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Critical Resource Information Brief (CRIB) #2: Overview of FANTA and WFP Guide on Food Assistance Programming in the Context of HIV

Africare Health, Nutrition, and HIV/AIDS Working Group[i]

Objective: This Critical Resource Information Brief (CRIB)[ii] presents an overview of the content covered in the extensive FANTA AND WFP guide "Food Assistance Programming in the Context of HIV" (FANTA and WFP 2007). The guide itself is available for download in its entirety from the FANTA website (http://www.fantaproject.org/downloads/pdfs/Food_Assistance_Context_of_HIV_Oct_2007.pdf, CAUTION: large file size of 1,584MB). It is also downloadable in section (usually two chapters at a time) from the FANTA website, but due to the difficulty in downloading a number of smaller files or one large file in areas with slow connections speeds the Africare Health, Nutrition, and HIV/AIDS Working Group identified the need for a quick reference or overview of this important FANTA AND WFP guide. Therefore this CRIB was developed to provide that condensed overview of the contents of each chapter and to note some of the topics and issues that would be of particular interest to Africare. This is consider a need to increase field staff capacity to track impact of food assistance programming on HIV-affected populations as outlined under the Africare Institutional Capacity Building (ICB) grant.[iii]

Background: The FANTA AND WFP guide covers a broad range of issues relevant to food assistance in areas of high HIV prevalence, from information on potential donors of programs that integrate food assistance and HIV to monitoring and evaluation systems, from education to emergency response. Its practical utility value is high, which has led Africare to develop this CRIB on the guide, as well as two other CRIBs that specifically address just the potential indicators presented in the guide for food assistance programming in the context of HIV (Africare Health, Nutrition, and HIV/AIDS Working Group 2008, AFSR No. 25) and potential proxy indicators for identifying HIV-affected households (Africare Health, Nutrition, and HIV/AIDS Working Group 2008, AFSR No. 22) that are covered in chapter eight and chapter three of the guide, respectively. Since these two sets of possible indicators are addressed in the other two Africare CRIBs, they will not be presented here in this overview or quick reference.

This CRIB is one of a series of published and upcoming briefs and papers on lessons learned that are aimed at building capacity for food programming in the context of HIV/AIDS (Maslowsky et al. 2008, AFSR No. 11; Africare Health, Nutrition, and HIV/AIDS Working Group 2008, AFSR No. 20 [CRIB#1]; Africare Health, Nutrition, and HIV/AIDS Working Group 2008, AFSR No. 22 [CRIB#3]; and Badiel et al. 2008, AFSR No. 24; and Africare Health, Nutrition, and HIV/AIDS Working Group 2008, AFSR No 25 [CRIB#4]). Africare's attention to HIV follows the specific directive of the USAID strategic plan to target vulnerable groups (including those affected by HIV) in Title II programming (USAID 2005).

Critical Information:

The Introduction to the FANTA AND WFP guide outlines the aims of the document. The first aim is to establish links between HIV and food security, which it describes as bidirectional. This means that HIV affects food security (e.g., through redirection of assets and income to medical and funeral expenses, reduction in labor supply, increased nutritional needs of PLHIV) and food security affects HIV (e.g., through increased likelihood of transfer of HIV to the fetus with malnutrition of the pregnant PLHIV and

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increases in risky behavior of other household members due to increased poverty, which increases the chances of contracting the disease). The guide also aims to presents the key considerations and to offer some of the promising practices and tools for topics discussed in the 13 chapters, which are organized into three main parts (Conceptual and Institutional Framework, Program Design Steps, and Sector Specific Program Design Steps). The call for programs that link food security and HIV, implement strategies with an HIV lens (Loevinsohn and Gillespie [2003]), and share results and lessons learned with the wider development community is prominent and an area in which Africare can contribute.[iv] The FANTA and WFP guide specifically addresses two situations, HIV programs that incorporate food assistance (whether in areas of high food insecurity or areas where there are pockets of food insecurity) and food assistance programs that incorporate HIV activities in high HIV prevalence areas. Africare's Title II food security programs work both in areas of high HIV prevalence and in lower HIV prevalence areas with high incidence of food insecurity. Africare may need to apply a different strategy in these lower HIV prevalence areas..For example, Africare may want to consider the potential or likely impact of interventions (such as improving market access and road infrastructure) on HIV prevalence. An explicit focus on HIV education and awareness activities may prevent a rise in rates due to such development activities.

Chapter 1: Conceptual Framework

Topics Covered (per FANTA and WFP Table of Contents)
1.1 Basic Concepts of 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

Summary of FANTA and WFP Guidelines and Synthesis

- The urban and rural response may be different. In rural areas common household (HH) responses to HIV include selling assets, household members migrating to find work, and increases in child labor resulting in a decline in schooling.
- Gender is important because women are at greater risk to contracting HIV and are more vulnerable to poverty and food insecurity once they are living with HIV. Furthermore, women bare the additional burden of caring for others who are living with HIV.
- The impact of HIV on assets is far-reaching and long-term (affecting human, financial, natural, physical, and social capital).

The complexity of the impacts of HIV are the reason that the nature of the effects and responses are still in need of exploration using multidisciplinary approaches. FANTA and WFP warn that food assistance specifically should be used with caution so it is not applied: (1) when food is not the issue, (2) where it will create dependency, or (3) where it will disrupt market function.[v] For more information on the content of this chapter download the front matter and chapter one at http://www.fantaproject.org/downloads/pdfs/Food_Assistance_Context_of_HIV_sept_2007_part1.pdf.

Chapter 2: Policy and Program Environment

Topics Covered (per FANTA and WFP Guide Table of Contents)
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

Summary of FANTA and WFP Guidelines and Synthesis
There are two main approaches to integrating HIV and food assistance programming, food security programs that consider HIV-related issues (USAID Title II) and HIV programs that integrate food assistance (the U.S. President's Emergency Plan for AIDS Relief [PEPFAR]) (FANTA and WFP 2007:25). One of the challenges that applies to Africare's situation is that there is little overlap between priority countries for USAID's Title II activities and the main body funding the response to HIV (PEPFAR) and even less overlap between these and the countries in which Africare works (four countries—Table 1).

Table 1. Priority Countries in Africa for USAID, PEPFAR, and Africare.

African Country	PEPFAR Priority[vi]	USAID Title II Priority[vii]	Africare Countries (that are also priority for either USAID or PEPFAR and/or have high HIV prevalence)[viii]
Bostwana*	X		
Burkina Faso		X	X
Chad		X	X
Cote d'Ivoire	X		X
Ethiopia	X	X	X
Kenya	X		X
Lesotho			X*
Liberia		X	X
Madagascar		X	
Malawi		X	X
Mali		Phasing out	X
Mauritania		X	X
Mozambique	X	X	X*
Namibia	X		X*
Niger		X	X
Nigeria	X		X
Rwanda	X	Phasing out	X
Sierra Leone		X	X
South Africa	X		X*
Tanzania	X		X
Uganda	X	X	X
Zambia	X	X	X*
Zimbabwe			X*

*These represent countries with HIV prevalence rates over 15% in 2005 (UNAIDS and WHO 2007).
Note: These countries do not represent only countries for which funding is available for integrated HIV/food programming.

However, since the FANTA AND WFP guide was written, USAID and PEPFAR have come together to write a strategy paper on integration of Title II and PEPFAR activities (USAID FFP and PEPFAR 2007).

While the main aims of Title II food security programs are the same for food security programs to those affected by HIV, the way these are implemented must consider the unique and complex nature of food security in HIV-affected households (essentially looking at food security activities through an HIV lens as recommended by Loevinsohn and Gillespie (2003) and FANTA and WFP (2007). FFP lists nine expectations for food assistance to HIV-affected households (see FANTA and WFP [2007: 26] for complete list). Of those nine expectations, Africare is working on several of these including targeting food insecure HIV population (see Badiel et al. 2008, AFSR No. 24 for a review of the findings of food security status of households of PLHIV in Burkina Faso), development of appropriate indicators for documenting lessons learned (see Maslowsky et al. 2008, AFSR No. 11; Africare Health, Nutrition, and HIV/AIDS Working Group 2008, AFSR No. 20; and Africare Health, Nutrition, and HIV/AIDS Working Group 2008, AFSR No. 25).

Due to the complex nature of HIV and of the impacts of food assistance, much of the work funded and done within the realm of HIV and food assistance is through multi-donor, multi-agency collaboration. Chapter Two also presents a brief description of the major players for funding work on HIV and food assistance and their priorities (see Table 2). Aside from donors, this chapter also describes some of the important national and international bodies that exist to coordinate the response to HIV with the aim of increasing the positive impact of work in this field.

Table 2. Key Policy and Funding Bodies for Integrated HIV and Food Assistance Programming

Organization/ Agency	Focus of Organization or Agency/ Funding Opportunity	References
WFP	WFP has global MOUs with major NGOs (three different types of partners); WFP has incorporated HIV into all of this programs.	WFP 2002 and 2006
European Commission Food Security Framework	Supports global food security as well as many other development goals by targeting low income countries. HIV activities through Global Fund (below), WFP distribute food for them along with NGOs, but ONLY when deemed most appropriate to solving food insecurity issues in long-term	
PEPFAR	Priorities include: 1. ART 2. Prevention of HIV 3. Care to HIV-affected individuals and OVC As of 2006 food insecurity interventions supported (food aid limited), focus on nutrition education, monitoring and assessments, therapeutic feeding per WHO criteria only for clinical malnutrition, micronutrient supplementation if needed, replacement feeding and support, and linking HIV work to food assistance (e.g., Title II), food security and safety-net programs (PEPFAR food aid funding can only be used in line with 3 goals, WHO assessment criteria and guidelines, programs 1st seek food from other sources, clear exit & eligibility criteria and support address health, FS and livelihoods of PLHIV HHs.	PEPFAR 2006
Global Fund to Fight AIDS, TB, and Malaria	Prevention and treatment priorities. Limited food assistance, funds M&E, design, and needs assessment for Global Fund type projects.	
World Bank	National awareness, mulit-sectoral response, "exceptional and extraordinary methods for combating epidemic, improved M&E to capture lessons learned. Does not address food assistance for HIV programs.	
Humanitarian Aid Department of the European Commission	Responds to natural or man-made disasters. Often works in areas of high HIV prevalence[ix], although not "front-line" actor on HIV it will fund food and livelihood security interventions for OVC and caretakers if not otherwise available, and will incorporate HIV prevention, awareness, monitoring rates, mitigation of HIV in emergency settings, health, nutrition (as well as other areas relevant to disasters).	

*Table created from information provided in Chapter 2 of FANTA and WFP guide (2007).

FANTA and WFP recommend that programs in food security and HIV work through or with existing national and international HIV coordinating bodies and resources (e.g., Poverty Reduction Strategy Papers, National AIDS Commissions, UN Development Assistance Frameworks, Title II Consortium Mechanisms, and local government and PLHIV networks such as District and Village AIDS Committees and Home-Based Care).

One of the most critical needs identified in the FANTA and WFP guide is for food security and HIV programs to implement integrated programs and initiatives that incorporate both elements and publish the results and lessons learned so that the entire CS community can evolve their understanding of the dynamics at play between food security and HIV and move forward to more effectively design and target helping these sub-groups of the populations. For more information on the issues covered in this chapter download chapters two and three at http://www.fantaproject.org/downloads/pdfs/Food_Assistance_Context_of_HIV_sept_2007_part2.pdf.

Chapter 3: Vulnerability Assessments

Topics Covered (per FANTA and WFP Guide Table of Contents)
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
Annex 1. Standard Format for a Vulnerability Assessment Report

Summary of FANTA and WFP Guidelines and Synthesis
There are ultimately three main outcomes to a vulnerability assessment:

1. Data that identify the target groups (most vulnerable),
2. Information that aids in designing the most effective and appropriate interventions, and
3. Outcomes that are most desirable and that should be monitored.

Due to the stigma associated with HIV in many regions, the progressive nature of the disease, and the complexity of the impacts (to social, human, physical, natural, and financial capital) it is a challenge to have firm, transparent, and reliable data to use to incorporate HIV into vulnerability assessments. Establishing good indicators is one of the current needs. The lack of awareness of the link between food security and HIV is being tackled by the development community and can be further diminished with trainings for food security and HIV program staff (see guidelines and tools developed for building capacity of country staff on FANTA website including the National Kenya Guidelines for Nutrition and HIV [National AIDS and STI Control Program 2006], the Zambia Nutrition Guidelines for Care and Support of People Living with HIV/AIDS [National Food and Nutrition Commission 2004], and Zambia's associated HIV and Nutrition Wall Charts and Flip Charts [http://www.fantaproject.org/publications/zambia_counseling2006.shtml] , Rwanda's National Guidelines for Food and Nutrition Support and Care for People Living with HIV/AIDS in Rwanda [Rwanda Nutrition Working Group, Republic of Rwanda, Ministry of Health 2006], as well as FANTA's general guidance on HIV and nutrition, Recommendations for the Nutrient Requirements for People Living with HIV/AIDS [Food and Nutrition Technical Assistance 2007]).

FANTA outlines the need to consider demographic characteristics, livelihoods, and other household information, as well as how HIV affects nutrition, household resources and food security when conducting vulnerability assessments. Other elements to incorporate include:

- A multidisciplinary team for vulnerability assessment and project design;
- Training HIV team members on food security and livelihood issues (as well as training FS team members on HIV issues);
- Involving local people and especially PLHIV and HIV-affected households;
- Identifying the most vulnerable people and communities (and developing different responses for different types of affected households, as needed—i.e., don't assume all HIV-affected households are the same);
- Mapping priorities (such as food availability, access, utilization, livelihoods, and nutrition) and how these interact with HIV (i.e., viewing project activities through HIV lens); and
- Regularly updating databases with relevant information (because the food security situation in HIV households is complex and dynamic).

Mainly, FANTA recommends examining the impact of HIV on food availability (agriculture), on access (income, assets) and utilization (knowledge, resources, time for feeding, care, and health seeking behavior, malabsorption, and infections of PLHIV). A list of possible HIV-related food security risk and vulnerability indicators is presented (FANTA and WFP 2007:48), many of which focus specifically on the established negative impacts of HIV on households. FANTA also provides a list of proxy indicators for identifying HIV-affected households (FANTA and WFP 2007:49). These indicators are addressed in Africare's soon to be published Critical Resource Information Brief (Africare Health, Nutrition, and HIV/AIDS Working 2008, AFSR No. 22). This section goes on to present some of the known or anticipated household coping

strategies (with a focus on coping strategies with negative long-term consequences, which are the households in most need of assistance), some community level indicators of risk and vulnerability, and integration of gender analysis (a list of key questions are presented in FANTA and WFP [2007: 52]) in the vulnerability assessment (based on the fact that women are more vulnerable to HIV and the negative impacts of HIV). Two of the main recommendations for gathering accurate and informative data are to consider the dynamic nature of HIV (e.g., by conducting vulnerability assessments regularly) and to incorporate participatory tools in areas of high stigma associated with HIV.

Step 1: Secondary Data Collection

- Context data—including social, political, demographic, agriculture, nutrition, health indicators, education, land tenure, the status and situation of orphans and vulnerable children, and morbidity and HIV rates.
- Community data—including livelihood systems, coping strategies, safety nets, health services, and labor networks.
- Household data—including information on human, financial, natural, physical, social and political capital, as well as livelihood strategies, diet, and health seeking behaviors.
- Intra-household data—including gender dynamics, age, dependency ratios, food distribution among household members, feeding practices, and caretaking roles.
- Relevant stakeholder data—including programs and activities of non-governmental organizations (NGOs), community-based organizations (CBOs), government agencies that touch on issues relevant to food security and HIV.

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

- Data that will be collected in this step will depend on data that were available from other sources (Step 1) (see list of sources for relevant primary and secondary data in FANTA and WFP 2007: 60).
- Gather information to complete picture on risks and coping strategies (HIV and other), income sources, food and non-food expenditures, assets and ownership (which relates to gender and age differential access), health and education, social networks, home and community based care systems, and standard food security indicators (see list of data topics related to food insecurity in FANTA AND WFP 2007: 59).
- Include a nutritional assessment that is appropriate in the context of HIV. Indicators related to nutritional status of children under five years are commonly used for nutritional assessments in food security vulnerability assessments; however, since HIV negatively impacts the nutrition of adults and high prevalence of HIV results in fewer children under five due to its impact on child-bearing women, this is not sufficient. In addition to standard indicators, include nutritional assessment of adults in HIV care programs and chronically ill adults (especially important in areas of high stigma).
- Consider ethical issues of gathering information related to the impacts of HIV by gaining permission and/or informed consent, coordinating and engaging community stakeholders, approaching interviews with sensitivity, and requesting participation from PLHIV and households affected by HIV.

Step 3: Analysis of Data

- Situation analysis—provides the initial understanding of the food insecurity situation and a description of the most vulnerable groups based on the secondary information provided in Step 1.
- Level I descriptive analysis—provides a description of target populations using both secondary and primary data, focusing on how behaviors increase risk of individuals being exposed to HIV as well as how HIV status affects food insecurity. Look at sources of risks, factors underlying nutritional status, coping strategies, social safety nets, livelihood outcomes, and other food security issues.
- Level II dynamic analysis—addresses the dynamic (i.e. changing) nature of HIV and its impacts by exploring previous, current, and projected characteristics that change vulnerability and exposure to HIV and food insecurity risks (e.g., examine household dissolution, community support networks that deteriorate with higher prevalence, and available interventions and

treatments). Here FANTA and WFP identify room to explore positive deviance cases that can be the basis for intervention designs (i.e., households and communities affected by HIV that have coped with this in a positive way). Africare's related experience with a positive deviance approach includes a highly successful Hearth program for rehabilitating malnourished children (Maslowsky et al. 2008).

- Always incorporate issues relevant to gender and age in this and other analyses.

Step 4: Vulnerability Assessment Report

- Prior to and during write-up of the vulnerability assessment report, team members should share and discuss findings and implications of information collected. FANTA and WFP (2007:69-70) provide an example of a table of contents for a vulnerability assessment report in the guidance.

Step 5: Program Design

- Ultimately the vulnerability assessment findings should inform and guide project design by providing information on target households and communities, the types of interventions that are most appropriate given the situation, and outcomes that should be monitored during the project.

The section on vulnerability assessment considering HIV in the FANTA and WFP guide is specifically aimed at high prevalence areas. While some of Africare's programs are conducted in high HIV prevalence areas, others are conducted in countries with lower rates. This does not mean HIV is not affecting the food security of households in these lower rate areas; however it may mean that Africare needs to focus some of its energy on establishing the context of the impacts of HIV in these areas and whether there are different concerns to address (given this and in the context of the FANTA and WFP guide it is particularly important for Africare to examine the potential for increased risk of exposure to HIV and associated impacts on food insecurity due to high levels of food insecurity and the negative coping strategies that may be used). The guidance notes that there will also be areas of high HIV prevalence, but only pockets of food insecurity and urges organizations to ensure that the households that receive food assistance are indeed food insecure.

Promising Practices

FANTA AND WFP present three tools that have been developed for different purposes/contexts in the final section of this chapter. The first is the Community and Household Surveillance (CHS) system developed by WFP and C-SAFE that is used in rural areas for periodic monitoring of the HIV situation (speaking to the dynamic nature of the disease and its impacts) in Zambia, Zimbabwe, Lesotho, Malawi, Swaziland, and Mozambique (FANTA and WFP 2007: 66). The second tool is the Food for the Hungry (FH) community vulnerability assessment which examines how communities have responded to HIV (FANTA and WFP 2007: 67). The third tool was developed by TANGO and WFP to assess vulnerability in urban areas (FANTA and WFP 2007: 68). For more information on the content of this chapter download chapters two and three at http://www.fantaproject.org/downloads/pdfs/Food_Assistance_Context_of_HIV_sept_2007_part2.pdf.

Chapter 4: Adaptive and Integrated Programming

Topics Covered (per FANTA and WFP Guide Table of Contents)

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

Summary of FANTA and WFP Guidelines and Synthesis

Given the focus of the guidance on two main program types (food security programs in areas of high HIV prevalence and HIV programs in areas of high or interspersed areas of high food insecurity) this chapter present two main considerations for adapting these programs. The first consideration is to examine constraints that households and communities affected by HIV may face in participating and benefiting from

traditional food security interventions. The second consideration is to explore how HIV prevention, treatment, and care and support programs can enhance their aims by incorporated or collaborating with food assistance programs and activities. Ultimately, both types of programs can benefit from mutual consideration and collaboration.

Food security programs (targeting food insecure households) should:

1. Ensure that households affected by HIV can participation and benefit from food security intervention activities by adapting program activities where necessary (this involves examining standard activities through an HIV lens—see FANTA and WFP [2007: 78] for list of questions to use and Annex I for CRS HIV/AIDS Analysis Tool as an example) and
2. Collaborate with HIV prevention, treatment, and care and support activities and initiatives to ensure these households receive this type of assistance as well. This may mean incorporating such activities into the food security program or collaborating with partners in the region that do this type of HIV programming through a referral system.

Food security programs should NOT:

3. Redirect all program activities toward HIV-affected households alone.

HIV programs (targeting HIV-affected households/individuals) should:

1. Consider whether incorporating food assistance to HIV-affected individuals and households on a short-term basis will improve use of the HIV services, improve effectiveness of the services (improve nutrition), or improve participation through food transfer incentives;
2. Integrate appropriate food security activities into HIV programming (e.g., growth monitoring and promotion for HIV-positive mothers and their infants with referrals between PMTCT and GMP activities or linking agricultural extension services to OVC support services); and
3. Explore ways to collaborate with organization and agencies doing food programming.

Due to the dynamic nature of HIV, households will not always need the exact same care over time. It is important to understand what stage they are in and what the appropriate interventions are for that specific stage and for which individuals or household members. Furthermore, since the impacts of HIV are far-reaching (e.g., social, physical, and financial) and occur at the individual, household, and community levels it is important to use a holistic and multisectoral approach.

The challenges to developing integrated programming include lack of coordination and collaboration, inadequate understanding of links between HIV and food security, compartmentalized funding mechanisms, difficulty attributing results to one project or another, short term focus of interventions limits investment in long-term sustainable impacts, and the urgency of HIV and food assistance programs. FANTA AND WFP present a number of considerations for facilitating integrated programs including adoption of assessment-based strategies that gather information relevant to both food security and HIV, understanding the context of other current or planned activities in HIV and food security (e.g., government, international and national NGOs and CBO), making women a priority due to their increased vulnerability and susceptibility to HIV infection and its impacts, and building integration between the two programming objectives into staff work plans (see FANTA AND WFP 2007:84-86 for a complete list of consideration for integration designs). For more details on the information provided in this chapter download chapters four and five at http://www.fantaproject.org/downloads/pdfs/Food_Assistance_Context_of_HIV_Oct_2007_part3.pdf.

Chapter 5: Targeting

Topics Covered (per FANTA and WFP Guide Table of Contents)
5.1 Targeting Food Assistance in Areas of High HIV Prevalence
5.2 Adapting Food Assistance Targeting Approaches and Tools
5.3 Promising Practices
Annex 1: WFP Zambia Targeting Tool: Food Security Screening Form
Annex 2: C-SAFE Zambia Targeting Tool: Household Food Security Appraisal Form
Annex 3: PCI Zambia Targeting Tool: Initial Home Visit, Monitoring Visit, and Reassessment Food Security Screening Forms

Summary of FANTA and WFP Guidelines and Synthesis

Targeting for food security programs in areas of high HIV prevalence: Normally targeted beneficiaries are selected through a vulnerability assessment to identify the most vulnerable areas and groups. In areas of HIV prevalence this vulnerability assessment should collect data on HIV rates, impacts, and causes in as well as other indicators that descript the causes and impacts of poverty (it is very important not to isolate HIV-affected households for food aid because in areas of widespread food insecurity this will create resentment and increase stigma). It is also important to remember that areas that are highly food insecure do not necessarily have high HIV prevalence and areas of high HIV prevalence are not necessarily highly food insecure. This is true at each of the levels relevant to targeting (geographic region, community, household and individual). A variety of indicators should be employed to establish the communities, households, and individuals that should be targeted given the dynamic and complex relationship between HIV and food security (e.g., often proxy indicators need to be included that identify PLHIV, households caring for OVCs, and households with a recent adult death due to AIDS and projects need to understand the food security status and different constraints for these households as well). In areas of high stigma associated with HIV, proxy indicators are often used (such as chronically ill adult); however, given the likelihood that proxy indicators may identify households that are not affected by HIV in particular and if the aim is to identify HIV-affected households, a number of indicators should be used at the same time (see Africare Health, Nutrition, and HIV/AIDS Working Group 2008, AFSR No. 22 for Africare's current focus on proxy indicators for identifying PLHIV based on FANTA's recommendations; proxy indicators are also addressed in FANTA and WFP 2007: Chapter 3). It is helpful to engage community members and stakeholders in the assessment process to gain a complete understanding, reduce stigma, and encourage participation in project activities (see FANTA and WFP 2007:93-94 for examples of how to engage the community).

Targeting for HIV programs: The primary aim for food assistance in areas of high HIV prevalence is to target the most food insecure of these region; however WFP has a secondary aim of providing food assistance to HIV programs in less food insecure regions based on the anticipation that high HIV rates will lead to increased food insecurity. In areas of high food insecurity it is probably that HIV-affected households will also be food insecure, whereas in areas of less food insecurity the selection criteria for food assistance is more challenging. The selection information can be gathered in clinical settings (where HIV-affected individuals receive care and treatment or through community and home-based care services and can be based on weight loss or wasting since these measurements are probably being taken already. In some areas stigma is so severe or such clinical services are not widespread enough to provide the data for targeting. In these cases socioeconomic data can be used. Indicators that describe assets, employment, income, food consumption, diet, level of production and levels of family assistance can be compared to food needs of the individual or household (including increased nutritional needs of PLHIV). Finally, socio-demographic criteria can be used such as household size, gender and age of household members or the head of household, presence of orphans and vulnerable children, dependency ratio and recent death of an adult (essentially proxy indicators for HIV and food security status). Africare has explored links between their food security measure MAHFP and some of these socio-demographic characteristics for households of PLHIV (Badiel et al. 2008, AFSR No. 24).

Regardless of which type of program is offering/facilitating food assistance to HIV-affected households the types of food and appropriate amounts will depend on the stage of the HIV-households and the purpose of the intervention of food assistance (e.g., incentive to participate in HIV care services compared to aim to decrease malnutrition and wasting in later stages of HIV).

Dealing with the stigma of HIV: Stigma associated with HIV makes it difficult for food assistance programs to consider the special needs of HIV-affected food insecure households in their activities. The stigma also makes it difficult for HIV programs to reach all households and individuals affected by HIV. Therefore, both types of programs benefit from putting efforts into reducing the stigma associated with HIV. While the level of stigma varies with regions, some measures that have reduced stigma include awareness-raising, participation of individuals with HIV speaking out openly against stigma and about the disease, and providing home based care and ART services to PLHIV and their households (see Kidd and Clay [2003] guidance on addressing stigma). On the other hand, food security projects must be careful not to increase stigma by focusing their intervention efforts on HIV-affected households only, while other food

insecure households are unassisted. In addition to working towards decreasing stigma is it very important to "do any harm" by identifying households or individuals with HIV to the community either directly or indirectly (e.g., in some areas the proxy indicator of chronic illness is already known by the community members as in indicator of HIV, therefore sharing the results of this measure by making it known that households with chronically ill individuals will be participating in a particular activity may put those households at risk for isolation due to stigma).

Dealing with gender issues in the context of HIV: As previously noted women are more vulnerable to infection with HIV and to the negative impacts of HIV on household livelihoods, assets, and food security. In addition, since women are often the primary caretakers and preparers of food they play a large role in caring for PLHIV and in understanding food security of the household. See the WFP guide "Getting Started: HIV/AIDS and Gender in WFP Programmes at www.wfp.org/food_aid/doc/GETTING_GENDER7.pdf for more information on gender and HIV.

Promising Practices

- Using a common framework for establishing vulnerability (a common definition) will facilitate targeting.
- Standardizing criteria for inclusion from region to region (with flexibility where needed and acceptable) will avoid confusion, competition, and will improve quality of information gathered and comparative analysis conducted.
- Since proxy indicators are not always accurate in all settings, conducting field-level verification of information gathered on the vulnerability status of households will improve project targeting.
- Linking health referral systems with home-based care groups and networks allows different community programs and intervention workers to share knowledge and more completely cover the needs of the community.
- "Do no harm" principles should be upheld to eliminate discrimination, impartiality, and establish equality.

For more information on the topics covered in this chapter download chapters four and five at http://www.fantaproject.org/downloads/pdfs/Food_Assistance_Context_of_HIV_Oct_2007_part3.pdf.

Chapter 6: Ration Design

Topics Cover (per FANTA and WFP Guide Table of Contents)
6.1 Challenges and Consideration 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
Annex 1: Additional Resources for Ration Design

Summary of FANTA and WFP Guidelines and Synthesis
Ration design elements in an HIV context are similar to typical food assistance ration design; however there are three main ways HIV affects ration design: (1) generally through objectives of the use of food (e.g., as incentive to go to HIV treatment facilities), (2) by changing the types of commodities that are appropriate (due to the different nutritional needs of PLHIV), and (3) through differences in ration sizes needed (due to increases in energy needs). Since non-emergency food assistance (whether in the context of HIV or not) is suppose to supplement household food these rations are never nutritionally or calorically complete. Furthermore, given the constraints on funding and food availability, decisions on rations sizes may be difficult since they may not cover all the needs, meaning programs must decide between provide complete supplementation for fewer households or inadequate supplementation for more households. These decisions are influenced by a number of considerations including:

- Level of food insecurity;
- The objectives of food assistance (which in high HIV prevalence areas or in HIV-affected households may be different from typical food assistance objectives);
- Lack of an easy-reference universal "HIV ration";
- The type of commodities that are most appropriate given side-effects, and constraints on caregivers' time (many HIV-affected households suffer from sever labor shortages);

- Nutrient recommendations for PLHIV (who need to consume substantially more calories and need to eat a balanced and varied diet to protect against micronutrient deficiencies—i.e., not only starchy stables);
- Food distribution (transportation);
- Ration sharing (it is common for individuals to share their rations with other members of the household—decreasing the benefit of the ration to the one individual living with HIV); and
- Behavior change communication (education on nutrition and symptom management, side effects and food-drug interactions may be necessary).

Similarly the steps of ration design in the context of HIV are like those of typical food assistant programs, but the outcomes are often different. FANTA and WFP present eight ration design steps that are different in the context of HIV from typical food assistance programming. These include the following.

1. Vulnerability assessment data review (exploring risks faced by beneficiaries, gender and age considerations, dependency ratios, seasonal patterns of malnutrition, food stocks and storage, months of self-provisioning [MAHFP in Africare's case], nutritional status of children under five AND in adults, consumption patterns and dietary diversity [such as HDDS], food habits, and food preparation practices [e.g., frequency of meals, sanitation]).
2. Determine program objectives and ration's role (e.g., maintain[x] nutritional well-being of PLHIV—food ration serving role of directly improving nutrition, as well as providing incentive for attendance at BCC and nutritional counseling sessions to receive ration or enhancing livelihoods of older OVCs through training for which food rations provide incentive to attend and cover opportunity costs of time spent in training).
3. Consider appropriateness of commodities in HIV context (consider foods that requires less energy and time to process, such as milled and fortified cereals; can be cooked easily and quickly, such as corn soy blend and wheat soy blend or ready-to-use foods; that taste good and are easy to eat and don't aggravate symptoms of PLHIV; that are fortified with micronutrients; that have been proven to be acceptable to beneficiaries, and [when food is to be used as incentive] select foods that are of appropriate value in local markets).
4. Determine the ration's size (for PLHIV this step should consider the increased energy needs of PLHIV,[xi] which is based on age and stage of the disease and size of the household [since rations are often shared and in areas with high HIV prevalence and households typically have more dependents]).
5. Determine the ration's duration (there is no standard duration, things to consider are the different impacts and duration of the shock that HIV presents to food security and longer-term impact to community and household resiliency—see FANTA and WFP [2007: 129] for examples of durations and criteria from other food assistance programs).
6. Design the ration (like other ration designs consider objectives, target population characteristics, and need, as well as program budget and resources).
7. Monitor the ration's use (e.g., how it is used, acceptability, beneficiary satisfaction, intra-household distribution and sharing).
8. Plan the exit strategy (in the case of food assistance in areas with high HIV prevalence this is challenging and should be facilitated by other program strategies to improve the capacity of households and communities to provide sufficient food for themselves, including building safety net systems, strengthened food production systems, BCC, food storage, and income generation).

Finally, there are several special commodities that may be relevant to designing rations in the context of HIV, including:

- Ready-to-Use Therapeutic Food (RUTF), (developed for nutritional rehabilitation of malnourished individuals, nutrient-dense and no need for preparation [although expensive, it is being tested for effectiveness with PLHIV in Malawi]);
- Breastmilk Substitutes (WFP does not provide infant formula because of a lack of acceptable, feasible, affordable, sustainable, and safe conditions for replacement feeding [although some of WFP's partners do provide formula]).
- Specialized food products (which are foods that are enriched or fortified and easy to prepare or cook, such as CSB and WSB).

For more information on the topics covered in this chapter download chapters six and seven at http://www.fantaproject.org/downloads/pdfs/Food_Assistance_Context_of_HIV_Oct_2007_part4.pdf.

Chapter 7: Implementation Strategies

Topics Covered (per FANTA and WFP Guide Table of Contents)
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
Annex 1: WFP Capacity Analysis Match

Summary of FANTA and WFP Guidance and Synthesis
Encouraging participation by beneficiary communities and individuals (including PLHIV and households affected by HIV) is important for food assistance and other programs that aim to increase resilience of the most vulnerable groups. For PLHIV (and other vulnerable groups) it is necessary to understand their particular constraints to food security. Their involvement will assist in decreasing the stigma and in normalizing discussion of HIV in communities. Also important is the realization and use of the community-based and grassroots responses to HIV and its impacts. Communities can participate in situation, stakeholder and food needs assessments; targeting; activity selection; implementation; M&E; and sustainability and exit strategy planning. Along with encouraging participation of PLHIV and their families it is also important to balance this with sensitivity to stigma and confidentiality.[xii]

Food assistance programs need to identify and collaborate with other organizations and agencies that are working in food security and HIV in the intervention areas or with other programs from within their own organization. Food assistance will achieve much better results if it is implemented in combination with other program activities that address the specific constraints to food security for individuals, households, and communities. When partnering with other organizations it is important to understand each of the organizations strengths (see FANTA AND WFP [2007: 156] for the WFP Capacity Analysis Match Tool). One effective mechanism for partnering between different development activities is referral systems (e.g., between HIV services [VCT facilities, ARV programs, TB programs, PMTCT programs, OVC programs, and HBC programs]; agriculture extension services and food assistance programs; youth associations and clubs; women's groups; traditional healers; water and sanitation services; antenatal clinics, and Hearth and growth monitoring and promotion services).[xiii]

The development community still has a lot to learn regarding effective strategies for scaling up successful programs that mitigation the negative impacts of HIV. The programs that have been scaled up effectively have reported a number of key consideration including, building bridges between partners using formal arrangements if necessary and careful design, decentralized operation through participatory approaches, building management capacity, ensuring transparency, and encouraging follow-up through M&E systems. Finally, before the project can be scaled up, the local community in which it was originally successful must take the lead on the local interventions.

The sustainability (and successful exit) of program-initiated activities and benefits requires local participation and capacity. The exit strategy should be incorporated into the design of the project from the beginning. A phase out or phase over may take longer in areas of high HIV prevalence due to the devastating impacts of HIV on households and communities. FANTA and WFP present a number of issues to consider in the context of HIV for exit strategies, including (but not limited to), potential for increasing numbers of chronically ill household members, potential for increasing numbers of orphan and elderly and singled headed households, decline in government services in area, increased poverty and malnutrition and food insecurity, increased nutritional requirements of PLHIV, decreased transfer of knowledge and skills from adults to children, diminished household labor supplies, and high staff turnover in NGOs, CBO, and

government offices.[xiv] For more information on the topics in this chapter download chapters six and seven at http://www.fantaproject.org/downloads/pdfs/Food_Assistance_Context_of_HIV_Oct_2007_part4.pdf.

Chapter 8: Monitoring and Evaluation

Topics Covered (per FANTA and WFP Guide Table of Contents)
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
Annex 1: Food Access Indicators
Annex 2: ECOG (Zubrod) Scale
Annex 3: WHO Disease Stages of HIV/AIDS
Annex 4: MOS-QOL Questionnaire for HIV-Infected Individuals

Summary of FANTA and WFP Guidance and Synthesis
There are a number of factors that affect the M&E system of food assistance programs in context of high HIV prevalence, including:

- Differing objectives (e.g., maintain nutrition rather than improve nutrition of PLHIV and use of food as an incentive to encourage treatment seeking or to mitigate side effects of ARVs);
- Stigma and discrimination make it difficult to reach HIV-affected households;
- Greater variation among beneficiaries due to more severe constraints to food security;
- Lack of documentation reporting on outcomes and impacts of food assistance on PLHIV;
- Need for greater interaction and reliance on health services (for data that cannot be obtained due to stigma and need for confidentiality);
- Need for capacity building of M&E and partners staff regarding issues relevant to HIV; and
- Need to pay attention to contextual issues (e.g., migration, gender, and civil conflict).

Many of the core elements for an M&E system in the context of HIV are the same as for a non-HIV context. However, some adjustment must be made to the five components of the system (i.e., information needs, indicators, targets, data collection and analysis, and uses of information). Issues of information needs are categorized by FANTA and WFP into two types: information that reports on program activity progress (measured by what Africare and many other CSs refer to as monitoring indicators) and information that reports on changes in beneficiaries (measured by what Africare and many CSs refer to as impact indicators).

The second component is selecting appropriate indicators. FANTA's framework for indicators for M&E systems include five categories of indicators. Generally, input, process, and output indicators are similar to Africare's concept of monitoring indicators and outcome and impact indicators are similar to Africare's concept of impact indicators.[xv] Although output and outcome indicators can be classified as either monitoring or impact indicators in different situation. In the specific context of HIV indicators are still being developed and field tested.[xvi] The types of outcome and impact indicators that can be selected from include anthropometric indicators (such as weight for age and mid-upper arm circumference measures), adherence/default, program uptake, food access, illness/disease status (including the WHO HIV Stage Scale available in Annex 3 of FANTA AND WFP 2007), functioning (e.g., ability to perform daily activities), and quality of life indicators (tools include CDC Health-Related Quality of Life 14-item Measure and the MOS-HIV scale in Annex 4 of FANTA AND WFP 2007).

In areas of high HIV prevalence, the targets may need to be adjusted from those of typical food assistance programs due to the more severe constraints to food security of HIV-affected households and communities. For example, it may be more appropriate in an HIV context to maintain rather than build food security levels, nutritional status, or assets. Since there has been only a short history for establishing solid and reliable indicators or realistic targets to date, it is important to consult beneficiaries about their expectations to gain an understanding about what is realistic. Use of baseline survey data, historic trends that pre-date project interventions, opinions and experience from local and regional HIV experts, and information from other accomplished or comparable programs will also aid in establishing realistic targets. Africare is in the

process of finalizing and field testing (from FANTA's recommended lists in Castleman et al. [2008] and FANTA and WFP [2007] a list of indicators to measure the impact of nutrition, education and counseling and the impact of food assistance programming on HIV-affected households (Africare Health, Nutrition, and HIV/AIDS Working Group 2008, AFSR No. 20 and 2008, AFSR No. 25). Furthermore, they have modified the MAHFP indicator to consider and isolate food aid in order to gain a better understanding of food insecurity and the role of food assistance for all households, including those impacted by HIV (Konda et al. 2008, AFSR No. 17) and will be field testing a selection of proxy indicators to identify HIV-affected households from lists provided by FANTA and WFP (2007: 49) as well as other organizations and researchers (Africare Health, Nutrition, and HIV/AIDS Working Group 2008, AFSR No. 22).

Data collection methods may need to be adapted in an HIV-context due to possible stigma and confidentiality issues. For example, if it is not possible or ethical to survey HIV-affected households or individuals directly, data may need to be gathered from healthcare centers or home-based care providers. Furthermore, it is important to realize that the situation of the PLHIV and their households may change dramatically during the course of the project. When building the cooperative relationship with health care providers needed to gather data in an HIV context it is important to maintain confidentiality of the beneficiaries while sharing information and data between FS programs and healthcare and education providers. It will take additional time to build this collaborative partnership and gather information and projects should anticipate this in project design. Other considerations in the context of HIV for data collection include the need to disaggregate data based on significant characteristics including, how the household has been impacted by HIV (e.g., adult death due to AIDS-related disease, presence and ages of OVCs, households of PLHIV) and gender and age of household heads.

Information should be used to assist in planning, implementation, and adjusting project activities, reporting to management and donors, and to support advocacy and share lessons learned about effective and ineffective interventions with donors, governments, organizations, and other stakeholders.

There are number of challenges for M&E that are unique to the context of HIV, including:

- Standard anthropometric measures (such as nutritional status of children under five) may not accurately reflect the general population's nutritional status since HIV mainly infects adults;
- Households may use food assistance in unintended ways (e.g., sharing it with other household members or selling it);
- The relationship between health outcome, food security, and HIV is complex and influenced by outside factors (e.g., civil conflict) making it difficult to see direct causes of project interventions,
- Proxy indicators must be interpreted carefully, accounting for the context of HIV;
- Standard sampling methods and units may be less appropriate in HIV-affected areas (e.g., the household as a basic unit ignores changing nature of households through dissolution and merging and the existence of many OVC living on the streets);
- Dietary recalls are not always reliable;
- Many of the tools being used are newly applied to the context of HIV and have not been tested and proven appropriate; and
- Staff may need additional training in the use of M&E systems and tools in the context of HIV.

For more information on the topics covered in this chapter and to download chapters eight and nine at http://www.fantaproject.org/downloads/pdfs/Food_Assistance_Context_of_HIV_sept_2007_part5.pdf.

Chapter 9: Operational Modalities

Topics Covered (per FANTA and WFP Guide Table of Contents)
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

Summary of FANTA and WFP Guidelines and Synthesis
Budget challenge for food assistance in HIV-affected areas include:

- Need for funding non-food activities to improve outcomes;
- Coordinating HIV programs with food assistance, food security and nutrition programs which are often separate;
- Increasing demand is for food assistance for ART recipients;
- Long lead times for commodities;
- Need for cash reserves for times when there are commodity pipelines breakdown;
- Specialized food needs of PLHIV are difficult to procure due costs and access;
- Higher costs of operations and logistics when distributing to HIV-affected beneficiaries due to need for higher technical training of staff, that in rural areas HIV-affected households are dispersed widely, and the recommended holistic approach of providing food and non-food assistance can increase costs);
- Higher costs of vulnerability and needs assessments, program appraisals, technical reviews, and capacity building activities; and
- Need to prioritize limited resource based on either distributing fewer commodities to more households or complete resources to fewer households given financial constraints.

How to respond to potentially increased costs of HIV food assistance programming:

- Mainstream HIV food support with ongoing food security activities (share office space, staff, and resources),
- Involve CBOs and PLHIV in design and implementation,
- Coordinate with other agencies and NGOs (typically Ministry of Agriculture and Ministry of Health and Population budgets cover food assistance and HIV programming, respectively),
- Apply for complimentary funding, and
- Establish central food distribution sites.

Commodity pipeline management issues include:

- Potential for breaks in availability of commodities, which can be mitigated by storing food and borrowing or purchasing from food assistance partners (projects will have to make decisions about priorities when shortages occur based on accurate data, stakeholder input and project objectives),
- Distribution sites (consider stigma in region, beneficiaries/targeted population in accessing rations versus costs of making it easier to access, and working with partners) and
- Various methods of food distribution (options include through HBO or health facilities, at the community level by local NGOs and CBOs and take home rations versus on site feeding).

Timing should consider the needs of beneficiaries and the mechanism through which commodities are delivered and accountability and transparency (which can be dealt with through posting of a chart that indicates the amount of food to be distributed to each type of beneficiary). In areas of conflict and displacement, the guidelines established by WFP and United Nations High Commissioner for Refugees (UNHCR) should be incorporated to avoid abuse and inappropriate use of food rations. Food ration distribution sites can also serve as HIV awareness education sites.

It is important (particularly in the context of working in high HIV prevalence areas) to create the type of work environment where HIV awareness is mainstream and openly discussed and understood, which

includes developing workplace HIV policies for staff. These policies include a transparency HIV policy (that outlines worker rights and responsibilities, a statement of agency's commitment regarding HIV, and confidentiality and non-discriminatory practices for PLHIV[xvii]), an assessment of HIV risk factors and opportunities for prevention, identifying the focal point and building partnerships and stakeholder groups and raising HIV awareness with staff and partners. For more information on the topics covered in this chapter download chapters eight and nine at http://www.fantaproject.org/downloads/pdfs/Food_Assistance_Context_of_HIV_sept_2007_part5.pdf.

Chapter 10: Health and Nutrition: Sector-Specific Program Design Considerations

Topics Covered (per FANTA and WFP Guide Table of Contents)
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
Annex 1: Additional Resources on Health and Nutrition
Annex 2: AMPATH Tool for Determining PLHIV Eligibility for Food

Summary of FANTA and WFP Guidance and Synthesis
Since there are two types of projects (food assistance and HIV) that may be incorporating programs somewhat outside their expertise (HIV and food assistance, respectively) FANTA AND WFP provided guidance in this chapter on what the most appropriate interventions are in each of these two areas in order to assist programs that are not necessarily accustomed to such programming.[xviii]

Typically food aid programs implement the following health and nutrition activities in high HIV prevalence contexts:

- Supplementary feeding,
- Therapeutic feeding,
- Growth monitoring and promotion,
- Nutritional assessment,
- BCC (including Hearth and other positive deviance approaches), and
- Promotion of home gardening and other similar activities.

All of these can include the elements that are vital to reach HIV-affected individuals. There are a number of recommended changes necessary for food assistance programs in high HIV prevalence areas. Targeting HIV-affected individual may require more careful consideration since they may not be able to participation in typical food security health and nutrition activities. For example, orphan household heads may not bring young children to participate in growth monitoring and promotion or Hearth. Ration sizes may need to be different for HIV-affected household that may have more dependent or higher nutritional needs (and deficits). Children with HIV take longer to recover from malnutrition so the duration of food assistance may be to be adjusted. Distribution systems of food may need to be altered for HIV-affected households to account for the need for decreased time to travel to distribution sites for households with labor shortages. Health and nutrition counseling will be differ for PLHIV and should follow FANTA guidelines.[xix] Since HIV-affected households are frequently headed by children or elderly, targeting approaches and messages may need to different to reach these individuals. Project staff should be trained on issues relevant in HIV context. Food assistance programs should also focus on establishing referral systems to HIV care services, promoting HIV awareness and education, and creating an HIV committee and action plan.

HIV programs need to modify some of their typical activities to include food and nutrition intervention for HIV-affected households. Food can improve side-effects of HIV treatment, improve health outcomes for PLHIV, as well as provide incentives for PLHIV to participate in HIV programming. Typical HIV programming activities that can incorporate food programming include:

- Prevention, treatment, care, and support;
- Preventing mother-to-child transmission (PMTCT);
- Antiretroviral therapy (ART);

- Tuberculosis treatment (directly observed treatment, short-course) (TB-DOTS);
- Palliative care (including HBC); and
- Care and support for OVCs.

While all of these programs may benefit (in terms of improving adoption of messages and improving treatment outcomes) at times from food assistance, the following are several of the considerations to keep in mind when designing an integrated HIV and food assistance program.

- Modified needs assessments will need to be done to ensure appropriate intervention is used (including that food assistance should be received by those who are food insecure).
- Having clear eligibility and exit criteria will ensure that the people targeted and most in need will receive food assistance and having transparent criteria will allow people in the community to understand when and why they do or do not receive food assistance.
- Training staff and adapting referral systems for the addition of integrated programming with food assistance will result in the two elements working smoothly together and providing mutual benefit.
- Monitoring consumption of the food rations will illuminate whether household members are sharing rations intended for individuals and this will allow programs to adapt their rations and education to better help those targeted.
- It is important to avoid stigmatizing beneficiaries by making it obvious by providing food rations that they are HIV positive. Programs need to consider ways to distribute food that will maintain confidentiality of beneficiaries' HIV status (covered in Chapter 9).
- There are certain drug-food interactions that need to be understood by staff and by beneficiaries so they do not reduce the therapy's effectiveness or result in negative side effects.
- HIV data reporting systems may need to be adapted to report on and track food assistance programming.

Some additional challenges for incorporating food assistance into HIV programming include, establishing food security status of potential beneficiaries, determining HIV status through proxy indicators, training of HIV staff in food assistance and food security programming essentials, realizing actions that are curative versus those that are preventative, food ration sharing, the need for sensitivity in preventing stigma and maintaining confidentiality, nutritional and HIV job aids and materials are often difficult to access, and there are often needs for other health and nutrition programs that are not the focus of the FANTA and WFP guide.

The relative newness of integration of food assistance and HIV programming means that such programs are in an excellent position to shape the understanding of the impact food has on nutritional and health status of PLHIV and their households. Additionally, guidance on specific elements of food assistance to those impacted by HIV is still developing and changing (e.g., infant and young feeding guidance and accelerated weaning). For more information on the topics covered in this chapter download chapters 10 and 11 at http://www.fantaproject.org/downloads/pdfs/Food_Assistance_Context_of_HIV_sept_2007_part6.pdf.

Chapter 11: Education

Topic Covered (per FANTA and WFP Guide Table of Contents)
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
Annex 1: Additional Resources on Food for Education and HIV

Summary of FANTA and WFP Guidelines and Synthesis
There are many types of education programs that incorporate food assistance (e.g., school feeding and food for training adults and out-of-school youth). This chapter focuses on how to adapt food assistance in education to reach HIV-affected individuals. The education system often helps to diminish the negative impact of HIV through providing skills learning that OVCs would normal learn from their parents, can

provide important HIV education and bring discussion of HIV out into the open, and can provide an entry point for other interventions into vulnerable families.

HIVs impact on the education system has been felt both through the spread of HIV to teachers and staff and withdrawal of students of HIV-affected households. Furthermore, those HIV-affected students who remain in school often have special needs. Food at schools can increase the attendance of HIV-affected students, which allows them to learn not only school curriculum, but life skills they need (if curriculum are adjusted this way), and HIV prevention. Girls in particular feel the impact of HIV as they are called home from school to care for sick family members and younger siblings when parents become ill or die. Ensuring that girls remain in school will also help them prevent becoming infected with the disease.

Food programs can be incorporated to target vulnerable and orphaned children in early childhood education centers, primary schools, and informal education and training programs. In primary schools food assistance should:

- Avoid stigmatization;
- Prioritizing girls and OVCs;
- Consider appropriateness of school feeding;
- Prepare for increased enrollment;
- Link to larger and complementary programs;
- Expand the role of schools to community education and assistance centers;
- Partner with other ministries, hospitals, clinics, CBS to expand HIV awareness, education and school feeding program information; and
- Train teachers and staff as needed in these new areas.

Non-formal education and training programs often education some of the most vulnerable individuals and children in communities and also provide good venues for food assistance to these families. Theses programs should consider:

- Facilitating partnerships between service providers and stake holders;
- Building on institutional strengths by identifying organizations that do vocational training and approach them about incorporating HIV programming;
- Linking over time with extension agents and social welfare departments and business and marketing resources to teach life skills to beneficiaries; and
- Avoiding stigmatization and ensuring that they are inclusive.

There are also opportunities to incorporate HIV education into adult education programs. This should be begin with an assessment of the context (policies, players, and interventions). Some of the key considerations are stigma reduction training, expanding the focus beyond prevention, developing support groups, considering the role of gender, implementing programs through participatory approaches, adapting models as appropriate, building on ongoing programs, and incorporating complementary services.

One of the challenges to incorporating HIV into education programs is that teaching and learning materials are difficult to access and teaching often focuses on facts rather than attitudes and behaviors or skills. Furthermore, teachers need adequate training and tools to incorporate factors such as gender and the socio-cultural context of HIV. Finally, little is known about what the impact of such programs is, monitoring this is essential to improving the approaches. Tools to help improve the inclusion of HIV education are HIV and AIDS Curriculum Manual (UNESCO 2006), the Education Planning and Management in a World with AIDS module (UNESCO/Mobile Task Team on the Impact of HIV/AIDS on Education 2006), and the HIV Education and Prevention Curriculum (Student for International Change Tanzania 2006). For more information on the topics covered in this chapter download chapters 10 and 11 at http://www.fantaproject.org/downloads/pdfs/Food_Assistance_Context_of_HIV_sept_2007_part6.pdf.

Chapter 12: Livelihood Strategies and Social Protection

Topics Covered (per FANTA and WFP Guide Table of Contents)
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
Annex 1: Additional Resources on Livelihood Programming in the Context of HIV

Summary of FANTA and WFP Guidelines and Synthesis
Chapter 12 of the FANTA and WFP guide focuses mainly on food security programs in areas of high HIV prevalence and food insecurity. One of the useful strategies for identifying specific areas of a program that need to be adapted in the context of HIV is the use of an HIV lens for all program activities. This essentially means examining each activity and considering the ways in which HIV or HIV-affected households may differ in their abilities to participate or benefit from such activities.[xx] However, it is important to note that this does NOT mean altering food security programming to only benefit HIV-affected individuals and households. It is mainly used to be inclusive of HIV-affected households since they have special conditions that may mean they are unable to participate at all in typical food security programming.

One of the first considerations when adapting food security programming to be inclusive of HIV-affected households is to solicit input from HIV technical staff from CBOs, associated institutions, home-based care networks, government HIV bodies or task forces, and from individual affected by HIV. Providing food security program staff with HIV-related training and resource materials (often available on the FANTA website) is also important. The following are a number of additional recommendations for food security programs in an HIV context.

- Examine impacts of HIV on assets, livelihood strategies, and coping mechanisms to the disease as well as how HIV has changed standard coping mechanisms to other risks and shock that affect food security. Programs should also explore how local, national, and international networks are addressing these issues in the intervention area. Ideally, these issues would be considered in the program design stage. FANTA and WFP (2007: 252-254) present a list of possible interventions that are aimed at dealing with HIV impacts to the six categories of assets (human, financial, natural, physical, social, and political assets), which is also available in Annex 1 of this CRIB.
- Identify resources available for assisting and targeting HIV-affected populations. Gather data from HIV-related organization and governmental offices.
- Involve people living with and affected by HIV in decision-making and design of adaptations to include HIV-affected households.
- Consider potential of livelihood activities of program to increase HIV transmission and incorporate mitigation measure to ensure this does not occur (e.g., crop marketing activities that link rural and urban communities may expose women to the risk of HIV infection).
- Consider household labor constraints of HIV-affected household since this constraint may prevent them from participation in project livelihood activities.
- Adjust working norms for PLHIV in programs such as FFW and FFA by including reduced labor categories of work or allowing household to “recruit” a non-vulnerable relative to participate on their behalf.
- As always, avoid stigmatizing beneficiary households and individuals.
- Modify rations (when used) to account for nutritional needs of PLHIV (see FANTA 2007).

There are also specific guidelines for incorporating FFA activities and creating safety nets for OVCs and other high risk groups. Since many communities affected by HIV have seen their traditional community-based safety nets weaken, support for formal safety nets that help reinforce community-based safety nets should be considered. There are unconditional (which provide assistance based on need), conditional (which provide assistance for specific behaviors), and productive (which prevent erosion and build assets) safety nets, which can be implemented on an individual, household, or community level. Design of food-assisted safety nets should consider:

- Needs assessment,
- Linking with existing programs,
- A clear rationale for incorporating food,
- Avoiding targeting only HIV groups when populations not affected by HIV may be just as vulnerable,
- Understanding the timing of vulnerability, and
- Supporting households caring for OVC (which will not necessarily be apparent with indicators for PLHIV).

Many organizations and governments are focusing on design of overarching social protection programs (of which safety nets are one component). For more information on the topics covered in this chapter download chapters 12 and 13 at http://www.fantaproject.org/downloads/pdfs/Food_Assistance_Context_of_HIV_Oct_2007_part7.pdf.

Chapter 13: Emergency Response

Topics Covered (per FANTA and WFP Guide Table of Contents)
13.1 Applying an HIV Lens to Emergency Food Assistance Programs
13.2 Programming Emergency Food Assistance in High HIV Prevalence Contexts
Annex 1: Additional Resources on Food Assistance and HIV in Emergency Settings

Summary of FANTA and WFP Guidelines and Synthesis
There are several modifications to food assistance in emergency settings to ensure inclusion of HIV-affected households and prevent an increase in the vulnerability of these households who tend to be exposed to risks during periods of emergencies. Aside from the guidelines in the FANTA and WFP document summarized here additional guidance is available in the Development of Programme Strategies for Integration of HIV, Food, and Nutrition Activities in Refugee Settings (UNAIDS 2005) and the Guidelines for HIV/AIDS Interventions in Emergency Settings (UNHCR 2004). One of the tools available in the UNHCR (2004) guide is a Matrix of Guidelines for HIV Interventions in Emergency Settings, which has been included in the FANTA and WFP guide as well (2007:2 269-270) and includes emergency preparedness responses, minimum responses, and comprehensive responses. Another tool that should be used to understand the context of HIV in the emergency setting is an HIV rapid risk and vulnerability assessment. It is important to understand how HIV in the area of intervention is transferred and how it impacts local food security. Some of the outputs of this assessment (described in more detail in UNAIDS 2005) are:

- Epidemiological patterns of disease and identification of high risk groups;
- Risks associated with refugee-host interactions;
- Principal routes of transmission;
- Roles of knowledge and behaviors; and
- Identification of priority strategies for HIV interventions (prevention, care, support to affected families, health care and treatment).

Other considerations for coordinating food assistance in high HIV prevalence areas that are directed more towards refugee situations include:

- Exploring potential unintended consequences (avoiding stigmatization);
- Ensuring that assistance to refugees is not creating resistance and resentment with local host populations who may not be receiving such assistance for similar conditions;
- Collaborate with other agencies and organization for comprehensive action;
- Coordinate across sectors (UN emergency response arms and health sector HIV arms);
- Provide adequate training on issues relevant to high HIV prevalence and emergency and food assistance;
- Recognize that the situation of each individual and household may change and their needs will change;
- Link HIV emergency activities with post-emergency, longer-term activities;
- Plan sites so that those who cannot travel great distances to collect food aid (e.g., severely ill or child household heads) can be placed closer to food distribution sites;

- Consider sexual and gender-based violence and how this affects the emergency and HIV situation
- Inclusion of HIV awareness, prevention, and care messages;
- Consider the special nutritional needs of PLHIV and modify ration sizes and types accordingly;
- Address food utilization by incorporating hygiene and sanitation measures, de-worming activities, and feeding practices; and
- Prioritize high risk groups.

Additionally, it is important for emergency efforts in the more stable phase of the emergency response to reconnect those affected by HIV to the HIV services that supported them prior to the emergency.

Much of the guidance in this chapter is focused on emergency situations that result in refugee population (often due to civil conflict). There is less in the literature on how to consider the specific context of HIV in emergencies caused by natural disasters. For more information on the topics covered in this chapter download chapters 12 and 13 at http://www.fantaproject.org/downloads/pdfs/Food_Assistance_Context_of_HIV_Oct_2007_part7.pdf.

Additional Resources:

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ANNEX 1
FANTA and WFP Recommendations for Modifying Programs
Taken directly from FANTA and WFP (2007: 252-254)

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

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[i] Members of the Health, Nutrition, and HIV/AIDS Working Group include Stacey Maslowsky, Sidikiba Sidibé, Alassane Aguili, Grace Kamba, Ignatius Kahiu, Valentin Badiel, Mahamat Saleh Radjab, and Pascal Payet. A critical need for a quick reference/summary of the important FANTA/WFP guidance on Food Assistance Programming in the Context of HIV was identified at the 2008 Africare Tools Workshop by the Africare Health, Nutrition, and HIV/AIDS Working Group. Leah A.J. Cohen (AFSR managing editor and consultant) produced the summary, Stacey Maslowsky (former Food for Development manager at Africare/Headquarters) and Della E. McMillan (AFSR advisory board member and consultant), and Bonaventure Traoré (AFSR advisory board member and former country representative in Guinea), and Sidikiba Sidibé (project coordinator for Africare's Title II efforts in Rwanda) reviewed and commented on the content.

[ii] Africare's Critical Resource Information Briefs are designed to provide a forum for Africare working groups to identify and efficiently respond to areas of urgent need in capacity building. The short format ensures that staff in the field can download and incorporate the information quickly and effectively. Another focus of the Africare CRIBs has been to provide as many direct website addresses for additional resources as possible to facilitate reference and readership of those materials from the field.

[iii] Africare ICB Strategic Objective One: Title II field level impact increased by developing better methodologies for enhancing local capacity to identify and reduce food insecurity in vulnerable groups including HIV/AIDS affected households.

[iv] The FANTA and WFP guide also recognizes and addresses programs and institutions that focus on HIV programming and are attempting to incorporate food assistance programming due to the now increasingly recognized link between HIV and food security; however, since this is not Africare's situation as Title II food security organization, this CRIB speaks less to that situation. See the FANTA and WFP guide for more complete information on this angle.

[v] The FANTA and WFP guide lists a set of questions to be asked to determine whether food assistance in areas of high HIV prevalence is appropriate (FANTA and WFP 2007:17).

[vi] Although there are only 13 priority countries for PEPFAR, it supported activities in 114 countries in 2006.

[vii] These are the countries that had current FFP programs and were determined to be priorities based on their food security status per specific indicators (Source: USAID gray literature, source not indicated).

[viii] Note: Africare worked in other countries as well that were not considered USAID or PEPFAR priorities at the time this was written.

[ix] UNAIDS reports countries in Sub-Saharan Africa with rate over 15% in 2005 to be Botswana, Lesotho, Mozambique, Namibia, South Africa, Swaziland, Zambia, and Zimbabwe (UNAIDS and WHO 2007).

[x] Unlike a typical food assistance program, it may be unrealistic to improve nutritional outcome for PLHIV—for these individuals who face deteriorating health and nutritional status as the disease progresses the object may be to maintain or low the decline in nutritional status.

[xi] See FANTA, Recommendation for the Nutrient Requirements for People Living with HIV/AIDS (Washington DC, Food and Nutrition Technical Assistance, 2007) at http://www.fantaproject.org/downloads/pdfs/Nutrient_Requirements_HIV_Feb07.pdf for the two page quick reference on this topic that was developed from FANTA's more extensive guidance on nutrition and HIV.

[xii] See WFP website for the WFP Guide on Participatory Techniques and Tools at www.wfp.org.

[xiii] See FHI guide on referral systems, Establishing Referral Networks for Comprehensive HIV Care in Low-Resource Settings at www.fhi.org/en/index.htm.

[xiv] See the Planning Matrix for Exit Strategies in the Context of HIV in FANTA and WFP's guidance (2007: 154-155).

[xv] See Bergeron et al. (2006) for an overview of this M&E framework for indicators.
[xvi] Africare has reformatted the complete list of FANTA recommended indicators for nutrition education and counseling activities in is Critical Resource Information Brief #1 (Africare Health, Nutrition, and HIV/AIDS Working Group 2008, AFSR No. 20) and the FANTA recommended indicators for food assistance programming in its Critical Resource Information Brief #4 (Africare Health, Nutrition, and HIV/AIDS Working Group 2008, AFSR No. 25) in order to facilitate selection and field testing of a number of these indicators by Africare field programs.
[xvii] See FANTA and WFP (2007: 203-206) for more details on these workplace HIV policies.
[xviii] FANTA and WFP guidance on these issues is for WFP partners and Title CSs mainly; although other sources of health, nutrition and food activities for high HIV prevalence areas exist.
[xix] See FANTA's (2007) two page quick reference to PLHIV nutritional requirements.
[xx] The concept of using an HIV lens to evaluate need for adaptation of typical program activities in HIV context is suggested in Loevinsohn and Gillespie (2003).