Security and HIV Goals

2.2 International Agencies' Response to Food Insecurity and HIV

2.3 Program Coordination Mechanisms

2.4 International and National Resource Coordination Mechanisms

2.5 Challenges in Coordinating Resources for an Integrated Response

In This Chapter

This chapter is intended to help food assistance and HIV program managers design and implement integrated programs by identifying opportunities and constraints in the policy and program funding environment.

The chapter begins with a description of global goals for food security and HIV and gives an overview of the policy frameworks international agencies have developed in response to food insecurity and HIV.

Chapter 2 then explains the mechanisms for program coordination that agencies have established to respond to food and nutritional challenges caused by HIV and to promote integrated food assistance and HIV programming at the international, national and local levels.

Finally, the chapter discusses mechanisms for coordinating food assistance and HIV funding resources as well as factors country-level institutions should keep in mind in negotiating assistance in this complex and dynamic environment.

2.1 Key Concept

International Food Security and HIV Goals

Global Food Security Initiatives and Goals

The first World Food Summit (WFS), held in Rome in November 1996, was convened to develop policies and identify actions for eradicating hunger and malnutrition, while ensuring food security for all. Two key documents present the policies and actions resulting from the Summit: The Rome Declaration on World Food Security and the World Food Summit Plan of Action. The overarching goal supported by these documents was to develop strategies for halving the ***number*** of food-insecure individuals in the world by 2015.

In 2000, the Millennium Summit outlined eight critical goals, known as the Millennium Development Goals (MDGs), that guide the efforts of governments, donors and development agencies to eradicate food insecurity and malnutrition.[1, 2, 3] The first MDG is to "eradicate extreme poverty and hunger," and the second target under this goal is to "halve, between 1990 and 2015, the ***proportion*** of people who suffer from hunger."[4]

However, Food and Agriculture Organization (FAO) findings suggest little progress toward these targets has been made. About 823 million people (20 percent of the population in developing countries) were malnourished in 1990–1992, according to FAO. In the ***State of Food Insecurity in the World: 2006***, FAO reported that the number of malnourished individuals remains at about 820 million, indicating that "no progress has been made" toward the WFS target of halving the ***number*** of malnourished people by 2015. The ***proportion*** of malnourished individuals in developing countries has fallen from 20 percent to 17 percent because of population growth, indicating some progress toward MDG goals related to hunger.[5] Still, these numbers overall suggest that as 2015 quickly approaches, the world is falling behind in its efforts to eradicate hunger and malnutrition.

In sub-Saharan Africa, poverty, food insecurity and the HIV epidemic are the major threats to human security. It is becoming more important to integrate global, regional and national policies and programs on poverty and HIV to address the underlying causes of food insecurity and respond to the immediate needs of those who are chronically food-insecure or suffering a transitory shortage worsened by HIV. The complex interactions between food insecurity and HIV, for both individuals and societies, make this trend particularly relevant to discussions of food assistance policy.

HIV Global Convention Goals and Targets

In 2000, the United Nations (UN) General Assembly committed to halt and begin to reverse the global spread of AIDS by 2015.[6] In June 2001, the General Assembly set targets for reducing HIV's spread and impact by 2003, 2005 and 2010. In June 2006, a new commitment on HIV specifically acknowledged the centrality of food and nutrition in the global response to HIV. Article 28 of the UN General Assembly Political Declaration on HIV and AIDS provides that UN Member States "resolve to integrate food and nutritional support, with the goal that all people at all times will have access to sufficient, safe and nutritious food to meet their dietary needs and food preferences for an active and healthy life, as part of a comprehensive response to HIV/AIDS."[7]

2.2 Key Concept

International Agencies' Response to Food Insecurity and HIV

Overall, international donors and implementing agencies offer two approaches to integrating food security and HIV interventions:

1. Food security programs that consider HIV-related issues in targeting food-insecure populations: United States Agency for International Development (USAID) Title II Program, WFP and European Commission (EC)
2. HIV programs that integrate food assistance: U.S. President's Emergency Plan for AIDS Relief (PEPFAR).

USAID Office of Food for Peace Strategic Objectives Related to Food Security and HIV

For over 50 years USAID's primary mechanism for distributing food assistance to food-insecure communities and households has been the Public Law 480 Title II program.[8] Food for Peace (FFP), which manages the Title II program, makes commodity donations to Cooperating Sponsors (CSs) that include WFP, NGOs and cooperatives to meet food-security needs via single-year and multi-year programs, depending on whether food insecurity is transitory acute or chronic.

FFP identified 18 priority countries for multi-year programs: Afghanistan, Bangladesh, Burkina Faso, Burundi, Chad, Democratic Republic of Congo, Ethiopia, Guatemala, Haiti, Liberia, Madagascar, Malawi, Mauritania, Mozambique, Niger, Sierra Leone, Uganda and Zambia.

FFP's 2006–2010 strategic objective is to reduce food insecurity among vulnerable groups, with priority on countries and populations where food insecurity is greatest. The strategy emphasizes integrating into emergency programs activities that address the underlying causes of food insecurity. Similarly, development programs should help vulnerable groups prevent and cope with potential shocks.

FFP's focus on countries and populations it deems to be most vulnerable presents a distinct challenge for integrating resources for food assistance and HIV programming. There are few countries that are priorities for both FFP and PEPFAR (Ethiopia, Haiti, Mozambique, Uganda, Zambia), and within those there may be little overlap of the programs' target populations.

Still, FFP is the primary U.S. Government (USG) agency responsible for providing food resources to NGOs and WFP to mitigate HIV's impacts on food security. The vast majority of USG food resources directed to support HIV interventions are allocated through the Title II program and are intended to coordinate with HIV activities supported by PEPFAR. HIV programs supported by FFP focus on the same broad objectives as other food security programs funded by Title II:[9]

- Meeting immediate consumption and nutritional needs of the most vulnerable groups, including HIV-affected households and at-risk communities
- Protecting lives and maintaining consumption levels while enhancing food security and creating more diverse and resilient livelihoods among affected households
- Strengthening individuals' capabilities by improving health, nutrition and education

In addition, when programming food assistance for PLHIV and affected populations, FFP expects CSs to ensure that:[10]

- Food-assisted food security and HIV programs do no harm
- A thorough analysis of food security and HIV—including a gender analysis—has been conducted before food-assisted HIV programs are designed and initiated
- Food-assisted HIV programs are targeted appropriately to food-insecure HIV-affected populations
- Food security and HIV practitioners collaborate effectively
- The objectives of food-assisted programs and interventions, e.g., home-based care (HBC) or food for training (FFT) activities, are clear and explicit, such as providing HIV-affected population with nutritional care and support, incentives to participate in program activities, and safety nets and/or income transfers
- Ration size and composition correspond to the food-assisted program's objective and that programmers consider nutrition issues, logistics and costs
- Important cash-based activities complement and reinforce food-assisted activities
- Graduation criteria and exit strategies are clear, realistic and explicit so that outcomes are sustainable
- Practitioners give adequate attention to monitoring and evaluation and documentation of lessons learned

CSs are also required to disaggregate and track both food and non-food resources and beneficiaries supported by HIV activities in their monitoring and evaluation (M&E) systems and financial reports.[11] For additional guidance on FFP's policy refer to ***Title II Assistance Program Guidelines*** available at www.usaid.gov/our_work/humanitarian_assistance/ffp/.

World Food Programme Food Assistance Policy Regarding HIV

WFP provides food and nutritional support to individuals and families affected by food insecurity and HIV. WFP tailors its operations to address the impact of HIV in the communities it serves. The focus of WFP's HIV interventions is to provide nutritional support to treatment and care programs, support orphans and children affected by HIV and link prevention education with school feeding programs and relief operations. As with all its programs, WFP works with partners to ensure that gender is mainstreamed into all HIV-related activities.

In 2003 the WFP board approved HIV policies outlined in its paper, ***Programming in the Era of AIDS: WFP's Response to HIV/AIDS***. The policy framework includes the following:[12]

- WFP will incorporate HIV concerns in all of its programming categories: country programs, protracted relief and recovery operations (PRROs) and emergency operations. WFP programs can directly address food insecurity driven by HIV, and WFP activities can be used as platforms for other types of HIV programs such as prevention education. All WFP activities and partnerships concerning HIV will be part of a broader multisectoral approach and will be aligned with national government strategies on HIV.
- WFP will work with local and international partners, NGOs, governments and UN agencies to ensure that food is incorporated into HIV activities if appropriate.

- WFP will adjust programming tools such as needs assessments, vulnerability analysis, the design of rations and other nutrition-related activities as new HIV-related information and findings become available.
- When HIV threatens food security and influences mortality, WFP considers the epidemic a basic component of a PRRO, consistent with current WFP policy on PRROs.

European Commission Food Security Framework

Since the International Food Assistance Convention started in 2000, the EC has sought to integrate food assistance into a broader framework of support for global food security, giving priority to the least developed countries and those with low income. The strategy also strives to limit adverse impacts of food assistance and promotes local purchases to support local agricultural production. The strategy's main objectives include:[13,14]

- Enhancing food security designed to alleviate poverty in recipient countries
- Reducing recipient countries' dependence on food aid
- Contributing to the countries' balanced economic and social development

The EC justifies in-kind food assistance when and where there are no alternatives, such as in emergencies, or when in-kind food assistance is most appropriate for targeting vulnerable groups.

While most EC funds for HIV are channeled through the Global Fund (discussed below), the EC encourages incorporation of HIV issues into all projects and programs. [15,16]

The EC provides food aid to programs that promote sustainable long-term food production and food security within a national food security strategy. The EC provides food aid only when it is deemed the most appropriate and effective way to address food insecurity's underlying causes. It is provided either directly through government programs or through NGOs. WFP receives the largest contribution of EC food aid through in-kind resources via international tenders or grants to promote local purchases. The EC, WFP and WFP's partners conduct joint assessments and monitoring to ensure that food security projects complement EC objectives.

NGOs are the second-largest recipient of EC food aid as well as financial and technical support. In-kind assistance to NGOs is channeled through EuronAid, a European network of NGOs that distribute food assistance through food security interventions. The EC provides direct financing through calls for proposals, and it selects target countries for such proposals each year.

PEPFAR Goals and Targets

The largest bilateral contribution for HIV is the USG's PEPFAR, initiated in 2003 to direct $15 billion over five years to combat the HIV epidemic in the places with the greatest need. PEPFAR coordinates and funds activities aimed at providing comprehensive and integrated HIV prevention, treatment, care and support. PEPFAR has three goals (known as the 2-7-10 goals) that it hopes to achieve in its first five years of implementation:[17]

1. Provide antiretroviral therapy (ART) for 2 million people
2. Prevent 7 million HIV infections
3. Provide care to 10 million people infected or affected by the disease, including OVC

In May 2006, the Office of the U.S. Global AIDS Coordinator (O/GAC), which manages PEPFAR, presented a USG-wide strategy for addressing food and nutrition needs of PLHIV, affected families, caregivers and community members. The strategy recognizes the complex relationship between HIV and food insecurity and the importance of food and nutrition in meeting PEPFAR's overall objectives.[18] However, PEPFAR funding for food assistance can be obtained only as a last resort in limited circumstances for high-priority target groups.

PEPFAR supports the following food and nutrition interventions, which contribute to achieving the 2-7-10 goals:[19]

- Development and/or adaptation of food and nutrition policies and guidelines
- Nutritional assessment and counseling, including hygiene and sanitation education, maternal nutrition, and safe infant and young child feeding related to preventing mother-to-child transmission (PMTCT)
- Under conditions where there is evidence of clinical malnutrition for PLHIV, therapeutic and supplementary feeding that is well-targeted and adheres to World Health Organization (WHO) recommendations for entry and exit criteria
- Micronutrient supplementation, including fortified foods, where adequate intake of micronutrients is not met through a diverse diet
- Replacement (weaning) feeding and support, within the context of WHO and national PMTCT and infant feeding guidelines
- Linking PEPFAR programs to food assistance, food security and safety-net programs

PEPFAR focuses on 15 countries in Africa, Asia and the Caribbean: Botswana, Côte d'Ivoire, Ethiopia, Guyana, Haiti, Kenya, Mozambique, Namibia, Nigeria, Rwanda, South Africa, Tanzania, Uganda, Vietnam and Zambia.

O/GAC also developed policy and program guidelines for using food assistance in HIV programs. As per current guidelines, PEPFAR resources can only be used for food assistance linked to HIV interventions when:

- Food and nutritional support directly contributes to the 2-7-10 prevention, treatment and care goals
- Food and nutritional needs are determined using the WHO assessment criteria and guidelines for nutritional care
- Programs first try to access food resources for therapeutic and supplementary feeding from other sources
- Food assistance to severely malnourished patients is provided with clear eligibility and exit anthropometric criteria and plans for beneficiaries to transition to more sustainable food security
- Support to PLHIV and their families addresses their broader health, food security and livelihood needs

For additional guidance on PEPFAR's food and nutrition support for PLHIV and OVC, refer to ***O/GAC Guidance on the Use of Emergency Plan Funds to Address Food and Nutrition Needs***: www.state.gov/documents/organization/66769.pdf.

The Global Fund to Fight AIDS, Tuberculosis and Malaria

The Global Fund to Fight AIDS, Tuberculosis and Malaria was established in January 2002 to support the rapid scale-up of prevention and treatment interventions for HIV, tuberculosis and malaria. The Global Fund supports integrated program proposals that include food assistance where appropriate, though support for direct food assistance is limited. It may support food-based interventions if applications meet all eligibility criteria, show that they contribute to specific improvements in HIV-related outcomes and are supported by broad-based country coordinating mechanisms (CCMs).

The Global Fund offers direct funding for HIV interventions and an array of technical assistance in these areas:[20]

- Provision of supporting data, such as country-specific epidemiological and clinical information related to HIV, tuberculosis and malaria
- Assistance with needs assessments and operational research in preparation for Global Fund applications
- Technical support in program design, including design and national adaptation of pilot projects, and scale-up of successful programs
- Program planning, including detailed systems analysis and operations planning
- Design and integration of monitoring and evaluation plans, including establishment of coordination and reporting mechanisms
- Budgeting and accounting support, including detailed program costing, and establishment of disbursement and financial reporting mechanisms

The Global Fund distributes resources primarily through CCMs, which typically comprise government representatives, NGOs, community-based organizations (CBOs), academic and educational institutions, PLHIV, companies, FBOs, and in-country multilateral and bilateral development partners.

The World Bank's Response to HIV

The World Bank has been among the largest sources of funding for HIV programs in the UN system since the HIV epidemic started and has committed $2.5 billion through grants, loans and credits to support countries in their fight against the disease.[21] The Bank's primary means of support for HIV interventions is the Multi-Country HIV/AIDS Program (MAP) in Africa. The MAP's specific objectives are to:[22]

- Increase national awareness, political commitment and available resources
- Promote multisectoral responses to HIV
- Adopt and promote "extraordinary and exceptional" methods of combating the epidemic
- Improve monitoring and evaluation systems to capture lessons learned and facilitate "learning by doing"

The World Bank does not address the use of food assistance with HIV programs. However, its MAP-supported regional HIV projects involve partnerships with the United Nations Economic Commission for Africa, United Nations High Commissioner for Refugees (UNHCR), United Nations Children's Fund (UNICEF), WHO, the Global Fund and the Clinton Foundation. In addition, in numerous sub-Saharan African countries, MAP support

has encouraged the formation of National AIDS Commissions, which, as discussed later in the chapter, coordinate HIV policy and, in some cases, have adopted food and nutrition guidelines.

Humanitarian Aid Department of the European Commission

Due to its core mandate to respond to natural or man-made disasters, the Humanitarian Aid Department of the European Commission (ECHO) is not a "front-line" actor in responding to HIV. However, because poverty, food insecurity and HIV overlap, ECHO is present in most high-prevalence countries. ECHO has a two-pronged strategy for responding to HIV:[23]

- Mainstream HIV prevention measures and enhance awareness of the epidemic at all levels.
- Accept proposals for mitigating the effects of HIV in emergency situations as part of multisectoral programs.

ECHO works toward its HIV mainstreaming objectives by incorporating into funded programs activities such as training in HIV prevention, awareness-building through information, education and communication (IEC), appropriate condom distribution, adopting internal policies on HIV, and mapping and monitoring of HIV where feasible.

ECHO prioritizes activities that "contribute to the prevention of any worsening in the impact of the crisis, saving and preserving life from the effects of HIV/AIDS during emergencies and their immediate aftermath." [24] ECHO gives highest priority to multisectoral preventive and curative activities, including distribution of food and non-food aid, health, nutrition, protection, rehabilitation, shelter, water and sanitation. Other activities that ECHO may fund—with "strong pre-conditions"—include ART, highly active antiretroviral therapy (HAART), PMTCT or support for food and livelihood security interventions for OVC and their caretakers, when these services are otherwise unavailable.

Key Concept

2.3 Program Coordination Mechanisms

Poverty Reduction Strategy Papers

National Poverty Reduction Strategy Papers (PRSPs) identify national priorities for addressing food insecurity and mitigating HIV's impact on households and communities. Most PRSPs address food insecurity caused by HIV through integrated food and nutrition action plans laid out as part of national food assistance policy. Several countries serve as positive examples of translating PRSP strategy into effective multisector food and HIV programming.

For example, Uganda has made considerable progress in coordinating strategies for the care and support of PLHIV. Through instruments such as the ***HIV and AIDS Policy Guidelines***

(1999), the ***Policy Guidelines on Feeding of Infants and Young Children in the Context of HIV/AIDS*** (2001) and the ***Uganda Food and Nutrition Policy*** (2003), the Government of Uganda has promoted nutritional standards for food supplements, outlined a comprehensive approach to addressing malnutrition and micronutrient deficiencies with a high priority on pregnant and nursing women, incorporated nutrition management into the care of HIV patients and provided therapeutic feeding for sick and malnourished children.[25] Kenya, Zambia and other African nations are adopting similar national policies and guidelines to improve nutrition among PLHIV.

Programs Supported by National Policy Institutions

In many sub-Saharan African nations, HIV policy is coordinated by National AIDS Commissions (NACs). Typically, NACs also establish partnerships with government and non-government stakeholders to support multisectoral approaches to HIV prevention and mitigation. While relatively few national multisectoral mitigation activities have been fully implemented, NACs in several countries have adopted national food and nutrition guidelines, facilitated development of national plans of action for OVC, supported the establishment of minimum care standards, and provided guidance on PMTCT and targeting of PLHIV and affected households. When designing national integrated food assistance and HIV programs, program managers should consider how to incorporate NACs' guidance in the early planning stages.

Kenya Integrates Food Assistance Into National HIV Response

Kenya offers an example of national coordinated food assistance and HIV programming through its National HIV/AIDS and STD Control Program (NASCOP). While not technically a National AIDS Commission (NAC), NASCOP has played a central role in coordinating Kenya's policy and interventions related to HIV and food assistance.

Situated in the Ministry of Health, NASCOP's work includes setting national policies, coordinating a range of HIV-related services, helping to determine target populations and areas, strengthening capacity in key technical areas and coordinating partners such as government agencies, NGOs, international agencies and food manufacturers that provide food products and nutrition services to clients at HIV facilities.

In 2005, recognizing the importance of nutrition in comprehensive HIV care, NASCOP established a nutrition unit, led by a nutritionist, that supports training and provides materials (e.g., nutrition assessment equipment, counseling materials, job aids) on food and nutrition components of HIV treatment and care to HIV facilities throughout Kenya.

As the central coordinating body to a range of government agencies, NGOs, international agencies, and food manufacturing groups, NASCOP supports appropriate targeting, ensures consistent standards are applied, helps define specifications for food products and for monitoring and evaluation indicators, and strengthens the capacity of service providers to support food and nutrition components of HIV treatment and care.

United Nations Development Assistance Frameworks

The UN's Development Assistance Frameworks (UNDAFs) are common strategic frameworks that guide UN operations in specific countries. UNDAFs emerge from the UN's Common Country Assessment (CCA), which analyzes national development

indicators and prioritizes key development issues. The CCA is conducted by UN Country Team Theme Groups covering areas such as food security, HIV, poverty monitoring and evaluation, gender and disaster management.

Most HIV Theme Groups set up special working groups that involve government representatives, donors, NGOs and PLHIV groups in their daily operations.[26, 27] The working groups provide a forum for more fully addressing national priorities such as access to care, PMTCT and HIV prevention for young people and sex workers. These efforts help give UN programming the flexibility to address local conditions and the specific constraints in the field.

Coordination of HIV programs at the national level was also a focus of the UN-sponsored 13th International Conference on AIDS and Sexually Transmitted Infections in Africa in 2003. At the conference, a working group of country and international representatives developed principles for improving the HIV response in highly affected countries. These principles are known as the "Three Ones":

- ***One*** agreed AIDS action framework that provides the basis for coordinating the work of all partners
- ***One*** national AIDS coordinating authority, with a broad-based multisectoral mandate
- ***One*** agreed country-level monitoring and evaluation system

The Three Ones were endorsed by donor countries, host countries, bilateral and multilateral institutions and international NGOs in 2004. The Joint United Nations Programme on HIV/AIDS (UNAIDS) facilitates countries' efforts to apply the principles.[28, 29] In addition to the Three Ones, the UN continues to support an overall harmonization, alignment and simplification process that it hopes will lead to one UN Program on HIV and AIDS supported by individual UN Country Teams.

Title II Consortium Mechanism

Title II CSs often form a consortium, with one "lead" organization reporting directly to USAID to implement food security and nutrition programming with Title II food assistance resources in a particular country. USAID has supported these mechanisms in an effort to streamline and consolidate proposals, promote the use and standardization of proven

Previous Experience With Consortia in the Context of HIV[31]

The Consortium for Southern Africa Food Security Emergency (C-SAFE) was among the largest food assistance projects in southern Africa throughout its implementation (2002-2006). Led by World Vision, CARE and Catholic Relief Services (CRS), and working closely with WFP, C-SAFE aimed to alleviate food and livelihood insecurity by addressing targeted groups' immediate nutritional needs, building productive assets and helping communities increase their resilience to food security shocks. C-SAFE was one of the first large-scale programs to explore providing food assistance as a safety net to HIV-affected households. Country consortia in Malawi, Zambia and Zimbabwe each reported that C-SAFE's support for interagency cooperation benefited commodity management, food for work (FFW) and nutrition interventions. C-SAFE's work also provided important lessons on targeting criteria and M&E systems. C-SAFE partners also reported an increase in HIV programming quality and consistency, as well as establishment of effective HIV workplace policies.

programming approaches, coordinate Title II funding and management responsibilities, and help increase coverage of funded interventions.[30] Key considerations for consortia in the context of HIV include the need to ensure that:

- Coordination in food security and nutrition assessment, including common monitoring and evaluation indicators, is enhanced
- Chronically food-insecure areas with a high HIV prevalence rate are covered
- Consortia programs serve not only administrative and logistical purposes but also operationalize multisectoral development strategies
- Program design addresses intersectoral challenges associated with food assistance, food security and HIV programs
- Comparative advantages of individual partners are understood
- Policy and program decisions include field-level representation to ensure that adopted strategies are flexible and responsive to local contexts

Coordination With Local Government and PLHIV Networks

Many of the national PRSPs noted earlier support addressing poverty and food insecurity by delegating authority to decentralized government coordinating bodies. Such approaches are a response to criticisms that highly centralized policies are inflexible and do not have enough input from targeted populations. Local coordination of food assistance and HIV interventions often include these formal and informal development institutions:[32]

District and Village AIDS Committees

District and village AIDS committees (DACs and VACs), composed of representatives from multiple sectors, work with NACs to design and implement food security and HIV interventions.

DACs and VACs often facilitate small grants programs that NACs administer for community-based HIV activities. They also act as intermediary organizations for the grant process by equipping CBOs to apply for and implement the grants.

National and international agencies implementing food assistance programs can build on the potential of DACs and VACs by helping to institutionalize their functions within local government. By doing so, they also can influence how much CBOs integrate food and nutrition activities into HIV programs.

Voluntary Home-Based Care Networks

Many aid agencies rely on home-based care (HBC) networks to help identify and support vulnerable households because of their knowledge of the community. HBC networks often are linked to local clinics and dispensaries and can connect ill community members with local health services.[33] HBC groups also provide safety nets to HIV-affected households by contributing cash and labor.

HBC groups encourage people to get involved in addressing food needs. They also supplement the care and support that the extended family and local development actors provide.

Food Assistance and HIV Agencies' Policy Role

Implementing agencies must be responsive to changing policy and programming environments. HIV and food assistance agencies also can play pivotal roles in advocating for policy and resource mechanisms that support the design and implementation of integrated programs. To meet the challenges posed by the HIV epidemic, food assistance agencies should work to expand food access and utilization, provide opportunities to establish sustainable livelihoods and continue to promote policies and institutional environments that address the primary causes of hunger, poverty and malnutrition. At the same time, HIV agencies should continue to inform policymakers about the importance of proper nutrition in combating the disease. Agencies also can influence policy by collecting, analyzing and disseminating quantitative and qualitative data that provide concrete, program-based evidence of what does and does not work in food insecurity and HIV contexts.

2.4 Key Concept
International and National Resource Coordination Mechanisms

WFP Field-Level Coordination

WFP works with partners ranging from large international NGOs to smaller community-level institutions, including local associations and FBOs. WFP's partnerships fall into three main categories:[34]

Cooperating partnerships, formerly called "implementing partnerships" are the most common relationship between WFP and NGOs. Typically, cooperating partners conduct activities such as food transport, storage and distribution on WFP's behalf. WFP is accountable to the host government and responsible for reimbursing the NGOs.

Complementary partnerships typically involve NGOs with objectives and target groups similar to those of WFP. WFP may provide food assistance as an element of larger NGO interventions that reach WFP beneficiaries. One example is the design of "essential packages" in which WFP provides the food element of interventions that include school feeding, basic education, de-worming, micronutrient supplementation, HIV education, malaria prevention and establishment of school gardens/woodlots.

Coordinating partnerships are arrangements in which NGO and WFP activities are separate, but both organizations share information and coordinate program implementation.

WFP uses two mechanisms for coordinating partnerships with NGOs. Memoranda of Understanding (MOU) are general agreements between WFP and NGOs that provide a global framework for the partnership that outlines strategic areas of cooperation, each partner's areas of responsibility and resources each partner will contribute. Field-Level Agreements (FLAs) are project-specific arrangements between NGOs and WFP country offices. The FLA functions as a standard agreement template that identifies the partnership's objectives; each partner's roles and responsibilities; details regarding food quantities, food rations and distribution mechanisms; and reporting and financial management requirements and payment procedures.

Areas of partnerships and coordination between WFP country offices and Title II CSs include:

- Developing and testing HIV vulnerability assessment and mitigation strategies, determining a set of core country-level indicators of HIV prevalence and impact, establishing collaborative interagency technical support teams or technical working groups that use common databases to improve vulnerability assessment of food security and HIV
- Developing sector-specific mitigation strategies and monitoring the impact of integrated food security and HIV programs in agriculture, education and health sectors
- Sharing lessons and experience gained in developing comprehensive HIV workplace programs, including sharing resource people
- Documenting, exchanging and disseminating best practices through workshops, in-service training and publications

Linking PEPFAR Funds With Food Assistance Programs

Through O/GAC, the USG coordinates internally with USAID, the U.S. Department of Agriculture (USDA), the U.S. Department of Health and Human Services (HHS) and the Peace Corps, and externally with UN agencies (especially WFP), NGOs, the private sector and other partners to integrate food and nutrition interventions within HIV care and treatment programs. O/GAC chairs the USG interagency work group on food and nutrition, which promotes a flexible and comprehensive approach to addressing HIV through collaboration by USG government agencies, NGOs and multilateral partners.

While O/GAC requires that non-HIV funding mechanisms, such as Title II and USDA, be used for broad food security programming for HIV-affected population, PEPFAR resources may be used to link HIV programs with food security and livelihood assistance programs such as income-generating activities and labor-saving agricultural techniques. In all cases, HIV programs that want to incorporate food assistance should first seek food resources from sources other than PEPFAR. To do this, country teams made up of USG agencies are encouraged to coordinate with national governments, UN partners, civil society and the private sector to plan and implement comprehensive HIV strategies.

FFP requires CSs to integrate PEPFAR, Development Assistance (DA) or other resources into Title II programs to fund HIV services for food-insecure HIV-affected populations and to distribute food directly to the widest number of food-insecure beneficiaries possible.

2.5 Key Concept
Challenges in Coordinating Resources for an Integrated Response

It is important for practitioners pursuing financing for food assistance and HIV programs to understand donors' potential responses and how assistance will flow to recipients. Country-level institutions should consider these factors when negotiating assistance in this complex and dynamic environment:[35]

Funding cycle. Most donors commit funds on an annual, biennial or short-term basis.

Disbursement rate of commitment. Disbursement is the expenditure of obligated funds. Rates of disbursement typically vary by donor but often lag official funding commitments. Disbursements, not commitments, are the basis for assessing available resources against estimated funding needs. Disbursement rates differ based on donor requirements for when funds must be spent; program start-up, grant and contracting rules; and program performance and governance.

Type of support. Funds may be part of HIV-specific projects, food security programs or sector-wide approaches, in which funding for a particular sector supports a government cross-sectoral policy and expenditure program.

Country or regional focus. Some donor governments focus on specific regions or countries. PEPFAR and Title II assistance focus on different sets of countries. France channels much of its assistance to Francophone Africa, Italy to the Horn of Africa, and Japan to Asia.

Tied aid. Donors have different requirements for how much aid must be used to buy certain goods and services from the donor country.

Implementing agencies. Some donors exclusively fund governments or multilateral agencies; others make funding available for NGOs and CBOs.

Earmarks. Funds are often limited to certain activities and resources, such as prevention, treatment, care or OVC support. Finding ways to integrate earmarked funds to design comprehensive programs is a challenge that calls for strategic advocacy.

Annex 1: UNAIDS Co-Sponsoring Organizations' Roles in the UN's Response to HIV

1. **United Nations World Food Programme (WFP)** focuses on fighting HIV through its food assistance programs by modifying food rations, helping poor HIV-affected, food-insecure households and individuals meet their basic nutritional needs, and providing food for education and training, and venues for awareness and prevention.

2. **United Nations Children's Fund (UNICEF)** has made HIV a key priority in its programming and focuses on HIV prevention among young people, PMTCT and the care, support and protection for orphans and children made vulnerable by HIV.

3. **World Health Organization (WHO)** has reinforced its commitment to support member states by providing technical support and building health sector capacity for a strategic and sustainable response to HIV; developing and implementing consistent evidence-based strategies and health sector interventions in prevention, treatment and care; and fostering collaboration with new partners, including civil society and the private sector.

4. **The World Bank** is helping countries to more effectively address the devastating consequences of HIV on development. Its efforts include committing nearly US$2 billion for HIV projects since 1986, launching a multi-country HIV program for Africa and the Caribbean (involving more than US$1 billion), and partnering with UNAIDS, donor agencies and governments.

5. **United Nations High Commissioner for Refugees (UNHCR)** has broadened and strengthened the UN's response to HIV by stringently implementing its protection mandate; providing HIV technical support and funding to its implementing and operations partners; advocating for refugees to be included and integrated into the country of asylum's HIV strategies, policies, programs and proposals; and fostering a sub-regional approach that addresses the displacement cycle.

6. **United Nations Development Programme (UNDP)** focuses on promoting action-oriented advocacy and policy dialogue for leadership at all levels; helping countries develop capacity for action, and plan, manage and implement their response; promoting a human rights framework and gender perspective in all aspects of the response; integrating HIV into development planning; and providing special assistance to the worst-affected countries to help mitigate the impact on human development.

7. **United Nations Population Fund (UNFPA)** supports a range of initiatives to prevent the sexual transmission of HIV, focusing on preventing HIV infection among young people and pregnant women by providing information, counseling and other services, and improving access to male and female condoms and promoting their correct and consistent use.

8. **United Nations International Labour Organization (ILO)** supports UNAIDS through activities including encouraging governments, employers and workers to mobilize against HIV; facilitating direct access to the world of work, where many possibilities exist for HIV prevention as well as for the care and support of affected persons; and providing its longstanding experience in framing international standards to protect the rights of workers.

9. **United Nations Educational, Scientific and Cultural Organization (UNESCO)** efforts focus on preventive education and include advocacy at all levels, developing effective and culturally sensitive information for target groups; developing education programs that teach young people about HIV and how to prevent it; helping build the knowledge, attitude and skills needed to provide care for the infected and affected; and developing and disseminating tools for monitoring, assessing and responding to the impact of the epidemic on schools, students and teachers.

10. **United Nations Office on Drugs and Crime (UNODC)** supports HIV prevention programs by including HIV prevention in its programs to reduce the demand for illicit drugs, targeting youth and high-risk groups, and promoting the expansion and diversification of drug dependence treatment services.

Additional UN Agency HIV-Related Activities

Food and Agriculture Organization of the United Nations (FAO). Although it is not an official co-sponsor, FAO has had a formal agreement to work with UNAIDS since 1999. Since first becoming involved in the fight against HIV in 1988, FAO's primary role has been to identify and develop means of mitigating HIV's impact on the agricultural sector with a particular focus on food security, nutrition and farming systems. More recently, FAO has made concerted efforts to address the adverse impacts of HIV on the technical capacity of key actors including agricultural staff and service organizations, national agricultural research organizations and institutions in higher education and training, and local informal institutions.

United Nations Standing Committee on Nutrition (UNSCN). Founded in 1977, the UNSCN bases its strategic policy framework on the principle of integrating nutrition considerations into national, regional and global development agendas. UNSCN's efforts in the arena of HIV focus on mainstreaming HIV in all sector activities (including agriculture), achieving a strategic balance in project design and implementation by combining mitigation measures with measures that reduce susceptibility to infection and vulnerability to HIV's impacts, and disseminating clear information to policymakers, health providers and communities regarding critical issues such as PMTCT, stigma and specific nutrition requirements of PLHIV.

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Chapter 3: Vulnerability Assessments

Program Design Steps

Chapter 3: Vulnerability Assessments

Program Design Steps

Key Concepts

3.1 Conducting Food Security Vulnerability Assessments in the Context of HIV

3.2 Adapting Vulnerability Assessments in the Context of HIV

3.3 Steps for Conducting Vulnerability Assessments

3.4 Minimum Vulnerability Assessment Requirements to Design HIV Programs

3.5 Approaches and Tools for Vulnerability Assessments

In This Chapter

This chapter begins with an overview of the key challenges in conducting a food security vulnerability assessment in the context of HIV. These challenges include stigma's effect on accurately identifying people affected by the disease, HIV's dynamic and progressive nature and cumulative impacts on individual and household food security, and the need to use multiple approaches to understand the complex relationship between HIV and food insecurity. Key Concept 3.1 then looks at a number of key considerations especially relevant to vulnerability assessments conducted in the context of HIV.

Key Concept 3.2 discusses adaptations to food security vulnerability assessments that must be made in the context of HIV. These include considering the disease's impacts on institutional capacity, service provision and informal support mechanisms within affected communities; selecting indicators appropriate for measuring HIV's impact on individual and household nutrition; and incorporating a gender analysis.

Key Concept 3.3 describes the process of assessment as part of the overall project cycle and explains the importance of appropriate assessment techniques for formulating effective project design, implementation and monitoring and evaluation. It then explains key steps in conducting a vulnerability assessment, from collecting and analyzing secondary and primary data to developing assessment reports that help guide project design.

Key Concept 3.4 discusses some of the minimum data on food security vulnerability needed for targeting in high-prevalence areas where HIV programmers seek to incorporate food and nutrition interventions into ongoing HIV programming for specific households. It stresses how important it is to collect this information frequently due to the dynamic nature of HIV's impact on livelihoods.

The final Key Concept provides three examples of food security vulnerability assessment approaches. The first is an approach used in southern Africa to monitor the evolving food security and HIV context. The second is a qualitative community assessment methodology Food for the Hungry (FH) used to help programmers understand how HIV and food insecurity interact within specific communities and project areas. The third is an urban assessment approach used in Zimbabwe.

3.1 Key Concept

Conducting Food Security Vulnerability Assessments in the Context of HIV

Primary Challenges to Assessing Vulnerability in the Context of HIV

There are a number of specfic issues that make conducting vulnerability assessments more challenging in HIV contexts.

Stigma. Stigma can lead individuals or households to conceal their status, making it difficult to accurately assess HIV's prevalence and role in food security dynamics. Approaches to addressing stigma include using proxies such as chronic illness and looking at outcomes of the disease, instead of the disease itself, such as household labor availability and frequency of infections and illnesses. Generating awareness about stigma and making direct efforts to reduce it can also help.

Difficulty assessing HIV's effects. The dynamic nature of HIV and its interactions with food security can mean that its effects on food security may not be evident when initial assessments are conducted. For example, the disease's progression can impair food security, treatment can improve it, and impacts on food access may take time to emerge as households deplete savings and run out of healthy coping strategies. Periodic assessments are one way to address this challenge (see the Community and Household Surveillance [CHS] system example later in this chapter). Looking for trends among the targeted population or similar populations elsewhere can also help predict future effects on food security.

Multiple factors affecting food security. In the context of HIV there are often multiple key factors affecting food security, more so than in non-HIV contexts. HIV itself has multiple components and pathways to food security outcomes, including biological effects on utilization, household labor/income/asset effects on food access, community effects on social safety nets and coping mechanisms, and institutional effects on health, education and other services. The food security environment's multifaceted nature can make it challenging to understand the main causes of food insecurity and what interventions are needed. Careful combination of qualitative assessments, quantitative surveys and contextual consideration can help identify the key factors requiring intervention.

Lack of awareness. In some cases, vulnerability assessments may be constrained by a general lack of awareness regarding the combined impacts of HIV and food insecurity. For instance, in areas with limited access to education and/or health services, vulnerable populations often have a limited understanding of how the virus is transmitted, how it can be detected and how the disease affects individual and household food security.

Key Considerations for Assessing Vulnerability in the Context of HIV

In the context of HIV, a food security vulnerability assessment should take into account:

- Demographic characteristics, livelihood situations and other factors
- How HIV affects individual nutritional status, household access to resources and household food security[1, 2]

These issues lead to several considerations that distinguish vulnerability assessments in the context of HIV from those in unaffected areas.

Multidisciplinary assessment and project design teams. Teams should have a mix of experience appropriate for the context in which the assessment will be conducted. This includes expertise in agriculture, livelihoods, nutrition and health, including HIV. Teams should also include people with experience in emergency response/development, food assistance, supplementary/therapeutic feeding and FFA work.

Pre-assessment training on HIV. Before conducting the vulnerability assessment, train the team on HIV's relevance to the food security and livelihoods of affected individuals, households and communities, and on ways to integrate HIV responses in food assistance interventions.

Local involvement. Involve local people—especially PLHIV and affected households—in vulnerability assessments to understand local practices, knowledge and traditions that influence individual and household perception of risks. Such understanding is critical to identify behaviors that increase vulnerability to food insecurity and HIV infection. Identify local networks and opportunities for intervention.

Identification of the most vulnerable. Focus on key assessment outputs such as the identification of the most vulnerable people and communities, where they are, behaviors that make them vulnerable to food insecurity and HIV, and how food assistance can minimize such vulnerability.

Profiling and multilevel analysis. Create vulnerability profiles of individuals and communities to determine their needs and understand the impact of different risk factors, including HIV, on the targeted population. Use multilevel analysis to develop food assistance responses appropriate for different demographic and socioeconomic groups, and individuals and households at different stages of the disease's progression.

Mapping out priorities. Map out possible intersections between priority areas of intervention: food availability, access and utilization; livelihoods; nutrition and HIV. Identify areas where strategies can be integrated synergistically and cost-efficiently.

Current information and reporting. Regularly update databases covering geographic areas of responsibility, including relevant data on food insecurity and on HIV prevalence and impact, to guide decisions on targeting resources.

3.2 Key Concept
Adapting Vulnerability Assessments in the Context of HIV

In addition to addressing the primary challenges and key considerations in conducting food security vulnerability assessments in the context of HIV, there are a number of specific actions that can be taken to more fully adapt to a high-prevalence environment.

Include HIV-Related Food Security Risk and Vulnerability Indicators

To understand HIV's impact on a community's food security, it is important to take into account HIV's potential impacts on:

- Availability of food, primarily through production

HIV-Related Food Security Risk and Vulnerability Indicators

Human Capital—Labor

- Number of days chronically ill persons did not work in the last month because of illness, disaggregated by household head and other adult
- Whether the sick person works the same or fewer hours per day
- Intra-household labor allocation, to measure time and quality of care for children and ill family members, and time devoted to funerals
- Land/labor ratio between affected and unaffected households
- Percentage of land cultivated with tubers, roots and other less labor-intensive crops by affected and unaffected households

Human Capital—Education

- Whether children in the family are enrolled and attending school
- Number of orphans attending school
- Number of children working in the households and types of work they do

Financial Capital

- Change in household income and sources of income, compared to previous year
- Time household member spends on productive or income-generating activities (seasonality of labor requirements must also be considered)
- Household expenditure profile
- Increase in health spending and amount spent on health care or funerals
- Money borrowed to pay for funerals or medicines
- Number and amount of loans taken in the last year and their purposes

Physical Capital

- Household assets
- Sale of assets (per asset type) in the past six months to pay for medicines, funeral expenses, food and household needs

Social Capital

- Presence of informal networks to support HIV-affected households
- Reliance on extended family for labor, domestic work or child care
- Household participation in community labor-sharing arrangements for agricultural production, child care, housework
- Nature of participation in relevant community groups, e.g., support groups, HIV support organizations
- Division of decision making by gender
- Perceptions of time available to be with friends, family

Political Capital

- Changes in participation in community meetings

Natural Capital

- Types and quantities of crops harvested and differences compared to previous year
- Amount of land left fallow
- Changes in land tenure
- Loss of agricultural production knowledge base (e.g., regarding land preparation, cropping plans, animal husbandry practices)
- Changes in farming strategies (e.g., declines in crop diversity)
- Distress sales of land or livestock

- Access to food, primarily through income, available assets, and food and non-food expenditures
- Utilization of food, primarily through loss of knowledge about and lack of resources and time for appropriate child feeding, care and health-seeking practices; malabsorption; increased nutrient requirements; and PLHIV's susceptibility to opportunistic infections

Collecting information on the indicators of HIV's impacts on livelihood assets, listed in the box on page 48, contributes to an understanding of the risk and vulnerability factors.

Use Proxy HIV Indicators

In many cases, because prevalence data may be unreliable or highly difficult to collect, data are obtained through proxy indicators such as a chronically ill person or recent death in the household. These indicators are usually collected through household questionnaires and are used to understand the extent and effects of HIV in surveyed households. They include the proxy indicators in the box below.

Proxy Indicators for HIV[3]

Morbidity Rates

- Chronically ill household head *(chronically ill* = with a condition, disease, or disability that prevents the subject from being fully functional for at least three months over the last 12 months)
- Number of chronically ill adults (ages between 18 and 59) living in the household
- For ill subjects, it is important to collect information about sex, age and type of condition (disability, short illness, chronic illness)

Mortality Rates

- Recent household member death (last 12 months)
- Recent death of an adult between 18 and 59
- For each death: age, sex and cause of death is recorded (AIDS, chronic illness, short illness, tuberculosis [TB])

Hybrid Mortality Rates

- Highly affected households (death and chronic illness)
- HIV-affected households (death or chronic illness)

Household Demographics

- Presence of orphans
- Number of orphans
- Effective dependency ratio (effective dependency ratios measure the ratio of productive to non-productive household members and capture the impact of chronic illness and death on the household)
- Orphans disaggregated by orphan status (double orphans, mother orphans and father orphans), sex and age
- Number of adults between 18 and 59

Use Food Security Analysis to Determine HIV Vulnerability

Vulnerability to the combined effects of food insecurity and HIV is particularly dynamic due to the complex relationship between the two factors and HIV's progressive nature. It is important, therefore, to:

- Examine how socioeconomic status (SES) is associated with HIV infection risks. Identify whether low SES (consider education, income or employment) and marginalization in

a community increase risk to HIV infection. Evidence has shown that these factors have resulted in different health and food security outcomes

- Examine whether individual, household and ethnic/cultural behavior and practices create additional risks
- Examine if local fragility in livelihoods, because of civil conflict, poor governance or natural disasters, create specific, additional risks for HIV infection among the poorest population groups
- Identify livelihood activities and the lifestyles and risks associated with them
- Examine any evidence of malnutrition among adults and children under five in the household. Malnutrition increases the risk of HIV progression and may also increase the risks of HIV transmission from mother to baby

Identify Household Coping and Survival Strategies

Other indicators should be measured to assess HIV's impact on household livelihood assets. ***Household coping or survival strategies*** can serve as fundamental indicators for HIV's direct impacts on household food security. As those impacts become more severe, households' coping or survival strategies are likely to become more desperate and often irreversible.[4]

Household Coping Strategies

Short-Term Coping Strategies

- Migration of household members to look for work
- Searching for wild foods
- Selling non-productive assets
- Reducing number and size of meals
- Changes in diet to less preferred or nutritious foods

Distress Coping Strategies

- Selling productive assets
- Household dissolution
- Theft
- Prostitution
- Mass migration
- Begging

Aggregate Risks and Vulnerabilities to Community-Level Indicators

Vulnerability assessments must provide information on how the disease progresses in households and targeted communities, bearing in mind that a single community may have households at different stages of disease progression. Indicators and information on HIV's impact should be collected at the community level, usually through focus groups and participatory data collection tools (see Key Concept 3.5 later in this chapter for approaches and tools for vulnerability assessments). Community-level indicators appear in the box on page 51.

Other indicators can be used to measure risks of HIV infection, including health awareness, access to health care systems and use of services for voluntary counseling and testing (VCT) and STIs. Post-infection vulnerability can be measured with indicators related to use

and quality of care. Possible indicators include ***percent of HIV-infected persons receiving full-course antiretroviral (ARV) treatment, reach of community and home-based care programs, and competency and attrition of health care personnel.***[5]

Community-Level Indicators of Risk and Vulnerability

Community Members

- Number and percentage of households with PLHIV
- Number and percentage of households where a productive member died

Demographic Composition and Structure

- Number and percentage of households that have dissolved
- Number and percentage of child-headed households

Education

- Number and percentage of household heads at different levels of education
- Number of children enrolled, and enrollment and attendance rates
- Number and percentage of children working

Income and Assets

- Major economic problems the community faces after the onset of the epidemic
- Changes in the supply and demand for wage labor

Change in Infrastructure

- Change/deterioration in community facilities and infrastructure (roads, water system, markets)
- Change in the use of community lands

Organizational Change

- Change in women's role and status
- Changes in men's role
- Community services for PLHIV
- Dissolution of community organizations, networks or groups

Integrate Gender Analysis[6]

As noted in **Chapter 1: Conceptual Framework,** HIV has different impacts on women (especially widows and single-headed households) than on men. Gender analysis is crucial to developing an effective food assistance program in the context of HIV. It considers the roles women and men play in areas such as division of labor, productive and reproductive activities, and access to and control over resources and benefits. Gender analysis also provides an in-depth understanding of the socioeconomic and environmental factors that influence women and men, as well as their needs, social norms, decision-making ability and their views on the issues relevant to the project.

In the context of HIV, gender analysis captures the dynamics in households directly affected by HIV and in communities where HIV-related interventions might be introduced. It provides information about the differences between women and men in their involvement and behavior in economic, social and legal structures, as well as in how they benefit from development programs.

To obtain a reliable gender perspective, programmers should speak separately and directly to women and men, obtaining both qualitative and quantitative information (see the box on page 52 for sample gender-analysis questions). Focus group discussions, structured and unstructured interviews, mapping exercises, gender analysis matrices, and role playing are some ways to conduct gender-sensitive analysis. In the context of HIV, it is also important to collect information disaggregated by age as well as gender. This is because within households and communities, individuals from different generations will likely be affected differently by the disease, particularly in terms of its social and reproductive health implications.

Key Questions for Use in Conducting Gender Analysis[7]

Household Roles/Social and Cultural Constraints

- What are the different needs, roles and interests of women and men?
- What are the power dynamics between women and men?
- Which decisions are made by men and which by women?
- What are the social and cultural constraints and opportunities of women and men?
- What are the relations between women and men in society, the community and the household?
- What different coping mechanisms are available to women and men to lessen the risk of food insecurity for their families?
- How do access to and control of resources, information and services affect participation by women and men in the program/project?
- How do gender roles (e.g., workload, time, mobility) influence the ability of women and men to participate in the project/program?

Food and Livelihoods

- Who manages food within the household?
- How is food distributed within the household?
- Who cultivates land and grows food?
- Who is the family's main income earner?
- What are the income-generating opportunities and needs of men and women?
- Where is it convenient for women and/or men to collect food assistance?
- Who collects food assistance?

Health Risks and Accessibility to Health Services

- What are the health risks for women and men? How and why are they different?
- What barriers (e.g., self confidence, mobility, financial resources, role in decision making) do women and men face in accessing health services and health information?
- Where do women and men go for health services and information?
- Which communication channels are most appropriate for women and men?
- Can women and men discuss their health problems/issues among themselves? Is this culturally accepted?
- Where can women and men learn more about how to address their health concerns?
- What social networks exist in the community for men and for women?
- Can these networks help address health concerns?

HIV-Affected Households

- For HIV-affected households, what are the different coping mechanisms of women and men? Of girls and boys?
- For HIV-affected households, what is the impact on girls' and boys' school attendance? Are more girls withdrawn from school?
- What are women's and men's responsibilities related to caring for PLHIV?

Consider the Dynamic Nature of HIV

Assessment tools must take into account the fact that HIV's impact on food security outcomes will vary according to the stage of the disease. Food assistance responses may also need to vary accordingly. The stages are:

- **Prevention**, when increasing access to food may reduce adoption of livelihood strategies that increase susceptibility to HIV infection
- **HIV asymptomatic** (early stage of the disease), when food assistance efforts to strengthen livelihoods and meet nutrient needs can promote positive living for PLHIV and improve immune function, quality of life and productivity
- **HIV symptomatic**, when food assistance can support treatment and care of PLHIV and improve affected households' food access
- **Advanced stage**, when food assistance can support palliative care and improve affected households' food access
- **After HIV-related death**, when food assistance can help ease the impacts on food access and nutritional status for households and OVC

Use Participatory Tools to Reduce Stigma

Data collection tools should also consider the problem of stigma, which could lead individuals affected by HIV to hide or lie about their status and conditions. Participatory tools such as social mapping and wealth ranking appear to be particularly appropriate in the context of HIV because they allow community members to discuss sensitive issues in groups without actually naming or identifying specific individuals or households. Men and women should be in separate groups, particularly in situations where women are not allowed to openly participate in group dialogues. Women tend to be custodians of social knowledge within communities and often know details such as the number of children in a family and which families have chronically ill members.[8] (See the box on page 54 for an example of participatory collection tools.)

CARE Zimbabwe Taps Community Knowledge With Participatory Tools[9]

In 2003, CARE Zimbabwe, an implementing partner for WFP, undertook a study of HIV-affected households using participatory social mapping and wealth indicator scoring to improve targeting criteria for HIV-affected households in the villages it served.

CARE used a participatory information collection methodology for several reasons. The tools enabled CARE to use an ethical approach that would not exacerbate any stigma. CARE also had found that participatory approaches provide a more detailed understanding (and ultimately better targeting) in complex emergencies. In addition, because quantitative information was already available, the participatory study findings could be compared with previous studies.

In the study, CARE divided participants from each selected village into male and female groups. This allowed women to have a voice in describing their communities and served as a method for cross-checking and triangulating information later.

Each group drew a social map showing general information about their community (e.g., infrastructure) and each household's demographic make-up (e.g., number of men and women, children and their ages). CARE facilitators then used the map to conduct community interviews, gathering additional information on household demographics, household chronic illness or death, orphans and other dependents, services the community was receiving, and other development projects the community had in the past.

The groups were then asked to develop indicators for "wealth" categories within their villages. Using those indicators, the groups ranked and scored, in order of importance, specific criteria for determining each household's category. CARE triangulated that information with data from the social map. CARE facilitators then asked groups about the characteristics of the households in relationship to the wealth indicators.

Once all facilitated discussions were complete, the groups reunited and presented their work to each other —providing another opportunity for the information to be cross-checked and verified.

Key Concept

3.3 Steps for Conducting Vulnerability Assessments

In the context of HIV, a vulnerability assessment involves collecting and using data on food availability, access and utilization to guide decisions on the design of food assistance programs. Such decisions will form the basis for targeting the most vulnerable populations, allocating appropriate food and non-food resources (quality and quantity) and implementing projects to reduce vulnerability to food insecurity.[10] The primary purpose of a vulnerability assessment is to understand the nature of food insecurity risks and vulnerabilities among various categories of households and identify opportunities for addressing critical constraints through food assistance programming.

Assessments are one component of a project cycle that feeds into project design. A thorough and accurate vulnerability assessment helps determine who should be targeted (**Chapter 5: Targeting**), what sector activities should receive priority (**Chapter 10: Health and Nutrition, Chapter 11: Education, Chapter 12: Livelihood Strategies and Social Protection** and **Chapter 13: Emergency Response**) and what outcomes should be monitored and

evaluated (**Chapter 8: Monitoring and Evaluation**). Because of the dynamic nature of HIV, continued vulnerability assessment should be built into the monitoring system.

Vulnerability assessments should inform program designers whether food assistance is the best way to address the basic causes of food insecurity and malnutrition in a target population.[11] At a minimum, assessments in the context of HIV should determine:

- Food security risks households and groups face
- How HIV impacts the food access and nutritional status of infected individuals and affected households
- Location-specific criteria for identifying food-insecure and vulnerable households
- Location-specific information on the constraints the households face
- Key leverage points and opportunities to pursue in future interventions

Accordingly, assessment information is often disaggregated by income, gender, HIV status, ethnicity, generation and other key factors. This will facilitate analysis of **vulnerability** that is contextual and differentiated according to specific locations and populations.[12]

In a comprehensive vulnerability assessment, a wide range of information on the food security of targeted areas is collected using secondary and primary data from quantitative and qualitative sources. The key steps for a successful assessment are explained in the following section. In addition, a summary of the type of information required and a list of possible sources of food security and HIV information for assessments appear in Figures 1 and 2, respectively.

Step 1. Desk Review/Secondary Data Collection and Analysis (Situation Analysis)

In this step, crucial information is collected to gain a broad understanding of the region and population for which the assessment will be conducted. In the context of HIV, overlaps between zones with high levels of food insecurity and those with high HIV prevalence should be a core component of secondary data analysis. However, secondary data can often be unreliable, outdated or non-existent, especially in the poorest countries and in countries experiencing or recovering from civil conflict. In these circumstances, primary data are required and can portray a more accurate picture of the current situation.[13] Where quality secondary information is available, it can be collected and analyzed for these factors:[14]

Context, conditions and trends, which consist of physical, geographical and environmental information about the assessment area, key political and social trends and characteristics, and institutions. Information on HIV prevalence, morbidity rates (chronically ill household heads or adults and type of illness), mortality rates in the last 12 months, AIDS-related deaths, and general demographics on the targeted areas from local health facilities or national statistics should be included. Information should also be collected on levels and diversity of crop production, food deficits, nutritional status and calorie gaps; and programmatic responses to food insecurity, particularly those aimed at addressing labor constraints within the target area. Access to educational, health and nutrition services (including ART and PMTCT services) as well as land tenure and land use constraints for OVC should also be included in the contextual information gathered in areas affected by HIV.

Community characteristics, including socio-political considerations at the community level, administrative systems, institutions, spatial considerations (e.g., settlement patterns), available information on livelihood systems and traditional coping strategies/safety nets, and access to

community care or HBC services. Knowledge of community labor-sharing and participation in relevant community groups also may be useful to consider during program design.

Household characteristics, including information on livelihood assets such as:

- **Human capital**. Nutritional status of adults and children, changes in health and education status due to chronic illness, and demographic changes of households
- **Financial capital**. Changes in poor households' income and expenditures, and how health spending compares to expenditures on food and other necessities
- **Natural capital**. Types and quantities of crops grown and harvested and whether there is any change in land cultivated and/or farming systems due to illness
- **Physical capital**. Assets and land available to the households
- **Social capital**. Households' dependency on informal community support networks, extended family structures or community labor-sharing systems
- **Political capital.** Participation in community decisions and power relations

Information will also be gathered on food and livelihood security strategies, characteristics of local diets, health and nutrition behaviors, and access to adequate water and sanitation. Much of this information is available from any national household surveys and Demographic and Health Surveys (DHS) that were conducted.

Intra-household characteristics, including gender and generational issues, dependency ratio, intra-household food distribution, and feeding and care of infants and young children.

If the secondary data provide sufficient information, preliminary **livelihood profiles** can be created for the region or areas of interest. Ideally, livelihood profiles will indicate how different livelihood groups earn income, the degree to which they attain food security, distinctions in nutritional status among groups, access to social and health care services, how various livelihood groups are affected by vulnerability and shocks such as HIV, and key gender considerations. Based on this information, livelihood profiles should identify the groups most vulnerable to food insecurity. Understanding the sources of vulnerability is critical to determining whether food assistance is needed and appropriate.

Preliminary profiles for relevant institutions and stakeholders—which could include government agencies and health care facilities, NGOs, CBOs and other community groups—should be created. Developing institutional profiles involves analyzing local capacity to respond to shocks (including HIV) and reduce vulnerability. The profiles can help assessment teams and program managers identify complementary services and pursue potential partnerships for future programming.

Step 2. In-Field Assessment (Primary Data Collection)

In this step, primary data will be collected. The amount and kind of information will depend on the availability and quality of secondary data (see Figures 1 and 2). Information requirements include:

- Sources of risk and strategies for risk management (including information on HIV prevalence and response)
- Sources of income
- Monthly food and non-food expenditures

- Ownership and availability of productive assets
- Access to health and education services
- Presence of formal/informal social networks
- Seasonal patterns of malnutrition and food gaps
- Access to health care and HIV treatment services
- Access to community- and home-based care[15]

In addition to standard indicators on food insecurity, specific indicators can be used to assess HIV's impact on livelihoods and food availability, access and utilization (see Figure 1). It is especially important to consider HIV's impact on the nutritional status of members of affected households, assets and livelihood strategies, and strategies and capabilities of affected households to respond to risks. This information provides a better understanding of the dynamics of vulnerability and possible trends in surveyed areas.

Using both qualitative and quantitative data collection methods is considered optimal for vulnerability assessments (see Figure 2).[16] This is because quantitative and qualitative methods allow for the collection of different types of complementary information and both are necessary for achieving a comprehensive understanding of vulnerability within a particular area. Quantitative data are important because they provide information about the magnitude of vulnerability and enable a relatively objective representation of its geographical distribution (i.e., *how many* vulnerable households live in each district of a country?). Qualitative information is equally important in that it highlights the diverse and dynamic nature of vulnerability and marginalization at the individual, household and community levels (i.e., *who* is most affected and *why* do people experience various degrees of deprivation?). When used together, quantitative and qualitative methods will enhance the assessment of the constraints leading to food insecurity as well as of the social and economic marginalization of individuals and households that often occurs in the context of HIV and AIDS.

Qualitative data collection methods include qualitative interviews (group interviews, focus group discussions, key informant interviews) and interactive data collection tools such as wealth ranking, Venn diagrams, transect walks, community mapping or seasonal calendars. Community focus group discussions, key informant interviews and other qualitative methods should collect in-depth information on targeted communities' nutritional issues and "success stories" to further understand causal factors and opportunities for programming.

Surveys are the main tools for collecting quantitative data in a vulnerability assessment Data are collected on income/livelihood sources, market dependence, expenditures, gender issues, credit and debt, available assets, months of self-provisioning and traditional coping mechanisms. (See the annexes in **Chapter 5: Targeting** for sample food security screening and appraisal tools.)

Ultimately, decisions regarding the specific research methods, scope of the assessment and composition of the assessment team will also be influenced by the particular organizations' financial, human and analytical capacities. For instance, during the initial stages of planning, assessment coordinators will need to carefully consider the technical skills necessary for accurately assessing vulnerability to food insecurity and/or HIV within the particular area. They will also need to determine both the time and resources available for collecting and analyzing data. In the context of HIV, it is particularly important that assessment teams are able to engage in the type of multisectoral data collection and analysis that enables an effective, integrated response to food insecurity in areas affected by the disease.

Nutritional Assessment Component

A critical component of vulnerability assessments in the context of HIV is assessing the nutritional status of target populations. The connection between HIV and malnutrition is often difficult to capture with current indicators and assessment tools. The nutritional status of children under five has been commonly used as an indicator of vulnerability during food emergencies and to measure a community's overall food security status. However, this indicator would not reflect HIV's effects on infected adults' nutritional status. Also, children under five are often underrepresented in HIV-affected households primarily due to the lower fertility of HIV-positive individuals and higher infant and child mortality in HIV-affected families. Therefore, it is important to measure the nutritional status of adults, including chronically ill adults and those participating in HIV care or treatment programs. While it is more difficult to collect nutritional information on older children and adults, these data may ultimately prove to be more relevant and useful in the context of HIV.[17] Nevertheless, even in HIV contexts, the nutritional status of children under five will continue to be an important indicator of food insecurity.

Two types of indicators should be used in a nutrition assessment in contexts with a high prevalence of HIV:[18]

Condition indicators, which describe the nutrition status of targeted populations and include traditional anthropometric data for children (underweight, stunting, wasting), edema as an indicator of severe malnutrition, adult body mass index (BMI), low birth weight (LBW), morbidity and opportunistic infections.

Indicators on underlying factors related to nutrition, which should include food access, health and care practices. To understand food security factors related to nutrition, programmers should collect data on household dietary diversity, number of daily meals, coping strategies, calorie and other nutrient gaps, and income, expenditures or wealth as a proxy indicator of food access. Nutrition determinants related to health include access to and/or use of health services, as well as water and sanitation infrastructure and practices. Data on care practices should at least include the main care provider's household role and education level, the effective dependency ratio as an indicator of the availability of other care providers, and the feeding and care of infants and young children.

To identify leverage points and increase the effectiveness of nutrition programming, additional data can be collected, including information on available services and potential risks and how to address them at the household and community level. At the meso (district and provincial) level, this may entail collecting information on effective food security and HIV programming modalities, while at the macro (national and regional) level, data on resource mobilization and relevant sectoral policies should also be collected.[19]

Ethical Considerations in Data Collection

Program managers who gather information in the field on food insecurity and HIV must maintain high ethical standards to protect and respect the households that are interviewed. An ethical framework should apply three fundamental principles:

- Show respect for persons by seeking informed consent from the individuals interviewed.
- Anticipate potential negative consequences from the data collection and make sure the information will not lead to direct or indirect harm.
- Ensure that the benefits from the information are equitably distributed.[20]

Programmers should have the information gathering activity reviewed by an in-country ethical review board or establish an in-house ethical review mechanism. In addition, when

Figure 1: Data Requirements to Assess Food Insecurity

Types of Information		
Food Availability	Secondary	Primary
Production statistics	☒	
Seasonality of production	☒	☒
National food stocks	☒	
Market and food supply infrastructure	☒	
Import/export statistics	☒	
Macroeconomic situation and government policies (trade policy, exchange rate, balance of payment constraints)	☒	
Market locations, accessibility, viability, volumes and prices (nationally, regionally)	☒	
Market locations, accessibility, viability, volumes and prices (locally)		☒
Change in functioning and flow of markets as a result of shocks		☒
Market demand (changes in purchasing power and reliance on market supply)		☒
Terms of trade between major cereals, livestock and income	☒	☒
History of shocks and impacts on food availability	☒	☒
Food Access	Secondary	Primary
Sources of food (crop production, livestock, purchase, fishing/hunting, remittances, labor exchange, trade, aid)	☒	☒
Socio-political structures (tribal and kinship affiliations, CBOs, local government offices)	☒	☒
Socioeconomic differentiation (wealth groups, ethnicity, caste)	☒	☒
Gender considerations relative to food access and use	☒	☒
History of shocks and impacts on food access	☒	☒
Land distribution and use	☒	☒
Mobility and migration trends	☒	☒
Seasonality (prices, types of food available, food shortages)		☒
Food stocks and storage		☒
Sources of income (trade, employment, sale of food/non-food produce, remittances, casual labor, theft, aid)		☒
Assets ownership or availability		☒
Debt		☒
Food expenditures		☒
Non-food expenditures (education, health, water, shelter, clothes)		☒
Months of self-provisioning in a normal year		☒
Infrastructure and market access		☒
Food Utilization	Secondary	Primary
Nutritional status of children under 5 (wasting, underweight, stunting)	☒	☒
Nutritional status of adults, especially women (body mass index: BMI)	☒	☒
Consumption patterns and household dietary diversity (number of food items consumed, frequency of consumption)	☒	☒
Food habits, preferences and acceptable food substitutes		☒
Availability of and access to milling facilities		☒
Food preparation practices		☒
Feeding, health, nutrition and sanitation practices	☒	☒
Normal access to and uptake of health services	☒	☒
Water supplies and sanitation provision	☒	☒
HIV prevalence rates	☒	
Access to HIV treatment and care facilities		☒
Disease prevalence (seasonal): diarrhea, fever, acute respiratory infection, outbreaks of cholera, yellow fever, dengue	☒	☒
Immunization coverage	☒	
History of shocks and impacts on food utilization		☒

Adapted from TANGO International. ***Food Security Needs Assessment Toolkit***. Prepared by TANGO International for ACDI/VOCA. Tucson: TANGO, 2005.

Figure 2: Sources of 1) Data to Assess Food Insecurity and 2) HIV Information

Food Availability	
Secondary	Primary
Ministry of Agriculture Ministry of Finance and Commerce National Statistics Offices USAID's Famine Early Warning System (FEWS) European Union (EU) Food Security Units Market information systems, if available World Bank WFP Vulnerability Analysis and Mapping (VAM) Surveys	Key informant interviews with government staff, traders Market observations in affected localities
Food Access	
Secondary	Primary
Local government NGO reports Livelihood profile data generated from secondary data review World Bank WFP VAM	Key informant interviews with district officials, village leaders, service providers, merchants, NGOs Group interviews/focus group interviews Household surveys Participatory rural appraisal (PRA) tools Transect walks, visual inspection Market interviews Wealth ranking
Food Utilization	
Secondary	Primary
Ministry of Health DHS UNICEF nutrition surveys WHO health surveys Local health center data	Key informant interviews with district health officials, health service providers, village leaders, NGOs Group interviews Focus group interviews Household interviews PRA tools Transect walks Visual inspection Health facility records Nutrition surveys Sentinel site surveillance Village level primary data ▶ Nutritional survey ▶ Growth monitoring
HIV Information	
Secondary	Primary
Ministry of Health DHS UNICEF WHO health surveys Local health center data UNAIDS FAO WFP	Key informant interviews with district health officials, health service providers, village leaders, NGOs Household interviews focused on chronic illness Health facility records Sentinel site surveillance Village level primary data ▶ Nutritional survey ▶ Growth monitoring Social mapping

Adapted from TANGO International. ***Food Security Needs Assessment Toolkit***. Prepared by TANGO International for ACDI/VOCA. Tucson: TANGO, 2005.

gathering information on children and adolescents, programmers should consult with local community groups to determine who must give permission for the data collection. Community stakeholder groups can help monitor the information gathering process.

Step 3. Analysis of Assessment Findings

Data collected in the assessments are analyzed in three ways:

Preliminary Analysis (Situation Analysis)

Preliminary analysis is based on secondary data and information collection and analysis. As noted in Step 1, this analysis should provide an overview of vulnerability given the context of food security, livelihoods, and health in the assessment area. The analysis looks at the socio-political context, and the interests and the activities of key institutional players in food security and vulnerability in the country. The analysis provides a preliminary understanding of the causes of food insecurity and vulnerability, and an initial description of the characteristics of the most vulnerable groups. The analysis should provide a narrative understanding of the causes and spatial patterns of food insecurity and vulnerability.[21]

Level 1 Analysis (Descriptive Analysis)

Level 1 analysis combines secondary and primary data to provide a detailed description of the target population's food insecurity, livelihoods and coping strategies. This looks in detail at the risks/shocks the target population faces (including HIV and food insecurity), the level of exposure and how the population manages risk and copes with shock. In the context of HIV, it is necessary to examine how the livelihoods and coping strategies can increase exposure to HIV (susceptibility) and vulnerability to food insecurity, and how HIV affects food security. The analysis should also provide a comprehensive description of livelihood characteristics of communities and households in the target areas, as well as insights on gender issues, intra-household resource allocation concerns and health and nutrition behaviors. After this analysis, it should be possible to describe the characteristics of the most vulnerable groups in the targeted areas and finalize livelihood profiles.

Sources of risk. Level 1 analysis should start by exploring the sources of risk affecting surveyed populations. Households face two types of risks: covariate (i.e., affecting a large majority of households or the entire community) or idiosyncratic (i.e., affecting specific households).[22] In areas with high prevalence of HIV, the disease should be considered a covariate risk/shock, since it directly or indirectly affects a large proportion of community members. For each risk, the analysis should determine the frequency, severity, recent trends, type (covariate or idiosyncratic) and the level of exposure.

Factors underlying nutritional status. In assessing food utilization, this analysis synthesizes information about factors underlying nutritional status, including food consumption patterns and dietary quantity and quality; feeding, care and hygiene practices; access to health services and water/sanitation infrastructure; and HIV infection and progression.

Coping strategies. As noted earlier, HIV could lead affected families to use distress coping strategies, such as selling productive assets to pay treatment or funeral costs. The coping strategies index (CSI) (see **Annex 1 in Chapter 8: Monitoring and Evaluation**) can be used to understand the types and gravity of households' coping strategies. The higher the index, the higher a household's vulnerability to food and livelihood insecurity.

Formal or informal social safety nets. During analysis, community information collected should be reviewed to identify formal or informal social safety nets and evaluate how well these formal/informal networks or institutions support households in managing risk and shocks, including HIV. Furthermore, it is important to find out whether certain families

Key Questions for Assessing HIV's Impact on Safety Nets

Formal Safety Nets

- Are public safety net measures being implemented in the region affected by HIV?
- Is the formal safety net designed to deal effectively with PLHIV?
- Can formal safety nets be scaled up to deal with the rising prevalence of HIV? Are the necessary resources and managerial capacity available?
- What targeting mechanisms are being used to deliver current safety nets (self-targeting, administrative targeting)?
- Is there the political will to develop formal safety nets, if necessary?

Informal Safety Nets

- Has HIV affected the village collectively or just specific households?
- How has HIV impacted community solidarity?
- What are the community's risk management strategies to cope with HIV (savings and credit associations, burial societies, labor sharing networks)?

or groups are excluded from these networks, increasing their vulnerability to shocks and possible future crises (see box above).

Formal safety nets can take the form of care provision or cash/food transfers. During analysis, programmers should determine what kind of support affected households in targeted communities have received, including assessing HIV's impact on formal support mechanisms and on resources. HIV can diminish the human and financial resources needed to implement formal safety nets, thus reducing the capability of government or NGOs to provide assistance.

Livelihood outcomes. Livelihood outcomes should be assessed to determine whether households are pursuing livelihood strategies that effectively manage risk and shocks, including HIV. Outcome indicators capture levels of need and well-being and serve as proxies for the results of risk exposure and vulnerability. Different household outcomes are determined by asset levels and risk management strategies used to respond to shock.

Food security. To assess food security, it is crucial to look at food consumption indicators such as household dietary diversity and meal frequency, as well as food access indicators such as food and non-food expenditures, income, and availability and ownership of assets.

Indicators of proper food utilization include adult and child nutrition measures, infant feeding and caring practices, and access to health, water and sanitation services. To allow for an adequate assessment of nutrition, nutrition-related data should be disaggregated by age (by month or relevant age ranges), gender, primary caregiver, HIV proxy indicators (chronic illness, death in the family and orphan status) and wealth (e.g., assets index).

The analysis of livelihood outcomes should be disaggregated by gender to determine gender's role in household food and livelihood security.

After a Level I analysis, vulnerability profiles should be developed for different groups with similar characteristics and outcomes related to food and livelihood security.[23] These profiles should include an analysis of probable causes of food insecurity and vulnerability at any given time in a particular location or population group. The profiles make it possible to

identify groups whose livelihoods have been most affected by risks and shocks, including groups that have been most affected by HIV.

Level II Analysis (Dynamic Analysis)

A Level II analysis focuses on vulnerability as a dynamic measure of exposure to risk. To understand possible paths of future vulnerability, it is necessary to analyze health, livelihoods, and institutional and demographic trends in targeted populations. For example, the analysis should seek to understand trends in household composition, health status, access to health and nutrition services, and livelihood strategies to determine whether vulnerability has increased or is likely to increase over time.

At the same time, it is important to analyze intra- and inter- community dynamics, paying special attention to how social networks and institutions adapt or deteriorate in response to the changing vulnerability context. In the case of HIV, continual erosion of community social support networks will make HIV-affected households and communities more vulnerable to future food insecurity.

The presence, intensity and availability of interventions such as HIV treatment and care interventions may also change over time for a targeted population, which can affect food access and utilization. The trends of such interventions should be considered in assessing food security over time.

An accurate determination of trends and dynamic relationships between multiple factors requires collection and analysis of time series data. Such analysis may be conducted by comparing assessment findings with previously collected secondary data or through the regular analysis of program monitoring data. By combining the descriptive (Level I) analysis with the identification of relevant food and livelihood security trends, the assessment team will be able to identify the most vulnerable individuals, households, groups, communities and populations in targeted areas. This in turn will help determine which groups should be the focus of interventions.[24]

The analysis should also determine individual, household and community resilience to existing and future shocks. This might include identification of:

- Examples of positive responses by individual, household and community responses to constraints and shocks related to HIV. These positive examples ("positive deviance") can form the basis for intervention designs.
- Promising initiatives implemented by CBOs and local NGOs, which could serve as entry points for interventions. In addition, identifying these organizations and their activities could provide crucial information on potential partners. Collaboration among multiple organizations can also help scale up proven risk management approaches.
- Positive changes in government policies or other enabling conditions that may create program opportunities in the affected areas

During the whole analysis process, it is critical to consider the gender dimension of HIV. Biological predisposition, household health and nutrition practices, gender inequality, the role of power in sexual relations, women's lack of economic empowerment, mobility and access to services and information, gender-based violence and migration increase the vulnerability of girls and women to HIV infection. Therefore, an assessment should include a comprehensive gender analysis to gain a full understanding of HIV's impact on vulnerability.

Step 4. Development of a Vulnerability Assessment Report

The process of report preparation should start during field work, when assessment team members meet regularly to discuss findings and develop the report content. These discussions help the team consolidate key information and trends and ensure that important details are not forgotten. The final report should provide a rational, useful analysis of the information collected (see Annex I for an example of a table of contents for such a report).

Step 5. Program Design Based on Assessment Findings

Once the final report has been circulated, assessment findings should guide program design. In particular, assessment findings should lead to recommendations that will guide program development or improvement. Findings should be used to select appropriate food and non-food interventions, target the most vulnerable groups, determine food rations' appropriate size and composition, and design an effective monitoring and evaluation system.

Assessment findings should first be used to determine the most appropriate food and non-food assistance interventions for the areas surveyed. The assessment analysis should also provide crucial information to evaluate the likelihood of assistance interfering with local food production, marketing and consumption; to identify possible partners; and to assess the influence of government and donor macro policy on the proposed interventions' success.

Assessment results will also contribute essential information to help select populations for proposed interventions (see **Chapter 5: Targeting**).

Finally, vulnerability assessment findings will be a crucial source of information for designing and implementing M&E systems to monitor program performance and assess program outcomes and impacts. Assessments should be used to identify appropriate indicators for program outcomes; they also could be used as a baseline for future comparisons if representative quantitative data are collected. **Chapter 8: Monitoring and Evaluation** offers a detailed description of how to design and implement an M&E system for food assistance programs in the context of HIV.

Key Concept

3.4 Minimum Vulnerability Assessment Requirements to Design HIV Programs

Key Concept 3.3 detailed the steps for conducting vulnerability assessments to design food assistance programs in the context of high HIV prevalence. Such comprehensive assessments are appropriate when a significant area is both food-insecure and suffering from high HIV prevalence. However, food security vulnerability information should also be collected in high-prevalence areas where pockets of food insecurity exist, in order to incorporate food and nutrition interventions into ongoing HIV programming. The food security information would be used to ensure that only food-insecure households are receiving food assistance as part of the intervention package. At a minimum, agencies wanting to identify these households will need to collect information such as:

- Sources of income
- Sources of risk
- Monthly food and non-food expenditure
- Ownership and availability of assets
- Food consumption indicators such as household dietary diversity and meal frequency, calorie and other nutrient gaps
- Traditional coping mechanisms
- Nutritional status
- Prevalence of diarrhea and other diseases affecting food utilization
- Hygiene practices

This information would be collected through a household questionnaire as part of a screening mechanism set up by the implementing agency. Agencies that primarily focus on health interventions could partner with an NGO or UN organization that has experience with food security assessments to help collect and analyze this information.

These assessments would have to be updated periodically to determine whether conditions have changed due to the dynamic nature of HIV's impact on livelihoods. Some households may require less food assistance as infected household members respond positively to treatment, while households that were not targeted with food assistance may require support if their livelihood systems have deteriorated.

3.5 Key Concept
Approaches and Tools for Vulnerability Assessments

This section explores three examples of food security vulnerability assessment approaches and tools. In the first example, the Community and Household Surveillance (CHS) system implemented by WFP and C-SAFE, is used as a rural vulnerability monitoring system incorporating HIV indicators. The example illustrates how periodic assessments can inform programming decisions in an evolving HIV context. The second is a community vulnerability assessment approach developed by FH, and the third is an urban vulnerability assessment conducted in Zimbabwe. Other examples can be found in the Horizons HIV AIDSQuest Survey Library at www.popcouncil.org/horizons/AIDSquest/description.html.

A Rural Vulnerability Assessment

WFP and the C-SAFE consortium implemented a joint food and livelihood security monitoring system called the Community and Household Surveillance (CHS) system in Zambia, Zimbabwe, Lesotho, Malawi, Swaziland and Mozambique. The system monitored vulnerable groups' food security and livelihood trends as well as food assistance outcomes using quantitative household surveys.

The CHS conducted surveys in areas where WFP implements food assistance and other interventions. In each country, the surveys used a two-stage random sampling methodology to provide an unbiased and representative estimate of the information required. The first stage was the random selection of final distribution points (FDPs) by district of intervention. A number of FDPs (the total varies by country) were selected from a list of distribution points. The second stage was a random selection of households within each selected FDP. Two sampling frames were used, one listing all beneficiaries and the other listing all non-beneficiaries, and a random sample of 15 households was selected from each frame. Some non-beneficiary households had never received food assistance, but others that were classified as non-beneficiaries may have received food at an earlier stage, but not in the month before the survey. [25]

The CHS used the CSI and the household dietary diversity index as the two main indicators to assess food security in targeted areas (see Chapter 8: Monitoring and Evaluation). Other indicators were also used, including debt, school attendance and asset ownership.

The CHS also tracked food security trends of a number of vulnerable groups, including households that were economically disadvantaged (based on assets owned), hosted orphans, had chronically ill members (often used as a proxy for AIDS) and were headed by women, the elderly or youth.

The regional CHS data analysis provided important insights into different groups' vulnerability based on key food security indicators. It also provided information for future programming and could be used to decide how best to identify vulnerable households and use this information in a targeting system.[26]

A Community Vulnerability Assessment[27]

FH developed a qualitative community assessment methodology to help programmers understand how HIV and food insecurity interact within specific communities and project areas. These assessments are highly focused and are appropriate in smaller areas where a single agency might be operating. Two to three villages that are considered representative of the area are selected in each project area. A team spends three days in each village.

The information gathered is intended to help determine what kinds of programs will best mitigate the interactions between HIV and food insecurity in the communities where FH works. Sources of information for the assessment include team members' knowledge of the context, input from community members and secondary data sources.

The assessment uses rapid rural appraisal techniques such as risk mapping, proportional piling and focus group discussions to conduct a dialogue with selected communities. Issues explored include:

- What is the stage of the HIV epidemic in the community?
- How are communities responding to the epidemic?
- How does stigma increase the risk of infection and contribute to food insecurity from HIV?
- How does gender inequity increase the risk of infection and contribute to food insecurity from HIV?
- What role are churches and other community groups playing to confront stigma, promote gender equity, reduce the risk of infection and combat food insecurity from HIV?
- How does HIV threaten the food security of OVC?
- How well can elderly caregivers provide for themselves and OVC under their care?
- How does HIV limit affected individuals' access to the education they need for future food security?
- How do AIDS-related illness and death threaten the food security of affected households by degrading such things as labor productivity, household income, household assets, nutrition, water and sanitation, and natural resources?
- How do shortages in food, labor, income, assets, water and natural resources increase the risk of HIV infection and/or speed up the progression from HIV infection to AIDS for different household members?

An Urban Vulnerability Assessment

In 2002, with support from TANGO International, WFP conducted a vulnerability assessment to examine the status of food insecurity among the poorest households in the urban area of Bulawayo in Zimbabwe.[28] The assessment showed that the area's increasing levels of food insecurity were due to the combined effects of the economic crisis, high unemployment, unavailability of staple foods, increasing prices and the effects of HIV. The study also identified the most vulnerable groups: orphans, elderly, chronically ill and female-headed households (particularly widowed).

After the study, C-SAFE established a routine monitoring system to track food price changes in the area of Bulawayo and in 2004, C-SAFE Zimbabwe conducted a new assessment to assist in further program development and gain deeper understanding of vulnerabilities and current challenges facing urban households.[29]

C-SAFE selected sample communities for this primarily qualitative assessment based on their economic development, primary occupations of residents and historical profile. Based upon these characteristics, C-SAFE's assessment team divided Bulawayo into inner and outer circles and randomly selected two communities from each, along with two squatter communities.

The focus groups, which had a balanced sample with men, women, boys and girls, discussed three themes: caring for others, livelihoods and wealth ranking. and household resilience. The assessment team used the *transformational development indicators scoring system,* developed by World Vision, to score and summarize the findings of these qualitative discussions.

The *caring for others* group discussions included use/sharing of community resources, gender relations (including equal opportunities for boys and girls), valuing and protection of children, well-being of vulnerable persons, and conflict prevention/resolution.

The *livelihood* groups discussed shocks such as food shortages, exorbitant basic food and commodity prices, the HIV epidemic, withdrawal of corpse collection services from homes by the police, unaffordable education costs, high unemployment rates, especially for youth, inaccessible or unaffordable health services, and coping strategies. Wealth ranking exercises were also conducted. In particular, participants indicated that two types of households were perceived as becoming poorer: those with chronically ill members and those who take in orphans, which, as noted earlier, are indicators that can be used as proxies for the presence of HIV.

The *household resilience* groups focused on community classification of food-secure households, identifying them as those that can afford to eat a variety of food three times a day and send their children to school. The groups also discussed dietary habits and household dietary diversity in their households, seasonal availability of food items and strategies for increasing access to food, including borrowing from others, engaging in illegal activities to obtain food, sending children to work or beg, or, in squatter communities, looking for food in garbage.

Annex 1: Standard Format for a Vulnerability Assessment Report

Executive Summary

1. Objectives and Methodology of the Assessment

- Objectives of the assessment
- How primary data were collected, the number and distribution of the sites visited and community groups/households interviewed, and how they were selected
- Secondary data sources used
- Approach/methods used to analyze the data
- Limitations of data and basis for generalizing from the sample to the population, uncertainty/confidence in the data and consequent conclusions, recommendations for follow-up data collection and analysis, if appropriate

2. Socioeconomic Background—Pre-Crisis Conditions in the Affected Areas

- Population and livelihood groups, their typical food security profiles and vulnerabilities
- Macro-economic situation, production systems, trade patterns, and fiscal and other policies affecting food security
- Political and social structures: social support systems, how they operate, whom they do/do not cover; power structures and their implications for the food security of different groups
- HIV prevalence rates, treatment facilities and services

3. Nature of the Shocks and General Demographic Impact

- Nature of the shocks/crisis, their general effects on population (morbidity and mortality) and infrastructure in different areas
- Numbers displaced, expected duration of displacement, whether those displaced have lost all means of livelihood

4. Food Availability and Markets

- Impacts on local/national food stocks and food production forecasts, changes in expected levels of imports, actions by government and others to increase supplies
- Impacts on prices and market integration; logistic bottlenecks or administrative regulations inhibiting the movement of goods; action by government, traders or others to repair infrastructure and facilitate market functioning; market's capacity to meet current and future food demand

5. Livelihoods and Households' Access to Food

- Impacts on local economies, employment opportunities, demand for local produce and services; action being taken to restore economic activity; seasonal considerations; when and how much activity and demand for local produce/services are expected to recover
- *For each distinct population group*: impacts on livelihood assets, sources of food and income (including entitlements from social networks/political allegiances) and obligatory expenditures (including rent, fuel, water, shelter, health, loan repayments, etc.); trade-offs between food and non-food needs; the type and sustainability of coping strategies adopted; when and how well livelihoods are expected to recover; present food access shortfalls and how they are expected to evolve
- Actions by government and others to enable households to access sufficient food, how long those actions will continue with available resources

6. Food Consumption and Utilization: Nutritional and Health Status

- Impact on the diets of each distinct population group; their ability to prepare food
- Present nutritional status and nutritional risks; disease-related mortality rates; water, sanitation and other public health concerns that threaten lives and nutritional status; HIV prevalence rates
- Actions by government and others to address problems of food use and consumption, malnutrition and the main public health risks (including HIV)

7. Current and Future Problems and Risks for Food Security and Livelihoods; Assistance Required

- Synthesis of the current situation, likely evolution and risks for food supplies, markets, livelihoods, household food access shortfalls and nutritional status
- Scenario(s) for the next six to 12 months and two to five years
- Numbers of people requiring assistance in different areas/population groups, levels of assistance required; when assistance will be required
- What would happen without any response or an inadequate response within the critical specified period

8. Response and Targeting Options

- Possible food and non-food responses to problems of food supply/availability (if any), markets, household food access, malnutrition and long-term food security (livelihoods); the advantages and disadvantages of each response;
- Social, political, security, logistic constraints; potential negative effects of current and possible future assistance strategies
- Capacities (including resources) of communities, NGOs, local authorities and the government to provide assistance or implement externally supported programs

9. Recommendations and Proposed Assessment Follow-up

- Recommended "package" of responses to most appropriately address the identified problems, with reasons
- For any food assistance: types and quantities of commodities, when required, proposed sources (external, local or other), targeting and implementation arrangements
- Specific aspects/indicators to be monitored during the next three, six and 12 months; arrangements (or recommendations) for follow-up assessments, if needed

Annexes

Map of the affected areas

Assessment instruments used

Seasonal calendar (and any other significant summary diagrams)

Schedule of the assessment activities and site visits

Members of the assessment team

Adapted from World Food Programme (WFP), ***Emergency Food Security Assessment Guidelines***. Rome: WFP, 2004.

Endnotes

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Chapter 4: Adaptive and Integrated Programming

Program Design Steps

Chapter 4: Adaptive and Integrated Programming

Program Design Steps

Key Concepts

4.1 Program Characteristics

4.2 Food Security Program Design Considerations

4.3 HIV Program Design Considerations

4.4 Accounting for the Changing Needs of HIV-Affected Individuals and Households

4.5 Challenges and Considerations in Developing Integrated Programs

In This Chapter

This chapter discusses design considerations for the two types of programs that are the focus of this guide:

- Food aid-supported food security programs operating in areas that also have a high prevalence of HIV
- HIV programs operating in areas that have a high prevalence of food insecurity or in areas where overall food insecurity prevalence is not high, but there are a substantial number of food-insecure households participating in the HIV program activities

The chapter discusses how the core activities of each type of program should be adapted to account for the contexts in which they operate and presents design considerations for integrated programs that address both food insecurity and HIV needs in an integrated, holistic and comprehensive way.

More specifically, the chapter looks at the need to adapt food security programs in a high HIV prevalence context to explicitly address the constraints PLHIV and HIV-affected households face that may make it difficult for them to fully benefit from the food security program activities. The chapter also examines how HIV prevention, treatment, and care and support programs can utilize food and food-related activities to better achieve their HIV-related outcomes. Subsequent chapters provide greater detail on sector-specific interventions.

Where both food insecurity and HIV prevalence are high, the chapter discusses the primary challenges and the key considerations for integrating food security and HIV activities so that both food security and HIV prevention, treatment, and care and support outcomes are promoted. It also discusses the challenges to designing comprehensive HIV programs that address the needs of food-insecure HIV-affected households, where a lower overall prevalence of food insecurity may make it less likely that food assistance programs will be available.

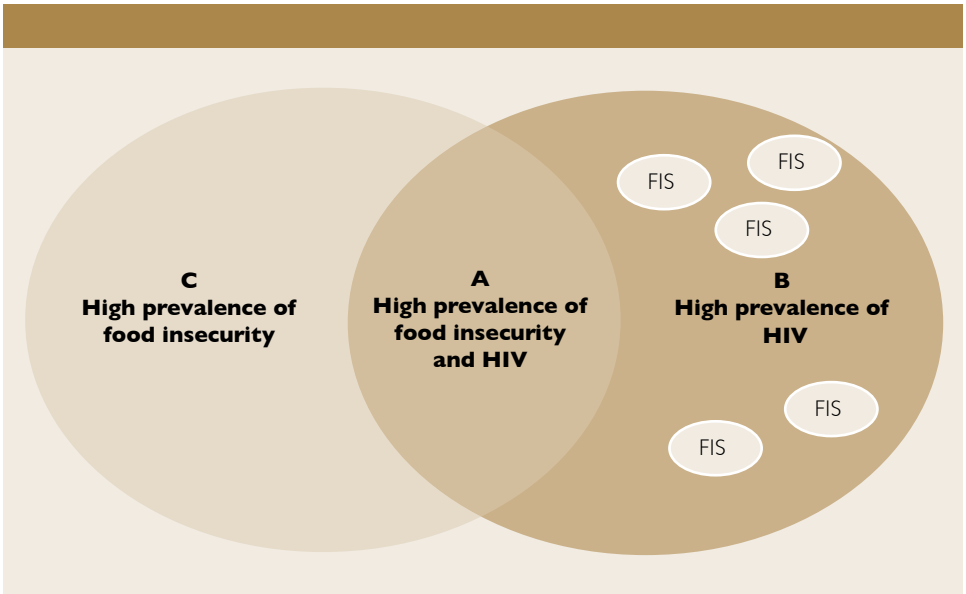
4.1 Key Concept
Program Characteristics

The information in this and subsequent chapters is relevant to two types of programs.

- Food aid-supported food security programs operating in an area that also has a high prevalence of HIV (area A in Figure 1). The program's core objective is to reduce food insecurity through improved availability, access and/or utilization of food and reduced vulnerability. The target population is the food-insecure.
- HIV programs operating in an area that also has a high prevalence of food insecurity (area A) or where food insecurity prevalence on average is not high, but there are many food-insecure households or individuals using HIV services (area B). The program's core objectives relate to prevention, treatment and/or care and support. The target populations are PLHIV, OVC and HIV-affected households.

The optimal approach for both program types involves using food assistance to support comprehensive and holistic programming so that objectives for both food security and HIV prevention, treatment, and care and support are achieved. Table 1 summarizes some of the program types' key characteristics.

Figure 1: Program Areas for Food Security and HIV Programming[A]



A While food security and HIV programs can have impact in areas in which high levels of food insecurity but low prevalence of HIV coincide (area **C** in Figure 1), such programs are not the focus of this guide. Still, the programming principles and approaches in this guide will also be useful in contexts where partnership and coordination among food security and HIV programmers are possible.

Table 1: Characteristics of Key Programs

	Core Objective(s)	Program Area (see Figure 1)	Target Population	Targeting Challenge	Design Modifications to Achieve Core Objective	Additional Programs to be Integrated/Linked
Food Security Program	Reduction of food insecurity	A	Food-insecure	Inclusive vulnerability criteria to ensure HIV-affected are included	Address constraints to participation of PLHIV and affected households	HIV interventions specifically targeting needs of PLHIV and affected households
HIV Program	Prevention, treatment and care and support	A or B	PLHIV, OVC and affected households	Identifying food-insecure individuals or households	Incorporate food and food-related interventions	Food security interventions to sustainably address broader food security needs of food-insecure PLHIV, OVC and affected households

Key Concept

4.2 Food Security Program Design Considerations

Achieving the food security objectives (improved availability, access and/or utilization, reduced risk and vulnerability) of food security programs in high HIV contexts requires two types of programmatic modifications.

- Food security activities must be adapted and modified to meet the special needs of communities experiencing high HIV prevalence. Without appropriate adaptations, some of the food-insecure will not be reached by the food security activities, and the program will be less likely to achieve its food security objectives.
- Programs should ensure that the HIV-specific prevention, treatment and care and support needs of the HIV-affected are addressed by incorporating HIV-related activities into the food security program and linking with HIV programs through partnerships and referral systems.

Adapting Food Security Program Activities

As discussed in **Chapter 1: Conceptual Framework**, HIV impacts households and individuals in ways that may prevent them from fully benefiting from food security activities in their communities. Food security programs in these communities should be designed to facilitate the inclusion of food-insecure households in the community.

This can be done by applying an "HIV lens" which can help program managers and field staff reassess food security program activities in light of HIV's specific characteristics and

the factors contributing to its spread. Used appropriately, the lens can help decision makers in all sectors reflect on how planned activities and ongoing interventions can be more inclusive of PLHIV and affected households, and how they might affect susceptibility to HIV and resiliency to its impacts on food and livelihood security.

Viewing current or planned food security programs through an HIV lens ***does not*** mean that activities are redirected toward HIV-infected individuals or affected households. Rather, it provides a way for programs to retain their primary goals and objectives of decreasing food insecurity among vulnerable populations while routinely considering the specific needs of HIV-affected households and communities during project planning and implementation. [1, 2]

Questions to consider in applying an HIV lens include:

- What are HIV's impacts in the targeted communities?
- What constraints do HIV-affected households face that might limit their ability to participate? How might the project be modified to address these constraints and facilitate their participation?
- Can the activity itself (e.g., repairing roads to markets) increase the spread of HIV or increase risky behavior? How can this be mitigated?
- How will the project affect individual and household coping strategies in the context of HIV?
- How could targeting mechanisms and referral systems be adapted to ensure that PLHIV and affected households benefit from food security programs?
- Can current or planned food security projects contribute to or reduce stigma among HIV-affected households?
- How could PLHIV and CBOs with direct experience in HIV programming contribute to improved food-security activities?

Applying an HIV Lens to a Food for Assets Activity

An HIV lens could be used to adapt a FFA project designed to rehabilitate feeder roads to markets. For example, the project might:

- Ensure the greater involvement of people with HIV and AIDS (GIPA) in decision-making at all stages.
- Consider whether increased mobility of people using the roads increases the risk of HIV transmission and take action to mitigate this with HIV prevention activities, e.g., in the marketplace, en route to market, on buses, at bus stops.
- Help HIV-affected households who are food-insecure but cannot participate in the FFA project due to constraints such as labor shortages caused by the disease. For example, the project could be situated closer to the homes of people who are also working as caregivers. Daycare services could be made available for workers, or food payments could be made to temporary home-based caregivers so that able-bodied workers could be away from home long enough to participate in the project. The project also could let these households "recruit" a non-vulnerable relative or a neighbor to participate on their behalf.

A CRS HIV/AIDS Analysis Tool with an expanded example of the application of an HIV lens to food for assets programming appears in Annex 1.

Addressing HIV-Specific Needs

If the prevention, treatment, and care and support needs of HIV-affected households and individuals are not addressed directly, it is unlikely that the program's food security objectives will be met because HIV is likely to further worsen the food insecurity situation if not addressed directly. This highlights the importance of integrating HIV services into the food security program through direct provision by the food security implementing agency and/or through links with HIV-service providers (see **Chapter 7: Implementation Strategies** for a discussion of partnerships and effective referral systems). Food security programmers may be able to develop an integrated food security program by ensuring synergy and coordination among different aspects of the country program. For example, an agency may have programs in agriculture, HIV, health and nutrition, and water and sanitation, funded by a range of donors. However, many food assistance agencies will not have programs in all areas important for integrated programming. In this case, it is especially important to emphasize strong coordination, partnerships, the development of referral systems and collaborative planning. In all cases, it is imperative that government ministries/departments, communities and other local service providers play a key, and often lead, role in coordinating and integrating food security and HIV programs.

It is important to recognize that integration is a process that entails careful consideration of the core objectives of both food security and HIV programming. The objectives of integrated programs should be a natural extension of the situation analysis and vulnerability and needs assessment, and should incorporate relevant stakeholders' input on prioritization of food security and HIV activities.

Key Concept

4.3 HIV Program Design Considerations

In contrast to the programs described in Key Concept 4.2, Key Concept 4.3 addresses programs with the core objective of improving HIV prevention, treatment, and care and support outcomes. These HIV programs incorporate food and food-related activities to support those outcomes. Program managers should answer these key questions to determine whether adding food and food-related resources would help achieve the program's HIV objectives:

1. Is lack of food interfering with optimal treatment by inhibiting or preventing people from starting or adhering to treatment regimes? Would food improve use of services?
2. Is lack of food reducing the effectiveness of care and support by inhibiting people's regular access to care and support services or by worsening functioning and quality of life? Is poor nutritional status aggravating symptoms or making it harder to manage symptoms? Is food likely to address the underlying nutritional issues? Would food increase use of care and support services?
3. Are there real or opportunity costs of program participation that a food transfer would help offset?

While lack of food can be an obstacle to achieving HIV objectives, incorporating food and food-related activities is likely to be a temporary solution. The longer-term food and

Table 2: Uses of Food to Support HIV Program Objectives

Intervention	Prevention	Treatment	Care and Support
Supplementary Feeding	Food for food-insecure vulnerable groups to prevent/reduce high-risk behaviors or reliance on negative coping strategies Food for replacement feeding or weaning food where mother is HIV-positive	Food for high-risk groups only (e.g. pregnant/lactating women who are HIV-positive, HIV-exposed, non-breastfed children) Food for replacement feeding or weaning food where mother is HIV-positive Food to support nutritional management of symptoms of opportunistic infections (OI), often using chronic illness as a proxy Food for persons who are losing weight and/or do not respond to medication Food to improve ART and TB treatment efficacy and help manage drug side effects Food to prevent nutritional deterioration for HIV-affected families who live in food-insecure communities and meet other vulnerability criteria	Food for use in home-, clinic-, hospital-, hospice-, and community-based care programs as a part of palliative care Food for high-risk groups (e.g., pregnant/lactating women who are HIV-positive , HIV-exposed non-breastfed children < 2 years or HIV-exposed children with growth faltering) Food to protect the nutritional status of OVC and surviving family members when livelihoods are compromised because of HIV-related sickness or death Food for households affected by HIV that also exhibit other vulnerabilities such as food insecurity and asset depletion
Therapeutic Feeding		Therapeutic feeding of moderately and severely malnourished HIV-positive children and adults Nutrition management of HIV-related OI, symptoms, and ART (where applicable)	Therapeutic feeding for moderately and severely malnourished HIV-positive adults and children Therapeutic feeding to treat moderate/severe malnutrition for children orphaned by AIDS and other high-risk groups (for HIV-exposed non-breastfed children < 2 years or children with growth faltering) Nutrition management of HIV-related OI, symptoms and ART (where applicable) in home-, clinic- and community-based palliative care
Food as an Incentive	Food as an incentive for participation in PMTCT Food as incentive to participate in HIV awareness, prevention, nutrition education and behavior change communication (BCC) programs FFT to support diverse, more resilient livelihood strategies that reduce the need to resort to risky livelihood strategies	Food as an incentive for participation in PMTCT Food as incentive for use of and adherence to OI treatment programs Food as incentive to improve adherence to ART Food as incentive to improve use of and adherence to TB directly observed treatment, short-course (TB-DOTS) Food as an incentive to participate in positive living training	Food for education (FFE) FFA to promote livelihoods FFT of OVC Food to support food-insecure households caring for orphans Food as incentive to improve adherence to ART

livelihood security needs of food-insecure beneficiaries of HIV prevention, treatment, and care and support programs should be addressed by linking to and integrating with food security programs (see Table 2 for uses of food to support HIV program objectives).

Three examples of this type of integration are:

- Integrating growth monitoring and promotion (GMP) activities into PMTCT services for HIV-positive mothers and their infants or establishing referral systems between PMTCT services and GMP activities
- Linking agricultural extension services and training for farmers with provision of agricultural skills in OVC support services and arranging for farmers in the extension program to mentor OVC
- Establishing linkages and referral systems between care and support services for PLHIV and OVC and activities that improve long-term food access, such as vocational training, microenterprise and other income-generation activities

When HIV programs are implemented in areas of high food insecurity prevalence, identifying food security programs to partner with and/or to refer food-insecure HIV program beneficiaries to may be relatively straightforward. HIV programs in areas where average food insecurity prevalence is lower will face greater challenges in finding both sources of food to incorporate directly into HIV programs as well as food security programs to which to link their program beneficiaries. These and other primary challenges and key considerations in developing integrated programming are discussed later in this chapter.

4.4 Key Concept
Accounting for the Changing Needs of HIV-Affected Individuals and Households

The needs of PLHIV and HIV-affected households change with time and disease progression. The challenge in designing appropriate interventions in the dynamic context of HIV lies in:

- Identifying the most **appropriate intervention**, whether it be nutrition, livelihoods or other
- Targeting the **right individuals**, **households or communities**
- Providing it at the **right time** and for the **right duration**

Visualizing beneficiary needs and program activities across a "continuum of care" can assist in planning appropriate interventions in an integrative, holistic and comprehensive manner. The ultimate goal is to provide a seamless continuum of care for individuals, families and communities throughout their entire experience of HIV. Potential interventions for addressing individual and household needs along this continuum are presented in Figure 2.[3]

To effect lasting change, people infected with HIV but not yet symptomatic need more than information about good food choices. For example, many need assistance in developing their production or purchasing power. At this point, households that are still food-secure do not need food assistance. And, chronically food-insecure households do not need food

in isolation from other forms of assistance. Rather, both would most clearly benefit from a long-term food and livelihood security strategy that provides resilience against the dynamic nature of both macroeconomic conditions and climate.

There is a tendency to think of food assistance as a palliative/end-stage measure, but it is equally important to identify the opportunities where food assistance can help prevent HIV transmission. Support to PMTCT programs, for instance, can improve maternal/infant delivery outcomes and encourage safer breastfeeding for HIV-positive mothers. Encouraging exclusive breastfeeding followed by rapid weaning is crucial to reducing HIV transmission, and can be further supported by providing suitable weaning food for the baby for 12 months after breastfeeding ends. Keeping the baby satiated reduces the temptation to intermittently breastfeed. Keeping mothers well-nourished also delays the onset of illness and ultimately, orphanhood. FFT and FFA can be used to support diverse, more resilient livelihood strategies that reduce the need to resort to strategies that may increase the risk of spreading or being infected by HIV.

Figure 2. Continuum of Care for PLHIV and Affected Households

HIV-free	HIV+/Asymptomatic	Chronically Ill	Time of Death	Survivors
PREVENTION				
	POSITIVE LIVING ⇢			
	⇠	**TREATMENT SUPPORT**	⇢	
		IMPACT MITIGATION	⇢	
Skills development/FFT for diverse and resilient livelihoods Provision of infant weaning foods FFA activities	Nutrition education Income-generation activities Training and inputs for gardening FFA	Nutrition education Access to health services Targeted food assistance Safety nets	Legal assistance Safety nets	Skills development/FFT for diverse and resilient livelihoods Income generation activities FFA Targeted food assistance

Adapted from Greenaway, K., and Mullins, D. "The HIV/AIDS Timeline Tool: Experiences from CARE and C-Safe (Draft)," paper presented at the IFPRI Conference on HIV/AIDS and Food and Nutrition Security, Durban, South Africa, April 14-16, 2005.

The best HIV programming is holistic and multisectoral. In food-insecure and resource-poor environments, social safety nets for high-dependency-ratio households (e.g., those with several orphans and/or few productive adults) should include short-term food assistance and must be linked with longer-term agriculture and income-generation strategies at both the household and community levels. Assisting health sector efforts by combining the provision of short-term food assistance with clinical tuberculosis (TB) treatment generates a synergistic effect that far outperforms a single intervention.

Similarly, ART is also likely to be more effective when it is part of a holistic package. For food-insecure and malnourished clients, a suitable food ration should be provided during the first few months of ART to ease early side effects and increase compliance. In keeping with the continuum of care, a transition to an independent food security/good nutrition

strategy should be encouraged among PLHIV if and when health and strength return. As with all programming in an HIV context, appropriate HIV information and sensitization should be integrated into each intervention.

By visualizing changing needs over time, holistically planned, food-based interventions can be integrated with other kinds of interventions to help prevent HIV transmission, reduce morbidity, delay orphanhood, and prolong health and productivity. When HIV has progressed to the point where health is not likely to return, food can also be used to ease suffering.

Using the Continuum of Care in Comprehensive and Holistic Programming

In a Specific Location

The continuum of care provides a framework for mapping out and reviewing programs and services implemented by all agencies, organizations, groups or departments working in a single community or district. This can enable them to better coordinate interventions with regard to:

- Interaction/referral between complementary programs
- Reach and coverage of various interventions within a community or district
- Opportunities for partnership, collaboration and learning
- Gaps in services and responses that require strengthening

By an Entire Agency or Government Ministry

The continuum of care can be used to help:

- Develop a strategy based on assessment of strengths, weaknesses, opportunities and threats
- Identify national or geographical gaps or niches
- Plan or enhance programs' complementarity
- Support fundraising and advocacy
- Identify options for the most strategic interventions
- Answer these questions:

  How can food help fill those gaps and/or strengthen existing responses?

  What programs can the food program serve or support?

  What programs can help target the food to the most vulnerable?

  What partners can the food agency link with to ensure complementarity and provision of non-food resources such as agricultural inputs, training, IEC and BCC in HIV prevention, etc.?

4.5 Key Concept
Challenges and Considerations in Developing Integrated Programs

Primary Challenges to Successful Integration

Implementing agencies will already be quite familiar with the challenges inherent in food and livelihood security programming in Africa. Poverty, disease, hunger, malnutrition and gender inequities are only some of the longstanding constraints faced every day. However,

the design, implementation, monitoring and evaluation of integrated food security and HIV programming present a new list of challenges, including:[4]

Lack of coordination and collaboration. Governments, donors and NGOs lack the mechanisms and intent for coordination and collaboration across sectors such as agriculture, health, emergency, education and social protection. Similarly, there is limited opportunity or demand for interaction or cross-fertilization within NGO, government or donor organizational structures.

Inadequate understanding. Knowledge of how to design programming strategies to address the known intersections between HIV and food security is often insufficient. Programmers are too busy "doing" their work to analyze and document their work. Networking and learning specifically about programming are generally underresourced.

Compartmentalized funding mechanisms. Where HIV and food security programming are not inherently complementary, funding mechanisms tend to be compartmentalized. It may be necessary to raise resources from multiple sources to fund integrated programming in areas such as Area B in Figure 1 where FFP and PEPFAR resources may not be simultaneously available.

Difficulty attributing results. As programs become better integrated, attributing results to any single intervention or investment grows more difficult.

Different objectives, different targets. HIV and food security programs have different objectives, which may complement and reinforce each other in some contexts but not others. This makes smooth integration of program interventions difficult. HIV and food security programs also have different target populations, which can overlap some but not completely. This can pose challenges for ensuring appropriate targeting and coverage in integrated programs.

Short-term horizons. The short-term nature of interventions leads to limited support for consultation or local empowerment, a prerequisite for creating or sustaining integrated programming.

Integrative programming should build on the comparative advantage of a program's core business, whether it is advancing food security goals and objectives, prolonging the period of healthy life for PLHIV or minimizing the impacts of AIDS-related illness and death.

Urgent nature of work. The intensity and urgency of HIV or food security programs often preempts even the best intentions for integration. This may be the most important and difficult challenge.

Key Considerations for Designing Integrated Programs

Some key considerations that are applicable across sectors and are necessary to address the primary challenges include:[5]

Developing assessment-based strategies. To design an appropriate strategy, programmers should begin with an assessment, establish priorities based on the assessment and set objectives stemming from those priorities. In addition to the traditional components of a food security assessment, these assessments should examine the prevalence and incidence of HIV within a community, the underlying causes, the effects on household food security and livelihood strategies and vice versa, and the ability of households and the communities to cope with the evolving impacts. These factors will help determine what type of integration strategy should be pursued.

Understanding current and planned efforts. It is important to have a solid understanding of current and planned food security and HIV prevention, treatment, and care and support efforts in a particular country, both nationally and locally. Connecting with key players, including UN agencies, donors, researchers, NGOs, CBOs, FBOs and relevant government bodies, will help develop this knowledge and build a network that may be useful later.

Identifying complementarities and entry points. Identifying where interventions may complement each other and where one set of services may provide a good entry point for another set of services is critical to designing integrated programs. Some HIV and food security interventions are well-suited for integration, while others are not. Similarly, some types of services are natural entry points or platforms for other services (e.g., PMTCT services as an entry point for nutrition counseling and GMP).

Ensuring that food is the appropriate input. Before any integrated program strategy is implemented, assessment results should be carefully examined to determine whether food is a needed and appropriate input in the local context. Food-based programming may be unnecessary—or even harmful—where food security is already established. Excess food distribution can undermine local production, disrupt food markets and/or impair coping strategies. Generally, food is an appropriate input only if assessments show that food is needed and valued by recipients and that food will have the intended effect (e.g., improve the nutritional status of HIV-affected individuals, increase use of PMTCT services or increase adherence to TB drug regimens).

The decision to implement integrated program strategies should be based on an epidemiological analysis of HIV (e.g., HIV prevalence, incidence, stage of the epidemic), malnutrition and food insecurity within the affected population (both displaced and resident communities) as well as other factors related to the population's vulnerability. [6]

Involving communities and government at every stage. The process of identifying and designing strategies and interventions should involve the affected households, communities and government representatives at every stage. Increasingly, programmers are developing food security and HIV activities jointly with communities and relevant government agencies. A participatory process establishes a relationship between programmers and these partners and facilitates a sense of empowerment that builds confidence, initiative and self-reliance. An inclusive and participatory approach is particularly important when food is used to complement and support existing services.

Making women a priority. Because of women's increased vulnerability and susceptibility to HIV infection and the negative effects of stigma and discrimination, all food security strategies should aim to increase the resistance and resilience of women to HIV. Other vulnerable groups, such as the elderly and children, should also be prioritized.

Situating the community in the progression from HIV to AIDS. To design appropriate strategies and interventions, it is important to recognize where the community lies within the progression of the HIV epidemic. A community with a low incidence of HIV infection but a high concentration of risk factors might require a strategy that emphasizes prevention, such as introduction of HIV-related messages into the agricultural extension program, promotion of alternative risk-reducing livelihood strategies or community-based contingency planning. A community with a high incidence of infection, morbidity and mortality might best benefit from the formation of community work groups or new skills training for HIV-affected households.

Building integration into staff work plans. Integration takes planning and intentional allocation of staff time to build skills and knowledge around HIV and food-based programming. Food security staff may need to expand their knowledge and skills on issues related to HIV, while HIV specialists may have to learn more about food programming.

Preventing stigma, abuse and harm. Risks such as creating stigma, increasing potential for abuse, encouraging dependency and providing inappropriate or unsafe rations or work conditions should be assessed, prevented and/or mitigated. There should be no discrimination against workers based on real or perceived HIV status. Discrimination is not merely unjustified; it contributes to stigma and persecution of PLHIV. Management must establish a climate of trust, understanding and freedom from fear of discrimination. Workplace policies and HIV-related information and education programs for staff are essential to promoting this climate (see **Chapter 9: Operational Modalities**).

Using participatory communication strategies. Effective community-level interventions should incorporate participatory communication strategies, community engagement and action supported by appropriate services and policies. Communications strategies should not focus on the transmission of messages, but rather the linkage of local dialogue to action, supported by accurate information services (e.g., VCT, PMTCT, ART, HBC) and policies.[7]

Building long-term food and livelihood security. Integrated food security and HIV-related programs should emphasize the use of food toward long-term food and livelihood security of affected households with seeds, tools, microcredit and income-generating activities rather than continuous direct distribution of food.[8]

Commitment to Program Integration at All Levels

At the *Africa Forum 2006* in Lusaka—designed in part to help change the way HIV and food security programs are conceived, managed and funded—delegates pledged to strengthen collective efforts to develop integrated programming and to inform policy decisions that inhibit effective integration. A number of concepts were agreed upon at this event.[9]

Institutionalizing collaboration and coordination at all levels to:

- Provide leadership and develop accountability mechanisms for harmonizing funding and systems that support integrated programming
- Ensure that projects in the same location use consistent, stratified approaches to targeting with well-articulated transition, graduation, re-entry and exit strategies
- Coordinate M&E systems that help capture project-level outputs and synergistic effects
- Devise tools that allow for integrated work planning across several related projects

Enhancing networks and referral mechanisms as close to the ground as possible to:

- Support or form interagency and multidisciplinary working groups
- Engage the most appropriate community structures as the driver of community-based referrals
- Capitalize on geographical overlap

One forum delegate likened the process of integration to applying mortar and plaster to a cinder-block house. Individual bricks (projects) can be well designed and even expensive, but may have gaps between them that allow beneficiaries to "fall between the cracks." Mortar and plaster will fill the cracks and help the bricks fit tightly together.[10]

Annex 1: CRS HIV/AIDS Analysis Tool: Checklist for Adapting Food for Assets Programming to an HIV/AIDS Context

Adapting Food for Assets Programming to an HIV/AIDS Context	
Programming Steps	**Key Questions to Ask**
Project Identification and Planning	1. What are the impacts of HIV/AIDS in the communities in which you are planning to work? 2. What resources are available that could help you integrate HIV/AIDS into your geographical targeting? 3. How are you involving community-level and district-level organizations who have experience, knowledge, or resources with HIV/AIDS issues? 4. How are you intentionally involving PLHA and households affected by HIV/AIDS in the identification and planning of the project? 5. Are there any assets included in your project that specifically aim to mitigate the impact of HIV/AIDS? What types of assets could you include that would do this? 6. What effect will the project have on traditional and existing coping mechanisms and strategies in the context of HIV/AIDS?
Building Staff and Community Capacity	7. What can be done to enhance the capacity of implementing agency to engage with the community regarding the inclusion of PLHA and affected households as planners, participants, and managers in FFA projects? 8. What can be done to enhance the capacity of the community and its leadership to support the inclusion of PLHA and affected households as planners, participants, and managers in FFA projects?
Beneficiary Identification	9. Will PLHA and affected households derive benefits from the assets being created? How could you modify the project to ensure that benefits are shared with the PLHA and affected households?
Identification of FFA Participants	10. Which targeting mechanisms have you included that seek to intentionally include PLHA as participants in the project? 11. Which organizations, institutions, and referral mechanisms could be approached for assistance in targeting able-bodied HIV+ participants? 12. Are there households that qualify yet cannot participate in the project? What are the precise reasons for their inability to participate? 13. How can the project be modified to accommodate those who are unable to participate for reasons identified above? 14. How can your work norms be adapted to enhance participation of PLHA and affected households? Are there aspects of the work that are less labor intensive and can be reserved for participants requiring lighter duties?
Implementation	15. Are there ways you could organize forms of compensation (food and in-kind) that do not rely on traditional person/hours worked, so as not to discriminate against PLHA or affected households? 16. How could you adapt the food ration to be more useful and appropriate for the needs of participant individuals and households?
Sustainability	17. How can you explicitly include PLHA and affected households in maintenance of the asset? 18. How have you adapted your maintenance plan to enhance sustainability in the context of HIV/AIDS?
Monitoring and Evaluation	19. How can existing FFA monitoring and evaluation tools be adapted to capture information measuring the community's response to HIV/AIDS-related shocks? 20. Does any aspect of the project have the potential to influence stigma?
Project Outcomes	21. Does the asset itself have the potential to increase the spread of HIV (or increase risk-taking behavior)? What ways can this be mitigated? 22. Does the process of creating the asset have the potential to increase the spread of HIV (or increase risk-taking behavior)? What ways can this be mitigated? 23. Will any stages of the project put people's health at greater risk, thereby hastening the progressing from HIV to AIDS? Will it have the potential to help slow progression of HIV to AIDS?

Source: Catholic Relief Services. ***Promising Practices: HIV & AIDS Integrated Programming***. Baltimore: CRS, 2006.

Endnotes

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6 United Nations High Commissioner for Refugees (UNHCR) and World Food Programme (WFP). ***Integration of HIV/AIDS Activities with Food and Nutrition Support in Refugee Settings: Specific Programme Strategies***. Geneva: UNHCR, 2004.

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Chapter 5: Targeting

Program Design Steps

Chapter 5: Targeting

Program Design Steps

Key Concepts

5.1 Targeting Food Assistance in Areas of High HIV Prevalence

5.2 Adapting Food Assistance Targeting Approaches and Tools

5.3 Promising Practices

In This Chapter

This chapter provides guidance on the critical issue of targeting food assistance in the context of HIV. It is intended to complement information in **Chapter 1: Conceptual Framework** and **Chapter 3: Vulnerability Assessments** by helping food assistance agencies identify the most vulnerable areas, communities, households and individuals while minimizing exclusion or inclusion error.

The chapter begins by reviewing several factors that will influence selection of food assistance beneficiaries in food security and HIV programs. For instance, in the context of HIV, the decision whether food assistance is best targeted toward entire communities, vulnerable households within the community or especially needy individuals will be influenced not only by the availability of resources and the capacity of participating institutions, but also on community perceptions of vulnerability within a given context and the level of stigma associated with HIV.

The chapter then discusses approaches to targeting and specific tools, as well as how they can best be adapted in the context of HIV. For example, given the dynamic relationship between HIV and food security, it is often essential to use multiple vulnerability indicators to identify those that stand to benefit most from integrated programming. In addition, in the context of HIV, many food assistance programs have found that using proxy indicators of vulnerability, involving HBC networks and working to reduce stigma are vital to targeting food assistance.

Finally, this chapter discusses the establishment of common vulnerability frameworks, the standardization of beneficiary selection criteria, processes of field-level verification and program referral mechanisms, each of which are promising practices in targeting food assistance in the context of HIV.

5.1 Key Concept
Targeting Food Assistance in Areas of High HIV Prevalence

The objectives and the scarcity of food resources dictate that targeting criteria for food assistance should include food insecurity or social welfare indicators to ensure that the most vulnerable individuals are reached. To reduce inclusion and exclusion errors, tools need to be introduced to objectively distinguish between households and individuals eligible for food assistance and households and individuals for whom food assistance may not be the most appropriate form of support.[A]

Food assistance must be carefully targeted to the most food-insecure to be the most beneficial and avoid disrupting local markets and creating disincentives to local food production.[1] The process of targeting food assistance in areas of high HIV prevalence is different for programs with food security objectives and those with HIV objectives. However, in both cases, food insecurity and vulnerability must form the basis for targeting food assistance. Targeting can take place at multiple levels: region, community, household and individual. Not all levels are necessary for all programs.

Programs With Food Security Objectives

To ensure cost-effectiveness and efficiency, food security programs must first target **geographic areas with the highest food insecurity**. Food-insecure areas should be selected based on an initial vulnerability assessment that includes data on food production, poverty, malnutrition and risk, including HIV prevalence rates (see **Chapter 3: Vulnerability Assessments**).

Because resources are rarely available to cover an entire population in a given area, food security programs usually will target specific districts within regions and communities within the districts. Finally, even in very food-insecure communities, there is often a need to target specific households within the communities for the program's food transfer component. Experience has shown that multiple indicators (multi-criteria targeting)—a combination of clinical, social, economic and demographic indicators—should be used to identify food insecure population groups or households within the targeted communities.

Targeting decisions should be integrated within a broader food security strategy that takes into account food insecurity and the underlying causes of poverty, as opposed to only HIV. Where food insecurity is broad-based, targeting choices can be controversial within a community. For example, targeting food assistance solely to food-insecure PLHIV for nutritional support is likely to create stigma and resentment when the entire community is food insecure.[2] Experience shows that, in a food security program, best practice is not to target only the HIV-affected because food insecurity is more generalized.

Even in areas highly affected by HIV, the main objective of food assistance interventions is to reduce general food insecurity. Accordingly, targeting in such areas should be based primarily on food security indicators, and if necessary, refined through the use of appropriate HIV-specific indicators. In most countries in southern Africa, initial targeting is done at the national level through vulnerability assessment committees.

A Inclusion and exclusion errors involve incorrect targeting of beneficiaries. In food assistance programs, inclusion errors are instances in which food-secure individuals or households are chosen to receive assistance. Alternatively, exclusion error occurs when needy, food-insecure individuals or households are ***not*** targeted for food assistance.

Geographic Targeting

When establishing new food security programs, agencies will target geographic areas based on food insecurity vulnerability assessments (see **Chapter 3: Vulnerability Assessments**). In many cases, agencies will have already established operational areas based on an analysis of need and their comparative advantage. In this case, targeting can be done within the context of existing programs where the characteristics of communities are already known.

In some countries, HIV prevalence is higher in some areas than others. The different HIV prevalence levels allow for clear geographic prioritization and targeting for HIV programming. However, areas with high HIV prevalence do not necessarily have high food insecurity prevalence. A combination of food insecurity data and HIV prevalence will locate areas with high or dual vulnerability as well as forecast future vulnerability.[3]

Community Targeting

While geographic targeting identifies areas with the greatest need, existing resources are unlikely to cover these regions entirely. It is necessary to target districts and communities with the greatest food security need in each area. Food assistance agencies can further refine their geographic target areas by compiling profiles to identify the most vulnerable food-insecure districts and communities, with criteria similar to those used in geographic targeting. Ideally such data will be overlain by community-level indicators related to food security and health outcomes to identify communities.[4]

Depending on the capacity of local and national government and participating NGOs, community-level data may be difficult to find or may not exist. In such cases, it is useful to conduct small-scale primary data collection exercises to produce current data for comparing communities within a priority region.

Household Targeting

In high-prevalence areas, HIV typically affects entire communities either directly or indirectly through increased dependency on households without infected members. However, vulnerability to HIV's impact is likely to be greater for poor food-insecure households, which are less able to absorb the loss of productive labor, increased costs related to illness and death, and higher dependency ratios. In addition, these households may be excluded from scarce or costly public assistance or services.[5]

For food security programs in high HIV contexts, the key challenge for targeting vulnerable households is to ensure that targeting criteria capture HIV-related vulnerabilities in addition to other food insecurity risks and vulnerabilities. Using multiple criteria for targeting is especially helpful considering the dynamic interaction between food security and HIV. For instance, multiple criteria using a range of social and economic factors may help identify needy households that do not have infected members but may care for OVC, support relatives who are ill or provide support to directly affected households through traditional community safety nets.[6]

Household targeting can be improved through community-based targeting (CBT), which draws on local knowledge about households.[7] By engaging community members in the targeting process, agencies may be able to increase awareness and understanding of HIV and promote a greater sense of ownership of the intervention. Although specific approaches will differ according to the local context, CBT involves:

- Community sensitization about the program, including identification of program objectives and methods of implementation

- Selection of committee members by the community, community groups, PLHIV associations and/or nearby clinics or ART sites
- Development of community-defined selection criteria with the support of an NGO or facilitating organization
- Beneficiary selection by the community at an open meeting using community-defined selection criteria, taking care to maintain confidentiality and avoid the stigmatization associated with HIV
- Verification of the list of selected beneficiaries by the NGO
- Communication of the list to the community at an open meeting
- Continual community involvement in regular updates of beneficiary lists

Household targeting can also be done by partnering with medical facilities offering ART or CBOs assisting PLHIV. Once particularly vulnerable areas or communities are identified, participatory techniques are often used to apply a combination of criteria to identify eligible

WFP Malawi's Approach to Community-Based Targeting[8]

In 2005, WFP Malawi, in conjunction with the Joint Emergency Food Aid Programme, developed HIV Targeting Guidelines promoting the use of CBT.

The guidelines state that after district executive committees, traditional authorities (including village headmen) and community groups are sensitized to the issues, community organizations—including VACs, HBC groups, orphan care centers, village relief committees, village development committees or other CBOs—should select food assistance beneficiaries, with WFP Cooperating Partners facilitating the targeting process. Beneficiary households should be enrolled in a transparent manner through village gatherings and told why they were selected. Cooperating Partners should work with the community organizations to continually verify beneficiary lists through regular community gatherings and random interviews of beneficiary and non-beneficiary households.

The guidelines provide several criteria to be used in combination with community-identified criteria to select areas of operation and beneficiary households, such as:

Geographic Targeting (district and community levels)

- High food insecurity as determined by the 2005 Malawi Vulnerability Committee Report
- High HIV prevalence based on the 2003 HIV/AIDS Surveillance Report by the NAC
- High population density

Household Targeting
(households must meet at least three criteria)

- Own less than two acres of land and be unable to hire it for food or cash
- Own no major common livestock (e.g., cattle, goats, sheep, pigs)
- Receive no formal wages
- Do not participate in a regular income-generating activities.
- Rely on piecework (ganyu) to meet daily food needs
- Have less than three months of food stock starting from harvest time

HIV-affected households targeted to receive food assistance must also meet these social criteria:

- Household must be caring for chronically ill member(s)
- Household must be caring for OVC

These households are prioritized in this order:

- Child-headed household with more than two orphans who have lost both parents
- Elderly-headed households with more than two orphans who have lost both parents
- Female-headed households with more than two orphans who have lost one parent
- Any other households with more than two orphans who have lost both parents

individuals or households. When using CBT, agencies should be careful to "do no harm" by avoiding stigma caused by public identification of HIV-positive beneficiaries.

Community-defined targeting criteria also should help identify characteristics of all food-insecure and vulnerable households, not just those affected by HIV. This is to avoid stigma and for several additional reasons:

- In food-insecure areas, targeting HIV-affected households alone would mean excluding other food-insecure households.
- HIV-affected households are not necessarily food-insecure.
- It is impossible to know for certain who is HIV-positive because testing facilities and reliable surveillance systems are lacking in most poor countries and, even if VCT services exist, many people are afraid to learn their HIV status.

Programs With HIV Objectives

Most HIV programs are implemented in areas and communities with high HIV prevalence. In many cases, areas with high HIV prevalence do not have populations who are the most food-insecure; the former tend to be in urban areas, while the latter are found more in rural areas. WFP and FFP prioritize food assistance to HIV interventions by focusing first on the most food-insecure areas that also have high HIV prevalence. WFP places second priority on areas that are generally food-secure but have high prevalence rates, with the expectation that they will become increasingly food-insecure due to the disease.[9]

Beyond prevalence rates, other factors that can help determine a community's needs include:

- Number of PLHIV
- Burden on services
- Community coping and care capacity

Individual Targeting

Food assistance programs may be explicitly designed to benefit PLHIV by supporting HIV or other medical treatment. This is usually done by targeting food-insecure individuals receiving TB and/or ARV treatment or participating in PMTCT or HBC programs.

The major targeting challenge food-assisted HIV programs face is identifying which PLHIV and HIV-affected households are food-insecure. In areas of high HIV prevalence but relatively lower food insecurity, where food resources to provide to food-insecure PLHIV and affected households are more limited, the targeting challenge is more sensitive and critical.

Clinical, social, demographic and/or economic criteria can identify food-insecure households and individuals affected by HIV. These indicators include direct measures of HIV infection and other clinical indicators, and food security indicators, including measures of household capital, nutritional status and income.

Clinical criteria assess HIV and nutritional status of the people receiving services. Where food assistance is provided through local clinics and community home-based care (CHBC) programs, food assistance targeting can be based on clinical criteria such as wasting or weight loss. However, this information is often not available where there are no testing facilities or stigma is severe.

Socioeconomic criteria assess whether a household has sufficient income to meet the additional food and non-food needs brought on by chronic illness. Socioeconomic indicators include assets, employment and income, food consumption patterns, diet quantity and quality, level of food production and levels of family assistance.

Sociodemographic criteria include household size, gender and age of household members, gender and age of household head, presence of OVC in the household, effective dependency ratio and recent death of an adult (age 18 to 59) in the household.

Using Multi-Criteria Targeting in an HIV Context in Zambia[10]

Using multiple clinical, social, demographic and economic criteria can help identify regions, communities, households and individuals most affected by the combined impact of HIV and food insecurity. These indicators include direct measures of HIV prevalence and other health data, as well as food security indicators such as measures of household capital and income. Below are examples of how some organizations use these criteria in Zambia (actual targeting tools used by WFP, C-SAFE and Project Concern International (PCI) in Zambia appear in Annexes 1-3). While each approach is useful, the differences between them highlight the importance of harmonizing targeting criteria, coordinating strategies and logistic systems, and enhancing referral and M&E systems to ensure transparency and accountability at the national level.

1) WFP targets vulnerable households identified by socioeconomic and demographic indicators. Specifically, WFP has been targeting nutritionally vulnerable women and children; PLHIV in PMTCT, TB and ART interventions; OVC; chronically ill households (used as proxy indicators for HIV); households that host OVC, are elderly-headed or care for chronically ill people; and school-age children in food-insecure areas.

WFP uses two tools for targeting in the context of HIV: a Food Security Screening Tool to assess potential beneficiaries and a set of food insecurity targeting criteria to select beneficiaries for individual and household ration distribution. The tools appear in Annex 1 of this chapter.

2) C-SAFE also used multiple criteria to identify households eligible for food assistance in Zambia. Targeted groups included extremely food-insecure households, ART patients, TB patients, HIV-positive pregnant and lactating women, HBC recipients or chronically ill family members, and OVC (which include child-headed households). Households had to meet at least three of these criteria to be eligible:

- Inadequate food production/income to meet household food requirements
- No liquid assets
- Presence of OVC
- Presence of chronic illness
- Headed by elderly or female or children
- Presence of nutritionally vulnerable women and children

C-SAFE found that tools such as questionnaires, when used alone for screening, did not help to accurately target food-insecure households over the life of the project. So C-SAFE conducted a comprehensive questionnaire-based household-level re-verification process every eight months. While it was more costly, the process became an integral part of graduating households from targeted food assistance, allowing households that regained viability to move into more sustainable livelihood activities. C-SAFE's Zambia Targeting Tools appear in Annex 2 of this chapter.

3) The Archdiocese of Lusaka, another WFP partner in Zambia, uses a socioeconomic assessment tool to select beneficiaries for food assistance and inclusion in its HBC program. Archdiocese staff noted that inclusion error can be reduced by visiting the individual household to get information to complement the medical screening done using a questionnaire.

4) PCI, in an urban program that provides wet feeding for OVC, uses a tool to identify beneficiaries for the take-home ration (THR). The tool includes the dependency ratio (targeting of larger families) and prioritizes female-, widow- and elderly-headed households affected by HIV. PCI also provides WFP food assistance through an urban clinic-based program that targets ART patients (identified in collaboration with district health centers) using multiple criteria including food consumption, coping mechanisms, income and food production levels, nutritional status and existence of other support systems. PCI's Zambia Targeting Form, Monitoring Form and Food Security Reassessment Form appear in Annex 3 of this chapter.

5.2 Key Concept
Adapting Food Assistance Targeting Approaches and Tools

While food assistance agencies have developed a range of tools for identifying households and individuals most vulnerable to food insecurity, these tools must be adapted in the context of HIV to account for the specific targeting challenges presented by the disease.

Adapt Targeting Criteria to the Purpose and Objective of Food Assistance

The targeting process depends on the type of program and the objectives of the food assistance. The selection of criteria to target food assistance in HIV contexts relies on several factors, including the purpose of the intervention and the stage of the epidemic in targeted individuals or households. For example, targeting criteria will differ when the focus is on prevention and vulnerability reduction compared with later efforts to mitigate the epidemic's impact on affected households.[11]

If the food assistance intervention's main objective is to reduce general food insecurity in areas highly affected by HIV, then targeting criteria should be based on food security indicators as opposed to more direct HIV indicators. It should be expected that households affected by HIV will also likely exhibit increased food insecurity and therefore qualify for food assistance. Using food security indicators to target HIV-affected communities and households is also likely to attach less stigma to beneficiaries than targeting approaches that directly identify HIV-affected households.[12]

An effective referral system among food aid agencies, health centers, community health workers, CBOs, and HBC groups helps to identify highly vulnerable PLHIV and ensure they are enrolled in a food-assisted treatment program.

Use Home-Based and Other Care and Support Community Groups

Household and invidividual targeting can be done in partnership with community health centers, HBC and support networks, PLHIV networks and facility-based care systems. Targeting through home-based and other care and support community programs usually follows two steps:

- First, clinics refer patients who test HIV-positive to an HBC program, or an HBC provider may encourage someone who is chronically ill to go to a clinic for VCT. Once a person tests positive, they voluntarily enroll in a HBC program. HIV-positive status is confirmed either by a clinic partner or test results presented by the patient.
- Second, the patient is assessed using socioeconomic and demographic criteria to determine eligibility for food assistance.

Tapping Community Home-Based Care in Kenya[13]

CARE expanded its livelihood security programming in the Rochounyo and Homa Bay districts of Kenya to support safety nets and strengthen community institutions caring for and supporting PLHIV, OVC and other vulnerable groups. In response to the increasing numbers of OVC, CARE identified community care and support groups to address needs of OVC and create effective referral mechanisms between OVC, CHBC organizations, and health and other social services providers. One CHBC partnering with CARE is the St. Raphael's Lombeni CHBC Program, which provides extended family support to OVC after parents die and cluster foster care services, in which a surrogate guardian cares for several OVC with community support. In the selection of CHBC beneficiaries:

- An initial village meeting is held with community leaders, ward councilors and village chiefs to endorse the targeting approach and the beneficiary selection criteria.
- Local leaders and community care and support groups conduct a needs assessment.
- Households are identified and targeted for food assistance. OVC age six to 18 are registered for apprentice training, and OVC up to age five are registered for supplementary feeding.
- CARE program facilitators work with community resource persons to confirm the beneficiary list and set an appropriate food ration size.
- An agreement on the food and distribution system is reached with CHBC.
- Beneficiaries are informed of ration entitlement, total amount of food to be delivered, arrangements for delivery and storage, and dates and time for food distribution or feeding.

Use of Proxy Indicators

In many areas, people do not know their HIV status. There may be limited clinical facilities to test for HIV or treat AIDS patients or a high degree of stigma that poses barriers to VCT. People may also simply choose not to know their status. In these environments, proxy indicators are used to target communities and households eligible for food assistance. However, this runs the risk of including households that are not food-insecure and excluding others who may qualify. To appropriately select and use proxy indicators for targeted interventions, program staff must have a clear understanding of critical distinctions between targeting food insecurity, targeting individuals and households affected by HIV, and using multiple criteria to identify the most vulnerable households and individuals.

One best practice for targeting is the development of standardized targeting procedures that:

- Use multiple criteria to assess socioeconomic and health status
- Incorporate a hierarchy of need that prioritizes the use of limited resources
- Are used by all government and non-government agencies in a location

Chronic illness is perhaps the most common proxy indicator used for identifying PLHIV.[14] As noted in **Chapter 3: Vulnerability Assessments**, chronic illness is generally defined as a condition, disease or disability that has prevented an individual from being fully functional for at least three months within the previous year.[15] However, chronic illness alone may not be a reliable indicator of HIV in communities that have a high rate of illness even without the disease. For example, many types of chronic illness, including cancer and asthma, are not associated with HIV.

Other proxy indicators measure changes and effects on household resources (assets and income) because of members' chronic illness. These indicators include:

- Loss of labor
- Delayed agricultural operations

CRS Zambia Fine-Tunes Chronic Illness Definitions[16]

The C-SAFE Program in Zambia found discrepancies in how program staff defined chronic illness. CRS developed this targeting tool to help field staff without any medical training identify patients' symptoms that are likely to be from AIDS so they can make program decisions and link people to medical services for testing and treatment.

Based on this checklist—which does not replace a formal diagnosis, a person is considered to be chronically ill with AIDS if he/she has two major and two minor conditions listed, or specific conditions like Kaposi's sarcoma.

1. Clients' Medical Condition/Illness (* = major conditions)

1a. Weight loss>10% from normal/regular weight	1=Yes	2=No	1h. Unexplained prolonged fever *	1=Yes	2=No
1b. Generalized lymph node enlargement	1=Yes	2=No	1i. Oral thrush *	1=Yes	2=No
1c. Skin infections	1=Yes	2=No	1j. Tuberculosis *	1=Yes	2=No
1d. Non-resolving herpes simplex	1=Yes	2=No	1k. Pneumonia *	1=Yes	2=No
1e. Herpes zoster within the last 5 years	1=Yes	2=No	1l. Kaposi's sarcoma *	1=Yes	2=No
1f. Recurrent upper respiratory infection	1=Yes	2=No	1m. Meningitis *	1=Yes	2=No
1g. Unexplained chronic diarrhea >30 days)	1=Yes	2=No	1n. Persistent confusion/dementia *	1=Yes	2=No
			1o. Other, specify:	1=Yes	2=No

- Land left fallow
- Changes in crop mixtures
- Changes in livelihood sources
- Increased dependence on casual labor opportunities

See **Chapter 3: Vulnerability Assessments** for a more detailed list of indicators that capture HIV's impact on assets.

Each indicator represents a trigger point that results in decreased agricultural productivity and the potential for decreased food security. By targeting households with these characteristics, food assistance agencies aim to reach the most food-insecure households affected by HIV.[17]

It should be noted that identifying vulnerable groups in terms of personal and household characteristics, such as people with disabilities or female-headed households, does not automatically identify the groups who require food assistance interventions.[18] Indeed, it would be unusual to find a context in which all members of these groups are vulnerable. In addition, many vulnerable individuals are not members of these groups. Thus targeting based exclusively on group characteristics may create considerable inclusion and exclusion errors.

Incorporate Stigma Reduction Measures

The level of stigma against HIV varies greatly; in general, it tends to be higher in rural than urban areas and lower in environments where HIV is talked about openly. In Zambia, stigma has been reduced considerably in recent years as prevalence rates have increased and as new services such as AIDS treatment services and social support (including food assistance) have emerged.[19] HBC providers credit ongoing sensitization, the feeling among people that "today it is you, but tomorrow it could be me," awareness raising and the willingness of some PLHIV to speak publicly for stigma reduction. Also, the advent of ART has helped reduce stigma because a positive diagnosis no longer necessarily means a long, steady decline into severe illness and/or death. Furthermore, the awareness created by institutionalization of HIV care and support and livelihood interventions within rural communities has a profound impact on stigma reduction and on promoting acceptance of PLHIV within the family and the community.

However, there are contexts in which stigma is still strong. For instance, in cases where food distribution points are established specifically for the HIV-affected, beneficiaries may be reluctant to personally collect food for fear of being publicly identified as infected. In addition, non-beneficiaries may grow resentful based on their perception that because PLHIV are going to die soon, they should not receive public aid.

Stigma can be a particularly significant issue in programs aimed at reducing mother-to-child transmission because it may follow a child throughout his/her youth. If adequate resources are available, it is preferable for PMTCT programs to target all pregnant and lactating women in food-insecure areas to avoid stigmatization.[20]

Guidance for Addressing Stigma[25,26]

Although health service providers and development practitioners have long been aware of the constraints presented by stigma, there have been few proven approaches to dealing with it. To address the urgent need for tools to address stigma, the International Center for Research on Women (ICRW) and the CHANGE Project developed an anti-stigma toolkit entitled "Understanding and Challenging HIV Stigma: Toolkit for Action." The toolkit's guidance is based on findings from four country studies and provides evidence-based guidance for stigma-reduction activities with key groups, including religious and political leaders, people living with HIV, and community members. The toolkit is designed to motivate and enable individuals to use these methods to address stigma in their communities, workplaces, organizations and households. Specific guidance in the toolkit is aimed at:

- Making stigma visible and helping resolve contradictions such as those between intentions and behavior
- Enhancing practical knowledge to reduce fear of casual transmission
- Providing a safe forum to discuss sensitive topics (sex, death, drug use, inequity)
- Finding a common language to talk about stigma
- Strengthening PLHIV capacity to challenge stigma in their lives
- Providing a process to determine appropriate and feasible individual and community responses to stigma
- Providing comprehensive, flexible tools for organizations to strengthen staff skills and develop or strengthen interventions to reduce HIV-related stigma

The toolkit is available at www.changeproject.org/technical/hivaids/stigma/StigmaToolkit.pdf.

Methods to Reduce Stigmatization

Given the stigma associated with HIV, food assistance programs specifically targeting infected individuals must take extreme precaution in controlling the use of targeting information. For obvious reasons, this is much more feasible for administratively targeted interventions than for those using CBT. Likewise, the degree of transparency in targeting is largely dependent on a program's objectives. A program with explicitly stated HIV objectives will necessarily target individuals based on HIV status, making it difficult for them to avoid stigma where it exists. However, food security programs may find it easier to avoid identifying beneficiaries as HIV-positive.

As discussed earlier, proxy indicators may be used to identify HIV-affected families. However, proxy indicators such as chronic illness should be used cautiously and should not be the sole means of identifying HIV-affected households. In addition, chronic illness may not be appropriate as a proxy indicator in areas where it has already become closely associated with HIV. In such cases, socioeconomic criteria may be a better alternative for reducing the risk of stigma.

CBT can reduce stigma in many cases.[21] It is most effective when the community has been fully sensitized to a program's objectives and targeting strategy. Social mapping exercises, which rely on community input and participation, can reduce stigma associated with food assistance in this context. Community participation in such exercises often helps to stimulate discussions about chronic illness, the situation for OVC and other vulnerable groups, the availability of community services and related community development projects. These discussions, in addition to other sensitization efforts such as discussions with local leaders, youth groups, women's groups and community groups, can directly contribute to stigma reduction in a community.[22] Findings from FFA programs in Zimbabwe indicate that food assistance in conjunction with community sensitization on HIV can reduce stigmatization of PLHIV beneficiaries.[23]

In many rural areas, people do not believe that others are dying of AIDS and instead attribute deaths to TB, pneumonia and other causes, hampering community targeting methods. Some agencies have made progress in addressing stigma by supporting community sensitization efforts and working to build the self-esteem of PLHIV. Experience shows that where HIV is openly discussed, stigma tends to decline as people learn more about the disease and become less fearful of associating with PLHIV, including their own family members.

Where feasible and appropriate, it is important to explicitly involve PLHIV, affected households and communities in each step of the targeting process to ensure equitable access to aid and services. While stigma remains an issue, the transparency of this process is important to avoid significant exclusion error.[24]

Gender and Targeting

For food assistance programs, consideration of gender is particularly important because of women's traditional role as household food managers and because of how gender influences household food production through small-scale agriculture. As discussed earlier, gender is also an important consideration in effectively targeting food assistance to reduce vulnerability to HIV. (See **Chapter 1: Conceptual Framework** for a discussion of gender and HIV, and **Chapter 3: Vulnerability Assessments** for an explanation of gender analysis and a gender analysis tool.)

For a more detailed discussion on the role gender plays in food assistance programs in the context of HIV, program managers can review ***Getting Started: HIV, AIDS and Gender in WFP Programmes,*** available at www.wfp.org/food_aid/doc/GETTING_GENDER7.pdf.

5.3 Key Concept
Promising Practices

Use a Common Framework of Vulnerability

Targeting requires a common definition of vulnerability to express the target population's immediate and long-term needs. A judgment has to be made as to whether food insecurity and HIV prevalence are homogeneous throughout an area or whether there are pockets of greater need and vulnerability that deserve specific attention. This judgment can be made only if there is a good understanding of food insecurity and HIV at the country, regional and district levels.

Furthermore, program managers will have to decide whether food assistance will be targeted specifically to food-insecure, HIV-affected people or will include other food-insecure households that are not directly affected by the disease. This is a delicate decision, especially in areas with widespread poverty and food insecurity. If the food assistance intervention's main purpose is to enhance general food security in areas highly affected by HIV, then targeting criteria should be based on multiple food security indicators that are likely to include direct and proxy HIV indicators.

Even in communities in the same food economy zones or livelihood zones, needs will vary among populations. Understanding who are the most vulnerable or most at-risk is a prerequisite for effective resource targeting.[27]

Standardize Program and Beneficiary Targeting Criteria

Standardizing targeting criteria is important for avoiding confusion at the community level, preventing competition among agencies for program participants and improving the quality of analysis. Developing a framework of analysis with standardized indicators allows for comparison of results, identification of cross-cutting issues and transferral of lessons on prevention, treatment, and care and support strategies across regions, countries and even communities in the same country. When developing such a framework, program managers should acknowledge that different funding sources may have a significant influence on the selection and application of specific targeting criteria, as is often the case regarding OVC.

Standardization does not imply a lack of flexibility. Criteria must be sensitive to the local context. For example, wealth ranking varies between communities; a person who owns one cow may be considered poor in one community and rich in another. Similarly, in highly food-insecure areas, households may take actions such as assuming care of orphans or the chronically ill just to become eligible for assistance. So while it is important to standardize criteria, community members should be involved in verifying eligibility criteria and, if necessary, changing them to ensure they are appropriate.

Conduct Field-Level Verification

Screening tools such as questionnaires alone are not sufficient for accurate targeting. Field-level verification, where staff periodically visits households to check information, is needed to avoid inclusion error, along with periodic re-verification to see if conditions have changed. Multiple means of verification improve the accuracy of targeting, helping to ensure that the

most vulnerable households and individuals are selected and that limited resources have the biggest impact.[28, 29] The best practice is multiple means of targeting with at least some levels of verification. Programs should include this as part of their budget.

Link Health Referral Systems With Home-Based Care Groups and Networks

Building strong links with community health centers, HBC and support networks, PLHIV networks, and facility-based care systems allows the benefit of community workers' knowledge about socio-economic factors, food insecurity and hunger in the community in the identification of the most vulnerable households and individuals to be referred for food assistance.[30] In addition, the use of health services outreach facilities that are linked to HBC, PLHIV networks, and other institutions providing treatment, support and safety nets enables programs to reach PLHIV and other vulnerable groups not accessible to centralized feeding programs.

Apply "Do No Harm" Principles

It is crucial to ensure that the targeting system adheres to the key principles of non-discrimination, impartiality and equity, and does no harm to the community. In particular, as an equity principle, targeting can be improved by involving women in the community at various stages of developing and applying the targeting system. Women caregivers as well as female-headed households should be given an opportunity to participate in food distribution activities.[32]

Zambia Case Study: Cross-Sector Referral Targeting Mechanisms Used to Guide Interventions[31]

In Zambia, whose national health care system tracks Zambians through an individual code connected to her/his medical records and local treatment facility, collaboration between hospitals providing ART, NGO-supported food assistance programs and HBC programs is strong. WFP Cooperating Partners in the same areas are beginning to exchange beneficiary lists to avoid targeting of the same beneficiaries. This is actively encouraged by WFP through district coordination mechanisms such as District Disaster Management Committees and District AIDS Task Forces. The District Development Coordinating Committee requires monthly updates and meetings so the Cooperating Partners are kept up to date.

Still, organizations are careful about how and with whom they share information. Due to stigma and other reasons, personal privacy is an issue, and ART patients do not like being identified on lists that may circulate in their communities.

Annex 1: WFP Zambia Targeting Tool: Food Security Screening Form

This form is taken from Fergusson, P. *Targeting Household Food Insecurity in the Context of HIV: A Report by WFP Zambia.* WFP Zambia, 2005.

WFP Zambia Food Security Screening Form	
Client Name:	Date: ____/ ____/ _____ Day Month Year
Client ID Number: (specify ID type)	
Client Sex: **(circle response)** Male Female	
School/HBCO/CBO Caregiver Name:	
Name of Respondent (if other than the client):	
Relation to Client:	
Client's Address:	

A. Demographic and Education		
A1	How many adults (19-59 years) stay in the household?	**Number of adults:**
A2	How many elders (60 years and older) stay in the household?	**Number of elders:**
A3	How many children (18 years or younger) stay in the household?	**Number of children:**
A4	Marital status of primary income earner	Married (1) Single (2) Separated (3) Divorced (4) Widowed (5)
A5	Sex of primary income earner	Male Female **(circle response)**

A6 In the following table, record the required information for all children in the household who are between 6 and 18 years of age.

	First name of the child (6-18 years only)	Age	Is the child currently attending school? **(circle response)**	1. Community school	2. Drop-in center	3. Government school	4. Fee-paying private school	5. Fee-paying tertiary education
1			Yes No					
2			Yes No					
3			Yes No					
4			Yes No					
5			Yes No					
6			Yes No					
7			Yes No					
8			Yes No					
9			Yes No					
10			Yes No					

B. Food Consumption

B1 How many bags of mealie-meal did the household consume in the last month?	**Bag Size**	Number Consumed
	50 kg	
	25 kg	
	12.5 kg	
	10 kg	
	5 kg	
	2.5 kg	
	0.5 kg	

B2 Where did the food that you ate yesterday come from? **(check all that apply)**

	YES	NO		YES	NO
1. From own harvest			7. Food received—General food distribution/nutritional support programme		
2. Casual labour			8. Food received—Home-based care		
3. Borrowed			9. Food received—School feeding/OVC take-home ration		
4. Bartered			10. Food received—Food for work/food for assets		
5. Gift			11. Purchased (shop, market, kantemba)		
6. Gathered from wild			12. Other sources **(specify)**		

B3	In the last month, did anyone in the household cut the size of meals or skip meals?	Yes No **(circle response)**
B4	If yes, how often did this happen? **(circle one response)**	Daily (1) Every other day (2) Weekly (3) Once (4)
B5	How many meals does the household usually have in a day?	Yes (1) (2) (3) **(circle response)**

C. Food Aid

C1	Is the household currently receiving any donated food?	Yes No **(circle response)**
C2	If yes, from whom is the food received?	
C3	How much food is the household currently receiving each month?	

D. Household Income and Production

D1	Was the client the primary income earner in the household before becoming ill?	Yes No **(circle response)**
D2	What is the estimated household income (from salary, rental income, vending, gifts, etc.) per month? **(circle one)**	Less than K50,000 (1) K50,000 to K199,000 (2) K200,000 to K500,000 (3) Over K500,000 (4)

WFP Zambia Food Insecurity Targeting Criteria for Use in the Context of HIV

Section A: Basic Criteria Guidelines

Clients meeting any of the following criteria will be eligible for the individual ration:

1. Monthly household income of less than K50,000 per month

OR

2. The household consumes 25 kg of maize meal or less per month AND household size is more than five people

OR

3. The household consumes 50 kg of maize meal or less per month AND household size is more than 10 people

OR

4. The respondent reports that during the past month, members of the household cut the size of meals or skipped meals because there was not enough food, daily or every other day, and the household consumes less than three meals per day on average.

OR

5. The respondent reports that the food eaten yesterday in the household came exclusively from borrowing, bartering, and/or gathering in the wild AND at least one other criteria above is also met.

In accordance with WFP protocol, those meeting the following criteria will receive the household ration:

6. Client was the household's primary income earner AND the household's monthly income is less than or equal to K200,000

Clients will not qualify for food aid (either the individual or household ration) if they live in a household which:

- Has children in fee-paying private schools
- Is currently receiving donated food including at least all of the following:
  - 25 kg or more bags of maize meal per month
  - 25 kg or more bags of HEPS per month
  - 2.5 liters of oil or more per month
  - 5 kg peas/beans or more per month

Section B: Demographic Qualifiers

Number of children under 18 not attending school
1. 0 = 0
2. 1-2 = 1
3. 3 or more = 2

Household head:
Child-headed household = 5
Elderly-headed household = 3
Female-headed household = 1

Marital status of HH head
1. Married = 0
2. Single = 1
3. Separated = 1
4. Divorced = 2
5. Widowed = 3

Dependency ratio:
(number of adults in the home divided by the total household size)
= A1/(A1+A2+A3)

0	= 3
.001 to 0.33	= 2
0.34 to 0.66	= 1
0.67 to 1.0	= 0

Total possible score: 13

Annex 2: C-SAFE Zambia Targeting Tool: Household Food Security Appraisal Form

C-SAFE Zambia Household Food Security Appraisal Form

Date of Interview: / /

District: FDP / Site Name: Village Name: HH No:

Name of Respondent: Sex: (Male = 1; Female =2)
(Should be household head or spouse)

Name of Primary Beneficiary: Sex: (Male = 1; Female =2)
(Would-be food aid recipient)

A1	A2	A3	A4	A5	A6	A7	A8	A9	A10	A11
						0-17 YEARS OLD ONLY, ELSE GO TO A10	**6-17 YEARS ONLY, ELSE GO TO A10**		**MORE THAN 5 YEARS OLD ONLY, IF YES GO TO A11, ELSE GOTO B1**	
	Please give me the first name of each household member, starting with you	What is (NAME) relation-ship to head of house-hold?	Is (NAME) male or female? *MALE = 1 FEMALE = 2*	How old is (NAME)? *IN YEARS IF < 1, WRITE 0*	What is (NAME) health status?	What is the (NAME) parental status?	What is (NAME) school status: *ENUMERATOR TO READ ALL CATEGORIES IN A8 BELOW IF CURRENTLY ENROLLED=1 OR PRIMARY/ SECONDARY COMPLETED = 5, GO TO A10*	What is the main reason for (NAME) absenteeism/ dropped out/never enrolled?	Is (NAME) engaged in any activity that brings an income in cash or in kind?	Income received /earned in the last three months (amount in kwacha)
1	Household head	01								
2										
3										
4										
5										
6										
7										
8										
9										
10										

A3 -Relationship

1 = head
2 = head spouse
3 = child
4 = father/mother
5 = brother/sister
6 = other relative (grandparents, uncle, aunt, cousin)
7 = no relation
8 = adopted/foster or step child
9 = grandchild, niece, nephew

A6 – Health status

1 = good
2 = ill for < 3 months
3 = ill for 3 months or more
4 = physically or mentally disabled

A7 – Parental status

1 = both parents alive
2 = mother alive, father dead
3 = father alive, mother dead
4 = both parents dead

A8 – School enrollment

1 = enrolled
2 = enrolled but absent > 1 week in past month
3 = dropped out this school year
4 = dropped out before this school year
5 = primary/secondary complete
6 = never enrolled

A9 – Primary reason absent, not enrolled or dropped out

1 = illness
2 = working
3 = help with HH work
4 = care for ill member/younger sibling
5 = not interested in school
6 = distance to school far
7 = hunger
8 = expensive/no money
9 = child considered too young
10 = pregnancy/marriage
88 = other (specify_____)

A10

1 = yes
2 = no

A11

1 = > 50,000
2 = 50,001 – 100,000
3 = 100,001 – 200,000
4 = 200,001– 300,000
5 = 300,001 – 400,000
6 = 400,001 – 500,000
7 = 500,000 +

Section B. Household Income and Expenses

B1 During the past year, what were your household's three main sources of livelihood? (starting with the most important)

(1) |_____| (2) |_____| (3) |_____|

If no source of livelihood, write 15 and go to B2

CODES FOR B1

1 = remittance
2 = crop production/sales
3 = casual labour
4 = begging
5 = livestock production/sales
6 = skilled trade/artisan
7 = small business
8 = petty trade (firewood sales, etc.)
9 = brewing
10 = formal salary/wages
11 = sale of fish
12 = gold panning
13 = vegetable production/sales
14 = food aid
15 = no secondary source of livelihood
88 = other (specify) _____

B2 During the past month, what were your household's three main uses of your income? (in order of importance)

(1) |_____| (2) |_____| (3) |_____|

CODES FOR B2

0 = none
1 = staple foods
2 = non-staple foods
3 = HH goods
4 = education
5 = health
6 = funerals
7 = travel
8 = agricultural inputs
9 = other (specify) _____

Section C. Household Food Stocks and Sources

C1	How much cereal does your household have from own production? (If no cereal, go to C3)	_____(x 50kg bags)
C2	How many months do you think cereal stock will last?	_____ (# of months)
C3	At what time of the year did cereal from own production dry out?	_____ (indicate month)
C4	In the past three months, what were your household's three most important sources of cereal/staple food to eat? **CODES FOR C4** 1 = from own harvest, 2 = casual labour, 3 = borrowed, 4 = gift, 5 = food aid, 6 = food received from FFA/FFW, 7 = purchased, 8 = barter, 9 = no source of food, 88 = other source (specify)_____	

Section D. Agricultural Production

D1	How much land did you cultivate this year? ***(1 hectare (ha) = 100x100m, 1 lima = 0.25ha= 50x50m, 1 acre = 0.4ha)*** **IF DID NOT CULTIVATE WRITE 00**	|__|__|.|__| Hectares **IF 00 MOVE TO D4**
D2	Compared to last season was the area of land you cultivated larger, the same or less	1 = larger 2 = same 3 = less **IF LARGER OR SAME, GO TO D5**
D3	What is the primary reason for cultivating less land?	Reason |____| **GO TO D5**
D4	What is the primary reason for not cultivating?	Reason |____| **GO TO E1**

CODES FOR D3 & D4

1 = planned fallow, 2 = weather related causes, 3 = could not access land, 4 = lack of seed, 5 = lack of fertilizer, 6 = lack of labour/insufficient manpower, 7 = pest problems, 8 = rented out, 9 = illness in the household, 88 = other (specify)_____

D5 Did you cultivate any of the following crops?

CODES FOR D5: Harvest Usage

1 = consumed
2 = sold
3 = bartered
4 = given out as gift
88 = other (specify)_____

Crop	YES	NO	How harvest was used
Maize	1	2	
Sorghum	1	2	
Millet	1	2	
Cassava	1	2	
Beans	1	2	
G/nuts	1	2	
S/potatoes	1	2	
Vegetables	1	2	
Cash crops	1	2	

Section E. Food Consumption

E1	How many meals did the adults in this household eat **yesterday**?	|___| NUMBER OF MEALS
E2	How many meals did the children (6-59 months old) in this household eat **yesterday**? **IF NO CHILDREN IN THE HH, WRITE 98 for N/A**	|___| NUMBER OF MEALS

Section F. Assets					
F1: How many of the following assets are owned by you or any member of your household? (indicate kwacha value where possible)					
Productive, Non-Productive & Transport Assets					
Asset	**No.**	**Asset**	**No.**	**Asset**	**No.**
Land (hectares)		Canoe		Radio	
Tractor		Harrow		DSTV	
Hand tractor		Plough		Fridge	
Hammer mill		Shops/kantemba		Fan	
Hand mill		Business		Sewing machine	
Treadle pump		Truck		Bicycle	
Fishing nets		Van/hilux		Other 1	
Ox cart		TV		Other 2	

G1 TO G4	**G1 How many of the following livestock does your household currently own?** **G2 How many livestock has your household purchased in past 3 months?** **G3 How many livestock has your household sold in past 3 months?** **G4 What was the main reason for selling this livestock?** **FOR EACH TYPE OF LIVESTOCK NOT OWNED, NOT PURCHASED AND NOT SOLD, WRITE 0**				
	Livestock	**G1** Currently owned	**G2** Purchased	**G3** Sold	**G4** Main reason for sale
1	Draught cattle				
2	Cattle				
3	Donkeys/horses				
4	Sheep/goats				
5	Pigs				
6	Chickens/ducks/other birds				
	Codes for G4	1. No longer needed 2. Pay daily expenses 3. Buy food for HH	4. Pay medical expense 5. Other emergency 6. Pay debt	7. Pay social event 8. Pay funeral 9. Pay school	88. Other (specify) _____ 98. N/A

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1. This part is to be filled in by the enumerator immediately after completing the appraisal form.

Based on answers to the above questions, in the enumerator's opinion, this household should be classified as:				
1 = Very eligible (Asset very poor, food insecure with hunger)	**2 = Eligible** (Asset very poor, food insecure with hunger	**3 = Moderately eligible** (Asset poor, food insecure without hunger)	**4 = Ineligible** (Asset rich, food secure without hunger)	**5 = Disqualify** (Asset very rich, food secure and not hungry

2. If ineligible or disqualified based on issues other than Food Security perception, please indicate these reasons:

1. _____

2. _____

3. _____

Name of HH head_____

Sign_____Date_____

Annex 3: PCI Zambia Targeting Tools: Initial Home Visit, Monitoring Visit, and Reassessment Food Security Screening Forms

PCI Zambia Initial Home Visit Form	
Patient Name:	Date: / / (Day/Month/Year)
Patient ID Number:	Patient Sex: Male Female **(circle)**
HBCO Caregiver Name:	HH Head Profile: Male Female **(circle)**
Name of Respondent (if other than patient):	
Relation to Patient:	
Does the patient address match the locator form? Yes No **(Please circle your answer)**	
If not, please record the patient's address and any additional information required to locate the patient.	

A. Demographic and Education		
A1	How many adults (19-59 years) stay in the household?	Number of adults:
A2	How many elders (60 years and older) stay in the household?	Number of elders:
A3	How many children (18 years and younger) stay in the household?	Number of children:

In the following table, record the required information for all the children in the household who are between 6 and 18 years of age

	First name of the child (6-18 years of age only)	Age	Is the child currrently attending school?		What type of school does the child attend?				
			Yes	No	1 = Community school	2 = Drop-in center	3 = Government school	4 = Fee-paying private school	5 = Fee-paying tertiary education
1			☐	☐	☐	☐	☐	☐	☐
2			☐	☐	☐	☐	☐	☐	☐
3			☐	☐	☐	☐	☐	☐	☐
4			☐	☐	☐	☐	☐	☐	☐
5			☐	☐	☐	☐	☐	☐	☐
6			☐	☐	☐	☐	☐	☐	☐
7			☐	☐	☐	☐	☐	☐	☐
8			☐	☐	☐	☐	☐	☐	☐
9			☐	☐	☐	☐	☐	☐	☐
10			☐	☐	☐	☐	☐	☐	☐

B. Food Consumption

		Bag Size	Number Purchased
B1	How many bags of mealie-meal did the household purchase for consumption in the past month?	**50 kg**	
		25 kg	
		12.5 kg	
		10 kg	
		5 kg	
		2.5 kg	
		0.5 kg	

B2 Where did the food that you ate yesterday come from? **(check all that apply)**

	YES	NO		YES	NO
1. From own harvest	☐	☐	7. Food received—General food distribution/nutritional support programme	☐	☐
2. Casual labour	☐	☐	8. Food received—Home-based care	☐	☐
3. Borrowed	☐	☐	9. Food received—School feeding/OVC take-home ration	☐	☐
4. Bartered	☐	☐	10. Food received—Food for work/food for assets	☐	☐
5. Gift	☐	☐	11. Purchased (Shop, market, kantemba)	☐	☐
6. Gathered from wild	☐	☐	88. Other sources **(specify)**	☐	☐

B3	In the past month, did anyone in the household ever cut the size of meals or skip meals because there wasn't enough food?	Yes No **(circle response)**
B4	If yes, how often did this happen? **(circle one response)**	Daily (1) Every other day (2) Weekly (3) Once (4)

C. Food Aid

C1	Is the household currently receiving any donated food?	Yes No **(circle response)**
C2	If yes, from whom is the food received?	
C3	How much food is the household currently receiving each month?	

D. Household Income and Production

D1	Was the patient the primary income earner in the household before becoming ill?	Yes No **(circle response)**
D2	What is the household income (from salary, rental income, vending, gifts etc.) per month? **(circle one)**	Less than K50,000 (1) K50,000 to K199,000 (2) K200,000 to K500,000 (3) Over K500,000 (4)

E. Buddy

E1	Does the patient have a buddy?	Yes No **(circle response)**

If no, the caregiver should: 1. Review with the patient the importance of having one, and
2. Review the characteristics of a good buddy and help the patient identify someone

PCI Zambia Monitoring Visit Form	
Patient Name:	Date: / / (Day/Month/Year)
Patient ID Number:	
HBCO Caregiver Name:	
Name of Respondent (if other than patient):	
Relation to Patient:	
Has the patient's address changed since the initial home visit? Yes No **(Please circle your answer)**	
If yes, please record the patient's new address and any additional information required to locate the patient.	

A. Adherence Support		
A1	**(Ask)** Have you missed any doses of your ARVs since I last visited you?	Yes No **(circle response)**
A2	**(If yes)** How many doses have been missed in this period?	|_____| NUMBER OF DOSES MISSED
A3	Review the Patient Care Card. According to the card, how many doses have been missed?	|_____| NUMBER OF DOSES MISSED
A4	If the number in A2 and A3 are different, try to determine with the patient and/or buddy the correct number of missed doses.	|_____| NUMBER OF DOSES MISSED
A5	Record the number of days since the last visit.	|_____| NUMBER OF DAYS
A6	Record the total number of pills which should have been taken during this period.	|_____| NUMBER OF PILLS
A7	Use the figures in A4, A5 and A6 to determine the patient adherence during the period in question. (Refer to Table 5.5)	**Adherence is less than 95%** _____ **Adherence is more than 95%** _____

IF ADHERENCE IS LESS THAN 95%:

- **» Assess the reason(s) for missed doses**
- **» Assess barriers to adherence and suggest solutions**
- **» Review with the patient the importance of 100% adherence**
- **» Complete a Follow-Up Required Card and return it to the HBC Supervisor**
- **» Caregiver must begin doing daily visits until adherence improves**

IF ADHERENCE IS GREATER THAN 95%:

- **» Assess any potential barriers to adherence and encourage the patient and buddy to continue**

B. Buddy		
B1	Does the patient have a buddy?	Yes No **(circle response)**

C. Potential Problems with ARVs		
C1	Is the patient having any problems taking all their medicines?	Yes No **(circle response)**
	If yes, describe:	

C2	Is the patient experiencing any of the following? **Tick if response is yes**	
a	☐ Nausea	If causing minimal intake for more than 48 hours
b	☐ Vomiting	If severe, limiting food or fluid intake or ART and lasting 24 hours
c	☐ Diarrhea	If more than three times per day, or bloody, or if associated with fever or dehydration
d	☐ Persistent headache	If severe, requiring frequent painkillers, lasting over one week
e	☐ Rash	If severe, especially if associated with blisters or peeling and covering more than 50% of the body
f	☐ Severe leg pain	If new or worsening or impairs walking
g	☐ Fever	If lasting more than one day
h	☐ Difficulty breathing	Any difficulty breathing or shortness of breath, even if mild, especially if associated with abdominal pain, nausea or vomiting
i	☐ Itching	Or swelling all over the body
j	☐ Fatigue	If normal activity reduced by more than 50%
k	☐ Severe abdominal pain	If it is too painful for the patient to move
l	☐ Dizziness/lightheadedness	If preventing standing from a seated or laying down position
m	☐ Yellow eyes	
n	☐ Other unusual signs or symptoms (describe below):	

If the patient is experiencing any of the problems above, please:

» Encourage them to return to the clinic for evaluation
» Complete the Follow-Up Required form and submit it to the HBC Supervisor

D. Food/Nutrition		
D1	Is the patient receiving an **individual ration** from the clinic through PCI/WFP (HEPS and oil)?	☐ Yes ☐ No **» if no, go to D6** ☐ Don't know **» if don't know, go to D6**
D2	**(If yes)** Did the patient eat any of this food during the past 24 hours?	☐ Yes ☐ No **» if no, go to D5** ☐ Don't know **» if don't know, go to D6**
D3	**(If yes)** What did they eat?	☐ Only the HEPS ☐ Only the oil ☐ Both the HEPS and oil
D4	How much did they eat?	☐ Less than 2 banana cups porridge ☐ 2 banana cups porridge ☐ More than 2 banana cups porridge ☐ Other **(specify how much)** _____ **(for all responses, go to D6)**

D5	**(If no)** Why not?	☐ Food is finished ☐ Food was sold/bartered/given away ☐ Food was not enough for the patient/others ate it ☐ No fuel to cook the food ☐ Nobody to cook the food for patient ☐ Patient wasn't hungry ☐ Patient didn't want the food (yesterday) ☐ Patient doesn't like the food (at all) ☐ Patient was sick ☐ Patient has trouble swallowing ☐ Other (specify)_____
D6	Is the patient receiving a **household ration** from the clinic through PCI/WFP (HEPS, oil, mealie meal, beans/peas)?	☐ Yes ☐ No **» if no, go to next page** ☐ Don't know **» if don't know, go to next page**
D7	**(If yes)** Did the patient eat any of this food during the past 24 hours?	☐ Yes ☐ No **» if no, go to D9** ☐ Don't know **» if don't know, go to next page**
D8	**(If yes)** What did they eat?	☐ HEPS ☐ Mealie meal ☐ Oil ☐ Beans/peas **(tick all that apply, then go to next page)**
D9	**(If no)** Why not?	☐ Food is finished ☐ Food was sold/bartered/given away ☐ Food was not enough for the patient/others ate it ☐ No fuel to cook the food ☐ Nobody to cook the food for patient ☐ Patient wasn't hungry ☐ Patient didn't want the food (yesterday) ☐ Patient doesn't like the food (at all) ☐ Patient was sick ☐ Patient has trouble swallowing ☐ Other (specify)_____

Is the patient experiencing any problems related to food consumption and the ARVs? If so, please describe the problem below and alert the HBC Supervisor to the problem:

_____

_____

_____

Provide any comments in the space below related to the patient's condition, adherence, needs for follow up, etc.

_____

_____

_____

Make sure you have covered all of the items in this checklist before leaving the patient.

CHECKLIST FOR HOME ADHERENCE SUPPORT

1. **Ask the patient if they are having any problems with the drugs.**
2. **Ask the patient how many doses they have missed?**
3. **Review the DOT card with patient to check for signatures.**
4. **Assess the reason for missed doses.**
5. **Assess barriers to adherence and suggest solutions.**
6. **Review with patient the reasons that we need 95-100% adherence.**
7. **Review with patient that they must attend all appointments and should have a buddy to directly observe therapy.**
8. **If a buddy has not been identified review the characteristics of a good buddy, and help the patient to identify a good buddy:**
   - **should be a responsible person who cares about the patient's well being.**
   - **should live near or in the same household as the patient.**
   - **should be able to come to clinic appointments with the patient.**
   - **should be able to observe the patient taking his or her medicines every day.**
   - **should be able to help remind the patient to take all of their medicines at the correct times.**
   - **should be able to maintain the patient's confidentiality.**
   - **should be able to communicate with the clinical staff in case the patient becomes too sick to come for an appointment.**
9. **Talk to the patient about creating reminders when it is time to take the drugs (visual cues, alarm clocks, etc.).**
10. **Assess if there is proper storage of the drugs.**
11. **Help patient repack their weekly pill box.**

PCI Zambia Reassessment Food Security Screening Form	
Client Name:	Date: / / (Day/Month/Year)
Client ID Number:	Client Sex: Male Female **(circle)**
HBCO Caregiver Name:	HH Head Profile: Male Female **(circle)**
Name of Respondent (if other than patient):	
Relation to Patient:	
Does the patient address match the locator form? Yes No **(Please circle your answer)**	
If not, please record the patient's address and any additional information required to locate the patient.	

A. Demographic and Education

A1	How many adults (19-59 years) stay in the household?	Number of adults:
A2	How many elders (60 years and older) stay in the household?	Number of elders:
A3	How many children (18 years and younger) stay in the household?	Number of children:

In the following table, record the required information for all the children in the household who are between 6 and 18 years of age

	First name of the child (6-18 years of age only)	Age	Is the child currrently attending school?		What type of school does the child attend?				
			Yes	No	1 = Community school	2 = Drop-in center	3 = Government school	4 = Fee-paying private school	5 = Fee-paying tertiary education
1			☐	☐	☐	☐	☐	☐	☐
2			☐	☐	☐	☐	☐	☐	☐
3			☐	☐	☐	☐	☐	☐	☐
4			☐	☐	☐	☐	☐	☐	☐
5			☐	☐	☐	☐	☐	☐	☐
6			☐	☐	☐	☐	☐	☐	☐
7			☐	☐	☐	☐	☐	☐	☐
8			☐	☐	☐	☐	☐	☐	☐
9			☐	☐	☐	☐	☐	☐	☐
10			☐	☐	☐	☐	☐	☐	☐

B. Food Consumption

B1 How many bags of mealie-meal did the household purchase for consumption in the last month?	**Bag Size**	Number Purchased
	50 kg	
	25 kg	
	12.5 kg	
	10 kg	
	5 kg	
	2.5 kg	
	0.5 kg	

B2	Where did the food that you ate yesterday come from? **(check all that apply)**					
		YES	NO		YES	NO
	1. From own harvest	☐	☐	7. Food received—General food distribution/nutritional support programme	☐	☐
	2. Casual labour	☐	☐	8. Food received—Home-based care	☐	☐
	3. Borrowed	☐	☐	9. Food received—School feeding/OVC take-home ration	☐	☐
	4. Bartered	☐	☐	10. Food received—Food for work/food for assets	☐	☐
	5. Gift	☐	☐	11. Purchased (Shop, market, kantemba)	☐	☐
	6. Gathered from wild	☐	☐	88. Other sources **(specify)**	☐	☐

B3	In the past month, did anyone in the household ever cut the size of meals or skip meals because there wasn't enough food?	Yes No **(circle response)**
B4	If yes, how often did this happen? **(circle one response)**	Daily (1) Every other day (2) Weekly (3) Once (4)

C. Food Aid		
C1	Is the household currently receiving any donated food from other than PCI/ WFP?	Yes No **(circle response)**
C2	If yes, from whom is the food received?	
C3	How much food is the household currently receiving each month?	

D. Household Income and Production		
D1	Was the client the primary income earner in the household before becoming ill?	Yes No **(circle response)**
D2	What is the household income (from salary, rental income, vending, gifts, etc.) per month? **(circle one)**	Less than K50,000 (1) K50,000 to K199,000 (2) K200,000 to K500,000 (3) Over K500,000 (4)

E. Buddy		
E1	Does the client have a buddy?	Yes No **(circle response)**
	If no, the caregiver should: 1. Review with the patient the importance of having one, and 2. Review the characteristics of a good buddy and help the patient identify someone	

F. Clinical Data		
F1	Is the client able to walk without assistance?	Yes, all the time (1) No, not at all (2) Sometimes (3) **(circle response)**
F2	Is the client suffering from chronic diarrhea? **(circle response)**	Yes (1) No (2) Don't know (3)
F3	If yes, how many months? **(circle response)**	Less than 6 months (1) 6 months or more (2)
F4	Is the client currently on TB treatment? **(circle response)**	Yes (1) No (2) Don't know (3)
F5	If yes, is client in intensive phase? **(circle response)**	Yes (1) No (2) Don't know (3)
F6	Is client receiving food ration as TB patient? **(circle response)**	Yes (1) No (2) Don't know (3)

Endnotes

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Chapter 6: Ration Design

Program Design Steps

Chapter 6: Ration Design

Program Design Steps

Key Concepts

6.1 Challenges and Considerations for Ration Design in an HIV Context

6.2 Key Steps for Ration Design in an HIV Context

6.3 Special Issues for Ration Design in an HIV Context

In This Chapter

Ration design in an HIV context will be similar to typical food assistance programming ration design. However, as this chapter outlines, there are several primary challenges and key considerations that will influence ration design in an HIV context, including factors that make the objectives of the use of food, appropriateness of commodities and determinants of the size of the ration different.

The chapter then outlines the key steps for ration design in the HIV context. Again, the steps themselves will be familiar to food assistance program managers, but the outcomes of these steps may be different due to HIV-related factors. It is important to remember that ration design is part of the larger process of program design and must focus on achieving the program's objectives. As with all food assistance programming, there must first be a determination that food is needed and is an appropriate response.

The chapter ends with a brief discussion of special issues that food assistance program managers may find relevant, including the use of ready-to-use therapeutic food (RUTF), breast milk substitutes and specialized food products in the HIV context.

6.1 Key Concept
Challenges and Considerations for Ration Design in an HIV Context

This section reviews a number of primary challenges and key considerations that can help guide ration design in the HIV context.

Primary Challenges to Ration Design

Limits of food assistance. Outside of the emergency context, food assistance and supplementary feeding rations are not intended to meet 100 percent of an individual's nutrient needs. Accordingly, there is no nutritionally complete food available through non-emergency food assistance programs. In most food assistance programs implemented in the context of HIV, rations are intended to be supplemented by food that the household accesses through other means.

Commodity and resource constraints. Program budget constraints may require difficult decisions when determining rations. In some cases programs may face trade-offs between reaching fewer beneficiaries with larger, more complete rations and reaching more beneficiaries with smaller rations. There are no hard and fast rules about this. Programs should base their decisions on the objectives for providing the ration and how best to meet the program objective.

Key Considerations for Ration Design

Determining food insecurity. Food assistance must be based on determination of food insecurity, even in the HIV context. Not all HIV-infected and -affected individuals and households are food-insecure. Therefore, indicators of food insecurity must also be used in designing rations for beneficiaries in the HIV context.

Objectives of food assistance in the HIV context. In some cases, the objectives of food distribution will be different in the HIV context than in a non-HIV context. For example, in a non-HIV context, the objective of food distribution may be to improve targeted groups' nutritional status. But in an HIV context, the objective may be simply to maintain chronically ill individuals' nutritional status or delay a decline in their nutritional status.

Lack of a universal "HIV ration." Ration design in the HIV context is based on determining such factors as the nutrient gap, the objectives of food support, the purpose of the ration, the most appropriate commodities available and the ability of beneficiaries to process, prepare and consume particular commodities.

Appropriateness of commodities. Due to HIV's symptoms, side-effects and how it constrains caregivers' time, some commodities may be more appropriate than others in the HIV context. Commodities that are processed, fortified, and easy to prepare and consume should be prioritized for PLHIV and their households.

Nutrient recommendations for PLHIV. While current evidence shows that PLHIV have an increased need for energy, data are insufficient to recommend an increase in protein, fat or micronutrient requirements due to HIV infection. Thus, protein should continue to provide 10 percent to 15 percent of daily energy intake, fat should provide at least 17 percent of energy intake, and micronutrients should be consumed at recommended daily allowance (RDA) levels.[1]

Staple food consumption. Any increase in PLHIV energy requirements should be derived from a balanced diet rather than from just an increase in staple foods. Because diets in

poor households around the world are dominated by starchy foods, it is very important to consider providing pulses and oils in household rations and/or fortified commodities, in addition to a reasonable cereal component.

Food distribution. When selecting the composition, size, and packaging of rations, program managers should consider the logistics of distributing the rations. Distribution factors include transport of commodities to sites that may be in remote rural areas, storage capacity at sites, distribution processes to beneficiaries, transport of commodities by beneficiaries to their homes or preparation requirements for wet feeding. The feasibility and costs of these factors will differ for different ration packages, so programs should consider what is manageable given their resources and contexts (see **Chapter 9: Operational Modalities** for more information on this topic).

Ration sharing. Individuals who receive take-home rations (THRs) may share them with other household members, diluting the rations' benefits. Programs should consider this when determining ration size. Programs also could try to reduce ration sharing by choosing commodities that are more likely to be associated with specific beneficiary groups (e.g., chronically ill individuals or children or pregnant women) or offering counseling and education about the ration's importance to the targeted population.

Behavior change communication. In the HIV context, behavior change communication (BCC) and nutrition counseling can help beneficiaries manage symptoms, side effects and food-drug interactions, and make the most of the ration and other foods.

Key Concept

6.2 Key Steps for Ration Design in an HIV Context

In many ways, designing rations in an HIV context is similar to designing rations for typical food assistance programs. Both involve a multi-step process that takes several factors into consideration. Key Concept 6.2 focuses on the eight key steps that are different in an HIV context:

1. Review the vulnerability assessment data.
2. Determine program objectives and the ration's role.
3. Consider appropriateness of various commodities for the HIV context.
4. Determine the ration's size.
5. Determine the ration's duration.
6. Design the ration.
7. Monitor the ration's use.
8. Plan the exit strategy.

Step 1. Review the Vulnerability Assessment Data

Before providing food assistance, food assistance program managers should carefully assess the root causes of hunger and malnutrition. **Chapter 3: Vulnerability Assessments** highlights the type of information that can be collected to determine the causes and

characteristics of food insecurity and in turn help guide ration design. Assessment information useful for ration design includes:

- Extent and type of risks beneficiaries face
- Gender and generational considerations relative to food access and use
- Dependency ratios
- Seasonal patterns of malnutrition
- Food stocks and storage
- Months of self-provisioning in a normal year
- Nutritional status in children under five and in adults
- Consumption patterns and household dietary diversity (number of food items consumed, frequency of consumption)
- Food habits, preferences and acceptable food substitutes
- Availability of and access to milling facilities
- Food preparation practices
- Feeding, health, nutrition and sanitation practices

For example:

- If dependency ratios are uniformly higher than normal in a program area, programmers might increase the household ration size.
- If months of self-provisioning are low, this information can be used to calculate the average household caloric gap and provide information for determining ration size.
- If milling facilities are not widespread in the program area, a program may decide not to provide unprocessed, whole grains.

Special assessments may be warranted to collect information on sub-populations of interest, such as OVC.

Step 2. Determine Program Objectives and the Ration's Role

The use of food can have several objectives, such as preventing malnutrition in vulnerable target groups, rehabilitating malnourished individuals, improving participation in services or activities, and providing a safety net.

Table 1: Food Assistance Objectives and Ration's Role in the HIV context

Food Assistance Objective	Ration's Possible Role in the HIV Context
Maintain the nutritional well-being of HIV+ pregnant and lactating women	Nutritional supplement, incentive for regularly attending BCC and nutritional counseling at service delivery points
Improve adherence to ART	Support for managing drug side-effects, incentive for regular attendance at ART site
Provide a safety net for HIV-affected households	Contribution to household food supply, income transfer, protection of productive assets, reduction of adoption of risky livelihoods
Enhance livelihoods of older OVC through livelihood training	Coverage of opportunity costs for time spent in training, incentive to attend and complete training

Ration design in an HIV context will be influenced by program objectives and the ration's role in achieving these objectives. Table 1 on page 126 provides some examples of food assistance objectives in the HIV context and the ration's role in support of the objectives.

The objectives of food distribution in an HIV context may be different from those in a non-HIV context, and food assistance program managers need to consider the impact of HIV on possible achievement of program outcomes and impact. In the case of non-infected OVC, improving nutritional status remains a realistic objective. However, as already noted, for individuals who are chronically ill the objective may be simply to maintain nutritional status or to delay a decline in nutritional status.

When a ration's role is to maintain or improve targeted beneficiaries' nutritional status, the ration should include commodities that are high in nutritional value and appeal to the targeted groups. When the ration's objective is to increase or ensure participation in services or activities, commodities should be chosen for their incentive or monetary value as well as their nutritional value. In addition, the ration's value must be equal to or slightly greater than the opportunity cost of participating in the service or activity. When the ration is to act as a safety net, it must be designed to provide protection from the risks the program hopes to help beneficiaries avoid, such as offering enough value to prevent the sale of productive assets or risky lifestyle choices.

Step 3. Consider the Appropriateness of Various Commodities for the HIV Context

There are several key considerations that help determine if the ration meets beneficiary needs and program objectives in an HIV context, including:

Processing requirements. Programs should explore opportunities to provide fortified milled cereals as well as already-processed, fortified blended foods. Fortified milled cereals take less time and energy for PLHIV or their caregivers to prepare because processing cereals often requires long walks to milling facilities—if they are available at all—as well as the strength to pound the grain into flour.

Preparation requirements. To simplify meal preparation for caregivers, programs should consider food commodities that can be cooked easily and quickly with minimum water and fuel. Partially precooked commodities such as fortified blended foods like corn soy blend (CSB) and wheat soy blend (WSB), or ready-to-use foods are preferred choices.

Palatability and digestability. Palatability and digestability are extremely important, particularly when providing rations for chronically ill people and PLHIV, who may have reduced appetite, eating difficulties or gastrointestinal problems such as diarrhea, nausea and vomiting from infections or drug side effects. Rations should be designed to minimize discomfort or aggravation of these symptoms. Fortified milled cereals, adequately soaked/cooked pulses and fortified blended foods that can be made into porridges often are more palatable and easier to digest for sick persons, as well as small children or the elderly.[2]

Fortification. Micronutrients are critical for all people and are vital in fighting infection. PLHIV in particular can benefit from commodities fortified with micronutrients.

Acceptability. As in all food assistance programs, some commodities are more readily accepted by beneficiaries than others, which affects food use and consumption. Factors that can influence acceptability include traditional diet patterns, taste preferences and foods avoided for cultural or religious reasons. For example, commodities like CSB may have high accepability in some areas but may be considered "children's food" and rejected by adults in other areas.

Value. When the ration serves as an income transfer or incentive, the commodities must have an appropriate value in local markets. Foods with high values may be good for income transfers but are more likely to be sold rather than eaten by beneficiaries. These factors determine a ration's income transfer value:

- What does it cost the target population to participate in the program (e.g., transportation, daily lost wages, daily wage rate)?
- What is the value of other incentives that are offered (e.g., training, health services)?
- What is the value of the commodities to the participants?

Step 4. Determine the Ration's Size

In food assistance programming, ration size can be based on:

- A specific percentage of the energy and protein needs of an individual or household
- The value of an income transfer that serves as an incentive for participation in services/activities or a safety net
- The nutritional value of the meal that the ration is assumed to replace (e.g., lunch as a part of school feeding)

Two factors unique to the HIV context can be considered in determining the ration size:

Increased energy requirements of PLHIV. The WHO recommendations for the nutritional requirements of PLHIV (summarized in Table 2) call for increases in energy. The amount of this increase depends on whether the individual is an adult/adolescent or child, asymptomatic or symptomatic and experiencing weight loss or no weight loss.[3] While there is no definitive answer regarding the appropriate increase in energy intake for PLHIV, there is a strong rationale for increasing the energy intake for individuals in an advanced stage of the disease or those who require higher energy levels to support medical interventions (e.g., ART, TB treatment).

Higher dependency ratios or larger household size. In areas of high, long-term HIV prevalence, higher dependency ratios or larger household size might be the norm. Programs should consider increasing ration size for these households. Where higher dependency ratios and larger household size are not widespread, programs should determine if they can offer households a larger ration on a case-by-case basis.

Table 2: Adults, Adolescents and Children: Energy Adjustments for HIV Status

	HIV Positive Phase	Energy	Protein
Adults and Adolescents	Asymptomatic	10% increase	No change (12-15% of energy intake)
	Symptomatic	20%-30% increase	No change (12-15% of energy intake)
Children	Asymptomatic	10% increase	No change (12-15% of energy intake)
	Symptomatic with no weight loss	20%-30% increase	No change (12-15% of energy intake)
	Symptomatic with weight loss	50%-100% increase	No change (12-15% of energy intake)

Step 5. Determine the Ration's Duration

The optimal duration for providing rations is still a matter of debate and, to a certain extent, trial and error. As discussed in **Chapter 1: Conceptual Framework**, HIV-induced food security shocks differ from other shocks and cannot be addressed in the same way as droughts and other natural disasters. HIV's impact on community and household resiliency may be more severe and long lasting than other shocks, which can influence the duration of the rations. Therefore, monitoring household resiliency in the HIV context is essential for guiding decisions on the duration of a ration.

Table 3 provides examples of ration duration used by various food assistance programs. These are not recommendations; they simply illustrate the range of durations programs use for different objectives and populations.

Table 3: Examples of Duration of Ration by Beneficiary Type and Program

Beneficiary	Objective	Duration of Ration Provision
ART clients	Improved nutritional status Stabilization to begin ART Improved adherence Management of drug side-effects	Until client reaches a specific anthropometric target (e.g., BMI = 18.5) Limited timeframe (e.g., 6 months after beginning treatment)
TB clients	Improved adherence	Duration of treatment
HIV+ pregnant/ lactating women	Maintain or improve nutritional status Improve participation in PMTCT services Improve follow-up of mother-child pairs	From pregnancy through 6–24 months post-pregnancy
PLHIV	Improved nutritional status Improved quality of life Safety net	Until PLHIV reaches a specific anthropometric target (e.g., BMI = 18.5) Until indicators of food access improve ***or*** Limited timeframe, such as 6 months–2 years
Affected households	Safety net	Until indicators of food access improve ***or*** Limited timeframe, such as 6 months–2 years ***or*** Until death of infected household member ***or*** 6 months–2 years after death of infected household member
OVC	Safety net Incentive for participation in services (e.g. school, training)	Until the child becomes an adult or is no longer vulnerable Duration of service

Step 6. Design the Ration

The process of designing a ration for the HIV context should not be significantly different from standard ration design. Assessment information, clear objectives for the food assistance and an understanding of the target population's special characteristics will help determine the optimal combination of commodities, within the program's budgetary confines.

Step 7. Monitor the Ration's Use

Monitoring the ration's appropriateness and use is an important aspect of monitoring program inputs. This can help programs refine and improve ration distribution, ration composition and complementary interventions to maximize the ration's effectiveness.

During implementation, programs should collect information about how beneficiaries are using the rations, perceived acceptability and quality, beneficiary satisfaction with the food, intra-household distribution and extent of ration sharing. Such monitoring enables programs to assess if the ration was appropriately designed and can provide timely beneficiary feedback that is crucial to adjust and improve the ration's effectiveness. (See **Chapter 8: Monitoring and Evaluation** for an example of end-use monitoring (EUM), a monitoring tool related to ration use.)

Step 8. Plan the Exit Strategy

The goal of an exit strategy is to ensure that a program's impacts are sustained after the program ends. As noted in **Chapter 7: Implementation Strategies**, which discusses sustainability and exit strategies in detail, developing appropriate exit strategies may be more challenging for food assistance programs—including program food distribution components—than other kinds of programs and is likely to be further complicated in a context of high HIV prevalence.

Ensuring impacts that depend on the continued delivery of an input, such as rations, may be particularly challenging because of the need to identify a reliable source of that input or, in the case of incentives, an equally valuable input that will result in the continued use of services. In planning an exit strategy, programs should critically evaluate the need to continue providing food to accomplish program objectives.

Effective food security programming should reduce the need for external sources of food to achieve program objectives. Objectives related to improving or maintaining nutritional status or providing a safety net can be met through a combination of strengthened home food production, BCC, food storage and preparation practices, and income generation. Improvements in program services or in the services' benefits can sometimes provide enough of an incentive for participation that a ration is no longer needed.

Chapter 7: Implementation Strategies also includes a planning matrix that provides information on key questions, components and challenges that will help food assistance program managers think through the steps for planning an exit strategy related to food distribution.

Key Concept

6.3 Special Issues for Ration Design in an HIV Context

In an HIV context, programmers face several additional issues related to ration design, including:

Use of Ready-to-Use Therapeutic Food. RUTF is a specialized food product developed specifically for the nutritional rehabilitation of malnourished individuals. It is typically nutrient-dense and can be eaten without any further preparation. Originally developed to support community-based therapeutic care for severely undernourished children, it is currently being used in Malawi and other countries for severely malnourished PLHIV, and its effectiveness as an adjunct to ART is being tested. One type of RUTF is spreads or pastes, such as Plumpy'nut® and its locally produced varieties. Since RUTF is sufficiently different in appearance, texture, taste and smell from regular household food, programs have successfully targeted it to vulnerable individuals as a special nutritional supplement. RUTF tends to be expensive, even when locally produced, so it is especially important to carefully consider its role and to target it effectively.

Use of breast milk substitutes. While some PMTCT programs supported by WFP may provide infant formula, WFP does not. WFP's policy is based on concerns that acceptable, feasible, affordable, sustainable and safe (AFASS) conditions (see **Chapter 10: Health and Nutrition**) for safe replacement feeding do not exist among the populations supported by WFP, the high cost of infant formula and WFP's Memoranda of Understanding with UNICEF and UNHCR for emergency settings, which place the responsibility for providing formula with those agencies. Breast milk substitutes also are not available as a FFP commodity for Title II programs.

Specialized food products. Specialized food products refer to cooked, partially cooked and uncooked blended foods that are enriched or fortified with nutrients and used for either supplementary feeding or therapeutic feeding, or as an incentive for participation in services or activities. The products can take the form of bars, flours, beverages, powders or pastes. A number of food aid commodities, such as CSB and WSB are considered specialized food products, as are locally manufactured food products like e'pap, Likuni Phala, SOSOMA, Medika Mamba and Foundation. A number of these products are being promoted specifically for PLHIV or immuno-suppressed clients. Information on nutrient content and product use may be available from the product label or advertising, from the manufacturer, or from a regulatory agency on file for public review. To evaluate manufacturer nutrient content or health claims, programs should check with government regulatory agencies or with WHO/FAO.

Annex 1: Additional Resources for Ration Design

NutriSurvey. A modeling tool that can be used to determine appropriate population-level rations available at www.nutrisurvey.de/lp/lp.htm.

Rogers, Beatrice Lorge & Macias, Kathy E. (2004) ***Program Graduation and Exit Strategies: A Focus on Title II Food Aid Development Programs*** available at www.fantaproject.org/publications/tn9.shtml.

United Nations High Commissioner for Refugees (UNHCR), United Nations Children's Fund (UNICEF), World Food Programme (WFP) and World Health Organization (WHO). (2003) ***Food and Nutrition Needs in Emergencies*** available at http://whqlibdoc.who.int/hq/2004/a83743.pdf.

United Nations High Commissioner for Refugees (UNHCR) and World Food Programme (WFP). (1999) ***Guidelines for Selective Feeding in Emergencies*** available at www.unsystem.org/SCN/archives/rnis26/ch7.htm.

USAID's Office of Food for Peace. "Commodities Reference Guide (CRG): Sections 1-4," January 2006 version available at www.usaid.gov/our_work/humanitarian_assistance/ffp/crg.

USAID's Office of Food for Peace. "Commodity Reference Guide (CRG): Part Two: Guidelines for Selecting Food Aid Commodities: An Overview," January 2006 version available at www.usaid.gov/our_work/humanitarian_assistance/ffp/crg/overview.html.

World Health Organization (WHO) and Food and Agriculture Organization of the United Nations (FAO). (2002) ***Living Well with HIV/AIDS: A Manual on Nutritional Care and Support for People Living with HIV/AIDS*** available at ftp://ftp.fao.org/docrep/fao/005/y4168E/y4168E00.pdf.

Endnotes

1 World Health Organization (WHO). ***Nutrient Requirements for People Living with HIV/AIDS: Report of a Technical Consultation***. Geneva: WHO, 2003.

2 USAID Office of Food for Peace. "Commodity Reference Guide, Section I: Commodities," available electronically at http://www.usaid.gov/our_work/humanitarian_assistance/ffp/crg/ (accessed January 2007).

3 WHO, ***Nutrient Requirements***.

Chapter 7: Implementation Strategies

Program Design Steps

Chapter 7: Implementation Strategies

Program Design Steps

Key Concepts

7.1 Implementing Food Programs in an HIV Context

7.2 Community Mobilization and Participation

7.3 Existing Programming and Complementary Inputs

7.4 Developing Partnerships

7.5 Intersectoral Referral Mechanisms

7.6 Scaling Up Programming

7.7 Sustainability and Exit Strategies

In This Chapter

This chapter identifies several guiding principles for the step-by-step implementation of food assistance programming in an HIV context. It begins by highlighting the importance of encouraging community participation in implementation of food assistance programs, including the greater involvement of people with HIV and AIDS (GIPA). The chapter then provides guidance on identifying and supporting exisiting programs as well as on securing complementary non-food inputs.

Next, the chapter explores the development of various types of partnerships and the potential need to strengthen partner organizations' capacity. The chapter also underscores the need to develop intersectoral referral mechanisms in areas simultaneously affected by food insecurity and HIV, giving specific attention to ethical considerations involving the potential overlap of benefits while maintaining confidentiality of beneficiaries' HIV status. The chapter then discusses the importance of program scale up, and identifies several key factors essential for effective scale-up of successful interventions.

The chapter ends with a discussion of exit strategies and challenges that must be addressed to ensure sustainability of food assistance interventions in the context of HIV.

7.1 Key Concept

Implementing Food Programs in an HIV Context

Key Considerations for Implementation

The following are key guiding principles for implementing food programs in an HIV context, along with sources for more detailed information on challenges, design steps, lessons learned and better practices within this guide with respect to each step:

Encourage participation and community mobilization. Participation from partner organizations, government and the community should be encouraged at every step of designing and implementing the program—from needs assessment to carrying out the exit strategy. GIPA is crucial to meeting the specific needs of PLHIV, mitigating against stigma and normalizing discussion of the disease. See Key Concept 7.2 in this chapter.

Support existing programming and ensure complementarity and provision of non-food requirements. Food interventions that are integrated into ongoing programs are often more successful than independent food pipelines. Especially in an HIV context, where food is only one part of a comprehensive package of support, it is important to recognize and plan for the non-food requirements that contribute to HIV prevention, treatment, and care and support. See **Chapter 4: Adaptive and Integrated Programming** and Key Concept 7.3 in this chapter.

Develop partnerships and strengthen intersectoral linkages and referral mechanisms. HIV touches all aspects of life for affected individuals and households. Multi-sector linkages and connections between service delivery channels are critical to providing an integrated and comprehensive system of livelihood support to PLHIV. As much as possible, two-way referral systems between food security programs and HIV services should be maintained. See Key Concepts 7.4 and 7.5 in this chapter.

Plan, implement and monitor exit strategies. Scale-up of successful programs and effective exit strategies are critical to promoting sustainability of program outcomes. In an HIV context, many factors affect an organization's ability to graduate beneficiaries and conduct a successful program exit. Perhaps most important among these is the capacity of the community and/or partners to care for vulnerable groups and assume responsibility for ongoing program activities and outcomes. See Key Concepts 7.6 and 7.7 in this chapter.

7.2 Key Concept

Community Mobilization and Participation

Community-based safety nets have been an effective means of preventing individuals and households made vulnerable by HIV from falling into destitution. A community may be geographically based or may describe a group of individuals who come together around a religious affiliation, women's issues, or through CBO or NGO associations, shared health practices or other areas of common interest. Many groups and communities have organized their own grassroots responses to food insecurity among HIV-affected families. However, they are often constrained by limited resources and organizational capacity.

Community Mobilization in Ethiopia: The MERET Program[1]

The Managing Environmental Resources to Enable Transitions (MERET) program uses food assistance to restore the environment and enhance livelihoods in chronically food-insecure communities through soil restoration and conservation, rural infrastructure development and reforestation activities. One of the methodology's major strengths is its emphasis on building beneficiaries' capacity to participate in issue/problem assessments as well as to plan and carry out diverse and sustainable livelihood strategies.

The MERET program builds community capacity largely through two community-based structures, Local Level Participatory Planning Approach (LLPPA) teams and Community Conversation groups. First, the LLPPA teams, composed of representatives from distinct livelihood/wealth groups and locations, work directly with Ministry of Agriculture and Rural Development Agents to identify and prioritize constraints to local development. Teams then present issues to the wider community through the Community Conversation groups.

Community Conversation groups have shown great promise in raising awareness and increasing community mobilization around HIV. Because of the groups, men, women, community elders and youth are increasingly able to discuss issues of gender, sexuality, livelihood strategies and customary practices that influence vulnerability to HIV. More important, the participatory nature of the process enables individuals and groups to take greater responsibility for preventing and mitigating HIV within their communities.

Community Conversation groups, LLPPA teams and government agents appoint Community Facilitators, who mobilize the community in support of HIV activities and sustain linkages between local stakeholders. Community Facilitators' responsibilities include:

- Facilitating regular biweekly community conversations
- Participating in regular planning and documentation meetings
- Disseminating HIV messages through MERET work activities and local meetings
- Mobilizing the community to provide care for PLHIV and orphans
- Fostering linkages between communities and school anti-HIV clubs
- Promoting women's direct participation in conversation groups and other community development activities
- Submitting quarterly activity plans to LLPPA teams and Rural Development Agents

Community mobilization is a capacity-strengthening process that helps communities take responsibility for identifying and deciding on an effective, coordinated response to food insecurity and HIV. Community participation ensures that those most affected by HIV, including stigmatized groups, play an active role in these processes.

Rigorous participation, a sense of ownership and community cohesion are critical to successful and sustainable food security programs. Likewise, community resource mobilization is unlikely to occur until there is adequate community involvement in planning and implementing a proposed program.

Promoting the Greater Involvement of People With HIV and AIDS[2]

Many factors make GIPA a critical component of the response to the epidemic. At the social level, publicly acknowledged involvement helps reduce stigma and discrimination, and sends a signal to society about the acceptance and importance of PLHIV. At its most basic, GIPA means two key things:[3]

- Recognizing the important contribution people infected or affected by HIV can make in the response to the epidemic
- Creating space within society for their involvement and active participation in all aspects of that response

A primary reason for including PLHIV and affected households in project planning and implementation is that they best understand their own needs, constraints and opportunities regarding food insecurity, assets and livelihoods.

Program managers should ask at the design stage of any food security program how they can intentionally involve PLHIV and affected households in the program's design, management and decision-making. When answering this question, program managers should consider involvement as both the level of ownership PLHIV have over the project and their stake in the benefits that accrue from project activities, such as products, revenue, etc.

Two approaches are critical to GIPA:

- Identifying relevant organizations, such as community-level PLHIV and OVC groups, as well as religious institutions and schools
- Using existing targeting processes, including community action committees, HBC networks or other support groups

Promoting Community Participation

Community participation is vital to effective project design and implementation. The planning and implementation process has several key decision points that can serve as points of entry for community participation, including:

- Situation analysis
- Stakeholder analysis
- Food needs assessment
- Targeting
- Activity selection
- Implementation
- Monitoring and evaluation
- Sustainability and exit strategy development

While time will be a limiting factor in emergency situations, there are still opportunities to use participatory processes to design the modalities for the program. Recovery and development programs offer a breadth of opportunities for community involvement in selecting, designing and implementing activities.

It is important to reiterate two key points in community participation: Regardless of the specific context, if HIV prevalence is high, a concerted effort should be made to ensure that PLHIV have a voice. In addition, community participation must be carefully balanced with confidentiality (e.g., for HIV status) when community representatives are involved in targeting.

Tools for Facilitating Participation

Tools and their potential applications are described in detail in the WFP Guide on ***Participatory Techniques and Tools***[4] available at www.wfp.org or at

www.livelihoods.org/info/pcdl/self/self_instruction_materials18.html. The tools can help partners with information gathering and analysis. All of them are participatory, i.e., inclusive, interactive and iterative.

Two other approaches have proven effective in facilitating collaboration and community participation. Participatory rural appraisal (PRA) is used to gather and analyze information about a particular community where an organization intends to work. CBT is an approach to targeting interventions that maximizes input from the community.

Varying Levels of Participation

Participation can occur at several levels of intensity. The ideal level is self-mobilization, with external actors serving as catalysts of change. At minimum, food programming should engage in consultative participation.

Self-mobilization: Communities or local partners take initiatives independent of external institutions to change systems; external agents may play a catalytic role.

Interactive participation: Partners and communities participate in joint analysis leading to action, formation of new local groups or strengthening of existing ones; local stakeholders take control over local decisions, giving them an incentive to maintain structures and/or practices.

Functional participation: Communities form groups to meet a program's pre-determined objectives, driven by external stakeholders. Such involvement tends to occur after major decisions have been made; such groups may be dependent on external initiators but can also become self-dependent.

Consultative participation: Communities are consulted. External stakeholders consider their knowledge and interests; outsiders define both problems and solutions but may modify these based on local people's responses. But communities do not make decisions, and outsiders are under no obligation to act on local people's views.

Information-giving participation: Communities answer questions posed by external stakeholders or program staff; they do not have an opportunity to influence decision making because findings are not shared.

Passive participation: Only external stakeholders make decisions; local communities are told what is going to happen or has already happened.

Key Concept

7.3 Existing Programming and Complementary Inputs

Agencies often experience greater success when integrating food interventions into existing programming, as opposed to introducing the food pipeline independently. This includes integration with programs implemented by the agency itself or other organizations to ensure a holistic approach to programming.

Food-based interventions that are introduced to communities via ongoing programs and services can complement these efforts and strengthen relationships between those programs and target communities. For example, some agencies provide food to institutions supporting vulnerable groups, particularly orphans. In order to receive support,

an institution must be registered, provide complementary services, demonstrate need and provide support to vulnerable groups. While it is understood that communities and extended families generally provide the most appropriate and most sustainable care, institutions may be the last resort for the most vulnerable, even if only for a short-term stay. Institutions may include orphanages, rural and urban child daycare facilities, hospice care facilities for adults and children, schools/homes for the disabled, skills training centers, homes for the elderly, centers for street children and OVC support programs.[5]

Complementarity and Non-Food Inputs

As described in **Part III: Sector-Specific Program Design Considerations**, a variety of non-food activities and inputs are integral to sector-specific interventions. While food assistance alone may be provided, complementary interventions are necessary to ensure and expand its impact. However, multiple funding streams are often needed to cover a range of complementary inputs, so it is critical to identify and access potential sources of funding for non-food inputs at the earliest stages of program planning. Projects with single-source donors that primarily provide food often cannot implement integrated projects readily—or at all—without complementary funding. There are often limitations on what costs food aid donors can cover when an activity is not directly tied to the food, particularly in emergency programs.

Agencies should be realistic about the non-food inputs needed for comprehensive programming, especially when integrating HIV-related issues into programming, and should assess donors' capacity to cover those costs. Two common strategies for acquiring these resources are 1) supporting existing programming within the agency itself or by linking with partners who can provide the complementary resources, or 2) raising funds among other public and private donors.

Complementary Programming: Linking C-SAFE Food Pipeline to Existing NGO Programs in Southern Africa

Salvation Army Combines Food with Community Counseling

The Salvation Army (TSA) Malawi combined food with community counseling and paved the way for community-based food assistance targeting. TSA strengthened an existing strategy by training community counseling teams, equipping them with skills much like a standard counselor, but with the intention of using their skills with small groups and families where a "shared confidentiality" model was more culturally congruent than one-to-one counseling. This provided a very strong foundation for the community to help households with chronically ill members and paved the way for targeting C-SAFE food distributions.

Area Development Programs Provide Entry Point for Food Programming

When C-SAFE targeted food assistance became available, World Vision (WV) Malawi was working in three districts with established Area Development Programs (ADPs), with a commitment to assist communities in integrated development programming for 10 to 15 years. The ADPs—each of which covers several communities with 4,000 to 6,000 households—provided an ideal structure for introducing the C-SAFE initiative because WV had an ongoing relationship with those communities, as well as extensive statistics on their vulnerability to food security to help identify C-SAFE's target groups.

One controversial type of complementary resource is food incentives for home-based caregivers and other volunteers. Many PLHIV support programs would not exist without these volunteers, who have high dropout rates and who may be as food-insecure as their PLHIV patients who receive food assistance. However, some donors do not support volunteer incentives. Program designers should be aware of the issues surrounding volunteer incentives and explore creative ways to support volunteers without undermining community spirit or creating competition. This might include possible FFT-type programs for counseling or other types of FFW programs.

7.4 Key Concept
Developing Partnerships

Forming partnerships to deliver food security, livelihood and HIV programming is common and often imperative in the quest to provide comprehensive and holistic programming. Partnerships are typically formed between NGOs (international, national and local), UN agencies, government bodies, CBOs, FBOs and community leaders. As noted in **Chapter 2: Policy and Program Environment,** Key Concept 2.4, partnerships can take many forms, including cooperating partnerships, complementary partnerships and coordinating partnerships.

Aside from more formal contractual arrangements, good relationships are key to successful partnerships. Good practices in the partnership process include:[6]

- Recognizing that participation will not happen on its own and planning for the involvement of key stakeholders as early as possible
- Consulting people at the community level about who will best represent them in the planning process

Partnership at Work: NGOs and Cambodian Government[7]

Cambodia's Home Care Program is a partnership between the government and the country's HIV/AIDS Coordinating Committee, which groups together Cambodia's NGOs involved in HIV.

Home Care Teams provide palliative care, counseling, education and welfare support to the patient and family members. They foster contacts within the community, pagodas, hospitals and other institutions to help support their activities, thus creating a Home Care Network of partnerships.

The results have been promising and community response has been very positive:

- PLHIV receiving home care visits report that they feel better able to look after themselves. By focusing on better nutrition and early treatment of infections, they say they enjoy both better health and a more positive outlook.
- Family members report a better understanding of HIV and greater confidence in caring for patients; they also say the program has saved them time and money.
- Community leaders report reduced discrimination, fear and anger and an increased knowledge and support for PLHIV.

Integrating School Feeding and HIV Programming[8]

In 2003, as part of their global strategic partnership, WFP and World Vision (WV) acquired a USAID grant specifically supporting joint programming to benefit orphans and other children affected by HIV, and their families and/or caregivers. Based on an initial short list of 12 countries, WFP and WV jointly selected five countries (Burundi, Mauritania, Rwanda, Sierra Leone and Uganda) to participate in the pilot, in which WFP provided food assistance linked with complementary activities by WV to mitigate the impact of HIV.

The pilot partnership was directed by a joint Partnership Coordination Team led by two partnership coordinators based at WV in Johannesburg and WFP in Rome. The objectives of the pilot project were to:

- Develop a partnership of equals
- Build on comparative advantages
- Focus on complementary activities
- Apply lessons learned from the pilot project
- Provide feedback to improve strategic partnerships

- Understanding and clearly outlining each partner organization's policies on participation—particularly the participation of women and PLHIV—to other partners
- Recognizing that identifying relevant stakeholders is an ongoing process
- Working jointly to arrive at operational strategies
- Being realistic about each partner's strengths and weaknesses and recognizing that capacity strengthening may be required

Capacity Development of Partners

Understanding one another's strengths, weaknesses and capacity limitations is integral to any partnership. Joint planning among various partners should consider members' strengths and weaknesses and make this part of the baseline information used to design the program. Conducting a capacity assessment of partners will help to determine what type of training and capacity building will be required to implement program plans.

There are a variety of tools that can facilitate this process in a participatory manner, including WFP's Capacity Analysis Match, a highly interactive tool than enables partners to assess their capacities and resources, learn from and/or train one another, and determine when outside help is required (see Annex 1).

There are also other tools, such as PACT's organizational capacity assessment tools at www.pactworld.org/services/oca/index_oca.htm, that are easily adapted to various settings and contexts.

In a high HIV prevalence context, adequate staff support and training for NGO and partner staff are also critical to providing effective HIV programs to communities. Workplace policies and staff training on HIV-related issues are discussed in **Chapter 9: Operational Modalities**, Key Concept 9.6.

7.5 Key Concept
Intersectoral Referral Mechanisms

Multisector and multi-actor linkages, along with well-functioning referral mechanisms, are critical to optimizing a continuum of care for PLHIV and affected households. Connecting various service-delivery channels can create an integrated, comprehensive support system for beneficiaries. For example, if a doctor sees that a TB patient needs nutrition assessment, counseling and/or food rations to support recovery, the doctor can refer the patient to a facility that provides those resources. Conversely, a food security program could refer its clients for clinical assessment and treatment.

Comprehensive Referral Systems

A comprehensive referral support system should link PLHIV, caregivers, family members, communities and aid organizations into an integrated referral network. Referral networks should include organizations in a certain location that can address health needs, support food and nutrition requirements, assist with livelihood and social protection needs, and provide microfinance training and support, education services, and a variety of other services. In an HIV context, some of these will include:

Comprehensive mapping of service delivery agencies may be a necessary first step to enhancing multisectoral referral mechanisms.

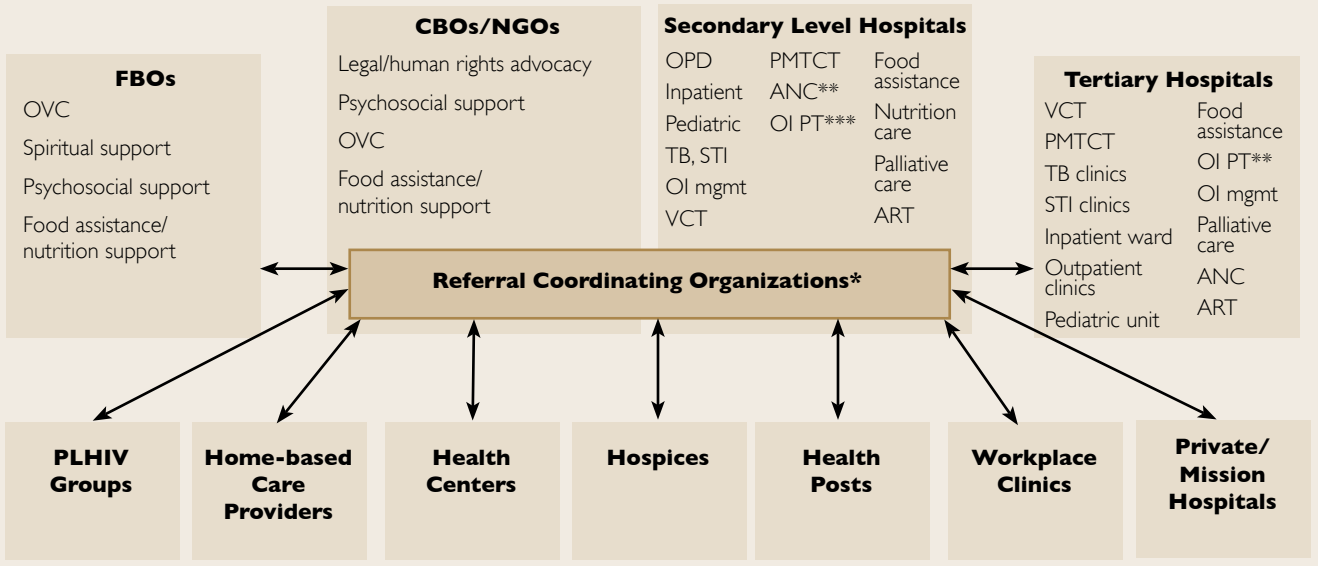
- VCT facilities, which often serve as a point of referral to health, physical, psychological and spiritual support programs
- ARV treatment programs
- TB treatment programs
- PMTCT programs
- HBC programs
- Youth associations and clubs, women's groups, FBOs
- Traditional healers and leaders
- OVC programs
- Food assistance programs

Ideally, a health facility or CBO would serve as the focal point and coordinate the services, as shown in Figure 1, adapted from Family Health International's (FHI's) Referral Network for Prevention, Treatment, Clinical Care and Support model.

FHI also has published a guide to creating referral networks, "Establishing Referral Networks for Comprehensive HIV Care in Low-Resource Settings" [9] and a companion toolkit. [10] These can be downloaded from FHI's website at **www.fhi.org/en/index.htm**.

Because of HIV's impact on pregnant women and their babies, strong referral systems should, at the very minimum, be in place to ensure that any HIV positive women seen at antenatal clinics are enrolled in an HIV clinic. PMTCT counselors should encourage family members to be screened for HIV and refer them when appropriate. Likewise, HIV clinic clients who become pregnant should be referred to the PMTCT programs. In these cases, programs should try to speed the process by sharing relevant medical records and follow up with referred patients who do not show up at either site within a reasonable period.

Figure 1: Referral Network for Prevention, Treatment, Clinical Care and Support



* Coordinating organization can be a health facility or CBO/NGO
** ANC=antenatal care
*** PT= prophylactic treatment

Family Health International (FHI). *Tools for Establishing Referral Networks for Comprehensive HIV Care in Low-Resourcing Settings*, Arlington, VA: FHI, 2005

Primary Challenges to Developing Intersectoral Referral Mechanisms

While linkages between sectors, departments and agencies are usually desired by all parties, they are difficult to maintain because of time pressures, workload, inadequate resources and competing agendas. There are several other well-documented challenges to developing effective intersectoral referral mechanisms for food assistance in an HIV context.

Overlap of benefits. One primary challenge is that households may receive food assistance from multiple sources if they qualify under various categories, including OVC-targeted aid or as members of PLHIV groups. While local and international NGOs have resolved and managed overlap in some areas, others report significant overlapping of food benefits because of referral mechanisms that are not well-coordinated. Although field-level

Rural Health Motivators Play Key Role in Referral Systems

Rural health motivators (RHMs) support rural communities in high prevalence areas in southern and eastern Africa by assisting with local health matters and promoting healthy practices. RHMs, typically women selected by traditional leaders and community members, play a primary role in identifying the chronically ill and referring people to health centers for testing and treatment.[11]

verification should ensure that each household receives an appropriate level of assistance, limited staff capacity as well as poor coordination and follow-up hampers these efforts.[12]

Coverage of ART programs. Another challenge for targeting and referral is the typically urban bias of ART programs, whereas food assistance programming is more commonly focused on rural, food-insecure populations (see **Chapter 1: Conceptual Framework** for more on urban versus rural environments). Similar obstacles are evident when referral mechanisms are triggered by eligibility for ART regimens. Since targets for ART are typically able to serve only a fraction of those in need, there will be food-insecure people who are medically eligible but unable to receive assistance.[13]

Confidentiality. Maintaining confidentiality in referrals between the health and social sector is a key challenge. A patient must be able to rely on the confidentiality of any health-related information, including HIV status, when a case is referred to a service provider. One option for food programming may be to use mechanisms that rely on self-identification and cross-reference these with permission against clinic records.

A referral system that functions properly brings health, social and economic empowerment programs around the same table—an essential prerequisite to creating a continuum of care.

7.6 Key Concept

Scaling Up Programming

Bringing successful pilot or small-scale interventions to a larger number of people is a common challenge. Hundreds, perhaps thousands, of community-driven interventions serving one or a handful of communities exceed their expectations and inspire community members and other stakeholders to sustain them for many years.

Despite the success of many small-scale initiatives, it is impossible to achieve national or international goals for food security and HIV without effective large-scale action.[14] The many lessons learned and best practices in successful small-scale interventions have not been translated into bigger projects or wider coverage.[15] Unfortunately, when programmers try to expand or replicate the interventions, they often find that the success stemmed from a level of attention and inputs that are not feasible for serving greater numbers in new target areas. For these and other reasons, attempts to significantly scale up projects often falter.

Still, several small-scale interventions have been brought to scale successfully. This Key Concept reviews the lessons learned from some of these experiences.

Lessons on Bringing Community-Driven Development to Scale[16]

The International Food Policy Research Institute (IFPRI) reviewed five community-driven development (CDD) projects in Zambia, Malawi, Kyrgyz Republic, India and Nepal, examining conditions for a successful scale-up as well as limiting factors. Two key conclusions were:

- Capacity is a pivotal factor. Capacity goes beyond resources and includes motivation, commitment and appropriate incentives at all levels. An upfront and ongoing investment in capacity, with particular attention to facilitators and local leaders, is vital.
- "Learning by doing," as opposed to mere replication, should be fostered at all levels, with time horizons adjusted accordingly. A "learning by doing" culture values adaptation, flexibility, and openness to change. One World Bank review concluded that because the success of CDD is linked to local cultural and social systems, it is best done not with a wholesale application of best practices from projects that were successful in other contexts, but by careful learning by doing.

The IFPRI study encourages CDD donors and supporters to think of the process beyond the project and transformation or transition, instead of exit, once the project has ended.

Ultimately, the study found, bringing CDD to scale is not about projects per se, but processes and principles that must become anchored in national policy frameworks and embedded within the country's social, cultural and institutional fabric.

Key Considerations for Scaling Up

Below are some key lessons gleaned from a review of eight HIV initiatives on three continents. While the contexts varied dramatically, the lessons in scaling up were remarkably similar: [17]

Building bridges. While some successful partnerships evolve naturally without formal planning, contracts or Memoranda of Understanding (MOUs), these arrangements depend heavily on the interpersonal skills of staff and mutual goodwill. Most effective scale-ups are the result of carefully designed cooperation between services. The partners have similar goals and objectives in HIV responses or recognize the potential to capitalize on synergies and complementary expertise between HIV-related activities and those in different fields. Partnerships with government, GIPA and community involvement are all critical to scaling up activities.

Decentralization. National HIV responses cannot reach the necessary scale, maintain quality or provide flexibility by acting solely through centrally operated programs. A decentralized, participatory approach that involves all sectors is the only way for programs to scale up and increase coverage, particularly to those who are hard to reach.

Building management capacity. In many developing countries, HIV projects are held back by administrative challenges. Some are the legacy of colonial times, and some are of more recent origin. But most are not peculiar to HIV and are encountered in all aspects of public administration and governance. In general, there is a need to:

- Build institutional capacity, including training managers and strengthening administrative infrastructure to manage given projects
- Establish or update administrative procedures to promote initiative and improve effectiveness

TASO Shares Experience/Builds Capacity[18]

Some successful programs choose not to scale up. One example is The AIDS Support Organization (TASO) of Uganda, which is arguably one of Africa's most successful HIV NGOs and has served as a model for others. In 1995, TASO was operating in eight of Uganda's 49 health districts and was often tempted to expand to respond to the obvious need in other districts. TASO decided to limit its own growth because of fears of overextending itself and, instead, decided to help other NGOs who were attempting to do home care, providing the benefit of its experience to these newer organizations.

- Ensure transparency to prevent inefficiency and corruption from depleting scarce resources
- Encourage follow-up by building monitoring and evaluation into planning cycles

Scaling down before scaling up. Scaling down before scaling up is integral to reaching a larger beneficiary audience. To foster the expansion of a successful small-scale operation, it is often necessary to transfer management responsibility to the community, thus reducing the international development organization's control and involvement.

A review of the Scaling Up HIV Interventions Through Expanded Partnerships (STEPs) program in Malawi found several other key factors for facilitating a scale-up: [19]

- An enabling policy environment and a commitment by the government to a multisectoral solution to the pandemic
- Demand-driven processes using communities as catalysts for change
- Flexibility and an ability to adapt to new information and change
- Documentation and management information systems that collect and disseminate better practices to facilitate learning

Key Concept

7.7 Sustainability and Exit Strategies

Ensuring sustainability in an HIV context presents additional challenges to food assistance programs, especially where poverty, food insecurity and HIV prevalence are closely related.

Sustainable development programs support activities and behavior changes that will become permanent and self-sustaining, so progress toward overall development goals will continue after program support is withdrawn.

Sustainability is built on participatory and inclusive programs and requires an individual, community, local organization or government to be fully equipped to carry out the actions required to maintain or sustain achievements. This guide presents approaches—from community participation and partnerships to holistic and complementary programming that

integrates HIV services into food security programs—intended to help program managers meet these challenges to sutainability.

An integral part of ensuring sustainability is a program exit strategy, which should be built into a program's design from the beginning, monitored throughout implementation and, ideally, reviewed for effectiveness once the program is completed.

Developing appropriate exit strategies may also be more challenging for food assistance programs than for other programs and is likely to be even further complicated in a context of high HIV prevalence. The planning matrix in Figure 2 on page 154 provides guidance on designing an exit strategy in an HIV context. Some of the more basic concepts and terminology related to exit strategies are provided below:[20, 21, 22]

What Is a Program Exit Strategy?

A program exit strategy describes how the program intends to withdraw its resources while protecting the program's achievements and ensuring continued progress toward its goals. An exit strategy could be accomplished through staggered graduation from specific project areas, simultaneous withdrawal from the entire program area, or transitioning to associated programming in selected areas.

Why Are Exit Strategies Important?

Exit strategies, when planned with partners in advance of close-out, ensure better program outcomes and encourage commitment to program sustainability. In addition, good exit strategies can help resolve tension that may arise between a program's need to withdraw assistance and its commitment to achieve its outcomes.

Exit strategies also can help define a sponsor's role to host countries and local partners as being time limited, reducing the potential for misunderstandings and future dependency. In addition, they are critical to food assistance programming as they inform a program's plan for sustainability or planning for its next phase.

Graduation Strategy Versus Exit Strategy

While an exit strategy involves the withdrawal of a program from the entire area, a graduation strategy refers to a program's withdrawal from specific communities or a project site.

In an HIV context, a graduation strategy can also refer to a plan for how a beneficiary will be discharged from food assistance while ensuring that achievement of the program objectives regarding that beneficiary is not jeopardized and that further progress will be made.

Similar to an exit strategy, the goal of the graduation strategy is to ensure sustainability of impacts. When the intervention involves food assistance, beneficiaries can be graduated to other food security interventions to ensure that their food security and livelihood status continues to improve.

What Is a Program Transition?

A program transition is defined as the change from one type of assistance program to another. It may mean changing a program's emphasis from one type of food assistance to another (e.g., from general food distribution to more targeted assistance to vulnerable groups such as the chronically ill or OVC), and usually indicates the scaling down of resources. A program transition could also refer to changing from a food assistance program to another type of programming (e.g., non-food). A key question to be addressed in this process is whether to continue food assistance. If so, how should food assistance be continued and from whom would the resources come? If not, then what other activities should continue?

Three Approaches to Exit Strategies[23, 24]

1. Phasing down. This is a gradual reduction of program activities, using local organizations to sustain program benefits while the original sponsor, implementing agency or donor deploys fewer resources. Phasing down is often a preliminary stage to phasing out and/or phasing over.

2. Phasing out. This refers to ending a program without turning it over to another institution for continued implementation. Ideally, a program is phased out after permanent or self-sustaining changes are achieved, eliminating the need for additional external inputs. In a high HIV prevalence context, reaching a level of self-sufficiency through behavior change and asset creation activities (such as crop diversification and nutrition education) requires a long-term investment and is unlikely to be realized entirely during the term of a given project.

Donor support and funding cycles may impose artificial timelines on program phase-out. For instance, where harvest cycles may be an obvious choice for timing a program phase-out, the donor's fiscal year and other pre-determined timing requirements for grant closeout may not accommodate this.

An exit strategy is successful if:

- The program impact has been sustained, expanded or improved after the program ends
- The relevant activities are continued in the same or modified format
- Systems developed continue to function effectively

3. Phasing over. The third approach is phasing over, in which a sponsor transfers program activities to local institutions or communities. During program design and implementation, emphasis is placed on institutional capacity building so program services can continue through local organizations.

Of the three approaches mentioned above, phasing over is often the most feasible and effective exit strategy available. For food assistance agencies intending to pass significant responsibility for program management to local organizations, these questions should be carefully considered during the design phase:[25]

- How strong is the community's sense of ownership/commitment to continue activities?
- To what extent does the community value program activities? What is the level of demand for the phased-over services?
- Do community members, groups and service providers have the knowledge and skills to implement the program activities?
- Do the local organizations implementing the phased-over activities have sufficient institutional and human resource capacity?

Lesotho FFA Builds In Phase-Out With a Fixed Timeframe[26]

The C-SAFE Lesotho nine-month modular FFA program was designed with sustainability and program exit in mind. Implemented between 2002 and 2006, the program targeted able-bodied beneficiaries from food-insecure households for food assistance, offering a ration as an incentive for participating in a hands-on gardening curriculum with household-level asset creation. When households completed the curriculum, each had a functioning garden as well as some level of self-reliance.

- Are the organizations responsible for implementing phased-over programs resilient to shocks and changes in the political and social environment?
- Is there a viable plan to generate the consumable supplies (such as food or agricultural inputs) that are required to implement activities?

Exit Strategies In the Context of HIV

When developing exit strategies for food assistance programs in the context of HIV, it is important to assess and monitor how much the disease will affect community organizations' capacity to maintain adequate levels of care for affected households and individuals. Several factors must be considered to accurately assess the current capacity of service organizations, as well as predict their future ability to provide nutrition and other support to HIV-affected community members.[27] The characteristics of HIV-affected communities likely to have the most immediate influence on exit strategies include:

- Large and often increasing numbers of long-term chronically ill members, both adults and children
- Higher numbers of households headed by orphans, the elderly or single parents
- Decrease in services available in communities (e.g., government extension services)
- Increases in poverty and chronic malnutrition
- Increased food insecurity, particularly regarding diet quality and diversity
- Among PLHIV, increased nutritional requirements and increased importance of meeting RDAs for both macronutrients and micronutrients
- Increased need for foods that are nutrient-dense, easy and quick to prepare, and portable for people who need to eat small frequent meals and must carry the food to garden or work
- Increased incidence of acute malnutrition in children and adults
- Decreased transfer of knowledge and skills from adults to children
- Diminished household labor supply, at least temporarily or intermittently, resulting in less household income and food production
- More frequent conflict over land/asset ownership and inheritance when adults die without sorting out inheritance issues
- Change in the types of beneficiaries typically targeted for livelihood and asset creation activities when heads of household are dead or incapacitated

- Changing needs of PLHIV and those affected over time, contributing to a constant steam of new beneficiaries whose programming and service needs also change over time
- High staff turnover within NGO, CBO and government programs and resulting need to repeat training and capacity building efforts

Each factor reflects HIV's dynamic and progressive nature and its influence on food security within affected communities. Accordingly, developing exit strategies in areas highly affected by HIV involves a more concerted approach to assessment, planning and monitoring. One way of doing so involves establishing benchmarks to gauge the community's resilience with respect to food insecurity and HIV, including its capacity to care for potentially growing numbers of chronically ill and destitute individuals.[28] Benchmarks for gauging a community's preparedness to accept a phased-over food assistance program might include:

- Number of local organizations trained in all aspects of food assistance programming with adequate staff capacity and a food pipeline in place
- Sufficient community programs, such as irrigated gardens, to provide for the needs of food-insecure chronically ill or destitute households
- Sufficient number of food-secure, able-bodied individuals and households with sufficient resources and commitment to "adopt" chronically ill or destitute households
- Evidence that the intervention will be sustained over time
- Local organizations' ability to access external resources through proposal development, targeting and accountability capacities

Planning for exit strategies may also be hampered by a lack of economic opportunities and longer-term livelihood options for communities as they transition from food assistance.

Exiting from areas with a high prevalence of HIV may take more time and involve a longer phase-down or phase-over or additional funding to continue the program's unsustainable components. Given that little is known about HIV's long-term effects on livelihoods, it may not be possible to sustain program outcomes after an exit, especially in situations where phase-over or phase-out is premature or shocks occur.

TASO's Economic Empowerment Framework

TASO in Uganda addressed a lack of economic opportunities and livelihood options by developing an Economic Empowerment Framework to guide the interventions of partner organizations. It is aimed at helping a range of clients transition from short-term food interventions to longer-term livelihood support.

The framework includes the provision of food and care for the most acutely affected, "jumpstart" programs providing training and resources for livelihood recovery, and financial services for PLHIV groups geared toward livelihood recovery and expanding income-generating activities.

Figure 2: Planning Matrix for Exit Strategies in the Context of HIV

Questions:

1) What is your program's objective?

2) What parts of your program and which of its outcomes do you want to sustain?

Component	Key Questions	Guiding Principles	Challenges
1. Plan for exit from the earliest stages of program design	How will we "phase down" our program? Will we "phase out" activities or "phase over" to a local actor? What is the appropriate time line? How will we know we are on track for phase-out? What indicators or benchmarks will we use? How will we monitor them? What are the specific action steps to reach the benchmarks?	1. Flexibility: Consider the HIV timeline, i.e. the needs of HIV-affected and infected beneficiaries are not static 2. Ongoing program review and revision 3. Transparency: Especially regarding program limitations and funding cycle 4. Participation: Include HIV service organizations, PLHIV, Ministries of Health (MOHs), Community Development or Social Welfare, HIV-affected households	Balancing firm commitments with flexibility as conditions change; sometimes planning is necessary although future funding is uncertain Allowing adequate time to develop capacity, while working within the program funding cycle Responding to changing needs of HIV-affected and infected individuals and communities
2. Develop partnerships and local linkages	With what types of organizations should we partner? What will our partners bring to the partnership? What can we offer? How will the partnership prepare for exit? How can the partnership help facilitate a successful exit?	1. Diversity: Other program inputs may be needed as well as food assistance 2. Complementarity: Consider all possible partners, build in coordination and referral as it is critical when serving PLHIV and HIV-affected households 3. Clear and common goals	Aligning the needs and objectives of diverse stakeholders Supporting local partners without building dependency Increased numbers of "role players" in areas of high HIV prevalence; more time needed to identify, select and build partnerships
3. Build local organizational and human capacity	What capacities are needed? What capacities already exist? What indicators will we use to monitor progress in building these capacities?	1. Build on existing capacity whenever possible 2. Sponsoring organizations and partners model appropriate organizational and individual behaviors given the HIV context 3. Create new environments that support new behaviors and skills 4. Monitor progress	Designing a monitoring system to track capacity building Providing appropriate, sustainable incentives Retaining experienced staff in program areas with high HIV prevalence and/or job mobility

Component	Key Questions	Guiding Principles	Challenges
4. Mobilize local and external resources as an exit strategy	What inputs will we require to maintain services? Who can provide these inputs? To what extent are they available locally? Externally? Which benefits of the program can be sustained without continued inputs? To what extent can the benefits be sustained without ongoing inputs?	1. Continue to progress toward sustainability, e.g. support the production of local fortified commodities 2. Generate and procure resources locally where possible 3. Bring external resources increasingly under local control 4. Advocate for long term needs of HIV-infected and affected communities and indivuals	Difficulty in finding adequate or available local resources Sources of other funding may not buy-in to all of the original program's objectives Resisting the tendency to cover a lack of sustainability by simply finding a new donor to fund inputs Sustaining program impacts among HIV-infected and affected households
5. Stagger phase-out of various activities	What are the key elements of the program? Which elements are dependent on others? What are the graduation and exit plan and timeline for the program components? How will it be implemented? How will it be monitored?	1. Flexibility: the logical sequence for staggering phase out of various activities may change once activities have been implemented	Sufficient time in program cycle to start seeing the impact of activities other than direct food distribution in order to effectively transition to them when food distribution is ended Increased nutritional needs of PLHIV Difficulty identifying program activities other than direct distribution that HIV-affected households can transition to in a staggered phase-out
6. Allow roles and relationships to evolve and continue after exit	What types of ongoing support would be most useful (e.g. advice, mentoring, technical assistance)? How will such ongoing support be funded when the project finishes?	1. Prevent slippage of program's results by re-entering if necessary	Availability of funding for ongoing support Availability of program staff who can focus sufficient time and energy on ongoing support in an area where a full program does not exist

Source: Gardner, A., Greenblott, K., and Joubert, E. ***What We Know About Exit Strategies: Practical Guidance for Developing Exit Strategies in the Field.*** Johannesburg, South Africa: C-SAFE Regional Learning Spaces Initiative, 2005.

Annex 1: WFP Capacity Analysis Match

Description: This is a highly interactive tool, which enables stakeholders to determine whether they have the capacities, skills, resources, knowledge and/or experience amongst them. These stakeholder capacities are relative to the activities within each stage of the programme, and can be done in the preparation stage, or before entering each subsequent stage.

Possible applications: Assess the potential or capacity of partners to learn from each other, train each other and determine when outside help is required.

What you need: Flipchart paper, pens.

How to use:

- Explain the task that has to be accomplished.
- Brainstorm the skills, experience and resources that are needed to accomplish the task.
- Place each one of these skills in the Match grid on the flipchart, as shown in the example.
- Have partners put their names down in the places where they have the necessary resources, skills or experience.
- Discuss the results, with special emphasis on the areas where capacity is not fully met by the partners.

Examples of Food Needs Assessment					
Program Stage Idea					
	M	A	T	C	H
1	Do you have access to, and the ability to interpret, national-level nutritional information?	Do you have an understanding of micro-economics?	Do you have adequate staff skilled in participatory techniques?	Do you have logistical support for the field (transportation, field offices, etc.)?	Do you have financial resources?
2	Do you have a good understanding of the cultural and political climate at the national and local levels?	Do you have experience and connections to the poor and marginalized populations?	Do you have a good understanding of food insecurity coping practices at the community and household levels?	Do you have staff who know the local languages?	Do you have a good understanding of food strategies?
Program Stage Design					
	M	A	T	C	H
1	Do you have staff trained in PRA techniques?	Do you have a broadbased (national and local) knowledge of natural resources (forestry, wildlife, parks, environment)?	Do you have broadbased (National and local) knowledge of health issues?	Do you have logistical support for the field (transportation, field offices, etc.)?	Do you have broadbased (national and local) knowledge of educational issues?
2	Do you have staff who know the local languages?	Do you have broadbased knowledge of infrastructures (roads, bridges, school buildings, clinics, etc.)?	Do you have experience in conducting community-based needs assessments?	Do you have experience in conducting participatory baselines?	Do you have a good understanding of food strategies?

Source: World Food Programme (WFP). *Participatory Techniques and Tools: A WFP Guide.* Rome: WFP, 2001.

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Chapter 8: Monitoring and Evaluation

Program Design Steps

Chapter 8: Monitoring and Evaluation

Program Design Steps

Key Concepts

8.1 Considerations in M&E for Food Assistance Programs in an HIV Context

8.2 Key Elements of M&E for Food Assistance Programs in an HIV Context

8.3 Challenges of M&E for Food Assistance Programs in an HIV Context

In This Chapter

This chapter brings together what has been learned to date about monitoring and evaluation (M&E) of food assistance programs in an HIV context and provides specific direction for monitoring and evaluating HIV-related activities such as PMTCT, ART, TB, OVC, and care and support programs that integrate food and nutrition.

The chapter identifies several significant issues that distinguish M&E for food assistance programs in areas of high HIV prevalence from M&E in a non-HIV context. These differences include the need for greater interaction with and reliance on health services, the variation among beneficiaries of integrated programs, and the issues presented by stigmatization of HIV-positive individuals and affected families. In highly affected areas, it also becomes increasingly important to monitor contextual issues influencing the relationship between food insecurity and HIV.

Next, the chapter describes the key elements of food assistance M&E systems. These include the information requirements for effectively monitoring and evaluating project activities and changes among beneficiaries and target populations, the identification of appropriate indicators and determination of program targets, as well as approaches to data collection and analysis.

The chapter then discusses some of the challenges that remain in adapting food assistance M&E systems to an HIV context. Among the more technically demanding challenges of M&E in highly affected areas are interpreting standard anthropometric measures, determining the validity of proxy indicators in differing contexts and adapting traditional sampling methods.

Despite the guidance this chapter provides on adapting M&E systems to account for the impacts of HIV, there are many potential areas for investigation that are beyond the capacity of a single program's M&E system. Many such questions and issues are better addressed through operations research. Where appropriate and feasible opportunities exist, programs may consider integrating an operations research component. However, in most cases, program M&E should remain focused on measuring and using information from program-specific indicators that staff can collect and analyze and should not be expected to address broader research questions.

8.1 Key Concept
Considerations in M&E for Food Assistance Programs in an HIV Context

Several key considerations make M&E of food assistance programs in an HIV context different from—and often more challenging than—in a non-HIV context. Some of the significant issues to consider include:

Differing objectives. The objectives of food-based interventions in an HIV context may be different from those in a non-HIV context; therefore indicators used to measure results require adaptation. For example, whereas the objective in non-HIV contexts may be to improve nutritional status of targeted vulnerable groups, for individuals who are chronically ill the objective may be simply to maintain nutritional status or slow its decline. Food may also be used for entirely different reasons than in traditional programs (e.g., to improve adherence to or mitigate side effects of ARVs, or increase use of PMTCT services). Relevant indicators appropriate for beneficiary groups being targeted should be developed and measured for these objectives (see **Chapter 5: Targeting**).

Attention to stigma. Stigma and discrimination should be considerations in M&E just as they are for targeting and other aspects of program planning. In many cases proxy indicators may be required (e.g., using chronic illness as an indicator because stigma may prevent people from identifying themselves as being HIV-positive). Also, beneficiaries who are afraid of being stigmatized may not properly register (e.g., give a false name or address) or not appear for regular follow-up, making it difficult to track progress. Program activities must include mechanisms for maintaining confidentiality when targeting PLHIV to guard people's privacy and reduce the possibility of discrimination or resentment among non-beneficiaries.

Variation among beneficiaries. While there is variation among beneficiaries in all food security programs, the variation may be much greater in HIV contexts. Individuals and households affected by HIV may face different and stiffer constraints to improved food security and may experience smaller improvements in food security from interventions than non-affected individuals and households do. Among HIV-infected individuals, there may be wide variation in outcomes depending on the stage of disease and their treatment status. These variations can have implications for the targets that a program sets and for data disaggregation and analysis.

Documentation of learning. To date, quantitative data demonstrating the outcomes and impacts of food assistance on PLHIV are weak or non-existent, though anecdotal evidence abounds. Both beneficiaries and clinical staff report that they observe positive impacts from food assistance, most often citing increased weight, strength, ability to work, increased food consumption and overall well-being.[1] Finding creative ways and reliable indicators to measure and document these improvements remains a challenge and an opportunity for learning. Where possible, opportunities to attach operations research to current programming should be identified and implemented to build the knowledge base about effective programming. However, such operations research efforts should not come at the expense of the programs' primary objective of effective implementation.

Greater interaction with and reliance on health services. Data collection, analysis and interpretation in an HIV context may require greater interaction with and reliance on health service providers than is usually the case for traditional food assistance programming. For example, clinical records may be a more prominent source of data than household-level surveys. Furthermore, since optimal programming may involve integrating food security and HIV interventions, M&E systems need to be planned carefully to collect necessary information on both food security and HIV outcomes, and to integrate data collection

systems to avoid duplicating efforts. Information sharing systems should provide program staff involved in clinical issues related to HIV with relevant food security information and should provide staff addressing food security issues with relevant HIV-related information.

Emphasis on capacity building. M&E of food assistance programming in an HIV context is still a relatively new area. Food assistance agency M&E staff, partners and health care providers may require significant training and capacity building on how to adapt and modify M&E systems to this context. As this area is evolving rapidly, capacity building in M&E should be considered an ongoing need and should be budgeted accordingly.

Attention to contextual issues. Tailoring program design to a particular setting in terms of local social, cultural, political, environmental or other factors is especially important in an HIV context. Given that vulnerability to the combined impact of food insecurity and HIV can be greatly influenced by issues such as migratory patterns, civil conflict and gender inequity, M&E systems in highly affected areas should pay specific attention to monitoring changes in context within the program area.

Key Definitions in M&E[2]

Inputs: Resources (e.g., staff, financial resources, space, equipment) utilized to accomplish the project's objectives

Processes: Specific activities (e.g., training, program design, planning) to which resources are allocated to pursue project objectives

Outputs: Products (e.g., number of trainees, immunized children, activities implemented) that result from the combination of inputs and processes

Outcomes: Beneficiary and population-level changes in knowledge, practices and attitudes (e.g., improved health practices, increased knowledge of nutrition) resulting from the intervention

Impacts: Long-term changes at the beneficiary and population level (e.g., improved food access, improved nutritional status, increased resiliency to shocks, reduced labor migration) resulting from changes in knowledge, practices and attitudes

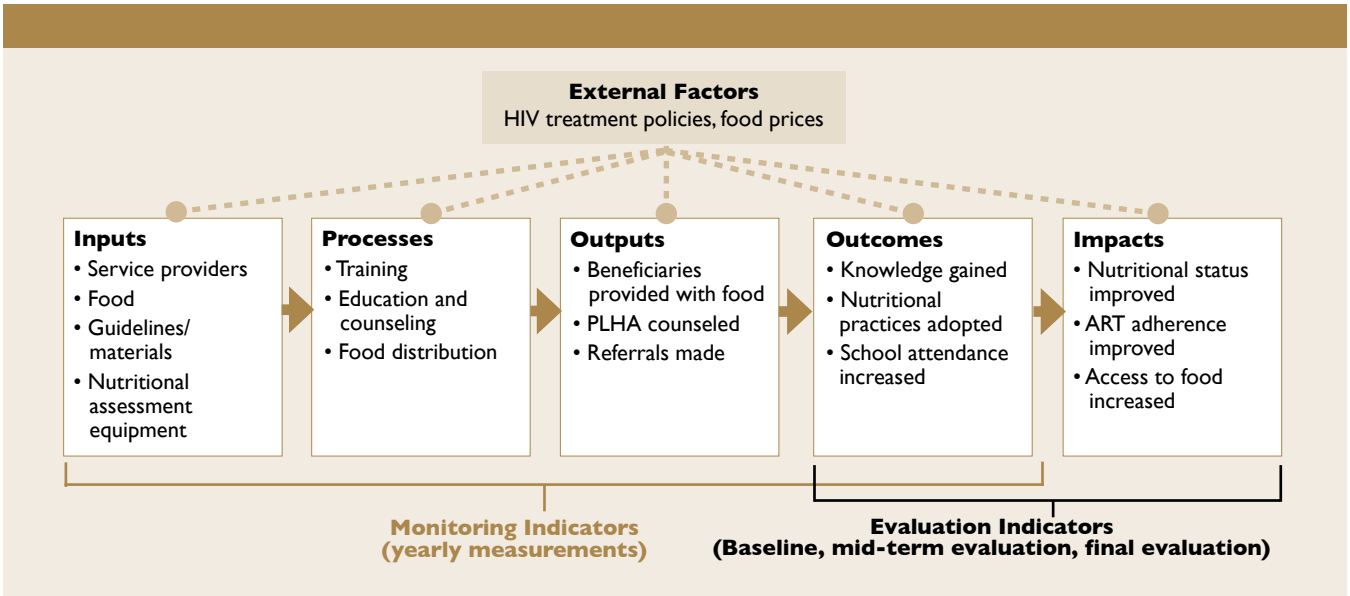
Key Concept

8.2 Key Elements of M&E for Food Assistance Programs in an HIV Context

While the core elements for designing an M&E system in an HIV context are the same as in a non-HIV context, there are specific issues and adjustments to consider to ensure that M&E systems are responsive to the information needs of the implementing organization and other stakeholders. This Key Concept discusses differences and adaptations to consider in an HIV context for the five main components of an M&E system:

1. Information needs
2. Indicators
3. Targets
4. Data collection and analysis
5. Uses of information

Figure 1: M&E Framework for Food Aid–HIV Programs



Adapted from Bergeron et al. ***Monitoring and Evaluation Framework for Title II Development-oriented Projects***. Technical Note 10. Washington, DC: FANTA Project, Academy for Educational Development, 2006.

Information Needs

There are two principal questions to ask about information needs: What are the purposes of collecting information? What information is needed to meet these purposes?

The primary purpose of collecting M&E information is typically to assess whether a program is achieving what it set out to do at the various stages of the program cycle, which are represented in the form of ***inputs***, ***processes***, ***outputs***, ***outcomes*** and ***impacts***. These stages are depicted in Figure 1, which has been adapted to an HIV context. Information on a program's progress and achievements is used for program management, reporting, learning what interventions work best, and advocacy.

Information can be organized into two categories: information on the progress of program activities and information on changes among beneficiaries.

Information on Program Activity Progress

Information on the progress of program activities—generally drawn from input, process and output indicators—should address these questions:

- Is implementation occurring at the planned levels and pace (inputs, outputs)?
- What is the quality of food-assisted services (inputs, processes)?
- Are beneficiaries accessing services? At what level of participation (outputs)?

In an HIV context, information about program progress can be critical. For instance, it may be important to know how many women have been referred to food assistance programs through involvement in PMTCT activities. In an FFA program, implementers may want to find out how well the program design and ongoing management adheres to GIPA guidelines. For nutrition education and counseling services, managers may want to know how well counselors are assessing clients' diets, educating clients and creating plans to address

nutritional concerns. Programs that support gender mainstreaming may want to monitor performance in incorporating and addressing concerns of women and men in their activities and assess any differences in how each group's concerns are addressed. (See Figure 2 for examples of input, process and output indicators for nutrition education and counseling.)

Information About Changes Among Beneficiaries and the Target Population

Information about changes among beneficiaries and target populations—generally measured with outcome and impact indicators—should address these questions:

- Have beneficiaries' knowledge, practices and attitudes improved (outcomes)?
- Has the nutritional status improved among beneficiaries and the target population (impacts)?
- Has access to food increased among beneficiaries and the target population (impacts)?

For example, in a PMTCT program, managers may want to know if women are following guidance on exclusive breastfeeding or learn how women's health and nutritional status have changed since enrolling in the program. For an FFA program, managers may want to find out how a community garden developed to provide food for PLHIV and OVC has contributed to these groups' household dietary diversity. In a nutrition education and counseling program, managers may want to know whether PLHIV are eating more frequently, are knowledgeable about using nutrition practices to manage symptoms, and have improved their nutritional status.

Figure 2: Example of the Input-Impact Sequence for Nutrition Education and Counseling (NEC) for PLHIV

Inputs	Processes*	Outputs	Outcomes	Impacts
Trained service providers Educational and counseling materials Adequate space for nutrition education and counseling Nutrition assessment equipment (e.g., scales), tools and documentation materials	Flow of clients to counselor or educator through referrals and other systems Quality of counseling: counselor behavior, assessment, provision of information, identification and planning of options for PLHIV Quality of group education	Provision of NEC as part of HIV treatment and care services Receipt by PLHIV of NEC services, such as individualized nutrition counseling and weight monitoring Receipt of follow-up nutrition counseling by PLHIV	Changes in PLHIV knowledge, dietary practices and related behaviors (for example, food purchase and preparation, water and sanitation, availing food supplementation, dietary response to symptoms, management of drug-food interactions)	Nutritional status (weight, nutrient deficiencies) Daily functioning and physical activity Severity, frequency and duration of symptoms Response to treatment, severity of side effects, and adherence

*These indicators could also be considered outcome indicators where the project is measuring systemic change in the quality of the health care system as a prerequisite to change in knowledge and behavior among targeted beneficiaries.

Source: FANTA Project. ***A Guide to Monitoring and Evaluating Nutrition Education and Counseling for People Living with HIV/AIDS.*** Draft. Washington, DC: Academy for Educational Development, 2006.

Identifying Appropriate Indicators

Once the specific information needs have been established, the next step is to identify reliable and measurable indicators for the information needs at each stage of the program cycle (input, process, output, outcome and impact). It may not be possible to collect all the data desired because of limitations of time, resources and staff capacity available for M&E. In such cases programs should prioritize their information needs, carefully balancing the need for information on program progress (to ensure the program is well-managed with effective service provision) with the need for information on individual changes (to ensure the program is having the intended effect on beneficiaries). Programs should also include indicators at each stage of the program cycle so that gaps can be easily identified and implementation processes refined where necessary.

M&E of food assistance programs in an HIV context is still a nascent field, and there is not yet a consensus about standard indicators. Still, much has been learned and documented in recent years to help practitioners select indicators. A number of groups are conducting pilot exercises and operations research to test various indicators and contribute to our understanding of what works. When selecting indicators, programs should consider:

- What the program expects to achieve
- How these achievements—and the processes leading up to them—can be measured
- The expected uses of the information collected
- The likelihood that the food assistance program will cause changes in indicators
- The cost and feasibility of collecting the data needed
- The expertise required to collect, analyze and interpret data generated by indicators
- Program staff capacity to collect, analyze and interpret the information
- Information currently being collected and existing data collection systems that may incorporate additional indicators

Figure 3 provides examples of indicators for food assistance programs in HIV contexts that are drawn from various sources, including FANTA, WFP and C-SAFE. These indicators reflect a range of interventions and program information needs and are intended to illustrate the various types of indicators that can be used. Programs should select their own indicators based on their specific objectives, interventions, expected uses of information and feasibility constraints.

Types of Outcome and Impact Indicators

There are various types of impact and outcome indicators, and in selecting which ones to use, programs should consider what changes the program interventions are expected to bring about and what can be feasibly collected. While some indicators must be collected by health care professionals because they require specialized expertise, food security program staff still should understand the indicators. Outcome and impact indicators that can be used in food assistance programs in HIV contexts include:

Anthropometrics. Anthropometric indicators use physical measurements to assess a person's nutritional status. They include BMI, percentage weight change, mid-upper arm circumference (MUAC), weight-for-age (W/A), height-for-age (H/A), weight-for-height (W/H),

Figure 3: Example Indicators for Food Assistance Programs in HIV Contexts

Input	Number or percentage of program sites with functional weighing scales Number or percentage of program sites with at least one service provider trained in nutritional care and support of PLHIV Number of staff trained in nutritional care and support for PLHIV Number of metric tons resourced
Process	Percentage of food rations distributed on time Percentage of beneficiaries aware of ration entitlement Percentage of beneficiaries satisfied with food quality Number of sensitization sessions conducted to inform beneficiaries about the purpose of the program and the criteria for participation Percentage of nutrition counseling sessions that meet a fixed criterion for quality (e.g., a counseling quality checklist)
Output	Number of metric tons of food distributed through each distinct food support activity Number of OVC (or ART clients or other targeted group members) receiving food Number of chronically ill individuals receiving food Percentage of care and treatment sites providing nutrition counseling with food Percentage of planned beneficiaries who actually receive food assistance, disaggregated by sex and age group Number of HBC groups formed Number of households affected by chronic illness that are provided inputs and training in labor-saving agricultural production techniques or household gardens Number or percentage of PLHIV who received nutrition counseling in the past three months
Outcome	Percentage of PLHIV beneficiaries consuming food the recommended number of times per day on the previous day Percentage of PLHIV beneficiaries who know appropriate dietary responses to symptoms and medication side effects Percentage increase in enrollment in PMTCT or ART services Percentage of households affected by chronic illness that are using labor-saving agricultural production techniques or household gardens Percentage increase in school attendance by OVC
Impact	Percentage of adult PLHIV beneficiaries with BMI < 18.5 Percentage of new ART clients with BMI < 18.5 who have BMI > 18.5 after six months of treatment Average percentage weight change among adult beneficiaries over the past three months Prevalence of malnutrition (weight/age) among children under five years of age born to HIV-infected mothers who were enrolled in the PMTCT program Percentage of beneficiaries still on ART 12 months after initiating treatment Percentage of beneficiaries performing moderate to intense physical activity (activities to be defined locally) for a fixed period of time (e.g., 45 minutes) on the previous day Percentage change in average quality of life (QOL) scores among beneficiaries

Adapted from 1) FANTA Project. *A Guide to Monitoring and Evaluating Nutrition Education and Counseling for People Living with HIV/AIDS*. Draft. Washington, DC: Academy for Educational Development, 2006; 2) Egge, K., and Strasser, S. *Measuring the Impact of Targeted Food Assistance on HIV/AIDS-related Beneficiary Groups With a Specific Focus on on TB, ART, CI and PMTCT Beneficiaries*. Johannesburg: C-SAFE Learning Spaces Initiative, 2005; 3) World Food Programme (WFP). *Proposal for Development of Monitoring and Evaluation Tools for HIV/AIDS Food-Assisted Programmes*. Draft. WFP, 2005.

skin fold thickness and others. Anthropometric indicators are widely used to measure the nutritional status of individuals or populations in HIV and non-HIV contexts.

Adherence/default. Treatment adherence or default rates are two sides of the same issue regarding people's participation in treatment services. Adherence measures patients' compliance in following prescribed dosages, while program default measures the percentage of patients who do not continue treatment. Programs usually choose the indicator that is easier to collect and most meaningful to them.

Program uptake. In programs such as PMTCT and TB-DOTS, enrollment before introduction of food assistance can be compared to enrollment after food assistance to see if the food assistance significantly influenced people to participate and receive counseling, treatment or other services.

Food access. Food access indicators measure individual or household access to food and include household dietary diversity, months of inadequate food provisioning, coping strategies, asset wealth, household food insecurity access scale, and others. Indicators and tools used to measure food access appear in Annex 1.

Illness/disease status. Illness indicators reflect the state of disease and opportunistic infections. Illness indicators include clinical symptoms and appearance, clinical events such as hospitalizations, and counts of CD4+ T-cells and viral load. Other indicators include scales such as the Karnofsky Scale, the Eastern Cooperative Oncology Group (ECOG)/ Zubrod Scale and the WHO HIV Stage Scale. The ECOG and WHO scales appear in Annexes 2 and 3.

There are specific factors in an HIV context that may affect indicators for coverage of services. For example, stigma could decrease coverage by preventing some beneficiaries from accessing services, while having a strong set of services could increase coverage by encouraging people to come forward.

Functioning. These indicators measure an individual's physical strength and ability to perform certain tasks. To measure a person's functional status, programs use hand grip strength, physical activity records, ability to perform daily activities, capacity to return to work, the extent of need for a caregiver, and Activities for Daily Living (ADL) questionnaires. A few organizations are experimenting with handgrip strength, using a mechanical handgrip dynamometer, as an easily administered measure of functioning. Used primarily with elderly populations, handgrip strength has been found to be positively correlated to BMI, MUAC and arm muscle area.[3]

Quality of life. Quality of life (QOL) is a multifaceted and subjective concept that considers the impact of impairments, function, perceptions and social opportunities. QOL measures can offer a rich assessment of the impact of food assistance programs, including physical, social and psychological status. There are a variety of tools for measuring QOL, including the Standard CDC Health-Related Quality of Life (HRQOL) 14-item Measure, the HRQOL-HIV scale and and the MOS-HIV scale. The MOS-HIV scale appears in Annex 4.

Setting Targets

Targets are commitments made by implementing agencies about the level of inputs and activities to be implemented and about the extent and timing of a particular program's results. Typically, a target will be defined by a specific indicator value to be accomplished by a particular date in the future.[4]

The process of setting targets in the HIV context should carefully consider the operating environment and limitations. For example, in non-HIV contexts, programs may aim to increase a household's accumulation of productive assets. In an HIV context, the target may

be a specific number or percentage of households that have maintained productive assets. Similarly, where coping strategies are being monitored as a measure of food security, the target in a high HIV prevalence context may simply be to prevent a certain number or percentage of households from engaging in negative coping strategies in the short term.

In some contexts, it may be most appropriate to set targets for recovering assets or health conditions or maintaining them at normal, pre-shock levels (e.g., pre-drought, civil unrest, pre-HIV epidemic levels). Data from earlier DHS surveys (www.measureDHS.com) and UNICEF Multiple Indicator Cluster Surveys (MICS) (www.childinfo.org) may be good sources of information on what is "normal" in a specific country.

In an HIV context, indicators often focus on changes that may not be easy to describe in quantitative terms, for example, improvements in the quality and delivery of nutritional care services through HBC. Appropriate performance indicators for such programs may include new HBC functions that participating organizations can perform and a set of standards for each of these functions. In such cases, descriptive, or qualitative, targets may provide more depth and contextual information than quantitative data. Qualitative targets are difficult to aggregate, but it is possible to transform qualitative information into quantitative scales against which targets can be set.

Examples of Expressing Targets in Food-Assisted HIV Interventions[5]

Targets may express quantity (how much), quality (how good) or efficiency (least cost) to be achieved within a specific timeframe. Ways to express targets include:

- Absolute level of achievement, e.g., 1,000 chronically ill individuals trained in positive living by 2007
- Change in level of achievement, e.g., ART adherence rates increased by 10 percentage points between 2006 and 2007
- Change in relation to the scale of the problem, e.g., percentage of food-insecure ART patients receiving food support increased by 10 percentage points by 2007
- Change in cost-efficiency of service, e.g., cost of PMTCT services (per individual) reduced by five percent between 2006 and 2007
- Proportion reaching a certain level of quality, e.g., proportion of HIV care sites meeting minimum standards for quality nutritional care based on a standardized checklist
- Creation or provision of something new, e.g., anti-stigma campaign conducted throughout the district by the end of 2006

Setting appropriate targets for food assistance programs addressing HIV can be challenging because there is little long-term experience with these programs and because many other factors affect program outcomes. These sources can help in setting realistic program targets:

Baseline survey. If secondary data of sufficient quality are available, organizations may be able to use them to establish baselines. Otherwise, agencies may need to collect primary data to establish baseline values. For individual or household indicators, baselines should disaggregate data by relevant target groups (e.g., gender, chronically ill, households caring for orphans) to help set disaggregated targets.

Transforming the Qualitative to Quantitative[6]

To measure an intermediate result that emphasizes improvements in quality of maternal and child health services, USAID/Yemen devised a scale that transforms qualitative information about services into a rating system that can be used to set targets. Similar scales can be developed for food assistance and HIV services.

0 points = Service not offered

1 point = Offers routine antenatal care

1 point = Offers recognition and appropriate management of high-risk pregnancies

1 point = Offers routine deliveries

1 point = Offers appropriate management of complicated deliveries

1 point = Offers postpartum care

1 point = Offers neonatal care

Score: Total actual service delivery points

Illustrative target: Increase average score to 5 by Year 3

Beneficiary expectations of progress. It is important to solicit input from community members (including HIV-related service organizations and the PLHIV and HIV-affected households who will be assisted by the interventions) to understand their preferences, needs and expectations for project activities. This information will help set relevant and realistic targets. Information collection may involve formal interviews, rapid appraisals or informal conversations with relevant groups or their representatives.

Trends observed before program implementation. Underlying historical trends in selected indicators may help provide a fuller picture than baseline values alone. Determining patterns of change with respect to individual performance indicators (e.g., recent increases/decreases, spreading geographic trends) can inform the process of setting targets.

Expert judgments. It is also useful to solicit expert opinion on what is feasible regarding a particular indicator or within a given context. As always, experts who are familiar with HIV-related issues—such as those from HIV coordinating bodies within the government as well as those directing HBC, VCT, PMTCT and other services—should be included.

Accomplishments of comparable programs. This may be especially helpful in an HIV context because many organizations are piloting/experimenting with different approaches. Gauging other organizations' progress with programs with similar contexts, resources and other factors may provide an effective means of setting targets.

Data Collection and Analysis

Data collection and analysis in an HIV context require flexibility, time and resources to adapt existing tools and approaches and to develop new systems as needed. Some issues to consider in adapting data collection and analysis processes to HIV contexts are noted below.

Data Collection Approaches

Programs may need to adapt existing data collection approaches to the specific constraints of HIV contexts. For example, stigma or confidentiality issues may make it difficult or

Progress Is Not Always a Straight Line

While it is easy to establish annual targets by picking an acceptable final performance level and dividing expected progress evenly by the number of years, such linear thinking about progress is often inconsistent with the way development programs really work, especially in HIV contexts.

In many cases, no real progress—in terms of measurable outcomes or impacts—may be evident during the start-up period or the early years, and most of the impacts occur in the final year or two. In a high HIV prevalence context, programs may have to be extremely conservative in setting expectations about the planned increases in beneficiary outcomes. In some cases, progress may be indicated by a relatively flat line instead of an incline, demonstrating that the intervention prevented an imminent decline.

On the other hand, for input and output indicators (such as coverage), the greatest increase may occur during the early stages of a project and plateau after that.

unethical to visit households to collect data from HIV-affected beneficiaries. An alternative approach could be collecting data at health care sites or collaborating with health care or HBC providers to solicit input from PLHIV. Illness may also interfere with normal data collection processes by limiting beneficiaries' availability. Programs could collect information from other household members instead, if stigma and confidentiality issues allow. Rapid changes in individuals' health because of treatment and infections may also affect the timing of data collection needed to obtain representative information.

Interaction With Health Care Providers

One significant difference in data collection and analysis in an HIV context is that there may be a need for greater interaction with and reliance on health care providers and clinical records. This may be obvious in cases where food programmers and clinical staff coordinate closely because food contributes to treatment adherence or reduced transmission rates among PLHIV. However, other food programs can also benefit from using clinical records.

Many NGOs collect fairly extensive information about household coping strategies, assets, use of food assistance and vulnerability levels, yet few use the anthropometric, clinical and performance measures collected by health staff to help make program decisions.[7] However, while health care providers can be a rich source of information, implementing agencies should take measures to protect the confidentiality of medical records, including restricting staff access to such information.

Information should also flow from food assistance programmers to health care staff and counselors because nutrition and household food security data may strengthen the delivery of health care services. **Chapter 5: Targeting** presents some complementary data collection tools for food assistance targeting adapted to an HIV context.

Resources for Measuring Illness, QOL and Functioning Indicators

There are several standardized indicators and data collection tools to measure illness, QOL and functioning, some of which have been adapted for use in an HIV context. In deciding whether to use these measures, the usefulness of the information should be weighed against the time and money needed for training, data collection, translation and analysis.

For example, because QOL indicators are subjective, substantial training is required to use them properly. Three tools used in HIV contexts to collect data on QOL, functioning and illness are included in Annexes 2–4: the ECOG Zubrod Scale (functioning), the WHO disease staging scale (illness) and MOS-QOL.

Incorporating Additional Indicators Into Existing Tools and Approaches

Given the time and resource constraints typically associated with M&E and food assistance programs, indicators and data collection processes should be integrated into existing M&E systems where possible, rather than creating entirely new systems. For example, additional questions could be added to end-use monitoring (EUM) or post-distribution monitoring (PDM) systems, if those tools are in use. While this may add several minutes to questionnaire implementation, it is generally less expensive than establishing a separate system for collecting the information.

Adapting Sampling and Disaggregation of Data

The sampling unit for many surveys in food assistance programs has been the household, with data typically disaggregated by the household wealth ranking and the sex of the household head, among other factors. For programs working in high HIV prevalence contexts, it may be useful to categorize households according to the effect HIV has on them, such as:

- HIV-affected households where a member is either ill or has died from AIDS-related diseases

Adapting End-Use Monitoring Tool to Changing Needs and Contexts[8]

End-use monitoring (EUM) is a tool that Title II CSs use to verify that commodities, processes and services provided during a food distribution meet expectations and are of the highest possible quality.

Used at food distribution sites as beneficiaries receive rations, the EUM questionnaire reflects the issues that program managers grapple with and is updated as needed. The data are analyzed directly after collection so program adjustments based on the new information can be made as quickly as possible.

Though not often used for this purpose, EUM can help provide insights on other programmatic issues. For example, in one country, EUM revealed that long distances to distribution sites forced beneficiaries to travel by night, exposing them to risks such as attacks and theft. In another location, EUM showed that "under-the-tree registrations" were excluding the poorest of the poor, who felt they did not have adequate clothing for attending these meetings.

C-SAFE adapted EUM when C-SAFE members wanted to better understand how food rations were affecting the chronically ill and households hosting the chronically ill. Several questions on these issues were developed in focus groups by C-SAFE Malawi. The questions were pilot tested in the EUM tool in Zimbabwe, revised and then rolled out in a finalized EUM tool to the other C-SAFE countries, Lesotho and Zambia.

EUM was again adapted when C-SAFE Zimbabwe needed to monitor its recently expanded FFA program, school feeding, and general food distribution. In addition, C-SAFE Zambia added questions to its EUM tool to find out what community members knew and thought about the upcoming closing of the C-SAFE program and the program's exit strategies.

- Households where members are not infected but have been affected by HIV (e.g., through the diversion of household resources to support an HIV-affected extended family member, the death of an extended family member who contributed resources to the household, or orphans joining the household)
- Households where members are unaffected by HIV either directly or through related households[9]

A recent UNICEF guide for M&E of OVC programs recommends that data comparing orphans with non-orphans be collected and disaggregated by age to account for differences in behaviors and opportunities for young orphans compared to older ones. The report provides guidance on estimating sample size for surveys measuring indicators for OVC and provides instructions on defining a sample frame and methodology.[10]

Using Information

As in other contexts, M&E information collected from food assistance and HIV programs has three primary uses:

1. To serve as a management tool for planning, implementing, and adjusting activities
2. To enable reporting and accountability to management and donors
3. To support advocacy and provide information about effectiveness of interventions to donors, host governments and other stakeholders

As food assistance programming in an HIV context is still relatively new, strong M&E systems are particularly relevant to provide evidence, document effective approaches and support learning in this area. M&E staff should document proven measurement techniques for use by the larger food assistance and HIV communities. In addition, food assistance programs can benefit by building on what is already being collected in HIV programs.

Tracking the progress and effectiveness of efforts to support food-insecure PLHIV and HIV-affected households and communities can help programmers adjust current programs and design future ones. Program staff should use the information to verify that their targeting criteria are correct and are being properly applied, as well as to do periodic reverification exercises and adjust the programs as needed. In particular, information from M&E systems can make program staff more sensitive to gender issues and ensure that program benefits are addressing these issues effectively. As in other program contexts, information flow systems should provide program managers and other staff with the critical information they need to make decisions and refine their activities.

Prioritizing the Use of Information

Different programs prioritize the uses of information differently. For example, at the Mildmay Centre in Uganda, the primary purpose of collecting data is to monitor patients' progress and to guide program and service provider decisions about their medical and nutritional care. In Zambia, CRS's SUCCESS and the WV-led RAPIDS consortium programs collect data primarily to assess the impact of their interventions as part of a larger evaluation that aims to contribute to the evidence base about how food programs can address the needs of HIV-affected communities.[11]

8.3 Key Concept
Challenges of M&E for Food Assistance Programs in an HIV Context

Monitoring and evaluation of food assistance programs in the context of HIV faces many of the same challenges as M&E in other types of programming—M&E efforts are often underbudgeted, often require greater technical skills or time availability than project staff have and are sometimes neglected or underemphasized in work plans and job descriptions. However, food-based programs in a high HIV prevalence context pose additional challenges to M&E, a number of which are listed below.

Anthropometrics. While anthropometric indicators have considerable value in assessing the impact of food assistance in various settings and circumstances, their usefulness may be more limited in an HIV context. In a non-HIV context, prevalence of wasting, underweight and stunting of children aged 0–5 is a good indicator of a population's health and nutritional status. However, in an HIV context the nutritional status of children aged 0–5 may be less reflective of the entire population because HIV infection affects adults most directly.

On an individual level, anthropometric measurements can provide an incomplete picture of the nutritional status of PLHIV if used in isolation. For example, improvements that occurred due to food and nutrition support may be masked by other effects of the disease.

Unintended household use of food assistance. Households might not use food assistance in the way it is intended. For example, a household might share food intended for PLHIV, or it may trade or sell food to pay for household expenses. This can substantially dilute food assistance impacts on targeted individuals.

Causal attribution is generally not possible, even in non-HIV contexts. Attributing specific changes in outcomes to food assistance is extremely difficult even under less complicated conditions. In HIV contexts, indicators such as morbidity, mortality and even nutritional status are influenced by many program and non-program factors besides food assistance. Therefore, without a very rigorous evaluation design—which programs are not expected to employ—it is not possible to isolate how much of observed impact is due to food assistance. Donors generally acknowledge these limitations, and programs should still try to measure outcomes and impacts to the best of their ability, while examining and acknowledging any changes in assumptions regarding the operating environment.

Validity of proxies. The validity of some indicators may be context-specific and defy straightforward interpretation. For example, area of cultivated land is an indicator that is predicted to decrease with the loss of productive household labor. However, a study in Kenya showed that the correlation between family size and land cultivated required two additional indicators—gender of deceased household member and type of crop being cultivated. Specifically, the death of an adult male may reduce cash crop production, and increase production of low-labor root crops. Understanding these relationships will help guide the inclusion of specific questions—in this case, questions about gender and type of crop—into M&E tools for more accurate analysis and interpretation of data.[14]

Validity of traditional sampling units. Some of the assessment or sampling methods traditionally used in food assistance programming may not be valid in HIV-affected areas. In particular, the household may not be an appropriate basic sampling unit because of adult death, household dissolution and large numbers of beneficiary orphans on the street or in institutional care.[15] In areas where most services are facility-based, clinics may not know which households their beneficiaries come from, making population-based sampling difficult. In addition, people who go to clinics may not be representative of the infected population, meaning that a programmer would not be able to generalize clinic-based samples to the

general population in the program's targeted area. Programs may need to adjust sampling methods to reflect the demographic situation and be transparent about a sample's limitations if the sampling frame is neither complete nor representative.

Dietary recall. Unreliable responses from caregivers and patients about food consumption and treatment adherence are a concern. In addition, dietary recall by a small number of participants may not accurately reflect actual dietary patterns across all participants.

Lack of proven assessment tools. There are few tried and true tools to measure some outcomes and impacts of food assistance in HIV contexts. These include tools for proven methods of assessing the impact of pre-existing malnutrition on disease progression and tools that can demonstrate causal attribution of food assistance provided to PLHIV.[16, 17]

Staff skills. Inadequate training and experience in data collection, especially where tools have to be adapted for HIV contexts, can result in poor quality data. In addition, there is a lack of staff who can design, supervise and analyze evaluations with the complexity needed to measure food assistance outcomes and impacts on individuals and households in an HIV context.

Tool for Monitoring the Use of M&E Systems

In 2003, C-SAFE in Zimbabwe found that its M&E systems were increasingly complex and grew concerned that unnecessary data may be generated, resulting in waste and inefficiency. To monitor the utility of various M&E tools, project managers were asked to provide feedback on how they had used information generated by the system. Their feedback was reported quarterly and discussed at M&E meetings in order to streamline systems. The M&E monitoring and feedback tool was later used in all three C-SAFE countries, Lesotho, Zambia and Zimbabwe.

Using Anthropometrics in an HIV Context

In a C-SAFE review of literature and field experiences on the impact of food assistance on PLHIV, the most common indicators found were BMI, MUAC and change in weight.[12] Other indicators used include head circumference, W/H, body circumferences, skin-fold measurements and biometric impedence analysis (BIA).

The review noted that even in ideal conditions where HIV-positive children receive well over the RDA of calories and protein, inferior growth may be seen, and HIV-positive adults with no enteric pathogens show diminished skin fold thickness and lower weight than HIV negative adults despite equal food intake. Furthermore, lipodystrophy may make MUAC unreliable for PLHIV who are on ART. This suggests that in HIV contexts, differences in anthropometry indicators do not necessarily imply differences in food intake.

Nutritional status and growth may be impaired because of malabsorption or metabolism that exceeds one's appetite or ability to consume. In such cases food assistance may be enhancing the food security of the family and even supporting the PLHIV's nutritional status, but the BMI or MUAC measurements may not reflect as large a positive change as expected.

Despite the need for caution in using BMI to assess nutritional status among HIV-positive individuals, C-SAFE Malawi field staff suggested BMI as a promising indicator for measuring the impact of food assistance on ART program participants. Staff did not feel collection of information on weight would pose additional burdens, as some of the ART drugs prescribed are dosed according to weight and patients are weighed regularly at the clinics. In fact, national guidance in Malawi calls for BMI to be measured for ART patients to determine if they should be referred to food assistance programs (for BMI < 16, patients are referred to therapeutic feeding; for BMI 16-17, they are referred to a supplemental feeding program, though these referral options may not always reliably exist).[13]

While change of weight is a common and important measure of changes in nutritional status, participants in a recent FANTA review pointed out some of its limitations:

- Weight alone may not provide sufficient information about nutritional practices; for example, a person may gain weight but still not be eating a sufficiently nutritious diet.
- Weight change may not be comparable across a population because a given weight change can have different implications for people of different weights.
- Food and nutrition interventions may not be effective in helping a person with AIDS to gain weight once the disease is in an advanced stage. The intervention may be helping to manage symptoms or improve the individual's quality of life, and weight alone may be an inappropriate measure of the intervention's benefits.
- Weighing an adult in community or home-based settings can be difficult because of the logistics of accessing accurate and reliable scales.

Annex 1: Food Access Indicators

Below are five indicators/indices that can be used to measure food access:

Months of Adequate Household Food Provisioning (MAHFP)
The MAHFP indicator is a measure of household food access that captures changes in the household's ability to access food by examining its food supply over the past year and assessing to what extent that level of supply was sufficient to meet household needs. Measuring MAHFP can capture the combined effects of a range of interventions and strategies, such as improved agricultural production, storage and interventions that increase the household's purchasing power. Guidance on using MAHFP can be found at www.fantaproject.org/downloads/pdfs/MAHFP_Jun07.pdf.

Household Dietary Diversity Score (HDDS)
HDDS is another indicator of household food access that assesses the number of different food groups consumed over a given reference period. Unlike the MAHFP, this indicator uses the diversity of the diet as a measure of household food consumption. One of these two indicators (MAHFP and HDDS) is required for all USAID FFP Multi-Year Assistance Programs (MYAP) that aim to improve food access. Guidance on using HDDS can be found at www.fantaproject.org/downloads/pdfs/HDDS_v2_Sep06.pdf.

Coping Strategies Index (CSI)
The CSI is a relatively simple and efficient indicator of household food security that correlates well with other more complex measures of food insecurity. Developed by CARE and field tested by WFP and CARE, the CSI has been used for early warning and food security monitoring in eight African countries and several Middle Eastern countries. It measures the frequency of use and the severity of a household's coping strategies for addressing shortfalls in food supply. Guidance on using CSI can be found at www.fao.org/crisisandhunger/root/pdf/cop_strat.pdf.

Household Food Insecurity Access Scale (HFIAS)
Developed by FANTA in collaboration with Cornell University and Tufts University, the HFIAS is a set of nine questions that distinguish food-insecure from food-secure households across different cultural contexts. These questions represent universal domains of the experience of insecure access to food that can be used to assign households and populations along a continuum of severity of food insecurity. Guidance on using HFIAS can be found at www.fantaproject.org/publications/hfias_intro.shtml.

Food Consumption Score (FCS)
The FCS represents a proxy for the diversity of the household diet and is calculated based on the household's reported diet over the three days before the survey. Each food type is allocated a score based on its nutrient density, and the maximum possible FCS score is 48. The higher the FCS score, the more nutritionally dense the diet is. The tool is described in *CHS Regional Analysis: Household Vulnerability and the Impact of Food Aid*,[18] available at: www.reliefweb.int/library/documents/2005/csafe-souafr-28feb.pdf.

Annex 2: ECOG (Zubrod) Scale

This scale can be used by doctors, clinical staff and M&E personnel to assess the progression of disease in individuals and its impact on their daily activity. It may also be helpful in determining appropriate care and treatment responses as well as potential options for food assistance (if needed).

ECOG Grade (PS)	Definition
0	Fully active, able to carry on all pre-disease activities with restriction (KS 90-100)
1	Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature (KS 70-80)
2	Ambulatory and capable of all self-care but unable to carry out any work activities. Out of bed > 50% (KS 50-60)
3	Capable of only limited self-care , confined to bed or chair > 50% waking hours (KS 30-40)
4	Completely disabled, cannot carry on any self-care, totally confined to bed or chair (KS 10-20)

Source: Eastern Cooperative Oncology Group (ECOG). ***ECOG Performance (Zubrod Scale)***. As published in ***American Journal of Clinical Oncology***: Oken, M.M., Creech, R.H., Tormey, D.C., Horton, J., Davis, T.E., McFadden, E.T., and Carbone, P.P. "Toxicity And Response Criteria of The Eastern Cooperative Oncology Group," ***American Journal of Clinical Oncology*** 5 (1982):649-655.

Annex 3: WHO Disease Stages of HIV/AIDS

WHO Clinical Staging of HIV/AIDS for Adults and Adolescents with Confirmed HIV Infection	
Clinical Stage 1	▶ Asymptomatic ▶ Persistent generalized lymphadenopathy
Clinical Stage 2	▶ Unexplained moderate weight loss (<10% of presumed or measured body weight) [a] ▶ Recurrent respiratory tract infections (sinusitis, tonsillitis, otitis media and pharyngitis) ▶ Herpes zoster ▶ Angular cheilitis ▶ Recurrent oral ulceration ▶ Papular pruritic eruptions ▶ Seborrhoeic dermatitis ▶ Fungal nail infections
Clinical Stage 3	▶ Unexplained [b] severe weight loss (>10% of presumed or measured body weight) ▶ Unexplained chronic diarrhea for longer than one month ▶ Unexplained persistent fever (above 37.6°C intermittent or constant, for longer than one month) ▶ Persistent oral candidiasis ▶ Oral hairy leukoplakia ▶ Pulmonary tuberculosis (current) ▶ Severe bacterial infections (e.g., pneumonia, empyema, pyomyositis, bone or joint infection, meningitis, bacteremia) ▶ Acute necrotizing ulcerative stomatitis, gingivitis or periodontitis ▶ Unexplained anaemia (<8.g/dl), neutropaenia (<0.5 x 10^9 per liter) and/or chronic thrombocytopaenia (<50 x 10^9 per liter)
Clinical Stage 4 [c]	▶ HIV wasting syndrome ▶ Pneumocystis pneumonia ▶ Recurrent severe bacterial pneumonia ▶ Chronic herpes simplex infection (orolabial, genital or anorectal of more than one month's duration or visceral at any site) ▶ Oesophageal candidiasis (or candidiasis of trachea, bronchi or lungs) ▶ Extrapulmonary tuberculosis ▶ Kaposi's sarcoma ▶ Cytomegalovirus infection (retinitis or infection of other organs) ▶ Central nervous system toxoplasmosis ▶ HIV encephalopathy ▶ Extrapulmonary cryptococcosis including meningitis ▶ Disseminated non-tuberculous mycobacterial infection ▶ Progressive multifocal leukoencephalopathy ▶ Chronic cryptosporidiosis (with diarrhea) ▶ Chronic isosporiasis ▶ Disseminated mycosis (coccidiomycosis or histoplasmosis) ▶ Recurrent non-typhoidal Salmonella bacteremia ▶ Lymphoma (cerebral or B-cell non-Hodgkin) or other solid HIV-associated tumors ▶ Invasive cervical carcinoma ▶ Atypical disseminated leishmaniasis ▶ Symptomatic HIV-associated nephropathy or symptomatic HIV-associated cardiomyopathy

a - Assessment of body weight in pregnant woman needs to consider the expected weight gain of pregnancy.

b - Unexplained refers to where the condition is not explained by other causes.

c - Some additional specific conditions can also be included in regional classifications (such as reactivation of American trypanosomiasis [meningoencephalitis and/or myocarditis] in the WHO Region of the Americas and disseminated penicilliosis in Asia).

Source: World Health Organization (WHO). ***WHO Case Definitions of HIV for Surveillance and Revised Clinical Staging and Immunological Classification of HIV-Related Disease in Adults and Children***. Geneva: WHO, August, 2006.

Annex 4: MOS-QOL Questionnaire for HIV-Infected Individuals

This survey is taken from Mast, T.C., Kigozi, G., Wabwire-mangen, F., et al. "Measuring Quality of Life Among HIV-Infected Women Using a Culturally Adapted Questionnaire in Rakai District, Uganda," ***AIDS Care*** 16 (1) (2004): 81-94.

Quality of Life								
Now, I would like to ask you a few questions about your health. [INTERVIEWER: Q1 - Q13 ARE PROMPTED]								
1.	In general, would you say your health is:					Excellent...1 Very good...2 Good...3 Fair...4 Poor...5		|____| {Q1}
2.	How much *bodily* pain have you generally had during *the past thirty days*?					None...1 Very mild...2 Mild...3 Moderate...4 Severe...5 Very severe...6		|____| {Q2}
3.	During *the past thirty days*, how much did *pain* interfere with your normal work, including both work outside the home and housework?					Not at all...1 A little bit...2 Moderately...3 Quite a bit...4 Extremely...5		|____| {Q3}
4.	The following questions are about activities that a person might do during a typical day. Does your *health now limit you* in the following activities? If so, how much?				YES, limited a lot	YES, limited a little	NO, not limited at all	
4a.	The kinds or amounts of *vigorous* activities you can do like, digging, fetching water from a well, carrying a big bunch of matooke, splitting firewood.				1	2	3	|____| {Q4A}
4b.	The kinds or amounts of *moderate* activities you can do like washing clothes, moving a jerrican of water or moving a bundle of firewood from one place to another.				1	2	3	|____| {Q4B}
4c.	Walking up a hill, climbing stairs.				1	2	3	|____| {Q4C}
4d.	Bending, lifting light objects or kneeling.				1	2	3	|____| {Q4D}
4e.	Walking a distance, like the length of a football pitch, about 100 meters.				1	2	3	|____| {Q4E}
4f.	Eating, dressing, bathing or using the latrine.				1	2	3	|____| {Q4F}
5.	Does your health *keep* you from working at a job, doing work around the house or attending school?					Yes...1	No...2	|____| {Q5}
6.	Have you been unable to do *certain kinds or amounts* of work, housework or schoolwork, because of your health?					Yes...1	No...2	|____| {Q6}
For each of the following questions, please tell me the answer that comes closest to the way you have been feeling in the past thirty days.		All of the time 1	Most of the time 2	A good bit of the time 3	Some of the time 4	A little of the time 5	None of the time 6	
7.	How much of the time, during the past thirty days, has your *health limited your social activities*, like visiting your friends or family?	1	2	3	4	5	6	|____| {Q7}
8.	How much of the time, during the past thirty days:							
8a.	Have you been a very nervous person?	1	2	3	4	5	6	|____| {Q8A}
8b.	Have you felt calm and peaceful?	1	2	3	4	5	6	|____| {Q8B}
8c.	Have you felt depressed?	1	2	3	4	5	6	|____| {Q8C}
8d.	Have you been a happy person?	1	2	3	4	5	6	|____| {Q8D}

8e.	Have you felt so depressed that nothing could cheer you up?	1	2	3	4	5	6	|____| {Q8E}
9.	How often during the past thirty days:							
9a.	Did you feel full of life and energy?	1	2	3	4	5	6	|____| {Q9A}
9b.	Did you feel totally without energy?	1	2	3	4	5	6	|____| {Q9B}
9c.	Did you feel tired?	1	2	3	4	5	6	|____| {Q9C}
9d.	Did you have enough energy to do the things you wanted to do?	1	2	3	4	5	6	|____| {Q9D}
9e.	Did you feel weighed down by your health problems?	1	2	3	4	5	6	|____| {Q9E}
9f.	Were you discouraged by your health problems?	1	2	3	4	5	6	|____| {Q9F}
9g.	Did you feel despair over your health problems?	1	2	3	4	5	6	|____| {Q9G}
9h.	Were you afraid because of your health?	1	2	3	4	5	6	|____| {Q9H}
		All of the time 1	Most of the time 2	A good bit of the time 3	Some of the time 4	A little of the time 5	None of the time 6	
10.	How often during the past thirty days:							
10a.	Did you have difficulty reasoning and making decisions, for example, making plans or learning new things?	1	2	3	4	5	6	|____| {Q10A}
10b.	Did you forget things that happened recently, for example, where you put things or when you had appointments?	1	2	3	4	5	6	|____| {Q10B}
10c.	Did you have trouble keeping your attention on any activity for long?	1	2	3	4	5	6	|____| {Q10C}
10d.	Did you have difficulty doing activities involving concentration and thinking?	1	2	3	4	5	6	|____| {Q10D}
			Definitely true 1	Mostly true 2	Don't know 3	Mostly false 4	Definitely false 5	
11.	Please tell me the answer that comes closest to describing whether the following statement is true or false for you. The answers are: [INTERVIEWER: READ RESPONSES ABOVE]							
11a.	You are somewhat ill.		1	2	3	4	5	|____| {Q11A}
11b.	You are as healthy as other people you know.		1	2	3	4	5	|____| {Q11B}
11c.	Your health is excellent.		1	2	3	4	5	|____| {Q11C}
11d.	You have been feeling bad recently.		1	2	3	4	5	|____| {Q11D}
12.	How has the quality of your life been during the *past thirty days*? That is, how have things been going for you?			Very well; could hardly be better...1 Pretty good...2 Good and bad parts about equal...3 Pretty bad...4 Very bad; could hardly be worse...5				|____| {Q12}
13.	How would you rate your physical health and emotional condition now compared to *thirty days ago*?			Much better...1 A little better...2 About the same...3 A little worse...4 Much worse...5				|____| {Q13}

Endnotes

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2 Bergeron, G., Deitchler, M., Bilinsky, P., and Swindale, A. ***Monitoring and Evaluation Framework for Title II Development-Oriented Projects***. Technical Note 10. Washington, DC: FANTA Project, Academy for Educational Development, 2006.

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4 Ortiz, E.F., Kuyama, S., Munch, W., and Tang, G. ***Implementation of Results-Based Management in the United Nations Organizations. Part I: Series on Managing for Results in the United Nations System***. Geneva: United Nations Joint Inspection Unit, 2004.

5 USAID. ***Establishing Performance Targets***. Performance Monitoring and Evaluation TIPS No. 8. Washington, DC: USAID Center for Development Information and Evaluation, 1996.

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8 Owubah, C., Greenblott, K., and Zwier, J. Top 10 C-SAFE ***Initiatives in Monitoring and Evaluation***. Johannesburg: C-SAFE Learning Spaces Initiative, 2005.

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10 United Nations Children's Fund (UNICEF). ***Guide to Monitoring and Evaluation of the National Response for Children Orphaned and Made Vulnerable by HIV/AIDS***. New York: UNICEF, 2005.

11 FANTA Project. ***A Guide to Monitoring and Evaluating Nutrition Education and Counseling for People Living with HIV/AIDS***. Draft. Washington, DC: Academy for Educational Development, 2006.

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14 Yamano, T., and Jayne, T.S. ***Measuring the Impact of Working-Age Adult Mortality on Small-Scale Farm Households in Kenya***. World Development 32 (1) (2004): 91-119.

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Chapter 9: Operational Modalities

Program Design Steps

Chapter 9: Operational Modalities

Program Design Steps

Key Concepts

9.1 Challenges and Considerations in Budgeting in an HIV Context

9.2 Addressing Budget Limitations and Challenges

9.3 Food Resource Supply Chain Management

9.4 Food Distribution Mechanisms and Operation

9.5 Adapting Food Distribution Methods

9.6 Workplace HIV Policy and Prevention Education for Food Assistance Support Staff

In This Chapter

This chapter complements the technical information provided earlier in this guide with practical guidance for planning and managing food distribution systems for people living with or affected by HIV. The chapter first addresses challenges in budgeting that distinguish food assistance programs in the context in HIV from those in unaffected areas. It then provides a detailed discussion of HIV-related factors affecting program budgets, ranging from greater staff and logistics costs to the restrictions on food and non-food resources in HIV programs. Next, the chapter provides insight into how agencies can respond to budgeting challenges by coordinating funding streams and partnering with government and civil society stakeholders.

The chapter goes on to explore issues surrounding commodity pipeline management, including possible responses to pipeline breaks as well as the shelf life, procurement, storage and handling requirements for commodities provided to HIV-affected beneficiaries. The chapter then explains decisions to be made about food distribution, such as the location of distribution points, take-home versus on-site feeding and the involvement of HBC networks, health facilities and CBOs in distributing food to HIV-affected beneficiaries. The chapter discusses important considerations for adapting food distribution mechanisms in the HIV context, including the timing of ration distribution, ensuring accountability in the process of food distribution and considerations for food distribution in settings characterized by conflict and/or displacement. Finally, the chapter explains the importance of implementing appropriate workplace HIV policies and providing prevention education to all individuals involved in the transport and distribution of food assistance.

Food assistance program managers can find additional guidance on commodity procurement, storage, accounting and reporting in WFP's 2002 Food Distribution Guidelines and USAID's Office of Food for Peace (FFP) guidelines.

9.1 Key Concept

Challenges and Considerations in Budgeting in an HIV Context

Primary Challenges in Budgeting in an HIV Context

The primary budgeting challenge facing UN organizations and NGOs implementing food security programs is a lack of funding to meet the food ***and*** non-food needs of all those that are either chronically or temporarily vulnerable to food insecurity. As is the case across all sectors, HIV further complicates efforts to overcome budget constraints to provide effective and sustainable programs. The primary challenges in the context of HIV include:

Funding for non-food activities. Securing funding for program activities other than food distribution often is difficult, particularly for countries or programs with limited potential for commodity monetization.[1]

Program compartmentalization. HIV programs often are compartmentalized as health sector interventions, while nutrition or food insecurity interventions are often viewed as agricultural or humanitarian issues.

ART recipient demand for food assistance. Demand is increasing for food assistance to support treatment adherence for a rapidly growing number of ART recipients.

Lead times for commodities. Long lead times required to obtain food commodities are particularly challenging for HIV-targeted programs because of fluctuating demand for ART and infected individuals' specialized food needs.

Difficulty procuring specialized foods. Specialized foods required by HIV-infected individuals can be difficult to procure because of higher costs and limited access due to restrictions on genetically modified organisms (GMOs) and other import constraints.[2]

Need for cash reserves. It is difficult to maintain cash reserves needed to protect particularly vulnerable HIV beneficiaries from commodity pipeline breaks.

Higher costs. Operational and logistics costs associated with distributing food to HIV-affected beneficiaries over a wide area are higher.

Initial program costs. Food assistance programs associated with HIV often require substantial cash resources for vulnerability and needs assessments, program appraisals, technical reviews and capacity enhancement activities before the actual food assistance begins. This can create considerable difficulties when cash is tied to commodity tonnage.

Other Budgetary Considerations

Balancing Equity and Impact

Another important consideration involves the balance between equity and impact. While distributing limited resources to the maximum number of beneficiaries may promote equity in areas prone to widespread food insecurity, spreading resources too thinly may limit the impact of food assistance. This issue can become contentious when food resources are targeted specifically for food-insecure populations who are HIV-positive or are directly affected by the disease. Food assistance programs that are closely tied to national services delivery may be required to cover the entire country, which could increase costs. In addition, serving relatively few people spread across large areas could increase costs and

raise questions about the feasibility of doing so. Issues surrounding equity versus impact also arise in the event of humanitarian emergency. Many livelihood and safety net interventions in high prevalence areas focus on protecting and creating vulnerable households' productive assets. However, asset creation is often suspended during emergencies because of the need to spread resources over a much larger needy population.

Funding Cycles and Non-Food Resources

The non-food needs of integrated food assistance and HIV interventions can be greater than those of conventional food assistance programs because of the need for technically qualified staff and the challenges of assessing vulnerability to HIV and monitoring impact on individuals and/or households. Though few direct cost comparisons have been conducted, integrated programs tend to be "cash heavy," particularly during project start-up.[3] Using HIV funding may be a viable option for food security interventions specifically targeting infected individuals and affected households. However, such arrangements are not viable for many of the other activities that food security program managers must implement.

Funding Restrictions

While there has been considerable financial investment in the fight against HIV, funding arrangements have at times placed significant restraints on food assistance programs' ability to cover the immediate costs of prevention and treatment as well as the longer-term development-oriented activities designed to improve food and livelihood security. Some donors set particular conditions that may interfere with appropriate response programming and budgeting. For example, certain funding sources may support nutrition supplementation for PLHIV but not for affected households, which means programs may be able to provide for an individual but not provide the necessary accompanying household food ration. In addition, funding agreements often lack specific guidance on allowable activities, particularly pertaining to medium- and long-term program objectives. Moreover, as discussed above, by limiting or disallowing expenditure on training, technical assistance, agriculture, tools and other capital equipment, donors may hinder effective multisectoral programming of food assistance in high-prevalence contexts.

The principal challenge in adequately budgeting for integrated food security and HIV programs is that food aid programs fund mostly food commodities and the cost of distribution, while effective interventions require a broad range of food and non-food interventions and partners.

HIV-Specific Cost Considerations

Logistics Costs

Several factors involved in HIV programming add to the logistical costs of traditional food assistance interventions:

- Vulnerability to HIV is determined by a complex array of factors, including mobility of populations.
- PLHIV and affected households are often widely dispersed, particularly in rural areas.
- Reaching the more geographically concentrated HIV-affected households in urban areas is costly given the need to develop household targeting strategies rather than geographical ones[4] (see **Chapter 5: Targeting** for a more detailed discussion of targeting).

The logistics involved in reaching a relatively small group of beneficiaries can raise an individual program's overall costs for internal transport, shipping and handling of commodities. Different donors provide different amounts of funding for internal transportation, and a program may have to adjust its coverage if there are not adequate funds to move food commodities over a large geographic area.

The cost of storage space for both small and large tonnages of food will be the same because the secure warehouse space is likely to be larger than needed in either case.[5] Additional logistics costs particular to HIV programs include the re-bagging of commodities into smaller containers so that beneficiaries, who are usually weak, can easily carry the food rations.[6]

Food assistance programs can reduce logistical costs by establishing central service provision and/or food distribution points such as community health centers or hospitals.[7] Costs also can be decreased by establishing greater linkages with informal HBC networks supported by community associations, funeral associations, family networks, religious groups and others.

Staff Costs

HIV programs require more technically qualified staff than do traditional food assistance programs, which often leads to higher staff costs. HIV program staff must have the skills to:

- Work with a range of HIV-affected beneficiaries, including ART and TB patients, pregnant women and lactating mothers, children with HIV and OVC
- Understand beneficiary groups' needs and capacities; in particular, those working in food assistance and ART programs must have technical knowledge about the interaction between food, nutrition, HIV and ARV drugs
- Conduct individual in-depth client assessments and apply multiple targeting criteria to meet program eligibility criteria and overcome barriers related to stigma
- Conduct the more frequent monitoring these programs require, as vulnerable populations' conditions can change rapidly

It may be possible to cover the cost of specialized staff and expanded assessments and monitoring through the project. However, some donors provide funds only for food distribution, and it is difficult to secure complementary funding for staff costs. In addition, while there may be opportunities to obtain complementary funding for food security programming for HIV-affected populations, donors often limit their support to agricultural inputs and other non-food resources rather than cash.[8]

Integrated programming often means increasing services in response to need, which can further increase overall expenses. If food assistance agencies or their implementing partners lack the staff and technical capacity to increase their services, they may need to hire external consultants, provide training or expand their partnerships, each of which can further increase costs.[9,10] Programs usually can get information about the costs of specific services from organizations with relevant experience. Since there are many ways to implement new services, organizations should also investigate the most cost-effective approaches.

Other Program Costs

Because of HIV's physical, economic, emotional and social impact on PLHIV, households and communities, effective interventions should be holistic and include both food and non-food assistance to support recovery and sustainable livelihoods (See **Chapter 12: Livelihood Strategies and Social Protection** for a discussion of specific activities that can help households restore assets). However, holistic interventions increase program costs. In addition, for some food assistance programs, the costs of food assistance determine a project's direct and indirect overhead costs, and non-food activities are often funded through such overhead. This will limit non-food activities by programs that distribute a small volume of food, as may be the case with programs that provide food to PLHIV or affected households.

Cost-Effectiveness

Given HIV's geographic scope and dynamic nature, it is difficult to determine the cost-effectiveness of food assistance programs in an HIV context. However, lessons from previous efforts can be applied. In general, implementing agencies can maximize programs' cost effectiveness by:

- Mainstreaming HIV food support with ongoing food security activities
- Directly involving CBOs and PLHIV in designing and implementing food-based activities
- Coordinating activities with other UN agencies and NGOs as possible
- Applying for complementary funding
- Establishing central food distribution sites to serve the most beneficiaries[11]

Key Concept

9.2 Addressing Budget Limitations and Challenges

Some of the budget limitations and challenges discussed earlier can be addressed by having food assistance programs and HIV programs share resources such as staff, office space, infrastructure, warehousing and logistical capacity.

Agencies can create opportunities to share resources among multiple partners operating in various sectors by mainstreaming HIV into ongoing food security programs (see **Chapter 7: Implementation Strategies,** Key Concept 7.4 on developing partnerships). In other cases, partners involved in HIV activities may be able to share greater responsibility for supporting OVC, PMTCT and medical interventions combined with food security programs. An organization that has separately funded food assistance and HIV projects can essentially share resources and have a multi-sectoral impact by working with the same beneficiary population, if program activities are jointly planned and managed well.

Two Approaches to Addressing Budget Constraints in Uganda

ACDI/VOCA and TASO

ACDI/VOCA and TASO have developed a partnership to provide food assistance to individuals and households affected by HIV. ACDI/VOCA provides food assistance to address the nutritional needs of PLHIV, while TASO distributes food to beneficiaries and provides complementary HIV-related services. By providing nutritional support to PLHIV (particularly women) attending the food distribution center, ACDI/VOCA reaches its intended beneficiaries and simultaneously provides an incentive for beneficiaries to use PMTCT and other HIV services. Likewise, by providing prevention education, HIV awareness, PMTCT services, and care and support services for infected individuals, TASO works toward its core objectives as an HIV service organization.

WFP Uganda

WFP Uganda uses its field offices to provide food support to different activities such as supplementary and therapeutic feeding, maternal and child health and nutrition (MCHN) and FFA programs being implemented in the same area. Field offices use the same logistics staff and partner whenever possible to deliver and monitor services. In some cases, partners supporting HIV activities also provide support to other vulnerable groups, along with medical treatment of opportunistic infections and food security programming. Such collaborations have not been assessed to determine overall cost-effectiveness but have proven effective.

Partnering With Government Stakeholders

For operational purposes, government resource streams for food security programs are often allocated through ministerial budgets for Ministries of Agriculture and for HIV through budgets for Ministries of Health and Population. The National AIDS Commission (NAC) is often the coordinating and implementing arm, while individual ministries take responsibility for monitoring the use of resources. Government contributions often include office space, food storage/distribution facilities, food handling and distribution staff and in some cases commodity distribution.

When pursuing funding for integrated food assistance and HIV programs, organizations should:

- Identify possible funding sources at the district and national levels
- Establish synergy between various funding streams and district planning processes to maximize the complementarity of district-level resources from government funding sources and donors
- Determine the amount of funding provided by various funding streams and how it will be used
- Discuss potential resource gaps with the district planning team and other donors funding food security and/or HIV programs directly to the district or through the central government
- Establish cooperative agreements for complementary funds from government ministries and/or other donors (there should be a consensus on when and how funds will be disbursed and used, as well as on reporting requirements)

9.3 Key Concept

Food Resource Supply Chain Management

Managing the Commodity Pipeline

Continuity and reliability are critical for many food assistance programs. Not only do ruptures in the pipeline affect the nutritional well-being of the target beneficiaries, but they may also harm the credibility of the service provider, affect the benefits obtained from other associated services (such as treatment, education, psycho-social support and income generation) and interrupt fragile community mobilization processes that form the basis of the program. In addition, where food support is a catalyst for target groups' participation in clinical or food security programs, the absence of the food component may demoralize them, possibly affecting future involvement.

Ideally, activities should not be initiated with a resource guarantee of just a few months. However, for practical reasons a steady food supply often cannot be guaranteed over an extended period. Particularly where commodities are provided, donor planning cycles might not accommodate a steady supply during the life of the program. As a result, programs may need to store large quantities of food over prolonged periods to ensure adequate and reliable food supplies for all intended beneficiaries.

A reliable pipeline often depends on the program's ability to combine international, regional and local purchases and/or in-kind donations. However, certain commodities may not be easily purchased in the program area, or programs supported by single donors may not be able to make local purchases with donor funds.

Program managers have a number of options for dealing with pipeline shortages. Shortages involving only one food or a few commodities may be addressed by temporarily increasing other ration components by following standard guidelines for commodity substitution. However, substitutions might not be appropriate if specific commodities are required to meet specific nutritional needs or have a definite role in meeting particular gaps in the household food ration.

Agencies that distribute food assistance through multiple programming channels may be able to borrow and repay commodities internally to meet the most urgent needs. In select instances, as was the case in southern Africa during implementation of C-SAFE, organizations distributing food assistance may be able to temporarily turn to a second pipeline in the event of severe shortages. Food assistance agencies may borrow and/or lend food resources from other cooperating partners in the event of food pipeline breaks. For instance, WFP Malawi accessed Global Fund resources to purchase substitute rations during breaks in the CSB pipeline. WFP and FFP Title II CSs borrowed from one another to cover shortages in countries with more than one pipeline.[12]

Regardless of the amount of planning and preparation at the program level, pipeline breaks do occur. In such instances, programs often have to make difficult decisions about the number of beneficiaries, the ration size and/or the ration composition. In other situations, programs may have to make hard choices about prioritizing activities. While it may be difficult to agree on how to prioritize resources when pipeline breaks occur, decisions should be based on information from accurate vulnerability assessments, include direct consultations with all relevant stakeholders and be consistent with the specific program objectives.

Substituting Rations in HIV Programs During Pipeline Breaks[13]

Breaks or shortfalls in standard commodities such as cereal and oil, as well as high-energy protein supplements (HEPS) are not uncommon for WFP Zambia. WFP Zambia's first response to pending pipeline shortages is to convene planning meetings between Programming, Logistics and Vulnerability Analysis and Mapping (VAM) Units to map out an "adaptive operational strategy" for managing available resources. The process involves framing possible scenarios based on a combination of a reduction in rations among various program areas (HIV-ART, OVC, FFA). The final decision is made by the Country Office, with an eye toward limiting the negative impacts of resource scarcity while maintaining key relationships among implementing partners.

A number of specific factors are considered in evaluating adaptive strategies. Assessment of these factors depends entirely on adequate M&E and commodity management systems. They include:

- Specific accounting of available stocks, including those in the pipeline, commodities due to arrive and resources that must be borrowed or repaid, both internally and externally
- Specific objectives of individual programs (is food intended to improve access or nutrition, or is it used as an incentive?)
- Determination of where the greatest positive impact of food assistance will be achieved or which response will minimize harm to beneficiaries and partners
- Determination of how resource prioritization will affect access to complementary resources and other support services

WFP Zambia made these decisions during a recent break in the pipeline for HEPS:

HIV: OVC Emergency Feeding Support

Substituted 100 g of HEPS and 10 g of oil per day per child with 100 g of bulgar wheat and 35 g of pulses per child per day. Take-home ration (THR) also changed from 59 kg cereal to 25 kg cereal and 10 kg pulses

HIV: ART Support

Reduced THR from 36 kg cereal and 4.5 kg pulses to 25 kg cereal and 6 kg pulses

Commodity Shelf Life, Procurement, Storage and Handling

Because of the compromised health status of many beneficiaries in HIV programs, commodity safety is particularly critical for food assistance programs in an HIV context. Products should be inspected upon procurement and at later stages during storage if there is any suspicion that the commodities are deteriorating.

Processed foods, such as milled cereals and fortified blended foods, tend to have a relatively short shelf life, particularly if purchased locally, and may be susceptible to spoilage (rancidity, contamination or infestation), especially if stored in large quantities under unhygienic conditions. Similarly, whole grain cereals and products such as groundnuts can be contaminated by afflatoxin, which may be present in locally-stored produce. In addition, salmonella contamination—a major cause of diarrhea—can occur in foods handled and/or stored in unhygienic ways.

Shelf life can be extended during cereal processing through lowering the extraction rate of the cereal flour/meal (the percentage of the original grain preserved in the flour/meal). The lower the extraction rate, the longer the shelf life. However, it should be noted that lower extraction rates are also normally associated with lower nutritional value. Another option for increasing shelf life is reducing the length of the supply chain by processing close to beneficiaries, for example through the use of local cereal mills.

Programs also should consider storage capacity and conditions among implementing partners, community-based facilities and households. Often the conditions in place at the primary stages of the supply chain (when controlled by large organizations) cannot be maintained at the secondary and tertiary stages when the food commodities are being integrated in community and institutional support programs. Furthermore, after distribution to households, commodities should be kept safe for the period of consumption. This highlights the importance of storage and handling conditions in households.

Although processed foods may be recommended in HIV-related food assistance programs, the ultimate decision on their use (and thus their procurement) should include careful consideration of whether food safety can be maintained along the entire supply chain (including transport, storage and handling).

Key Concept

9.4 Food Distribution Mechanisms and Operation

Many of the conventional approaches to food distribution should be adapted in the context of HIV because of the constraints the disease places on distribution systems. The principal constraints include: [14,15]

- Effects of stigma on food assistance
- Beneficiaries' challenges in accessing designated food distribution centers
- Challenges in delivering the appropriate quantity and quality of food assistance at reasonable cost
- Working with new partners—particularly HBC systems, PLHIV networks and CBOs—that are less familiar with food assistance operations

The distribution of food to PLHIV or affected households is complicated because potential beneficiaries may be young (OVC), old (elderly caregivers) or in an advanced stage of illness, all of whom may be too weak to transport food from the distribution centers to their homes. Furthermore, many of those infected and/or caring for PLHIV are women, for whom long distance distributions may become an insurmountable burden and exclude them from receiving food. Decisions on the number and location of final distribution points (FDPs) therefore should take into account beneficiaries' limitations and accessibility constraints. Table 1 on page 194 compares the advantages of having fewer or more distribution centers.

In general there is a tradeoff between the need to bring food assistance close to beneficiaries and the cost and difficulties in doing so. These factors should be considered in selecting the locations of food distribution points:

- Proximity to communities and homes of PLHIV and HIV-affected households
- Food delivery trucks' access to the sites
- Availability of sufficient space to accommodate beneficiaries and the caregivers/guardians or porters accompanying the beneficiaries

Table 1: Distribution Centers: Pros and Cons of Few Versus Many

	Advantages	Disadvantages
Few Distribution Centers	▶ Fewer staff ▶ Less infrastructure (distribution structures) ▶ Less transport required for distribution ▶ Lower distribution costs as percent of program budget	▶ Longer journey to the households ▶ Potential cost of transport for the beneficiaries relative to the "value" of the food ▶ Difficult access for weaker groups, e.g., PLHIV, pregnant and nursing women ▶ Potential crowding ▶ Potential to barter part of the ration to pay porters ▶ Long waiting period ▶ Potential exposure to stigma due to high visibility of activity
Many Distribution Centers	▶ Easier access by PLHIV, children and elderly caregivers ▶ Easier access by women caregivers ▶ Shorter journeys home ▶ Beneficiaries can easily see the distribution taking place; self policing facilitated ▶ Special arrangements for home-based caregivers easily made	▶ More staff required ▶ More transport needed ▶ High transport costs ▶ Accessibility problems for transport to some centers ▶ Longer travel time for transporters ▶ Higher overall program costs

Options may include strategically placing distribution sites in centralized areas for optimal accessibility. For example, this may mean establishing FDPs on the road to a marketplace and distributing food on market days to attract people where and when they are more likely to be traveling anyway. Centralized distribution points such as these are generally more efficient, but programs must take concerns about stigma into account when conducting distributions in highly public places (see **Chapter 5: Targeting** for a more detailed discussion about avoiding stigma).

Methods of Food Distribution

Food assistance programs use various food distribution methods, including food distribution through HBC systems, facility-based distribution and community-based distribution. Each method uses a different food delivery system, mix of services, staff and coverage.

Food Distribution Through HBC Systems

A number of NGOs use HBC systems to distribute food and provide other nutrition care and support services to PLHIV and their households. The success of HBC food distribution system depends on several things, including:

- Strength of the HBC networks
- Volunteers' capabilities
- Good supervision and oversight

Potential steps involved in using HBC volunteers to distribute food include:

- Preparing a distribution plan based on HBC service coverage and the population of PLHIV in the targeted community

- Having the HBC group divide the commodities among the HBC volunteers based on the number of households and the approved ration
- Having each HBC volunteer supervise the distribution process to individuals and households in his/her HBC operational area
- Having each HBC volunteer assess the household's living environment, storage conditions for food and other non-food needs of the household

There are advantages and disadvantages of food distribution through HBC groups, as illustrated in Table 2.[16] Accordingly, distribution should be monitored to ensure that registered PLHIV and their households receive their rations and are not neglected or exploited by volunteers.

Health Facility-Based Food Distribution for PLHIV

In many cases, food distribution is conducted in locations such as health facilities that present an opportunity to combine food distribution with other services for PLHIV. Food distribution is the last activity, normally conducted after the beneficiary completes the required consultations with health staff. Table 3 shows the advantages and disadvantages of distribution through health facilities.

Table 2: Distribution Through HBC Systems: Pros and Cons

Advantages	Disadvantages
▶ Less agency staff involved ▶ Can reduce the burden of individual targeting ▶ Ration cards may not be required as volunteers know the HIV infected individuals and household sizes (ration cards may still be used to ensure transparency/accountability) ▶ Allows for easy follow-up, close monitoring of beneficiaries by HBC volunteers ▶ Rations can be distributed by HBC volunteers from the HBC community storage point ▶ Potential for complementarity with other support services offered by HBC networks ▶ HBC volunteers are familiar to beneficiaries, creating an enabling environment for trust, confidence building and wider community sensitization	▶ HBC volunteer services may be overburdened ▶ HBC volunteers may have limited skills beyond food handling (HIV care and support) ▶ Livelihood insecurity among HBC volunteers may lead to misuse or diversion of resources ▶ Increasing workload often results in demand for incentives from HBC volunteers ▶ Mobility constraints by HBC volunteers ▶ Limited capacity for monitoring and reporting ▶ Use of HBC volunteers from the community may increase the risk of stigmatization or breach of confidentiality ▶ Priority on food assistance may result in de-emphasis of other HBC services

Table 3: Distribution Through Health Facilities: Pros and Cons

Advantages	Disadvantages
▶ Food distribution can be linked with triage, nursing care, nutrition monitoring, counseling and HIV awareness; linkage to conditionality (e.g., clinic/program attendance) is more direct ▶ A number of HIV-positive individuals can be easily reached ▶ Fewer sites are designated as FDPs, reducing transportation costs	▶ May overburden health facility staff ▶ Health facility staff traditionally do not have experience with food distribution ▶ Needs adequate infrastructure and space to store and distribute food ▶ Needs registration and substantial administration ▶ Receiving food at health facilities rather than at community distribution sites may increase stigmatization of beneficiaries

Table 4: Community-Level Distribution: Pros and Cons

Advantages	Disadvantages
▶ Relies on NGO/CBOs field staff and community-level food distribution committees ▶ Shares responsibility of food distribution with beneficiaries ▶ Requires a small number of field staff ▶ Monitoring and reporting are easily done ▶ Distribution is transparent, with community watchdogs (village HIV committee, local leaders) monitoring the process	▶ Accessibility to the food distribution points may be a problem for some beneficiaries ▶ More administratively intensive and costly for implementing partner ▶ May be more sharing of ration cards if food is handed out by outsiders ▶ Exposure may lead to stigma ▶ Potential diversion of food to local influential people

Community-Level Food Distribution Systems by Local NGOs or CBOs

Local food distribution committees usually help NGOs and WFP organize community-level food distributions. The food distribution committee is responsible for organization, information sharing, planning the distribution process and reporting. The committee establishes communication between the food assistance agency or implementing partner, PLHIV and the community institutions monitoring food distributions. In areas affected by both food insecurity and HIV, food distribution committees should establish links and collaborate directly with community-level HIV committees. Table 4 shows the pros and cons of community-level distribution.

Take-Home Rations Versus On-Site Feeding

Programs distributing food assistance to HIV-positive beneficiaries will need to decide whether to provide take-home rations (THRs) or to conduct on-site feeding for individuals. Typically, on-site feeding is provided when an individual is in an advanced stage of illness or a household lacks safe and sanitary conditions, both of which can limit an individual's ability to adequately prepare meals in the home. On-site feeding is typically conducted under the supervision of trained health professionals in clinics and/or HIV treatment facilities. Table 5 lists the advantages and disadvantages of THRs and on-site feeding.

Table 5: THRs Versus On-Site Feeding

	Advantages	Disadvantages
On-Site Feeding	▶ Rations eaten under supervision ▶ Ill or anorexic participants can get help with eating ▶ Feeding problems can be identified and addressed ▶ Ensures that food ration is consumed by target population ▶ Opportunity to provide information to the caregiver ▶ Provides a social atmosphere for those who otherwise might have to eat alone ▶ For OVC receiving on-site school feeding along with the rest of the student body, there may be less stigma than being singled out for a THR based on their status	▶ Recipients may be given less food at home (substitution) ▶ Participants and sometimes caregivers must travel to feeding center daily ▶ Resource-intensive, requiring equipment, fuel, a feeding facility and well-trained staff
THRs	▶ Large numbers of recipients can be reached ▶ Fewer resources required to administer the program ▶ Fewer costs for preparation and distribution ▶ Participants or caregiver spends less time and effort attending feeding site ▶ Less exposure to other beneficiaries/ community (and possible related stigma)	▶ No guarantee that recipient consumes the food ration because it may be shared with other family members, sold or traded ▶ Less time for BCC ▶ Exposure of condition to family members (for example in PMTCT)

9.5 Key Concept

Adapting Food Distribution Methods

Timing of Ration Delivery/Distribution

The frequency of ration delivery/distribution should be based on PLHIV's consumption needs and should take into account the accessibility constraints between the extended delivery points (EDPs), the main warehouses where food is stored in-country and the designated FDPs. Food distribution organized in short, more frequent intervals permits agencies to distribute smaller quantities of food—which are easier for PLHIV or OVC to carry home—but also is likely to increase costs.

The timing (e.g., day of the week, time of day) of food distributions should consider clients' attendance at associated activities and daily household routines, particularly related to the target beneficiary, the caregiver and/or the head of household.

Certain food assistance programs may distribute food through facilities with daily hours, such as an ART clinic's storage facility. This type of service delivery requires dedicated staff capacity, on-site facilities and associated resources.

Efficiency and Accountability for Distributed Rations

The amount of food distributed to beneficiaries will differ based on whether rations are for an individual or a family. Efficiency and transparency of food distribution can be ensured by displaying a simple chart indicating the amount of food allotted for each category of beneficiary at food distribution points.

Customizing Family Rations for Efficient Distribution

The Associazione Volontari per il Servizio Internazionale (Association of Volunteers in International Service, or AVSI) program in Uganda repackages food received from WFP into three family-sized rations to simplify the distribution process:

- One- to four-member households are entitled to three daily rations
- Five- to seven-member families are entitled to six daily rations
- Households of eight or more members are entitled to nine daily rations

During distribution, beneficiaries are grouped by family size and food entitlement group, which also speeds the distribution process.

Close supervision and corrective action are critical to ensuring proper rations are distributed. For example, particularly when bagging facilities are not available, food often is distributed by weighing each commodity during distribution or using equipment such as buckets and bowls calibrated before starting food distribution for each commodity. This is important, especially for cereals, because measuring cups with the same volume will give different weights depending on the weight and density of the food being scooped, which can lead to significant inequity in food distribution.

To facilitate transparency of entitlement and the efficiency of food distribution, some programs adjust the ration size to accommodate whole packaging units. For example, each household receives 50 kg of cereals, based on a standard household size of five persons (333 grams per person per day). However, this may not provide all households with the same contribution to their household food consumption, nor will it meet the exact nutritional requirements for household members. This approach may be appropriate when the food ration is not expected to cover an exact nutritional requirement but instead provides an income transfer and/or contributes to household food security.

"Alternative Collectors" for HIV-Infected Beneficiaries

As noted earlier in this guide, when the target beneficiary may not be able to get to distribution sites because of weakness, illness or stigma, it may be appropriate to identify another household member or a friend who can pick up rations on her/his behalf. This person can be registered as an "alternative collector" for food rations. When alternative collectors are used, post-distribution monitoring must be able to detect instances of waste/fraud and link to effective means of enforcement.

Food Distribution in Areas Affected by Conflict and/or Displacement

Refugees and other displaced populations living in camps often rely heavily on external assistance for nutritional, health and other basic needs. They also face particular risks related to food security and HIV. For example, refugees sometimes are unfamiliar with the food provided, or food resources are misused or inappropriately distributed by camp residents, humanitarian aid workers or combatants. In addition, in camp settings, inappropriate management of food assistance has also been linked to the sexual exploitation of women and children, which can further the spread of HIV.

Refugees' multifaceted needs call for integrated, tailored interventions. However, research has found a general lack of coordination among cooperating partner agencies operating in settings involving refugee and displaced populations and little consideration given to how integrated food assistance and HIV programs can be designed and implemented.[17]

To improve programming in such settings, UNHCR and WFP developed guidance on the integration of HIV activities with food and nutrition support for refugees.[18] Within refugee settings, UNHCR and WFP identify general food distributions (GFD), supplementary (SFP) and therapeutic (TFP) feeding programs as key points where the community and individual beneficiaries can receive information on preventing and mitigating HIV.

In established settlements, feeding committee representatives should regularly consult with refugee community leaders and food beneficiaries to conduct pre-distribution sensitization, distribution supervision and post-distribution monitoring. These forums provide opportunities to promote community engagement and action around HIV prevention. Discussions and participatory activities at food distribution sites can also address issues related to the food distribution, such as access to food assistance by vulnerable groups (including households headed by the chronically ill), the role of food in managing illness, as well as safe storage and palatable preparation of commodities in the ration.

In areas highly affected by HIV, UNHCR and WFP further recommend that refugee communities establish multisectoral and participatory HIV committees to facilitate dialogue and coordination of decisions regarding HIV-affected refugee households. Through HIV committees' involvement in providing food assistance, food distribution leaders can learn

Integrating Food Distribution and HIV Awareness in a Refugee Settlement[19]

At Uganda's Kyangwali Refugee Settlement, the food management committee, as part of its involvement in a GFD led by Aktion Afrika Hilfe, wanted to incorporate HIV sensitization into its distribution-related activities. The committee felt there were extensive opportunities for it to participate in the settlement-wide HIV prevention effort through its community contact before, during and after distributions. The committee also requested training on the linkages between nutrition and HIV, and asked to be brought into the process as partners.

The committee proposed that its members participate in HIV sensitization dramas (led by community counseling aides) and HBC visits, thinking that food management committee members who were involved in HIV outreach would be better equipped to help target the GFD to vulnerable households affected by chronic illness (a group that is often difficult to reach).

how to lead HIV discussions and training in their communities. They may also conduct appropriate HIV prevention education activities at distribution sites in collaboration with health and social welfare services offered by partner organizations.

For a more detailed discussion of food assistance in emergency situations, see **Chapter 13: Emergency Response**.

Prevention Education at Food Distribution Sites

Food distribution sites offer excellent opportunities for disseminating HIV education and awareness messages because these venues provide a "captive audience" and often attract both beneficiaries and non-beneficiaries.

Some educational activities that may be conducted at distribution sites include:

- Training family and community caregivers in preparing nutritious recipes suitable for those with AIDS-related illnesses, using food assistance commodities and locally available foods
- Delivering messages on positive living (PL) and treatment literacy
- Providing information on transmission and prevention of HIV
- Conducting stigma reduction training and activities
- Raising awareness on gender issues and HIV
- Adapting and providing training material on home gardening and medicinal crops for PLHIV
- Marking events such as World AIDS Day, World Food Day, International Women's Day
- Supporting community-led dramas, songs and rallies on HIV awareness, prevention and gender issues

Health Tables Give Advice on Health Issues at Food Distribution Sites

CARE Zambia obtained ECHO funding to initiate 'health tables' at distribution sites to communicate important health messages to the community. Pamphlets were distributed and discussions were held on a variety of health issues, e.g., HIV, PMTCT, PL, exclusive breastfeeding, condom use, dangerous cultural practices, safe water and nutrition. Non-beneficiaries also frequented the health tables on distribution days, asking questions and seeking practical advice for health concerns. Health table staff also offered free condoms to both beneficiaries and non-beneficiaries.

Delivering HIV Messages at Food Distributions

In Zimbabwe, World Vision (WV) and Population Services International (PSI) formed a partnership to bring PSI sensitization activities to FDPs. PSI and WV agreed on key messages that included STI prevention and treatment, HIV transmission and prevention, VCT and PMTCT. These messages were relayed to beneficiaries through short dramas and discussions.

Key Considerations for Food Distribution in the Context of HIV

Experience gained and lessons learned from a range of food assistance and HIV interventions has revealed a number of critical considerations and guiding principles for adapting operational modalities for food assistance among affected communities. They include:

Coordination with district and community stakeholders. Improve coordination by establishing cooperating agreements with HBC groups, community health workers (CHWs) and PLHIV networks, as well as district level health and agriculture administrative structures. Such agreements can help improve the planning, delivery, receipt, distribution, documentation and reporting of food assistance.

Training. Ensure that food distribution agents receive adequate training in food handling, storage and distribution procedures, as well as in commodities and packaging appropriate for PLHIV. Staff support and training should include implementation of an HIV workplace policy and program (see Key Concept 9.6 in this chapter).

Avoidance of stigmatization. Ensure that the food distribution timing, frequency and location are amenable to beneficiaries and do not expose them to stigma. This can be done by involving beneficiaries, local leaders and HBC networks in distribution planning.

Linkages to complementary programming. Structure the distribution to provide linkages among complementary programming activities, such as information sharing, nutrition education and HIV awareness building.

Attendance at conditional services. Organize food distributions to stress the importance of and facilitate attendance at other services on which food assistance may be conditional, such as clinical care and treatment activities and/or community-based OVC support programs.

9.6 Key Concept
Workplace HIV Policy and Prevention Education for Food Assistance Support Staff

Given the context in which most food assistance and HIV programs operate, agencies must implement appropriate and effective workplace policies to prevent the spread of the disease and support infected employees. While development of workplace HIV policies may require an initial investment of personnel, time and funding, the process ultimately results in increased organizational effectiveness by contributing to a healthy and responsible workforce.

An HIV policy—and an inclusive process of developing and implementing it—can provide a foundation for a workplace environment that values trust, learning, understanding and freedom from stigma and discrimination. With so many affected by the epidemic, a well-thought-out policy can provide all staff with the information and support they need to work and live in this environment. A good policy should benefit both employer and employee, boosting morale and productivity, and reducing the impacts of known threats (such as sickness and death) through early intervention. An HIV policy, when properly implemented, can enhance programming, as staff feel more confident and better placed to identify programming needs and opportunities.[20]

In addition, food assistance agencies also can help mainstream HIV awareness by providing comprehensive prevention education for all personnel who handle and distribute food assistance. Implementing appropriate workplace policies and providing HIV prevention education are essential for ensuring that personnel responsible for implementing food assistance and HIV programs consistently follow the principle of "do no harm" in their communities.

Typically, workplace HIV policy and programs focus on limiting the incidence of new infections among staff and the community and on managing the impact of existing infections on the organization, staff and community. To achieve these objectives, agencies normally set goals in two key areas: changing behavior/increasing the use of preventive measures and improving care and support of persons affected by HIV and other infectious diseases. These objectives are often based on an appraisal of particular circumstances, including areas of operations, level of risks, available resources and partners that can help develop and implement workplace HIV programs and action plans. Such interventions involve:

- Developing a workplace HIV policy
- Determining the agency's HIV-related risks and opportunities for prevention
- Identifying a "focal point" at the organization and building partnerships and stakeholder groups
- Raising organization and implementing partner awareness of HIV, including providing appropriate HIV prevention education to all food assistance intervention staff

Develop a Workplace HIV Policy

Developing a workplace policy is a critical step in informing employees of their rights and responsibilities, articulating management's commitment and clarifying expectations from both sides. Key elements of such a policy generally include a statement on the agency's commitment to address HIV, a respect for confidentiality of HIV status and the establishment of non-discriminatory practices regarding PLHIV. The policy also helps agencies integrate HIV in their programming more effectively.

Code of Practice for HIV Workplace Policy

The ILO's Code of Practice for HIV offers guidance for developing a workplace HIV policy. The full document is available at www.ilo.org/public/english/protection/trav/aids/code/languages/hiv_a4_e.pdf, but here are some key points:

Recognition of HIV as a workplace and program operation issue. HIV is a workplace issue, not only because it affects staff, but also because the workplace and program operations can play a vital role in limiting the epidemic's spread and impact.

Non-discrimination. There should be no discrimination against or stigmatization of workers on the basis of real or perceived HIV status.

Gender equality. More equal gender relations and the empowerment of women are vital to preventing the spread of HIV and enabling women to cope with HIV.

Healthy work environment. The work environment should be healthy and safe, and adapted to the state of health and capabilities of workers.

Screening for purposes of employment. HIV screening should not be required of job applicants or persons in employment.

Confidentiality. Access to personal data relating to workers' HIV status should be bound by rules of confidentiality consistent with an agency's human resources policy.

Care and support. Solidarity, care and support should guide the responses to HIV in the workplace.

Continuing employment relationship. HIV infection is not a cause for termination of employment. Persons with HIV-related illnesses should be able to work for as long as medically fit in appropriate conditions.

Social dialogue. A successful HIV policy and program requires cooperation, trust and dialogue between employers, workers, government and implementing partners such as transportation, warehousing and food distribution staff.

Prevention. Employees and their interactions with the community provide an opportunity to promote prevention efforts through information and education and support for changes in attitudes and behavior.

Determine the Risks and Opportunities for Prevention

Many food assistance agencies realize that HIV can pose serious health risks to their staff, as well as financial and logistical challenges to their operations. The spread of HIV can also be a very real outcome arising from food assistance agency interaction with communities.

It is important to determine the agency's and employees' level of exposure and understanding with respect to the spread of HIV, both internally and in the broader community. Many food assistance staff still lack correct, relevant and up-to-date information—or confidence in their information—about HIV, opportunistic infections, treatment and risk of transmission. When working in a context that is influenced by HIV, educating staff is a responsibility of all food assistance agencies, irrespective of whether they are providing HIV-related services.

Identify a Focal Point for the Organization and Build Partnerships

Appointing a staff person or committee to serve as focal point for handling all organization HIV-related activities brings accountability and focus to the process. These individuals should have authority over activities and be given direct line of communication with senior management. In some cases, a committee may be needed to enhance coordination and ownership of the program.

Partnership with other stakeholders in food assistance operations may be helpful to design and implement focused programs, leverage resources, learn from the experience of others and ensure independence and confidentiality of employees' condition and care. The focal points can represent the agency in multi-stakeholder forums with implementing partners, transporters and community representatives.

Raise Organization and Implementing Partner Awareness of HIV

A number of food assistance agencies have implemented awareness programs involving IEC activities that offer facts about HIV transmission, promote preventive measures and seek to de-stigmatize the disease. Awareness activities should inform employees and partners about risks and educate them how to minimize their exposure.

In addition, food assistance staff occasionally have said they feel ill-equipped to address HIV-related issues raised by the community in relation to food programming.[21] Especially where food insecurity and high HIV prevalence intersect, staff may find that the need for assistance outstrips their ability to provide it.

Training can help address these issues. In particular, regular training aimed at staff from all sectors and in both development and relief contexts is essential to ensure that food programming benefits from cross-sectoral exchange and learning about HIV. Trainings, technical briefings and new-employee programs should provide technical updates, facilitate internal networking and information-sharing between NGO staff, provide insight into capacities and expertise, and facilitate external networking and information-sharing to connect NGO managers with relevant government strategies and other stakeholders' work.

Staff Training in the Prevention of Sexual Exploitation and Abuse

In Zimbabwe, UNFPA—in collaboration with WFP—trained 379 relief committees at 79 food distribution points in 2004 to provide counseling to communities on HIV/AIDS prevention, sexual exploitation and abuse. Relief committees have shared the information with the rest of their communities during food distributions with the help of their Cooperating Partners.

Key Considerations for Designing Prevention Education for Food Assistance Support Staff

Several high-risk groups, including dock workers, transporters, military food escorts and merchants, are closely associated with the delivery of food assistance in areas of high HIV prevalence. As a result, the community may consider the workers to be agency employees, leaving the agencies with a social responsibility to address the issue.

However, these groups are hard to reach through standard health delivery services and not commonly targeted for HIV education interventions (and therefore have relatively little knowledge about HIV issues). Program managers should explore implementing HIV education activities for these groups to ensure that their efforts to assist affected populations are also helping to prevent the disease, with these considerations in mind:

Prevention education needs. Target group prevention education needs will differ according to level of awareness, work-related exposure to local populations and other factors. In the case of truckers, dock workers and military personnel, most agree that HIV education and access to condoms are both critical components of an HIV workplace policy.

Management buy-in. Managers can play a critical role in removing barriers to employees' participation in training at all levels. This is relevant to any setting that targets employees. For instance, a key reason truckers and dock workers did not attend training when it was offered by WFP in its transport corridor initiative was that they did not want to miss out on a whole day's salary.

Institutionalizing processes and services. Whenever possible, ensure that training and sensitization of workers is supported by relevant policies, procedures and guidelines. These can cover a number of issues such as organizing condom distribution or leave provisions for dealing with discrimination. Ensure, also that these are consistent with the organization's pre-existing structures and mechanisms, as well as with any relevant local and national statutes.

Highly mobile populations generally experience greater vulnerability to HIV infection. A 2002 study found an HIV prevalence rate of 56 percent in truck drivers and sex workers along the main highway from Durban north to Zimbabwe and concluded that "truck drivers may have facilitated the spread of HIV infection throughout southern Africa."[22]

Adequate resourcing. Success in BCC programming depends heavily on providing follow-up training and services, and monitoring the progress of those targeted for behavior change. This requires intentional planning and resource allocation.

Sustainable tools and approaches. Use low-cost creative tools and approaches (peer educators, HIV technical working groups, buy-in from business and industry) to ensure sustainability and replicability.

Consultation with stakeholders and partners. Undertake a consultative approach with all stakeholders and partners to ensure that initiatives are appropriately focused.

Additional information on providing prevention education to transport workers is available from ***Getting Started: WFP Support to HIV/AIDS Training for Transport and Contract Workers*** (2006) available at www.wfp.org/food_aid/doc/HIV_Training_Transporters.pdf.

Public-Private Partnerships Seek to Curb HIV's Spread in Transport Sector

In southern Africa, TNT, the global express mail company, WFP and Ikaheng, a South African company that manages 12 roadside Wellness Centers for truckers formed a partnership to expand the Wellness Center network.

Wellness Centers provide truckers with HIV education, counseling, condoms, treatment for STIs, primary healthcare and referrals to HIV testing and treatment. Based on the model established by South Africa's National Bargaining Council for the Road Freight Industry and the Road Freight Association, Wellness Centers are housed in low-cost, portable containers situated in places where truckers congregate, such as the border post and WFP warehouse, and are open at hours convenient for the drivers. The centers are staffed with a clinician and an outreach worker; they also use peer educators who speak to drivers in the truck park.

Working with other international agencies, local government and business associations, the partners opened their first two Wellness Centers in Malawi in 2005 and one in Swaziland in 2007. The partners plan to open 10 to 12 others in sub-Saharan Africa by 2010.

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Chapter 10: Health and Nutrition

Sector-Specific Program Design Considerations

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Sector-Specific Program Design Considerations

Key Concepts

10.1 Food Aid-Funded Health and Nutrition Programming in a High HIV Prevalence Context

10.2 Integrating Food and Nutrition Interventions Into HIV Programming

10.3 Challenges and Considerations for Food and Nutrition Programming in the HIV Context

10.4 Critical Gaps in Knowledge

In This Chapter

Food assistance program staff implementing health, nutrition and food interventions in high HIV prevalence environments may want to know what interventions are the most appropriate or how interventions can be adapted to better respond to the context. Likewise, many HIV program staff may have wondered about the best ways to integrate health, nutrition and food interventions into their programming to respond to clients' needs and improve their program outcomes.

This chapter discusses programming food-aid supported health, nutrition and food interventions in areas of high HIV prevalence and including food and nutrition interventions in HIV programming where there is high food insecurity or pockets of food insecurity.

Ideally, fully integrated programs that take advantage of all contact points for comprehensive service delivery or institute strong referral systems will become the norm where both high food insecurity and HIV prevalence exist. However, for integrated programming, a number of primary challenges, key considerations and critical gaps in knowledge still exist. These are addressed at the end of the chapter.

The health, nutrition and food programming discussed in this chapter is limited to interventions typically implemented by Title II CSs and WFP implementing partners. Although O/GAC and the Global Fund also support health, nutrition and food activities in the HIV context, this chapter does not provide guidance on the use of those funds.

10.1 Key Concept

Food Aid-Funded Health and Nutrition Programming in a High HIV Prevalence Context

Food aid-funded health, nutrition and food programming refers to the package of interventions that are typically a part of food aid-funded maternal and child health and nutrition (MCHN) programming. These interventions include:

- Supplementary feeding
- Therapeutic feeding, including the use of the community-based management of acute malnutrition (CMAM) approach
- Growth monitoring and promotion (GMP)
- Nutritional assessment
- BCC, including Positive Deviance approaches, such as the Hearth Model and nutrition counseling
- Promotion of home gardening and other homestead production

A brief description of these interventions follows:

Supplementary feeding prevents or treats moderate malnutrition when there are no medical complications. Typically, beneficiaries are selected from vulnerable populations, such as pregnant and lactating women, infants and young children, using additional vulnerability criteria (e.g., geographical determination of vulnerability, anthropometric measurements).

Therapeutic feeding is used to treat severely malnourished children and adults, both as inpatients and outpatients, and is usually combined with supplementary feeding programs. The standard approach for treating severely acutely malnourished individuals consists of two phases:

1. The ***stabilization phase***, or the treatment of severely acutely malnourished individuals using standard WHO/Integrated Management of Childhood Illness (IMCI) protocols to provide energy and nutrients using therapeutic foods such as the UN-supplied F-75 therapeutic milk or RUTF like Plumpy'nut®;
2. The ***rehabilitation phase***, or the treatment of individuals with foods such as F-100 therapeutic milk or through the continued use of RUTF. Severely malnourished individuals without medical complications can be treated in their communities with RUTF, an approach commonly known as CMAM (see box below).

Community-Based Management of Acute Malnutrition

CMAM is an innovative approach to managing severe acute malnutrition in children using RUTF such as Plumpy'nut® on an outpatient basis instead of in a facility. CMAM provides rapid assistance that is less disruptive to affected communities and focuses on outreach and community mobilization to promote participation and maximize impact and coverage.

The combination of a community-based approach and the provision of RUTF has been instrumental in moving a nascent home-based treatment to a widely recognized approach that WHO and UNICEF are now adapting and integrating with facility-based approaches.[1]

HIV-Positive Children Continue to Fall Through the Cracks

Field staff from OVC programs in southern Africa were recently interviewed for a WFP/UNICEF review[3] and noted that without strong GMP for early identification of HIV-positive children, these children will continue to elude much-needed early intervention for both nutrition and initiation of ART. Good GMP with strong coverage can identify HIV-positive children as soon as they exhibit growth faltering. The need for early identification was further exemplified by the high prevalence of HIV found among children admitted to nutritional rehabilitation units with severe acute malnutrition.

GMP is an essential program component that uses regular measurement of children's height and weight to monitor physical developments and accompanies this activity with information on optimal feeding and care. GMP promotes healthy development and acts as a screening tool to detect problems. GMP also can be used as a contact point to provide other services such as micronutrient supplementation, vaccination and hookworm treatment, as well as to offer information on other topics such as HIV prevention.

It should be noted that HIV-infected children are estimated to be significantly shorter and lighter than uninfected children, with growth differences increasing with age, studies have shown. Once HIV-positive children's growth falters, it generally takes them longer to recover.

Understanding HIV's influence on growth is important for GMP interpretation, both for formulating growth promotion advice and monitoring program impacts. This knowledge should also improve GMP volunteers' capacity and confidence in making referrals for HIV-related services.[2]

Nutritional assessment is similar to GMP in that it can be used as a screening tool for targeting interventions and to monitor nutritional status of both children and adults. It includes assessment of anthropometric status, dietary practices and micronutrient status.

BCC includes a range of techniques and approaches aimed at improving behaviors, including those that influence an individual's health or nutrition status. In nutrition counseling, which is frequently a part of food aid-supported MCHN programming, a provider and a client discuss dietary/nutrition recommendations, the specific needs of the individual and the family, and steps to take to overcome constraints and achieve improved nutritional status.

Promotion of home gardening and other homestead food production is intended to improve individual and household dietary diversity and, possibly, income. Home gardening and homestead food production are done by women.

Program Modifications for an HIV Context

Programming food aid-supported health, nutrition and food interventions in a high HIV prevalence context may require changes to existing program design in a number of areas, including:

Targeting

Targeting approaches, systems and criteria may need to be adjusted to ensure inclusion of PLHIV and affected beneficiaries. For example, it might not be effective to try to reach malnourished children at GMP sites or health facilities if elderly heads of households and

time-constrained caregivers are less likely to use these services and therefore less likely to bring children there. In these cases, programs may need village leaders, community groups and CHWs to help identify beneficiaries who cannot seek services on their own. Training CHWs to screen for malnourished children and refer them for follow-up at clinics or other GMP sites is another way to increase coverage (see **Chapter 5: Targeting**).

Ration Size and Composition

Rations may need to be modified when targeting PLHIV or when household size has substantially changed for a significant number of families (because of an influx of OVC or other reasons). Programs may be more inclined to provide milled and micronutrient-fortified staples, such as CSB, because of time and capacity constraints households face. If HIV-exposed infants and young children are not being breastfed, nutrient-dense foods will be needed to minimize gaps in their daily nutrient intakes (see **Chapter 6: Ration Design**).

Duration of Food Assistance

HIV-infected adults and children generally take longer to recover from malnutrition, particularly severe acute malnutrition, than other individuals. As a result, food assistance interventions for these individuals may need to last longer.

Distribution System for the Ration

In an HIV context, where beneficiaries may be too ill to collect their food from distant food distribution sites, programs may need to rely on social workers, HBC or other community volunteers to deliver food to beneficiary households or may need additional food distribution sites. Programs also may address potential stigmatization by providing smaller, more frequent rations, so food can be brought home more discreetly (see **Chapter 9: Operational Modalities**).

Health and Nutrition Counseling Messages

In high HIV prevalence situations, counseling on feasible nutrition actions is essential. For PLHIV, counseling messages may need to focus more on maintaining body weight, preventing food- and water-borne infections, managing dietary complications of HIV-related symptoms and secondary infections, and managing side effects from ART and other medications. In addition, in some cases, the audience for counseling may be grandparents, adolescents and other non-traditional caregivers, so the delivery of messages may need to be tailored to their circumstances and needs.

Program Outreach

In an HIV context, non-traditional heads of households may need additional outreach or different types of information to encourage their participation in services. Programs need to consider how to best reach heads of households, such as grandmothers, grandfathers, young siblings or foster parents and what types of information and/or services are most useful to them.

Staff Training

Staff training should be expanded to focus on HIV-related skills and understanding in a number of areas, including HIV's impact on health and nutrition status, key HIV services, increased vulnerability due to the HIV context and stigma.

Key Considerations for MCHN Program Design in the HIV Context

When designing food-aid funded MCHN interventions in the HIV context, a number of key considerations should be taken into account, including:

Creating linkages with HIV-related services. Referral services should be established to link food aid-funded program beneficiaries with HIV-related services, such as VCT, PMTCT, ART, TB-DOTS and palliative care. Referrals from health facilities to MCHN programs should also be established. Program beneficiaries who do not respond to health, nutrition and food interventions may need to be referred for VCT and other HIV services. This includes infants and young children receiving supplementary or therapeutic feeding who do not recuperate or take longer to rehabilitate.

Creating linkages with HBC support. Linkages with HBC support are important in the HIV context for several reasons. The debilitating effects of the disease can make PLHIV less mobile than other food-insecure populations and less likely to access support on their own. HBC support can help PLHIV obtain food and, if necessary, help prepare it. It also can reach out to non-traditional household heads. In addition, children born to HIV-infected mothers, who are often lost to the health system after completing their vaccinations, can receive additional monitoring through HBC.

Promotion of HIV awareness and education. Service delivery points, including food distribution sites, can provide opportunities to disseminate information about HIV and available services.

Creating an HIV committee and action plan. UNHCR/WFP recommends the establishment of multisectoral HIV committees for supplementary feeding. These committees can create and serve as the focal point for action plans that integrate HIV-related activities into health, nutrition and food programming. The committees also can link with relevant stakeholders (e.g., health, social welfare and protection services).

HIV Prevalence Among Severely Malnourished Children

Mozambique: In 2006, HIV prevalence among children admitted to the nutrition ward of the hospital in Beira ranged from 31.5 to 54.5 percent between January and June 2006.[4]

Northern Uganda: In 2005, HIV prevalence among children admitted to the nutrition ward was 23.9 percent. HIV infection was higher in children under age three.[5]

10.2 Key Concept

Integrating Food and Nutrition Interventions Into HIV Programming

Food and nutrition interventions strengthen and support HIV programming in several ways, both through the interventions' direct benefits (e.g., providing food or increasing dietary diversity through nutrition counseling or home gardening) and through the use of these interventions as an incentive for using HIV services. Food and nutrition interventions can be integrated into HIV programming that supports prevention, treatment, and care and support, including PMTCT, ART, TB-DOTS, palliative care (including HBC) and care and support for OVC.

Prevention of Mother-to-Child Transmission

HIV-infected mothers need accurate health and nutrition counseling, good follow-up and, in many cases, replacement and complementary foods for their children to prevent or reduce high rates of HIV transmission. In addition, while mothers are counseled to stop breastfeeding when replacement feeding becomes acceptable, feasible, affordable, sustainable and safe (AFASS), many mothers stop even when AFASS replacement foods are not available because of fears of transmitting the virus to their children or poor guidance or understanding of infant feeding in the HIV context. When breastfeeding is stopped earlier, infant feeding may be suboptimal, leading to higher rates of child malnutrition, morbidity and mortality in some countries.

In the absence of interventions to prevent or reduce transmission, approximately 5-10 % of HIV-infected mothers pass the virus to their infants during pregnancy; between 10-20 % during labor and delivery; and another 10-20 % through breastfeeding to 24 months.[6]

Integrating food and nutrition interventions into PMTCT services may improve the nutritional status of mothers and their children and serve as an incentive for mothers to return to PMTCT sites, thereby decreasing the number of mother-infant pairs lost to follow-up in HIV programming (see Table 1 on page 220).

It is important to note that Title II programs cannot provide infant formula. While some PMTCT programs supported by WFP may provide formula, as a policy, WFP does not (see **Chapter 6: Ration Design**, Key Concept 6.3).

Antiretroviral Therapy

Nutrition, and, where appropriate, food support are increasingly understood to be a critical aspect of HIV treatment. As the availability of ART expands, reaching ART clients with appropriate nutrition and food interventions may help improve their health and nutritional status, mitigate drug side-effects and improve adherence to the drug regimen (see Table 1).

While anecdotal evidence supporting the use of nutrition and food interventions to obtain ART objectives is widespread, there is still a dearth of empirical evidence to support the claim that food improves ART's efficacy. This is an area that urgently needs to be studied and documented.

Nutrition and food interventions to ART clients are provided mostly by targeting through ART sites, health facilities or PLHIV associations or other community groups with rosters of eligible clients.

Integrating Food, Nutrition and PMTCT Programming

In Zambia, the risk of infant infection is about 40 percent without PMTCT interventions.[7] To address this, WFP and the Government of Zambia have partnered at seven PMTCT sites across the country to provide food assistance to participating women. The project seeks to enable women to participate more fully in PMTCT programs, support women's nutritional status at a particularly vulnerable period of their lives, and gather operational and experiential information on the feasibility and acceptability of linking food to ongoing PMTCT services.

Beneficiaries said the food was an important motivator for attending follow-up appointments. Women also reported that they were eating a greater variety of food, including more fruits, vegetables, soybeans, meats and eggs, and were eating more frequently. Although WFP did not distribute fruit, vegetables, meat or eggs, some beneficiaries said receiving WFP food had enabled them to buy some of these items themselves. Four of the six women interviewed said they felt they had gained weight as a result of the rations, and all six said they felt healthier because of the food. [8]

TB Treatment

In southern Africa, 40 to 70 percent of all TB patients are HIV-positive.[10] Someone who is HIV-positive is about 20 times more likely to develop TB than someone who is not, and an individual with AIDS is 100 times more at risk of contracting the disease.[11] TB patients are more likely to drop out of treatment before it is completed than patients on other medication regimens; when a patient does not finish the full course of treatment, he or she can develop and spread drug-resistant strains of TB that are much harder to treat and up to 100 times more expensive to cure.[12]

Providing food as an adjunct through the entire course of TB-DOTS has similar objectives to those of integration for ART (see Table 1 on page 220).

Providing Nutritional Support for HIV-Positive Mothers in Malawi

In Malawi, health personnel at St. Gabriel's Hospital were concerned about HIV-positive mothers' suboptimal nutritional status and the impact that had on their infants' health. In collaboration with WFP, St. Gabriel's piloted a nutrition intervention to support HIV-positive mothers and their families.

All pregnant women were offered VCT during antenatal visits. Women who tested positive were admitted to the PMTCT program and provided with nutritional support that included nine kg of CSB or Lukini Phala (locally produced fortified blend) for their consumption, and a family ration of 50 kg of maize, four liters of oil and 7.5 kg of pulses monthly.

The 150 HIV-positive women who enrolled in the program received the ration for the rest of their pregnancy (normally four to five months) and 18 months after delivery. The objective of providing food for an additional 18 months was to encourage continued participation in the program, which resulted in continued opportunities to:

- Monitor the nutritional status of the mother and child
- Provide ongoing counseling and educational support
- Support the mother with infant feeding choices
- Ensure that the infant was fully immunized
- Offer VCT on behalf of the infant at 18 months
- Link the women with other support interventions, including income-generation activities

Providing Rations to ART Patients in Swaziland

In Swaziland, WFP supplies individual rations of CSB to ART patients at Good Shepherd Hospital, a private faith-based facility and one of two hospitals in the country that provide clinical services to ART patients every day.

The CSB supplement is a pilot to gauge the feasibility of distributing food supplements at clinics to support ART patients' nutritional requirements. The hospital's HBC staff monitors patients within about a 40 km radius. The hospital provides a small storage room, and WFP supports the salaries of two staff who distribute the food.[9]

Palliative Care

Palliative care is individual and family-centered care that optimizes the quality of life of adults and children living with HIV by preventing and treating pain, symptoms and suffering throughout the period from HIV diagnosis to death.[13] Well-implemented food and nutrition interventions as a part of palliative care are believed to help improve PLHIV's health and nutrition status and optimize their quality of life (see Table 1).

Food and nutrition interventions can be integrated into palliative care at clinics and in communities. Supplementary feeding, therapeutic feeding, GMP (for children), nutritional assessment, BCC and home gardening all can strengthen both clinical and community-level palliative care.

Care and Support for OVC

Since there are several definitions of OVC, organizations first should determine which definition applies to their programming areas. O/GAC, for example, defines an OVC as a child from 0–17 years old who has lost one or both parents to HIV and is vulnerable (i.e., faces serious impairment to prospects for continued growth and development) because of any of these conditions:

- The child is HIV-positive.
- The child lives without adequate adult support (e.g., in a household with chronically ill parents, a household that has experienced a recent death from chronic illness, a household headed by a grandparent and/or a household headed by a child).

Enhancing TB Treatment With Title II Food Aid

CARE Zambia specifically targets TB patients, providing a household ration as an adjunct to treatment. Drawing on the experience and relationships of an existing TB project, CARE has developed a close relationship with District Health Management Boards. This has facilitated CARE's access to the TB registers at the clinic level, making it possible to identify potential beneficiaries who need additional support.

- The child lives outside of family care (e.g., in residential care or on the streets).
- The child is marginalized, stigmatized or discriminated against.

Regardless of how OVC is defined, it is clear that there will be numerous situations where HIV programming for OVC can benefit from the integration of food and nutrition interventions, including supplementary feeding, therapeutic feeding, GMP, nutritional assessment, BCC and home gardening. The objectives of integrating these interventions range from improving the health and nutritional status of OVC by preventing and treating malnutrition, to providing a resource transfer to their households (see Table 1).

OVC are usually identified at the community level, but that can also be done through schools or other institutions that work with OVC.

Key Considerations for Integrating Food and Nutrition Interventions Into HIV Programming

Integrating food and nutrition interventions into HIV programming may require changes to the program design. Programs may need to consider:

Modified needs assessments. In integrated programming to determine the type of food and nutrition interventions that can best meet the needs of the targeted beneficiaries, needs assessments must be conducted, including assessment of nutritional status, dietary practices and food security status.[14] This is necessary because some interventions are not always needed or do not provide the appropriate resource. For example, nutritional counseling can improve dietary choices and practices and may be more appropriate than supplementary feeding in many cases.

Eligibility and exit criteria for food assistance. Clear, standardized eligibility and exit criteria for food assistance are essential for program planning, implementation, monitoring and evaluation. Clear entry and exit criteria allow HIV programming staff to have confidence in determining when an individual should receive or be referred for food assistance. They also provide a greater level of transparency so beneficiaries can understand why they were included or excluded from the food assistance program.

In some cases, exit criteria may be time-bound. For example, food assistance as an adjunct to TB-DOTS is usually based on the time needed to complete the treatment. Since food assistance with ART is still a fairly new area, many programs continue to adjust their entry and exit criteria. In some cases, exit from food assistance is based on reaching a certain nutritional status as measured by BMI (e.g., BMI=18.5), while in other cases it is time-bound based on assumptions of when an individual will either have adjusted to the treatment or be well enough to return to work (e.g., six months).

Staff training and referral systems. It is important that staff understand the benefits of food and nutrition interventions in HIV programming and are trained to provide the service or make referrals. Food and nutrition interventions provide a number of important benefits to clients participating in HIV programs. For example, when GMP is integrated into a PMTCT program, participating infants and young children can be better monitored for growth faltering (leading to earlier detection of children at risk), mothers have a reason to continue visiting PMTCT sites and infant feeding counseling can be fine-tuned. Providing supplementary feeding to OVC in high-risk households may prevent some of these children from becoming severely malnourished, thus requiring more intensive care.

Integrating these interventions will require changes to staff training and, in some cases, referral systems. HIV programs with access to partners who can provide these food and

Table 1: Objectives of Integrating Food and Nutrition Interventions Into HIV Services

HIV Service	Target Group	Food and Nutrition Services	Objective of Food and Nutrition Intervention
Palliative care	PLHIV	▶ Supplementary feeding ▶ Therapeutic feeding ▶ GMP (for children) ▶ Nutritional assessment ▶ BCC ▶ Home gardens	▶ Improve the health/nutritional status of PLHIV ▶ Optimize PLHIV's quality of life
PMTCT	HIV-positive pregnant/ lactating women Infants	▶ Supplementary feeding ▶ Replacement feeding ▶ Therapeutic feeding ▶ GMP (for children) ▶ Nutritional assessment ▶ BCC ▶ Home gardens	▶ Improve the health/nutritional status of pregnant/lactating women ▶ Improve the health/nutritional status of infants and young children ▶ Provide incentive for continued use of PMTCT services
ART	ART clients	▶ Supplementary feeding ▶ Therapeutic feeding ▶ GMP (for children) ▶ Nutritional assessment ▶ BCC ▶ Home gardens	▶ Improve the health/nutritional status of PLHIV before starting ART ▶ Improve the health and nutritional status of ART clients ▶ Mitigate drug side effects and improve tolerance of the drugs, especially at the initial stages of treatment ▶ Improve adherence to the drug regimen
TB-DOTS	TB patients	▶ Supplementary feeding ▶ Therapeutic feeding ▶ Nutritional assessment ▶ BCC ▶ Home gardens	▶ Improve the health/nutritional status of TB-DOTS clients ▶ Mitigate drug side effects and improve tolerance of the drugs, especially at the initial stages of treatment ▶ Improve adherence to the drug regimen and completion of treatment course
Care and support for OVC	OVC	▶ Supplementary feeding ▶ Therapeutic feeding ▶ GMP (for children) ▶ Nutritional assessment ▶ BCC ▶ Home gardens	▶ Improve the health/nutritional status of OVC

nutrition interventions will still need to inform their staff about the objective of these interventions, criteria for referrals and the follow-up needed.

Monitoring consumption of food rations. It is important to monitor whether the intended beneficiary is consuming the ration or whether it is being shared with other family members. If the main beneficiary is not consuming enough of the ration, programs should consider strengthening sensitization efforts, increasing the individual ration, and/or providing a household ration in addition to the individual one.

Avoiding stigmatization. One of the main principles of food assistance is "First, do no harm." In many cases, when individuals bring home large bags of donated food, especially from health facilities, they are identifying themselves as HIV-infected to their community.

PCI Zambia Experiments With Criteria for Food-Supported ART

PCI in Zambia initially provided ART patients with food rations for six months, with the possibility of an extension of two to three months under exceptional circumstances. However, PCI found that readiness for discharge varied dramatically case by case and that six months was not enough time for most patients to resume work, even with maximum adherence to the drugs.

PCI then extended the provision of food to a maximum of one year, with evaluation of both medical and socioeconomic criteria every three months. These discharge criteria were developed and paired with a socioeconomic assessment for evaluating the need for extension:

- Weight gain
- Functional status: bedridden, walking with assistance or walking (WHO criteria)
- On ART but unresponsive to treatment (e.g., chronic diarrhea)
- Currently receiving TB treatment

Chapter 9: Operational Modalities addresses ways to handle food distribution to avoid unnecessary stigmatization.

Understanding and communicating drug-food interactions. When integrating food into ART services, programs must take into account drug-food interactions that may affect the drugs' efficacy. Food-drug interactions vary from one drug to another and require appropriate dietary responses to optimize the medication's efficacy. If not properly managed, these interactions can reduce the therapy's effectiveness and result in unnecessary side effects.[15, 16, 17]

Modifying program strategic information and data reporting systems. HIV programs that have data reporting systems should consider what modifications are needed to integrate food and nutrition interventions. The same reasons for collecting data on the provision of HIV program services exist for food and nutrition interventions.

Key Concept

10.3 Challenges and Considerations for Food and Nutrition Programming in the HIV Context

Implementation of food aid-funded MCHN interventions in high HIV prevalence environments and the integration of food and nutrition interventions into HIV programming have a number of other challenges and considerations that must also be addressed.

Food assistance should be tied to a determination of food insecurity. Not everyone affected by HIV or AIDS requires food assistance. Food security status must be assessed before determining that a food intervention is appropriate.

Not everyone knows their status. Perhaps one of the greatest challenges of food and nutrition programming in the HIV context is that so many PLHIV do not know their status. Some programs have tried to overcome this challenge by using proxy indicators, which also

have their weaknesses. When PLHIV do not know their status or are unwilling to share their status, it is extremely difficult for programs to begin interventions early enough to ultimately have a positive impact.

Determination of food insecurity depends on staff capacity and requires a significant investment of time. The HIV programming staff determining eligibility for food must be trained on doing food security assessments. Conducting food security assessments properly for clients at a health facility requires having enough time with the client and could require home visits. **Chapter 5: Targeting** provides more information on determining food insecurity for HIV programming.

HIV programming staff capacity to implement nutrition and food interventions may be limited. Food and nutrition interventions are frequently a new technical area for HIV programming staff. Assistance must be provided so HIV programming staff can conduct GMP, nutritional assessments, nutritional counseling and other related activities.

Targeting for health, nutrition and food interventions often focuses on the curative rather than the preventive. The use of proxy indicators such as chronic illness and identification of malnourished adults or children whose growth has faltered will target individuals once they need a higher level of assistance. This may be particularly true in the HIV context, where PLHIV do not know their status or are afraid to ask for help and where traditional support systems are too overwhelmed to seek assistance for OVC.

Parents share their food with their children. Food-insecure, HIV-positive adults who receive an individual food ration are almost certain to share the ration with others in their household, especially their children. This reality must be considered when determining what a minimum ration should include.

Food rations do not reflect optimal nutritional formulations and are not intended to meet all of an individual's nutrient needs. There is no nutritionally complete food available through food assistance programs, nor is a supplementary feeding ration intended to meet 100 percent of an individual's nutrient needs. Outside of an emergency situation, food rations are intended to be supplemented by food the household accesses through other means.

Sensitization of staff is important to avoid stigma. Stigma continues to be a formidable deterrent preventing HIV-infected and -affected individuals from using services. This includes stigma experienced when in contact with food assistance and HIV program staff. To ensure optimal uptake of services, program managers need to provide their staff with adequate training and information about HIV transmission.

AMPATH Assessment to Determine PLHIV Eligibility for Food

In Kenya, AMPATH uses a *Nutrition Initial Encounter Form* to determine whether a PLHIV meets the criteria for food rations in addition to the nutrition education and counseling provided to all patients. Criteria include:

- Anthropometrics (height, weight, BMI, MUAC, skin fold and CD4 count)
- Indicators of access to adequate food
- Economic criteria
- Food safety
- Symptoms
- Medications (ARVs and opportunistic infection prophylaxis)

The AMPATH tool appears in Annex 2 at the end of this chapter.

Nutrition job aids and materials for the HIV context are still limited or hard to access. Progress has been made in several countries over the past few years to develop job aids and materials that strengthen the nutritional response to PLHIV and OVC needs. However, job aids and materials may still be limited or not available in every locale. Efforts to develop or reproduce materials need to continue in order to strengthen and standardize the nutrition response to HIV.

Other health and nutrition interventions are also important. This chapter focuses on the integration of the types of health, nutrition and food interventions typically offered by food assistance programs. However, there are several other health and nutrition interventions that should be considered for integration into HIV programs, including:

- Vitamin A supplementation
- Iron-folic acid supplementation for pregnant and lactating women
- Malaria prevention
- Prevention and treatment of parasitic infections
- Prevention and treatment of diarrhea, including the use of oral rehydration solution (ORS) and zinc supplements
- Prevention and treatment of acute respiratory infections
- Water and sanitation programs

Key Concept

10.4 Critical Gaps in Knowledge

As noted earlier in this guide, food assistance programming in an HIV context is a relatively new field. As a result, there are critical gaps in knowledge about health and nutrition interventions to guide efforts to integrate programs. These gaps include:

Food's Impact on Nutritional and Health Status

Though results from studies and public health evaluations are beginning to emerge, there is very limited evidence on the nutritional and health impact of food programs for PLHIV. Few would debate that food is a powerful component of health and nutrition programming, but there is not yet sufficient evidence from randomized controlled trials to identify food's specific impacts on PLHIV, including clinical status and disease progression. Some trials are in progress, but in the meantime, programs need to effectively monitor and evaluate programming to assess results and improve approaches (see **Chapter 8: Monitoring and Evaluation** for suggested indicators).

Infant and Young Child Feeding Guidance Continues to Evolve

WHO currently recommends that HIV-positive mothers avoid all breastfeeding from birth if replacement feeding is AFASS. Otherwise, exclusive breastfeeding is recommended during the infant's first six months and then should be discontinued as soon as AFASS conditions can be met. When HIV-infected mothers choose not to breastfeed from birth

or choose to wean a child early, they should receive specific counseling and support for at least the first year of the child's life to ensure adequate replacement feeding. Evidence needs to be collected and analyzed on the effect of these practices on the HIV-free survival of HIV-exposed children.

Replacement Feeding

Priority must also be placed on access to replacement foods to support accelerated weaning for HIV-positive women who opt to cease breastfeeding, as well as nutrient-dense complementary foods for children over six months of age. Unfortunately, there is still very little guidance or practical support on accelerated weaning and how to safely achieve the most suitable diet for these infants with available commodities or locally available foods.

Annex 1: Additional Resources on Health and Nutrition

FANTA Project. (2004) ***HIV/AIDS: A Guide for Nutritional Care and Support***, 2nd Edition, available at www.fantaproject.org/downloads/pdfs/HIVAIDS_Guide02.pdf.

LINKAGES Project. (2005) ***Women's Nutrition throughout the Life Cycle and in the Context of HIV and AIDS***, Training of Trainers Module, available at www.reliefweb.int/rw/rwt.nsf/db900SID/EVIU6FBDV9/$File/WomensNutrition_module_May_05.pdf?OpenElement.

Regional Centre for Quality of Health Care, LINKAGES and FANTA Projects. (2005) ***Counseling Materials for Nutritional Care and Support of People Living with HIV/AIDS*** available at www.fantaproject.org/publications/uganda_counseling2005.shtml.

SARA Project. (2006) ***Nutrition and HIV/AIDS: Evidence, Gaps and Priority Actions*** available at http://sara.aed.org/publications/cross_cutting/hiv_nutrition/NutritionHIVbrief_2.pdf.

Valid International. (2006) ***Community-based Therapeutic Care (CTC): A Field Manual,*** First Edition, available at www.fantaproject.org/downloads/pdfs/CTC_Manual_v1_Oct06.pdf.

World Food Programme (WFP). (2004) ***Getting Started: WFP Support to the Prevention of Mother-to-Child Transmission of HIV and Related Programmes*** available at www.wfp.org/food_aid/doc/Getting_Started.pdf.

World Health Organization (WHO). (2003) ***Nutrient Requirements for People Living with HIV/AIDS: Report of a Technical Consultation*** available at www.who.int/nutrition/publications/Content_nutrient_requirements.pdf.

Annex 2: AMPATH Tool for Determining PLHIV Eligibility for Food

Nutrition Initial Encounter Form							
Name:_____ First Middle Last						**Date:** _____ **AMPATH No:**	
Age:				**Date of Birth:** / /			
Marital Status: ☐ Married ☐ Single ☐ Divorced/ Separated ☐ Widowed							
Clinic Site: MTRH Module: 1 2 3 4							
☐ Mosoriot	☐ Turbo	☐ Chulaimbo	☐ Burnt Forest	☐ Amukura	☐ Mt. Elgon	☐ Naitiri	☐ Kapenguria
☐ Teso	☐ Webuye	☐ Kitale	☐ Iten	☐ Kabarnet	☐ Busia	☐ Other:	

I. ANTHROPOMETRIC ASSESSMENT			
Height:	Weight:	BMI:	CD4:
MUAC:		Skin fold thick:	Site:
CD4 Criteria Met? ☐ Yes ☐ No		**BMI Criteria Met?** ☐ Yes ☐ No	

II. ACCESS TO ADEQUATE FOOD							
Quantity:							
1. In the last 3 days, did you miss a meal because there was not enough food in the house?							
2. In the last 3 days, did anyone in your immediate family miss a meal because there was not enough food in the house?							
3. In the last 3 days, did you go to bed hungry?							
4. In the last 3 days, did anyone in your immediate family go to bed hungry?							
Quality: In the last 3 days did the patient have access to any of the following foods?							
Carbohydrates			Times	**Proteins**			Times
Ugali	☐ Yes	☐ No	_____	Meat	☐ Yes	☐ No	_____
Rice	☐ Yes	☐ No	_____	Fish	☐ Yes	☐ No	_____
Sweet Potatoes	☐ Yes	☐ No	_____	Chicken	☐ Yes	☐ No	_____
Potatoes	☐ Yes	☐ No	_____	Beans	☐ Yes	☐ No	_____
Cassava	☐ Yes	☐ No	_____	Split peas	☐ Yes	☐ No	_____
Arrowroot	☐ Yes	☐ No	_____	Soyabeans	☐ Yes	☐ No	_____
Bread (chapatti etc.)	☐ Yes	☐ No	_____	Milk	☐ Yes	☐ No	_____
Other:	☐ Yes	☐ No	_____	Egg	☐ Yes	☐ No	_____
Note: Eating less than 3 protein rich foods in 72 hours = inadequate quality							
Vegetables/Fruits							
Sukuma wiki/Spinach	☐ Yes	☐ No	_____	Carrots/Pumpkin	☐ Yes	☐ No	_____
Managu/Kienyeji	☐ Yes	☐ No	_____	Banana	☐ Yes	☐ No	_____
Cabbage	☐ Yes	☐ No	_____	Pineapple	☐ Yes	☐ No	_____
Other:	☐ Yes	☐ No	_____	Orange/Mango	☐ Yes	☐ No	_____
Note: Less than 3 vegetable/fruit servings in 72 hrs = inadequate quality							
Is inadequacy of food quality due to food access rather than food preference					☐ Yes ☐ No		

Food Access Criteria Met? ☐ Yes ☐ No (Yes if Inadequate quantity or quality of food)

Quantity: ☐ Adequate ☐ Inadequate (Inadequate if yes to any of the quantity questions)

Quality: ☐ Adequate ☐ Inadequate

Note: Access to food needs to be confirmed with the economic confirmation questions

III. ECONOMIC CRITERIA	
Formula: (all costs should be documented per month)	**Amount**
A. House Income per month (average)	
B. Fixed expenses (rent etc)	
C. Money for food: A_____ - B_____ =	
D. Number of people living in household: Adult_____ + Children _____ =	
E. Food money per person eating in household C_____/D_____=	
F. Source of Food: % bought _____ % grown _____ % donated _____	
G. Amount of money required per person for food % bought _____ x 1000 Ksh/month =	
H. Difference between required and actual E_____ - G _____ =	

If the answer to H is a negative number the household meets economic criteria for food. This should be confirmed with the confirmation questions below. If the number is positive then the patient does not meet economic criteria. If the patient also did not meet access to food criteria skip to IV.

Confirmation Questions	
Patient Occupation:	Patient Income:
Spouse Occupation:	Spouse Income:

Patient Level of Education: ☐ Primary ☐ Secondary ☐ Tertiary ☐ Other:

Type of Housing: ☐ Temporary ☐ Semi-permanent ☐ Permanent ☐ Other:

Housing status: ☐ Rented ☐ Owned ☐ Other:

Amount of land cultivated: ☐ None ☐ <¼ acre ☐ ¼- ½ acre ☐ ½ -1 acre ☐ >1acre _____

In the past 7 days have you done any of the following activities?

1. Worked on your own farm or with your livestock ☐ Yes ☐ No
2. Worked as a casual laborer ☐ Yes ☐ No
3. Worked in your own business or enterprise ☐ Yes ☐ No
4. Worked in a formal salaried employment ☐ Yes ☐ No

How many hours have you worked in the past week?

Food Crops Grown:

☐ Maize/wheat/other cereals ☐ Legumes/ Beans ☐ Roots/ Tubers/Potatoes ☐ Fruits ☐ Vegetables ☐ Other:

Cash Crops Grown:

☐ Tea ☐ Coffee ☐ Pyrethrum ☐ Sugar Cane ☐ Other:

Animals/Livestock owned:

☐ Cows:	☐ Goats:	☐ Sheep:	☐ Chickens:	☐ Other:
_____ number	_____ number	_____ number	_____ number	

Economic Criteria met?	☐ Yes ☐ No (Criteria met if both formula criteria met and confirmation criteria met)
Formula Criteria met?	☐ Yes ☐ No
Confirmation Criteria met?	☐ Yes ☐ No
(Confirmation criteria met if patient does **not** have cultivatable land or livestock adequate to support the patient's family's needs)	

IV. FOOD SAFETY	
1) Water Source: ☐ River, stream, pond, ditch, borehole ☐ Public standpipe/Tap water ☐ Rain water ☐ Other:	
2) Do you treat or boil your drinking water? ☐ Yes ☐ No	
3) Fuel source: ☐ Fire wood ☐ Charcoal ☐ Gas ☐ Electricity ☐ Paraffin ☐ Solar ☐ Other:	

V. SYMPTOMS			
Nausea	☐ Yes ☐ No	Fatigue	☐ Yes ☐ No
Vomiting	☐ Yes ☐ No	Heartburn	☐ Yes ☐ No
Diarrhoea	☐ Yes ☐ No	Lack of appetite	☐ Yes ☐ No
Constipation	☐ Yes ☐ No	Other:	☐ Yes ☐ No
Difficulty chewing/Swallowing	☐ Yes ☐ No	Other:	☐ Yes ☐ No

VI. MEDICATIONS			
ARVs	☐ Yes ☐ No	Nutrition supplements	☐ Yes ☐ No
OI prophylaxis	☐ Yes ☐ No	Other:	☐ Yes ☐ No

Access	Economic	BMI <19	CD4<200	Result	Additional Recommendations
Yes	Yes	Yes	Yes	Food	
Yes	Yes	Yes	No	Food	
Yes	Yes	No	No	Food	
Yes	Yes	No	Yes	Food	
Yes	No	Yes	Yes	Counseling	Food if inadequate quantity
Yes	No	Yes	No	Counseling	Food if inadequate quantity
Yes	No	No	Yes	Counseling- No food	Refer to social worker
Yes	No	No	No	Counseling- No food	Refer to social worker
No	Yes	No	Yes	Counseling- No food	Refer to social worker
No	Yes	Yes	Yes	Counseling- No food	Refer to social worker
No	No	No	No	No Food	
No	Yes	No	No	No Food	
No	Yes	Yes	No	No Food	
No	No	Yes	No	No Food	
No	No	No	Yes	No Food	
No	No	Yes	Yes	No Food	

ALL PATIENTS WILL UNDERGO NUTRITION EDUCATION AND COUNSELING

Does patient meet criteria for food ☐ Yes ☐ No

If patient eligible for food has social work referral been made? ☐ Yes ☐ No

Nutritionist's Name _____ Signature _____

Code_____

Endnotes

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5 Langlo, U., Pierotti, C., Atim, P., Ojom, L., and Ciantia, F. "HIV Infection among Severely Malnourished Children in Conflict-Affected Areas in Northern Uganda," paper presented at the XVI International AIDS Conference, Toronto, August 13-18, 2006.

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7 Zambia Ministry of Health. ***Integrated Prevention of Mother-to-Child Transmission of HIV/AIDS Protocol Guidelines***. Lusaka, Zambia: 2003.

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15 Regional Centre for Quality of Health Care (RCQHC), LINKAGES Project, and FANTA Project. ***Nutrition and HIV/AIDS: A Training Manual***. Kampala, Uganda: RCQHC, 2003.

16 Castleman, T., Seumo-Fusso, E., & Cogill, B. ***Food and Nutrition Implications of Antiretroviral Therapy in Resource Limited Settings***. Technical Note 7. Washington, DC: FANTA Project, Academy for Educational Development, 2004.

17 FANTA. ***HIV/AIDS: A Guide for Nutritional Care and Support***. Washington, DC: FANTA Project, Academy for Educational Development, 2004.

Chapter II: Education

Sector-Specific Program Design Considerations

Chapter 11: Education

Sector-Specific Program Design Considerations

Key Concepts

11.1 Rationale for Integrating HIV and Food-Assisted Education Programming

11.2 Responding to HIV in Pre-Primary and Primary School Settings

11.3 HIV and Non-Formal Education for Children and Youth

11.4 Integrating HIV Into Adult Education

11.5 HIV and Nutrition Education

In This Chapter

Education services that benefit from the support of food and nutrition assistance encompass not only traditional school feeding programs but can also include nutritional support for young children in daycare centers and food as an incentive for training of adults and out-of-school youth. In the context of HIV, food-assisted education can also include provision of food support for effective implementation of HIV prevention education.

This chapter provides guidance on how to adjust food-assisted education programming to ensure that HIV-affected children and adults can benefit from educational opportunities. It begins with a brief description of HIV's impacts on the education sector and the variety of ways food-assisted education can help reduce vulnerability not only to food insecurity but also to HIV.

The chapter goes on to describe possible ways to adapt food-assisted education progams in a variety of settings to account for the challenges that HIV presents. These include providing take-home rations (THRs) to encourage attendance by girls and other vulnerable children, creating school and community gardens to enhance nutrition through household dietary diversity, and developing life skills and employment training activities for out-of-school youth and adults.

This chapter then identifies key considerations for integrating HIV and nutrition education into both formal and non-formal curricula, and lists additional resources on food for education and HIV.

11.1 Key Concept
Rationale for Integrating HIV and Food-Assisted Education Programming

A recent UNICEF review of social protection with respect to the education sector points to the crucial need to get children into school (improving access) and to keep them there (increasing retention), particularly those whom UNICEF refers to as "educationally marginalized."[1] For communities highly affected by HIV, the education sector plays a particularly important role, not only in achieving HIV objectives, but also in supporting vulnerable children. Critical needs that educational institutions meet often include:

- A reliable and safe environment where care, support, protection and development are provided to children of all ages with varied needs
- A means of providing intergenerational guidance and knowledge, normally gleaned from family and older community members but possibly not available to orphans and other vulnerable children
- A vehicle for age-appropriate HIV prevention and stigma reduction messages
- An entry point for multisectoral support for the child and family

HIV's Impacts on Education

HIV diminishes the demand for and supply of education, as well as the quality of education children in highly affected environments receive. On the demand side, HIV can result in reduced enrollment and attendance among school-age children. Young people, particularly girls, are often withdrawn from school to help at home or care for siblings and chronically ill household members.

In addition, among the children who remain in school, HIV can lead to a higher proportion of students with special needs, including:

- Orphans
- Children exposed to infectious diseases and emotional trauma because they live with and care for family members with HIV
- Children who are discriminated against or isolated because they or their families are infected
- Children in households where a parent is ill or has died, or where orphans have been taken in

On the supply side, when teachers and other education professionals are infected or affected by HIV, education systems suffer. Ultimately, a vicious cycle often ensues where increasing prevalence of HIV leads to a deterioration of educational institutions and services, which leads to greater vulnerability.[2, 3]

In areas affected by both food insecurity and HIV, integrating HIV education and training into food-assisted education programs can help attain educational outcomes, mitigate

HIV's impacts and prevent the spread of the virus. In such contexts, integrated education programming offers an opportunity to influence HIV and food security outcomes simultaneously.

Thoughtful food-assisted education programming not only exposes individuals to information about HIV prevention, treatment, and care and support, but can improve long-term food security outcomes in these ways:

Increased enrollment and attendance of vulnerable populations in educational programs. School-based meals or THRs can attract students, especially girls and orphans, to school and keep them there, despite pressures (economic or otherwise) on families due to illness or death.

Improved ability of individuals, especially children, to protect themselves from HIV. Education's protective effect against HIV infection is well documented.[4,5] This derives not only from exposure to HIV prevention information but from increased empowerment and income-earning capacity that reduces vulnerability and risk-taking.

Better understanding of all facets of HIV. An improved understanding of all aspects of HIV—including treatment, care and support and mitigation of the impacts—is crucial to survival in a high prevalence context for young people, their families and their communities.

Strengthened household food security. Where THRs are used to support various educational or training activities, improved household food security can prevent children and adults from engaging in risky coping strategies, help keep PLHIV healthy and working, and provide a valuable incentive for continued attendance.

Improved individual and household knowledge and skills for managing livelihoods. In the context of high HIV prevalence and chronic food insecurity, integrated education programming in formal and non-formal settings helps build the knowledge and skills vulnerable populations need to secure livelihoods. For example, food-assisted vocational programs for OVC can strengthen their long-term food security. Using food as an incentive in educational activities through applying FFT or FFA models can offset the opportunity costs of education for families. It may be beneficial for programs to:

- Develop curricula that integrate agriculture or home gardening methods with information on nutrition for PL
- Adapt materials to train clinic or agricultural extension staff, teachers, farmer-to-farmer groups, community health volunteers, HBC providers or PLHIV peer education groups in prevention, PL, and care and support of PLHIV
- Train family and community caregivers in the preparation of nutritious meals suitable for those with AIDS-related illnesses and using locally available foods
- Integrate BCC activities on general nutrition and nutrition issues specific to HIV into adult education programs when appropriate

Gender Considerations

In the context of HIV, it is particularly important that food assistance contribute to greater access to quality education among girls and women. This not only provides an especially vulnerable segment of society with valuable knowledge, it also helps to empower them to make responsible, healthy choices that benefit themselves and their families. Educated women and girls are inherently less vulnerable to HIV and food insecurity because they are:[6, 7]

- Better equipped to protect themselves against sexual exploitation and HIV
- More likely to postpone marriage and have fewer children, who are in turn more likely to be well nourished and well educated
- Better paid and have greater access to formal employment
- Able to assume more active roles in social, economic and political decision-making throughout their lives

11.2 Key Concept
Responding to HIV in Pre-Primary and Primary School Settings

Early childhood is the most rapid period of development in human life and has an enormous impact on the individual's future health, cognitive development, cultural attitudes and productivity.

Although there is little research on the impact of early childhood programming in the context of HIV, findings extrapolated from primary school interventions indicate that this programming can be a significant component of child care and protection and play a key role in identifying and supporting children and families at risk.

Food assistance can be used in early childhood development programs to encourage enrollment of vulnerable children, particulary girls, and to provide a nutritious morning or lunchtime meal. Some donors support using food assistance as an incentive for volunteer child care providers, although there are concerns that incentive rations may cause people to volunteer solely because of the ration, not out of concern for their community.

In the context of HIV, community day care and early childhood education centers can provide much-needed support to caregivers while they:

- Care for others in the home
- Earn income or produce food
- Attend training or support group meetings
- Access health services

Primary School Settings

In primary schools, Food for Education (FFE) programming, also known as "school feeding," is common in many developing countries. In the context of HIV, school feeding has become an increasingly important component in the care and protection of children and is seen as one way to reverse declines in enrollment and attendance, especially among girls, attributed to HIV.

In addition to school meals, other food security interventions such as THRs, after-school care and community gardens can extend benefits to especially vulnerable households while helping to increase enrollment and attendance. For example, some schools encourage out-of-school children to come to school to participate in the school feeding program. This helps schools find ways to overcome barriers to attendance and enroll or re-enroll the children.

When appropriate for addressing both HIV and food insecurity, food assistance can be used to help transform schools into multipurpose community development and welfare centers where assistance (including food) to families becomes an integral part of a school's operations.

'Do No Harm' in School Feeding

One food assistance intervention offers a lesson in the importance of anticipating and monitoring the implications of targeting strategies.

In Zambia, food assistance was being provided via school feeding to community schools, no-fee alternative schools that typically attract low-income (often HIV-affected) families.

However, students in government schools began enrolling in community schools so their households would receive rations. In addition, since the program also provided a THR to households caring for orphans, some households began "borrowing," or taking in, orphans in order to qualify.

Key Considerations for Providing Food Assistance in Primary Schools

Programs should consider a number of critical factors during the design and implementation of primary school programs to account for the impacts of HIV:

Avoiding stigmatization. When planning the intervention, programs must avoid stigmatizing OVC and other HIV-affected children. Children may be stigmatized when they are singled out for rations or benefits. As such, teachers and other school personnel should avoid using the term "AIDS orphan" and ensure targeting strategies and delivery mechanisms are sensitive and appropriate in the eyes of the community.

Prioritizing girls and OVC. Keeping children in school is essential, especially when the household is under pressure or in transition because of food insecurity and/or HIV. However, in the context of HIV, it is important to acknowledge that the selective use of food assistance (for instance, THRs for girls or OVC only) can result in stigmatization or jealousy on the part of non-beneficiaries. It is critical that members of recipient groups, whether in the school, community or individual households, as well as those involved in the beneficiary selection and ration delivery process, are sensitized to its purpose.

Appropriateness of school feeding. School feeding is not always the most appropriate way to support vulnerable children. For example, where school attendance is declining, the reasons for the decline (disaggregated by sex and age) must be clearly identified.

Preparing for success. Providing food rations can result in increased enrollment and attendance, which can put tremendous strain on teachers and administrative staff. Programs should plan for this increased workload, either by finding ways to compensate teachers or discussing how parents and communities can help.

Linkages to larger and complementary efforts. Food assistance should be viewed as a complementary input and linked to larger efforts. To ensure long-term benefits to the individual, household or community, school-based food assistance should try to integrate FFA activities such as developing school orchards, woodlots and gardens, or improving educational structures.

Strengthening the role of schools. Schools can play a crucial role in providing information, especially in high prevalence countries. As noted, schools also can become multipurpose centers that provide assistance (including food) to families.

Facilitating partnerships. Reaching out to Ministries of Education (MOEs), hospitals, clinics and CBOs will help to further integrate HIV awareness and prevention education into school-based programs such as school feeding. For example, health facilities can provide classroom materials for teachers and health workers can be guest speakers at schools and give talks on HIV to students and parents.

Meeting training needs. Teachers and administrative and district-level MOE staff may require training before they can adequately respond to the needs of HIV-affected children or accurately convey information about HIV to students and community members. Training topics might include raising awareness about HIV and procuring appropriate teaching aids such as IEC and BCC materials, posters, pamphlets and videos.

Food-Assisted Education Targets OVC in Zambia

WFP began food assistance to community schools and street children centers in Lusaka Province in January 2003, with Project Concern International (PCI) as the implementing partner. About 40 percent of the more than 67,000 children receiving food monthly are affected by HIV.

At most schools, students receive one on-site meal a day, consisting of vegetable oil and high energy protein supplement (HEPS), a locally produced fortified soya blend donated by WFP. All children receive the on-site meal to avoid stigmatization.

In addition, children who are particularly vulnerable receive a monthly family THR, a 50 kg bag of grain offered as an incentive to encourage households to keep children in school. Specific targeting tools help identify the most vulnerable households with OVC, and the school feeding committee makes sure the monthly ration reaches the selected households.

The project also incorporates a BCC component using trained local facilitators and is piloting a school-based agriculture project.

The project has faced some challenges. Enrollment and attendance rates increased by 27 and 40 percent, respectively, since the start of the project and are straining schools' physical capacity. As a result, the program expanded to a three-class rotation from a two-class rotation. While the reduced contact time and larger class sizes may hurt academic results, anecdotally, teachers feel the project has been positive overall.

In addition, at the onset, monitoring daily attendance and accounting of the food and store capacity were difficult, requiring new measurement tools and further training.

Due to the increased numbers of students and new rotation system, on-site cooking had to be done more than once a day. Fuel for cooking is often limited; charcoal often is not available or is used up quickly. PCI is exploring an energy-saving stove, or *jiko*. It also can be difficult to find volunteers to do the cooking. [8]

11.3 Key Concept
HIV and Non-Formal Education for Children and Youth

School feeding programs are not always suited to capture the most vulnerable children in communities because some youth do not attend school. Practitioners should broaden their outreach efforts beyond formal institutions to reach out-of-school youth through non-formal educational venues. Alternatives to formal education such as Junior Farmer Field and Life Schools supported by FAO and WFP or Mobile Farm Schools coordinated by CRS in Uganda provide useful insights into addressing the needs of out-of-school youth and teen orphans.

Besides benefiting from basic literacy, numeracy, health and cognitive skills, children and young people who must face the world of work at an early age may also benefit from entrepreneurial and vocational skills.[10] When these youth work toward improved nutrition, agricultural knowledge, employment skills and self-esteem, they are less likely to pursue high-risk behaviors. The knowledge and skills that young participants gain from such programs is particularly crucial where HIV prevalence is high and intergenerational knowledge transfer is threatened when parents die prematurely.

Children, especially those orphaned by AIDS or in highly affected environments, also need skills that will help them avoid being exploited economically, legally or sexually. Many non-formal education programs can use participatory methodologies to explore sensitive issues around health and nutrition, psychosocial problems, gender roles and HIV. Such approaches, often termed "life skills programming" may be offered in many settings and can often benefit from food assistance. Training generally includes topics such as:

- Making sound decisions about relationships and sex
- Resisting pressure for unwanted sex or drugs
- Recognizing and avoiding situations that might turn risky or violent
- Learning how and where to get support and access to youth-friendly health services
- Negotiating for safer sex, including protected sex
- Obtaining information, advice and assistance about human rights, including legal rights such as inheritance
- Caring for people with HIV in their families and communities

Food for Training: Teen Orphans Learn Farming Techniques in Mozambique

When parents die, surviving children face social exclusion, and there is widespread loss of local knowledge about agro-ecology and farming practices. In areas highly affected by HIV, this loss of productive knowledge puts an added burden on those surviving to cope with labor shortages and added household responsibilities, including caring for the ill.

In response, FAO and WFP in Mozambique developed Junior Farmer Field and Life Schools to help bridge the intergenerational knowledge gap for youth who have lost their parents and caretakers to AIDS.

As part of the program, OVC age 12 to 17 are trained for one year using a combination of traditional and modern agricultural techniques. An equal number of boys and girls learn about field preparation, sowing and transplanting, weeding, irrigation and pest control, utilization and conservation of available resources, utilization and processing of food crops, harvesting, storage, and entrepreneurial skills. Participants also receive nutritious on-site meals to offset the opportunity cost of their participation in the program.[9]

CRS Mobile Farm Schools in Uganda

CRS Mobile Farm Schools in Uganda train young people in agricultural production technologies, marketing agricultural commodities, team building, HIV education and PL.

The program—in which CRS partners with the Ministry of Agriculture, the Department of Education and the CBOs that manage the schools—also empowers young people by promoting their access to land, lent to them by guardians or community members.

The targeted community provides land for a demonstration garden, and the education sector offers school facilities and plots of land next to the schools to be used for demonstration purposes. The local agricultural office provides extension services and helps develop the training curriculum. Food rations, seeds and tools are also provided to participants.

After completing two years of classroom and field practical training, graduating apprentices receive a certificate in technology adoption.

Key Considerations for Food Assistance Programs Targeting Out-of-School Children and Youth

Several critical factors should be carefully considered during the design and implementation of food-assisted educational programs for out-of-school children and youth:

Facilitating partnerships. To maximize the child's access to assistance, interventions should facilitate partnerships between all service providers and stakeholders. Children and youth who have "fallen through the cracks" of the formal education system need multisectoral support. Opportunities should be sought to form partnerships with NGOs and CBOs that can provide the inputs needed to draw out-of-school youth back into the formal school setting (e.g., school fees, books, school uniforms).

Building on institutional strengths. Programs should identify organizations that are conducting vocational training or livelihood programs with youth and propose integrating HIV education into the curriculum. They should work with NGOs and MOEs to improve access to non-formal education alternatives such as vocational training, life skills programs and income-generating activities for OVC and out-of-school youth.

Life skills and employment training. Practitioners can ease transitions from training to livelihood activities by linking participants to extension agents or social welfare departments and incorporating business/market linkages into the training to ensure that youth who graduate with new life and livelihood skills have opportunities to apply their new skills.[11] Programs can provide youth with start-up rations for the first several weeks while they get their new careers or businesses started.

Inclusive and appropriate program design. As noted, programs in an HIV context must address the challenges of stigmatization and the fact that people might not know their HIV status. Programs should be designed to be inclusive and appropriate for those that are HIV negative and positive, whether or not their status is known.

11.4 Key Concept
Integrating HIV Into Adult Education

Opportunities to integrate PL training into adult learning are an important component of integrated education programming. PL introduces adults to a collection of strategies aimed at increasing the quality of health through improved nutrition, immune-strengthening and disease-prevention methods—thus extending the length of healthy living—in the period between contracting the virus and the onset of AIDS-defining illness. PL has evolved as a response to the HIV epidemic that offers PLHIV direction and a sense of empowerment in managing HIV.

Key Considerations for Integrating HIV Themes Into Adult Educational Curricula

Given the sensitivity of this programming area, the design of programs to integrate HIV themes into adult education must first be supported by meticulous groundwork. For any educational intervention, practitioners should start by ensuring that they understand the policies, players and interventions relating to HIV in the sector(s) in which they will work. At the outset, practitioners should coordinate with relevant government ministries (not only education, but possibly health, social services, community development and/or agriculture), the national and local AIDS committees and local government offices. Practitioners should also develop partnerships with local organizations with the specific technical expertise and capacity needed to plan, implement and evaluate their strategy.

Key considerations for integrating HIV themes into adult educational curricula include:

Stigma reduction training. In many instances, the entry point to HIV education with adults is stigma reduction training. In designing an approach, practitioners should consider not only initiating the program with activities that deal with deep-rooted stigma and fear, but also regularly including stigma reduction activities.

Expanding the focus beyond prevention. Focusing exclusively on HIV prevention education will marginalize participants who are HIV positive or who suspect that they are, especially in high prevalence settings. Prevention information—and the way it is presented—should not contribute to stigma.

Developing support groups. Creating resilient communities starts with adults sharing accurate information on HIV-related topics and is further supported by discussions that arise from personal experience. Programs should capitalize on any opportunity to develop support groups or networks.

Gender concerns. Practitioners need to incorporate gender dimensions of HIV—such as women's physiological susceptibility; women's unequal social and economic situation; power imbalance between men and women; roles of men and women; gender norms within cultures; burden of care and coping; and access to care, treatment, support and information—in all HIV- and AIDS-related awareness and prevention education activities.

Participatory approaches. Target groups and PLHIV should be involved in planning and implementing activities. Practitioners should be sure they understand the learning needs of the target group and not merely assume they know what the groups need.

Adapting appropriate models. Programs should identify organizations that are implementing effective and innovative HIV education activities, and work with local partners to adapt these models for their own audience.

Building on ongoing activities. Programs should support others' efforts to address HIV in their communities, especially where schools are already engaged in non-formal education, HIV rallies, community dramas, town meetings, etc.

Incorporating complementary services. Other organizations can provide complementary services and resources for beneficiaries, such as training in income-generating activities, psychosocial support, self-help groups, assistance with inheritance rights and other legal issues, microcredit, employment, livelihood initiatives, etc.

Key Concept

11.5 HIV and Nutrition Education

Food assistance can be used to support specific training and education related to preventing the disease and caring for those infected by it. Efforts to improve nutrition knowledge and practice are also essential for enhancing and maintaining food security in the context of HIV.

Integrating HIV Themes Into Educational Curricula

In many countries, both the formal and non-formal education sectors are responding to the demands of the HIV epidemic, with educators and education planners at all levels integrating HIV themes into curricula. However, evaluations of HIV prevention education in school settings have highlighted a number of common challenges:[12]

- Within an already full curricula, HIV is not often covered comprehensively
- Teaching and learning materials are poor or not available
- Learning of facts is generally emphasized over acquiring attitudes and adopting effective life skills
- Teachers are inadequately trained, and teaching methods are often inappropriate, failing to account for factors such as gender inequality and socio-cultural context
- MOEs rarely specifically assess learning outcomes, including acquired skills

Within school settings, while curricula must maintain the integrity of the core educational program, it is important that schools in highly affected countries begin incorporating HIV prevention in the early stages of primary school. Children age 10 to 14 who are targeted for early HIV-related learning are more likely to adopt safer sex practices if they receive accurate, gender-sensitive and age-appropriate reproductive health education before they become sexually active. In addition, because many students in highly affected countries will not go on to secondary education, getting an early start on HIV education is critical.[13]

To effectively educate students, teachers and school administrators must be adequately trained and have the support of parents and community organizations. Ideally, HIV training for educators will be administered through universities and teacher training institutions and complemented by continuing professional development. Teachers may also benefit from HIV-specific information provided by local health facilities and HIV-related service organizations.

The current curriculum can be used as a springboard to a range of HIV-related topics, including:

- Accurate, age-appropriate information about transmission, prevention, care and treatment
- Life skills education adapted to incorporate HIV
- Psychosocial support for adults and children who have experienced loss and transition
- Inclusive messages, "normalization" of HIV and role-modeling to overcome the barriers of stigma and discrimination
- Instruction on how to talk about HIV, relationships and sex within families
- Information on HIV's gender dimensions and how to address them
- Substance abuse and its relationship to HIV transmission (e.g., alcohol's effect on decision-making and the risk of injection-drug use)
- Location and role of relevant HIV-related services, such as VCT, PMTCT, STI treatment, needle exchange venues and substance abuse programs
- How to advocate for the community for better access to services or for the support and protection of vulnerable children and women
- Guiding and mentoring skills to support the transfer of intergenerational knowledge and skills with OVC in the community
- Treatment literacy to prepare individuals and communities for access to ARVs

Several tools have been designed to assist education policymakers, school administrators and teachers incorporate HIV-related information into the curriculum, including:

HIV & AIDS Curriculum Manual. Second Version (2006). International Bureau of Education/ UNESCO, available at http://unesdoc.unesco.org/images/0014/001463/146355e.pdf.

Educational Planning and Management in a World with AIDS. Module 13—A Curriculum Response to HIV/AIDS (2006). E. Miedema. UNESCO/Mobile Task Team on the Impact of HIV/AIDS on Education (MTT), available at www.unesco.org/iiep/eng/focus/hiv/hiv_4.htm.

HIV Education and Prevention Curriculum, Version 2.3 (2006). Students for International Change Tanzania, available at http://www.sichange.org/home/index.php?option=com_docman&task=doc_view&gid=5&Itemid=52.

Nutrition Education

Nutrition education can play an especially important role in preventing the spread of HIV and mitigating its impacts among affected households. Accordingly, nutrition education should be seen as a critical cross-cutting issue in all programs operating in a high HIV prevalence context. Furthermore, nutrition education should aim to influence food utilization by going beyond simply improving basic nutrition knowledge to supporting better hygiene practices, encouraging PL, facilitating access to related health services (especially important for HIV-positive adults) and sharing information about child feeding and care practices, as well as food handling and preparation methods suitable for PLHIV's home-based care.

The combination of food assistance and nutrition education can help programs with HIV-related objectives ensure that participants can access services and benefit from the food

HBC, Nutrition and Gardening in Lesotho[14]

In 2004, the Lesotho Association of Non-Formal Education (LANFE), in conjunction with the Ministry of Health, began training volunteers in basic hygiene, food gardening, nutrition and education related to HIV prevention and PLHIV care. The volunteers in turn trained community members involved in HBC.

In addition to food, vulnerable households targeted by the program received tools and seeds to create home gardens, as well as training in income-generating activities based on non-food crops such as aloe.

LANFE not only improved the nutritional status of PLHIV and affected households, but also realized unexpected benefits:

- It contributed to increased enrollment among school-age children as their parents' health and nutrition improved through their participation in the project.
- Household dietary diversity increased because of the introduction of vegetables that were not widely consumed by households before home gardens were established.

The Mobile Task Team on the Impact of HIV/AIDS on Education evaluated the project and found that LANFE's approach to integrated HIV and nutrition support is both sustainable and relatively easy to scale up given its potential for income generation and its support from community members.

resources provided. In food-insecure communities, food assistance often benefits nutrition training and education initiatives targeted at youth or adults participating in HIV prevention, care and support programs. Training programs can incorporate FFT rations to encourage establishment of community and home gardens, which both increases household dietary diversity and contributes to the development of critical livelihood skills. Likewise, food assistance may be offered to encourage educators and community health volunteers to participate in applied nutrition training activities.

Nutrition training and counseling are particularly important for food-insecure PLHIV and those who care for them (e.g., family members, HBC volunteers). For programs targeting nutritional training specifically toward PLHIV and affected households, these topics are among the most critical: [15]

- Increasing energy intake and maintaining weight of PLHIV (whether they are receiving ART or not)
- Safe infant feeding practices to prevent transmission and non-HIV-related illness or death (e.g., early and exclusive breastfeeding or replacement feeding options)
- Safe handling and use of food and water to prevent diarrhea
- Using diet to 1) promote drug adherence through management of symptoms such as anorexia, diarrhea and nausea and 2) recover lost weight during recuperation from acute infections

For a more detailed discussion of the role of nutrition education, see **Chapter 10: Health and Nutrition**.

Annex 1: Additional Resources on Food for Education and HIV

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Chapter 12: Livelihood Strategies and Social Protection

Sector-Specific Program Design Considerations

Chapter 12: Livelihood Strategies and Social Protection

Sector-Specific Program Design Considerations

Key Concepts

12.1 Food-Assisted Livelihood Programs in the Context of HIV

12.2 Incorporating FFA Activities

12.3 Strengthening Safety Nets for OVC and Other High-Risk Groups

12.4 Designing Effective HIV-Related Social Protection Programs

In This Chapter

This chapter focuses on programs aimed at enhancing livelihood strategies and addressing risks to food availability and access among food-insecure households in areas with a high prevalence of both food insecurity and HIV. It begins by explaining general key considerations for designing livelihood programming in an HIV context. These considerations include ensuring the involvement of PLHIV and affected households in decision-making, adjusting the targeting of livelihood programs to account for labor constraints, avoiding stigmatization of and/or discrimination against HIV-affected beneficiaries, and avoiding the risk of increased HIV transmission resulting from livelihood activities.

The chapter then describes potential responses to mitigate HIV's impacts on a range of livelihood resources. Examples include implementing interventions to reduce or share labor needed to sustain agricultural livelihoods, providing training and credit opportunities to support off-farm income strategies, and encouraging community involvement in establishing and maintaining productive assets.

Next the chapter discusses FFA programming as a useful and flexible mechanism for using food to strengthen livelihood strategies. It explores the use of FFA to protect and promote the human, physical and natural assets of individuals, households and communities. The chapter then discusses providing food assistance in support of safety nets for OVC and other vulnerable groups, and it describes key considerations in developing unconditional, conditional and productive safety nets, as well as the importance of linking safety net resource transfers with livelihood-enhancing activities.

The chapter's final Key Concept provides guidance on designing effective social protection programs in the context of HIV.

12.1 Key Concept

Food-Assisted Livelihood Programs in the Context of HIV

There are a variety of ways livelihood programs can be adapted to an HIV context. Many are common to traditional livelihood programs, while others might be considered unique. Using an HIV lens, as described in **Chapter 4: Adaptive and Integrative Programming**, is critical to identifying appropriate program adaptations. This approach helps programmers understand HIV's impacts on livelihoods and various ways of responding to those impacts. It also helps identify how to adapt activities to ensure participation of HIV-affected households, design and implement activities targeting HIV-affected households, and ensure that the HIV-affected people are viewed as critical resources for addressing food insecurity in target communities.[1]

Developing food-assisted livelihood programs in the context of HIV does not mean altering activities to serve only PLHIV and affected households. In fact, implementers must keep the project's primary purpose (e.g., creating programmatically sound food security and livelihood strategies that benefit food-insecure populations) foremost in their minds.

In adapting livelihood programs for a food-insecure, high prevalence HIV context, programmers need to understand the target area's socio-cultural context. For example, while encouraging community ownership of the program, programmers must consider the cultural implications of stigma in a community-based livelihood or social protection program. The role of gender also should be considered in determining individual and household vulnerability (see **Chapter 3: Vulnerability Assessments** for details on conducting a gender analysis).

Programmers should also recognize that programs will need cash to implement many of the interventions discussed in this chapter. Additional cash resources can be obtained in USAID-funded Title II projects through monetization, but this may be more difficult in WFP projects unless obtained through partnerships.

Key Considerations in Designing Programs in an HIV Context

Staff training, workshops and program design assistance from HIV technical staff can facilitate the modification of livelihood programs to account for the needs of PLHIV, OVC and HIV-affected households. CBOs, institutions, networks and HBC groups should be involved in designing and implementing livelihood interventions. In addition, these design considerations should be taken into account when adapting livelihood programs to an HIV context:[2]

Examining impacts. Programs should examine HIV's impacts on assets, household livelihood strategies and coping mechanisms, as well as identify shocks, risks and how HIV has amplified them (see **Chapter 3: Vunerability Assessments**). Programs also should examine how local institutions are helping households cope with the prevailing risks among chronically food-insecure populations and among PLHIV, OVC and HIV-affected households. It is important to be aware of these impacts upfront so they can be addressed in the program's design. **Chapter 1: Conceptual Framework** discusses these impacts with respect to the various asset categories.

Resources for targeting. It is important to investigate what resources are available to help integrate HIV into geographic targeting. In addition to collecting standard DHS data and

Vulnerability Analysis and Mapping (VAM) surveys, be sure to include information from the NAC, district level health officials, local AIDS service organizations, etc. Identify areas where high HIV prevalence rates overlap with chronic food insecurity. HIV-sensitive targeting can help food-assisted livelihood programs focus on responding to the severe limitations and additional constraints experienced by PLHIV, including accounting for HIV vulnerability factors in design. Such targeting, however, should not facilitate preferential treatment for PLHIV or HIV-affected households. The primary entry point of food-assisted livelihood programs is food insecurity.

Inclusive targeting and decision making. Programs should ensure GIPA in decision-making at all stages. This includes decisions on selecting and designing livelihood activities, targeting criteria/mechanisms and implementation, as well as decisions on how benefits/revenues from activities will be shared and used. In developing targeting criteria, programs should devise mechanisms to include PLHIV and HIV-affected households, taking into account physical needs and exploring alternative forms of participation such as committees, supervising and monitoring. Involving AIDS service organizations, HBC networks, VCT center staff, PLHIV and HIV-affected households on relevant committees, boards and management teams is a first step toward ensuring GIPA.

Risk of increased HIV transmission. Programs should consider whether livelihood activities being proposed or implemented could contribute to the spread of HIV and find ways to address this. For example, crop marketing activities that link rural and urban communities or agricultural-inputs credit programs may, if not properly managed, create circumstances in which women can be exploited for transactional sex, further exposing them to risks of HIV infection. In addition, the development of roads, community centers or markets to improve access and mobility also can increase interaction between men and women—and the risk of increased HIV transmission.

Household labor constraints. There may be food-insecure households in the community that cannot participate in the program because of HIV-related labor constraints. Programs should determine exactly where and why this is a problem and then try to find solutions such as daycare services or incentives for temporary caregivers of OVC and chronically ill family members. Some specific program adaptations to address this problem appear in the next section of this Key Concept.

Adjusting work norms for PLHIV. There may be ways to adjust work norms to get PLHIV and/or their representatives more involved. This is especially relevant to FFW and FFA projects, where adaptations could include "half day" (two hours of work instead of the standard four), "light duties" (full day of work that is less physically demanding) or "auxiliary duties" (duties that help other community members participate in FFA, such as caring for children or patients). Also, in some cases, the project may be able to allow vulnerable

Less Labor-Intensive Tasks

Examples of less labor-intensive duties appropriate for those with limited strength and stamina, by project type:

- *Agricultural projects*: Light field clearing, watering fields, surfacing or leveling fields, earth removal using small buckets
- *Conservation agriculture:* Managing the tool bank
- *Any project:* Food and non-food item management, labor management, accounting, clerical tasks and participant registration, marketing, cooking at labor sites, caring for children, monitoring activities.

When dividing up tasks and devising work norms, it is important to use language that is not stigmatizing and is sensitive to the HIV context.

households to "recruit" a non-vulnerable relative or a neighbor to participate on their behalf and share the benefits.

Avoiding stigma. As reiterated throughout this guide, programs must be very careful to not increase stigma, whether through targeting mechanisms, adjusted work norms or any other means. Programs should take advantage of opportunities to address stigma by offering stigma reduction training to program staff, project beneficiaries and other stakeholders.

Modifying rations. Where food rations are involved, ration design should account for the special nutritional needs of PLHIV and other household members. Fortified nutrient-dense commodities (e.g., CSB), which are easily prepared and digestible, could be included in the ration.

Program Adaptations to Address HIV's Impacts on Livelihood Assets and Strategies

Understanding how HIV impacts livelihood strategies through its effects on livelihood assets and how livelihoods might be strengthened to address these impacts is a critical starting point for designing livelihood programs in an HIV context. While **Chapter 1: Conceptual Framework** describes HIV's impacts on livelihood assets and strategies, the following summarizes possible program adaptations to address these impacts, based on the six categories of assets (or capital) commonly used in a livelihood framework.[3]

Addressing HIV's Impacts on Human Assets: Labor

- Introduce agricultural practices that reduce labor use or bottlenecks (e.g., no tillage)
- Diversify production to reduce labor use or bottlenecks
- Intensify or promote new labor-sharing schemes
- Introduce less labor-intensive livelihood strategies
- Provide cash for hired labor
- Introduce small-scale, labor-saving food-processing technology, fuel-efficient stoves and water pumps
- Strengthen shared childcare, daycare and care of the chronically ill
- Support training of caregivers and families on caring for the chronically ill
- Encourage balanced diets, appropriate health-seeking behavior and treatment literacy to reduce morbidity and delay mortality
- Introduce workplace policies and programs

Addressing HIV's Impacts on Human Assets: Knowledge and Skills

- Disseminate new agricultural technologies and practices for the HIV context
- Introduce HIV prevention and PL information into extension messages
- Provide agricultural extension for widows, orphans and other survivors

- Encourage communities to share practical experience, such as agricultural knowledge, with widows, orphans and other survivors
- Provide business and management training for women, orphans and other survivors
- Provide training in new marketable skills
- Incorporate agricultural training into school curriculum
- Offer incentives for school attendance to reduce absenteeism and attrition
- Train the community in problem diagnosis, planning and organizational management

Addressing HIV's Impacts on Financial Assets

- Introduce low external input technologies and practices
- Emphasize crops requiring fewer external input needs
- Emphasize appropriate substitute local wild foods
- Provide grants to buy or rent draught animals, hire labor or pay for other inputs
- Provide microfinance for operating expenses to fund draught animals, hired labor, inputs, etc.
- Help improve food storage and preservation to maintain quality and quantity of food stocks
- Use cash-for-work where appropriate
- Help develop markets for local products to expand income-earning opportunities
- Introduce vouchers for commodities (e.g., food, seeds) or inputs (e.g., fertilizer)

Addressing HIV's Impacts on Natural Assets

- Advocate for changing rules governing land tenure to strengthen rights of widows and orphans
- Strengthen land rights and flexibility of land-use laws
- Replant community woodlots and forests

Addressing HIV's Impacts on Physical Assets

- Provide grants for asset protection and restocking
- Provide repair service for productive and household assets to make them useable
- Provide grants or loans for land rental
- Provide microfinance to increase or diversify incomes
- Introduce animal husbandry
- Invest in community-owned assets (e.g., plows, draught animals)

Addressing HIV's Impacts on Social Assets

- Encourage communal food and cash crop production

- Build/repair community grain stocks
- Encourage community works to repair assets and structures
- Improve social infrastructure (e.g., access to water, sanitation and health posts to reduce morbidity)
- Create/support all networks and community organizations
- Modify costly customs (e.g., funerals, marriages)
- Provide support/incentives to keep families unified and encourage families to take in orphans

Addressing HIV's Impacts on Political Assets

- Encourage GIPA
- Implement anti-stigma campaigns and legislation
- Implement campaigns for social services for PLHIV
- Train communities in HIV awareness and inclusion of PLHIV and HIV-affected households in political processes

CARE Lesotho, TEBA Help Vulnerable Groups Develop 'Keyhole' Gardens

In Lesotho, CARE and local partner TEBA have developed a nine-month curriculum that teaches food-insecure households how to build and maintain a 'keyhole' garden, so named because its shape resembles a keyhole.

Designed with sustainability in mind and to benefit the most vulnerable groups, including the elderly, PLHIV and OVC, the gardens are built with readily available and affordable materials such as manure, bones, stones and aloes. The gardens are resistant to dry weather and provide high yields of vegetables year-round using only waste water, which helps households conserve their limited water supplies. The gardens also are easily protected during cold spells.

Although keyhole gardens are labor-intensive to build, they are waist-high and round to provide easy arm's-length access, which make it easier for ill and elderly people to maintain them.

The program develops two types of assets: the garden (physical asset) and the knowledge/skills to build and maintain it (human asset). Households graduate from the program only after they have a functioning garden and experience maintaining it.[4]

Key Concept

12.2 Incorporating FFA Activities

In the context of HIV, FFA is a useful and flexible mechanism for using food to achieve livelihood objectives. FFA strategies emphasize creating productive assets that are owned, managed and used by the household or targeted community.[5] The accumulation of productive assets enhances household and community resilience to HIV-induced shocks,

including sickness and other disruptions to livelihoods.[6] Programming of FFA activities, such as FFE and FFT, are also discussed in **Chapter 11: Education**; programs with health and nutrition objectives are explored in **Chapter 10: Health and Nutrition**.

FFA not only creates physical assets (e.g., health infrastructure, gardens), but, just as important, it contributes to human assets (also called human capital) such as health, education, skills and awareness. FFA activities that can support livelihood strategies in HIV-affected communities include:

Promoting the Creation and/or Rehabilitation of Physical and Natural Assets

- Food for creating community and homestead gardens
- Food for rehabilitating feeder roads to improve market access
- Food for building dams, irrigation systems and water catchments to improve water access
- Food for planting fruit trees and vegetable and herb gardens to promote a diverse and nutritious diet

A transition from FFW to FFA was initiated by the WFP 1998 "Enabling Development" policy, which shifted the focus from emergency-driven employment creation and income transfers to an emphasis on community-managed asset accumulation and human capital development.

Promoting Development of Human Assets (Human Capital) Such as Knowledge and Skills

- Food for training in conservation farming to improve food access and diversity
- Food for training in business development, entrepreneurship, marketing, etc.
- Food for training in life skills to avoid negative coping strategies
- Food for training in labor-saving technologies
- Food for training in food processing and storage to improve dietary stabilization (increasing diversity year-round)
- Food for training in PL to prolong life and increase quality of life
- Food for developing gardens and for training in healthy dietary practices to reduce negative coping strategies and improve nutrition and health

Protecting Household and Community-Based Assets, Especially Productive Assets

- Food for reforestation projects to prevent soil erosion
- Food for creating community grain banks to provide support to vulnerable families
- Food for agricultural labor to replace labor of households whose productive members have fallen chronically ill

Key Considerations for Designing FFA Activities

Programs should follow standard FFA guidelines when designing and implementing responses. In addition, there are a number of other key considerations that should be taken into account:

Adequacy of non-food inputs. Communities heavily affected by HIV may no longer have sufficient access to the resources, such as tools and construction materials and/or agricultural implements, needed for successful and sustainable FFA projects. Relying exclusively on locally available material (e.g., mud bricks and thatch) may not be appropriate for creating a durable asset. It is important to conduct a realistic assessment of the community's capacity to "cost-share" FFA activities.

Appropriateness of food. It is important to ensure that food is the appropriate response. Food should be used as an input only where underlying food insecurity exists. If this is not the case, another input (cash or other in-kind) should be selected.

Community prioritization. As previously noted, FFA programs can mitigate the impacts of HIV through support to a number of livelihood strategies. Programs in HIV-affected communities should select responses that address the food security impacts prioritized by the community through participatory methods.

12.3 Key Concept
Strengthening Safety Nets for OVC and Other High-Risk Groups

HIV leaves affected households and communities increasingly unable to meet the needs of their vulnerable members. The community's traditional safety nets become overburdened or collapse, particularly as women—who form the backbone of a community's social network—and community caregivers become sick themselves or must focus on caring for their own ill family members.

As a result, formal safety nets provided by government, PVOs, local NGOs and donor partners are needed to strengthen community safety nets and provide the multilevel, targeted interventions that at-risk groups need. These formal safety nets should not replace or displace community safety nets, but should work through them and support them.

Households that are both HIV-affected and food-insecure can benefit from short-term food assistance, which is linked to longer-term livelihood support (e.g., agricultural or microcredit programs). While some households will recover and return to their livelihoods, others will need long-term welfare mechanisms.

Community safety nets sustain a household in crisis by providing material relief as long as possible or until the household is out of danger. However, over the long run, the household should once more rely on its own resources, freeing up community resources for others in dire need. Similarly, formal safety nets—which have limited resources—should include interventions that help the household maintain assets, remain economically productive and possibly help others, thus strengthening the community.

In particular, there is growing concern about safety nets for OVC. While it is generally preferable to place orphans or unaccompanied children with local families than with orphanages, caring for an additional child can become an unmanageable burden where the fostering family is poor, headed by an elderly or ill

CRS Malawi—Promoting Communities' Capacity to Care for OVC

CRS implemented a Title II Development Assistance Program in Malawi from 2000 to 2005 to help improve the food security of HIV-affected households.

Guardians or families caring for OVC received food rations to ease the financial burden of care, help keep OVC in their own communities and improve the nutritional status of at-risk children. These households participated in complementary livelihood training programs on topics such as soil fertility, crop diversification and improved seeds. In 2003, 95 percent of beneficiaries who received food directly also participated in activities aimed at improving productive assets, such as building fish ponds.

In addition, CRS established 43 community-based child centers (CBCC) to enhance child care practices and give guardians an opportunity to participate in general development activities. The CBCCs, staffed by community volunteers, provided OVC with food donated by the communities. Growth monitoring is also conducted at the CBCCs to ensure that children who are growth faltering are identified for interventions and, if necessary, referred to a health facility.

The program also used Title II food commodities to encourage OVC school attendance and supported community artisan apprenticeship programs to support skills development.

person or is food-insecure. Material assistance for foster families (such as a supplementary ration) can ease the burden of caring for these children and enable more families to take them in.

Unconditional, Conditional and Productive Safety Nets[7]

Three kinds of safety nets are relevant in the food assistance programming context:

- **Unconditional** safety nets provide resource transfers based solely on criteria of need.
- **Conditional** safety nets provide a resource transfer contingent on certain behaviors, such as sending children to school or bringing them to health centers regularly. Conditional safety nets address both short-term protection objectives while promoting the longer-term accumulation of human capital.
- **Productive** safety nets provide a resource transfer to meet basic needs; prevent households from selling off productive assets such as animals, tools and equipment; and help build household and community assets. In a chronic food insecurity situation, a productive safety net might be a seasonal intervention.

Strengthening individual livelihood capacities. For individuals, food-assisted conditional safety nets can be linked with vocational training, apprenticeships, agricultural extension tailored to women or OVC, formal and informal education, income-generating activities, assistance to protect investment in microfinance and other livelihood promotion strategies. Providing credit, savings and other financial services; job and business skills training (especially for women) relevant to rural industries; and rural contracting opportunities (e.g. farming as a business) also can be linked with conditional safety nets. These interventions help create self reliance, reduce risky coping behaviors and help at-risk groups improve the social conditions that can lead to HIV infection.

Strenthening household livelihood capacities. Conditional and productive safety nets for households include activities that enhance household productivity by supporting the adoption of labor-saving technology, labor-sharing practices, post-harvest transformation technologies, and market knowledge and linkages.

Strengthening community livelihood capacities. Productive safety nets for communities include activities that help the community provide for its most vulnerable members, such as FFA activities for village grain storage structures and communal gardens.

AMPATH Links Safety Net, Livelihood and HIV Treatment Interventions in Kenya

The WFP/AMPATH collaboration in Kenya is an innovative example of integrating food and nutrition (safety net) and livelihood interventions into an HIV treatment program that seeks to preserve beneficiaries' health status (human assets).

In the AMPATH treatment program's early years, it became apparent that most HIV-positive patients were malnourished. Several reasons were cited, including a lack of access to food, poor appetite and poor food preparation. In response, a project to provide supplementary food to AMPATH ART patients was initiated through the HAART and Harvest Initiative in 2002.

The program established production farms near four AMPATH treatment sites, which provided locally acceptable, nutritious food to undernourished and food-insecure PLHIV. Local produce—including eggs, milk, fresh fruits and vegetables, and herbs—was included in household rations.

As the number of people seeking ARVs increased, WFP began providing food to complement local produce. AMPATH also created a Family Preservation Initiative to augment, restore and improve PLHIV's incomes as part of the comprehensive recovery strategy, establishing resilient livelihoods for those discharged and continuing with home care activities. Core activities include agricultural microfinancing, business training and technical support for poultry and horticultural services.

Key Considerations in Designing Food-Assisted Safety Nets for At-Risk Groups

These design steps and considerations should be taken into account when designing food-assisted safety nets for OVC and other high-risk groups:

Needs assessments. It is important to conduct a needs assessment to determine the level and type of food insecurity within the targeted community and among specific at-risk groups, identifying the risks they are exposed to, their vulnerability and capacity to cope.

Linkages with existing programs. Collaborating with other programs can support at-risk groups and provide food as an input to an existing package of services in health care, education, psychosocial support, etc.

Clear rationale for incorporating food. Programs should establish the objectives of providing food as well as indicators for monitoring the food's outcome and impact. When conditional safety nets are used to advance HIV-related outcomes such as care, support and protection of at-risk groups, the objectives are not likely to be directly related to food security or nutrition status. Instead, the objectives may be to help increase school attendance or use of health services. It is important to determine the level of attendance

HACI in Mozambique

Mozambique's Hope for African Children Initiative (HACI OVC) expands on already established HIV, livelihood and microfinance programs, placing a strong emphasis on training people who work with children in the communities, such as social welfare service providers and traditional leaders. In sum, the project—established in 2000 by CARE, Plan International, Save the Children, the Society for Women and AIDS in Africa, the World Conference on Religion and Peace and World Vision—aims at scaling up existing interventions to increase the capacity to care for OVC, OVC awareness and advocacy activity, and the number of organizations on all levels that respond to OVC needs.

Several of the NGOs implementing HACI OVC receive food from WFP as an input to the care and protection package. Food has an important role, but it is seen as only one of the many inputs that advance the program's care and protection outcomes.

or participation and the use of services before food support to assess what changes result from the food.

Avoiding "AIDS exceptionalism." It is critical to ensure that interventions targeting at-risk groups do not exclude groups who are equally vulnerable for reasons unrelated to HIV.

Understanding vulnerability. Programs should understand when OVC and affected households become vulnerable. For example, children often become vulnerable in the period before they become orphans, when their HIV-infected parents fall chronically ill. Programs can find ways to keep children in school and out of harm's way during this period. Likewise, vulnerable households should be targeted before they start using negative coping strategies such as selling off productive assets.

Supporting households caring for OVC. When specifically targeting orphans outside an institutional program such as school feeding, programs should provide food assistance to an entire household rather than solely to the orphans in that household. This assistance can ease the burden extended and foster families take on when caring for orphans and enable more families to take in orphans.

Linking Livelihood and HIV Programming to Address PLHIV Food Security

ACDI/VOCA Uganda, TASO and a local consortium of NGOs are partnering to combine livelihood and HIV programming to address the food security needs of PLHIV and OVC.

The program provides PLHIV with support in counseling, HIV prevention education, nutrition education and easier access to health services and food assistance. The program also encourages PLHIV to complete TB treatment and/or adhere to ART regimens.

Recognizing the need to link short-term nutrition support with longer-term livelihood promotion, the program offers PLHIV access to microcredit facilities via TASO. The microcredit programs aim to improve the livelihood security of households with chronically ill adults and provide income-earning opportunities for asymptomatic PLHIV so they can support their families and, by extension, strengthen their communities' socio-economic safety nets.

In addition, TASO conducts informal apprentice training for OVC youth and negotiates with local tradesmen to find placements and mentors for the youth in their communities. OVC receive take-home rations during their placement period that benefits both the OVC and hosting family. [8]

Key Concept

12.4 Designing Effective HIV-Related Social Protection Programs

The topic of social protection has raised renewed interest in the context of HIV. Various UN agencies (including WFP), donors and international NGOs have begun exploring ways to support and promote emerging social protection programs in a host of developing countries, including Afghanistan, Ethiopia, Malawi and Zambia.

While there is no commonly agreed-upon definition, one common purpose across social protection interventions is to support the most vulnerable segments of society by providing financial, material, social or psychological support to people who are otherwise unable to obtain it through their own efforts.[9]

In Malawi, for example, WFP is supporting the Government and its partners—including the UK Department of International Development (DFID), European Union (EU), World Bank, German Society for Technical Cooperation (GTZ), USAID, Canadian International Development Agency (CIDA), FAO, UNICEF and UNDP—in developing a national social protection policy. Malawi's National Safety Net Program builds on the strategic framework laid out by the country's PRSP and includes targeted inputs, public works programs, a nutrition component, welfare support and disaster risk management as a cross-cutting theme.

An effective social protection approach emphasizes both short- and long-term responses within a holistically designed framework. Although social protection approaches have traditionally sought to protect the livelihoods of vulnerable groups, recent debates have focused on the need to broaden the concept to include promoting livelihoods using a framework that draws on a range of mechanisms.[13] These mechanisms may include anti-discrimination legislation, contributory insurance schemes, pensions for the elderly and disabled, grants to people caring for orphans, food stamp programs, school feeding and anti-stigma campaigns.

Safety nets are one component of a social protection strategy. In the past, safety nets—which, as discussed earlier, typically involve a targeted

WFP defines social protection as integrated systems of institutionalized national measures which may include contributory pensions, insurance schemes and safety nets. Safety nets are further defined as a social protection component targeted at the most vulnerable sections of a population.[10]

Ethiopia Undergoes Strategic Shift on Social Protection

In Ethiopia, relief provided on an emergency basis has barely kept the poor above water. It has not built assets nor has it secured livelihoods. At best, it has simply kept people in a holding pattern.

Recognizing this, Ethiopia's leading bilateral and multilateral donors have played a key role in advocating for new strategies to assist chronically food-insecure households.

As a result, in 2005, Ethiopia initiated the Productive Safety Net Programme, a five-year social protection scheme that represents a significant institutional transformation of the country's aid system. A critical feature is multi-annual funding commitments by donors, which will enable the Government of Ethiopia to provide predictable resources to chronically food-insecure beneficiaries. There is broad donor support for the government's decision to address chronic food insecurity through a recurring budget line item rather than an annual appeal.[11]

social transfer such as cash, food or other input—were seen as protecting the chronically poor and most vulnerable members of society. While both food and cash are legitimate modalities for social transfers, there is debate over which to use. Programs should carefully consider each modality in the context of an overall social protection package for individuals, households and communities affected by HIV, as well as the target group's needs and the local operating environment.[14]

HIV'S Effect on Local Social Protection Services and Institutions

As stated earlier, in many regions of high HIV prevalence, informal community safety nets are overstretched or have collapsed. This is occurring in countries such as Malawi where informal safety nets are critical for helping households adapt to economic crises. The strain on community safety nets also has a devastating effect on local health and educational services (see **Chapter 1: Conceptual Framework**). In such situations it is critical to expand social protection measures beyond those implemented by the community and local social services to the regional and national scale.

Externally sourced and managed food assistance programs can play an important role in social protection programs by meeting HIV-affected families' immediate food and nutrition needs. Where food assistance is needed, implementing agencies can coordinate their efforts to scale up delivery systems so that they have wider reach and greater efficiency. For example, nutrition support can be linked to ART rollout. Coordinated efforts must harmonize targeting criteria and strategies, link institutional partners, enhance referral systems, install procurement and logistic systems, and establish common monitoring and evaluation systems to ensure accountability.[16]

Social protection must be tailored to the specific sources of vulnerability and the forms that vulnerability takes. Programs should ask these key questions:

- What specific source of vulnerability are we trying to mitigate?
- What is the most appropriate social protection response to this source of vulnerability? [12]

Understanding the evolving needs of individuals, households and communities affected by HIV is crucial for effective planning for social protection.[17] Using a timeline for HIV intervention planning such as that discussed in **Chapter 4: Adaptive and Integrative Programming** can foster the integration of responses across institutions and sectors. Organizational linkages and systematic referral mechanisms are essential for optimizing the continuum of care.

Social Protection and Social Safety Nets

The terms *social protection*, *social welfare* and *social safety nets* are often used interchangeably. In conventional terms, they describe "social transfers to vulnerable groups in response to poverty or threats to their livelihoods." However, recent thinking broadens the notion of social protection to that of an "overarching framework that goes beyond mere transfers and toward comprehensive policies."[15] The intent of a social protection framework is to ensure an element of predictability and national ownership while promoting adequate budget allocations and program coverage at the national level.

Along these lines, safety nets and welfare mechanisms are not equal to social protection, but are rather considered components of a social protection framework. They not only include measures to protect livelihoods, but also measures to promote livelihoods (e.g., school feeding and microfinance interventions). There are different views on the extent to which measures that promote livelihoods should be considered social protection.

CARE Zimbabwe Restores Community Seed Banks

In the past, community granaries were established in Zimbabwe to support vulnerable community members, such as the elderly and orphans, who relied on the village chief for support. Unfortunately, this traditional safety net vanished in the early 1980s after the country became independent.

Responding to the community's request, CARE Zimbabwe helped restore this traditional mechanism with the aim of supporting vulnerable community members, including those affected by HIV. The community contributed all construction materials, while CARE supplied food and technical assistance, and helped with activity planning. The Department of Agriculture and Extension provided training and assisted with community mobilization.

Each participating farmer contributes 20 percent of his produce and seeds for the bank. Excess seed is sold and proceeds used to support seed protection interventions for participating farmers.[18]

Annex 1: Additional Resources on Livelihood Programming in the Context of HIV

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Chapter 13: Emergency Response

Sector-Specific Program Design Considerations

Chapter 13: Emergency Response

Sector-Specific Program Design Considerations

Key Concepts

13.1 Applying an HIV Lens to Emergency Food Assistance Programs

13.2 Programming Emergency Food Assistance in High HIV Prevalence Contexts

In This Chapter

As is true for many aspects of food assistance programming in the context of HIV, effective program design for emergencies is still evolving. Much of the literature on HIV and emergencies is focused on conflict and refugee situations, with very little on natural disasters.

This chapter offers guidance to help plan and implement emergency responses in a variety of settings where HIV-related challenges and opportunities should be considered. The chapter first looks at modifications to food assistance program design and implementation needed to ensure that the food security needs of PLHIV and affected households are appropriately addressed. It then outlines specific guidelines for HIV interventions in emergency settings.

This chapter identifies approaches that could be employed in quick-onset emergencies where international organizations and government are likely to provide large amounts of food assistance to refugee camps, the internally displaced or communities affected by conflict or natural disaster. For slow-onset emergencies, the guidance provided in other sector-specific chapters (**Chapter 10: Health and Nutrition**, **Chapter 11: Education** and **Chapter 12: Livelihood Strategies and Social Protection**) can be applied.

The chapter also discusses specific program design steps and key considerations in developing or adapting food assistance programs in high HIV prevalence contexts. These include the importance of conducting HIV rapid risk and vulnerability assessments to fully understand the local context, as well as the need to reconnect the HIV-affected to services.

13.1 Key Concept
Applying an HIV Lens to Emergency Food Assistance Programs

Applying an HIV lens to food assistance programs in emergency situations helps to address the constraints and needs PLHIV and HIV-affected households face and supports food security outcomes in a high-prevalence context. This is especially important because PLHIV and affected households may be more vulnerable during emergencies. For example, emergencies often aggravate the vulnerability of children affected by HIV. In addition, displaced people and refugees may become more vulnerable to HIV and its impact because of changes in social structures and livelihoods caused by emergencies.

Relief operations and other emergency settings provide unique opportunities to implement tailored interventions to directly address the vicious cycle of HIV, AIDS and vulnerability. Because refugee or displaced people interact with their host communities in one way or another, it is crucial to establish programs that take this interaction into account and are in line with host government protocols, guidelines and strategic plans.

When designing interventions for emergency settings program managers have several opportunities to modify food assistance programs to address HIV considerations and needs. Some are listed in the UNHCR/WFP publication ***Development of Programme Strategies for Integration of HIV, Food and Nutrition Activities in Refugee Settings***, including:[2]

- Support to enable and encourage participation in PLHIV groups
- Modification of a general food distribution program to better meet the nutritional needs of people affected by HIV
- Modification of a SFP or TFP to better meet the nutritional needs of HIV-affected subgroups
- Support for OVC by providing complementary rations to foster families and orphanages
- Awareness campaigns and prevention education at distribution sites

The prevailing context within the country or region, as well as situation and capacity assessments, will help determine how these interventions can be implemented and which additional HIV responses are needed.

WFP defines emergencies as "urgent situations in which there is clear evidence that an event or series of events has occurred which causes human suffering or imminently threatens human lives or livelihoods and which the government concerned has not the means to remedy; and it is a demonstrably abnormal event or series of events which produces dislocation in the life of a community on an exceptional scale."[1]

Key Actions for Responding to HIV in Emergencies

The ***Guidelines for HIV/AIDS Interventions in Emergency Settings***, produced by the UN Interagency Standing Committee (IASC) in 2003, include a matrix that establishes key actions for responding to HIV in emergencies by program sector (see Table 1). The matrix is divided into three parts: emergency preparedness, minimum response and comprehensive response. The country's or region's situation and capacity assessment will help determine which additional HIV responses are needed.

The matrix covers the requisite design steps for responding to HIV in emergencies. For more detail on the emergency preparedness steps, and/or comprehensive response steps, the full IASC Guidelines are on the IASC website: www.humanitarianinfo.org/iasc/content/products/docs/FinalGuidelines17Nov2003.pdf.

Table 1: Matrix of Guidelines for HIV Interventions in Emergency Settings

Sectoral Response	Emergency Preparedness	Minimum Response (to be conducted even in the midst of an emergency)	Comprehensive Response (stabilized phase)
1. Coordination	▶ Determine coordination structures ▶ Identify and list partners ▶ Establish network of resource persons ▶ Raise funds ▶ Prepare contingency plans ▶ Include HIV in humanitarian action plans and train accordingly relief workers	1.1 Establish coordination mechanism	▶ Continue fundraising ▶ Strengthen networks ▶ Enhance information sharing ▶ Build human capacity ▶ Link HIV emergency activities with development activities ▶ Work with authorities ▶ Assist government and non-state entities to promote and protect human rights
2. Assessment and Monitoring	▶ Conduct capacity and situation analysis ▶ Develop indicators and tools ▶ Involve local institutions and beneficiaries	2.1 Assess baseline data 2.2 Set up and manage a shared database 2.3 Monitor activities	▶ Maintain database ▶ Monitor and evaluate all programs ▶ Assess data on prevalence, knowledge attitudes and practice, and impact of HIV ▶ Draw lessons from evaluations
3. Protection	▶ Review existing protection laws and policies ▶ Promote human rights and best practices ▶ Ensure that humanitarian activities minimize the risk of sexual violence, exploitation, and HIV-related discrimination ▶ Train uniformed forces and humanitarian workers on HIV and sexual violence ▶ Train staff on HIV, gender and non-discrimination	3.1 Prevent and respond to sexual violence and exploitation 3.2 Protect orphans and separated children 3.3 Ensure access to condoms for peacekeepers, military and humanitarian staff	▶ Involve authorities to reduce HIV-related discrimination ▶ Expand prevention and response to sexual violence and exploitation ▶ Strengthen protection for orphans, separated children and young people ▶ Institutionalize training for uniformed forces on HIV, sexual violence and exploitation, and non-discrimination ▶ Put in place HIV-related services for demobilized personnel ▶ Strengthen IDP/refugee response
4. Water and Sanitation	▶ Train staff on HIV, sexual violence, gender and non-discrimination	4.1 Include HIV considerations in water/sanitation planning	▶ Establish water/sanitation management committees ▶ Organize awareness campaigns on hygiene and sanitation, targeting people affected by HIV
5. Food Security	▶ Contingency planning/pre-position supplies ▶ Train staff on special needs of HIV-affected populations ▶ Include information on nutritional care and support of PLHIV in community nutrition education programs ▶ Support food security of HIV-affected households	5.1 Target food assistance to affected and at-risk households and communities 5.2 Plan nutrition and food needs for populations with high HIV prevalence 5.3 Promote appropriate care and feeding practices for PLHIV 5.4 Support and protect food security of HIV-affected and at-risk households and communities 5.5 Distribute food assistance to affected households and communities	▶ Develop strategy to protect long-term food security of HIV-affected people ▶ Develop strategies and target vulnerable groups for agricultural extension programs ▶ Collaborate with community and home-based care programs in providing nutritional support ▶ Assist the government in fulfilling its obligation to respect the human right to food
6. Shelter and Site Planning	▶ Ensure safety of potential sites	6.1 Establish safely designed sites	▶ Plan orderly movement of displaced

7. Health	▶ Map current services and practices ▶ Plan and stock medical and reproductive health supplies ▶ Adapt/develop protocols ▶ Train health personnel ▶ Plan quality assurance mechanisms ▶ Train staff on the issue of sexual and gender-based violence (SGBV) and the link with HIV ▶ Determine prevalence of injecting drug use ▶ Develop instruction leaflets on cleaning injecting materials ▶ Map and support prevention and care initiatives ▶ Train staff and peer educators ▶ Train health staff on RH issues linked with emergencies and the use of RH kits ▶ Assess current practices in the application of universal precautions	7.1 Ensure access to basic health care for the most vulnerable 7.2 Ensure a safe blood supply 7.3 Provide condoms and establish condom supplies 7.4 Establish syndromic STI treatment 7.5 Ensure appropriate care for injecting drug users 7.6 Manage the consequences of SGBV 7.7 Ensure safe deliveries 7.8 Universal precautions	▶ Forecast longer-term needs; secure regular supplies; ensure appropriate training of the staff ▶ Palliative care and home-based care ▶ Treatment of opportunistic infections and TB control programs ▶ Provision of ARV treatment ▶ Safe blood transfusion services ▶ Ensure regular supplies, include condoms with other RH activities ▶ Reassess condoms based on demand ▶ Management of STI including condoms ▶ Comprehensive sexual violence programs ▶ Control drug trafficking in camp settings ▶ Use peer educators to provide counseling and education on risk reduction strategies ▶ Voluntary counseling and testing ▶ Reproductive health services for young people ▶ Prevention of mother-to-child transmission ▶ Enable/monitor/reinforce universal precautions in health care
8. Education	▶ Determine emergency education options for boys and girls ▶ Train teachers on HIV and sexual violence and exploitation	8.1 Ensure children's access to education	▶ Educate girls and boys (formal and non-formal) ▶ Provide life-skills-based HIV education ▶ Monitor and respond to sexual violence and exploitation in educational settings
9. Behavior Change Communication and Information, Education and Communication	▶ Prepare culturally appropriate messages in local languages ▶ Prepare a basic BCC/IEC strategy ▶ Involve key beneficiaries ▶ Conduct awareness campaigns ▶ Store key documents outside potential emergency areas	9.1 Provide information on HIV prevention and care	▶ Scale up BCC/IEC ▶ Monitor and evaluate activities
10. HIV in the Workplace	▶ Review personnel policies regarding the management of PLHIV who work in humanitarian operations ▶ Develop policies when there are none, aimed at minimizing the potential for discrimination ▶ Stock materials for post-exposure prophylaxis	10.1 Prevent discrimination by HIV status in staff management 10.2 Make post-exposure prophylaxis available for humanitarian staff	▶ Build capacity of supporting groups for PLHIV and their families ▶ Establish workplace policies to eliminate discrimination against PLHIV ▶ Post-exposure prophylaxis for all humanitarian workers available on regular basis

Source: Inter-Agency Standing Committee Task Force on HIV/AIDS in Emergency Settings (IASC TF). *Guidelines for HIV/AIDS Interventions in Emergency Settings*, 2003.

13.2 Key Concept
Programming Emergency Food Assistance in High HIV Prevalence Contexts

Assessing the Local Context

Historically, food assistance is used in emergencies to prevent increases in malnutrition and unnecessary deaths. While these objectives will always apply, the food assistance response strategy will depend on the nature of the crisis and its impact on people, their livelihoods and assets.

Understanding the ecology of HIV in crises and emergencies is important for effective programming. In fact, some of the same factors that cause food insecurity and humanitarian emergencies drive the HIV epidemic. In addition to standard emergency assessments, programs should conduct an HIV rapid risk and vulnerability assessment to identify risk groups, assess existing risks and determine specific factors that make the risk groups more vulnerable to HIV transmission. This information will guide program design and policy implementation. As much as possible, agencies should agree on standardized terminology, survey methodologies, definitions and forms, and they should develop a common database that respects confidentiality.

An assessment of the local epidemiology of HIV—in both the displaced population and the host communities—and how it interacts with the current and anticipated food security situation should underpin the design and implementation of interventions. The epidemiology of HIV varies widely in displaced-population settings, with some populations exhibiting a low HIV prevalence except in defined high-risk groups, while other populations struggle with a more generalized epidemic. HIV epidemics may also be associated with different patterns of food and nutritional insecurity among vulnerable groups. In situations involving displaced populations, both the displaced population and the host communities should be assessed. Initial HIV-prevalence rates and the nature of displaced populations' interactions with host communities can be significant determinants of HIV risk in both populations. UNHCR/WFP's ***Integration of HIV/AIDS Activities with Food and Nutrition Support in Refugee Settings*** describes outputs that should be included in a situational assessment:[3]

- Epidemiological patterns of disease and identification of high-risk groups
- Risks associated with refugee-host interaction
- Principal routes of transmission
- Roles of knowledge and behaviors
- Identification of priority strategies for HIV interventions, including prevention, care and support for affected families, health care and treatment interventions

Key Considerations for Program Design in High HIV Prevalence Contexts

These considerations should be taken into account when programming food assistance in high HIV prevalence emergency settings:[4]

Unintended consequences. Programs should follow the principle of "First, do no harm." Effective emergency programming requires consideration of both short- and long-term consequences to make sure that expedient responses today do not create problems in the future. To help avoid unintended consequences, all phases of an emergency response plan should include HIV technical support and cross-sectoral approaches. Whenever possible, large-scale distribution activities should be linked to sensitization, prevention awareness and stigma reduction.

Avoiding stigmatization. It cannot be overemphasized that avoidance of stigma and discrimination should be a priority at every stage of a program. Particularly in an emergency context, providing humanitarian assistance, whether it be food rations or training in vocational skills, can contribute to the stigmatization of PLHIV and HIV-affected households or be seen as giving preferential treatment to these groups. Programs should engage the community to dispel the fear and myths that fuel stigma and denial; in particular, PLHIV and their families can play a key role in deciding how to design sensitive programming that addresses stigma. In addition, wherever possible, assistance should be provided based on transparent, multiple-vulnerability criteria and in ways that do not single out PLHIV or affected families.

Aligning humanitarian strategies with host community norms. While ensuring at least minimum standards of prevention activity, provision of HIV-specific care and support services, and access to appropriate treatment to primary beneficiaries, be mindful of the HIV response in the local community. Providing services to refugee populations and not to host populations may spark tensions or hostility between the groups. Working toward parity with the host community in service availability and quality is very important and will help avoid creating a double standard that marginalizes one group over the other.

Effective collaboration mechanisms. Effective collaboration and coordination mechanisms are key to the success of any emergency response, especially one implemented amid the complexities of HIV. For example, ensuring a continuum of care for PLHIV, their families and at-risk groups during an emergency requires interagency collaboration, a common agenda and the authority and political will to deliver. As a mandatory first step, programs must ensure collaboration at the regional, national and local levels between UN agencies, NGOs and government bodies, and establish point persons for different aspects of the response.

Facilitating linkages across sectors. Collaboration is essential within agencies to bridge the "inter-sectoral divide." Emergency response arms of UN agencies and NGOs traditionally do not have HIV specialists on staff, and the responsibility for addressing HIV is often

Serving Refugees and the Community in Zambia

Where possible and practical, extremely vulnerable host populations can be considered for programmes provided to refugees that combine food and HIV prevention, treatment, care and support. In northern Zambia, for example, host community members living near the Kala and Mwange refugee camps are eligible for free care, integrated maternal and child health (MCH) services and VCT services at health clinics in the refugee camps.

As with refugee programs, the decision to provide external support to a host population should be based on a needs assessment. Host populations may have lower, equal or higher HIV prevalence rates, and often exhibit poorer health status than stable refugee populations.

delegated to health staff within the development arm of many agencies. Regular inter-sectoral meetings in-house and with partners—including government and civil society—should ensure that humanitarian actions minimize risk of transmission and maximize personnel and resource costs.

Internal capacity and staff. Staff must be adequately trained in HIV-related programming as part of an organization's emergency preparedness, and relevant organizational policies must be up to date. Many organizations have regional or global technical resource people who serve a specific region or work in a particular program sector. Field offices should collaborate with these technical advisors to train field staff on programming for PLHIV in emergency response. In addition, the technical advisors should be called on to provide program guidance during an emergency response. Programs also should consider creating point-person positions specifically to manage HIV-related interventions and ensure adequate technical back-stopping. In addition, because staff in any humanitarian response are often stretched thin, additional staff may be needed to implement HIV-related strategies and meet minimum standards for food security program performance. Programs also should recognize that capacity-building should not be limited to the needs of refugee or displaced PLHIV in emergencies. Workplace policies and training in prevention, treatment and care of HIV for all levels of field staff involved in emergency contexts also are an essential part of any emergency response.

Continuum of care. Individuals and households must be allowed to move in and out of programs as their circumstances change. Especially where chronic food insecurity and high prevalence of HIV intersect, affected families often face a thin line between relative wellness and illness, chronic malnutrition and acute hunger, chronic poverty and destitution, and coping and not coping. Movement in and out of programs allows them access to a continuum of care that is crucial to their well-being.

Continuity between emergency and recovery phases. Where possible, HIV emergency activities should be linked from the outset with development activities and longer-term social protection mechanisms, preferably those that are government-supported. Purposeful capacity-building of local social welfare structures is encouraged.

Site planning. Emergency sites may be dispersed settlements, mass accommodation in existing shelters or organized camps. Programs should consider how sites' location and layout affect beneficiaries' safety and the delivery of food. For example, households that have chronically ill members or are headed by children should be placed near the food distribution point and should be ensured safe passage once they collect their rations.

Sexual and gender-based violence. The risk of sexual exploitation, abuse and gender-based violence often dramatically increases in emergency situations. Sexual and gender-based violence (SGBV) not only harms its victims, but also often contributes to the spread of HIV during protracted crises.[5] Some important safety-related issues are covered in the IASC Code of Conduct on Sexual Violence and Exploitation (see box on page 274).

HIV awareness, prevention and care. IEC and BCC in emergency situations are essential to help people maintain or adopt behaviors that minimize their risk of contracting HIV or accessing services and assistance if they are living with or affected by HIV. Food assistance agencies can collaborate with IEC and BCC specialists to provide information at food distribution sites, as well as to transporters and food distribution staff.

Meeting dietary and nutrition needs. As discussed in **Chapter 10: Health and Nutrition**, PLHIV have specific dietary and nutritional needs. HIV can increase rates of malnutrition and mortality in emergencies, raising the importance of nutritional considerations when designing rations for populations with a high prevalence of HIV.

Sexual Exploitation: Being Part of the Solution, Not the Problem

In 2002, the international community was rocked by allegations of widespread sexual exploitation and abuse of refugee and internally displaced women and children by humanitarian workers and peacekeepers in Liberia, Sierra Leone and Guinea. Human Rights Watch and other NGOs called for a full investigation, action against the perpetrators and comprehensive protection measures to prevent such abuse.

Because of these events and the obvious implications for HIV infection, it is highly recommended that all humanitarian workers, food distributors, and international, national and local partner organizations receive training on the IASC Code of Conduct on Sexual Violence and Exploitation, whose core elements include: [6]

- Sexual exploitation and abuse by humanitarian workers constitute acts of gross misconduct and are therefore grounds for termination of employment.
- Exchange of money, employment, goods or services for sex, including sexual favors or other forms of humiliating, degrading or exploitative behavior, is prohibited. This includes exchange of assistance that is due to beneficiaries.
- Sexual activity with children (persons under the age of 18) is prohibited, regardless of the age of majority or age of consent locally. Mistaken belief in the age of a child is not a defense.
- Sexual relationships between humanitarian workers and beneficiaries are strongly discouraged because they are based on inherently unequal power dynamics. Such relationships undermine the credibility and integrity of humanitarian aid work.
- Where a humanitarian worker develops concerns or suspicions regarding sexual abuse or exploitation by a fellow worker, whether in the same agency or not, s/he must report such concerns via established agency reporting mechanisms.
- Humanitarian workers are obliged to create/maintain an environment that prevents sexual exploitation and abuse and promotes the implementation of their code of conduct. Managers at all levels have particular responsibilities to support and develop systems that maintain this environment.

For additional information on workplace issues, see Chapter 9: Operational Modalities.

Modifying ration size and mix. Where food rations are involved, they should be designed to help meet the special nutritional needs of PLHIV and other household members. Especially where participants are selected because of chronic illness in the household, a fortified, nutrient-dense commodity such as CSB should be included in the ration. (For more information, see **Chapter 6: Ration Design**.)

Improving food utilization for PLHIV. Providing food assistance in a high HIV prevalence context should go beyond simply improving access to food. It must also influence food utilization by supporting better hygiene practices, facilitating access to deworming (including adults living with HIV) and sharing information about child feeding and care practices, nutrition and food preparation.

Prioritizing high-risk groups with targeted interventions. Programs should remember that in emergencies, certain individuals may be more at risk than others. These are often the same people whose food insecurity is exacerbated by HIV and may include female-, child- and elderly-headed households; families hosting orphans; and families caring for the chronically ill. Where possible, programs should partner with or seek complementary resources from organizations such as schools, orphanages, churches, hospitals, maternal and child health (MCH) clinics and HBC programs already involved with HIV-affected households. In addition, in large-scale emergencies, some agencies map "hot spots"—areas where food insecurity overlaps with other indicators of vulnerability, such as high rates of HIV prevalence—to help prioritize high-risk groups.

Joint IEC Programming Reaches Swaziland Communities

In Swaziland, WFP and UNFPA, in partnership with the MOE, jointly implemented a project to raise awareness and understanding of HIV and related issues among communities through relief committees (RCs) that are responsible for food distribution and management.

There are 179 RCs, each composed of 11 women and two men. Two leaders each from 163 RCs participated in a five-day training of trainers (TOT) by UNFPA and the MOH, which included participatory methods and videos. The training modules were developed by WFP and UNFPA and covered a range of topics including HIV (including PMTCT and ART), nutrition education, gender issues, SGBV, sexual/reproductive health, family planning, safe motherhood, adolescent health and child abuse. After the TOTs, RC leaders were expected to train their fellow committee members, who were then mandated to educate the general community at food distribution points.

The project also developed IEC materials such as posters on male involvement, family planning, adolescent health and SGBV and disseminated them to clinics.

Reconnecting the HIV-Affected to Services

When displacement occurs, regardless of whether it is in a rapid or slow-onset emergency, PLHIV and their families are separated from the medical, social and other services that help sustain them. For example, it is difficult to provide ARVs to PLHIV in most post-disaster settings, although this may become more feasible in the future. Where ART is not available, humanitarian response programs should provide basic health care and palliative care to PLHIV. Once the situation has stabilized, humanitarian agencies should also introduce comprehensive surveillance, prevention, treatment, care and support services in conjunction with HIV protection and education programs to reduce stigma and discrimination.

Although typically not feasible in the earliest phase of an emergency response, a stabilized situation provides opportunity for several HIV initiatives, many of which can benefit from the integration of food assistance, including:

- Integration of a supplementary ration, supported by nutrition and PL education, into ART, HBC, TB control or PMTCT programs
- Support for inpatient hospital/clinic feeding programs with nutrition training and the establishment of a hospital/clinic demonstration garden for vegetables, fruit and medicinal herbs
- Support for nutrition education training and other capacity-building activities for formal and traditional/community-based HBC providers
- Incorporation of food and nutrition resources to support the establishment or continuation of community HIV-related activities, including peer education and treatment supporters
- Support for training in topics such as nutrition, treatment literacy, PL, SGBV, stigma reduction, gender, substance abuse, etc.

Connecting the Displaced to HIV Services

UNAIDS and UNHCR recommend that refugee programming include culturally and linguistically relevant community-based prevention interventions (UNHCR 2005). In Uganda, where more than 220,000 refugees share health services with 135,000 people from surrounding communities, UNHCR works with the government to provide refugees with access to VCT, screening and treatment for STIs, and PMTCT services.

Annex I: Additional Resources on Food Assistance and HIV in Emergency Settings

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Endnotes

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5 Created by Kara Greenblott for World Vision US to facilitate the use of IASC Guidelines for SGBV by field staff.

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There is increasing acknowledgment in the development community of the links between food insecurity and HIV, and the corresponding need to integrate food and nutritional support into a comprehensive response to the epidemic. The goal of Food Assistance Programming in the Context of HIV is to improve capacity to design and implement food security programs that respond to HIV-related challenges and HIV programs that respond to food security challenges. The guide provides a set of tools, promising practices and key considerations that enhance the flexibility and appropriateness of program design and implementation modalities.

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