

Nutrition, Food Security and HIV: A Compendium of Promising Practices



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Acknowledgments

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The compendium is based on the results of program reviews carried out by teams in five countries. Members of the review teams were Prisca Tuitoek and Anne Pertet (Kenya), Victoria Ndolo and Catherine Mkangama (Malawi), Joyce Kinabo and Silas Carle Lyimo (Tanzania), Elizabeth Kiboneka and Bernard Lukwago (Uganda), and Dorothy Nthani and Agnes Mugala-Aongola (Zambia).

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The cover photo, a participant in a Junior Farmer Field and Life School in Zambia, is by Dorothy Nthani.

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Acronyms

| | |
|-----------|---|
| ANC | Antenatal care |
| ART | Antiretroviral therapy |
| BMI | Body mass index |
| CCC | Comprehensive care centers |
| CHAM | Christian Health Association for Malawi |
| CRS | Catholic Relief Services |
| FAO | Food and Agriculture Organization |
| FANTA | Food and Nutrition Technical Assistance |
| GTZ | German Agency for Technical Cooperation |
| JFFLS | Junior Farmer Field and Life Schools |
| M&E | Monitoring and evaluation |
| MCH | Maternal and child health |
| MMAAK | Movement of Men against AIDS in Kenya |
| MUAC | Mid-upper arm circumference |
| NAC | National AIDS Commission |
| NASCOP | National AIDS and STI Control Program |
| NGO | Non-governmental organization |
| OVC | Orphans and vulnerable children |
| PEPFAR | President's Emergency Plan for AIDS Relief |
| PLHIV | Person (people) living with HIV |
| PMTCT | Prevention of mother-to-child transmission |
| PVO | Private voluntary organization |
| RCQHC | Regional Centre for Quality of Health Care |
| REDSO/ESA | Regional Economic Development Support Office/East and Southern Africa |
| RUTF | Ready-to-use therapeutic food |
| TB | Tuberculosis |
| TSA | The Salvation Army |
| UNICEF | United Nations Children's Fund |
| USAID | United States Agency for International Development |
| VCT | Voluntary counseling and testing |
| WFP | World Food Program |
| YOPAC | Youth and Parents Crisis Counseling Centre |

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1. Background and Rationale

For many people living with HIV (PLHIV), the disease causes or worsens malnutrition by a combination of reduced food intake, nutrient malabsorption, and increased energy needs. Malnutrition in turn can worsen the disease and its impacts by impairing immune function, increasing vulnerability to infections, and in some cases reducing the effectiveness of treatment. The disease also reduces access to food for many HIV-affected households due to decreased labor availability and income, erosion of savings and productive assets, and increased health care and other related expenses.

Nutrition and food security interventions for HIV-affected populations can help to break this vicious cycle. Nutrition assessment, education, counseling, and provision of specialized food products to PLHIV help to prevent and manage malnutrition, promote effective treatment, and manage symptoms. Agriculture extension, introduction of income generating activities, food assistance, cash transfers and microfinance can help increase availability of and access to food among HIV-affected populations.

Increasingly countries in east, central, and southern Africa are integrating nutrition and food security interventions into HIV services at national, facility, and community levels through programs operated by governments, non-government organizations (NGOs), private companies, and international organizations. Several countries have established national guidelines and developed national-level training on nutrition care for PLHIV. In a few countries, national HIV control programs have devoted substantial human and financial resources to nutrition interventions (Mwadime 2007). USAID/East Africa supported the initial capacity strengthening in several countries in the region through development of national guidelines, training manuals, and service provider materials.

As the number, variety, and reach of these programs expand, identifying and documenting promising practices and approaches becomes valuable in order to help understand what works, replicate successful approaches, and incorporate lessons into programs. Identification of promising practices is particularly important because activities aimed at improving the nutritional status and food security of HIV-affected populations are relatively new and successful approaches continue to emerge.

Recognizing the need to identify promising practices, the Regional Centre for Quality of Health Care (RCQHC) at Makerere University in Kampala, Uganda and the Food and Nutrition Technical Assistance (FANTA) Project at the Academy for Educational Development (AED) in Washington DC organized reviews of nutrition, food security, and HIV programs in five countries: Kenya, Malawi, Tanzania, Uganda, and Zambia. In each country, the review was carried out in 2006 by a two-person team composed of a program manager and a technical specialist (in most cases from academia), both of whom were from the country under review and had prior experience with nutrition and HIV.

In addition to identifying promising practices in nutrition, food security and HIV programs, the process also strengthened the capacity of the ten resource persons who

carried out the reviews, thereby helping develop a pool of resource persons in the region with knowledge and skills to support nutrition and HIV programs. The activity was funded by USAID/East Africa.

The reviews were conducted in 2006, but the results remain relevant to programming today. While nutrition and HIV activities have continued to grow over the past two years, the conditions that affect the content and impact of the programs reviewed have not changed significantly. The promising practices identified are still highly relevant to the food and nutrition needs of HIV-affected populations and to the operational realities of programs working in this field.

The compendium is designed for use by individuals who are designing, managing, or implementing programs. It does not provide step-by-step instructions for applying the practices identified, but instead offers an overview of the types of programs found in the countries reviewed and describes selected practices that were identified by the reviewers to be particularly promising. The information is intended to be instructive to the design and implementation of programs by giving program staff examples of effective practices and helping them understand the conditions that enable or constrain successful implementation. In some cases, programs may use the compendium to replicate identified practices and incorporate them into services. In other cases, programs may not replicate the specific practices but can gain insight into new approaches and the factors affecting their success, which they can use to improve their own services. The compendium can also contribute to advocacy and support policy decisions on integrating nutrition and food security into national HIV strategies and programs.

The compendium draws from the detailed country reports that each team prepared from their program reviews and draws from presentations and discussions during workshops held prior to and after the country visits. More detailed information about the programs and practices is available in the country reports themselves, which can be obtained from RCQHC.

2. Review Process and Criteria

2.1. Country Selection

RCQHC and FANTA selected Kenya, Malawi, Tanzania, Uganda, and Zambia for the country reviews based on a number of factors. Five countries was determined to be a reasonable number to represent a sufficient range and variety of settings on the one hand, while keeping the review feasible within management and resource constraints on the other hand. Targeted countries were drawn from the east, central, and southern Africa region covered by USAID's Regional Economic Development and Support Office/ East and Southern Africa (REDSO/ESA). Since the time the activity was initiated, REDSO/ESA has been renamed USAID/East Africa.

Once it was determined to work with five countries in the region, a number of criteria were used to select the particular countries. All selected countries have generalized HIV epidemics and have high rates of malnutrition, pointing to the pressing need for nutrition and food security interventions as part of HIV programming. Because identification of promising practices was a primary objective of the reviews, countries with a sizable number and variety of HIV programs with food and nutrition components were selected to ensure a sufficient pool of programs and practices from which to draw. Countries with relatively wide-scale integration of nutrition into national HIV programming, such as Malawi and Kenya, were included, as well as countries that are at earlier stages of national-level integration, such as Tanzania, Uganda, and Zambia. This variety enabled identification of practices from both types of settings.

2.2. Team Selection

The review teams in each country were selected to include one resource person with strong technical and academic background in nutrition and HIV and one resource person with experience managing programs in nutrition, food security, and HIV. The team members with academic backgrounds, most of whom were professors or lecturers in university nutrition departments or medical schools, had all been trained in the use of RCQHC/FANTA's *Nutrition and HIV/AIDS: A Training Manual* (2003), and were using the training manual in their instruction of health care workers.

The team composition was designed to ensure the reviews considered both the technical soundness of interventions and practical and operational program aspects. Because one objective of the activity was to strengthen the capacity of a pool of resource persons to support nutrition and HIV programming in the region, an additional selection criterion was the candidates' interest and potential for such work in the future.

Table 1 lists the review teams and their positions at the time of the review.

Table 1 – Country Review Teams

| Country | Name | Position | Organization |
|----------------|----------------------|--|---|
| Kenya | Prisca Tuitoek | Associate Professor and Chairperson, Department of Food, Nutrition and Dietetics | Egerton University |
| | Anne Pertet | Coordinator | Social Science and Medicine Africa Network |
| Malawi | Victoria Ndolo | Lecturer and Head, Department of Home Economics | University of Malawi |
| | Catherine Mkangama | Chief Nutritionist and Acting Head, Nutrition Section | Ministry of Health |
| Tanzania | Joyce Kinabo | Senior Lecturer, Department of Food Science and Technology | Sokoine University of Agriculture |
| | Silas Carle Lyimo | Regional AIDS Control Coordinator | Ministry of Health, Morogoro |
| Uganda | Elizabeth Kiboneka | Consultant Pediatrician and Head, Mwanamugimu Nutrition Unit | Mulago Hospital (Makerere University) |
| | Bernard Lukwago | Senior Training Officer | The AIDS Support Organization (TASO) |
| Zambia | Dorothy Nthani | Senior Training Officer | National Resources Development College |
| | Agnes Mugala-Aongola | Nutrition Specialist | Central Board of Health, Ministry of Health |

2.3. Program Review

The program review entailed the following steps:

- Development of the review process and tools (questionnaires, program information templates, criteria for practice selection, country report templates) by RCQHC and FANTA.
- Initial workshop in Uganda with country review teams to orient them in the program review process and in the use of the tools, facilitated by RCQHC and FANTA.
- Desk review of nutrition, food security and HIV programs in the five countries. Country review teams used a range of methods to identify and collect information about programs, including interviews with staff from government ministries and agencies, meetings with donors and international organizations, reviews of literature and reports, email and telephone communication with programs and specialists, and networking among stakeholders.

- Identification of programs for more in-depth field visits and reviews. Country review teams selected programs for more in-depth review based on information and reports from the desk review indicating effectiveness and innovation. Selection of programs for field review also aimed to include a variety of types of programs, e.g. both facility and community-based, geographically diverse, and targeting a range of population groups including orphans and vulnerable children (OVC), PLHIV, and clients from prevention of mother-to-child transmission of HIV (PMTCT) services.
- Field visits to selected programs where country review teams carried out key informant interviews, directly observed program activities, and reviewed program documents and monitoring and evaluation information.
- Documentation of review results in draft country reports by country review teams.
- Four-day regional workshop in Uganda for the five review teams.
 - The first two days of the workshop were facilitated by a specialist in building resource person capacity. Sessions focused on improving team members' abilities to undertake future assignments in nutrition and HIV. Topics covered included planning, budgeting, preparing deliverables, adhering to timelines, identifying a niche for nutrition and HIV services, and other topics relevant to providing consultant services in this field.
 - The next two days of the workshop were facilitated by RCQHC and FANTA and focused on the results of the program reviews and next steps. Each country team presented the process and results from its program review, followed by extensive feedback and discussion by the larger group about each country's results, gaps and clarifications that need to be addressed. The group also agreed on timeframes and formats for in-country follow-up reviews and information collection, final country reports, and the compendium.
- Additional field visits and information collection by country teams to fill gaps identified during the workshop.
- Finalization of the five country reports, including maps, tables and descriptions of nutrition, food security and HIV activities in the country; analysis of gaps challenges and recommendations; and documentation of promising practices identified.
- Review of country reports by RCQHC and FANTA and dissemination within countries.
- Compilation and preparation of the compendium of promising practices based on country reports.

2.4. Identification of Promising Practices

Identification of promising practices employed a multi-step process. In the initial orientation workshop, country teams agreed on criteria for identification of promising practices. Based on the desk reviews and in-depth program reviews, each country team identified candidate practices that met most of the criteria, documented these practices, and presented them to the larger group at the workshop following the reviews. At this workshop the country review teams, RCQHC, and FANTA refined the criteria and the specific components to be documented for each practice. These components are described for each practice in Section 4.

The practices consist of specific interventions or specific approaches to implementing interventions, as opposed to being entire programs¹. Entire *programs* were reviewed (as summarized in section 3), and specific *practices* were identified from these programs. The criteria used to identify promising practices are listed below. Not all the identified practices explicitly meet all the criteria; for some practices, information about certain criteria was not available, and for others, certain criteria were not applicable.

- **Appropriate and relevant.** Practices should be appropriate for the specific population targeted and should be designed to meet identified food and nutrition gaps and problems the population faces.
- **Technically sound.** Practices should be consistent with international guidelines and protocols where they exist and based on the evidence base where applicable. This criterion applies particularly to management of malnutrition and other approaches for which international guidelines and evidence exist.
- **Effective.** Practices should demonstrate positive results. Evidence of these results should be available from monitoring and evaluation information or, if possible, from external evaluations or studies. In this review, application of the criterion of effectiveness depended on the information about results that was available to the review teams. The quantity and quality of information available varied across practices, depending on the program's monitoring and evaluation (M&E) capacity and the timing of the program cycle. The nature and timeframe of the review process did not allow for in-depth, independent review and analysis.
- **Ethical.** Practices should do no harm. For example, practices should not worsen stigma, create inequities, enable abuse of rights, or facilitate discrimination against PLHIV.
- **Innovative (or not).** Innovative practices are valued for the “new and improved” approaches they offer. However, not all promising practices need to be innovative. Promising practices also can be effective practices that are commonly

¹ In the case of scaling up nutrition interventions in Malawi and Kenya (section 4.3), the practice is similar to the program, but it is the approach to scale-up that comprises the practice.

implemented (e.g., mobilization of community volunteers in Malawi), or approaches to reach more beneficiaries with an established practice (e.g., scale-up of nutrition counseling in Kenya).

- **Replicable.** Practices should not be so context-specific or so dependent on the individuals implementing them that they cannot be replicated in other settings. Replication may require adaptation and contextualization, but a promising practice should be flexible and relevant enough that with suitable resources and preparation it can be effectively replicated. One of the greatest values of identifying promising practices is to facilitate adoption and adaptation of the practices by other programs to improve program quality and impacts.
- **Potential for scale-up.** Practices should either reach or have the potential to reach a significant number of beneficiaries. This does not mean the practice reviewed must currently be implemented on a large scale, but rather that there is no inherent obstacle to reaching scale, e.g., very high cost per beneficiary, or requiring a particular type of individual or local institution that is not available in most locations. Potential for scale-up is distinct from replicability; scale may be achieved in two ways – increasing coverage of existing programs, or introducing interventions in additional programs.
- **Sustainable.** In this context, sustainability refers to the feasibility of continuing the practice with available resources and within operational constraints. Recognizing that many types of HIV interventions – e.g., antiretroviral therapy (ART) – require continued donor support, the criterion of sustainability does not mean that communities or even local governments should necessarily be able to independently sustain the practice independently. Rather, it means that within the context of the program and its stakeholders – including individual beneficiaries, communities, NGOs, government, private firms, and donors – operation of the practice should be able to sustain. An intervention that requires continued donor support at the levels currently provided could be considered sustainable if the donor intends to continue providing this support (e.g., Mildmay’s package of nutrition services in Uganda). For some practices, sustainability may also refer to continuation of benefits conferred to beneficiaries, such as improved dietary practices as a result of nutrition counseling.
- **Culturally acceptable or adaptable.** Practices should be acceptable to the target beneficiaries and not offend cultural mores or sensibilities. While some practices may be specifically designed for and suited to a particular cultural group (e.g. a practice related to Ramadan fasting for Muslims), in general practices should either be applicable to a large enough group that adaptation to other groups is not needed to achieve sufficient impact, or should be sufficiently adaptable that they can be implemented with other populations as well.

3. Overview of Programs Reviewed

The country desk reviews covered approximately 195 programs in the five countries. In-depth reviews and field visits were carried out for 35 programs. Maps of the programs reviewed in each country are in the Appendix.

Country review teams had strong knowledge and networks related to the programs in their countries and they used a range of mechanisms to identify programs with substantial nutrition, food security, and HIV interventions. As a result, the review results give comprehensive pictures of programs in the five countries. However, the reviews neither aimed to, nor had the time and resources to, cover every single program with nutrition, food security, and HIV components. In all five countries, the reviews found that there was a plethora of small, community-based programs offering nutrition or food security services to small numbers of beneficiaries. Some of these activities were linked to or supported by larger programs, and others were not. While many of these programs were identified and reviewed, it is likely that some small programs were not included.

Although nutrition, food security, and HIV programming has expanded since the reviews took place in 2006, the bulk of the programs in operation are included and perhaps more importantly, the types of programs operating are all represented in the review. As with any review, the content is influenced by the composition of the review teams, and it is likely that teams focused greater emphasis on geographic and technical areas with which they were most familiar. However, the matrices of programs in the country reports, the identified practices, and the results of the mapping exercises indicate that a wide variety of programs were covered.

The types of programs reviewed are summarized below. More detailed information about the programs in each country is available in the individual country reports.

Problems addressed: The programs reviewed aim to address a range of nutrition and food security problems faced by targeted populations, including severe and moderate malnutrition among HIV-infected and affected adults and children; poor access to food on the part of PLHIV, orphans and vulnerable children (OVC) and their households; limited human capacity in nutrition; poor sustainability of food and nutrition services following withdrawal of external support; and limited or inaccurate information about commercially sold nutrition supplements.

Implementers: A wide range of entities were identified that implement nutrition and food security programs for HIV-affected populations, including: small community groups of volunteers, PLHIV groups and support networks, community-based organizations, religious groups, schools, local NGOs, international NGOs and private voluntary organizations (PVOs), private companies, health clinics and hospitals, and government agencies. In all five countries the reviews found a large number of small community organizations, churches, and PLHIV networks that use available resources to provide nutrition or food security support to HIV-affected community members.

Target populations: The programs reviewed target a range of populations including: ART clients, adults living with HIV who are not on ART, bedridden PLHIV, pregnant and lactating women living with HIV, infants and young children of HIV-infected mothers, pediatric HIV clients, OVC, households caring for OVC, and households of PLHIV². There is also a significant range in the numbers of beneficiaries reached by programs, from relatively small community programs that reach a few hundred beneficiaries in a few communities (e.g., community programs in Tanzania and Malawi) to nearly national-level programs that reach several thousand beneficiaries with nutrition interventions (e.g., the Malawi and Kenya national programs).

Interventions: The programs reviewed implement a wide range of nutrition and food security interventions, including: nutrition assessment, nutrition education and counseling, provision of household food baskets, provision of specialized food products, provision of micronutrient supplements, training in income-generating activities, provision of livestock and other productive assets, agriculture extension, and provision of cash and in-kind materials to support food security for OVC.

Entry points for services: Programs utilize a range of entry points for nutrition and food security interventions, including: HIV treatment and other health care facilities such as hospitals, clinics, and health centers; hospices; schools; extension services; community-based health and livelihood services; PLHIV network meetings; community meetings and other structures; religious activities; and home-based care services.

Results: Results documented by the program reviews vary considerably across programs but include receipt of nutrition services by targeted beneficiaries, improved community support structures, increased access to food among HIV-affected households and individuals, and improvements in nutritional status among PLHIV and OVC. Review teams found that M&E was weak for many programs, making it difficult to ascertain program results.

Source of resources: Resources to support the programs came from a range of sources, including: contributions from community members; church funds; donations from individuals (not necessarily community members); NGO funds; private companies; government agencies; bilateral donors; and international donors such as the Global Fund for AIDS, Tuberculosis and Malaria, UNICEF, and the World Food Program.

Gaps, limitations, and challenges: Review teams identified a variety of gaps, limitations, and challenges faced by the programs reviewed. Common gaps included: weak nutrition education and counseling; limited or short-term funding for nutrition and food security interventions; stigma and discrimination that affect targeting and coverage of nutrition services; weak M&E systems; and inadequate human resources in nutrition.

² Some of these population groups overlap with each other, as different programs define their target groups differently.

4. Promising Practices

Each country review team identified between two to five promising practices from the programs reviewed, and all of these practices are described in the country reports. For this compendium, a subset of these practices was selected that best meet the criteria described above and that are most likely to be relevant and useful to ongoing and future programs. These practices can be organized under three themes: building on existing community capacities; linkages and integration; and scale-up. Table 2 and the subsequent descriptions present the practices under each of these three themes.

Table 2 – Promising Practices

| Theme | Practices |
|---|---|
| Building on existing community capacities | Community-enforced agreements with households to sustain nutrition support for OVC and PLHIV (Tanzania) |
| | PLHIV network negotiation with supplement producers (Kenya) |
| | Mobilization of community volunteers and leaders for nutrition support of PLHIV (Malawi) |
| Linkages and integration | Linkages to agriculture extension for OVC (Zambia) |
| | Integrated package of nutrition services as a routine part of HIV care and treatment (Uganda) |
| Scale-up | National scale-up of management of malnutrition among adult ART clients (Malawi) |
| | National scale-up of nutrition counseling for PLHIV (Kenya) |

Descriptions of each practice include the country, implementing organization, problem addressed, situation where the practice is applicable, description of the practice, enabling factors, constraints and challenges, resource implications, monitoring, results, linkages to other services, variations of the practice, policy implications, replication considerations, and issues for implementing at scale.³

³ As discussed above, replication and implementation at scale are related but distinct concepts, and replication is one means of scaling up a practice. The replication considerations refer specifically to issues to consider when initiating the practice in a new area, such as relevant characteristics of the area. Issues for implementing at scale are specifically relevant to applying the practice at a large scale, such as coordination and maintaining quality.

4.1. Building on existing community capacities

Communities possess a variety of capacities that can be tapped to support nutrition and food security for vulnerable HIV-affected populations. While people are generally the strongest capacity in communities, other important capacities include food production and processing systems, social support systems, and community governance and organization structures. Building on existing capacities can foster ownership and sustainability of activities. The promising practices selected under this theme include: 1) community-enforced agreements with households to sustain nutrition support for OVC and PLHIV following withdrawal of external support in Tanzania; 2) PLHIV network negotiation with commercial nutrition supplement producers to ensure transparent consumer information and optimal prices and terms in Kenya; and 3) mobilizing community volunteers and leaders for nutrition support of PLHIV and affected households in Malawi. These practices are described in detail below.

Other practices related to this theme were identified by the country reviews but are not detailed here because of limited information or failure to meet the above criteria. These practices include: using locally available and traditional foods and local food processing to provide food support to PLHIV, a practice that occurs in most of the countries reviewed; and using community chiefs and traditional practices to support nutrition interventions in Zambia. More information about these practices is available in the country reports available from RCQHC. Another practice relevant to this theme is involving community members in planning, targeting, and implementing Junior Farmer Field and Life Schools (JFFLS) in Zambia. This practice is described in section 4.2.1. under the integration and linkages theme because there it also falls under that theme.

4.1.1. Practice: Community-enforced agreements with households to sustain nutrition support for OVC and PLHIV

Country: Tanzania

Implementing organization: Youth and Parents Crisis Counseling Centre (YOPAC). YOPAC is an NGO that provides a range of HIV-related services including home-based care, OVC psychosocial and other support services, and counseling and testing.

Problem addressed: In the areas where YOPAC works, food insecurity is a serious problem among many households caring for OVC and households with adult PLHIV. YOPAC and other institutions provide food support and other services, but such support is limited in duration and scope. Service providers report dependency on the food assistance and other services provided, and many households are not prepared when assistance ends or phases down, negatively affecting the food security of OVC, PLHIV, and other household members.

Situation where practice is applicable: Programs providing food or other food security and nutrition support to HIV-affected households for limited durations.

Description of practice: YOPAC provides a range of goods and services to PLHIV and OVC, including nutrition education and provision of rice, maize flour, beans, soybeans, and milk to food insecure clients. For ambulatory clients the food is distributed at the YOPAC center, and for bedridden clients the food is delivered to homes by volunteers or collected from the center by household members. Before providing support to PLHIV and OVC, YOPAC meets with members of the household caring for them to jointly assess the client's needs and household capacities. Based on this joint assessment, YOPAC and the household agree on the type and duration of support provided. They also define what the household will do to continue support after YOPAC's support phases down and withdraws. In most cases the household's commitment involves continuation of basic support for the clients, including food provision, support for good nutrition, and other support services such as school fees for OVC. YOPAC and the household (and the client, where possible) sign a written agreement detailing the roles, support responsibilities and timeframe.

During the period in which clients receive support, YOPAC maintains records that monitor client progress. Following withdrawal of YOPAC support, staff and community volunteers monitor whether households are following through on their commitments to continue support. If households are failing to provide the agreed support, community leaders and church leaders take up the matter with them, pressuring household members to follow through. In the few cases in which households are determined to be unable to continue support, community members help identify options for continued support. As of 2006, the program had covered 625 households caring for OVC, and an additional 250 households caring for PLHIV.

Enabling factors:

- Existence of community structures such as religious institutions or community committees that can provide leadership and "enforcement" following withdrawal of external support. The existence of such structures that have credibility and leverage with households is key to following up on household commitments.
- Sufficient awareness and commitment among community members to work effectively with households on OVC and PLHIV support.
- Sufficient resources within households to be able to provide continuing support, which may not be possible in some situations, such as during a severe food security shock.
- Strong human resource base of home-based care or other community providers.

Constraints and challenges:

- High levels of poverty affect households' capacity to provide ongoing support and lead to high levels of client need, making it difficult to provide support to all clients needing it within program resource constraints.
- Limited capacity and motivation of home-based care providers impinges on the effectiveness of the activity, because home-based care providers are the front-line workers for this practice.

- Inadequate financial and technical resources for training home-based care providers in nutrition issues limits the capacities of these crucial service providers.
- Limited staffing at YOPAC constrains the quality and reach of services.

Resource implications:

- Food is required for the program described here, although the sustainability agreements that comprise the core of the practice could be used for other services instead.
- Human resources, including home-based care providers, supervisors, and staff, are critical to prepare and monitor the agreements.
- A certain amount of materials are needed for agreements, monitoring, and tracking. YOPAC uses a computer to support these functions.

Monitoring:

- Periodic visits are made to assess the status and progress of clients, using records and agreement files.
- Home visits continue after withdrawal of YOPAC support to check whether households are continuing support as agreed.
- While the above monitoring mechanisms are part of the activity, systematic M&E of program results and impacts is not in place, apparently due to limited capacity and resources.

Results:

- At the time of the review, 875 households were participating in the program.
- Of the 250 bedridden PLHIV supported by YOPAC, 60% had graduated, and all of them were being supported by their households as per agreements.
- 30% of the PLHIV households were earning additional income through income generating activities such as gardening and food vending supported by YOPAC.
- Community members reported that stigma associated with HIV had declined as a result of the program, and that community sensitivity and involvement in care of PLHIV and OVC had increased.

Linkages to other services:

- The program refers clients to facilities providing ART.
- YOPAC has established linkages to banks and microfinance institutions for financial support for clients.
- The Centre for Counseling, Nutrition, and Health Care (COUNSENUH), a Tanzanian NGO, provides training in nutrition for the program's home-based care providers.

Variations: None observed.

Policy implications:

- Policy efforts to organize and involve local leaders in creating structures to encourage communities and households to provide support to vulnerable community members would bolster and expand the “peer-pressure” approach that YOPAC applies.
- In order to strengthen the home-based care services that YOPAC provides and that are a central part of this practice, there is a need to incorporate specific strategies and activities for home-based care into HIV policies and strategies. For example, in some settings funds could be allocated to local government structures to support and institutionalize home-based care. This would build a stronger foundation for practices such as this.

Replication considerations:

- The types of household structures that support OVC and PLHIV (e.g., extended families, nuclear families, child-headed households, single-person households, institutions) and their capacity to enter into agreements to sustain support.
- Community characteristics, such as intra-community relations, sensitization to HIV-related issues, levels of stigma, and even ethnic and religious homogeneity. The practice relies heavily on community support and the role of “peer pressure” from the community for households to continue support. This role of the community could be challenging in areas with high levels of stigma.
- The composition and strength of existing structures and leadership that can be used for community enforcement of agreements. In addition to the structures YOPAC uses, alternative structures may be considered, e.g., mosques in communities with large Muslim populations, or PLHIV networks where they are well established.

Issues for implementing at scale:

- Given the intensive community-based nature of the practice, wide scale-up may require engaging many local organizations that adapt the practice based on their own organizational realities and community contexts. This may be a more effective scale-up strategy than trying to significantly increase coverage by a small number of community organizations. This is especially true because maintaining strong ties between the organization and the communities seems to be essential for this practice, and this relationship may weaken if too large an area is covered.
- Umbrella coordination among the different implementing organizations may help maintain consistency during scale-up and ensure learning across areas. Involving religious organizations throughout a region, or even a country, may be an effective strategy for scale-up since religious institutions are a key supporting structure for the sustainability approach and may have strong networks or even central coordination structures.

4.1.2. Practice: PLHIV network negotiation with supplement producers

Country: Kenya

Implementing organization: Movement of Men against AIDS in Kenya (MMAAK). MMAAK is a support network in Kenya for HIV-infected men and their spouses and children. At the time of the review, MMAAK had chapters in five towns and had approximately 4,500 clients.

Problem addressed: In many countries, including Kenya, there has been a proliferation of nutrition supplement products sold by private companies that target PLHIV and are marketed as supplements that boost immunity, increase energy levels, or improve strength for sick individuals. Individual PLHIV, program staff, and support networks often do not have the knowledge or resources to determine the veracity of company claims about product composition and benefits. Often they rely on the marketing information, on specialists from the industry, or on advertised results of trials sponsored by the manufacturers. Moreover, some PLHIV end up using multiple products from different companies, some of which have similar composition, thereby running the risk of consuming dangerously high levels of certain nutrients.

Situation where practice is applicable: Contexts where nutrition supplement products are aggressively marketed by private companies or where there are a large number of such products on the market without accompanying authoritative, objective information about their contents and benefits.

Description of practice: MMAAK invites nutrition supplement industry representatives to make presentations to their members at some of the weekly chapter meetings, with only one such company at any given meeting. The weekly meetings are part of MMAAK's group therapy approach. Clients have an opportunity to ask questions about the products, and PLHIV members who have used products share experiences with the group. Doctors, nurses, and nutritionists unconnected to the companies are invited to the meetings to ask questions, examine products, and ensure that correct information is provided. These professionals offer recommendations to the group about the safety and usefulness of the products. These professionals also report any side effects that may be associated with the supplements and advise clients on the implications that using the product has on consumption of other supplements.

Based on this information, individual clients can decide whether or not to use the product. If the group decides they do want to use the product, they negotiate with the company for a subsidized price. For group members who cannot afford to purchase supplements, the group pools money to support purchases for them. At the time of the review, the group had only agreed on the purchase of one nutrient supplement and had mobilized resources from a donor to purchase the supplements to ensure that all members could benefit from it.

Enabling factors:

- Solid PLHIV networks. Strong PLHIV networks should exist with a reasonable level of social capital (i.e., trust and willingness to cooperate) among members. This facilitates cooperation among members for decisions about products and resource pooling.
- Education levels of clients. Most of the group members are educated, which helps enable critical assessment and absorption of the information presented and informed choices to be made.
- Network leadership. A related factor is that the leaders of the groups are often quite well educated and many even have knowledge of nutrition issues from participation in workshops and are therefore able to share experiences and guide group members.
- Participation of health care professionals. The availability of doctors, nurses, and nutritionists to participate in the meetings and advise the group is a critical factor. Linkages with private and government medical care facilities allow this valuable input.

Constraints and challenges:

- Where external funding was used to purchase supplements, sustainability was a challenge, as group members were sometimes unable to purchase products after funds were expended. Establishment of a common pool of resources was one response used.
- Individual monitoring of health and nutritional status was not part of MMAAK's services and it was not possible to assess the impact of the supplements and services provided. Individual health and nutrition information is part of patient forms, but these forms are not available or analyzed in the MMAAK program.
- There was a tendency for group members to make decisions about products primarily based on cost rather than the content of the supplement.
- Systems may need to be instituted that ensure that group leaders are not unduly influenced by the companies presenting the products.
- Ideally, micronutrient supplementation⁴ for PLHIV should be based on individual clinical assessments to determine the need for such supplements, including whether clients are already consuming supplements or fortified foods. The MMAAK approach does not include such assessments. While the active involvement of health care professionals helps to prevent any potential harm from supplements, there may still be some risk that group members are unnecessarily spending money on supplements that do not confer significant benefits. Reporting use of supplements to one's health care provider can help to address this concern. Furthermore, it is recommended that PLHIV (and others) obtain nutrients from a diverse diet where possible. Provision of supplements and highlighting privately marketed products as part of a support network may lead to less emphasis on healthy diets among members. Counseling on the importance of diverse diets can help to address this issue.

⁴ While several types of nutrition supplements are presented to MMAAK, micronutrient supplements are among the most common.

Resource implications:

- Adequate human resources are critical, including doctors, nurses, or nutritionists who have knowledge of nutrition, HIV, and safe and effective micronutrient supplementation.
- Availability of nutrition supplements is required for this practice to operate.
- A critical mass of group members must have sufficient resources to be able to contribute to the pool that supports purchase of supplements for members who cannot afford them.
- In some cases, external support from donors may be needed to support purchase of supplements.
- The group meetings for contacts with companies and follow-up require a regular time commitment on the part of group members.
- Organizational structures and systems are needed for the groups to function well and to organize the meetings, presentations, funding pools, etc.

Monitoring:

- As mentioned above, individual indicators of clinical and nutritional status are not collected through the MMAAK program, though they are available with clinicians and health facilities who examine the clients.
- The program relies heavily on self-reporting and personal testimonies about changes such as increased appetite, weight gain, and improved functioning.
- Monthly financial and progress reports and regular meetings are used to monitor activities and solicit feedback on activities.

Results:

- The practice led to increased knowledge on the part of PLHIV group members about nutrition and HIV and the role and safety of micronutrients. This was largely the result of participation of health care professionals at the meeting, as well as information provided by the group leaders with experience in nutrition and HIV.
- The practice led to lower prices for the supplement selected by the group.
- Although this is difficult to document, it is likely that the practice prevented members from consuming supplements or combinations of supplements that are possibly harmful.
- By facilitating interactions among PLHIV and specialists, the practice led to more open interactions among PLHIV, stronger relationships with health care workers, reduced stigma, and increased membership in the groups.

Linkages to other services:

- The linkages to health facilities enable participation by the health care professionals, who play a critical role in advising group members on the safety and efficacy of products.
- Linkages to health care facilities also support ART treatment and treatment of opportunistic infections among group members. The health status of clients is

also used to help prioritize clients for supplementation, and linkages to health care services facilitate this determination.

Variations:

- A different group, The Association of People with AIDS, Kenya (TAPWAK), introduced nutrition supplements at a subsidized price to its members following a study sponsored by a drug company that showed benefits for PLHIV. At the time of the review, the interactions, negotiation, and external health professional input in the MMAAK practice were not part of TAPWAK's practice. However, since the time of the review, TAPWAK has introduced greater interactions with health workers.

Policy implications: Two strong policy implications emerge from this practice:

- The need for guidelines and if possible stronger regulation of the nutrition supplement industry by the government. The practice was developed out of concern that some parts of the industry may not be providing complete and accurate information about their products and that some PLHIV may be harmed financially or possibly physiologically from purchase and consumption of supplements. Because not all PLHIV can participate in a program such as MMAAK's, stronger regulation is needed at the national level. Part of the regulation should require public presentation of objective, evidence-based information about nutrition supplements.
- WHO guidelines for micronutrient consumption by PLHIV should be followed in the composition of micronutrient supplements, i.e., consumption of one RDA of micronutrients by PLHIV unless prescribed otherwise by a clinician due to assessed deficiencies.

Replication considerations:

- Existence of PLHIV networks and the strength of the trust and cooperation among network members.
- Whether micronutrient deficiencies are endemic. If deficiencies are endemic, whether micronutrient supplements are the best approach to address them as opposed to food-based strategies and public health approaches such as deworming.
- Availability of mechanisms to support purchase of supplements, such as pooling resources, external donations, or sufficient group member resources to individually purchase supplements.
- Existence and reliability of linkages to health care professionals to provide guidance and technical input, and linkages to health care facilities for referrals and assessments as needed.

Issues for implementing at scale:

- As mentioned above, national-level regulation of nutrition supplements and their marketing would help address at a national scale some of the issues that the practice addresses on smaller scale, such as transparency of information about the

- products and their impacts. The issue of cost, however, would not necessarily be addressed by regulation, unless subsidization is also introduced.
- To support scale-up, consideration should be given to whether other structures exist in addition to PLHIV networks that can facilitate PLHIV to engage the nutrition supplement industry. More formal structures such as health facilities could be used, as could more widespread structures such as community centers, community governance structures, and religious institutions. Using other structures may change the particulars of how the practice is implemented (e.g., how meetings and negotiations are carried out), but the basic approach could remain the same.
 - National networks of PLHIV can also be a mechanism for scale-up. Since the practice by its nature involves working through relatively small groups, balancing some level of centralized coordination with flexible functioning of the individual groups is an important issue to keep in mind when identifying mechanisms for scale-up.

4.1.3. Practice: Mobilizing community volunteers and leaders for nutrition support of PLHIV

Country: Malawi

Implementing organization: The Salvation Army (TSA). TSA is an international faith-based organization that provides a wide range of humanitarian support in many countries. At the time of the review, TSA was implementing a community HIV care and prevention program in Bangwe Township in Malawi.

Problem addressed: When community leaders and members are not involved in the design, implementation, and monitoring of community-based HIV programs (including nutrition and food security interventions), the services can be difficult to implement and unsustainable, and often yield limited impacts. It is usually not recommended to rely heavily on paid staff from outside the community to provide services, especially when behavior change is an objective, as is the case with nutrition education and counseling of PLHIV.

Situation where practice is applicable: Where community HIV programs are introducing nutrition and food security interventions, and particularly where community ownership, volunteers, and monitoring are required.

Description of practice: TSA used a multi-pronged approach to engage and involve different groups of community members in all aspects of the nutrition and food security program components. The activities and roles of community members and external agents were jointly determined and transparently communicated from the outset of the activity. Through a series of sensitization meetings, TSA engaged community leaders, chiefs and other community members to identify priority nutrition and food security needs, as well as non-nutrition related needs. TSA facilitated the formation of community action teams and committees. These groups were composed of volunteers

tasked with responsibility for planning and carrying out specific support activities for vulnerable community members, such as provision of food support, education and counseling, regular home visits, income generation, and monitoring status and needs.

TSA then provided a series of trainings to the community leaders and volunteers. Essential information about nutrition and HIV, food groups, and consuming a healthy, balanced diet were covered in the training. Following the training, the community committees and action teams supported a range of services for HIV-affected households, including nutrition education and counseling through home-based care visits, provision of food assistance (maize, vegetable oil, and beans), establishment of communal gardens, and poultry rearing.

Nurses from the College of Medicine and a nearby hospital support the volunteers in providing care services, and they are available for referrals as needed. This link between the community care providers and clinical nurses helps ensure that the services provided by community volunteers is sound and enables clients to access a fuller set of nutrition care services including clinical care.

Chiefs and other community leaders are responsible for monitoring the volunteer activities, which helps ensure community commitment to the services and – importantly in the context of HIV – signifies the value that is placed on the services.

Enabling factors:

- Cohesive communities that respect community leaders and are open to interactions among community members about nutrition and HIV issues.
- Strong community mobilization strategy on the part of the implementing organization. TSA facilitates regular meetings and uses other interactive mechanisms such as public announcements and activities at marketplaces, local events organized by religious institutions, and existing local governance meetings.
- A certain level of initial willingness on the part of community leaders to engage in issues related to nutrition, food security, and HIV and the absence of too severe stigma. While community sensitization helps strengthen these attitudes, a certain enabling environment is necessary at program inception.
- Willingness on the part of the implementing organization (TSA) to cede control of the direction of activities to the community.

Constraints and challenges:

- Some community members are reluctant to volunteer due to lack of information and perhaps concerns about the nature of the program and their duties.
- Limited literacy and other capacities of the volunteers constrains their ability to learn all the information needed for assessment and counseling, or to use materials.
- Stigma is prevalent in many communities, especially during the early stages of activities, which hinders the targeting approach. TSA uses chronic illness as a proxy targeting criterion instead of HIV status. Community sensitization programs and involvement of community leaders can help to address stigma.

- Availability and quality of materials for training and counseling are extremely limited. Most materials are in English, which limits their utility for volunteers. In addition, information about adult malnutrition and nutrition and infection is not included in the materials. The program has made efforts to translate materials into Chichewa, the local language.

Resource implications:

- A range of human resources is needed, including volunteers, community leaders, and health care staff. Because one strength of the program's approach is the link between nurses and community care providers, nurses must be available to support the program.
- Financial and in-kind resources are needed for the food, education materials, and other materials and services.

Monitoring:

- Monthly meetings with volunteers are used for reporting on activities, gathering feedback, and identifying changes needed.
- There are no standard monitoring tools, but TSA uses monthly activity reports to collect information and assess progress.
- Community action teams and community leaders carry out home visits to monitor uses of food and other services.

Results:

- Nearly 4,000 individuals have been reached through home-based care visits.
- The program achieved high numbers of volunteers, with growth from 76 volunteers in 2002 to 361 in 2006. This indicates strong community involvement in nutrition care for chronically ill clients.
- Volunteers gained substantial knowledge of nutrition care and sanitation. Many volunteers reported that they apply the skills they have gained in the program to their own relatives as well as to clients they care for.

Linkages to other services:

- TSA's collaborations with health care institutions such as the College of Medicine strengthen the quality of home-based care services through the contact between home-based care providers and nurses.
- Linkages to Queen Elizabeth Central Hospital and Bangwe Health Center offer referrals and health care to clients, complementing the services provided by the community program.

Variations:

- In some locations where high illiteracy rates prevented use of written materials, drama and music are used to communicate key messages on nutrition and HIV and other topics.

Policy implications:

- While the TSA program managed to reliably attract sufficient numbers of volunteers, volunteer fatigue remains an issue, as is sometimes the case in community-based programs. National initiatives to train community workers and identify modest forms of support to provide to community workers would strengthen community-based activities like this and enable greater scale-up.
- National guidelines for provision of services by home-based care providers, in particular nutrition and food security services, would help programs establish roles and set parameters for volunteer home-based care providers, ensuring consistent and safe services by volunteers. The guidelines should be broad enough to allow programs to innovate and design programs based on the capacities and needs of communities with which they work.

Replication considerations:

- Strong community sensitization and mobilization. This is particularly important during early stages of activities. Community involvement throughout the program cycle (planning, implementation, monitoring) is critical.
- The composition and degree of unity in a community. This is an important criterion when considering locations for replication because commitment from community leaders, members, and volunteers is essential to this practice.

Issues for implementing at scale:

- Given the intensive community-based nature of the practice, implementation at scale is likely to require use of multiple community organizations located in different areas.
- With the heavy involvement of community leaders, there may be opportunities to make use of existing training structures for community chiefs and introduce components on nutrition and food security interventions for vulnerable groups. Including these components in training of community chiefs can help support broader scale-up, more consistent capacities and approaches, and stronger coordination among community programs.

4.2. Integration and linkages

For nutrition and food security interventions for PLHIV to be effective and sustainable, they must be integrated into larger systems of HIV care and treatment services. Nutrition activities should not be implemented through a parallel system; integration into broader clinical and community HIV services both enhances these broader services and strengthens the impact of the nutrition services. Linkages among services are also critical. Linkages refer to connections between distinct but complementary services, e.g., referral systems between community household food support and clinical nutritional assessment and management of malnutrition.

The selected promising practices related to integration and linkages include: 1) linking OVC care services to agriculture extension through JFFLS in Zambia; and 2) an integrated package of nutrition services as a routine part of comprehensive care and

treatment for PLHIV in Uganda. Other practices related to this theme that were identified by the country reviews but are not detailed here include: establishing two-way referral systems between clinical nutrition assessment and support at health facilities and community services such as nutrition screening and household food security support in Malawi and Tanzania; linking schools to agriculture and food security support for OVC in Uganda; and establishing channels between PLHIV support groups and income-generating activities and markets in Kenya and Uganda.

4.2.1. Practice: Linking OVC to agriculture extension

Country: Zambia

Implementing organizations: Government of Zambia Ministry of Agriculture and Co-operatives, the German Agency for Technical Cooperation (GTZ), World Food Program (WFP), and the Food and Agriculture Organization (FAO). GTZ and WFP support the interventions, providing resources, food support, and monitoring, in collaboration with the Ministry, which employs extension workers and coordinates activities. FAO provides technical support.

Problem addressed: HIV can cause or worsen food insecurity for affected children due to loss of labor and income in the household, health care and funeral expenses, and the time required to care for ill household members. In addition, adult illness and death can limit the ability of children to gain the skills and knowledge needed to earn livelihoods as intergenerational transfer of knowledge is weakened or severed. These losses are often particularly severe for agriculture, which is the most common source of livelihood in many HIV-affected areas and which often relies on indigenous knowledge and techniques. This situation can have significant negative impacts on the food security of OVC.

Situation where practice is applicable: In areas with a high prevalence of HIV and a significant number of OVC, and where a significant proportion of the population relies on agriculture for livelihoods.

Description of practice: Junior Farmer Field and Life Schools provide agriculture extension to vulnerable girls and boys aged 12 to 20. Extension workers generate awareness about their services through house-to-house campaigns. Community members define the vulnerability criteria used for eligibility and identify the children who are most vulnerable. Identified children are told what the program entails and must agree to participate in order to be part of the activity.

Community members consult with the extension staff and identify the specific interventions to be introduced. The community also identifies locations for the extension activity to occur; these locations are where suitable land exists that is not owned by any individual (i.e., commonly owned by the community), water is available, security and safety are assured, and, if possible, toilets are available. The extension workers then train the children in specific agricultural practices including both traditional and modern

techniques. Practices include field preparation, sowing and transplanting, weeding, irrigation, pest control, conservation of available resources, processing of food crops, harvesting, storage, and marketing. In addition to crop production, other productive activities such as bee-keeping and poultry production are also taught. Emphasis is placed on low-input production and labor-saving technologies to address the loss of adult labor. Emphasis is placed on skills and knowledge that children have not learned due to illness or death of one or both parents. By including traditional knowledge, the approach also aims to maintain indigenous knowledge about local crops, medicinal plants, and biodiversity.

Part of the food produced is sold, providing income for the OVC and their households, and part of the food is provided directly to participants for consumption in their households. WFP and GTZ also provide monthly take-home food rations of maize, beans, and cooking oil to support participating households.

The program involves collaboration and linkages among several government ministries: Agriculture and Co-operatives for the extension services and outlay of financial resources, Education for care of the children, Health for staff that provide health support to program participants, and Community Development for mobilization activities. The government's Agriculture Sector Support Programme provides technical support on agricultural production.

The program that was reviewed covers six villages, but JFFLS are also implemented in many other areas using similar approaches.

Enabling factors:

- Strong involvement of community members throughout the process. This was critical to encouraging participation, identifying appropriate land, and providing monitoring and trouble-shooting support. Orientation and sensitization meetings held with the communities help to facilitate this process.
- Orientation and sensitization among Ministry of Agriculture and Co-operatives staff, particularly extension workers. This helped to focus extension approaches on the specific needs of HIV-affected children. Training materials on HIV, food security, and appropriate agricultural techniques are used to train provincial and district staff.
- Availability of communal land that is not owned by individual households and that is appropriate for cultivation.
- Existence of markets accessible to the communities for sale of produce.

Constraints and challenges:

- Harmonizing the timing of trainings and other activities is a significant constraint as children have different time commitments for school (some in the morning, some in the afternoon) and other activities. Following discussion and adjustments, the program fixed trainings at three specific times of the week when most children were able to attend.

- Graduating children require capital starter packs, comprised of tools, seeds, and other materials, so they can continue production. Initially resources were not available to support these, limiting opportunities following graduation. As a result, the program kept children in the program for an additional cycle until the starter packs were available.
- Facilitators are not skilled in child learning techniques and as a result there were no games, songs, or opportunities to learn from play. Facilitators are also not trained in dealing with issues of abuse that some children have experienced. These limitations may reduce children's attendance or retention of information.
- With limited transport for program staff, community mobilization and other field-based activities are time-consuming and somewhat inefficient.
- Practice of techniques outside of trainings and following graduation is limited in some cases where children's guardians do not provide conducive environments or opportunities to practice.

Resource implications:

- Human resources in the form of extension staff and a coordinator are needed. If possible, staff should be trained in life skills for older children and in child learning techniques.
- Appropriate land needs to be available on an ongoing basis.
- Capital starter packs are needed to enable graduating children to work productively.
- A number of resources for program operation are needed which require donations or financial support, including food resources, training materials, transport of staff to sites, and initial transport of outputs to external markets.

Monitoring:

- Monitoring visits are made twice per month from the district office.
- Reporting mechanisms are weak, and neither monthly nor quarterly reports exist.
- Performance indicators used include:
 - Quantity of produce generated
 - Attendance rate of children
 - Performance of children in managing assigned tasks.

Results:

- Children learned food production skills and many were able to continue production following completion of the training received at the JFFLS.
- Although strong monitoring data were not collected, households reported being more food secure as a result of the program.
- Children gained confidence and skills and many support their peers and even train others, e.g. manure composting in adult farmer field schools.

Linkages to other services:

- The program itself is operated through collaboration and linkages among several institutions and services, as described above, including Ministries of Agriculture and Co-operatives, Education, Health, and Community Development, WFP, GTZ, and FAO.
- The program also has links to a children's training program operated by UNICEF, the Peace Corps, and local NGOs.

Variations:

- In some situations, children trained other children which led to greater sharing and ownership and which helped deal with the limited time available by facilitators and extension workers.
- Initially the food support was intended for on-site feeding of the children, but because discrimination and animosity at home became a problem, this approach was shifted to take-home rations, which helped mitigate the intra-household problems.

Policy implications:

- Issues related to HIV should be integrated into the curricula used in pre-service training of agriculture extensionists so that all extensionists enter the field with knowledge of the constraints and issues HIV-affected populations face, particularly those faced by vulnerable populations such as orphans.
- Incorporating the JFFLS into the Ministry of Agriculture and Co-operatives policy framework would enable it to become an integral part of the Ministry's approach at a national level.

Replication considerations:

- Availability of suitable food production enterprises that do not require high levels of capital inputs, e.g., mushroom production, and poultry raising.
- Availability of appropriate land resources for training and production.
- Existence of established markets for the types of foods produced.
- Existing agriculture extension services that the JFFLS can build upon.
- The circumstances children face in targeted communities, i.e., children's needs, roles in community activities and food production, and time availability.

Issues for implementing at scale:

- The policy recommendations given above related to integration into the Ministry policy framework and into pre-service training for extensionists are important policy steps for facilitating larger scale-up.
- While a significant amount of food produced through this practice is used for subsistence consumption, as the practice is scaled up, a potential challenge is to ensure markets for the products generated. While some produce would continue to be used for participant and community consumption, income generation from sales is also a key objective of the practice, especially for crops such as mushrooms and pawpaw. If many communities in the same areas are producing the same or similar products, there may not be sufficient markets to absorb all the

- products. Careful analysis of markets and demand should be part of any planned scale-up, and if necessary, diversification of products used across communities should be promoted.
- Establishment of a systematic monitoring system should also be part of a scaled-up program to better understand the effectiveness of various aspects of the practice.
 - As the approach is scaled up, the need for central management and control of activities through the Ministry needs to be balanced with the involvement of community organizations and the flexibility and adaptations that stem from community ownership.

4.2.2. Practice: Integrated package of nutrition services as a routine part of HIV care and treatment

Country: Uganda

Implementing organization: The Mildmay Center. Mildmay is a UK-based NGO that has been providing outpatient services to PLHIV in Kampala, Uganda since 1998.

Problem addressed: Malnutrition is common among children and adults living with HIV yet food and nutrition components are often not a part of care and treatment services. When food and nutrition are included, it is often through individual interventions that are not integrated into the broader package of HIV care and treatment services that are increasingly available in many countries.

Situation where practice is applicable: Where care and treatment services are provided to PLHIV, and where a significant number of PLHIV are nutritionally vulnerable, malnourished, or experience other nutrition-related challenges such as diet-related symptoms or drug-food interactions.

Description of practice: Mildmay operates an HIV care and treatment center for adults and children living with HIV in Kampala. A package of nutrition services is fully integrated into the other clinical and counseling services. A nutritionist is on-staff at the center, which has a room where the nutritionist conducts assessment and counseling with clients. Based on assessments, food support is provided to eligible clients, including therapeutic food for management of severe acute malnutrition among HIV-infected children. The nutrition services are a central part of the flow of services. Nutrition information flows to clinicians and counselors, and clinical information flows to the nutritionist through a record-keeping system and through consultations between the nutritionist and other providers.

Mildmay also operates a day care service for HIV-infected children and provides daily transport for children to and from the center. As part of this program, Mildmay provides participating children with two meals, a snack and frequent drinks, as well as periodic nutrition assessment. As with adults, the food and nutrition support are an integrated component of the clinical and psychosocial care provided to the children.

Enabling factors:

- The multidisciplinary nature of the care providers at the center, which include medical doctors, nurses, physiotherapist, nutritionist, teacher, pastoral care workers, counselors, and other staff. The multidisciplinary staff facilitates the holistic approach in which nutrition is integrated into other services. If all providers had only medical backgrounds, the extent of integration achieved may not have been possible. Mildmay's philosophy of holistic care is an enabling factor in this process as well.
- The center's solid financial support, which ensures regular supply of food, consistent staffing, and availability of records and other components necessary for successful nutrition programming. The center received some food from WFP and other food was purchased locally.
- The nutritionist's strong coordination and professional relationship with other care providers. This helps prevent the nutrition component from becoming a parallel activity.

Constraints and challenges:

- While the program is likely to continue because Mildmay and its donors plan to continue to provide the necessary resources, the program's continuation is dependent on this ongoing provision of resources.
- Because all services are provided free of charge, dependency can occur among clients, especially for the food assistance provided. This may not pose a challenge as long as clients attend the center but it can make graduation or transition to other services a challenging adjustment. This arrangement also creates dependency by the center on external resources to maintain the level of services provided. Applying clear entry and graduation criteria for food provision among clients could help partially address this challenge.

Resource implications:

- Significant financial resources are needed for a comprehensive program such as Mildmay implements. Such high levels of resources may not be necessary for the integration of nutrition into clinical services, which is the core of this practice, if a less comprehensive set of nutrition interventions were used. However, for a comprehensive program such as this one, resources are needed for the nutritionist, food assistance, separate room, equipment, and educational materials, as well as the other HIV services with which the nutrition component is linked.
- The nutritionist serves as the nodal point for the nutrition services at the center and for the linkages to other services. Therefore, availability of at least one skilled and knowledgeable nutritionist is required for this practice, or possibly a nurse who is well trained in nutrition.

Monitoring:

- Nutritional status is regularly monitored for all clients. For clients receiving specialized food products to address malnutrition, assessment is at least monthly.

- Client records are used to monitor individual progress and outcomes and these can be aggregated to document overall program outcomes.
- The center also keeps records of the numbers of clients, disaggregated by sex, age, ART status, and other categories.
- Regular meetings among the providers are used to monitor the systems and develop greater coordination and linkages as needed.

Results:

- Program records indicate that, at the time of the review, 66% of adults and 72% of children receiving food support had gained weight and maintained a healthy nutritional status since entering the program, though these improvements cannot be attributed entirely to the nutrition services.
- Records also indicate high coverage and retention of clients for nutrition services, though quantitative data on coverage and retention were not collected as part of the review.

Linkages to other services:

- While the nutrition services are strongly linked to other HIV services at the center, the links to other, outside services are more limited. In large part, this is because the center provides such comprehensive services that linkages to outside services are less critical than in other programs.
- Referrals to Mulago Hospital are made for cases with medical complications that Mildmay does not have facilities to handle.
- Mildmay operates a similar day care program for orphans in a rural area of Uganda (Luwero District). Nutrition services are similar and there are strong linkages to the local health center, where children receive clinical care.

Variations: None observed.

Policy implications:

- Mildmay's experience demonstrates that with commitment from the center's leadership, full integration of nutrition as part of routine HIV care is possible and beneficial. One implication this points to is the importance of cultivating commitment on the part of policy makers for including nutrition care in national HIV policies, and cultivating commitment on the part of the leaders of individual facilities. Such commitment can help to move integration of nutrition into HIV services from a possibility to a reality on a wider scale.

Replication considerations:

- Availability of a comprehensive care and treatment set-up, especially if the practice is to be implemented in the same way that Mildmay implements it. The core practice of integration of nutrition into routine care and treatment could be replicated in services that are less comprehensive than Mildmay's. This would likely require fewer resources but may also lead to lower impacts.
- Availability of qualified nutritionists (or nurses well trained in nutrition) to lead the nutrition component. This can be a challenge in many settings.

- The disciplines and orientation of the other providers in the facilities. An enabling factor of the successful links between nutrition and the other services in Mildmay is the multi-disciplinary team at the center.

Issues for implementing at scale:

- Implementing this integration at a significant scale is likely to require strong government commitment to nutrition and HIV services. The commitment would need to include resources for the various components of the nutrition services.
- Given that the nutritionist is the central component of this approach, availability of a sufficient number of qualified nutritionists is an important consideration for scale-up.
- Training and supervision need to be carefully planned for scale-up of the approach described here because both human resource capacity coordination systems within the facilities are so critical. The training may need to entail training of doctors and nurses as well as nutritionists.

4.3. Scale-up

Scale-up is often framed as the final phase and ultimate goal of a set of program activities. While there are undoubtedly many beneficial impacts from the intensive implementation of activities in a limited geographic area, scale-up enables benefits to reach a larger population of beneficiaries. As with other program areas, scale-up of nutrition, food security, and HIV activities entails a number of challenges, such as maintaining quality, ensuring adequate management and coordination, and cultivating innovation and variation.

National HIV control programs offer a strong channel for scale-up of nutrition, food security, and HIV activities. These programs are coordinated by the national government, often with some external funding support, and operate through an array of service delivery points including clinical HIV care and treatment facilities. Both of the selected promising practices under this theme involve scaling up nutrition interventions through the clinical services of national HIV programs: 1) scaling up management of malnutrition among adult ART clients in Malawi; and 2) scaling up nutrition counseling for PLHIV in Kenya.

4.3.1. Practice: National scale-up of management of malnutrition among adult ART clients

Country: Malawi

Implementing organization: Government of Malawi Ministry of Health, in collaboration with UNICEF, WFP, the Global Fund for AIDS, Tuberculosis and Malaria, Christian Health Association for Malawi (CHAM), and the National AIDS Commission (NAC). The program is implemented by the government at HIV treatment facilities with technical, funding, and operational support from the partners listed above.

Problem addressed: High malnutrition rates among new adult ART clients undermine the effectiveness of ART, leading to high mortality. A pilot project demonstrated that interventions to manage severe and moderate malnutrition among ART clients are effective on a small scale; these interventions require scaling up.

Situation where practice is applicable: Where systematic ART treatment is occurring and a high prevalence of malnutrition exists among ART clients.

Description of practice: As ART scaled up in Malawi, reports showed very high mortality rates, with 71% of clients dying during the first three months. In January 2005, a Ministry of Health commission identified malnutrition as a major factor contributing to the high mortality and strongly recommended introduction of nutrition care and treatment for ART clients. Following this recommendation, the government launched a pilot nutrition program at six ART sites. The primary focus of the pilot was provision of specialized food products to malnourished clients.

After a review of the pilot showed it to be achieving improved nutritional status, the Ministry of Health planned a major scale-up of the program in collaboration with UNICEF, WFP, CHAM, and NAC. A number of actions were taken to make such a scale-up possible. Advocacy efforts were carried out within the Ministry and the Office of the President, communicating to policymakers the critical need of addressing malnutrition among PLHIV to maximize the lives saved and ensure that investments in ART are successful. Design of the program interventions was based on the limited existing international guidance and evidence, literature, and experience in HIV programs and in community-based approaches to managing severe acute malnutrition in children in Malawi. Food procurement and other operational components were arranged, and training of staff in the program protocols was rolled out.

The program targets new and existing ART clients and TB clients, most of whom are HIV-positive. Similar services are also provided to PMTCT clients. Anthropometric entry and graduation criteria are used for receipt of specialized food products. Therapeutic milk is provided to severely malnourished clients with medical complications on an inpatient basis; a ready-to-use therapeutic food (RUTF), Plumpy'nut, is provided to severely malnourished clients without medical complications on an outpatient basis; and either a) RUTF or b) *likuni phala* (a fortified blended food) and vegetable oil are provided to moderately malnourished outpatients, depending on the site.

The *likuni phala* is produced locally; the therapeutic milk is imported; and, at the time of review, RUTF was imported from France. Local production of RUTF has been established in Malawi so locally produced RUTF may also be used now. Nutrition education and counseling is provided to clients, and, at the time of the review, educational materials to support counseling were being finalized.

At the time of the review, the program was operating at 60 ART sites in all 28 districts of the country with plans to scale up to 100 sites shortly. At the time of the review, Malawi was the only country with such a large-scale, government-led program to manage

malnutrition among ART clients. (With PEPFAR support, a smaller-scale “food by prescription” program was getting underway in Kenya at the time of the review, and this program has since expanded.)

Enabling factors:

- Commitment within the highest levels of government to nutrition interventions for PLHIV. Strong advocacy efforts by stakeholders helped to facilitate this commitment. A Permanent Secretary for Nutrition and HIV is located in the Office of the President.
- Inclusion of nutrition in national HIV policies and strategies. The nutrition program is in line with the national HIV response that promotes universal access to ART and related services as part of an essential health care package.
- Local acceptability of Plumpy’nut, the peanut-based RUTF. Acceptability is relatively high because peanuts are a common part of the local diet and because of familiarity and experience with Plumpy’nut from existing community programs in Malawi to treat severe acute malnutrition in children. Local production of RUTF in Malawi also facilitates acceptability.
- Strong partnerships. A strong set of partners and stakeholders are supporting the program, including financial support from the Global Fund, technical support from UNICEF and others, and operational support from WFP and CHAM.
- Training of cadres of health care staff to bolster human resource capacity in nutrition.

Constraints and challenges:

- Human resource limitations pose significant constraints. It was planned to have two service providers implement the nutrition component at each site, but demand for services is so high at some sites that two providers have not been sufficient. Furthermore, Malawi is facing a shortage of nurses, which has required other cadres such as community-based service providers and health surveillance assistants to play leading roles in nutrition service provision. However, these service providers often do not have adequate technical capacity to provide high quality nutrition services.
- The program is quite costly, in particular the RUTF requires a high level of financial support.
- High default rates are common due to the distance to facilities, transport requirements, and inadequate follow-up and community support.
- Follow-up of clients to prevent defaulting and after graduation is weak. The weak follow-up is due to inadequate linkages with community-based services and shortages of community-based workers to carry out follow-up. Also, community services have different entry criteria than this program does, which complicates coordination and follow-up.
- The monitoring system is limited, which prevents analysis of information collected and subsequent adjustments to activities. The monitoring system for the nutrition program is a parallel system and not integrated into the larger HIV M&E system.

- It is reported that severely malnourished adults are unable to consume the full quantity of RUTF needed to meet their nutritional needs. While most children in malnutrition programs are able to eat the full portion of RUTF required, adults have more difficulty, perhaps due to the sweet taste of the food, the lack of variety in consuming only RUTF, and the larger quantity that adults need to consume.

Resource implications:

- Significant financial resources are needed for the program. The RUTF is quite expensive. Trainings and other program activities can also be costly.
- To reach a large scale with such a program, adequate human resources must be in place or available to provide direct services, ensure technical quality, and manage and coordinate program operation.

Monitoring:

- The program uses a set of tools and client records for monitoring. Indicators collected include client anthropometric indicators (body mass index (BMI), weight-for-height, mid-upper arm circumference (MUAC)), drug adherence, opportunistic infection incidences, duration in program, and mortality.
- Periodic monitoring visits are made to sites to document performance and lessons.
- Service providers are supposed to send reports every month to enable supervisors to assess progress and results, reporting is often slow.

Results:

- The program had not been evaluated at the time of the review, but initial records indicate positive responses from program interventions, including weight gain and recovery of healthy nutritional status.
- Facility records indicate that the average duration in inpatient care was 11 days before transitioning to outpatient care. Severely malnourished outpatients require an average of 6 weeks to recover, while those who present earlier without complications require an average of 4 weeks to recover.
- The planned scale-up was achieved quite rapidly with effective operations at targeted sites. Reaching significant scale with such a complex program is a significant result in and of itself.

Linkages to other services:

- As a component of the ART scale-up plan of the national HIV/AIDS response, the program is linked directly to ART services.
- The program is also linked to TB services; like ART clients, TB clients are nutritionally assessed and referred for nutritional treatment if needed.
- In some sites, clients are referred to community-based services such as home-based care, food security support, and other safety net services. Referrals can be made directly at the clinic or through the National Association of People Living with HIV and AIDS. These referrals vary widely by site, depending on availability of the community services.

Variations:

- The PEPFAR-supported food-by-prescription approach is a variation of this program that provides a similar package of nutrition services through clinical HIV treatment facilities. As food-by-prescription programs expand, examination of the Malawi program – the first of its kind – may yield useful lessons. While the Malawi program is coordinated and operated directly by the government, albeit with NGO implementation in some areas, the PEPFAR-funded food-by-prescription programs have to date been run by implementing partners (an NGO or private company) in collaboration with the government.
- A possible variation that has been considered in Malawi is to refine the food packages provided based on emerging evidence. Modifying the type of RUTF is also being considered as new formulations for adults are developed.

Policy implications:

- International guidelines from WHO for appropriate food protocols for malnourished adult PLHIV could strengthen programs such as this. Currently, there is not international agreement on such protocols, and programs apply different protocols based on limited existing documentation and experience.
- Ministry of Health action is needed to obtain sufficient technical staff at clinics for the nutrition program. A recruitment campaign for nurses was underway at the time of the review. In-service training in nutritional care of PLHIV must also continue in order to ensure sufficient skills and knowledge. To increase availability of health care staff who can provide nutritional care over the long run, pre-service training is also required, as is incorporation of nutrition into medical and nursing school curricula. This will help ensure human resources are available for a sustained national-scale program.

Replication considerations:

- Extent of political will and commitment to move such a program to national scale. The policy landscape is an important factor in the feasibility of carrying out this program at a national scale.
- Commitment of sufficient financial resources to cover program costs. Given the high costs of the program, donor commitment and resource availability are important considerations in whether and how to replicate this approach.
- Availability and acceptability of appropriate specialized food products.
- Mechanisms for procuring, transporting, storing, and distributing food products. Such mechanisms need to be in place or feasible to establish.
- Acceptability of food products. While products such as Plumpy'nut are usually acceptable among children, they may not be as acceptable for adults in all settings so acceptability tests may be needed, and alternative formulations may need to be considered.
- Existence and availability of adequate numbers of health care staff with adequate skill levels to provide the nutrition services required by the program.

Issues for implementing at scale: As this practice is inherently about reaching scale, most of the issues discussed above are relevant to implementing at scale. Three issues of particular relevance to scaling up this practice are:

- Management of the supply chain logistics for procurement and distribution of food products to a large number of sites can pose a challenge. This process can be challenging and costly, whether integrated into national drug supply processes or carried out by private sector or NGO systems.
- A strong commitment from policy makers is essential for implementation of a program such as this on a national scale. Inclusion of the nutrition program in national strategies, guidelines, or plans can be an important step. Malawi offers an instructive example of how to advocate for and generate such commitment.
- Coordination and consistency become critical when such a complex program is taken to scale. This applies to both operational issues such as food procurement and distribution, and technical issues such as the protocols and criteria used for management of malnutrition.

4.3.2. Practice: National scale-up of nutrition counseling for PLHIV

Country: Kenya

Implementing organization: Government of Kenya National AIDS and STI Control Program (NASCOP). NASCOP, located in the Ministry of Health, is the national coordinating body for HIV activities in Kenya.

Problems addressed: Knowledge of nutrition actions required by PLHIV is limited among both clients and service providers. Recommended actions are individual-specific and depend on the client's clinical and nutritional status, preferences and tastes, household situation, and other factors. This situation calls for individual nutrition assessment and counseling, but nutrition components other than food assistance are often not valued by clients or providers. Where nutrition counseling for PLHIV has occurred in the past, it has usually been in specific, isolated programs.

Situation where practice is applicable: Where HIV clients face nutrition issues and lack knowledge of appropriate actions, pointing to the need for nutrition education and counseling.

Description of practice: Recognizing the need for nutrition counseling to improve the health and nutritional status of PLHIV, NASCOP embarked on a systematic process to integrate nutrition counseling into HIV services at comprehensive care centers (CCCs), which are outpatient wards for HIV care and treatment. Nutrition counseling entails an interactive process between provider and client to identify and communicate the client's nutrition needs based on assessment information, consider options to meet these needs, and jointly negotiate actions that are feasible for the client.

As the convener of Kenya's National Technical Working Group on Nutrition and HIV, NASCOP collaborated with USAID, FANTA, UNICEF, WHO, and local NGOs to

develop a set of counseling materials on nutrition and HIV, consisting of a flip chart of counseling cards and posters. The materials are disseminated to CCC service providers along with orientations in how to use them. The USAID-funded materials are designed to facilitate interactive counseling and center around eight critical nutrition practices for PLHIV: periodic nutrition assessment, increased energy intake through a balanced diet, prompt treatment of opportunistic infections and dietary management of symptoms, good water and food hygiene and sanitation, drinking of plenty of water, physical activity and exercise, positive living practices, and management of drug-food interactions.

Concurrent with development of the counseling materials, a national training manual on nutrition and HIV for CCC workers was developed and rolled out to strengthen the capacity of nutritionists, nurses and other service providers to provide nutritional care. With resources from the Global Fund, NASCOP also posted 50 new nutritionists at CCCs. These are in addition to the cadre of nutritionists and nurses already working at service delivery sites in Kenya.

These multiple components together support the introduction of a strong nutrition counseling component in many CCCs – and nearly all of the large CCCs. Clients at these sites receive nutrition counseling as part of routine services, based on the training and using the counseling materials.

Enabling factors:

- Strong human resource base in nutrition. As alluded to above, Kenya has many nutritionists; a number of degree programs exist, which generate many qualified nutritionists each year. Furthermore, the Global Fund support for additional nutritionists at CCCs further strengthened this human resource base at clinical sites.
- Substantial technical assistance. With funding from USAID, technical assistance is provided to NASCOP in the development of the materials and the training on nutrition and HIV. This support helps ensure the materials and training content are technically sound and reflect the latest evidence base.
- Government policy. The Government's HIV strategy and policy includes nutrition as an integral part of HIV treatment and management. This creates an important enabling environment for introduction and integration of nutrition counseling for PLHIV.

Constraints and challenges:

- Service providers face significant time constraints. Nutritionists report that there are times when client load is so high that adequate time cannot be given to all clients seeking counseling. In these situations, prioritization among clients is made to ensure the most needy receive counseling. Facilities develop criteria for this prioritization.
- Variation in service provider skills, time availability, and level of support supervision lead to considerable variation in the quality of the counseling provided. When implemented at such a large scale, consistently high levels of quality are not always maintained at all service points.

- Nutrition counseling is often undervalued by clients and service providers, especially compared to the highly visible provision of food assistance. Where food was not available at sites, some clients and service providers exhibited less interest in nutrition counseling because of the attitude that unless food is provided, counseling recommendations are not useful. Emphasizing the eight critical nutrition practices is one approach NASCOP uses to help overcome this challenge since most of the practices do not require external food assistance.
- Poverty and poor food access poses a challenge to the capacity of some clients to follow optimal dietary recommendations. It sometimes becomes necessary to use feasible “second-best” options, which counselors can help clients to identify.
- Client absorption of and responsiveness to counseling information is sometimes limited as a result of poor attention span due to illness, presence of children, or other factors. Low literacy levels also reduce understanding in some cases.

Resource implications:

- Financial resources are needed for production of materials, as well as to support the nutritionists or nurses providing the counseling.
- Human resources must be available, in particular nutritionists or other health care providers with capacity to provide nutrition counseling.
- Counseling materials need to be reliably available at care and treatment sites.
- While there are definitely resource implications to national scale-up of quality counseling, it requires many fewer resources than provision of specialized food products.

Monitoring:

- At the time of the review, no monitoring tool had been developed for nutrition services at CCCs.
- NASCOP requested service providers to record the number of clients counseled and feedback from clients about the counseling.
- Since the time of the review in 2006, NASCOP developed a specific nutrition register for CCCs that collects a range of nutrition data, including counseling information.

Results:

- At the time of the review, monitoring of quantitative results had not occurred.
- Regular nutrition counseling has begun in many CCCs using the counseling cards and using information and skills gained from the training.

Linkages to other services:

- Although the counseling materials were designed for use in CCCs, they are being used in other settings as well, including PMTCT, VCT, ART, and TB services.
- Based on the results of counseling, nutritionists also make referrals to other clinical services or to community programs if needed and if these services are available.

- As the food-by-prescription program began in Kenya, the counseling services became an integral part of the program, and counseling and food support served as complementary interventions.

Variations:

- Catholic Relief Services (CRS) implements nutrition counseling in Kenya through community structures such as chief barazas, churches, and community health workers. This differs from the NASCOP approach of providing nutrition counseling in clinical CCC facilities.
- CRS also printed counseling cards that were in the local language.
- Counseling varies according to the nutrition services provided at the site. For example, at some CCCs provision of specialized food products is being provided in addition to counseling while at others food support is not available. Where food is provided, counseling incorporates messages about the appropriate preparation and use of the food provided. Where food is not provided, there may be greater emphasis placed on how to optimize food resources available at home.

Policy implications:

- Formalizing the inclusion of nutrition counseling in HIV services as a policy generates momentum that enables fuller and more rapid integration of counseling in CCCs. This policy initiative and commitment was an important factor in enabling the scale-up of nutrition counseling.
- A similar approach could be applied to efforts to enhance nutrition counseling in other services such as VCT, PMTCT, ANC, and MCH clinics, and the process may move faster now that counseling is underway at CCCs.

Replication considerations:

- Assessment and planning of human resource availability and capacity building. Replication of nutrition counseling runs a high risk of being ineffective if the human resources to carry it out with high quality are not in place. To bring nutrition counseling to scale, human resource gaps need to be identified and plans made to address them.
- Availability of government structures and services that reach PLHIV and that have feasible opportunities to include nutrition services.
- Involvement of PLHIV in the development of messages and materials. This ensures messages are appropriate and effective, an essential prerequisite for successful counseling.
- Counseling approach. Counseling should always be client-specific in that the content, pace, and conclusions of a counseling session will depend on the specific conditions and situation of the client. Keeping this in mind during replication will help ensure that counseling is effectively tailored to client needs, as opposed to applying a counseling “blueprint” from another location or client.

Issues for implementing at scale: As this practice is inherently about reaching scale, most of the issues discussed above are relevant to implementing at scale. Two issues of particular relevance to scaling up this practice are:

- To reach national scale, some contextualization of the counseling materials may be needed, such as translation into local languages and adapting key messages to local conditions. Local NGOs may be best positioned to support this process.
- Awareness and coordination with other related, large-scale initiatives (e.g., food-by-prescription programs) is important when planning scale-up of activities such as nutrition counseling, especially since counseling is an important complement to other services such as provision of specialized food products.

5. Conclusions

One simple conclusion that emerges from the program reviews is that there are a large number and variety of programs providing nutrition and food security services for PLHIV. At the time of the review, several national governments and donors were in the process of incorporating nutrition into their HIV policies and strategies, e.g. PEPFAR was in the process of preparing policy guidance on food and nutrition. Results from the review suggest that even before these policies were put in place, many implementing organizations – from small community organizations to international NGOs – were innovating and implementing nutrition and food security interventions in response to the observed needs of their target populations.

In particular, one striking finding from the reviews is the large number of small community groups that are providing nutrition and food security services to HIV-affected populations. These groups are often not highly visible to the government or other stakeholders in their countries, but they are utilizing whatever resources are available to them to address the nutrition and food security needs of the populations they work with. While the reviews documented some insights into the approaches these small groups are using, it is likely that more can be learned from them. Linking these groups to other technical resources will help enhance their services and enable replication and scale-up of some of the promising approaches these groups have initiated.

Related to this finding, the promising practices identified in the reviews reinforced the importance of building on existing capacities and facilitating community involvement and leadership in nutrition and food security activities for PLHIV. Many of the successful practices are rooted in community involvement, from household commitment to sustain OVC support in Tanzania, to chiefs monitoring nutrition support in Malawi, to community identification of vulnerable children and land for agriculture extension in Zambia.

Linkages and integration constituted another theme for promising practices because of the benefits – and often the necessity – of integrating nutrition and food security services into broader HIV services. Such linkages and integration become even more essential with the large influxes of HIV resources seen in many countries and the subsequent proliferation of HIV program initiatives. Successful approaches identified by the reviews were able to bring together multiple partners and services as the JFFLS does in Zambia,

and were able to integrate nutrition into comprehensive HIV care as the Mildmay Center does in Uganda.

The Government of Malawi's management of malnutrition services and the Kenya government's nutrition counseling both demonstrate that scale is possible, but both also point to the challenges of scaling up, including coordination and maintenance of quality. The scale-up experiences also demonstrate that political will and commitment can be critical ingredients in scale-up. Such political commitment and subsequent policies often develop simultaneously with field activities, with each reinforcing the other. However, not all practices are suited to large government scale-up; some practices, e.g., the community-based activities in Tanzania and Malawi described above, may call for other approaches to scale, such as replication and adaptation among different community organizations.

A number of common gaps emerged from the reviews. Review teams found M&E to be weak in most of the programs and practices. Strengthening M&E will help improve interventions, increase accountability, and enable programs to share and learn more about effective services in the relatively nascent program area of nutrition, food security, and HIV. For example, in the review itself, availability of stronger program M&E information would have enabled better documentation of processes and results and more useful recommendations about promising practices.

Limited human resources skilled in nutrition support is another major gap identified in many programs. This constrains the capacity to provide nutrition assessment and counseling in many settings and limits the quality of such services when they are provided. Approaches such as pre-service training are needed to address this gap over the long term. Shorter-term approaches are also required, such as in-service training of existing staff, provision of support materials, development of standard operating procedures for nutrition interventions, and if possible increases in overall numbers of health care staff, home-based care providers, and community volunteers to address the time constraints that many providers face.

The issue of stigma emerged as a challenge in a number of programs. Stigma remains prevalent in many settings and interferes with targeting and provision of nutrition and food security services.

Another challenge related to targeting involves the ethical and programmatic challenges of distinguishing between HIV-affected and other vulnerable populations for targeting nutrition and food security services, as in the case of the food support in Malawi. The program in Malawi decided to target TB clients as well as PLHIV for food support, and some of the community programs reviewed use chronic illness or other measures of vulnerability to target nutrition and food security services. These responses help to mitigate the targeting challenge. Coordinating coverage of HIV programs with other programs that provide food and nutrition services to a broader population (i.e. including non-HIV-affected) can help ensure that all vulnerable individuals receive services and thereby help address this challenge.

While the programs and promising practices reviewed in these five countries offer rich experience that future programs can draw from and build upon, the gaps and challenges identified suggest areas where scope exists to further improve nutrition care and food security support for HIV-affected populations.

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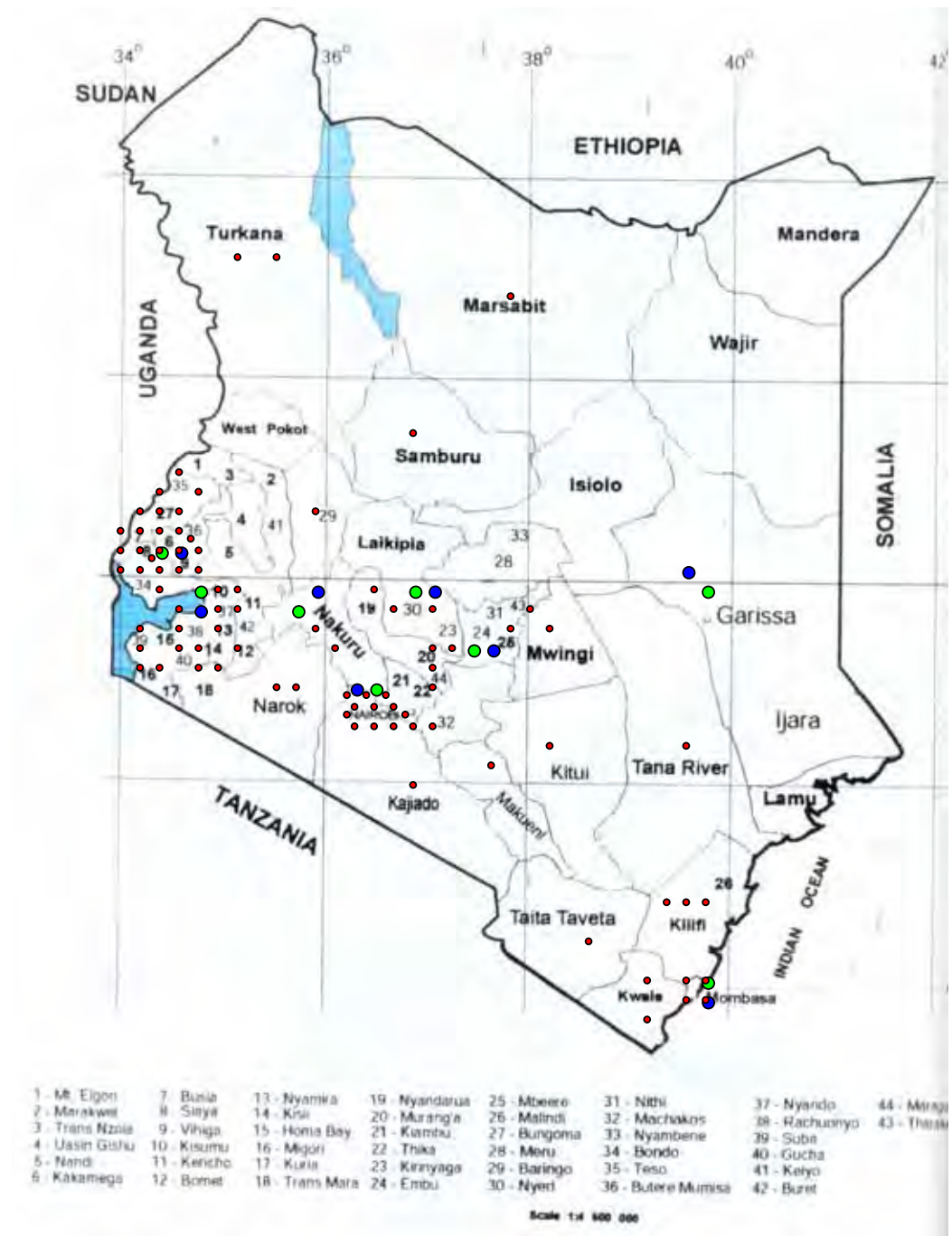
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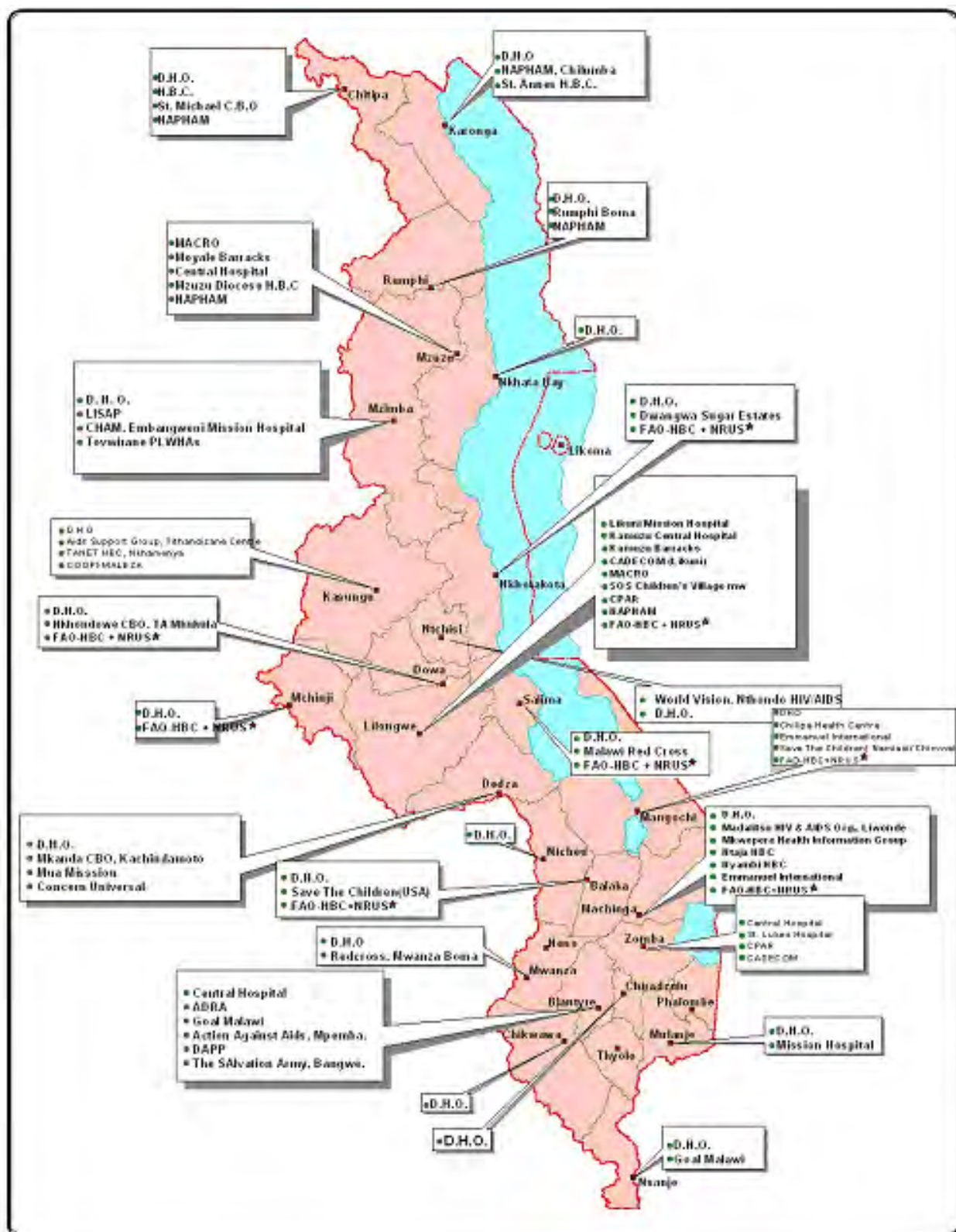
Appendix: Maps of Nutrition, Food Security, and HIV Programs in Reviewed Countries

Nutrition, Food Security, and HIV Programs in Kenya

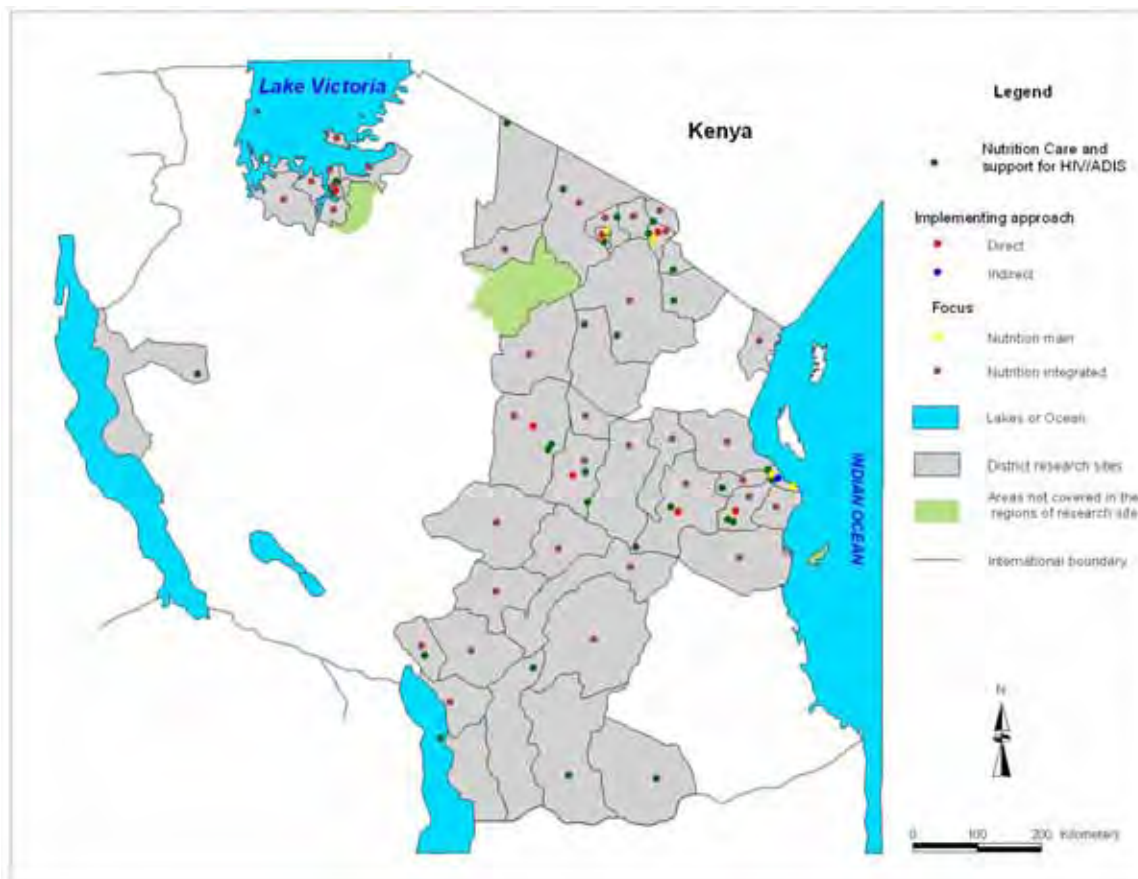


- Key
- Provincial General Hospitals
 - INGOs with countrywide coverage (in all districts)
 - NGOs, CSOs, CBOs

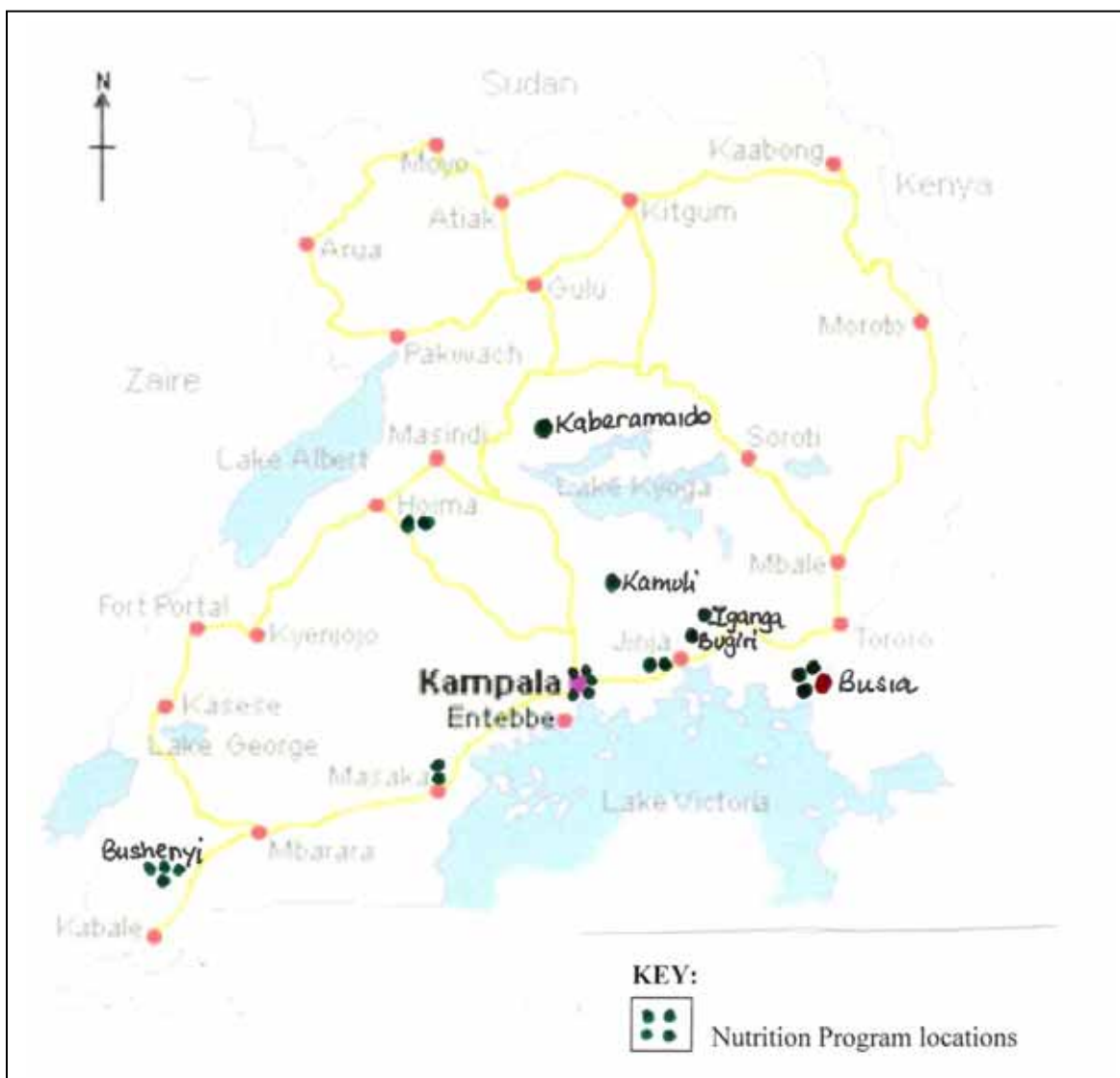
Nutrition, Food Security, and HIV Programs in Malawi



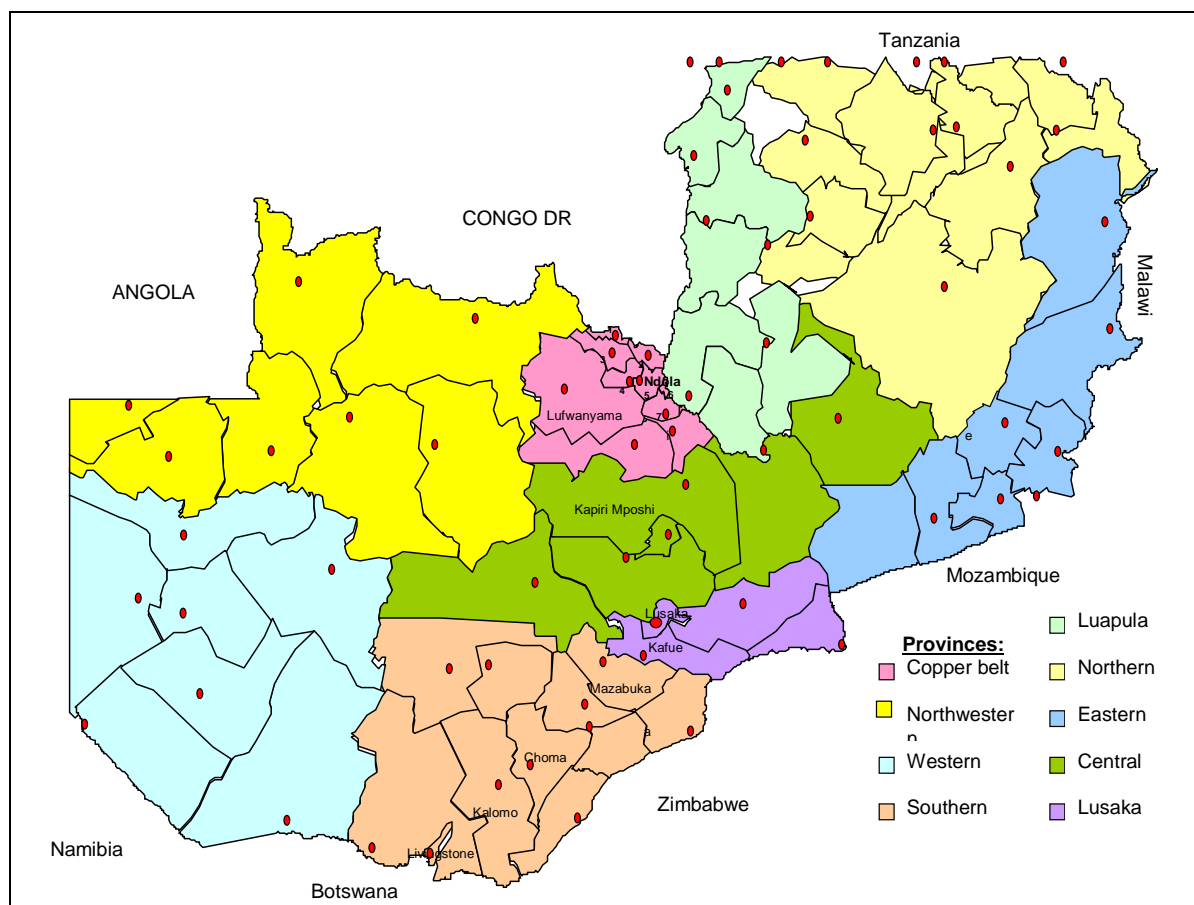
Nutrition, Food Security, and HIV Programs in Tanzania



Nutrition, Food Security, and HIV Programs in Uganda



Nutrition, Food Security, and HIV Programs in Zambia





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