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Direct Distribution of Commodities for People Living with HIV/AIDS: Lessons Learned from Rwanda and Burkina Faso

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Objectives: This paper presents some of the initial experiences and preliminary observations from Burkina Faso and Rwanda where two Title II pilot projects (FY05-FY09) are being executed in which food aid is used to improve the living standards and nutritional status of people living with HIV/AIDS (PLWHA).[iv] These pilot projects are expected to illustrate valuable lessons learned regarding how food can be used to improve the nutritional status and living standards of PLWHA (both at the individual and the household levels) in Africare's other Title II programs. The main objective of this preliminary assessment and this paper is to present needs that have been identified thus far and to inform both the anticipated final evaluations of these pilot projects and future HIV/AIDS programming (should the needs identified in the paper be confirmed at the end of the projects).

Background:

Africare's Experience with HIV/AIDS Programming. In the FFP Strategy 2006-2010 (USAID 2005), HIV/AIDS was recognized as one of the challenges affecting household food security and an area where FFP intends to be actively involved. Up until recently, Africare's strategies for meeting this directive have focused on a number of activities in selected countries,[v] including behavior change and communication (BCC) and the creation of safety nets through food assistance to vulnerable groups (which includes PLWHA); Community-Based Orphan Care, Protection, and Empowerment (COPE); and activities under the Improving Livelihoods through Increasing Food Security (I-LIFE) program (see Annex C for more information regarding HIV/AIDS-related programs by Africare and other NGOs and agencies in Rwanda). These country-specific activities are in addition to general awareness-raising activities that take place in most of Africare's Title II programs.

The Africare Burkina Faso and Rwanda Pilot Projects. In each of the two pilot countries, food is only one of several activities focused on maintaining the well being of individuals and households affected by HIV/AIDS.[vi] In terms of HIV/AIDS related activities, the programs invest in providing a number of services to the communities at large, such as prevention education through behavior change and communication (BCC), care and support, community and/or household gardens, growth monitoring promotion (GMP) for children, and medical insurance.[vii] The general recommendations for improved nutritional status of PLWHA from FANTA and FFP that emphasize enhancing food security for individuals infected with and affected by HIV/AIDS were the basis for both pilot projects (see Annex B for a summary of FANTA's recommendation; FANTA 2007).[viii]

The method for determining whether a household will be a beneficiary of direct food distribution under these programs is the same in both Rwanda and Burkina Faso. Beneficiaries must satisfy three criteria: they must reside in the

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intervention zone, they must provide proof of their HIV/AIDS infection status, and they must belong to one of the HIV/AIDS associations.

Direct Food Distribution. The objective of the direct distribution of food is to provide PLWHA, and those affected by the virus (such as other household members), with supplemental food products in order to improve their nutritional status. In general, for these two project areas it is recognized that targeting PLWHA with food rations occurs within the cultural context of food sharing (including ration food) between family members within each household, which needs to be considered when assessing the nutritional impact of food rations. In addition to assisting PLWHA directly, the program also provides a one-quarter food ration to home-based care providers and peer educators in Rwands and peer educators in Burkina Faso (as there are no home-based care providers in Burkina Faso). This may be particularly important given the demands on their time and, therefore, their limited ability to procure food for themselves.

Rwanda. The Africare, USAID Titled II-funded Rwanda program, implemented under a sub-grant from ACDI/VOCA, operates in Nyamagabe Province and is called the Gikongoro Food Security Initiative (FY05-FY09). The HIV prevalence rate was estimated at eight percent in the intervention area in Rwanda (according to 2007 unpublished data from the Africare voluntary counseling and testing (VCT) center and eight public health VCT centers located in Africare's intervention zone). Antiretrovirals (ARVs) are more available in Rwanda than in Burkina Faso. The basic components of Africare's nutritional intervention for households affected by HIV/AIDS in Rwanda[ix] includes (1) home-based care; (2) behavior change and communication (BCC) through voluntary counseling and testing (VCT), mobile VCT, mobile cinema, youth centers, peer education, and peer counseling; (3) food distribution to PLWHA; (4) COPE; and (5) health insurance for each PLWHA who receives commodities. Furthermore, awareness-raising focused on the high nutritional value of *Moringa* (a nutrient-rich plant that was successfully promoted in Afircare's Guinea Food Security Initiative) has been incorporated into the Rwanda activities for PLWHA. In Rwanda, Africare staff travel to 12 distribution sites identified by community members (usually in the center of the villages), to distribute the rations to individuals who present their ID cards. Since January 2006 in Rwanda, 1408 individuals infected with HIV/AIDS (648 of which are on antiretrovirals) in 1150 households, belonging to a total of 35 associations of people living with HIV/AIDS, have received monthly household rations of 25 kg of bulgur, 25 kg of corn soya blend (CSB), and four liters of vegetable oil per household.[x] This ration amount is the same regardless of the number of people or PLWHA residing in the households.

Burkina Faso. The Africare, USAID Title II-funded Burkina Faso program operates in Zondoma Province and is called the Zondoma Food Security Initiative (FY05-FY09). HIV prevalence was estimated at two percent in the intervention area in Burkina Faso (UNAIDS 2007). There is limited access to ARVs in Burkina Faso. Specific intervention strategies for the Africare pilot program in Burkina Faso include (1) BCC (behavior change and communication) through awareness-raising, mobile cinema, theater forums, radio emissions, peer education, peer counseling, and cyber café (with proceeds generated going to members of associations that are fighting AIDS); (2) VCT and mobile VCT that collaborate with the National AIDS Organization/IEC center; and (3) food distribution. In Burkina Faso food rations are not distributed directly to PLWHA due to the higher level of stigma associated with HIV/AIDS. Instead, Africare gives the food rations to the HIV/AIDS associations who then distribute the rations to individuals living with HIV/AIDS. The Africare program in Burkina Faso also has nutrition, agricultural production, animal production, water, and micro-finance components that have the potential to improve the lives of households affected by HIV/AIDS, depending on their available labor, time, and resources to participate in these activities. Since September 2007 in Burkina Faso 120 households who have individuals infected with HIV/AIDS, belonging to two associations have received 10.5 kg of bulgur, 9 kg of lentils, 5 kg of deffated soy flour, and 7.5 liters of oil per household per month.

Methods: Stacey Maslowsky, FFD Manager at headquarters, visited Rwanda in August 2007 for 10 days (August 21-31) to assess the early impact and needs of the pilot projects through focus group discussions with hospital workers, local health clinic personnel, Africare VCT (voluntary counseling and testing) personnel,

home-based care providers, PLWHA who belong to associations and receive food aid, peer educators, and Africare staff (including the country representative and advisor to COPE). Furthermore, she attended a food distribution session, a home-based care session, and visited a youth center. The Burkina Faso pilot project assessment was conducted through correspondence with key Africare staff from the Burkina Faso project, including the HIV/AIDS coordinator.

Results and Discussion: The early qualitative evidence of the impact of food rations on households with persons living with HIV/AIDS include reported improvement in the physical condition of PLWHA (linked to nutrition) observed by the focus group participants, implying that the rations have improved their food security situation (see Box 1 for focus group comments). Aside from the descriptive statements about improvements in physical conditions as a result of food rations, focus group participants offered some anecdotal examples of significant weight gain for PLWHA who have benefited from receiving rations from Africare. Respondents reported that four different individuals living with HIV/AIDS had gained weight as a result of receiving food rations. Specifically 10kg, 21kg, 20kg, and 29kg were gained by these four individuals who were beneficiaries of the Africare food rations. Since Africare did not weight these or any other individuals, these results cannot be confirmed with quantitative data. However, these reports do suggest that implementing weighing as part of the food distribution activities may demonstrate success of food distribution to PLWHA.

In addition to the reported improvements in physical conditions of beneficiaries, focus group members have observed a decrease in the level of stigmatization associated with HIV/AIDS. They have noted that HIV/AIDS is discussed more freely within the project communities. This is an excellent indication that awareness-raising is working, especially when implemented in combination with other components of these programs.

The fact that food ration consumption by PLWHA is not sufficient was one of the most common critiques made by respondents. The focus group discussions brought to light the fact that the number of people who reside in a household and the number of infected people within a household are not factors in determining the quantity of food the household receives (e.g., a household with only one person receives the same ration size as a household with 15 members). The custom of sharing food (even rations) with other members of the household results in infected persons not receiving sufficient rations for themselves. Furthermore, since many households have more than one individual infected with HIV/AIDS, again, the infected individuals do not receive sufficient food rations since they only receive one ration to share. Another factor that may be contributing to perceived need for more food rations is that people on ARVs have an increased appetite. Many respondents reported that their stock lasted them just two weeks when it was suppose to last one month. While increasing food rations is one option, it is not the only option and may not be the most appropriate one (at least if it is not combined with other strategies for addressing these issues that are more sustainable). Since the pilot projects have no tracking system in place to assess the differences in impact (nutritional, weight change, illness frequency, or work capacity), this needs to be addressed first (before food rations are increased) in order make food rations most efficient and effective.

It is known that household members share rations (as they share all food), but the situation of food ration distribution within the household (between household members) is not known. The portion sizes given to individual household members may vary based on illness, gender, birth order, age, or family position. It is important to understand how family dynamic affects the impact of food rations. One of these factors that should be explored (particularly since focus group participants highlighted it) is the impact that the number of individuals within a household may have a direct impact on improved nutrition of the individual with HIV/AIDS in light of food sharing.

There was an observed lack of income generating activities tailored specifically to PLWHA. It is assumed that PLWHA also benefit from general Title II activities that do not specifically target them (e.g., agricultural development, income generating activities, and nutritional counseling). However, it is unclear whether PLWHA participate on an equal level with other beneficiaries in these types of interventions. It is possible that due to the nature of this disease and how it affects financial

Box 1. Quotes from PLWHA who Received Rations from Africare/Rwanda.

"I had a CD4 count of 200. I started ARVs and had it not been for the ration, I would have died. Without the combination of the rations and the ARVs, I would have died directly."

"In 2004, my CD4 count was 2, but after the rations it increased to 300."

"I began receiving assistance from Africare in 2002 (under the Gikongoro Aids Project). At first, I was given flour, which I used to make porridge. It gave me force. I was able to cultivate food and was able to work. I was able to live because of Africare."

"The rations are very important! I mix the rations with other foods and eat them regularly, since I am no longer able to produce my own food."

"I can now take my medications in the morning, since porridge is now available to me. The oil and bulgur have lots of vitamins and are good for my organism! Before the distribution, I had no force to work, but now I do. I add vegetables, dried fish and beans to the rations."

Source: (S. Maslowsky and S. Sidibé, Focus Group Discussions-Rwanda August, 2007).

resources, assets, labor, and (quite obviously) health and energy levels (of not just the individual infected, but all other members of the household who endure a prolonged period of caretaking), these households may not benefit equally from general Title II initiatives. To date, there is very little tracking of the degree of participation of PLWHA in "mainstream" project interventions. This information is critical in order to see if conditions can be modified to increase their participation or if separate activities are the best path.

When PLWHA are referred to and visit health centers it was observed that the nutritional information provided to these individuals is the same as that for the general population. This information is not tailored to the unique nutritional requirements of individuals infected with HIV/AIDS, despite the fact that these individuals have special nutritional needs.

Another way that the project needs to consider more specific tailoring to the situation of PLWHA is in the types of food provided in the rations. The specific types of foods Africare hands out have not been evaluated for optimal effectiveness for PLWHA. Considering the lack of research on the effectiveness of food in general, it is impossible to state that one commodity is better than another. In the draft midterm evaluation report (Ndagiyimfura In press), one quarter of those interviewed said they would like for bulgur to be replaced with a more convenient commodity, such as rice or beans. This may be related to a lack of program support for the commodities distributed. In Rwanda, Africare staff noted that beneficiaries who received bulgur (which was previously unfamiliar to them) had to experiment with ways to prepare the food. This was done by beneficiaries without assistance from Africare, who did not provide cooking demonstrations for bulgur. Both this preliminary assessment of the pilot projects and the independent midterm evaluation observed the need for culinary demonstrations specifically linked to the foods being distributed and to the context of households with HIV/AIDS.

One component of these projects that has been essential in Rwanda is the home-based care component. In the original design of these projects it was estimated that home-based care providers would be assisting between 10 and 15 households; however, at midterm each home-based care provider in Rwanda was assisting 20 to 35 households. This makes the limited ration these individual receive (as well as any other encouragement and motivation) important since they are dedicating even more time than anticipated helping PLWHA. One member of an association for PLWHA reported that home-based care providers are assisted at times by members of the community who see the need to help them in the field in order to free up time for them to spend on home-based care. These both demonstrate the importance of home-based care providers.

Recommendations:

Recommendation #1. The most commonly observed weakness of the pilot projects from this preliminary qualitative review of the activities in Rwanda and Burkina Faso until midterm is the lack of specific, informative indicators to track impact. This observation was confirmed by the independent mid-term evaluation (Ndagiyimfura In press). In designing these pilot projects it was not possible to do a baseline study. Therefore, the data used for the baseline were secondary (*Institut National de la Statistique du Rwanda* (INSR) and ORC Macro 2006) and the assumptions and characteristics of the data were not known by Africare. This makes it even more important for Africare to collect good impact indicators during the project. Due to importance of relevant and informative impact indicators on the successful design of future HIV/AIDS projects and the degree to which a positive or negative impact can be assessed for these two pilot projects, this paper primarily emphasizes the need to develop an adequate tracking indicators to monitor impact of direct distribution of food aid to PLWHA. The follow are some of the relevant suggestions for tracking this impact

- These pilot projects assumed that households affected by HIV/AIDS are necessarily food insecure. There is an excellent opportunity to relate food insecurity with HIV/AIDS infection by using Africare's widely implemented indicator MAHFP for beneficiaries of food rations to PLWHA. It is recommended that a measure (such as MAHFP) be tracked for each household with a person living with HIV/AIDS that receives food rations.
- It is also recommended that projects that distribute food to PLWHA (or any other intervention activities aimed at minimizing the negative nutritional impacts of HIV/AIDS) incorporate monthly weighing of the individuals infected with HIV/AIDS into the tracking system. In Rwanda this could be implemented at the point of distribution by Africare field staff bringing a scale and record book and making weighing a requisite for each individual receiving food rations. Sensitivity issues need to be considered when implementing weighing as it may be uncomfortable for individuals to be weighed in public. Furthermore, in areas where food distribution is done through associations (such as in Burkina Faso), it is understood that Africare could not manage weight records directly. Options should be explored for associations weighing and recording weights monthly in the register they already use to record the names of food ration beneficiaries.
- Indicators should be developed (if food aid and rations are to continue to be made available to PLWHA) that will explore the potential for predictable differential distribution of food to family members based on status or role within the household or based on the size of the household.
- It would be useful to develop indictors that track participation of households affected by HIV/AIDS in mainstream food security activities (e.g., income generating activities, agricultural extension, health and nutrition, and Hearth). The impact that HIV/AIDS has on energy, finances, and time constraints may prevent households from participating to the same extent. Furthermore, their participation may depend on the stage and progression of the disease (the length of time the household has had to deal with the disease). Therefore, if possible, any indicators used to track participation in mainstream project activities should also include the stage or number of months since initial HIV/AIDS status was detected. These data will contribute to adapting these typical project activities to the specific needs of household affected by HIV/AIDS. When implementing these sorts of tracking indicators it will be necessary to consider the level and type of stigma in each intervention area.

Recommendation #2. In light of the new use of food aid for PLWHA that has been initiated by these two projects and the opportunities to respond to the recommendation above to develop informative impact indicators, it is also recommended that Africare headquarters begin a dialogue aimed at producing an easy to use mechanism through which programs can share their experiences, lesson learned, and impacts. A variety of options should be considered and a network of key players should be involved in this dialogue, perhaps in the form of a working group

to develop such a mechanism at the next Africare food security workshop. Options might include (1) a dedicated session on HIV/AIDS programming during each Africare food security workshop,[xi] (2) creation of PowerPoint presentations by individual projects that summarize their experiences and lessons learned and that would be submitted to headquarters where all such PowerPoint files could be managed and shared with other relevant country programs, or (3) development of a briefing paper from the mid term or final reports to be published in the new *Africare Food Security Review* paper series. Headquarters should outline a specific plan to distribute project experiences with other programs.

Recommendation #3. By implementing a modified Hearth/FARN for adult PLWHA, with an emphasis on nutritional recommendations specifically tailored to PLWHA, beneficiaries will be equipped to utilize nutrient-rich, locally available foods, to supplement the food rations provided by the project. Furthermore, this type of program would facilitate the cooking demonstrations for unfamiliar foods so that people are well equipped to prepare new foods. This recommendation was also presented in the independent mid-term evaluation draft report (Ndagiyimfura In press).

Since these two pilot projects are only at mid-term, the final evaluations (FY09) should take into consideration the issues and recommendations presented in this paper.

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Annex A:
Overview of Food Security Issues Specific to PLWHA

Link between HIV/AIDS, Food Insecurity, Nutrition and Risk

The HIV/AIDS (Human Immunodeficiency Virus/Acquired Immuno Deficiency) pandemic has increased the risk of household food insecurity (availability, accessibility, and utilization) in many households that were already food insecure **prior** to the arrival of HIV/AIDS and in a context of endemic malnutrition in Rwanda. These underlying factors (food insecurity and malnutrition) contribute to the fact that people are compelled, and sometimes forced, to engage in behavior that puts them at risk for contracting HIV/AIDS, such as unprotected transactional sex. Not only is improving food security and nutrition necessary for protection against risk, these strategies also serve as ways of improving the standard and quality of life of those who are affected by and infected with HIV/AIDS.

Context of Malnutrition and HIV/AIDS

The importance of considering context is illustrated when the following fact is presented. The time period between HIV and AIDS diagnosis and death may be shortened by exposure to pathogens and infectious diseases due to lack of proper health care, decreased immunity, and, finally, (of particular importance in this paper) malnutrition (Piwoz and Preble 2000). There exists an unmistakable dichotomy between developed and developing countries demonstrated by the varying degrees of malnutrition prior to infection, the availability of medicines (such as ARVs and those to treat opportunistic infections) the level of stigmatization, testing (which becomes more important when in the early stages of infection--before the onset of secondary infections--since nutritional support can have the greatest impact during this time period [Piwoz and Preble 2000]), the role of the government, and the livelihoods of populations.

The area in which a person infected with HIV/AIDS lives plays a large role in how that person's condition progresses. Exposure to pathogens, infectious diseases, poor healthcare, and malnutrition shorten the time period between contraction of HIV and development of full-blown AIDS (Piwoz and Preble 2000). All of these risk factors are present in the Rwandan context. Furthermore, in Rwanda and many places in Africa, the level of stigmatization regarding HIV/AIDS is high and prevents people from talking about it, getting tested, and seeking treatment (even if ARVs are available). In order for improvements in nutrition to have a chance at increasing the success of ARV treatment and the lifespan of individuals infected with HIV and AIDS, they need to be implemented in the early stages of the infection, before the onset of secondary infections (Piwoz and Preble 2000).

The fact that many people who became infected with HIV are already malnourished to start with means that once they are infected their nutritional status deteriorates further, resulting in a diminished quality of life and more rapid progression to AIDS because the body is already weak and cannot fight co-infections (particularly without access to ARVs and prophylactic medicines that are so often not available in Africa). In other words, malnutrition may be a contributor to HIV/AIDS disease progression (Piwoz and Preble 2000). Therefore, nutritional care and support is especially effective for those HIV-positive people who have not yet progressed to the stage requiring ARV treatment (FANTA 2004).

Studies illustrate that the impact of nutritional interventions will depend, in part, upon the stage of disease, as well as the types of nutritional management provided. This has important implications for PLWHA in Africa. In the early stages of HIV infection, especially before the onset of secondary infections, simple, affordable nutritional supplementation and counseling may be feasible and have a positive impact on body composition and weight. Therefore, proper nutrition and a nutrient-rich diet consisting of healthy food products **MAY** help prolong the period of time between HIV infection and the onset of secondary infections commonly attributed to progression to AIDS (Piwoz and Preble 2000).

Antiretroviral Therapy and Nutrition

Considering that ARVs must be taken for the duration of the life of a PLWHA (Hope and Israel 2007), the need to examine the link between ARVs and nutrition is imperative. "There is a need to better understand the impacts of ARVs on undernourished populations and the role nutritional status plays in ARV efficacy and side effects" (FANTA 2007). Fortunately, there is ever-increasing access to ARVs, even in resource-limited settings, but, unfortunately, pre-existing malnutrition has the potential to darken an otherwise optimistic picture. With the increased availability of these treatments, comes an increased need and demand for food since there is an increase in appetite. Additionally, it is necessary to increase overall consumption in order to ensure efficacy and some side effects must be managed nutritionally. Optimally, the food would be nutrient-rich to empower and strengthen those who are taking ARVs. Furthermore, some of the medications given to treat opportunistic infections have nutritional consequences either because of drug-nutrient interactions or because of side effects, such as nausea and vomiting, that affect the intake and retention of nutrients.

Case for Food Aid

The importance of food security is illustrated in the following statement: When PLWHAs are questioned about their priority needs, **food**--not drugs, health services, or relief from stigma--is often the predominant response (FANTA 2004). This is a result of the vicious cycle of weight loss that occurs with the virus and the increased fatigue and decreased physical activity (including the inability to cultivate, prepare, and consume food (Piwoz and Preble 2000).

In the ever-changing environment of development, HIV/AIDS has caused a shift. The high incidence of HIV/AIDS and its often dire consequences has often meant the dismissal of the regularly spoken "buzz word" sustainability that is often used when dealing with direct distribution in a non-emergency context. In the context of AIDS though, the focus is, and should be, more short-term and the patience that is usually applied to long-term development strategies becomes overshadowed by the need to provide people with food from day to day. There is a real need to provide nutritious food for AIDS-affected families living in conditions of food insecurity. The key phrase here when talking about food aid is "AIDS-affected families," considering that in many places in Sub-Saharan Africa food aid or food from other sources is not designated to one family member even if they are sick with HIV/AIDS. Food is instead shared amongst family members. Considering this, it is necessary to consider food aid to PLWHA as a complement to the existing diet and other food sources, rather than as a complete and sole source of food.

Lack of Guidance and Nutritional Counseling Tailored to PLWHA

"The food and nutrition dimension is missing in the package of treatment and care for PLWHA" (Republic of Rwanda 2005). The fact that "the nutrient requirements for people living with HIV/AIDS differ from those for non-HIV-infected individuals" (FANTA 2007) is often ignored in the palliative care and nutritional support for PLWHA. Instead GENERAL nutrition guidelines are utilized. Currently, the nutrient requirements are not detailed for each individual according to their clinical stage of the disease. This may be explained by the fact that there is a lack of information and emphasis on studies and information that link HIV/AIDS and nutrition.

A short sample of guidelines specific to PLWHA would be (Piwoz and Preble 2000):

- Improve or develop better eating habits and diet among PLWHA,
- Build or replenish body stores of micronutrients,
- Prevent or stabilize weight loss,
- Preserve (and gain) muscle mass,
- Prevent food-borne illness, and
- Prepare for and manage AIDS-related symptoms that affect food consumption and dietary intake.

All of these guidelines could (and should) be elaborated with detailed suggestions that are context specific that would help patients fulfill these aims.

Annex B: FANTA Guidelines for PLWHA

The following guidelines[xii] are for **all** adults living with HIV/AIDS: those who are on ARVs, those who are not, those who have pre-existing malnutrition, and those who do not. In reality, many PLWHA suffer from deficiencies in specific micronutrients or macronutrients (energy and protein), therefore, higher levels of intake of these nutrients may be necessary.

> Consumption of additional energy by people living with HIV/AIDS should not lead to reduction in consumption of protein and micronutrients. When possible, people living with HIV/AIDS should meet their additional energy needs by increasing consumption of foods with high nutrient densities, rather than increasing consumption of high-energy foods that are low in protein and micronutrients (such as high fat and high sugar foods) (FANTA 2007: 2).

Nutrient requirements change as HIV infection progresses from the first to the second of the two distinct phases of HIV infection. WHO classifies HIV infection into **four clinical stages**:

- **Clinical Stage I**: asymptomatic, normal activity,
- **Clinical Stage II**: symptomatic, ambulatory, unintentional weight loss < 10%,
- **Clinical Stage III**: symptomatic, in bed <50%, unintentional weight loss > 10%, and
- **Clinical Stage IV**: symptomatic, in bed >50%, HIV wasting syndrome.

The asymptomatic phase refers to Clinical Stage I and the symptomatic phase refers to Clinical Stages II-IV.

<u>*Energy Intake (Calories)*</u>
The percentage increases in energy requirements outlined below for each of these two phases of infection for adults and adolescents and for pregnant or lactating women refer to increases over the intake levels recommended for healthy non-HIV infected individuals of the same age, sex, and physical activity level.

Adults and Adolescents:

- During the **asymptomatic** phase (Clinical Stage I), energy requirements **increase by 10 percent**.
- During the **symptomatic** phases (Clinical Stages II-IV), energy requirements **increase by 20 to 30 percent**.

Pregnant and Lactating Women:

- During the **asymptomatic** phase (Clinical Stage I), energy requirements **increase by 10 percent**.
- During the **symptomatic** phases (Clinical Stages II-IV), energy requirements **increase by 20 to 30 percent**.

Although the percentage increases in energy requirements for pregnant and lactating women in the two phases of the disease are the same as the percentage increases for adults and adolescents, it is important to keep in mind that pregnant and lactating women already need to consume extra energy, protein, and micronutrients required by pregnancy or lactation. The 10 and 20 to 30 percent increases are to be above their already elevated intake due to pregnancy and lactation.

<u>*Protein and Micronutrients*</u>: Based on current evidence, protein and micronutrient requirements for all PLWHA (adults, adolescents, children, and pregnant and lactating women) are the same as for healthy non-HIV-infected individuals of the same age, sex, and physical activity level. Although, as mentioned above, there is a great chance that a PLWHA from Sub-Saharan Africa has one or more micronutrient deficiencies.

<u>*Fat:*</u> There is no evidence that the requirements for intake of fat of individuals infected with HIV/AIDS are different from those not infected with HIV/AIDS, but with the prevalence of diarrhea, both due to the disease and the lack of clean water for much of the populations in Africa regardless of infection, they may need to change the timing or quantity of fat intake in some cases (FANTA 2004).

Annex C:
Sample of Leading NGO and Non-NGO Programs in Rwanda

There is a multitude of NGO's (both local and international) with a presence in Rwanda. Most notably, the following organizations, which receive USAID Title II funding under their current DAP (Development Assistance Program) in Rwanda (these Cooperating Sponsors [CSs] meet on a monthly basis in Kigali, though there is no technical exchange between them).

ACDI/VOCA and Africare

Forty farmer/members of the TERIMBERE-MUHINZI Cooperative in Rwamaganga District are currently cultivating cuttings of sweet-potato (red-fleshed variety). These cuttings will be reserved for multiplication and a program for distribution of the cuttings to the associations of PLWHA will be implemented in the near future. Successful results are expected, but will not be visible until next year after the associations have an opportunity to plant the cuttings and produce a harvest that will be utilized for both individual consumption and for sale.

Africare is ACDI/VOCA's sub-grantee. Of the three objectives, Africare focuses on the second objective (improved health and nutrition and reduced vulnerability to households infected and/or affected by HIV/AIDS) in Nyamagabe and ACDI/VOCA focuses on the remaining two objectives: 1) increased incomes and reduced vulnerability to food insecurity and 2) increased access to basic food commodities through monetization and local production.

Africare

In Nyamagabe District, Africare provides food distribution to PLWHA, as well as volunteers who support those who are infected and those who work to prevent the disease. Africare provides palliative care activities to PLWHA, which include HBC, nutritional counseling, psychosocial support, and spiritual support. It also promotes Prevention and Behavior Change and Communication through:

- Promotion of voluntary counseling and testing (VCT) and prevention of mother to child transmission (PMTCT),
- Peer education and peer counselor networks, and
- A youth center at Africare's office.

Catholic Relief Services (CRS)

Catholic Relief Services (CRS) was scheduled to begin work in Karongi District (former Kibuye Province) and Muhanga District with PLWHA and orphans and vulnerable children (OVC) affected and infected with HIV/AIDS in October 2007. The activities were postponed as a result of the delayed arrival of commodities. A package of food security activities focused on the most vulnerable households (determined by degree of food insecurity) will be executed. Currently, CRS is working with "safety net centers" that target orphans, street children, and the elderly population. Food distribution, mobilization of resources, and provision of small grants for income generating activities (IGAs) and training in human resources and financial management comprise this particular intervention.

World Vision

World Vision provides food distribution to PLWHA in Nyamagabe District. In addition to this particular activity, other activities in the DAP include nutritional counseling, home and community gardens (which have been introduced to members of PLWHA associations with which World Vision works and are maintained by the community and serve as an additional food source for families), psychosocial support, adherence counseling, prevention messages, and spiritual support.

Potential for Funding from President's Emergency Plan for AIDS Relief (PEPFAR)

All four of the organizations above (which includes Africare as a sub grantee under ACDI/VOCA), have programs that "directly meet PEPFAR objectives and indicators." USAID missions in other countries have demonstrated success with integrating food and nutrition programs with PEPFAR activities (known as "wrap around activities," which link PEPFAR programs with programs from other sectors--in this case food and nutrition) to provide comprehensive program support and improve the quality of life of HIV/AIDS affected and infected communities.

> The key precepts of the emergency plan programs include maximizing leverage with Title II partners and providing support for food for individuals infected or affected with HIV/AIDS. Because Title II partners have experience and a strong comparative advantage providing direct food assistance to HIV-affected populations, the partnership strengthens the food and nutrition component of the HIV/AIDS programs (USAID/Rwanda 2007: 10).

Obtaining PEPFAR funding for any one of these Title II programs not only has the benefit of expanding the existing program, but of strengthening the nutritional component and, especially important for Africare, incorporating IGAs in order to diminish the effects of the termination of the food commodities.

Rwanda Government Role in the HIV/AIDS Intervention

The Government of Rwanda has recognized the fact that nutritional care and support is not fully integrated into the fight against HIV/AIDS. In order to respond to this, the Ministry of Health has developed a number of guidelines and protocols aimed at integrating nutrition into the national response to HIV/AIDS; these include a Minimum Food Package for those infected or affected by HIV/AIDS to alleviate food insecurity. Recently, as mentioned above, the government adopted guidelines for nutritional care and support of PLWHA in Rwanda that can be used by service providers and personnel responsible for HIV/AIDS management including the ARV and the Prevention of Mother to Child Transmission (PMTCT) programs (Republic of Rwanda 2005).

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[iv] To date the main contribution to this set of activities by Africare's ICB grant have been the time and travel costs for Stacey Maslowsky to conduct research and develop the report on the pilot projects that will feed into future ICB activities aimed at reducing food insecurity in vulnerable populations. This is paper satisfies ICB deliverable for "Strengthening Models for Using FFW and High Protein Products to Reduce Vulnerability in PLWHA" (IV. of Scope of Work dated July 17, 2007).

- **Deliverable 1:** Review of Nutritional Recommendations specific to PLWHA and activities in a sample of leading NGO and non-NGO programs in Rwanda.
- **Deliverable 2**: Case study of the current program that will include a fairly detailed review and description of the program based on current data sets (baseline surveys, routine M&E, etc.).
- **Deliverable 3:** Short list of recommendations for the Burkina program.
- **Deliverable 4:** Revised paper that summarizes the method adopted for the assignment and principal lessons learned.

[v] HIV/AIDS oriented activities have been implemented in Africare programs in Sierra Leone, Mozambique, Rwanda, Burkina Faso, Uganda, Tanzania, and Malawi.

[vi] In Rwanda Africare is also conducting Hearth/FARN to rehabilitate moderately malnourished children in combination with the HIV/AIDS interventions. In Burkina Faso Africare is focusing on improved agricultural methods and techniques, diversified income and enterprise activities, health, water and sanitation, Hearth/FARN, literacy, management, and entrepreneurial training courses. In both countries Africare collaborates with the governments through Technical Services (Hospitals Kigeme and Kaduha) and also with the local authorities in the District of Nyamagabe. They also collaborate with the District Committee for the Fight Against AIDS. Africare is invited to participate in workshops organized by the Technical Services of the government (e.g., Ministry of Health workshop) during which Africare presents on its activities under these projects. In Burkina Faso, Africare works with the district hospital by training health workers and members of PLWHA associations and works with the director at the provincial level for Social Action and National solidarity, which focuses on psycho-social support.

[vii] Furthermore, in Rwanda Africare offers medical insurance for beneficiaries of 1000 frw ($1.8) per person per year for the whole family. For example, for a family of five the insurance paid is 5000 frw ($9.2). Africare collaborated with health centers to perform a census of every beneficiary receiving insurance for comparison with the records from the health center. Africare only pays for the costs of beneficiaries who are not covered by other NGOs.

[viii] These pilot projects did not implement the FANTA recommended measurement method for change in body composition (see Annex B). Africare has used weight as a measure of change, while FANTA recommends using bioelectrical impedance analysis (BIA). Improving growth monitoring measurements by measuring changes in body weight (the sole strategy employed in Africare's intervention area) is less than optimal and can be misleading because weight gain or stabilization can occur in the presence of muscle wasting when feeding interventions increase body fat and water only (Piwoz and Preble 2000). However, the expense and technical requirements of FANTA's recommended methods may be prohibitive.

[ix] ACDI/VOCA is the lead agency in this consortium that is implementing a project using Title II resources to focus on improving agricultural productivity; Africare is responsible for the health and nutrition component related to HIV/AIDS.

[x] Figures as of September 2007.

[xi] The last Title II food security workshop was held in Niamey, Niger in Sept 2007. It consisted of the following two parts. Part I: "Good Tools and How to Use Them." Part II: "How to Program Food Aid: Monetization, Food for Work and Direct Distribution."

[xii] From a FANTA report in February 2007, based on the report of the May 2003 WHO technical consultation on nutrient requirements for PLWHA, which is available at:
http://www.who.int/nutrition/publications/Content_nutrient_requirements.pdf.