

## Chapter 2: Policy and Program Environment

### HIV and Food Security: Conceptual and Institutional Framework

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### Key Concepts

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## In This Chapter

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

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

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

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

# 2.1 Key Concept

## International Food Security and HIV Goals

### Global Food Security Initiatives and Goals

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

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

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

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

### HIV Global Convention Goals and Targets

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

# 2.2

## Key Concept

### International Agencies' Response to Food Insecurity and HIV

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

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

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

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

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

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

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

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

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

In addition, when programming food assistance for PLHIV and affected populations, FFP expects CSs to ensure that:<sup>10</sup>

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

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

## World Food Programme Food Assistance Policy Regarding HIV

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

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

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

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

## European Commission Food Security Framework

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

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

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

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

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

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

## PEPFAR Goals and Targets

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

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

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

PEPFAR supports the following food and nutrition interventions, which contribute to achieving the 2-7-10 goals:<sup>19</sup>

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

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

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

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

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

## The Global Fund to Fight AIDS, Tuberculosis and Malaria

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

The Global Fund offers direct funding for HIV interventions and an array of technical assistance in these areas:<sup>20</sup>

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

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

## The World Bank's Response to HIV

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

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

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

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

## Humanitarian Aid Department of the European Commission

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

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

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

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

## 2.3 Key Concept

### Program Coordination Mechanisms

#### Poverty Reduction Strategy Papers

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

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

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

## Programs Supported by National Policy Institutions

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

### Kenya Integrates Food Assistance Into National HIV Response

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

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

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

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

## United Nations Development Assistance Frameworks

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

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

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

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

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

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

## Title II Consortium Mechanism

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

### Previous Experience With Consortia in the Context of HIV<sup>31</sup>

The Consortium for Southern Africa Food Security Emergency (C-SAFE) was among the largest food assistance projects in southern Africa throughout its implementation (2002-2006). Led by World Vision, CARE and Catholic Relief Services (CRS), and working closely with WFP, C-SAFE aimed to alleviate food and livelihood insecurity by addressing targeted groups’ immediate nutritional needs, building productive assets and helping communities increase their resilience to food security shocks. C-SAFE was one of the first large-scale programs to explore providing food

assistance as a safety net to HIV-affected households. Country consortia in Malawi, Zambia and Zimbabwe each reported that C-SAFE’s support for interagency cooperation benefited commodity management, food for work (FFW) and nutrition interventions. C-SAFE’s work also provided important lessons on targeting criteria and M&E systems. C-SAFE partners also reported an increase in HIV programming quality and consistency, as well as establishment of effective HIV workplace policies.

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

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

## Coordination With Local Government and PLHIV Networks

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

### District and Village AIDS Committees

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

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

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

### Voluntary Home-Based Care Networks

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

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

## Food Assistance and HIV Agencies' Policy Role

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

### Key Concept

## International and National Resource Coordination Mechanisms

### WFP Field-Level Coordination

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

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

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

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

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

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

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

## Linking PEPFAR Funds With Food Assistance Programs

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

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

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

## 2.5 Key Concept Challenges in Coordinating Resources for an Integrated Response

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

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

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

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

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

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

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

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

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

1. **United Nations World Food Programme (WFP)** focuses on fighting HIV through its food assistance programs by modifying food rations, helping poor HIV-affected, food-insecure households and individuals meet their basic nutritional needs, and providing food for education and training, and venues for awareness and prevention.
2. **United Nations Children's Fund (UNICEF)** has made HIV a key priority in its programming and focuses on HIV prevention among young people, PMTCT and the care, support and protection for orphans and children made vulnerable by HIV.
3. **World Health Organization (WHO)** has reinforced its commitment to support member states by providing technical support and building health sector capacity for a strategic and sustainable response to HIV; developing and implementing consistent evidence-based strategies and health sector interventions in prevention, treatment and care; and fostering collaboration with new partners, including civil society and the private sector.
4. **The World Bank** is helping countries to more effectively address the devastating consequences of HIV on development. Its efforts include committing nearly US\$2 billion for HIV projects since 1986, launching a multi-country HIV program for Africa and the Caribbean (involving more than US\$1 billion), and partnering with UNAIDS, donor agencies and governments.
5. **United Nations High Commissioner for Refugees (UNHCR)** has broadened and strengthened the UN's response to HIV by stringently implementing its protection mandate; providing HIV technical support and funding to its implementing and operations partners; advocating for refugees to be included and integrated into the country of asylum's HIV strategies, policies, programs and proposals; and fostering a sub-regional approach that addresses the displacement cycle.
6. **United Nations Development Programme (UNDP)** focuses on promoting action-oriented advocacy and policy dialogue for leadership at all levels; helping countries develop capacity for action, and plan, manage and implement their response; promoting a human rights framework and gender perspective in all aspects of the response; integrating HIV into development planning; and providing special assistance to the worst-affected countries to help mitigate the impact on human development.
7. **United Nations Population Fund (UNFPA)** supports a range of initiatives to prevent the sexual transmission of HIV, focusing on preventing HIV infection among young people and pregnant women by providing information, counseling and other services, and improving access to male and female condoms and promoting their correct and consistent use.
8. **United Nations International Labour Organization (ILO)** supports UNAIDS through activities including encouraging governments, employers and workers to mobilize against HIV; facilitating direct access to the world of work, where many possibilities exist for HIV prevention as well as for the care and support of affected persons; and providing its longstanding experience in framing international standards to protect the rights of workers.
9. **United Nations Educational, Scientific and Cultural Organization (UNESCO)** efforts focus on preventive education and include advocacy at all levels, developing effective and culturally sensitive information for target groups; developing education programs that teach young people about HIV and how to prevent it; helping build the knowledge, attitude and skills needed to provide care for the infected and affected; and developing and disseminating tools for monitoring, assessing and responding to the impact of the epidemic on schools, students and teachers.

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

## **Additional UN Agency HIV-Related Activities**

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

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

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## Chapter 3: Vulnerability Assessments Program Design Steps

# Chapter 3: Vulnerability Assessments

## Program Design Steps

### Key Concepts

3.1 Conducting Food Security Vulnerability Assessments in the Context of HIV

3.2 Adapting Vulnerability Assessments in the Context of HIV

3.3 Steps for Conducting Vulnerability Assessments

3.4 Minimum Vulnerability Assessment Requirements to Design HIV Programs

3.5 Approaches and Tools for Vulnerability Assessments

## In This Chapter

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

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

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

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

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

## Conducting Food Security Vulnerability Assessments in the Context of HIV

### Primary Challenges to Assessing Vulnerability in the Context of HIV

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

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

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

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

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

### Key Considerations for Assessing Vulnerability in the Context of HIV

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

- ▶ Demographic characteristics, livelihood situations and other factors
- ▶ How HIV affects individual nutritional status, household access to resources and household food security<sup>1,2</sup>

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

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

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

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

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

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

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

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

## 3.2

### Key Concept Adapting Vulnerability Assessments in the Context of HIV

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

## Include HIV-Related Food Security Risk and Vulnerability Indicators

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

- ▶ Availability of food, primarily through production

### HIV-Related Food Security Risk and Vulnerability Indicators

#### Human Capital—Labor

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

#### Human Capital—Education

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

#### Financial Capital

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

#### Physical Capital

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

#### Social Capital

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

#### Political Capital

- ▶ Changes in participation in community meetings

#### Natural Capital

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

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

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

## Use Proxy HIV Indicators

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

### Proxy Indicators for HIV<sup>3</sup>

#### Morbidity Rates

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

#### Mortality Rates

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

#### Hybrid Mortality Rates

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

#### Household Demographics

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

## Use Food Security Analysis to Determine HIV Vulnerability

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

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

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

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

## Identify Household Coping and Survival Strategies

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

### Household Coping Strategies

#### Short-Term Coping Strategies

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

#### Distress Coping Strategies

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

## Aggregate Risks and Vulnerabilities to Community-Level Indicators

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

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

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

## Community-Level Indicators of Risk and Vulnerability

### Community Members

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

### Demographic Composition and Structure

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

### Education

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

### Income and Assets

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

### Change in Infrastructure

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

### Organizational Change

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

## Integrate Gender Analysis<sup>6</sup>

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

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

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

## Key Questions for Use in Conducting Gender Analysis<sup>7</sup>

### Household Roles/Social and Cultural Constraints

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

### Food and Livelihoods

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

### Health Risks and Accessibility to Health Services

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

### HIV-Affected Households

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

## Consider the Dynamic Nature of HIV

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

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

## Use Participatory Tools to Reduce Stigma

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

## CARE Zimbabwe Taps Community Knowledge With Participatory Tools<sup>9</sup>

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

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

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

Each group drew a social map showing general information about their community (e.g., infrastructure)

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

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

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

## 3.3 Key Concept Steps for Conducting Vulnerability Assessments

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

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

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

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

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

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

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

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

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

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

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

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

**Household characteristics**, including information on livelihood assets such as:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

## Nutritional Assessment Component

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

Two types of indicators should be used in a nutrition assessment in contexts with a high prevalence of HIV:<sup>18</sup>

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

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

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

## Ethical Considerations in Data Collection

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

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

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

Figure 1: Data Requirements to Assess Food Insecurity

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

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

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

<b>Food Availability</b>	
Secondary	Primary
Ministry of Agriculture Ministry of Finance and Commerce National Statistics Offices USAID's Famine Early Warning System (FEWS) European Union (EU) Food Security Units Market information systems, if available World Bank WFP Vulnerability Analysis and Mapping (VAM) Surveys	Key informant interviews with government staff, traders Market observations in affected localities
<b>Food Access</b>	
Secondary	Primary
Local government NGO reports Livelihood profile data generated from secondary data review World Bank WFP VAM	Key informant interviews with district officials, village leaders, service providers, merchants, NGOs Group interviews/focus group interviews Household surveys Participatory rural appraisal (PRA) tools Transect walks, visual inspection Market interviews Wealth ranking
<b>Food Utilization</b>	
Secondary	Primary
Ministry of Health DHS UNICEF nutrition surveys WHO health surveys Local health center data	Key informant interviews with district health officials, health service providers, village leaders, NGOs Group interviews Focus group interviews Household interviews PRA tools Transect walks Visual inspection Health facility records Nutrition surveys Sentinel site surveillance Village level primary data <ul style="list-style-type: none"> <li>▶ Nutritional survey</li> <li>▶ Growth monitoring</li> </ul>
<b>HIV Information</b>	
Secondary	Primary
Ministry of Health DHS UNICEF WHO health surveys Local health center data UNAIDS FAO WFP	Key informant interviews with district health officials, health service providers, village leaders, NGOs Household interviews focused on chronic illness Health facility records Sentinel site surveillance Village level primary data <ul style="list-style-type: none"> <li>▶ Nutritional survey</li> <li>▶ Growth monitoring</li> </ul> Social mapping

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

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

## Step 3. Analysis of Assessment Findings

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Data collected in the assessments are analyzed in three ways:

### Preliminary Analysis (Situation Analysis)

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

### Level I Analysis (Descriptive Analysis)

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

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

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

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

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

## Key Questions for Assessing HIV's Impact on Safety Nets

### Formal Safety Nets

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

### Informal Safety Nets

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

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

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

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

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

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

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

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

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

## Level II Analysis (Dynamic Analysis)

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

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

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

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

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

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

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

## Step 4. Development of a Vulnerability Assessment Report

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

## Step 5. Program Design Based on Assessment Findings

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

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

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

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

# 3.4

## Key Concept

### Minimum Vulnerability Assessment Requirements to Design HIV Programs

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

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

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

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

## 3.5 Key Concept Approaches and Tools for Vulnerability Assessments

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

## A Rural Vulnerability Assessment

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

The CHS conducted surveys in areas where WFP implements food assistance and other interventions. In each country, the surveys used a two-stage random sampling methodology to provide an unbiased and representative estimate of the information required. The first stage was the random selection of final distribution points (FDPs) by district of intervention. A number of FDPs (the total varies by country) were selected from a list of distribution points. The second stage was a random selection of households within each selected FDP. Two sampling frames were used, one listing all beneficiaries and the other listing all non-beneficiaries, and a random sample of 15 households was selected from each frame. Some non-beneficiary households had never received food assistance, but

others that were classified as non-beneficiaries may have received food at an earlier stage, but not in the month before the survey.<sup>25</sup>

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

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

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

## A Community Vulnerability Assessment<sup>27</sup>

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

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

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

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

## An Urban Vulnerability Assessment

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

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

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

The focus groups, which had a balanced sample with men, women, boys and girls, discussed three themes: caring for others, livelihoods and wealth ranking, and household resilience. The assessment team used the *transformational development indicators scoring system*,

developed by World Vision, to score and summarize the findings of these qualitative discussions.

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

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

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

# Annex I: Standard Format for a Vulnerability Assessment Report

## Executive Summary

### 1. Objectives and Methodology of the Assessment

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

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

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

### 3. Nature of the Shocks and General Demographic Impact

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

### 4. Food Availability and Markets

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

### 5. Livelihoods and Households' Access to Food

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

## 6. Food Consumption and Utilization: Nutritional and Health Status

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

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

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

## 8. Response and Targeting Options

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

## 9. Recommendations and Proposed Assessment Follow-up

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

## Annexes

Map of the affected areas

Assessment instruments used

Seasonal calendar (and any other significant summary diagrams)

Schedule of the assessment activities and site visits

Members of the assessment team

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

## Endnotes

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