

## Chapter 4: Adaptive and Integrated Programming Program Design Steps

# Chapter 4: Adaptive and Integrated Programming

## Program Design Steps

### Key Concepts

4.1 Program Characteristics

4.2 Food Security Program Design Considerations

4.3 HIV Program Design Considerations

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

4.5 Challenges and Considerations in Developing Integrated Programs

## In This Chapter

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

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

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

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

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

# 4.1 Key Concept

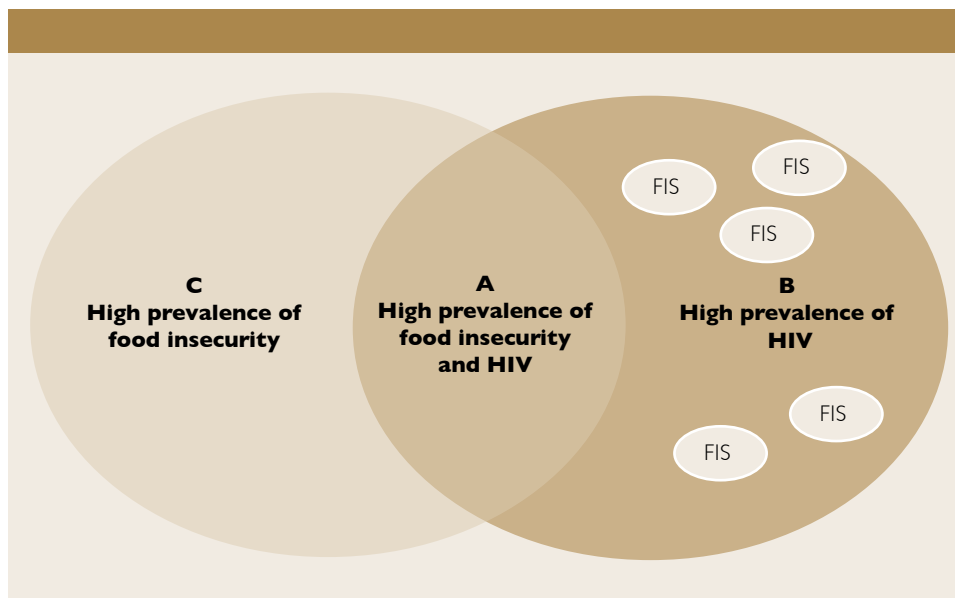
## Program Characteristics

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

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

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

**Figure 1: Program Areas for Food Security and HIV Programming<sup>A</sup>**



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

Table I: Characteristics of Key Programs

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

# 4.2

## Key Concept

### Food Security Program Design Considerations

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

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

### Adapting Food Security Program Activities

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

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

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

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

Questions to consider in applying an HIV lens include:

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

## Applying an HIV Lens to a Food for Assets Activity

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

- ▶ Ensure the greater involvement of people with HIV and AIDS (GIPA) in decision-making at all stages.
- ▶ Consider whether increased mobility of people using the roads increases the risk of HIV transmission and take action to mitigate this with HIV prevention activities, e.g., in the marketplace, en route to market, on buses, at bus stops.
- ▶ Help HIV-affected households who are food-insecure but cannot participate in the FFA project due to constraints such as labor shortages caused

by the disease. For example, the project could be situated closer to the homes of people who are also working as caregivers. Daycare services could be made available for workers, or food payments could be made to temporary home-based caregivers so that able-bodied workers could be away from home long enough to participate in the project. The project also could let these households "recruit" a non-vulnerable relative or a neighbor to participate on their behalf.

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

## Addressing HIV-Specific Needs

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

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

# 4.3

## Key Concept

### HIV Program Design Considerations

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

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

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

Table 2: Uses of Food to Support HIV Program Objectives

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

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

Three examples of this type of integration are:

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

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

# 4 4

## Key Concept

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

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

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

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

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

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

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

Figure 2. Continuum of Care for PLHIV and Affected Households

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

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

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

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

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

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

## Using the Continuum of Care in Comprehensive and Holistic Programming

### In a Specific Location

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

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

### By an Entire Agency or Government Ministry

The continuum of care can be used to help:

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

#### ▶ Answer these questions:

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

What programs can the food program serve or support?

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

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

# 4.5

## Key Concept

## Challenges and Considerations in Developing Integrated Programs

### Primary Challenges to Successful Integration

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

the design, implementation, monitoring and evaluation of integrated food security and HIV programming present a new list of challenges, including:<sup>4</sup>

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

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

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

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

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

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

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

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

## Key Considerations for Designing Integrated Programs

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Some key considerations that are applicable across sectors and are necessary to address the primary challenges include:<sup>5</sup>

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

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

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

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

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

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

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

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

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

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

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

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

## Commitment to Program Integration at All Levels

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

Institutionalizing collaboration and coordination at all levels to:

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

- ▶ Devise tools that allow for integrated work planning across several related projects

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

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

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

# Annex I: C-SAFE HIV/AIDS Analysis Tool: Checklist for Adapting Food for Assets Programming to an HIV/AIDS Context

<b>Adapting Food for Assets Programming to an HIV/AIDS Context</b>	
<b>Programming Steps</b>	<b>Key Questions to Ask</b>
<b>Project Identification and Planning</b>	<ol style="list-style-type: none"> <li>1. What are the impacts of HIV/AIDS in the communities in which you are planning to work?</li> <li>2. What resources are available that could help you integrate HIV/AIDS into your geographical targeting?</li> <li>3. How are you involving community-level and district-level organizations who have experience, knowledge, or resources with HIV/AIDS issues?</li> <li>4. How are you intentionally involving PLHA and households affected by HIV/AIDS in the identification and planning of the project?</li> <li>5. Are there any assets included in your project that specifically aim to mitigate the impact of HIV/AIDS? What types of assets could you include that would do this?</li> <li>6. What effect will the project have on traditional and existing coping mechanisms and strategies in the context of HIV/AIDS?</li> </ol>
<b>Building Staff and Community Capacity</b>	<ol style="list-style-type: none"> <li>7. What can be done to enhance the capacity of implementing agency to engage with the community regarding the inclusion of PLHA and affected households as planners, participants, and managers in FFA projects?</li> <li>8. What can be done to enhance the capacity of the community and its leadership to support the inclusion of PLHA and affected households as planners, participants, and managers in FFA projects?</li> </ol>
<b>Beneficiary Identification</b>	<ol style="list-style-type: none"> <li>9. Will PLHA and affected households derive benefits from the assets being created? How could you modify the project to ensure that benefits are shared with the PLHA and affected households?</li> </ol>
<b>Identification of FFA Participants</b>	<ol style="list-style-type: none"> <li>10. Which targeting mechanisms have you included that seek to intentionally include PLHA as participants in the project?</li> <li>11. Which organizations, institutions, and referral mechanisms could be approached for assistance in targeting able-bodied HIV+ participants?</li> <li>12. Are there households that qualify yet cannot participate in the project? What are the precise reasons for their inability to participate?</li> <li>13. How can the project be modified to accommodate those who are unable to participate for reasons identified above?</li> <li>14. How can your work norms be adapted to enhance participation of PLHA and affected households? Are there aspects of the work that are less labor intensive and can be reserved for participants requiring lighter duties?</li> </ol>
<b>Implementation</b>	<ol style="list-style-type: none"> <li>15. Are there ways you could organize forms of compensation (food and in-kind) that do not rely on traditional person/hours worked, so as not to discriminate against PLHA or affected households?</li> <li>16. How could you adapt the food ration to be more useful and appropriate for the needs of participant individuals and households?</li> </ol>
<b>Sustainability</b>	<ol style="list-style-type: none"> <li>17. How can you explicitly include PLHA and affected households in maintenance of the asset?</li> <li>18. How have you adapted your maintenance plan to enhance sustainability in the context of HIV/AIDS?</li> </ol>
<b>Monitoring and Evaluation</b>	<ol style="list-style-type: none"> <li>19. How can existing FFA monitoring and evaluation tools be adapted to capture information measuring the community's response to HIV/AIDS-related shocks?</li> <li>20. Does any aspect of the project have the potential to influence stigma?</li> </ol>
<b>Project Outcomes</b>	<ol style="list-style-type: none"> <li>21. Does the asset itself have the potential to increase the spread of HIV (or increase risk-taking behavior)? What ways can this be mitigated?</li> <li>22. Does the process of creating the asset have the potential to increase the spread of HIV (or increase risk-taking behavior)? What ways can this be mitigated?</li> <li>23. Will any stages of the project put people's health at greater risk, thereby hastening the progressing from HIV to AIDS? Will it have the potential to help slow progression of HIV to AIDS?</li> </ol>

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

## Endnotes

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## Chapter 5: Targeting Program Design Steps

# Chapter 5: Targeting Program Design Steps

## Key Concepts

**5.1** Targeting Food Assistance in  
Areas of High HIV Prevalence

**5.2** Adapting Food Assistance Targeting  
Approaches and Tools

**5.3** Promising  
Practices

## In This Chapter

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

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

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

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

# 5.1 Key Concept

## Targeting Food Assistance in Areas of High HIV Prevalence

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

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

### Programs With Food Security Objectives

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

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

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

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

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

## Geographic Targeting

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

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

## Community Targeting

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

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

## Household Targeting

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

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

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

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

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

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

## WFP Malawi's Approach to Community-Based Targeting<sup>8</sup>

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

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

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

### Geographic Targeting (district and community levels)

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

### Household Targeting

(households must meet at least three criteria)

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

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

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

These households are prioritized in this order:

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

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

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

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

## Programs With HIV Objectives

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

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

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

### Individual Targeting

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

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

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

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

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

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

## Using Multi-Criteria Targeting in an HIV Context in Zambia<sup>10</sup>

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

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

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

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

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

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

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

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

# 5.2

## Key Concept

### Adapting Food Assistance Targeting Approaches and Tools

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

#### Adapt Targeting Criteria to the Purpose and Objective of Food Assistance

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

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

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

#### Use Home-Based and Other Care and Support Community Groups

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

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

## Tapping Community Home-Based Care in Kenya<sup>13</sup>

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

- ▶ An initial village meeting is held with community leaders, ward councilors and village chiefs

to endorse the targeting approach and the beneficiary selection criteria.

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

## Use of Proxy Indicators

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

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

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

- ▶ Loss of labor
- ▶ Delayed agricultural operations

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

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

## CRS Zambia Fine-Tunes Chronic Illness Definitions<sup>16</sup>

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

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

### I. Clients' Medical Condition/Illness (\* = major conditions)

Ia. Weight loss >10% from normal/regular weight	1=Yes	2=No	Ih. Unexplained prolonged fever *	1=Yes	2=No
Ib. Generalized lymph node enlargement	1=Yes	2=No	Ii. Oral thrush *	1=Yes	2=No
Ic. Skin infections	1=Yes	2=No	Ij. Tuberculosis *	1=Yes	2=No
Id. Non-resolving herpes simplex	1=Yes	2=No	Ik. Pneumonia *	1=Yes	2=No
Ie. Herpes zoster within the last 5 years	1=Yes	2=No	Il. Kaposi's sarcoma *	1=Yes	2=No
If. Recurrent upper respiratory infection	1=Yes	2=No	Im. Meningitis *	1=Yes	2=No
Ig. Unexplained chronic diarrhea (>30 days)	1=Yes	2=No	In. Persistent confusion/dementia *	1=Yes	2=No
			Io. Other, specify:	1=Yes	2=No

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

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

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

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

## Incorporate Stigma Reduction Measures

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

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

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

### Guidance for Addressing Stigma<sup>25,26</sup>

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

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

The toolkit is available at [www.changeproject.org/technical/hiv aids/stigma/StigmaToolkit.pdf](http://www.changeproject.org/technical/hiv aids/stigma/StigmaToolkit.pdf).

## Methods to Reduce Stigmatization

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

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

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

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

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

## Gender and Targeting

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

For a more detailed discussion on the role gender plays in food assistance programs in the context of HIV, program managers can review *Getting Started: HIV, AIDS and Gender in WFP Programmes*, available at [www.wfp.org/food\\_aid/doc/GETTING\\_GENDER7.pdf](http://www.wfp.org/food_aid/doc/GETTING_GENDER7.pdf).

# 5.3

## Key Concept

### Promising Practices

#### Use a Common Framework of Vulnerability

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

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

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

#### Standardize Program and Beneficiary Targeting Criteria

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

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

#### Conduct Field-Level Verification

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

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

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

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

## Apply “Do No Harm” Principles

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

### Zambia Case Study: Cross-Sector Referral Targeting Mechanisms Used to Guide Interventions<sup>31</sup>

In Zambia, whose national health care system tracks Zambians through an individual code connected to her/his medical records and local treatment facility, collaboration between hospitals providing ART, NGO-supported food assistance programs and HBC programs is strong. WFP Cooperating Partners in the same areas are beginning to exchange beneficiary lists to avoid targeting of the same beneficiaries. This is actively encouraged by WFP through district coordination mechanisms such as District Disaster

Management Committees and District AIDS Task Forces. The District Development Coordinating Committee requires monthly updates and meetings so the Cooperating Partners are kept up to date.

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

# Annex I: WFP Zambia Targeting Tool: Food Security Screening Form

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

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

<b>A. Demographic and Education</b>										
<b>A1</b>	How many adults (19-59 years) stay in the household?								<b>Number of adults:</b>	
<b>A2</b>	How many elders (60 years and older) stay in the household?								<b>Number of elders:</b>	
<b>A3</b>	How many children (18 years or younger) stay in the household?								<b>Number of children:</b>	
<b>A4</b>	Marital status of primary income earner								Married (1) Single (2) Separated (3) Divorced (4) Widowed (5)	
<b>A5</b>	Sex of primary income earner								Male Female <b>(circle response)</b>	
<b>A6</b>	In the following table, record the required information for all children in the household who are between 6 and 18 years of age.									
	First name of the child (6-18 years only)	Age	Is the child currently attending school? <b>(circle response)</b>		1. Community school	2. Drop-in center	3. Government school	4. Fee-paying private school	5. Fee-paying tertiary education	
	1		Yes	No						
	2		Yes	No						
	3		Yes	No						
	4		Yes	No						
	5		Yes	No						
	6		Yes	No						
	7		Yes	No						
	8		Yes	No						
	9		Yes	No						
	10		Yes	No						

<b>B. Food Consumption</b>					
<b>B1</b> How many bags of mealie-meal did the household consume in the last month?	<b>Bag Size</b>			<b>Number Consumed</b>	
	50 kg				
	25 kg				
	12.5 kg				
	10 kg				
	5 kg				
	2.5 kg				
0.5 kg					
<b>B2</b> Where did the food that you ate yesterday come from? <b>(check all that apply)</b>					
	YES	NO		YES	NO
1. From own harvest			7. Food received—General food distribution/nutritional support programme		
2. Casual labour			8. Food received—Home-based care		
3. Borrowed			9. Food received—School feeding/OVC take-home ration		
4. Bartered			10. Food received—Food for work/food for assets		
5. Gift			11. Purchased (shop, market, kantemba)		
6. Gathered from wild			12. Other sources <b>(specify)</b>		
<b>B3</b> In the last month, did anyone in the household cut the size of meals or skip meals?			Yes	No	<b>(circle response)</b>
<b>B4</b> If yes, how often did this happen? <b>(circle one response)</b>			Daily (1) Every other day (2) Weekly (3) Once (4)		
<b>B5</b> How many meals does the household usually have in a day?			Yes (1) (2) (3) <b>(circle response)</b>		

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

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

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

### Section A: Basic Criteria Guidelines

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

1. Monthly household income of less than K50,000 per month  
OR
2. The household consumes 25 kg of maize meal or less per month AND household size is more than five people  
OR
3. The household consumes 50 kg of maize meal or less per month AND household size is more than 10 people  
OR
4. The respondent reports that during the past month, members of the household cut the size of meals or skipped meals because there was not enough food, daily or every other day, and the household consumes less than three meals per day on average.  
OR
5. The respondent reports that the food eaten yesterday in the household came exclusively from borrowing, bartering, and/or gathering in the wild AND at least one other criteria above is also met.

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

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

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

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

### Section B: Demographic Qualifiers

Number of children under 18 not attending school

1. 0 = 0
2. 1-2 = 1
3. 3 or more = 2

Household head:

Child-headed household = 5  
Elderly-headed household = 3  
Female-headed household = 1

Marital status of HH head

1. Married = 0
2. Single = 1
3. Separated = 1
4. Divorced = 2
5. Widowed = 3

Dependency ratio:

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

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

Total possible score: 13



Section B. Household Income and Expenses		
<b>B1</b>	During the past year, what were your household's three main sources of livelihood? (starting with the most important)	(1)  _____  (2)  _____  (3)  _____  If no source of livelihood, write 15 and go to B2
<b>CODES FOR B1</b> 1 = remittance 2 = crop production/sales 3 = casual labour 4 = begging 5 = livestock production/sales 6 = skilled trade/artisan 7 = small business 8 = petty trade (firewood sales, etc.) 9 = brewing 10 = formal salary/wages 11 = sale of fish 12 = gold panning 13 = vegetable production/sales 14 = food aid 15 = no secondary source of livelihood 88 = other (specify) _____		
<b>B2</b>	During the past month, what were your household's three main uses of your income? (in order of importance)	(1)  _____  (2)  _____  (3)  _____
<b>CODES FOR B2</b> 0 = none 1 = staple foods 2 = non-staple foods 3 = HH goods 4 = education 5 = health 6 = funerals 7 = travel 8 = agricultural inputs 9 = other (specify) _____		

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

Section D. Agricultural Production				
<b>D1</b>	How much land did you cultivate this year? (1 hectare (ha) = 100x100m, 1 lima = 0.25ha = 50x50m, 1 acre = 0.4ha) IF DID NOT CULTIVATE WRITE 00	_ _ .  _  Hectares <b>IF 00 MOVE TO D4</b>		
<b>D2</b>	Compared to last season was the area of land you cultivated larger, the same or less	1 = larger 2 = same 3 = less <b>IF LARGER OR SAME, GO TO D5</b>		
<b>D3</b>	What is the primary reason for cultivating less land?	Reason  _ _  <b>GO TO D5</b>		
<b>D4</b>	What is the primary reason for not cultivating? <b>CODES FOR D3 &amp; D4</b> 1 = planned fallow, 2 = weather related causes, 3 = could not access land, 4 = lack of seed, 5 = lack of fertilizer, 6 = lack of labour/insufficient manpower, 7 = pest problems, 8 = rented out, 9 = illness in the household, 88 = other (specify) _____	Reason  _ _  <b>GO TO E1</b>		
<b>D5</b>	Did you cultivate any of the following crops? <b>CODES FOR D5: Harvest Usage</b> 1 = consumed 2 = sold 3 = bartered 4 = given out as gift 88 = other (specify) _____	<b>Crop</b>	<b>YES</b>	<b>NO</b>
		Maize	1	2
		Sorghum	1	2
		Millet	1	2
		Cassava	1	2
		Beans	1	2
		G/nuts	1	2
		S/potatoes	1	2
		Vegetables	1	2
		Cash crops	1	2

Section E. Food Consumption		
<b>E1</b>	How many meals did the adults in this household eat <b>yesterday</b> ?	_ _  NUMBER OF MEALS
<b>E2</b>	How many meals did the children (6-59 months old) in this household eat <b>yesterday</b> ? <b>IF NO CHILDREN IN THE HH, WRITE 98 for N/A</b>	_ _  NUMBER OF MEALS

## Section F. Assets

**F1: How many of the following assets are owned by you or any member of your household?** (indicate kwacha value where possible)

Productive, Non-Productive & Transport Assets

Asset	No.	Asset	No.	Asset	No.
Land (hectares)		Canoe		Radio	
Tractor		Harrow		DSTV	
Hand tractor		Plough		Fridge	
Hammer mill		Shops/kantemba		Fan	
Hand mill		Business		Sewing machine	
Treadle pump		Truck		Bicycle	
Fishing nets		Van/hilux		Other 1	
Ox cart		TV		Other 2	

**G1** **G1 How many of the following livestock does your household currently own?**

**TO** **G2 How many livestock has your household purchased in past 3 months?**

**G4** **G3 How many livestock has your household sold in past 3 months?**

**G4 What was the main reason for selling this livestock?**

**FOR EACH TYPE OF LIVESTOCK NOT OWNED, NOT PURCHASED AND NOT SOLD, WRITE 0**

	Livestock	G1 Currently owned	G2 Purchased	G3 Sold	G4 Main reason for sale
1	Draught cattle				
2	Cattle				
3	Donkeys/horses				
4	Sheep/goats				
5	Pigs				
6	Chickens/ducks/other birds				
<b>Codes for G4</b>		1. No longer needed 2. Pay daily expenses 3. Buy food for HH	4. Pay medical expense 5. Other emergency 6. Pay debt	7. Pay social event 8. Pay funeral 9. Pay school	88. Other (specify) 98. N/A

## FOR OFFICIAL USE ONLY

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

Based on answers to the above questions, in the enumerator's opinion, this household should be classified as:

<b>1 = Very eligible</b> (Asset very poor, food insecure with hunger)	<b>2 = Eligible</b> (Asset very poor, food insecure with hunger)	<b>3 = Moderately eligible</b> (Asset poor, food insecure without hunger)	<b>4 = Ineligible</b> (Asset rich, food secure without hunger)	<b>5 = Disqualify</b> (Asset very rich, food secure and not hungry)
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**2. If ineligible or disqualified based on issues other than Food Security perception, please indicate these reasons:**

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

Name of HH head \_\_\_\_\_

Sign \_\_\_\_\_ Date \_\_\_\_\_

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

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

A. Demographic and Education										
<b>A1</b> How many adults (19-59 years) stay in the household?					Number of adults:					
<b>A2</b> How many elders (60 years and older) stay in the household?					Number of elders:					
<b>A3</b> How many children (18 years and younger) stay in the household?					Number of children:					
In the following table, record the required information for all the children in the household who are between 6 and 18 years of age										
	First name of the child (6-18 years of age only)	Age	Is the child currently attending school?		What type of school does the child attend?					
			Yes	No	1 = Community school	2 = Drop-in center	3 = Government school	4 = Fee-paying private school	5 = Fee-paying tertiary education	
1			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<b>B. Food Consumption</b>					
<b>B1</b> How many bags of mealie-meal did the household purchase for consumption in the past month?	<b>Bag Size</b>		Number Purchased		
	50 kg				
	25 kg				
	12.5 kg				
	10 kg				
	5 kg				
	2.5 kg				
0.5 kg					
<b>B2</b> Where did the food that you ate yesterday come from? <b>(check all that apply)</b>					
	YES	NO		YES	NO
1. From own harvest	<input type="checkbox"/>	<input type="checkbox"/>	7. Food received—General food distribution/nutritional support programme	<input type="checkbox"/>	<input type="checkbox"/>
2. Casual labour	<input type="checkbox"/>	<input type="checkbox"/>	8. Food received—Home-based care	<input type="checkbox"/>	<input type="checkbox"/>
3. Borrowed	<input type="checkbox"/>	<input type="checkbox"/>	9. Food received—School feeding/OVC take-home ration	<input type="checkbox"/>	<input type="checkbox"/>
4. Bartered	<input type="checkbox"/>	<input type="checkbox"/>	10. Food received—Food for work/food for assets	<input type="checkbox"/>	<input type="checkbox"/>
5. Gift	<input type="checkbox"/>	<input type="checkbox"/>	11. Purchased (Shop, market, kantemba)	<input type="checkbox"/>	<input type="checkbox"/>
6. Gathered from wild	<input type="checkbox"/>	<input type="checkbox"/>	88. Other sources <b>(specify)</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>B3</b> In the past month, did anyone in the household ever cut the size of meals or skip meals because there wasn't enough food?			Yes	No	<b>(circle response)</b>
<b>B4</b> If yes, how often did this happen? <b>(circle one response)</b>			Daily (1) Every other day (2) Weekly (3) Once (4)		

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

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

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

### PCI Zambia Monitoring Visit Form

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

<b>A. Adherence Support</b>	
<b>A1 (Ask)</b> Have you missed any doses of your ARVs since I last visited you?	Yes No <b>(circle response)</b>
<b>A2 (If yes)</b> How many doses have been missed in this period?	_ _ _  NUMBER OF DOSES MISSED
<b>A3</b> Review the Patient Care Card. According to the card, how many doses have been missed?	_ _ _  NUMBER OF DOSES MISSED
<b>A4</b> If the number in A2 and A3 are different, try to determine with the patient and/or buddy the correct number of missed doses.	_ _ _  NUMBER OF DOSES MISSED
<b>A5</b> Record the number of days since the last visit.	_ _ _  NUMBER OF DAYS
<b>A6</b> Record the total number of pills which should have been taken during this period.	_ _ _  NUMBER OF PILLS
<b>A7</b> Use the figures in A4, A5 and A6 to determine the patient adherence during the period in question. (Refer to Table 5.5)	<b>Adherence is less than 95%</b> _____ <b>Adherence is more than 95%</b> _____
<p><b>IF ADHERENCE IS LESS THAN 95%:</b></p> <ul style="list-style-type: none"> <li>» Assess the reason(s) for missed doses</li> <li>» Assess barriers to adherence and suggest solutions</li> <li>» Review with the patient the importance of 100% adherence</li> <li>» Complete a Follow-Up Required Card and return it to the HBC Supervisor</li> <li>» Caregiver must begin doing daily visits until adherence improves</li> </ul> <p><b>IF ADHERENCE IS GREATER THAN 95%:</b></p> <ul style="list-style-type: none"> <li>» Assess any potential barriers to adherence and encourage the patient and buddy to continue</li> </ul>	

<b>B. Buddy</b>	
<b>B1</b> Does the patient have a buddy?	Yes No <b>(circle response)</b>

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

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

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

<b>D5 (If no)</b> Why not?	<input type="checkbox"/> Food is finished <input type="checkbox"/> Food was sold/bartered/given away <input type="checkbox"/> Food was not enough for the patient/others ate it <input type="checkbox"/> No fuel to cook the food <input type="checkbox"/> Nobody to cook the food for patient <input type="checkbox"/> Patient wasn't hungry <input type="checkbox"/> Patient didn't want the food (yesterday) <input type="checkbox"/> Patient doesn't like the food (at all) <input type="checkbox"/> Patient was sick <input type="checkbox"/> Patient has trouble swallowing <input type="checkbox"/> Other (specify) _____
<b>D6</b> Is the patient receiving a <b>household ration</b> from the clinic through PCI/WFP (HEPS, oil, mealie meal, beans/peas)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <b>» if no, go to next page</b> <input type="checkbox"/> Don't know <b>» if don't know, go to next page</b>
<b>D7 (If yes)</b> Did the patient eat any of this food during the past 24 hours?	<input type="checkbox"/> Yes <input type="checkbox"/> No <b>» if no, go to D9</b> <input type="checkbox"/> Don't know <b>» if don't know, go to next page</b>
<b>D8 (If yes)</b> What did they eat?	<input type="checkbox"/> HEPS <input type="checkbox"/> Mealie meal <input type="checkbox"/> Oil <input type="checkbox"/> Beans/peas <b>(tick all that apply, then go to next page)</b>
<b>D9 (If no)</b> Why not?	<input type="checkbox"/> Food is finished <input type="checkbox"/> Food was sold/bartered/given away <input type="checkbox"/> Food was not enough for the patient/others ate it <input type="checkbox"/> No fuel to cook the food <input type="checkbox"/> Nobody to cook the food for patient <input type="checkbox"/> Patient wasn't hungry <input type="checkbox"/> Patient didn't want the food (yesterday) <input type="checkbox"/> Patient doesn't like the food (at all) <input type="checkbox"/> Patient was sick <input type="checkbox"/> Patient has trouble swallowing <input type="checkbox"/> Other (specify) _____
Is the patient experiencing any problems related to food consumption and the ARVs? If so, please describe the problem below and alert the HBC Supervisor to the problem:	
<hr/> <hr/> <hr/>	
Provide any comments in the space below related to the patient's condition, adherence, needs for follow up, etc.	
<hr/> <hr/> <hr/>	

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

### **CHECKLIST FOR HOME ADHERENCE SUPPORT**

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

**PCI Zambia Reassessment Food Security Screening Form**

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

**A. Demographic and Education**

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

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

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

**B. Food Consumption**

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

<b>B2</b> Where did the food that you ate yesterday come from? <b>(check all that apply)</b>					
	YES	NO		YES	NO
1. From own harvest	<input type="checkbox"/>	<input type="checkbox"/>	7. Food received—General food distribution/nutritional support programme	<input type="checkbox"/>	<input type="checkbox"/>
2. Casual labour	<input type="checkbox"/>	<input type="checkbox"/>	8. Food received—Home-based care	<input type="checkbox"/>	<input type="checkbox"/>
3. Borrowed	<input type="checkbox"/>	<input type="checkbox"/>	9. Food received—School feeding/OVC take-home ration	<input type="checkbox"/>	<input type="checkbox"/>
4. Bartered	<input type="checkbox"/>	<input type="checkbox"/>	10. Food received—Food for work/food for assets	<input type="checkbox"/>	<input type="checkbox"/>
5. Gift	<input type="checkbox"/>	<input type="checkbox"/>	11. Purchased (Shop, market, kantemba)	<input type="checkbox"/>	<input type="checkbox"/>
6. Gathered from wild	<input type="checkbox"/>	<input type="checkbox"/>	88. Other sources <b>(specify)</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>B3</b> In the past month, did anyone in the household ever cut the size of meals or skip meals because there wasn't enough food?				Yes	No <b>(circle response)</b>
<b>B4</b> If yes, how often did this happen? <b>(circle one response)</b>				Daily (1) Every other day (2) Weekly (3) Once (4)	

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

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

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

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

## Endnotes

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