Chapter 8 Contents

8. HIV

Abstract

HIV activities were implemented by 41 Title II development programs in 20 countries. Nearly all of these programs were in Africa, where half of all programs in the FAFSA-2 universe had HIV components. HIV programming evolved significantly during the FAFSA-2 time frame, spurred by an exponential increase in donor resources, most notably PEPFAR, with major advances in access to and quality of prevention, counseling, testing, treatment, and care, including nutrition support. However, nearly all Title II programs reviewed were designed without the benefit of the increased resources and more recent knowledge and experience on what works, because 85 percent of them began in FY 2005 or earlier. The main HIV intervention in 78 percent of the programs reviewed was SBCC to prevent HIV transmission by reducing high-risk sexual practices. Fourteen of the programs that worked on HIV prevention measured behavior change and half of these programs reported reducing high-risk practices. Nineteen programs did direct food distribution in 10 countries, primarily to PLHIV, HIV-affected households, orphans and vulnerable children (OVC), TB cases, and other vulnerable households for short-term food insecurity mitigation. With few exceptions, there were no specific objectives or results reported beyond the number of food recipients. Coverage of food recipients with livelihood strengthening and protection interventions was very low, with little focus on achieving long-term solutions to food insecurity. Title II development programs need to move beyond short-term mitigation and implement effective and sustainable long-term solutions to food insecurity in the context of HIV. In FY 2009, US$21.1 million was spent on Title II HIV activities, reaching 514,169 beneficiaries; this represents approximately 7 percent of the total cost of Title II development programs. Nearly all of these resources supported HN or AG/NRM interventions, with only 7 percent of the US$21.1 million attributed to VGF. The policy implications of the HIV assessment are provided in Box 8.4 and the conclusions and recommendations are provided in Sections 8.6.1 and 8.6.2.

8.1 Introduction

8.1.1 Policy and Program Environment

Recognition of the importance of nutritional management of HIV grew by leaps and bounds during the FAFSA-2 time frame, as did the delivery science of HIV interventions (FANTA, 2004; World Bank, 2007). At the time of the first FAFSA, the USAID/FFP focus on HIV was via direct food distribution for humanitarian assistance or general relief. Starting with its FY 2002 Proposal Guidelines, USAID/FFP broadened the definition of HIV activities it would support to include AG, MCH, or other sector(s) where: (1) HIV/AIDS is a critical constraint to food security, (2) direct and measurable impact on food security in that sector can be achieved, (3) primary USAID/FFP input is food distribution, and (4) integration with HIV/AIDS activities and service providers funded by others can be maximized.[252] With the issuance of its Strategic Plan in 2005, USAID/FFP called for activities "to help prevent, treat and mitigate the impact of chronic diseases such as HIV/AIDS and TB" (see Table 8.1). From FY 2006 onward, the USAID/FFP Proposal Guidelines stressed tightening the targeting of food rations to ensure that HIV-infected people and HIV-affected households assisted with Title II resources were indeed food insecure. That year, USAID/FFP introduced the requirement to separately track and report Title II resources and beneficiaries for HIV activities.

Two major developments during the FAFSA-2 time period were the launchings of PEPFAR and the Global Fund, which together greatly increased the resources available to address HIV. Through PEPFAR, which began in 2003 and was reauthorized in 2008, and the Global Fund, billions of dollars of assistance to HIV programs in developing countries have expanded access to PMTCT and NACS. Co-programming using PEPFAR funds for services and Title II food aid for direct mitigation and strengthening of food and livelihood security of PLHIV and affected households was first recommended in the FY 2006 USAID/FFP Proposal Guidelines. The USAID/FFP and PEPFAR HIV and Food Security Conceptual Framework, issued in 2007 for guidance on coordinating activities with mutual objectives, encouraged Title II programs to provide food and livelihood assistance to HIV-affected vulnerable families, while PEPFAR dedicated its resources to food and nutrition support, including provision of specialized food products at the clinic level for specific priority target groups.[253] The extent to which USAID and its implementing partners were able to co-program Title II and PEPFAR resources is discussed later in this chapter.

8.1.2 Methods

The FAFSA-2 HIV reviewer employed the same methods used to review the Title II-supported MCHN activities described in Chapter 6. Most of the assessment was based on reading 287 program documents and using a specially designed Excel spreadsheet to tabulate the results (see Box 8.1 for limitations of the review).

This chapter covers primarily Title II HIV HN and VGF activities. Livelihood strengthening and protection interventions, which are critical to achieving sustainable solutions and helping PLHIV and their household members successfully exit from receiving food aid, were integrated with supplementary feeding for PLHIV in a number of programs reviewed. Therefore, they are also discussed. The interventions and approaches used and the outcomes and impact achieved by Title II programs are presented. A brief summary of the state of the art of interventions and approaches to which the Title II programs were compared is also described. Finally, this chapter identifies issues and opportunities for program improvement and provides conclusions and recommendations.

[252] USAID/FFP annual Proposal Guidelines for FY 2002 through FY 2005.

[253] The PEPFAR target groups for nutrition support or supplementary feeding are: (1) orphans and vulnerable children (OVC) born to an HIV-infected parent, (2) HIV-positive pregnant or lactating women in PMTCT programs, and (3) adult patients in antiretroviral therapy and care programs with a BMI < 18.5 (PEPFAR, 2008).

Table 8.1. Illustrative Activities from the 2006–2010 Strategic Plan Related to Sub-IR 2.1, Human Capabilities Protected and Enhanced

Illustrative Activities: To help prevent, treat, and mitigate the impact of chronic diseases, such as HIV/AIDS and TB	
Non-Food Assistance	**Food Assistance**
The Title II program: • Incorporates HIV/AIDS prevention education as a cross-cutting theme in community-level activities. • Provides training to village health workers and caregivers in home-based care and support, including preventing mother to child transmission (PMTCT) of HIV/AIDS. • Provides training and supports the implementation of community-based nutrition recuperation programs. • Coordinates with HIV/AIDS service providers to increase access to critical HIV/AIDS services such as voluntary testing and counseling and antiretroviral therapies. • Educates women with HIV/AIDS about appropriate breastfeeding practices to prevent mother to child transmission.	The Title II program: • Provides food as an incentive for people to get tested for HIV/AIDS and to get counseling. • Provides food transfers as part of home-based care services. • Provides food as part of community-based nutrition recuperation programs. • Provides food as an incentive for Directly Observed Treatment, Short-Course (DOTS) of TB patients.

Source: This table is taken verbatim from the USAID/FFP Strategic Plan (2005, p. 66).

Box 8.1. Limitations of the FAFSA-2 Review of HIV Components of Title II Programs

The completeness and accuracy of this assessment are dependent on the completeness and accuracy of the program documents and results data reported by Awardees. The reviewer was unable to verify the quality of the reported evaluation data or conduct new re-analysis of survey datasets. However, when survey limitations were reported, the problems were documented and the data were not used. Indicators that measured knowledge instead of actual practice at the highest outcome level were eliminated from the review of results. The Title II reports had more information on **what** interventions and approaches were implemented and the results achieved than on **how** programs were designed and implemented; the quality of implementation; or the extent of coverage, participation, or exposure of the beneficiaries to the interventions. This review could have been improved by having more information to explain **why** certain results were or were not achieved and to describe program models. The FAFSA-2 team was able to observe the quality of service delivery during field visits to HIV activities in two ongoing programs in two countries.

8.2 Basic Facts about Programs Addressing HIV in the FAFSA-2 Universe

8.2.1 Projects and Countries

The number of programs using Title II resources to address the impact of HIV increased during the FAFSA-2 time frame. During this period, 41 Title II development programs included HIV interventions in 20 countries: 34 of these programs were in Africa, 7 in LAC, and none in Asia. (See Table 1.3 for the list of the 41 programs reviewed.) In Africa, 76 percent of the Title II programs with a significant HN component (26 of 34) also included HIV interventions.

Eighty-five percent of the programs reviewed started in FY 2005 or earlier, well before the importance of comprehensive nutrition care for PLHIV and approaches to providing it were well understood. Nearly half started in FY 2003 or earlier, before PEPFAR funding became available to address the epidemic. Of the 15 focus countries in the first phase of PEPFAR (FY 2003–FY 2008), which coincided with the FAFSA-2 time frame, 7 countries had a combined total of 20 Title II programs with HIV components (Ethiopia, Haiti, Kenya, Mozambique, Rwanda, Uganda, and Zambia), but most of these programs started before PEPFAR. In the current Phase II of PEPFAR (FY 2009–FY 2013), the number of countries receiving PEPFAR assistance has more than doubled, whereas the list of USAID/FFP focus countries has been shortened. Given the differences between PEPFAR and USAID/FFP focus country lists, there is now potential for Title II and PEPFAR to converge in only six countries (DRC, Ethiopia, Haiti, Malawi, Mozambique, and Uganda).

8.2.2 Resources, Technical Sectors, and Beneficiaries

In the FAFSA-2 analysis of the FY 2009 Tracking Tables, 18 awardees (40 percent) reported HIV components using 26,245 MT of Title II commodities to reach 514,169 beneficiaries at a total annual cost of US$21.1 million.[254] Funding for Title II HIV interventions reported that year represented 6.7 percent of the total cost of Title II development programs. Nearly all of these resources supported activities for PLHIV and HIV-affected households in the HN or AG/NRM technical sectors (46 percent each), with only 7 percent of the US$21.1 million attributed to VGF (see Table 8.2). Awardees attributed two-thirds of the more than half a million HIV beneficiaries reached in FY 2009 to HN activities, 18 percent to VGF, and only 13 percent to AG/NRM.

[254] This excludes FY 2009 Title II PM2A research programs in Burundi and Guatemala, which were just beginning in late FY 2009, and the Afghanistan program, because they are not part of the FAFSA-2 universe.

Table 8.2. HIV Activities: Technical Sector Distribution of Commodities Used and Beneficiaries Reached in Title II Development Programs in FY 2009*

Technical Sector	Commodities for HIV (Percent)	HIV Beneficiaries	
		Number	Percent
Health and nutrition	45.8	352,607	68.6
Sustainable agricultural production/natural resources management	45.7	68,116	13.2
Vulnerable group feeding	7.2	92,672	18.0
Emergency preparedness and disaster management	1.2	0	0.0
Non-agriculture	0.0	774	0.2
Education	0.1	0	0.0
TOTAL	**100.0**	**514,169**	**100.0**

* The FY 2009 data presented exclude Title II PM2A research programs in Burundi and Guatemala, which were just beginning in late FY 2009, and the Afghanistan program, because they are not part of the FAFSA-2 universe. Data come from the FY 2009 Resources and Beneficiaries Tracking Tables in the ARRs submitted to USAID/FFP by Title II Awardees.

Title II HIV work was underreported and underrepresented. In FY 2010, not one Mission reported Title II resources under the HIV/AIDS "F" Program Element, despite the fact that a number of Title II programs worked on HIV prevention and home-based care and support, and provided direct food distribution to PLHIV and orphans and vulnerable children (OVC).[255]

In 2011, USAID/FFP revised its annual reporting guidance to include 14 "F" program elements, one of which is HIV/AIDS. These are now aligned with the Foreign Assistance Framework and should better capture the important role of Title II programs in USG HIV programming than did the previous reporting system that used technical sectors unique to USAID/FFP. With the aim of giving Title II the credit it deserves for contributing to U.S. foreign assistance objectives, Table 8.3 documents the interventions supported using the standard "F" sub-elements under the HIV/AIDS Program Element.

8.3 Program Approaches and Interventions

Prevention, counseling and testing, treatment, and care are the main health interventions of HIV programming worldwide. Support for the needs of OVC affected by HIV is another priority. Equally important is supplementary feeding using food assistance directly to help meet the nutritional needs of PLHIV and to strengthen their food and livelihood security (FANTA, 2004; FANTA and WFP, 2007; PEPFAR, 2006). Table 8.3 lists the HIV interventions implemented in the 41 Title II programs reviewed, namely, prevention of sexual transmission, food rations for adult care and support and OVC, and HIV counseling and testing (HCT).

FAFSA-2 found that the focus of the 41 Title II programs reviewed was on HIV and not on other chronic diseases, though a number of programs targeted individuals infected with and households affected by "chronic illness" as a proxy for HIV. Some programs provided food aid to people with TB, identified by HIV or broader chronic illness eligibility criteria. However, the only program that stated it worked to increase treatment for TB using Directly Observed Treatment, Short-Course (DOTS) was CRS/Ethiopia (FY 2003–FY 2008). None of the programs reported working directly on PMTCT, but a number of programs promoted use of PMTCT services as part of their educational activities.

8.3.1 Prevention of Sexual Transmission of HIV

The principal HIV intervention assisted by Title II programs was prevention of sexual transmission using SBCC and "ABC" messages.[256] Prevention is the most cost-effective response to public health problems. Therefore, this emphasis in Title II

[255] The FY 2010 rack-up of Title II reporting by "F" program elements shared with the FAFSA-2 team by USAID/FFP illustrates this underrepresentation of Title II. This underreporting is similar to that in Title II MCHN programs, as discussed in Section 6.2.2.

[256] The ABC approach to HIV prevention promotes the following safe sex practices: **A**bstain from sex until marriage, **B**e faithful to your partner (or reduce the number of partners), and **C**onsistently and correctly use condoms.

Table 8.3. HIV Interventions in Title II Programs in the FAFSA-2 Universe and Their Contribution to Program Element 3.1.1 HIV/AIDS of the U.S Foreign Assistance Program Area 3.1 Health

HIV/AIDS Sub-Element	Number of Programs	Percent of Programs (N = 41)
Sexual Prevention*: 3.1.1.2 Abstinence/Be Faithful 3.1.1.5 Other Sexual Prevention	32	78
3.1.1.6 Adult Care and Support (Food Rations)	19	46
3.1.1.8 Orphans and Vulnerable Children (Food Rations)	12	29
3.1.1.9 Counseling and Testing	2	5

* It is not possible to disaggregate sexual prevention by sub-elements 3.1.1.2 and 3.1.1.5 from the available documentation.

programs was appropriate and consistent with the USAID/FFP Strategic Plan Illustrative Activity to incorporate HIV/AIDS prevention education as a cross-cutting theme in community-level activities (see Table 8.1). Most programs with an HIV component (78 percent) implemented SBCC to prevent HIV. However, Awardees not providing direct food distribution to PLHIV tended not to attribute Title II resources to this HIV prevention work in their annual reporting Tracking Tables.[257] They may have mainstreamed SBCC for HIV prevention into other health education activities. The programs used awareness-raising, mobile cinema, theater forums, computer literacy classes, radio broadcasts, peer education, and peer counseling to disseminate HIV prevention messages and to promote participation in HCT and PMTCT.

Outcomes. While participants in a number of programs increased their knowledge of the causes of HIV and how to prevent it, indicators of improved practices are more important. One-half of the 14 programs that had outcome indicators on reducing high-risk sexual practices for HIV transmission achieved improvements in these HIV prevention practices. Unfortunately, given the heterogeneity of indicators measured, it is impossible to report overall quantitative results here.

8.3.2 HIV Counseling and Testing

While a number of programs promoted HCT as part of their HIV prevention strategy, only two programs worked directly to increase use of HCT. The ACDI/VOCA/Rwanda FY 2005–FY 2010 program, with ACDI/VOCA's partner, Africare, in the lead, trained staff at seven public HCT centers. Africare also provided HCT through a mobile clinic as well as a stationary center.[258] SC/Uganda offered mobile HCT on a small scale.

Outcomes. The only outcome reported was in the ACDI/VOCA/Rwanda program in which 72,866 people received HCT (nearly twice the target).

8.3.3 Supplementary Feeding for PLHIV, OVC, TB Cases, and Other Vulnerable People

The term "supplementary feeding," as used in the FAFSA-2, refers to direct distribution of Title II food rations to individuals infected with and households affected by HIV.[259] Food rations are intended to supplement the diet and may include cereal and legume staples, vegetable oil, or FBF. Although Title II supplementary feeding for HIV is a form of nutrition support, it should not be confused with the narrower definition of "nutrition support" used in PEPFAR programs. Introduced by PEPFAR in the latter part of the FAFSA-2 time period, nutrition support refers mainly to providing RUTF or other specialized food products to malnourished PLHIV for therapeutic feeding. This was not done in the Title II programs reviewed.

Adequate dietary intake is a challenge for PLHIV because of the increased energy needs created by HIV; micronutrient deficiencies precipitated by HIV and opportunistic infections; HIV-related symptoms and frequent diarrhea that interfere with appetite, digestion, absorption, and metabolism; and the difficulty of remaining economically productive and accessing sufficient food. The increased availability of antiretroviral therapy (ART) has resulted in a better understanding of the difficulty that patients face in complying with drug regimens without sufficient food (FANTA, 2004). Food security and HIV are linked in a bidirectional relationship. Food insecure PLHIV are less able to meet their nutrient requirements to stay healthy with HIV, and energy- and resource-depleted PLHIV are less able to produce food or earn income. Thus, food assistance is important in effective HIV care, treatment, and food insecurity mitigation.

[257] This may be because USAID/FFP expressed, in its FY 2006 through FY 2010 Proposal Guidelines, its preference for using Title II monetization resources for "direct food security mitigation or intervention to strengthen food and livelihood security for those affected by HIV/AIDS rather than for HIV/AIDS prevention or education programs."

[258] The latter was started earlier under Africare's USAID-funded sub-agreement with Family Health International.

[259] This should not be confused with the narrower use of this term in CMAM to refer only to providing supplementary foods to recuperate children with MAM (low weight-for-height).

Supplementary feeding in the context of HIV can be used either (1) for nutrition support for care and treatment programs or (2) as a safety net for social protection and food insecurity mitigation. Nutrition support to PLHIV uses food assistance to enable PLHIV in food insecure households to participate in treatment, increase adherence to treatment, and help prevent or treat undernutrition (World Bank, 2007). The performance of Title II supplementary feeding for HIV nutrition support or safety nets should be reviewed in the context of the current state of the art, which is summarized briefly here.

Since 2006, PEPFAR has contributed a great deal to the knowledge and experience base on how to use food assistance cost-effectively for nutrition support to PLHIV in order to save the most lives, an approach initially referred to as "Food by Prescription" (FBP) and first introduced in Kenya. Program implementers have learned that while distributing food to treat undernutrition (nutrition support) is often the most visible intervention that attracts the most attention, nutrition assessment and counseling are equally important components that need to be firmly established before prescription of specialized food products is rolled out. PEPFAR now considers an integrated approach known (since 2010) as NACS to be an essential standard of care (PEPFAR, 2011).

In the NACS approach, **nutrition assessment** includes anthropometric measurements and clinical assessment to identify individuals with weight loss or wasting, which are independent risk factors for HIV progression and mortality,[260] and assessment of biochemical, dietary, and food security parameters. Both clinic- and community-based providers can do anthropometric, clinical, and dietary assessment, while biochemical assessment is done in clinics and food security assessment is usually done in the community. **Nutrition counseling** is tailored to the results of the nutrition assessment and includes determining enablers and barriers to optimal behaviors and counseling on diet, treatment adherence, WASH, IYCF and other positive living behaviors. **Nutrition support** at the clinic level includes provision of therapeutic food to treat SAM (extreme thinness or wasting) and FBF to clients with MAM, micronutrient supplements, and point-of-use water treatment products. Nutrition support at the community level includes food assistance, economic strengthening, and livelihood services such as those supported by Title II to improve food security.

PEPFAR prioritizes food assistance for those groups for whom it will have greater impact on reducing undernutrition, mortality, and HIV progression and transmission, and will likely be more cost-effective. PEPFAR food assistance targets: (1) HIV-exposed infants from 6 to 23 months (irrespective of anthropometric status); (2) underweight pregnant and lactating women in PMTCT programs; (3) OVC, including children of HIV-infected parents, with acute malnutrition; and (4) adult HIV patients with moderate or severe acute malnutrition (i.e., with a BMI < 18.5). Specialized food products "are prescribed for a limited duration on the basis of clear anthropometric entry and exit eligibility criteria or nutrition vulnerability" (PEPFAR, 2011, p. 3).

The state of the art for food assistance for **safety nets** in rural areas where food insecurity is widespread, such as those where Title II programs work, calls for **not** targeting food assistance solely to food insecure PLHIV and HIV-affected households. The reason is a likelihood of creating stigma and resentment for beneficiaries when the entire community is food insecure (FANTA and WFP, 2007). Multi-criteria targeting is recommended, using clinical, social, economic, and demographic indicators. This can be further improved using community-based targeting, which engages community members with knowledge of households in the targeting process, thereby increasing community awareness and understanding of HIV as well as ownership of the intervention. Any food assistance should be short term and part of an overall strategy that strengthens livelihood security of HIV-affected and other food insecure households to live independently in the long term. It is important not

[260] Taken from "A Wholesome Approach: Nutrition and HIV/AIDS." http://transition.usaid.gov/our_work/global_health/aids/TechAreas/caresupport/nutrition.html. Accessed October 19, 2012.

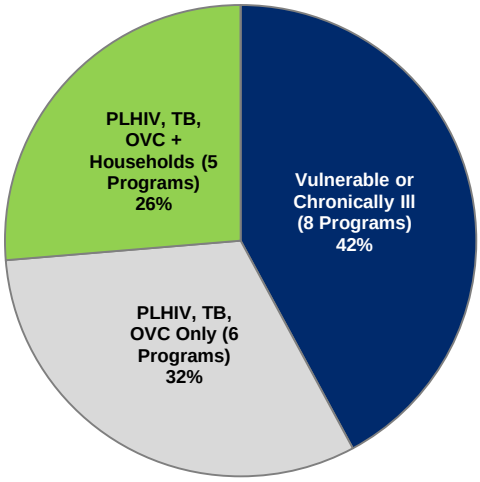
to disrupt local markets and create disincentives to food production or create dependency (FANTA and WFP, 2007).

8.3.3.1 Characteristics and Targeting of Title II HIV Supplementary Feeding

Nineteen of the Title II HIV programs reviewed (46 percent) did direct food distribution. Several Awardees used the FANTA 2004 manual, *HIV/AIDS: A Guide for Nutrition Care and Support*, to determine rations and nutrition counseling to meet the nutritional needs of PLHIV. Programs strived to maintain the confidentiality of beneficiaries' HIV status by distributing food outside the community or using associations of PLHIV to distribute food rations, rather than the Awardee distributing rations directly. Program implementers reported that empowering PLHIV through membership in associations (discussed later) and working with community leaders to reduce the stigma associated with HIV were critical to increasing participation of PLHIV. Implementers were also careful when collecting and disclosing M&E data to maintain the confidentiality of beneficiaries' HIV status. Awardees sought to follow other "do no harm" principles for HIV food assistance, e.g., not to exacerbate community divisions, disrupt traditional safety nets and support systems, or create dependency and community resentment.

Three types of targeting were used in the 19 programs, namely, food assistance for: (1) PLHIV, TB cases, and OVC only (32 percent); (2) PLHIV, TB cases, OVC, and their households (26 percent); and (3) food insecure households, including the chronically ill, the elderly, PLHIV, TB cases, OVC, and female-headed households (42 percent) (see Figure 8.1.) Most of the programs provided food rations to all household members. Twelve programs (63 percent) benefited OVC. In those programs targeted to PLHIV that had been diagnosed as HIV-positive by clinics, local NGOs, or community associations, the ability to ensure that beneficiaries were not only HIV-positive but also the most food insecure, was limited. On the other hand, programs that used broader criteria and proxy indicators at the community level

Figure 8.1. Target Groups for Food Rations in Title II HIV Programs in the FAFSA-2 Universe



identified households that were food insecure, but not necessarily HIV-affected.[261, 262] Since ensuring that beneficiaries were food insecure emerged as a challenge in the early years of the FAFSA-2 time period, USAID/FFP began to stress in its Proposal Guidelines for HIV programming from FY 2006 onward that Title II food go to food insecure HIV-affected populations.

Unlike PEPFAR, none of the Title II programs reviewed used BMI or other anthropometric measurements of nutritional status as an entry criterion. Thus, there was no targeting of food rations specifically to underweight and malnourished PLHIV. Only in their last two program years did the Rwanda ACDI/VOCA (FY 2005–FY 2010), CRS, and WV programs use BMI > 18.5 in adults (the cutoff for moderate thinness or acute malnutrition) as a graduation criterion from supplementary feeding, and monitor relapse post-graduation of BMI < 18.5 for readmission. The late introduction

[261] The CRS/Rwanda program was in the third category and did targeting based on broader vulnerability criteria. However, they did report in their final evaluation that 45 percent of those that qualified for supplementary feeding were PLHIV.

[262] In the CRS/Zambia and CRS/Malawi programs, the broader targeting of food insecure households had its historical roots in the beneficiary selection process used in the emergency response to drought in Southern Africa in 2003–2004 implemented by the Consortium for Southern Africa Food Security Emergency, which CRS was a member of.

of BMI measurement was a result of efforts to make Title II targeting criteria consistent with those of PEPFAR in Rwanda.

In its newer follow-on Title II program in Malawi (FY 2009–FY 2014) and in Zambia (FY 2006–FY 2011), CRS has used a more systematic selection process known as "Community-Managed Targeting and Food Distribution." This approach combines community-defined criteria with other predetermined criteria to identify the most food insecure households. This approach was also used in Kenya, South Sudan, and Tanzania and is featured in the FANTA and WFP 2007 publication, *Food Assistance Programming in the Context of HIV*. The first stage identifies households that are poor or very poor with limited food availability and access using the following criteria: (1) own less than two acres of land; (2) have less than three months of food stock, starting from harvest time; (3) own no livestock; and (4) do not participate in regular income-generating activities. Among households that meet at least three of those criteria, village committees then select the most vulnerable with any of the following characteristics:

- Caring for orphaned children (with both parents dead)
- Child-headed (parent or grandparent cannot play usual head of household role)
- Elderly-headed (> 60 years of age) with no other able-bodied adult members
- Chronically ill members or PLHIV
- Female-headed
- Two or more years of crop failure

The selected households are announced at a public meeting. In the CRS experience using two-phase, multi-criteria targeting in rural Southern Malawi, about 15 percent of households in the target communities qualified.

8.3.3.2 Objectives of Title II HIV Supplementary Feeding

From 2006 onward, USAID/FFP's Proposal Guidelines called for clearly defined objectives for food assistance to HIV-affected populations. This was much needed, as corroborated by the FAFSA-2 finding that most programs with an HIV component did not have well-defined objectives for distributing food, e.g., HIV, nutrition, livelihood security, or income generation objectives. Half of the programs had no stated objective or IR to describe the purpose of providing HIV supplementary feeding. A quarter of the programs had a food insecurity mitigation objective. Three programs had the stated goals of improving health services, and care and support, including nutrition support. Food rations were not conditioned on attending health services, except in a couple of cases where being on antiretroviral drugs (ARVs) was required. Only one program had an objective of improving livelihood outcomes, and two strove to maintain or mitigate impact on the nutritional status of PLHIV and affected households.

Given the mitigation focus, the lack of clear technical sector objectives and nutritional targeting criteria, and the paucity of evaluation indicators in the programs reviewed, the supplementary feeding in nearly all of the programs is best described by USAID/FFP's VGF technical sector, as defined in Box 8.2. However, Awardees reported most of the beneficiaries of HIV food distribution under the HN technical sector (see definition in Chapter 6, Box 6.1, and Table 8.2), and not as VGF. However, many of these programs did not belong in the HN technical sector because they did little, working directly or in partnerships, to ensure that people received HCT or that PLHIV received ARVs, NACS, and other health services. These complementary services were usually provided by the clinics and organizations that referred PLHIV for food assistance, and most Title II development programs were not proactively involved.

Box 8.2. USAID/FFP Definition of Its "Vulnerable Group Feeding/ Social Safety Net" Technical Sector

"Objectives include saving lives and providing food to low-income and other vulnerable individuals and populations who are unable to meet basic needs for survival and human dignity. Individuals may be unable to meet these needs due to an external shock, such as a natural disaster or war, or due to socioeconomic circumstances, such as age, illness, disability or discrimination. Such individuals are often dependent to some extent on outside resources to meet their basic food and livelihood needs. Activities include provision of general or supplementary on-site or take-home rations through unconditional safety nets, and food support to institutions assisting the destitute, terminally ill, or highly vulnerable children and youth."

Source: USAID/FFP Annual Results Reporting Guidance for FY 2009.

8.3.3.3 Nutrition Assessment, Counseling, and Support for PLHIV

Building on earlier experiences with FBP, the NACS approach has been introduced by PEPFAR programs in Côte d'Ivoire, Ethiopia, Haiti, Kenya, Mozambique, Tanzania, Uganda, and Zambia over the last several years. Title II programs with HIV components are ongoing in two of these countries—Haiti and Uganda. However, in contrast to these PEPFAR programs, the Title II programs providing supplementary feeding or nutrition support for PLHIV did not provide the complete NACS package as a practice. The component most often lacking was nutrition assessment. This was not surprising given that most Title II programs reviewed started in 2005 or earlier before FBP/NACS was introduced by PEPFAR. The three programs in Rwanda came closest to doing NACS once they started measuring the BMI of adult supplementary feeding beneficiaries in the later years of these programs. One handicap of Title II programs in implementing NACS, compared to PEPFAR, was that they did not have access to the therapeutic foods (RUTF) required to treat SAM in adults or children, if they had diagnosed it. As USAID/FFP increases the availability of RUTF on the Title II commodity list, this will become less of a constraint. A different challenge is that therapeutic feeding is done under clinic-based protocols and Title II programs are community-based, not clinic-based. Thus, none of the Title II programs were doing therapeutic feeding for PLHIV, nor did programs report referring malnourished PLHIV to clinics for this. In contrast, PEPFAR programs are mainly clinic-based and are authorized to do local, regional, or international procurement of RUTF as well as FBF.

Counseling. The CRS/Rwanda program had an innovative approach to nutrition education through village *hearth* cooking demonstration sessions for vulnerable adults (not necessarily PLHIV) with BMI < 18.5 enrolled in supplementary feeding. The purpose was to teach them to cook complete, nutritious meals and to practice good hygiene. These sessions afforded the opportunity for interpersonal counseling. According to the final evaluation, the proportion of adults with low BMI decreased from 88 percent at the beginning of the sessions to 52 percent after six months, and fell further to 39 percent six months after food supplements had stopped. Examples of other programs providing nutrition counseling for PLHIV are those of CPI/Senegal and ACDI/VOCA/Uganda (FY 2007–FY 2011). The latter also provided hygiene education and did cooking demonstrations at the food distribution using recipes with CSB. In the communities, program extension workers gave classes using a manual on nutrition for PLHIV adapted from a national manual prepared by FANTA (ACDI/VOCA, 2007; Sserunjogi, 2004).

Outcomes. USAID/FFP introduced new required indicators in 2007, including "percent of PLHIV eating: (1) the recommended number of times per day, (2) the recommended number of food groups, or

(3) the percent of caregivers using diet appropriately to help manage symptoms or side effects of medication" (FFPIB 07-02, USAID/FFP, 2007). Beginning in that year, improvements in dietary practices of PLHIV in Title II development programs with HIV activities should have been measured. However, only two of the programs reviewed measured meal frequency—ACDI/VOCA/Uganda FY 2002–FY 2006 and FY 2007–FY 2011—and they improved this indicator in both cases. Most other programs with no outcomes measured (88 percent) started before USAID/FFP introduced required indicators for HIV components of Title II programs.

8.3.3.4 Approaches Used in Title II HIV Supplementary Feeding

Associations or PLHIV support groups. In some countries, such as Rwanda, the government requires PLHIV to belong to associations to receive services. In the ACDI/VOCA/Rwanda program (FY 2005–FY 2010), its partner Africare formed 35 such associations, many of which were consolidated into registered cooperatives. Africare/Burkina Faso also worked through community HIV associations to deliver services and required supplementary feeding beneficiaries to be members of associations. SC/Uganda formed livelihood support groups where PLHIV received assistance. WV/Ethiopia reported that in its FY 2003–FY 2008 program, the most successful component was community mobilization of PLHIV. The program organized Community Care and Coalition committees to raise money for OVC and PLHIV and their families and for self-care community support groups.

In Ghana, CRS safety net food rations played a key role in motivating PLHIV to join community associations. In the OICI/Ghana program, the majority of PLHIV served belonged to community associations whose primary purpose was care and support. The program got a list of existing support groups from hospitals and vetted them to decide which ones to assist. The CRS/Malawi program (FY 2004–FY 2009) formed some HIV support groups. During field visits in Malawi, the FAFSA-2 team met with members of one of these support groups from the prior project that was still going strong two years after Title II assistance had ended. The members were self-assured as they explained the positive role such groups and community mobilization supported by the Title II program had played in reducing stigma and discrimination against PLHIV in their community.

Home-based care. Six programs provided home-based care along with supplementary feeding—Africare/Burkina Faso, WV/Ethiopia FY 2003–FY 2006, OICI/Ghana, CRS/Malawi (FY 2009–FY 2014), CPI/Senegal, and CARE/Haiti. During home visits, CHWs provided care that consisted primarily of checking on the health and nutritional status of the PLHIV and providing information, education, and counseling. Illustrative topics addressed included hygiene, infection prevention, safe sex, diet, stress management, adherence to ART, management of common illnesses, and psychosocial support.

Food-for-Work. OICI/Guinea, Africare/Burkina Faso, and ACDI/VOCA/Rwanda (FY 2005–FY 2010) used FFW to pay peer educators and counselors and also paid volunteer, home-based care and nutrition community workers in food. No further details were reported by Awardees.

8.3.3.5 Graduation Criteria from Title II HIV Supplementary Feeding

Since 2006, USAID/FFP has required clear, realistic, and explicit graduation criteria and exit strategies in Title II proposals for HIV programming to ensure that positive outcomes are sustainable. Fixed terms of participation are desirable to avoid creating dependency. Furthermore, several programs reported that fixed, shorter terms for participation gave other qualified community members, who could not be covered initially due to the limits of food aid available, the opportunity to participate. In the ACDI/VOCA/Uganda program (FY 2007–FY 2011), which started under these newer guidelines, graduation took place after a one-year fixed term of participation. The need to tighten graduation criteria was a lesson learned in ACDI/VOCA's earlier program (FY 2003–FY 2007) in a different part of Uganda. This program had no graduation criteria,

and PLHIV and their household members received rations for the life of the program, even after the HIV-infected person died. The implementers found that this created dependency and resulted in hardship when the program ended. The OICI/Ghana program had a two-year fixed term of participation. Another program noted that graduating PLHIV from food rations is difficult because, although the participants may be self-reliant with sufficient income, they feel insecure and do not want to lose the psychosocial support from the program in case they become more ill. No services were provided once a participant graduated out of the program.

Three Awardees' programs in Rwanda initially had no graduation criteria. Any HIV-positive person with proof of their HIV status and membership in an association could participate in sequential six-month cycles. Starting in 2007, in the last two years of these programs, more stringent health, nutrition, and socioeconomic eligibility and graduation criteria were introduced for six-month supplementary feeding cycles.[263] However, PLHIV could re-enroll for another cycle if they met the eligibility criteria; 54 percent of graduated participants were re-admitted for another cycle in the ACDI/VOCA/Rwanda program (FY 2005–FY 2010), according to the final evaluation. The CRS/Rwanda final evaluation found, through interviewing former participants (vulnerable households, not necessarily PLHIV), that 28 percent were self-sufficient and 21 percent reverted to their initial nutritional vulnerability status. The latter category included patients that had no strength to work and healthy people that had no land to apply the bio-intensive agricultural techniques taught by the project. Another 45 percent experienced intermediate levels of vulnerability after graduation as measured by weight loss, not eating enough, and reducing the number of meals eaten, citing lack of CSB (previously received from CRS) as a major hindrance to taking their ARVs.

The earlier CRS/Malawi program (FY 2005–FY 2009) used suffering from chronic illness as a proxy indicator for identifying PLHIV eligible for food rations. Only 10–20 percent of the beneficiaries graduated before the end of the program, according to the final evaluation.[264] CRS found that chronic illness alone was not a reliable indicator of HIV or food insecurity. Applying this lesson in its ongoing program, CRS/Malawi (FY 2009–FY 2014) uses a two-stage food targeting process: first, meeting food insecurity criteria, then also meeting chronic illness or demographic criteria, both reassessed every year. Participants graduate when they no longer meet the eligibility criteria. The program implementers expect only about one-third of the participants to graduate because many of the vulnerability characteristics that made them eligible for food rations are permanent or difficult to improve.

Beyond the examples of graduation criteria from HIV supplementary feeding described, most programs had no criteria for graduation from assistance. Eligibility for supplementary feeding continued until the end of the program or the death of the participant.

8.3.4 Livelihood Strengthening and Protection

A recognized strength of Title II development programs is working to enhance food and livelihood security. A number of programs complemented HIV supplementary feeding with livelihood strengthening and protection interventions for the beneficiaries. No Title II HIV programs reviewed did livelihood strengthening or protection alone without direct HIV food distribution. Long-term, sustainable solutions are needed as an exit strategy from providing food rations to PLHIV and HIV-affected households, either through national, community, or faith-based social protection programs or through

[263] The more recent Rwanda graduation criteria were improved health and nutritional status as measured by increased CD4 count and BMI > 18.5, respectively; not taking ARVs; a regular source of income; and better socioeconomic status. Criteria were reassessed every six months. However, people could re-enroll if any of those factors deteriorated, if they started ARVs, if the number of PLHIV in the household increased, or if there were infected child survivors after an HIV-positive parent participant died.

[264] Chronic illness is defined as a condition, disease, or disability that has prevented an individual from being fully functional for at least three months within the previous year.

enhanced livelihood security. However, it has been a challenge for Title II programs with broader income generation activities and VGF for PLHIV to integrate the participants of these two interventions. One constraint is that often the PLHIV do not live in the same geographic areas where the projects' mainstream income generation activities are located. Another is that when projects have insufficient resources to do livelihood interventions in all project communities and with all participating households, PLHIV may get left out of projects that focus mainly on agriculture, if they need non-agricultural income-generating activities or are less viable. The importance of livelihood strengthening for PLHIV and acknowledgment of gaps in programs implemented during the FAFSA-2 time period were important lessons learned by Awardees (see Box 8.3). USAID/FFP has recommended using an HIV lens to modify program approaches to income generation activities for PLHIV in its Proposal Guidelines from FY 2008 onward. However, FAFSA-2 cannot assess if this was done in the older programs reviewed in the FAFSA-2 time frame prior to these guidelines.

The principal livelihood strengthening and protection interventions and approaches used in HIV components of Title II programs reviewed were the following.

Agriculture and animal husbandry. To generate income for PLHIV in urban areas, the CRS/Ethiopia program (FY 2003–FY 2008) assisted them with animal fattening and vegetable production. Africare, the partner of ACDI/VOCA in the Rwanda program (FY 2005–FY 2010), trained program participants in new agricultural techniques, provided seeds and seedlings, and promoted growing and consuming the nutritious leaves of the *Moringa* tree. In Rwanda, the WV and CRS programs also assisted PLHIV with progressive terraces, seeds, and the introduction of bio-intensive kitchen gardens. Both ACDI/VOCA and CRS found that vegetable gardening in Rwanda is not possible during the dry season on plots not close to a water source, and that other strategies were needed. ACDI/VOCA/Uganda also provided seeds and tools.

Box 8.3. Lessons Learned by Awardees on the Importance of Livelihood Strengthening for PLHIV as a Food Aid Exit Strategy

- Implementers of the CRS/Ethiopia (FY 2003–FY 2008) program learned that they needed to reduce food support to PLHIV and focus more on sustainable livelihoods and community support strategies. Food assistance was expensive and food beneficiaries often did not graduate from the program, thereby limiting the number of PLHIV that the program could help.

- The final evaluation of the Africare/Burkina Faso program noted that, while nutrition support with food aid for PLHIV is critical, it needs to be better targeted to avoid leaving participants with a permanent need for food aid. "Support in the form of income-generating activities is more sustainable and it needs to be strengthened in terms of both the number of beneficiaries and amount of credit" (Gordon et al., 2009).

- The final evaluation of the OICI/Ghana program found that the program did not have adequate resources for viable income-generating activities, which were needed to reduce the dependency on food rations and to ensure the program's sustainability.

- A program review by Africare identified the lack of income-generating activities for PLHIV as a gap in its Burkina Faso and Rwanda (FY 2005–FY 2010) programs (Maslowsky et al., 2008). ACDI/VOCA was a partner in the Rwanda program.

Microenterprise. ACDI/VOCA/Uganda (FY 2007–FY 2011) partnered with a local microenterprise NGO that facilitated small business start-ups by PLHIV and provided in-kind inputs, such as sewing machines and grain mills. The Africare/Burkina Faso program provided microcredit, whereas the CPI/Senegal program provided PLHIV with small grants for microenterprise.

Vocational training. Scholarships given to children of PLHIV by the OICI/Ghana program provided them with an otherwise unobtainable opportunity to acquire income-generating skills. This had the additional benefit of easing parents' worries about what would become of their children if they died.

Village savings and loans. Formation of VSL groups has been a very popular, mainstream, successful intervention in Malawi in the previous CRS program (FY 2005–FY 2009) (I-LIFE Consortium) and in the ongoing program (FY 2009–FY 2014) (WALA Consortium). It has been equally popular with PLHIV and helped them save to meet the costs of their health care and other contingencies. VSLs were also formed in the CRS/Ethiopia (FY 2003–FY 2008) and Rwanda programs, where they were known as Savings and Internal Lending Committees (SILCs). However, the CRS/Rwanda final evaluation reported that most PLHIV and OVC caregivers were too poor to save much, contributing on average US$2.00 per month. The ACDI/VOCA/Rwanda program (FY 2005–FY 2010) also promoted VSLs.

Health insurance. Health insurance can protect livelihoods from the shock of catastrophic medical costs that can drive households into extreme poverty and debt. In the ACDI/VOCA/Rwanda program (FY 2005–FY 2010), its partner Africare paid health insurance premiums for 997 households with PLHIV, which covered 3,950 family members at US$1.80 per person per year as part of the community-based health insurance offered through the national health system. However, in the other two programs in Rwanda (CRS and WV), participants paid their own premiums. In the CRS program, these funds were taken from the SILC. Thus, Africare's payment of these premiums was an additional income transfer to the beneficiaries, but was not sustainable in the absence of successful livelihood strengthening activities to help HIV-affected households generate increased income.

Outcomes. In most programs that had data on the coverage of their supplementary feeding participants with livelihood strengthening or protection interventions, the coverage rates were quite low. For example, by the fourth year of the ACDI/VOCA/Uganda program (FY 2007–FY 2011), cumulatively, 40,881 HIV-affected household members had received food. The target was 17 percent (7,000) of those household members graduating to livelihood groups after one year of food rations. However, ACDI/VOCA/Uganda's FY 2010 ARR stated that only 1,072 HIV-affected household members receiving rations had transitioned to participate in livelihood activities by FY 2010 (15 percent of the target of 7,000). The program made a special effort in its final year to increase the number of PLHIV receiving livelihood assistance. The CPI/Senegal program gave an average of 30 small grants per year to PLHIV for income-generating activities through FY 2009, exceeding its target, but falling far short of the need for these grants by the 1,100 PLHIV receiving food rations. Only the SC/Uganda program reported almost universal enrollment (92 percent) of food beneficiaries in livelihood support groups. The low coverage of PLHIV with livelihood strengthening activities found by the FAFSA-2 is consistent with the low percentage of HIV beneficiaries reported for AG/NRM in the FY 2009 Tracking Tables, only 13 percent, despite attribution to AG/NRM of nearly half of all Title II commodities that supported HIV activities (see Table 8.2).

None of the program documentation went beyond reporting on coverage to describe the outcome, i.e., whether HIV-affected households had achieved self-reliance and were able to support themselves without food rations or other project inputs as a result of the livelihood strengthening and protection interventions.

8.3.5 Co-Programming with PEPFAR

Mitigating food insecurity and strengthening livelihoods for households affected by HIV is a logical niche for Title II development programs that could complement PEPFAR programs in target geographic areas where both programs operate (USAID/FFP and PEPFAR 2007 Conceptual Framework). However, the distinct geographic locations of the highest concentrations of HIV and of food insecurity are major constraints to realizing this complementarity. HIV prevalence is highest in urban and peri-urban areas, while food insecurity is found mainly in rural areas. Title II focuses on rural areas with the highest levels of food insecurity, while PEPFAR focuses more on urban and peri-urban areas with the highest HIV prevalence, leaving little opportunity to work together with the same participants. Furthermore, Title II programs identify the most food insecure beneficiaries using community-level mechanisms and vulnerability criteria and further seek out PLHIV among the food insecure. In PEPFAR programs, patients are tested for HIV, assessed for nutritional status, and selected for nutrition counseling and support based on the results (mainly at hospitals and clinics); food insecurity criteria are not used.

Due to these fundamental differences and constraints, the ideal of PEPFAR and Title II development programs working together to serve the same HIV-infected individuals and HIV-affected households—with Title II resources meeting food and livelihood security needs and PEPFAR resources funding prevention, testing, treatment, and care, including NACS—has been difficult to achieve. The FAFSA-2 found no examples of PEPFAR and Title II working together to improve longer-term food and livelihood security for the same HIV-affected households. Three Title II programs reported doing shorter-term food insecurity mitigation through supplementary feeding of PLHIV on ARVs from PEPFAR—the CRS/Ethiopia (FY 2003–FY 2008), CRS/Haiti, and ACDI/VOCA/Uganda (FY 2003–FY 2007) programs. Partly in recognition of the constraints to co-programming with Title II, PEPFAR procured another food security solution to serve its clients. The Livelihood and Food Security Technical Assistance Project (LIFT) (FY 2009–FY 2013) provides TA to link clinic-based services with community-based economic strengthening and food security support services so that PLHIV that graduate from receiving PEPFAR-funded food rations do not relapse into undernutrition.

Several other types of collaboration between PEPFAR and Title II were reported. In each case, it was a result of Title II Awardees receiving separate PEPFAR grants to work with the same population served in the Title II programs, rather than collaborating with other PEPFAR implementers or doing jointly funded activities planned from the proposal stage. The ACDI/VOCA/Uganda program (FY 2003–FY 2007) reported receiving complementary funding from PEPFAR for community-based nutrition and hygiene education. In the CRS/Ethiopia program (FY 2003–FY 2008), PEPFAR complemented Title II food assistance for PLHIV with funds for meeting their health, education, shelter, and psychosocial support needs. The Africare/Mozambique and ACDI/VOCA/Rwanda (FY 2005–FY 2010) programs coordinated with Africare's PEPFAR-funded regional Community-Based Orphan Care, Protection, and Empowerment Project (COPE) for OVC. Prevention of HIV with PEPFAR funds complemented Title II resources in the CRS/Malawi program (FY 2005–FY 2009). In the ongoing Malawi Title II program, CRS implements a PEPFAR-funded initiative (Integrated HIV Effect Mitigation and Positive Action for Community Transformation [IMPACT]) to provide services to OVC and PLHIV. The IMPACT Project uses Title II program staff and structures, namely, Care Groups, VSLs, and support groups. In Guinea, funding from PEPFAR to Africare's HIV/AIDS Service Corps made possible educational and promotional meetings for HIV prevention with videos and audio-visual equipment in some of the Title II communities.

8.4 Program Impact

The only program with impact data was CRS/Rwanda, which measured BMI of PLHIV at the beginning of supplementary feeding and six months later at graduation. This was done in the later years of the program. From these service statistics, the final evaluation reported an impressive decline in low BMI—from 44 percent at enrollment to 21 percent six months later. These findings also highlight that 56 percent of the participants were not underweight at enrollment and did not necessarily need supplementary feeding. The program used broad chronic illness vulnerability targeting criteria and was not restricted to PLHIV or the malnourished. There may have been impact in other Title II programs, if any had been measured. Even though most of the programs reviewed primarily provided general relief, the FAFSA-2 is unable to document the development impacts of this large investment of food aid because they were not measured.

8.5 Cross-Cutting Issues and Opportunities

8.5.1 Role of Title II Supplementary Feeding in the Context of HIV

General relief. While using Title II food assistance for general relief to PLHIV and HIV-affected households was the charitable thing to do, especially before treatment became widely available and palliative care was the only option, should this be a high priority for scarce development food aid resources going forward? The dilemma is that in communities with widespread food insecurity where Title II works, there is never enough food aid available to provide it as an income transfer to all the extreme poor that might need it. Furthermore, what is the exit strategy to avoid creating dependency and hardship when the food assistance stops at the end of the program? For OVC, people that are too ill to work, the indigent, and helpless people in institutions, it is appropriate to use Title II resources for VGF? But what about the general feeding of PLHIV and their families that most of the programs described in this chapter were doing?

Food aid is usually provided as short-term humanitarian assistance or general relief to mitigate transitory food insecurity. However, unlike natural disasters, famine, war, and drought, the HIV pandemic is not cyclical or limited in duration; the disease is chronic. Fortunately, now in 2012, increased access to ART is serving both to prevent new cases of HIV and to increase longevity and quality of life for PLHIV, making many less vulnerable and more economically productive. This is a dramatic improvement from the early 2000s, when most of the Title II programs reviewed began. The more hopeful current situation argues for prioritizing the use of Title II resources for achieving long-term solutions through feasible livelihood strategies for the food insecure, including HIV-affected households. As Title II programs run for five years or less, their strength is not long-term social protection, which is normally the purview of national governments. In contrast, well-designed Title II programs can do a great deal to strengthen long-term food and livelihood security for HIV-affected and other vulnerable households, if this is one of their main priorities and if it is adequately funded. According to the Development-Relief concept promoted in the USAID/FFP Strategic Plan, programs should be designed to achieve both an immediate impact—protecting lives and maintaining consumption levels—and longer-term impacts—helping people and communities build more resilient livelihood bases.[265] Thus, future Title II programs should play to their strengths by focusing a significant amount of their budgets on increasing livelihood security for food insecure populations in target communities, including the food insecure PLHIV that live there (FANTA and WFP, 2007).[266]

[265] USAID/FFP Proposal Guidelines for FY 2006.

[266] The FAFSA-2 team benefited greatly from the insights of Tony Castleman, former Deputy Director for Field Support of FANTA-2, based on his extensive experience in nutrition and food security programming for HIV throughout the FAFSA-2 time period. Dr. Castleman is a co-author of the publication cited.

Nutrition assessment, counseling, and support. Integrating NACS into both clinical and community HIV care and treatment services is a priority for PEPFAR. PEPFAR programs are best equipped to implement NACS because PEPFAR supports all of the components of this integrated nutrition services package, as well as HIV testing, treatment, and care. Some Title II programs provided nutrition counseling for PLHIV and a few started measuring BMI (nutrition assessment) in the later years of the review period. But these programs were designed before NACS became the norm, and they could not provide all three components of NACS due to lack of funding, experience, links with clinics and hospitals, and RUTF for treating SAM (nutrition support). Title II programs could complement the clinical HIV services provided by national health systems by assisting NACS in the community in countries with generalized HIV epidemics, if there were additional funding for this. This suggested division of responsibility for nutrition and HIV is analogous to the way some Title II programs screen children for SAM in the community and refer them to clinical therapeutic feeding or CMAM (done by others using RUTF), and sometimes provide supplementary feeding to children that recover from SAM but are still moderately malnourished. However, given that PEPFAR's annual budget for bilateral HIV is at least 14 times greater than the Title II development food aid budget and that the Title II budget supports 14 program elements, whereas PEPFAR supports only 3, one could argue that NACS should continue to be done mainly by PEPFAR.[267]

Furthermore, the different geographic locations of PEPFAR and Title II (the urban and peri-urban concentration of HIV and the rural concentration of food insecurity) present formidable constraints to working together to implement NACS. The two programs co-exist in only six countries. However, if PEPFAR could complement Title II food resources in those countries via co-programming cash resources and co-locating programs, then Title II programs could play a role providing some NACS services at the community level and referring PLHIV to PEPFAR-supported or other clinical services. This has not been possible to date. Regardless, a vital and feasible role for Title II is providing food and livelihood security strengthening services to which food insecure HIV-positive clients, including those graduating from treatment of severe or moderate acute malnutrition with therapeutic foods, can be referred—a niche rarely filled by anyone else in rural areas.

8.5.2 Clear Objectives and Measurable Results

Most of the programs reviewed that provided supplementary feeding to address HIV did not specify a clear objective for doing so, which is understandable given that their aim was general relief. However, without clear objectives, program designs lacked clarity and evaluating program results was not possible. Only a couple of programs measured any results. The majority of programs measured only the number of people that received rations. Examples of some objectives that might have been appropriate are to: (1) improve nutritional status and the effectiveness of ART through care and support, (2) prevent or mitigate malnutrition in PLHIV or HIV-affected households, (3) improve dietary practices of PLHIV, (4) improve adherence to ART, and (5) increase access to food (apart from food aid) and prevent negative coping strategies.

The bottom line is that the FAFSA-2 estimates that approximately US$148 million in Title II resources were spent on HIV-related programming, for which there are few available, measured development impacts.[268] This contrasts sharply with the many

[267] In FY 2009, US$5.503 billion was enacted for PEPFAR bilateral HIV/AIDS programs according to http://www.pepfar.gov/documents/organization/80161.pdf. The same year, USAID/FFP received US$377.5 million for non-emergency programs according to USAID/FFP's "Fact Sheet: Office of Food for Peace 2009 Statistics." http://foodaid.org/news/wp-content/uploads/2011/01/fy09_factsheet.pdf.

[268] The US$148 million is an amount for the seven-year FAFSA-2 time frame extrapolated by multiplying seven times the total cost of Title II programming attributed to HIV of US$21.1 million in the FY 2009 Resources Tracking Tables submitted by the Awardees.

positive results reported when food aid was used for MCHN programming. If Title II resources are to be used to address HIV, clear objectives must be established, such as the examples listed, and the results must be measured and demonstrated.

8.5.3 Food and Livelihood Security Solutions

Low coverage, underfunding, and a lack of available, measured results for sustainable food and livelihood security interventions for PLHIV and HIV-affected households receiving food assistance (as described in Section 8.3.4) are serious concerns. The Title II program is one of the largest sources of USG resources dedicated to reducing food insecurity in vulnerable populations internationally. This comparative advantage was not capitalized on adequately in Title II development programs that provided supplementary feeding to PLHIV or HIV-affected households. What was needed, because it was not being done by other donors or with national resources, was "strengthening the capacity of all individuals and families receiving nutrition and food support to sustainably address their long-term food needs through improved food production, employment and other vocational and livelihood assistance" (USAID/FFP. n.d., p. 42).

8.6 Conclusions and Recommendations

8.6.1 Conclusions

- The focus on preventing sexual transmission of HIV through SBCC in a large number of Title II programs was appropriate. The reduction in high-risk behaviors in half of the programs that measured these indicators is encouraging.
- The 19 HIV supplementary feeding programs reviewed appear to have been successful at food insecurity mitigation in the short term and are best characterized as VGF and not HN. Many lacked clear, time-bound graduation criteria.
- Program objectives of Title II direct food distribution for HIV were unclear, and there were few documented results. It is understandable that almost no programs measured the USAID/FFP required indicators, since most started before these were required. However, without results data, the FAFSA-2 can say very little about the outcome of nutrition counseling or the impacts of supplementary feeding and livelihood strengthening.
- NACS for PLHIV is best assisted by PEPFAR. Title II programs did some nutrition counseling, but little nutrition assessment, which PEPFAR is better equipped to do for a variety of reasons. Title II programs lack cash resources and ample access to RUTF to treat SAM in adults or children, which is PEPFAR's mandate. However, if PEPFAR could complement Title II food resources in the six countries that the two programs have in common via co-programming cash resources and co-locating programs, then Title II development programs could conduct some NACS activities at the community level and refer PLHIV to PEPFAR-supported or other clinical services. Furthermore, PEPFAR-supported clinical care and treatment services could refer PLHIV to Title II programs for food assistance/safety nets and livelihood strengthening to prevent relapse into malnutrition.

Box 8.4. HIV Policy Implications

Title II development programs should move beyond short-term mitigation and implement effective and sustainable solutions to food insecurity in the context of HIV by:

- Addressing HIV less through food rations as relief and more through improving long-term food and livelihood security of households and communities to provide sufficient food for themselves (including, but not restricted to, HIV-affected households)
- Defining objectives and measuring the results of their efforts

- There are considerable constraints to co-programming Title II and PEPFAR resources to reach the same PLHIV and HIV-affected households and few examples of both programs working together. Collaboration occurred where the Title II Awardee received separate funding from PEPFAR for complementary activities with the same population served in its Title II program.
- Enrollment of Title II HIV program food ration recipients in livelihood security activities was low, due in part to resource constraints. Greater effort should have been dedicated to income generation and livelihood security interventions to benefit PLHIV and HIV-affected households, along with the larger, food insecure, rural populations in projects' target geographic areas.

8.6.2 Recommendations

USAID/FFP and Awardees should:

- Continue to mainstream SBCC for prevention of sexual transmission of HIV in Title II programs in countries with generalized HIV epidemics. (**Recommendation 39**)[269]
- Define clear objectives for HIV components of Title II programs and measure results. Indicators should be included in IPTTs and selected from those recommended by Castleman et al. (2008) or FANTA and WFP (2007), depending on the objectives of the program. (**Recommendation 40**)
- Design programs to address HIV less through food rations as *short-term relief* and more through interventions that improve *long-term food and livelihood security* of households and communities to provide sufficient food for themselves. These interventions include building safety net systems, increasing food production and marketing, improving food storage, and creating employment and income generation opportunities. Implementers should apply an HIV lens to make livelihood strengthening activities more accessible to PLHIV (see FANTA and WFP, 2007). However, they should not design food security programs to benefit only PLHIV and HIV-affected households. (**Recommendation 41**)

[269] The numbers after certain recommendations are the same as those assigned to the major recommendations in the FAFSA-2 summary report.

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