The Food by Prescription Experience

Food by Prescription was first implemented in Kenya with support from the U.S. Agency for International Development (USAID) beginning in 2008 as a 2-year pilot under the National AIDS and STI Control Programme, and between 2009 and 2013 as a public-private partnership among the Ministry of Medical Services, the Ministry of Public Health and Sanitation, and Insta Products, Ltd., a Kenyan food manufacturing company. The program provided nutrition assessment, monitoring, and counseling; specialized food products; and safe water counseling and water treatment solutions through comprehensive care centers (outpatient HIV treatment units) to malnourished HIV-positive adults, pregnant and lactating women, and orphans and vulnerable children. An assessment of the Food by Prescription project in Kenya was conducted in 2009.

In Zambia, Catholic Relief Services (CRS) piloted Food by Prescription in 20 sites from 2008 to 2010, reaching over 5,000 HIV-exposed children under 2 years of age and HIV-positive children and adults. At the onset of the pilot, 33 percent of the clients were severely malnourished and 44 percent were moderately malnourished. Of the 22 percent of clients discharged at the time of analysis, 84 percent were no longer malnourished, 11 percent had died, 4 percent were lost to follow-up, and 1 percent had been removed from treatment because of medical complications. Lessons learned included the importance of ensuring the commitment of senior health managers and having well-trained staff, strong community follow-up, and consistently strong record-keeping. In 2011, CRS published an evaluation report on the Zambia Food by Prescription pilot.

The Ethiopia Food by Prescription program was implemented by Save the Children, USAID/Ethiopia, and the Ethiopian Ministry of Health from 2010 to 2014. A 2012 evaluation of the program found a high rate (58 percent) of non-response to treatment of malnutrition, partly because clients shared ready-to-use therapeutic food with family members and had limited access to other food. The marginal cost per client recovered was high, but the marginal cost of improving nutritional status by at least one BMI point was much lower. The report recommended improving client adherence to the protocol as well as improving health worker understanding of the protocol, program needs, and record-keeping approach. It also recommended linking food-insecure households with economic strengthening and livelihood opportunities for longer-term sustainability of the therapeutic feeding results.