Integration of HIV/AIDS activities with food and nutrition support in refugee settings: specific programme strategies

December 2004

First Version

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SPECIFIC PROGRAMME STRATEGIES

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Contents

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Preface

This document provides practical guidance on the integration of food and nutrition programmes with support activities for people with human immunodeficiency virus (HIV) infection or acquired immunodeficiency syndrome (AIDS) among refugees and host populations. It has been written principally for United Nations agencies, their cooperating partners, and other organizations working with populations affected by an emergency. While the guidelines focus mainly on refugees, internally displaced populations and asylum-seekers, they are also applicable to host communities and other populations affected by emergencies.

This initiative – to identify opportunities to address both malnutrition and HIV/AIDS through combined programmes – grew out of the recognition of the many complex interactions between HIV infection, nutritional status and livelihood resilience. In populations with a high prevalence of HIV/AIDS, such as in southern Africa, profound changes are likely to occur in the demographic, social, economic and political environments in which people make a living.[1] [2] [3] HIV/AIDS can cause hunger and malnutrition in households stricken by illness, where family members are unable to continue working for food or income. HIV/AIDS can also be a consequence of hunger, as when women and girls resort to high-risk sex to earn food or income.

Refugee protection programmes often include a range of health (including HIV/AIDS) and food and nutrition activities. Refugee food and nutrition programmes offer unique, and often relatively straightforward, opportunities for HIV/AIDS prevention and mitigation; at the same time, HIV/AIDS programmes present vital entry points for activities to prevent and reduce food insecurity and malnutrition. This document focuses on how to gain the most benefit from working at this intersection between food and nutrition and HIV/AIDS activities, by asking two key questions:

1. ***How can emergency food and nutrition programmes incorporate HIV/AIDS-related activities, in support of HIV/AIDS prevention efforts or to increase care, treatment and support for affected households?***
2. ***How can HIV/AIDS prevention, care, treatment and support programmes in refugee settings better utilize food and related resources to improve nutritional outcomes for people living with HIV/AIDS, as well as to build local capacity to provide HIV/AIDS-related services?***

A document of this length cannot possibly give detailed attention to all aspects of HIV/AIDS and food security/nutrition interactions. Nonetheless, it seeks to expand our capacity as an international community to engender and support HIV prevention, care, treatment and support and good nutrition in refugee settings. An epidemic as vast and complex as HIV/AIDS demands that we commit ourselves, fully and with humility, to honest dialogue and continual learning about how to lessen the effects of the disease across the globe. With this in mind, we expect that this document will continue to evolve to reflect lessons learned.

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1 Harvey P. *HIV/AIDS and humanitarian action*. London: Overseas Development Institute, 2004 (Humanitarian Policy Group Report 16).

2 Loevinsohn M, Gillespie S. *HIV/AIDS, food security, and rural livelihoods: understanding and responding* Washington, DC: International Food Policy Research Institute, 2003 (Discussion Paper 157).

3 De Waal A. *HIV/AIDS and emergencies: challenges of measurement and modelling*. Johannesburg: United Nations Regional Inter-Agency Coordination and Support Office (RIACSO), 2003.

Acronyms used in this document

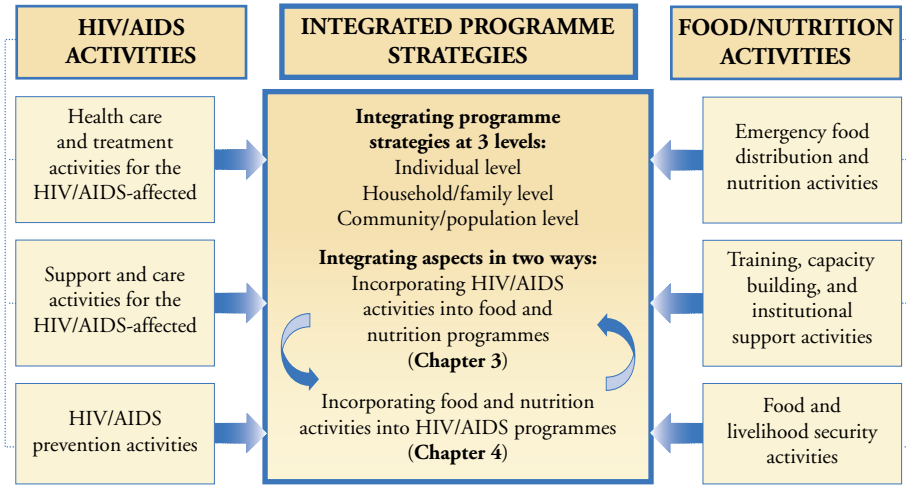
AAH	Aktion Afrika Hilfe
ACORD	Agency for Cooperation and Research in Development
ADEO	African Development and Emergency Organization
AIC	AIDS Information Centre
ANC	antenatal care
ART	antiretroviral therapy
ARV	antiretroviral (medication/drug)
AVSI	Association of Volunteers in International Service
CBO	community-based organization
CCA	community counselling aide
CP	cooperating partner
CSB	corn–soya blend
CTC	community therapeutic care
FFW	food-for-work
GFD	general food distribution
HAP	Health of Adolescents Programme
HBC	home-based care
HEPS	high energy and protein supplement
HIV/AIDS	human immunodeficiency virus/ acquired immunodeficiency syndrome
IASC	United Nations Inter-Agency Standing Committee
IDP	internally displaced person
IFRC	International Federation of the Red Cross
IGA	income-generating activity
MAHA	Madi AIDS Heroes Association
MCH	maternal and child health
NGO	nongovernmental organization
PLWHA	people living with HIV and AIDS
PMTCT	prevention of mother-to-child transmission [prevention of parent-to-child transmission]
PPPD	per person per day
RDA	recommended dietary allowance
RTP	Right to Play
SFP	supplementary feeding programme
SGBV	sexual and gender-based violence
TB	tuberculosis
TBA	traditional birth attendant
TFP	therapeutic feeding programme
THETA	Traditional and Modern Health Practitioners Together Against AIDS
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNGASS	United Nations General Assembly Special Session HIV/AIDS
UNICEF	United Nations Children's Fund
UNHCHR	United Nations High Commissioner for Human Rights
UNHCR	United Nations High Commissioner for Refugees
VCT	voluntary counselling and testing
WFP	United Nations World Food Programme
WHO	World Health Organization
WVI	World Vision International
YASSA	Youth Anti-AIDS Services Association
ZRCS	Zambia Red Cross Society

Executive Summary

This document provides practical guidance for managerial and technical staff of the United Nations and cooperating partner agencies on implementing programmes that incorporate both HIV/AIDS and food security/nutrition activities. While much research is still needed about the interactions between HIV/AIDS, food security and nutritional status, it is known that food insecurity, poor nutrition and the incidence and severity of HIV infection are associated in complex, multitiered ways. Because refugees often depend, at least in part, on external assistance for nutritional, health and other basic needs, refugee settings provide unique opportunities to implement tailored interventions that mitigate the effects of the illness and prevent HIV transmission – to directly address the vicious cycle of HIV/AIDS and food insecurity.

This document describes two types of integrated programme strategies. Strategies described in Chapter 3 incorporate HIV/AIDS prevention, care, treatment and support activities into food and nutrition programmes. Strategies presented in Chapter 4 incorporate food and nutrition training, or use food resources for capacity-building and/or institutional support activities, in HIV/AIDS programmes. It is not true that programme strategies across sectors should always be multisectoral. Food and nutrition programmes are not a "magic bullet" for preventing HIV transmission or mitigating the effects of the HIV/AIDS epidemic. Additionally, it is vital to avoid over-reliance on food programmes, which could disrupt agricultural production and markets in refugee communities. Agency staff should identify interagency and intersectoral linkages that make sense in the local context.

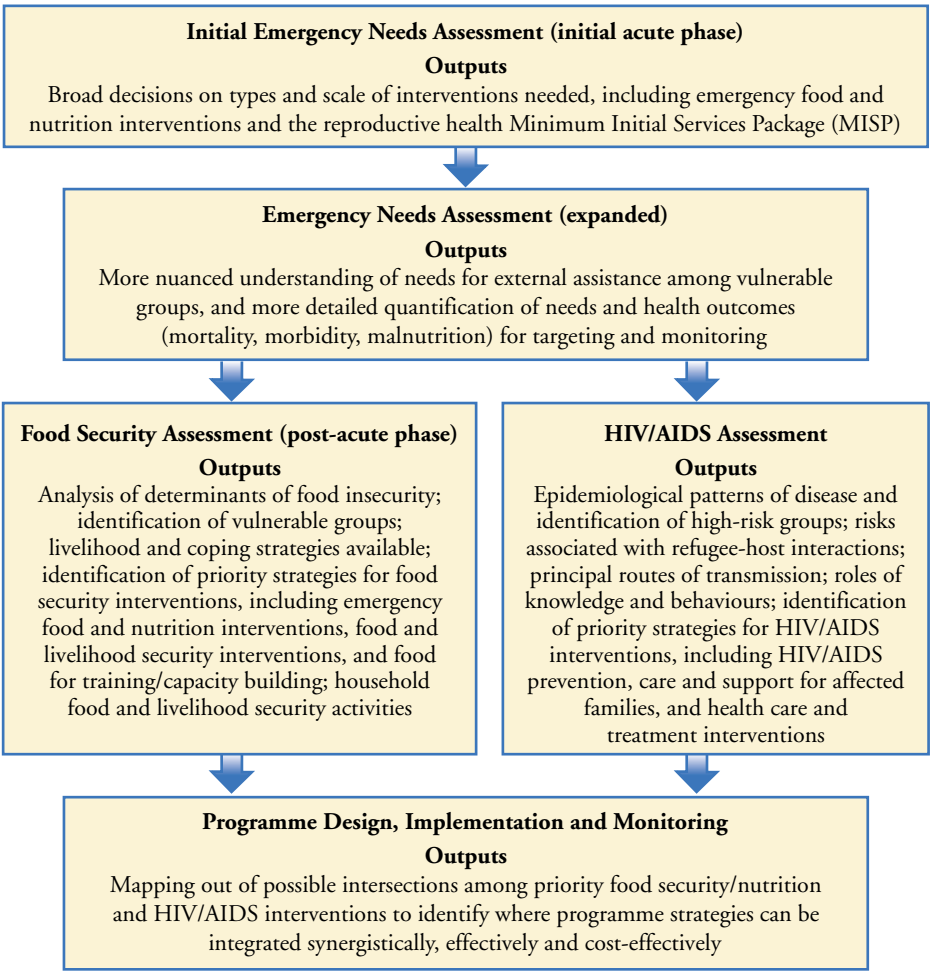
The decision to implement one or more of these integrated programme strategies should follow from a local assessment, preferably conducted in both the refugee and host communities. Across refugee settings, the epidemiology of HIV/AIDS varies widely, with some populations exhibiting a low HIV prevalence except in defined high-risk groups, and others struggling with a more generalized epidemic. HIV epidemics may also be associated with different patterns of food and nutritional insecurity among vulnerable groups. Assessment and analysis of food security and malnutrition in affected populations are essential in deciding



whether food-based programmes are appropriate in the context of HIV/AIDS. Initial HIV prevalence rates and the nature of refugee-host interactions can be significant determinants of HIV risk in both populations. In this document, readers will find many examples of agency field staff drawing on refugee and host community skills (e.g., music, dance and drama talents; teaching, training and peer education skills) to build more community-driven refugee health programmes to prevent HIV transmission and provide medical, health, nutrition and livelihood support to the HIV/AIDS-affected.

Implementation of integrated programme strategies should be accompanied by rigorous monitoring and evaluation of both process and outcome indicators. Pilot-testing and evaluation will provide valuable data on the effectiveness of these activities.

A situational assessment should be conducted as a basis for programme design:



The integrated programme strategies

Incorporating HIV/AIDS prevention into food and nutrition programmes	
Strategy 1	*Incorporation into a general food distribution of activities designed to promote community engagement and action around HIV/AIDS prevention*
Strategy 2	*Incorporation of HIV/AIDS awareness and prevention activities into a supplementary feeding programme*
Strategy 3	*Incorporation of HIV/AIDS awareness and prevention activities into a therapeutic feeding programme*
Strategy 4	*Incorporation into a school feeding programme of activities designed to promote knowledge and engagement around HIV/AIDS among young people*
Incorporating care and support for HIV/AIDS-affected, vulnerable groups into food/nutrition programmes	
Strategy 5	*Modification of a general food distribution programme to better meet the needs of people affected by HIV/AIDS*
Strategy 6	*Modification of a supplementary feeding programme to better meet the needs of population subgroups affected by HIV/AIDS*
Strategy 7	*Support for HIV/AIDS-affected families and children through a school feeding programme*
Strategy 8	*Support for HIV/AIDS-affected families and children through provision of a complementary ration to foster families and orphanages*
Strategy 9	*Support for the establishment of home gardens and agricultural plots for PLWHA and HIV/AIDS-affected families*
Strategy 10	*Support for income-generating activities, microcredit and community banking, training and other capacity-building activities for PLWHA and HIV/AIDS-affected families*
Strategy 11	*Support for food-for-work (FFW) projects that employ or directly assist PLWHA and HIV/AIDS-affected families*
Strategy 12	*Support to enable and encourage participation by HIV-infected individuals in community groups formed by PLWHA*
Incorporating food and nutrition support into health care and treatment services for people living with HIV/AIDS	
Strategy 13	*Establishment of an inpatient hospital/clinic feeding programme with nutrition education*
Strategy 14	*Establishment of a hospital/clinic demonstration garden with nutrition education*
Strategy 15	*Integration of a supplementary ration and nutrition education into a home-based care programme*
Strategy 16	*Integration of a supplementary ration and nutrition education into an antiretroviral therapy programme*
Incorporating food and nutrition resources to support training and capacity-building activities to clinic-based and community-based care providers	
Strategy 17	*Support for training and other capacity-building activities for formal and traditional health care providers*
Strategy 18	*Support for training and other capacity-building activities for community resource persons who can play a vital role in HIV/AIDS prevention efforts*
Incorporating food and nutrition resources to support the establishment or continuation of community-level HIV/AIDS-related activities	
Strategy 19	*Support to community health volunteers engaged in HIV/AIDS prevention or caring for PLWHA and HIV/AIDS-affected families*
Strategy 20	*Support to community awareness and mobilization activities of PLWHA*

Epidemiological and situational assessments should be used for planning integrated programme strategies in refugee settings:

		HIV/AIDS Prevention
Emergency Food Distribution and Nutrition Activities	*Programme objective:*	To equip intended beneficiaries of emergency food distribution and nutrition programmes with essential information about HIV/AIDS risk and prevention.
	Evidence from assessment that programme may be justified:	• Estimated HIV prevalence rates may be low but at risk of rapid rise (e.g., higher prevalence in host population, behavioural risk factors) and lack of knowledge about HIV/AIDS contributes to risk
	Strategies:	*Strategies 1-4*
Food for Training, Capacity Building, and Institutional Support Activities	*Programme objective:*	To build the capacity of HIV/AIDS prevention and education volunteers, PLWHA groups and other valuable community resource persons to effectively undertake HIV/AIDS prevention activities through the use of food and/or related resources.
	Evidence from assessment that programme may be justified:	• Minimum food needs are already met; and • Estimated HIV prevalence rates may be low but at risk of rapid rise (e.g., higher prevalence in host population, behavioural risk factors) and lack of knowledge about HIV/AIDS contributes to risk; and • Community-supported HIV/AIDS prevention groups exist but need external support and training/capacity building until local sustainable solutions are found; and • Food is an appropriate resource to use for this external support
	Strategies:	*Strategies 18-20*

	Care and Support for HIV/AIDS-Affected People and Families	Health Care and Treatment for Affected People and Families
	To ensure adequate nutritional intake of PLWHA and HIV/AIDS-affected families to prevent widespread malnutrition and associated mortality.	To ensure that PLWHA and their caretakers receiving health services fully benefit from treatment through the provision of nutritional support and education on nutrition.
	• HIV/AIDS-affected families are suspected to be at greater risk of food insecurity and malnutrition, and have higher food needs; and • Estimated HIV prevalence rates are high enough to warrant significant changes in the general or supplementary food ration; or • Impacts of HIV/AIDS on community justify school feeding or food distribution to orphans and foster families; or • Externally-supported nutritional safety nets are needed for PLWHA and affected families until local sustainable solutions are found	• Estimated HIV prevalence rates are high enough to suspect that a significant percentage of people admitted to health facilities have the disease, and thus have higher nutrient requirements; and • Their access to a diet of adequate quantity and quality is known to be constrained (e.g., because the family is unable to provide them with enough food); and • A lack of accurate knowledge among caretakers about nutrition during illness may contribute to malnutrition and/or morbidity
	Strategies 5-8, 11-12	*Strategies 13-16*
	To build the capacity of community volunteers and PLWHA groups to engage in effective community-level support programmes for PLWHA and affected families through the use of food and/or related resources.	To build the capacity of formal health care providers (e.g., clinic-based and health extension staff) and traditional providers (e.g., traditional healers, traditional birt h attendants) to prevent HIV transmission and provide appropriate care for PLWHA through the use of food and/or related resources.
	• Minimum food needs are already met; and • Estimated HIV prevalence rates are high enough to warrant building capacity of local community to care for PLWHA; and • A lack of accurate knowledge or stigma among caretakers and community members about caring for PLWHA may contribute to increased malnutrition and/or morbidity; and • Community-supported PLWHA groups or volunteers exist but need external support and training/capacity building until local sustainable solutions are found; and • Food is an appropriate resource to use for this external support	• Minimum food needs are already met; and • Inadequate knowledge among care providers is related to increased risk of transmission and/or worsened outcomes among PLWHA; and • Formal and traditional health care providers actively request training on HIV prevention, recognition/ diagnosis, treatment and referral; and • Community-supported PLWHA groups or volunteers exist but need external support and training/capacity building until local sustainable solutions are found; and • Food is an appropriate resource to use for this external support
	Strategies 19-20	*Strategy 17*

		HIV/AIDS Prevention
Household Food and Livelihood Security Activities	*Programme objective:*	Outside the scope of this document.
	Evidence from assessment that programme may be justified:	Outside the scope of this document.
	Strategies:	*Outside the scope of this document.*

	Care and Support for HIV/AIDS-Affected People and Families	Health Care and Treatment for Affected People and Families
	To protect and promote the food security status of HIV/AIDS-affected families, through food security interventions such as gardening and agriculture, income-generating activities, microcredit, community banking and other activities requiring training through the use of food and/or related resources.	Outside the scope of this document.
	• Estimated HIV prevalence rates are high enough to warrant designing and implementing food security interventions designed to take into account the effects of HIV/AIDS; and • HIV/AIDS-affected families are at elevated risk of food insecurity, and thus of worse health and nutritional status; and • Food security interventions need external support and training/capacity building until local sustainable solutions are found; and • Food is an appropriate resource to use for this external support	Outside the scope of this document.
	Strategies 9-10	*Outside the scope of this document.*

CHAPTER 1:
Introduction

1.1 Why is this document important?

This document provides an overview of twenty specific opportunities for more effective, collaborative and innovative integration of HIV/AIDS activities with food and nutrition support in refugee settings.[4] Refugees have a range of needs that are important for survival, health and well-being. Ensuring adequate food, water, basic health services, sanitation, hygiene, clothing, shelter and security is paramount for all refugee populations, independent of HIV/AIDS. A high prevalence of HIV/AIDS, however, may call for different approaches to implementing these interventions, to address the causes and mitigate the effects of the epidemic. This document describes how the design or implementation of HIV/AIDS and food and nutrition programmes can be modified to better address the complex links between HIV/AIDS, food insecurity and malnutrition, which can exacerbate vulnerability in post-acute refugee communities and worsen long-term health outcomes.

The objectives of this document are:

1. *to identify strategies to strengthen food and nutrition programmes to support HIV prevention, and enhance treatment, care and support for families and communities in refugee settings; and*
2. *to identify strategies to strengthen HIV/AIDS programmes to support nutritional status, food security and resilience of affected households, with particular attention to targeted use of food resources in refugee settings.*

These integrated programme strategies are presented in the form of summary action sheets.

As articulated at the 2001 United Nations General Assembly Special Session on HIV/AIDS, the members of the United Nations are committed to addressing HIV/AIDS globally, with particular attention to ensuring access to social services, support, treatment, information and legal protection.[5] The core participants in this interagency initiative – the United Nations High Commissioner for Refugees (UNHCR), the World Food Programme (WFP) and the United Nations Children's Fund (UNICEF) – have all articulated a commitment to address HIV/AIDS globally. The Strategic Plan of UNHCR for 2002–2004 identifies HIV/AIDS as a priority refugee protection issue, and expresses a commitment to assist in the establishment of legislation, policies and programmes that support HIV/AIDS prevention, care, treatment and support, and prevention of discrimination.[6] WFP uses food and nutrition programmes to support the most vulnerable households, with specific attention to those affected by AIDS.[7] The commitment of UNICEF to support and protect the world's most vulnerable children embodies a commitment

[4] Unless otherwise noted, in this document the term "refugee" encompasses refugees, internally displaced persons and asylum-seekers.

[5] United Nations General Assembly Special Session on HIV/AIDS. *Declaration of Commitment on HIV/AIDS.* New York: United Nations, 2001 (Resolution A/RES/S-26/2, 2001).

[6] UNHCR. *HIV/AIDS and refugees: UNHCR's Strategic Plan, 2002-2004*. Geneva: UNHCR, 2002.

[7] WFP. *Consolidated framework of WFP policies: an updated version*. Rome: WFP, 2003.

to protect children's welfare and rights from the effects of HIV/AIDS.[8] This initiative aims to contribute to the fulfillment of these institutional mandates in the field.

1.2 HIV/AIDS in refugee populations

It is often assumed that refugee communities have higher HIV prevalence rates than their host neighbours. Available data suggest, however, that the situation varies widely, with refugees often exhibiting lower rates than neighbouring communities. The ultimate effects of conflict and displacement on HIV transmission depend on many competing, interacting factors (Figure 1).[9] In some cases, the social isolation imposed by conflict protects populations from rapid spread of the AIDS epidemic. On the other hand, while migration to another country may protect refugees from active conflict, it may at the same time increase population mixing, often with a population with higher HIV prevalence, thus accelerating HIV transmission. Refugees may face a risk of HIV exposure during migration, when crossing transit points and borders, and when seeking humanitarian and government services in the country of asylum. Refugee camps may inadvertently increase HIV risk in the short term by placing poverty-stricken households in highly dense settlements, often without adequate health care, health education, control of sexual and gender-based violence (SGBV) or livelihood support in the early phase of the emergency. Each situation is unique and context-specific, and must be examined carefully.

General food distribution is the main way in which international health programmes protect the nutritional status of displaced communities. Such communities frequently settle in marginal environments where access to water, productive agricultural land and markets is poor. Their ability to farm, keep livestock or participate in regional markets depends on the policies of the host government. Refugees in low-income countries are at risk of acute malnutrition until essential nutrition, health, water, shelter and sanitation services are established. Long-term refugee populations with access to adequate health and public health services, however, often exhibit better health indicators than surrounding low-income populations.[10]

1.3 How are HIV/AIDS and nutrition programmes currently implemented among refugees?

Recent years have seen the establishment of a number of international guidelines for humanitarian programmes. These guidelines provide frameworks for implementing and evaluating assistance to crisis-affected populations. HIV/AIDS is still treated principally as a health-sector problem, with support funds and project managers coming from the health sector. Water, sanitation, shelter, food distribution, and longer-term interventions (e.g., agricultural production and income-generating activities) tend to be implemented separately. Often, there is little coordination among cooperating partner agencies, and no consideration of how cross-cutting integrated programmes can be designed and implemented.

The increasing political momentum in Africa and globally to increase access to antiretroviral drugs has shifted international attention from community-level prevention and mitigation to

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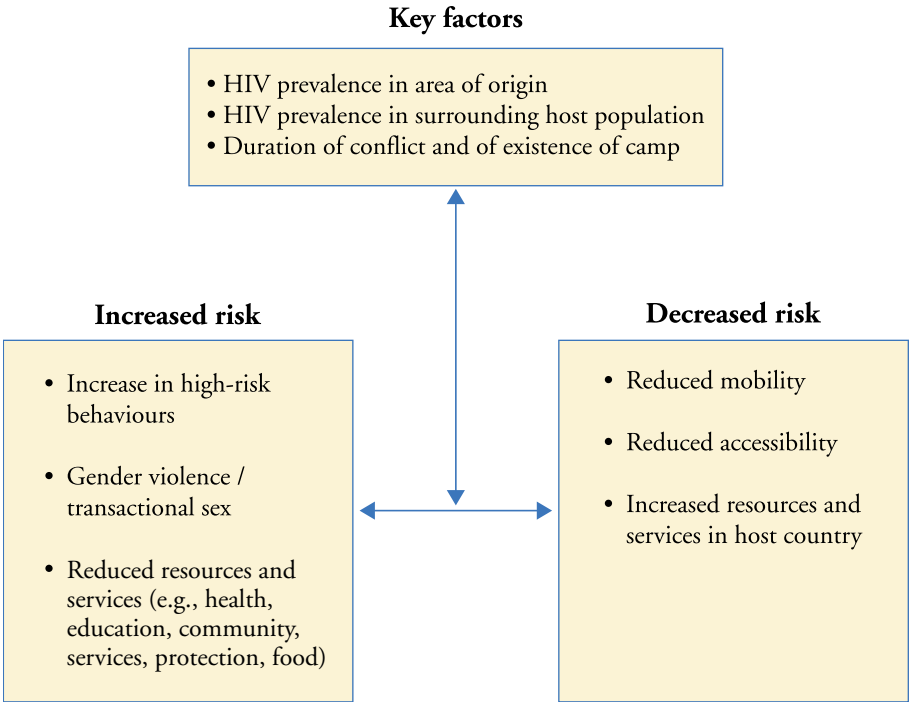
[8] UNICEF. *Fighting HIV/AIDS: strategies for success, 2002-2005*. New York: UNICEF, 2003.

[9] Spiegel PB. HIV/AIDS among conflict-affected and displaced populations: dispelling myths and taking action. *Disasters* 2004;28(3):322.39.

[10] Spiegel P, Sheik M, Gotway-Crawford C, Salama P. Health programmes and policies associated with decreased mortality in displaced people in postemergency phase camps: a retrospective study. *Lancet* 2002;360(9349):1927-34.

individual treatment. Notwithstanding the vital importance of treatment, the profound consequences of HIV/AIDS are manifest in every sector: food security and nutrition, agricultural production, economic productivity, social networks, governance, human capital, and so on. Agency field staff working with refugee populations report that HIV/AIDS-affected families tend to receive uncoordinated services, with inadequate provision for family-level or longer-term (e.g., livelihood) support.

Figure 1. Risk factors for HIV in conflicts and in displaced persons camps



1.4 What are "integrated programme strategies"?

The term "integrated programme strategies" is used in this document to describe programmes that include aspects related to both HIV/AIDS and nutrition/food security. As a cross-cutting issue, HIV/AIDS should be considered in the design and implementation of virtually any intervention. The 1995 UNHCR/WHO/UNAIDS document, Guidelines for HIV interventions in emergency settings, placed HIV/AIDS squarely on the agenda of priorities for intervention in crises. The 2003 Inter-Agency Standing Committee on HIV/AIDS (IASC) document, Guidelines for HIV/AIDS interventions in emergency settings, clearly identified HIV/AIDS as an issue that cuts across all of the intervention areas in acute (immediate crisis) settings.[11]

[11] Inter-Agency Standing Committee (IASC). *Guidelines for HIV/AIDS interventions in emergency settings*. Geneva: IASC reference group, 2004.

The 2004 update however did not explore how HIV/AIDS should be "mainstreamed" into refugee programmes after the acute emergency phase has passed. The complex links between HIV/AIDS and food and nutrition are increasingly demonstrated in the scientific literature, but have not been sufficiently applied to programme implementation. Recognizing the vicious cycle between HIV risk, AIDS progression, poverty, food insecurity and individual nutritional status, this document identifies ways to address all these issues through integrated refugee health programmes, primarily in the post-acute phase.

1.5 The role of host communities in refugee programmes

The decision to implement integrated programme strategies should be based on an epidemiological analysis of HIV/AIDS and malnutrition in both the host and the refugee communities, as explained in Section 2.5. Where possible and practical, extremely vulnerable host populations should be considered for all programmes provided to refugees that combine food and HIV/AIDS prevention, treatment, care and support. As with refugee programmes, the decision to provide external support to a host population should be based on a needs assessment. As noted above, host populations may have lower, equal or higher HIV prevalence rates, and often exhibit poorer health status than stable refugee populations. HIV/AIDS is frequently transmitted between refugee and host populations, and many opportunities can be taken to address the risks from both sides. Provision of services to refugee populations and not to host populations may spark tensions or hostility between the two groups. Working towards parity with the host community in service availability and quality is very important. For example, host community members living near Kala and Mwange camps in northern Zambia are eligible for free curative care, integrated maternal and child health (MCH) services, and voluntary counselling and testing (VCT) services for HIV at health clinics in the refugee camps.

1.6 How were the programme strategies in this document identified?

Following a secondary literature review, mission teams undertook extensive primary research during two interagency field missions. The mission teams comprised thirteen staff of UNHCR, UNICEF and WFP, working at headquarters, regional and country programme levels, with an external team leader. In northern Zambia (September–October 2003), interviews were conducted with over 400 Congolese refugees, UN staff, coopering partner agency staff, government partners, and health facility staff. In western and northwestern Uganda (November–December 2003), the mission team conducted comparable research with Sudanese and Congolese refugees. The teams consulted closely with over sixteen implementing agencies, including international nongovernmental organizations (NGOs) (e.g., International Federation of the Red Cross (IFRC), Aktion Afrika Hilfe (AAH), and Agency for Cooperation and Research in Development (ACORD)), national NGOs (e.g., AIDS Information Centre (AIC), Traditional and Modern Health Practitioners Together against AIDS (THETA)) and local community-based organizations and groups of people living with HIV/AIDS (e.g., Meeting Point, Madi AIDS Heroes Association (MAHA)).

Focus group interviews were conducted with a cross-section of refugees and members of the host community:

- **formal and traditional refugee and local leaders,** e.g., refugee welfare committees, HIV/AIDS committees, food management committees, health management committees, sexual and gender-based violence committees;

- **health facility staff,** e.g., doctors, nurses, midwives, counsellors in VCT or prevention of mother-to-child transmission (PMTCT) programmes, laboratory staff;
- **traditional and agency-affiliated health extension workers,** e.g., community health workers, community reproductive health workers, community counselling aides, peer educators, community social workers, traditional birth attendants, traditional healers/spiritualists;
- **beneficiaries of relevant agency programmes,** e.g., beneficiaries of general food distribution programmes, supplementary feeding programmes, therapeutic feeding programmes, VCT and PMTCT programmes, agricultural projects, income-generating projects, microcredit and community banking projects; and
- **people with HIV infection,** including community members who have formally joined groups of people living with HIV/AIDS (PLWHA), as well as individuals not yet living "openly" with HIV infection.

Focus group discussions typically lasted 1½–2 hours, and explored topics relevant to the group being interviewed. Broadly, the mission members strove to achieve three goals: (1) to understand and observe the services being provided in the areas of HIV/AIDS and nutrition; (2) to discover how these programmes were perceived by beneficiaries, including determinants of use and non-use; and (3) most important, to identify opportunities and constraints for more effective integration of HIV/AIDS and nutrition/food security activities at field level.

Despite the similarities between the national refugee policies of Zambia and Uganda – the Zambia Initiative and the Uganda Self-Reliance Strategy – in practice, the two refugee settings were highly divergent. Kala and Mwange camps in northern Zambia each host 25 000 refugees in densely populated, closed areas. The Congolese refugees depend heavily on the United Nations and cooperating partner agencies for food, health care, water and education. Local restrictions on land allocation limit the implementation of food security programmes such as farming. Equally restrictions on refugee movement limit their ability to earn income outside the camps. In contrast, the Self-Reliance Strategy in Uganda encourages refugees to settle in small, scattered communities and to be integrated into national health and educational systems. Agricultural cultivation is far more widespread among refugees in Uganda than in northern Zambia. The differences between the two settings allowed the mission teams to explore integrated programmes that might be appropriate at different points along the integration/isolation spectrum.

In conducting a comprehensive analysis of the findings, every attempt was made to cross-check results between UN and implementing agency reports, government interviews and documents, refugee interviews, and direct observations. The guidelines for programme implementation were developed collaboratively with partners in the field. Space limitations do not allow us to present the evidence base for each programme strategy, and users are strongly encouraged to systematically implement monitoring and evaluation systems as part of their interventions, to strengthen the evidence base for both effectiveness and cost-effectiveness.

1.7 Structure of the document

Figures 2 and 3 in Chapter 2 summarize the integrated programme strategies described in this document. Chapter 3 presents programme strategies that incorporate HIV/AIDS activities into food and nutrition programmes, while Chapter 4 presents programme strategies that integrate

food and nutrition components into HIV/AIDS programmes. Agencies working principally in the emergency nutrition sector in refugee settings may therefore wish to focus on Chapter 3, while those working principally in the HIV/AIDS and health sectors may prefer to begin with Chapter 4.

The three main types of HIV/AIDS activities in this document are: health care and treatment activities; support and care activities; and HIV/AIDS prevention activities. The three main types of food and nutrition activities considered in this document are: emergency food distribution and nutrition activities; food and nutrition training, capacity building, and institutional enabling and sustaining activities; and food and livelihood security activities. Box 1 outlines the structure of each programme strategy description.

Box 1. Structure of integrated programme strategy action sheets

The initial section presents the summarized programme strategy. It generally provides a brief statement on when and why the programme strategy would be important.

What does this integrated programme strategy aim to achieve? *This section presents the principal objectives of the programme. Readers may review this section to identify programmes that match their objectives.*

How would this integrated programme strategy be implemented? *This section highlights key issues that should be considered when deciding whether the programme might be feasible and appropriate for a given setting. Issues are discussed under three headings: institutional collaboration and coordination, emphasis on participatory and community-led approaches, and logistics of implementation.*

How would this integrated programme strategy be monitored? *This section proposes selected indicators that should be used for monitoring each programme strategy. Because impact indicators (e.g., malnutrition prevalence, crude mortality rate) have many determinants separate from programme exposure, outcome indicators may be more useful measures of a programme's effects.*

Experiences from the field... *Relevant programme experiences are highlighted. This section draws extensively on the mission teams' field work in Zambia and Uganda in 2003, with quotations and photographs where possible.*

CHAPTER 2:

Creating a policy environment that supports integrated programme strategies

2.1 National policies and guidelines on HIV/AIDS and nutrition

As a general principle, the policies of the host country regarding HIV/AIDS should be followed when developing HIV/AIDS programmes for refugees, as the countries of asylum bear the ultimate responsibility for the protection and health of refugees they host.[12] However, as of December 2003, of the 29 countries in Africa that hosted more than 10 000 refugees, only 10 (34%) had national HIV/AIDS strategic plans that specifically mentioned activities for refugees.8 Where national policies do not specifically mention refugees, and where refugees are systematically excluded from national interventions, internationally accepted guidelines should form the basis of programme design and implementation.

Increasingly, countries are developing national HIV/AIDS control policies with an explicit nutritional care and support component. Nutritional programmes in refugee communities still tend to be based on international emergency nutrition guidelines, particularly where the population receives food, nutrition and health services from external agencies rather than the host country government. With the recognition of the close association between nutritional status and HIV/AIDS progression, the development of national policies and guidelines on nutritional care and support for PLWHA is becoming an international priority.

2.2 United Nations policies and guidelines on HIV/AIDS and nutrition

Since the first UN strategy document on HIV/AIDS was published in 1986, the UN has continued to update and refine its recommendations on how to deal with the disease. The World Health Organization (WHO) has developed an extensive literature base on HIV/AIDS care, counselling, testing and treatment, as well as several key publications on nutrition programmes for emergency settings. UNHCR and WFP have developed a range of operational guidelines related to HIV/AIDS, food and nutrition in refugee settings. Since its establishment, the Joint United Nations Programme on HIV/AIDS (UNAIDS) has served as a focal point for research and programming related to HIV/AIDS. A number of UN policy and programme guidelines are available, of which the following are worthy of special mention:

- Food and nutrition handbook[13]
- Food and nutrition needs in emergencies[14]
- Guidelines for HIV/AIDS interventions in emergency settings[11]
- HIV/AIDS: a guide for nutrition, care and support[15]
- HIV/AIDS and refugees: UNHCR's Strategic Plan 2002-2004[6]

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[12] Regional Centre for Quality of Health Care, Kampala, Food and Nutrition Technical Assistance (FANTA) Project. *Handbook: developing and applying national guidelines on nutrition and HIV/AIDS*. Kampala: Regional Centre for Quality of Health Care, 2003.

[13] WFP. *Food and nutrition handbook*. Rome: WFP, 2000.

[14] UNHCR, UNICEF, WFP, WHO. *Food and nutrition needs in emergencies*. Geneva: UNHCR, 2003.

[15] Food and Nutrition Technical Assistance Project, Academy for Educational Development. *HIV/AIDS: a guide for nutrition, care and support*. Washington, DC: Academy for Educational Development, 2001.

- Humanitarian charter and minimum standards in disaster response[16]
- Joint UNHCR/WFP guidelines on selective feeding programmes[17]
- Living well with HIV/AIDS: a manual on nutritional care and support for people living with HIV/AIDS[18]
- Nutrient requirements for people living with HIV/AIDS: report of a Technical Consultation[19]
- Programming in the era of AIDS: WFP's response to HIV/AIDS[20]
- Reproductive health in refugee situations: an inter-agency field manual[21]
- The Global Strategy Framework on HIV/AIDS[22]
- The United Nations Special Session Declaration of Commitment on HIV/AIDS[5]

2.3 Framework for implementing integrated programmes

As the acute emergency phase ends and relative stability is achieved, refugee settings present opportunities for a broad range of interventions that address HIV/AIDS, food and nutrition needs. This document examines three particular types of HIV/AIDS activities (Figure 2):

- **Health care and treatment activities** aim to improve the health and nutritional status of people living with HIV/AIDS in three settings: at health facilities, in the community (via health extension or traditional care providers), and within the family. These activities may involve working directly with the chronically ill, or working in the community to improve available health services.
- **Support and care activities** aim to provide various types of support to HIV/AIDS-affected people, their families/households, and highly affected communities. Support may include provision of food (e.g., through a general food distribution or supplementary feeding programme), or interventions to improve food and livelihood security (e.g., farming and gardening, microcredit, training).
- **HIV/AIDS prevention activities** aim to promote community engagement and action around HIV/AIDS. Prevention activities may be integrated into food and nutrition programmes of all types. Alternatively, food resources may be used to establish and sustain the activities of community HIV/AIDS prevention workers and promote public participation in HIV/AIDS prevention activities.

In addition, the document focuses on three types of food and nutrition activities (Figure 2):

- **Food distribution and nutrition activities** aim to prevent excess mortality and malnutrition through food and nutritional support. Activities include general food

[16] The SPHERE Project. *Humanitarian charter and minimum standards in disaster response*. Geneva: The SPHERE Project, 2004.

[17] UNHCR/WFP. *UNHCR/WFP guidelines for selective feeding in emergency situations*. Geneva, Rome: United Nations High Commissioner for Refugees, World Food Programme; 1999.

[18] FAO, WHO. *Living well with HIV/AIDS: a manual on nutritional care and support for people living with HIV/AIDS.* Rome: FAO, 2003.

[19] WHO. *Nutrient requirements for people living with HIV/AIDS: report of a Technical Consultation*. Geneva: WHO, 2003.

[20] WFP. *Programming in the era of AIDS: WFP's response to HIV/AIDS*. Rome: WFP, 2002.

[21] UNHCR. *Reproductive health in refugee situations: an inter-agency field manual*. Geneva: UNHCR, 1999.

[22] UNAIDS. *The global strategy framework on HIV/AIDS*. Geneva: Joint United Nations Agency on HIV/AIDS, 2001.

distribution, supplementary feeding of vulnerable groups, therapeutic feeding programmes, school feeding, and integration of a supplementary ration into AIDS-related programmes (e.g., home-based care).

- **Training, capacity building, and institutional support activities** aim to build the capacity of families, health care providers (facility-based, extension and traditional) and community groups to care for people infected or highly affected by HIV/AIDS, and to be self-sufficient.
- **Household food and livelihood security activities** aim to involve HIV/AIDS-affected families in projects that increase their nutritional security, self-sufficiency and resilience over time.

Figure 2. Integration of HIV/AIDS, food and nutrition activities into integrated programme strategies

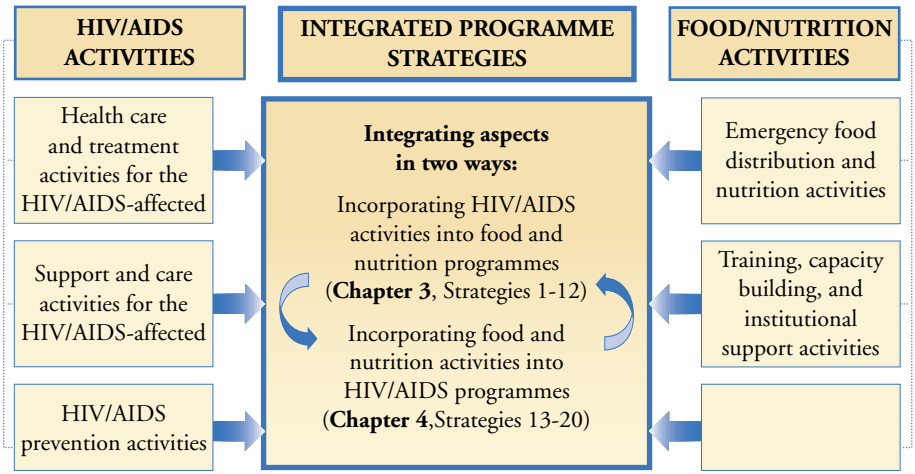


Figure 3 shows how the integrated programme strategies link the three areas of HIV/AIDS intervention with the three areas of food and nutrition intervention.

2.4 Guiding principles of integrated programmes

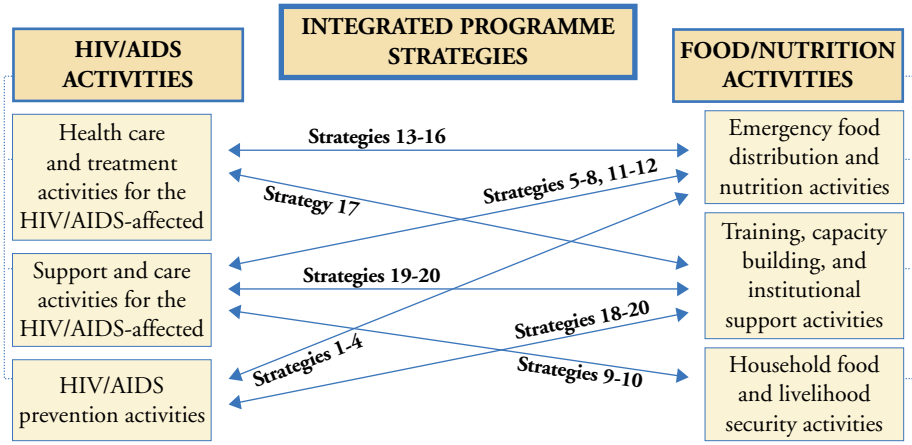
The integrated programme strategies included in this document are diverse, but they share a number of guiding principles.

1. *Refugee protection programmes should be based on a local analysis of the HIV/AIDS and the food security/nutrition situations, and will often benefit from a comprehensive approach towards HIV/AIDS and nutrition services or interventions.*

An assessment of the local epidemiology of HIV/AIDS, in both the refugee and the host communities, as well as of food security and nutrition, is the essential first step towards identifying programme strategies, objectives, indicators for monitoring and evaluation, and benchmarks for programme decision-making. A comprehensive approach recognizes that PLWHA and their

families have important needs for support in the community over the long term, in addition to other essential services such as voluntary counselling and testing and prevention of mother-to-child transmission programmes. Refugees living with HIV/AIDS often face acute constraints in trying to earn a basic living (e.g., because of restrictions on their movement or discrimination). Programmes should be put in place that enable AIDS-affected families to survive after the loss of their loved one, by addressing comprehensively health and livelihood needs.

Figure 3. How the integrated programme strategies combine HIV/AIDS and food/nutrition components



2. Coordination and partnership between government, UN, NGOs (both emergency-oriented and development-oriented), refugees and host community members are essential to success.

HIV/AIDS and nutrition cannot be addressed solely through emergency interventions. As a truly cross-sectoral issue, HIV/AIDS requires active collaboration between local and national governments, national and international agencies, including the UN, and local communities. A broadly participatory HIV/AIDS committee should provide a forum for joint planning and monitoring. It is preferable in most cases to strengthen national structures to provide services to refugees than to establish parallel structures. Regular coordination meetings among all partners serve as a valuable forum for exchanging ideas and coordinating future activities. Coordinating bodies should include representatives of all community-based organizations (CBOs) and social groups, such as traditional healers, elders, tribal chiefs, youth and women's groups, traditional birth attendants and community counsellors.

Because of their extensive interactions (social, economic and sexual) with host communities, refugees cannot be considered in isolation in HIV/AIDS prevention efforts. Refugee–host interactions may heighten the risk of HIV transmission for both populations. Nevertheless, full economic integration into the host community should be promoted to foster economic stability and self-sufficiency. Host–refugee integration presents constructive advantages which should be capitalized upon: each community will have skills and knowledge to contribute to a comprehensive HIV/AIDS prevention programme.

3. *Effective community-level interventions should incorporate participatory communication strategies, community engagement and action supported by appropriate services and policies.*

The HIV risk that refugees face is inextricably linked to the cultural, social and economic conditions of their lives, which often undergo rapid and profound change with displacement. HIV/AIDS programmes need to be locally adapted – a one-size-fits-all approach cannot be successful in all settings. Refugee and host communities must be engaged in the planning and implementation of programmes. Community representatives should not be seen simply as "implementers" of UN and NGO programmes, but rather as active partners in the development and implementation of programmes. Because of conflict-related isolation or low education levels, many refugee communities are ignorant about AIDS. Participatory communication and planning approaches imply that community members themselves are assisted to understand the risks posed by HIV/AIDS locally, and that they lead the effort to identify and put in place responses to the problem. Music, dance and drama can provide an opportunity to raise issues, and should be complemented by interactive discussions.

Communications activities should not focus on the transmission of messages, but rather the linkage of local dialogue to action, supported by accurate information, services (voluntary counselling and testing, prevention of mother-to-child transmission, antiretroviral therapy, home-based care, etc.) and policies. Local management and ownership of activities should be encouraged. Messages should be brief, simple and appropriate to the population (e.g., in terms of age and sex). Interactive drama should encourage the population to identify problems and commit themselves to implementing their own solutions. Community engagement should give a voice to the voiceless: it should build channels of communication between the community and the various agencies (CPs, UNHCR, WFP, UNICEF and government) so that plans are supported with policies and services.[23] Rather than focusing on community problems, agencies should explore what communities have done successfully in the past and look for ways to apply existing skills to HIV/AIDS prevention.

4. *Integrated food, nutrition and HIV/AIDS-related programmes should emphasize the Use of food or related resources geared towards long-term food security of affected households – such as seeds, tools, microcredit and income-generating activities – rather than the continuous direct distribution of food.*

In this document, the term "food or related resources" includes resources programmed to support household food and livelihood security. Direct food distribution is appropriate only where the population would otherwise face a significant food gap. UN policy encourages self-sufficiency, particularly through agriculture, for refugee communities within 1–2 years of arrival. Despite the uncertainty of planning for displaced populations, community development and self-reliance initiatives should be prioritized over food distribution. Where food has nevertheless been identified as the appropriate and desired input, care should be taken that it is does not undermine local cultivation or food markets. Inappropriate use of food as an incentive may handicap existing programmes and compromise the success of future programmes in which incentives are not provided. Where local communities view a programme as valuable and are themselves able to provide incentives to volunteers, this should be promoted as it is more sustainable than external incentives.

[23] Domatob A, personal communication, 2003.

5. *Avoidance of stigma and discrimination (and other unintended negative consequences) should be considered at every step of programme development, implementation, monitoring and evaluation.*

Avoidance of stigma and discrimination should be considered in all aspects of programme design, implementation and monitoring. In most cases, programmes that target HIV/AIDS-affected families should not be implemented separately from programmes targeting the community as a whole. Fear, ignorance and inadequate information about HIV/AIDS enhance stigma and discrimination and every effort should be made to actively engage the community in order to dispel fear and myths. HIV/AIDS-affected people can play a key role in deciding how to address stigma and discrimination, with the support of families, communities, NGOs, faith-based organizations and the media. Integration and coordination of refugee and host community interventions could help reduce stigma and discrimination.

2.5 Developing a coherent approach to integrated programming

As Figure 4 illustrates, an emergency needs assessments should be conducted in stages, with a very rapid initial assessment in the acute phase. Once programmes are in place to meet survival needs and the situation allows for rapid population-level research, an expanded assessment can be carried out. Protocols for meeting emergency food, nutrition and reproductive health needs are articulated in international best practice documents, such as the SPHERE guidelines 19 and the Minimal Initial Services Package (MISP) guidelines[24]. In the post-acute phase, more detailed research is needed to expand interventions and tailor them more closely to local factors. Food security and HIV/AIDS assessments provide additional information on epidemiology and sources of health risks in the population.

In most cases, the integrated programme strategies described in this document must follow these assessments, because they require epidemiological data on high-risk groups, as well as information on factors such as relevant knowledge, attitudes and behaviour that affect health outcomes. Selection of individual programme strategies should follow from the assessment findings, as shown in Table 1. This table identifies key preconditions that should be in place before particular programme types should be considered for implementation. Each detailed summary action sheet provides further guidance about the conditions under which the activity may be appropriate.

Before any of these integrated programme strategies is implemented, assessment and analysis are needed to determine whether food is an appropriate input in the local context. Food-based programming may be unnecessary – or even harmful – where food security is established, such as through provision of a universal full ration or local food production. Excess food distribution can undermine local production and disrupt food markets. Generally, food is an appropriate input only if research demonstrates that the food is needed and valued by recipients; and that the receipt of food will have the intended effect (i.e., improve nutritional status among the HIV/AIDS-affected, or increase participation in public health programmes). With all food-based programmes, food as an external input should be phased out for more sustainable solutions as quickly as possible.

[24] United Nations High Commissioner for Refugees. Reproductive Health in Refugee Situations: An Inter-Agency Field Manual. Geneva: United Nations High Commissioner for Refugees, 1999.

Figure 4. Situational assessment as a basis for programme design

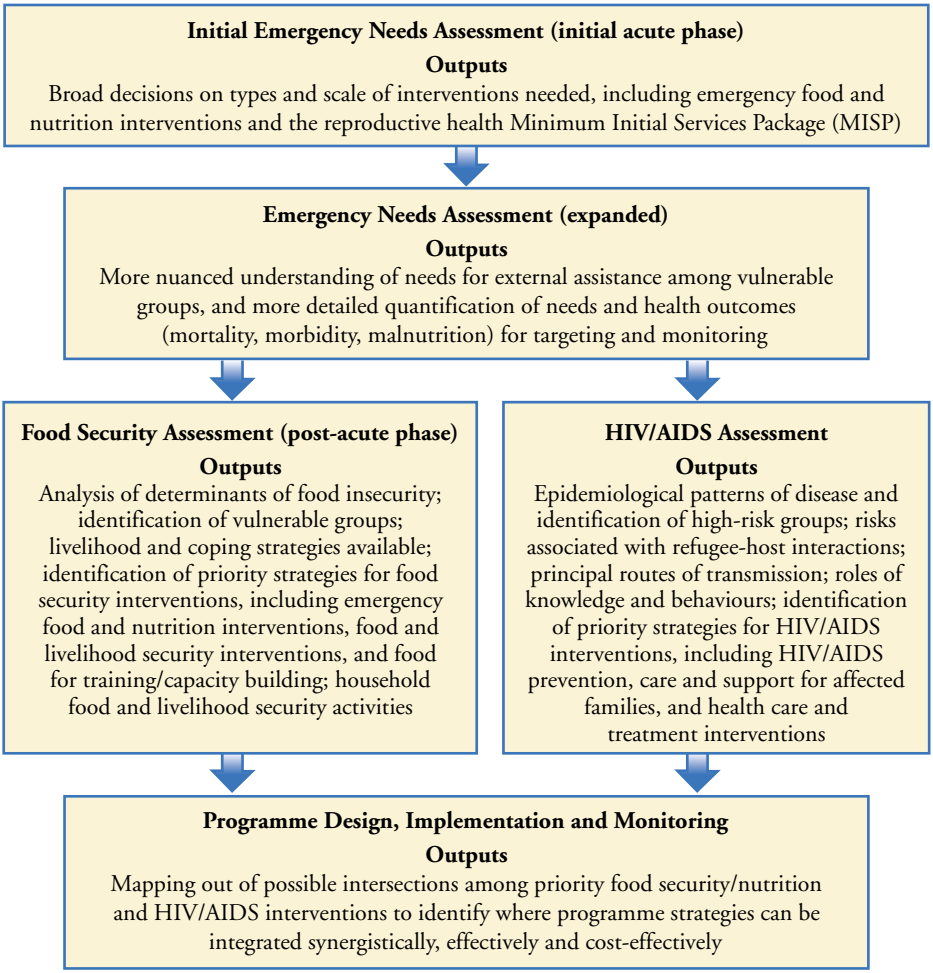


Table 1. Epidemiological and situational assessment for intervention planning in emergencies

		HIV/AIDS Prevention
Emergency Food Distribution and Nutrition Activities	*Programme objective:*	To equip intended beneficiaries of emergency food distribution and nutrition programmes with essential information about HIV/AIDS risk and prevention.
	Evidence from assessment that programme may be justified:	• Estimated HIV prevalence rates may be low but at risk of rapid rise (e.g., higher prevalence in host population, behavioural risk factors) and lack of knowledge about HIV/AIDS contributes to risk
	Strategies:	*Strategies 1-4*
Food for Training, Capacity Building, and Institutional Support Activities	*Programme objective:*	To build the capacity of HIV/AIDS prevention and education volunteers, PLWHA groups and other valuable community resource persons to effectively undertake HIV/AIDS prevention activities through the use of food and/or related resources.
	Evidence from assessment that programme may be justified:	• Minimum food needs are already met; and • Estimated HIV prevalence rates may be low but at risk of rapid rise (e.g., higher prevalence in host population, behavioural risk factors) and lack of knowledge about HIV/AIDS contributes to risk; and • Community-supported HIV/AIDS prevention groups exist but need external support and training/capacity building until local sustainable solutions are found; and • Food is an appropriate resource to use for this external support
	Strategies:	*Strategies 18-20*

	Care and Support for HIV/AIDS-Affected People and Families	Health Care and Treatment for Affected People and Families
	To ensure adequate nutritional intake of PLWHA and HIV/AIDS-affected families to prevent widespread malnutrition and associated mortality.	To ensure that PLWHA and their caretakers receiving health services fully benefit from treatment through the provision of nutritional support and education on nutrition.
	• HIV/AIDS-affected families are suspected to be at greater risk of food insecurity and malnutrition, and have higher food needs; and • Estimated HIV prevalence rates are high enough to warrant significant changes in the general or supplementary food ration; or • Impacts of HIV/AIDS on community justify school feeding or food distribution to orphans and foster families; or • Externally-supported nutritional safety nets are needed for PLWHA and affected families until local sustainable solutions are found	• Estimated HIV prevalence rates are high enough to suspect that a significant percentage of people admitted to health facilities have the disease, and thus have higher nutrient requirements; and • Their access to a diet of adequate quantity and quality is known to be constrained (e.g., because the family is unable to provide them with enough food); and • A lack of accurate knowledge among caretakers about nutrition during illness may contribute to malnutrition and/or morbidity
	Strategies 5-8, 11-12	*Strategies 13-16*
	To build the capacity of community volunteers and PLWHA groups to engage in effective community-level support programmes for PLWHA and affected families through the use of food and/or related resources.	To build the capacity of formal health care providers (e.g., clinic-based and health extension staff) and traditional providers (e.g., traditional healers, traditional birth attendants) to prevent HIV transmission and provide appropriate care for PLWHA through the use of food and/or related resources.
	• Minimum food needs are already met; and • Estimated HIV prevalence rates are high enough to warrant building capacity of local community to care for PLWHA; and • A lack of accurate knowledge or stigma among caretakers and community members about caring for PLWHA may contribute to increased malnutrition and/or morbidity; and • Community-supported PLWHA groups or volunteers exist but need external support and training/capacity building until local sustainable solutions are found; and • Food is an appropriate resource to use for this external support	• Minimum food needs are already met; and • Inadequate knowledge among care providers is related to increased risk of transmission and/or worsened outcomes among PLWHA; and • Formal and traditional health care providers actively request training on HIV prevention, recognition/ diagnosis, treatment and referral; and • Community-supported PLWHA groups or volunteers exist but need external support and training/capacity building until local sustainable solutions are found; and • Food is an appropriate resource to use for this external support
	Strategies 19-20	*Strategy 17*

		HIV/AIDS Prevention
Household Food and Livelihood Security Activities	*Programme objective:*	Outside the scope of this document.
	Evidence from assessment that programme may be justified:	Outside the scope of this document.
	Strategies:	*Outside the scope of this document.*

	Care and Support for HIV/AIDS-Affected People and Families	Health Care and Treatment for Affected People and Families
	To protect and promote the food security status of HIV/AIDS-affected families, through food security interventions such as gardening and agriculture, income-generating activities, microcredit, community banking and other activities requiring training through the use of food and/or related resources.	Outside the scope of this document.
	• Estimated HIV prevalence rates are high enough to warrant designing and implementing food security interventions designed to take into account the effects of HIV/AIDS; and • HIV/AIDS-affected families are at elevated risk of food insecurity, and thus of worse health and nutritional status; and • Food security interventions need external support and training/capacity building until local sustainable solutions are found; and • Food is an appropriate resource to use for this external support	Outside the scope of this document.
	Strategies 9-10	*Outside the scope of this document.*

Box 2. The integrated programme strategies

Incorporating HIV/AIDS prevention into food and nutrition programmes	
Strategy 1	*Incorporation into a general food distribution of activities designed to promote community engagement and action around HIV/AIDS prevention*
Strategy 2	*Incorporation of HIV/AIDS awareness and prevention activities into a supplementary feeding programme*
Strategy 3	*Incorporation of HIV/AIDS awareness and prevention activities into a therapeutic feeding programme*
Strategy 4	*Incorporation into a school feeding programme of activities designed to promote knowledge and engagement around HIV/AIDS among youth*
Incorporating care and support for HIV/AIDS-affected, vulnerable groups into food/nutrition programmes	
Strategy 5	*Modification of a general food distribution programme to better meet the needs of people affected by HIV/AIDS*
Strategy 6	*Modification of a supplementary feeding programme to better meet the needs of population subgroups affected by HIV/AIDS*
Strategy 7	*Support for HIV/AIDS-affected families and children through a school feeding programme*
Strategy 8	*Support for HIV/AIDS-affected families and children through provision of a complementary ration to foster families and orphanages*
Strategy 9	*Support for the establishment of home gardens and agricultural plots for PLWHA and HIV/AIDS- affected families*
Strategy 10	*Support for income-generating activities, microcredit and community banking, training and other capacity-building activities for PLWHA and HIV/AIDS-affected families*
Strategy 11	*Support for food-for-work (FFW) projects that employ or directly assist PLWHA and HIV/AIDS-affected families*
Strategy 12	*Support to enable and encourage participation by HIV-infected individuals in community groups formed by PLWHA*
Incorporating food and nutrition support into health care/treatment services for people living with HIV/AIDS	
Strategy 13	*Establishment of an inpatient hospital/clinic feeding programme with nutrition education*
Strategy 14	*Establishment of a hospital/clinic demonstration garden with nutrition education*
Strategy 15	*Integration of a supplementary ration and nutrition education into a home-based care programme*
Strategy 16	*Integration of a supplementary ration and nutrition education into an antiretroviral therapy programme*
Incorporating food and nutrition resources to support training and capacity-building activities for clinic-based and community-based care providers	
Strategy 17	*Support for training and other capacity-building activities for formal and traditional health care providers*
Strategy 18	*Support for training and other capacity-building activities for community resource persons who can play a vital role in HIV/AIDS prevention efforts*
Incorporating food and nutrition resources to enable the establishment or continuation of community-level HIV/AIDS-related activities	
Strategy 19	*Support to community health volunteers engaged in HIV/AIDS prevention or caring for PLWHA and HIV/AIDS-affected families*
Strategy 20	*Support to community awareness and mobilization activities of PLWHA*

CHAPTER 3:

Incorporating HIV/AIDS-related activities into food and nutrition programmes in refugee settings

3.1 Introduction

This chapter presents twelve integrated programme strategies. Each strategy is essentially a food and nutrition programme, modified to contribute to HIV/AIDS prevention efforts (section 3.2) or to meet the needs of the HIV/AIDS-affected (section 3.3).

3.2 Integrated programme strategies that incorporate HIV/AIDS prevention activities into food and nutrition programmes (Strategies 1-4)

Each of the four principal food-support programmes commonly implemented in refugee populations – general food distribution, supplementary feeding, therapeutic feeding and school feeding – provides unique opportunities to conduct HIV/AIDS prevention activities among those participating in the programme.

Strategy 1 *Incorporation into a general food distribution programme of activities designed to promote community engagement and action around HIV/AIDS prevention*

Strategy 2 *Incorporation of HIV/AIDS awareness and prevention activities into a supplementary feeding programme*

Strategy 3 *Incorporation of HIV/AIDS awareness and prevention activities into a therapeutic feeding programme*

Strategy 4 *Incorporation into a school feeding programme of activities designed to promote knowledge and engagement around HIV/AIDS among young people*

Integrated programme strategies 1-4 should only be considered under the following conditions:

1. **The feeding programme itself is justified.** The decision to implement an emergency nutrition programme is normally made on the basis of nutritional status, not HIV prevalence. Measurable objectives and exit strategies should be put in place.

2. **Local research has been used for programme design.** Appropriate quantitative and qualitative research has been conducted to tailor the activity to the local situation. There should be evidence that lack of knowledge about HIV/AIDS is a significant determinant of HIV risk in the programme target group. Alternatively, high conflict-related risk of infection (i.e., systematic rape) or close interaction with high-prevalence groups (e.g., with military forces or a high-prevalence host population) can also justify prevention programming. Qualitative formative research should be used to target the programme to specific target groups and behaviours. It should also place HIV/AIDS-related health messages in the context of broader health risks. These four strategies may be more appropriate if the epidemic is generalized, because a significant percentage of programme participants would then be expected to be HIV-positive. This is especially true of GFD and school feeding programmes.

3. **A monitoring and evaluation system is in place to measure changes in priority indicators over time.** Regardless of the strategy chosen, education programmes must always be closely monitored and evaluated to determine whether behaviour changes. Even where social mobilization interventions are designed using qualitative research, programme participation will not necessarily reduce high-risk behaviour. Monitoring of behavioural variables and health outcomes is invaluable for estimating likely impact – preferably including a pre-intervention "baseline" assessment.

4. **The programme is organized for maximum impact.** The programme should be of adequate length and intensity to be reasonably expected to bring about the desired behavioural changes. The specific HIV/AIDS prevention activities should be tailored to the programme into which they are incorporated. For example, general food distribution sites are typically crowded and considerable coordination is needed to ensure that messages are received and understood by the intended beneficiaries. Drama, music and dance may be used to communicate AIDS-related messages to attendees (either those collecting the ration or other community members at the distribution site) without causing excessive disruption to the distribution process itself. In contrast, in supplementary, therapeutic, school feeding and home-based care programmes, staff typically have closer, more interactive contact with participants. Music, dance and drama may still be used where large crowds are present (such as large-scale on-site supplementary feeding programmes), but where the participant-to-staff ratio is sufficiently small, more inter-active small-group or individual discussions become possible. In refugee settings, feeding centre staff are often stretched thin. To implement one of these strategies while meeting minimum standards for feeding programme performance may well require additional staff.

Integrated Programme Strategy 1: Incorporation into a general food distribution programme of activities designed to promote community engagement and action around HIV/AIDS prevention

Managing a general food distribution programme requires continuous communication with the community.
GFD programme staff and local leaders must talk with beneficiary refugee communities about the food to be distributed (pre-distribution sensitization) and food already received (on-site or post-distribution monitoring), and identify and resolve problems that arise during distribution. These forums can be used to promote community engagement and action around HIV/AIDS prevention. Community action may take place during food distribution or at other times. The activity should be pilot-tested to evaluate the extent to which the desired effects are achieved and retained before being scaled up.

What does this integrated programme strategy aim to achieve?

Interactions between programme staff, local leaders and refugee community members during food distribution are used as opportunities to generate public dialogue about HIV/AIDS. Typically in refugee communities, community leaders or food distribution committees conduct pre-distribution sensitization, distribution supervision and post-distribution monitoring. Strategy 1 uses these interactions to generate participatory discussions among community members, community leaders and external agencies about HIV/AIDS. These discussions can focus on issues related to the food distribution, such as access to food aid by vulnerable groups (including households headed by the chronically ill), the role of food in illness, and safe storage and palatable preparation of commodities in the ration. In many refugee communities, low levels of knowledge and stigma prevent such discussions from taking place. These discussions can reduce discrimination against PLWHA by promoting a more accurate understanding of the illness.

This community dialogue is used as a basis for developing a community plan of action to address HIV/AIDS, and to link that plan of action to local initiatives. Community engagement and action around HIV/AIDS means that community members themselves feel that HIV/AIDS is an important problem (they "own" the problem), and have identified key strategies for addressing it. Community development staff should then facilitate the application of those strategies to community-driven programmes. Community groups may present drama, puppet shows, music or dance for crowds gathered at the site, preferably combined with group discussion (Photo 1). It is vital that this does not hamper implementation of the food distribution programme. The distribution of condoms, HIV/AIDS newsletters or educational materials during the GFD may also be considered, depending on local factors such as cultural acceptance.

How would this integrated programme strategy be implemented?

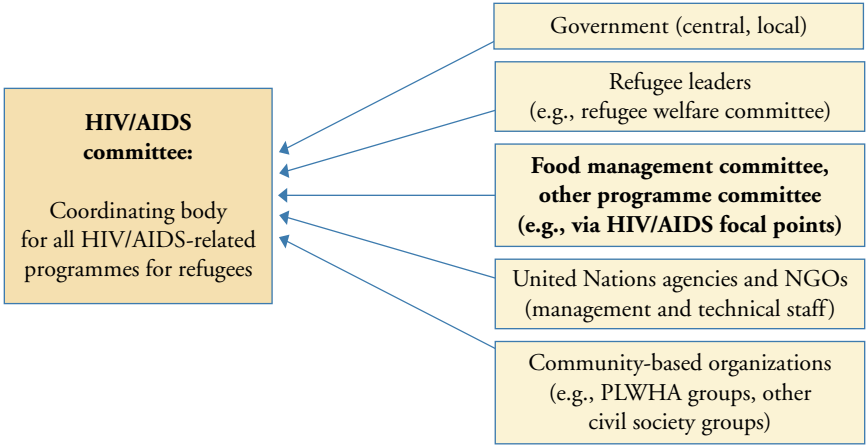
Institutional collaboration and coordination. A multisectoral and broad participatory HIV/AIDS committee should be established to promote dialogue and coordination in all decisions regarding HIV/AIDS policies and programmes for the refugees. A representative of the food management committee (or relevant local leaders overseeing the GFD) should participate in the HIV/AIDS committee (see Figure 5). The food management committee, which should

be gender-balanced, may elect an HIV/AIDS focal point for that purpose. By participating in AIDS-related dialogue, planning and training, food distribution leaders will acquire the skills needed to facilitate dialogue and training about HIV/AIDS in their own communities. They can also coordinate HIV/AIDS sensitization events to take place at the distribution site. Large-scale prevention and education programmes should be implemented in close collaboration with health and social welfare and protection services among the partners.

Emphasis on participatory and community-led approaches. Discussions may be held about how foods distributed (and available locally) may be prepared for family members who are ill and nutritionally at risk. Agency staff should work closely with local communities to identify the types of HIV/AIDS sensitization activities to be undertaken and the issues and concerns of the refugee community to be addressed. Participatory techniques may be supplemented – but not replaced – by posters and leaflets at the distribution site or given to take home. To ensure that community-based HIV/AIDS prevention and education activities are designed effectively, expert advice should be sought.

Logistics of implementation. Activities conducted at the distribution site should not interfere with the distribution process. Though women are often encouraged by implementing agencies to register as household ration recipients, other family members (men, children) often attend to help carry the ration home, so wide population exposure to the programme is possible. If an HIV/AIDS committee decides to make condoms available at the GFD site, they may be placed at a private, sheltered location nearby, where community members may pick them up together with information on proper use and disposal. To avoid stigmatization, other materials should also be available at the condom distribution site, so that those entering the site are not assumed to be receiving condoms. Alternatively, condoms could be placed in a building that all ration recipients must enter. As with strategies 2-4, this strategy should be coordinated with follow-up services (e.g., VCT, ART) for those who request them.

Figure 5. Coordination structure for linking general food distribution management with HIV/AIDS planning



How would this integrated programme strategy be monitored?

Monitoring and evaluation of this strategy should focus on changes in knowledge, attitudes and behaviours related to HIV/AIDS, as well as changes in the incidence of HIV infection. Qualitative research can explore perceptions of the programme among community and target groups.

Programme-level indicators		Population-level indicators	
Input/process	*Output*	*Outcome*	*Impact*
• No. of IEC materials developed/procured in local language of refugees for use at GFD site (and % of planned) • No. of people/groups trained and/or supported to conduct HIV/AIDS prevention/ IEC activities at GFD site (and % of planned) (could include food management committees, IEC volunteers, etc.)	• % of general distribution days accompanied by HIV/AIDS prevention/ IEC activities (and no. of activities conducted by type of activity, before, during and after GFDs) • No. of condoms or educational materials distributed at GFD site per month (and % of planned)	• % of target population reporting exposure to HIV/AIDS prevention/ IEC activities at GFD site per month (and % of planned) • % of people aged 15-24 who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission • % of people aged 15-24 reporting the use of a condom during sexual intercourse with a non-regular sexual partner	• % of people aged 15-24 who are HIV-infected • % of infants who are HIV-infected

Experiences from the field…

Mwange Refugee Camp, Zambia. AIDS-related education at the GFD is limited to small-scale sensitization by peer educators. During distribution, recipients wait in a designated area organized by administrative sector (area of residence within the camp). It is estimated that about 7000 people attend the distribution per day, on 6 days each month. The Red Cross (ZRCS/ IFRC) and the Mwange Food Committee together suggested that HIV/AIDS prevention activities could be implemented in the waiting area, including posters, pamphlets, videos, dramas and songs. Activities targeted to ration recipients mostly reach women, who most frequently pick up the ration. Activities conducted outside the waiting area reach more men and schoolchildren. The NGO Right-To-Play, which conducts educational and recreational activities for refugee children, was observed to be well placed to organize age-appropriate awareness-raising activities for children at the distribution site, to try to avoid exposing children to messages felt to be more appropriate for adults.

Kyangwali Refugee Settlement, Uganda. As part of an AAH-led GFD, one food management committee was enthusiastic about incorporating HIV/AIDS sensitization into their distribution-related activities. They requested training on the links between nutrition and HIV/AIDS, since they had participated in only one related workshop in the past. They believed that exten-

sive opportunities existed for participation by food management committees in the settlement-wide HIV/AIDS prevention effort through their community contact before, during and after distributions, and they asked to be brought into the process as partners. They proposed that food management committee members could actively participate in HIV/AIDS sensitization, dramas (led by community counselling aides) and home-based care visits. It was felt that food management committee members who were involved in some type of HIV/AIDS outreach activity would be better equipped to help target the GFD to vulnerable households affected by chronic illness (a group that is often difficult to reach), as a result of their improved understanding of HIV/AIDS and familiarity with illness-affected households.

HIV/AIDS drumming and dance group, Kala Camp, Zambia

E. Mathys Kirkaldy

Integrated Programme Strategy 2: Incorporation of HIV/AIDS awareness and prevention activities into a supplementary feeding programme

Supplementary feeding programmes (SFPs) provide nutritional support to people at risk of, or suffering from, malnutrition. These programmes can provide nutritional support to high-risk groups, such as pregnant and lactating women and young children. SFPs can be used as opportunities to conduct HIV/AIDS awareness and prevention activities. Activities can address participants' specific concerns and risks related to HIV/AIDS and malnutrition, or refer them to appropriate AIDS-related services where available and requested.

What does this integrated programme strategy aim to achieve?

Health and nutrition-related discussions that take place between SFP participants and programme staff are used as opportunities to engage participants in discussions about HIV/AIDS risk and prevention. In many camp settings, supplementary feeding programmes for pregnant women are an integral part of antenatal care services. This programme strategy aims to enable SFP service providers to help beneficiaries assess sources of risk of HIV exposure in their own lives and in the lives of family members, and to take action to reduce those risks. They would then be able to make informed decisions about seeking voluntary counselling and testing (VCT) services, enrolling in a programme to prevent mother-to-child transmission, or seeking care for opportunistic infections and where possible and feasible, antiretroviral therapy. The programme should aim to impart accurate, clear and sensitive information and promote open dialogue about HIV/AIDS. Condoms may also be placed at the programme site (with educational information on correct use) for participants to take.

Referral systems are established between the SFP and the health facility to support SFP participants who decide to seek AIDS-related services, such as VCT, PMTCT and care for opportunistic infections. Where a VCT programme is in place, participants wishing to be tested should be promptly referred to VCT counsellors. Where a PMTCT programme is in place, women in the SFP should have the opportunity to discuss with VCT/PMTCT counsellors the benefits of PMTCT participation to themselves, their newborn and their spouse, so that they can make informed decisions. Where feasible, and in line with national protocols, ART should be introduced and made accessible to eligible people. Where these services are not yet established, however, support may be given to families of people thought to have HIV infection, so that good nutrition and care are ensured within the household, and appropriate care is sought for opportunistic illnesses.

How would this integrated programme strategy be implemented?

Institutional collaboration and coordination. Under the umbrella of the HIV/AIDS committee (Figure 5), SFP staff should collaborate with health staff (e.g., HBC, VCT and PMTCT counsellors) and other community resource persons (e.g., HIV/AIDS peer educators) to design and conduct appropriate HIV sensitization/prevention activities for the SFP site. Formal referral systems should be put in place to assist SFP participants in seeking AIDS-related services. SFP staff can also be linked to health outreach workers so they can follow up on SFP partici-

pants. SFP staff should be trained on AIDS-related issues so that they are able to engage effectively in these activities.

Emphasis on participatory and community-led approaches. SFP staff should work closely with community members – particularly groups targeted by the SFP, such as pregnant and lactating women or mothers of preschool children – to decide how AIDS-related activities will be incorporated into the SFP. Because participants may stay in an SFP for weeks or months, their beliefs, practices and needs can be discussed on an ongoing basis. The importance of confidentiality should be emphasized with participants. Mothers in the community who show particular skills in preparing rations and feeding children can be involved, by showing locally appropriate successful strategies for feeding children, including those who are ill. Women living openly with HIV/AIDS may also attend to discuss their experiences of caring for themselves and their children.

Logistics of implementation. Blanket SFPs target all members of at-risk groups, such as pregnant and lactating women and preschool children. Targeted SFPs focus on individuals suffering from moderate acute malnutrition. Blanket SFPs for pregnant and lactating women should include pregnant women by the third trimester, and continue for 3–6 months after delivery, to support breastfeeding and the mother's recovery. Since SFPs are generally on a smaller scale than GFDs, they may present more opportunities for interactive activities. For example, young people or traditional birth attendants (TBAs) can visit the SFP to perform music, dance and drama related to safe delivery and infant feeding practices. Including eligible members of the host community should be considered.

While on-site feeding programmes ("wet feeding") involve more active contact and time spent with participants than take-home feeding programmes ("dry feeding"), the challenge of maintaining an environment conducive to learning and active engagement is considerable. The establishment of small, decentralized community-managed SFPs may increase access by PLWHA to the programme, as well as promoting interactive dialogue. As with the GFD programme, activities should be tailored to the setting, using participatory techniques of community engagement wherever possible. The HIV-related activities should not interfere with the function of the feeding programme. Food aid commodities may be used as incentives to support individuals conducting participatory activities.

How would this integrated programme strategy be monitored?

The indicators below pertain to monitoring the education and prevention component. Readers should consult integrated programme strategy 6 for guidance on monitoring SFPs designed to protect the health status of PLWHA.

Programme-level indicators		Population-level indicators	
Input/process	*Output*	*Outcome*	*Impact*
• No. of IEC materials developed/ procured in local language of refugees for use in SFP programme (and % of planned) • No. of people trained and/or supported to conduct HIV/AIDS prevention/IEC activities at SFP site (and % of planned)	• % of supplementary food distribution days accompanied by HIV/ AIDS prevention/IEC activities (and no. of activities conducted by type of activity) • No. of condoms or educational materials distributed at SFP site (and % of planned) • % of participants reporting exposure to HIV/AIDS education as part of the SFP (and % of planned)	• % of adults in SFP target groups (e.g., pregnant and lactating women, caretakers of malnourished children) who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	• % of people aged 15-24 who are HIV-infected • % of infants who are HIV-infected

Experiences from the field…

Mwange Refugee Camp, Zambia. Despite the many risk factors present for a rapid escalation of the epidemic in Mwange camp, HIV/AIDS prevention activities have not yet been incorporated into any of the SFPs. Three SFPs are in place: (1) pregnant and lactating women may receive one or more rations depending on their health status and the progress of the pregnancy; (2) most malnourished children receive a take-home ration; and (3) on-site "wet feeding" is given to children where clinic staff feel that the mother would benefit from additional training on food preparation (Photo 2). The Red Cross (ZRCS/ IFRC) staff suggested that the protected, uncrowded setting of the on-site SFP would most easily permit interactive discussions about HIV/AIDS risk and prevention with at-risk mothers and their malnourished children.

On-site supplementary feeding programme run by the Red Cross, Mwange Camp, Zambia

E. Mathys Kirkcaldy

Integrated Programme Strategy 3: Incorporation of HIV/AIDS awareness and prevention activities into a therapeutic feeding programme

Therapeutic feeding programmes (TFPs) provide intensive nutritional and medical support to individuals with severe acute malnutrition. Most, but not all, TFP beneficiaries are children. Children living with HIV/AIDS in poor countries often become very sick before the age of five as a result of repeated opportunistic infections, particularly diarrhoea and respiratory infections.[25] TFPs should be started on the basis of assessments of the prevalence of severe acute malnutrition. They should be used as an opportunity to link participating families with services for treatment of opportunistic infections, and HIV/AIDS awareness and prevention activities (including voluntary counselling and testing and family planning services). If HIV is suspected in a child, testing the parents as well as the child for HIV would help to provide more comprehensive services to the family.

What does this integrated programme strategy aim to achieve?

Health discussions between participants (caretakers and patients) and TFP staff are used as opportunities to engage in discussions of HIV/AIDS risk and prevention in participants' lives. These discussions empower caretakers and adult participants with skills to prevent HIV transmission to themselves and their children, who may be engaging in high-risk behaviours. This programme is designed to empower people to assess and reduce their own risk of HIV exposure, and to make informed decisions about seeking voluntary counselling and testing (VCT) services, by providing accurate, sensitive information and fostering dialogue about HIV/AIDS.

Referral systems are established between the TFP and the health facility to support TFP participants who decide to seek AIDS-related services, such as VCT and ART. Where VCT services are available, participants who wish to be tested should be promptly referred to qualified counsellors. Where a PMTCT programme is in place, women in the TFP should have the opportunity to discuss with qualified VCT counsellors the benefits of PMTCT participation to themselves and their future children. For breastfeeding women known or suspected to be HIV-positive, supplemental suckling techniques can be discussed to reduce the risks of HIV transmission associated with mixed feeding during rehabilitation. Where ART is not yet established, support may be given to families with possible HIV infection to ensure good care and nutrition. Referral to hospital settings can also help to ensure adequate medical care for acute and underlying conditions.

How would this integrated programme strategy be implemented?

Institutional collaboration and coordination. For infants and young children who fail to thrive, referral to the TFP should be accompanied by assessment of indicators of HIV infection. Where acute conditions (e.g., opportunistic infections) are present, admission to hospital may be necessary. TFP staff should collaborate with health staff (e.g., VCT and PMTCT counsellors) and other community resource persons (e.g., HIV/AIDS peer educators) to design and conduct

[25] Shearer WT, Hanson IC, eds. *Medical management of AIDS in children*. Philadelphia: Elsevier Science (USA), 2003.

appropriate sensitization activities with patients and family members in the TFP centre. TFP staff should be educated on the ability of malnourished HIV-positive children to recover from malnutrition given proper care, to avoid false attribution of acute malnutrition to HIV/AIDS, and to ensure that all malnourished children (regardless of HIV status) receive adequate care.

Formal referral systems should be in place to assist TFP participants in seeking VCT, PMTCT or ART where these are available. Follow-up support is important for families severely malnourished children, and TFP staff may be able to collaborate with community health workers to monitor the children. Follow-up can help to identify the main causes of malnutrition so that appropriate supportive actions may be taken for the household.

Emphasis on participatory and community-led approaches. TFP staff should work closely with community members to decide how AIDS-related dialogue should be fostered within the context of the TFP. As with the SFP, mothers in the community who show particular skill in preparing rations or feeding children should be involved at the TFP to show locally appropriate and successful child feeding strategies. The causes of severe acute malnutrition are often complex and difficult to resolve. TFP staff may work with agency social services staff and community groups or networks to ensure that ongoing support is provided for vulnerable families.

Logistics of implementation. TFP staff who interact directly with health care providers – doctors, nurses, auxiliaries – should be trained to provide AIDS-related information accurately and sensitively. Alternatively, qualified VCT/PMTCT counsellors may meet with families participating in the TFP, collectively or individually, but taking care to avoid stigmatization. As with the GFD and SFP programmes (Strategies 1 and 2), activities should be tailored to the setting, using participatory techniques wherever possible and avoiding disruption of the function of the TFP. Because working in a TFP setting can be very demanding, TFP workers may also offer services to participants with external help, rather than providing the services themselves. Food commodities may be used as incentives to support volunteers assisting with these activities (see Chapter 4).

For community therapeutic care (CTC),[26] trained health outreach workers who support and oversee the rehabilitation of severely malnourished children at home should be trained to implement HIV/AIDS sensitization and prevention activities, or collaborate with HIV/AIDS outreach staff with these skills. Establishment of decentralized, home-based rehabilitative programmes has the advantage of allowing the carers more time in the home, and may make it easier for HIV-affected households to access these programmes.

[26] Collins S. Changing the way we address severe malnutrition during famine. *Lancet* Volume 358, Issue 9280, Page 498, 2001.

How would this integrated programme strategy be monitored?

Programme-level indicators		Population-level indicators	
Input/process	*Output*	*Outcome*	*Impact*
• No. of IEC materials developed/ procured in local language of refugees for use in TFP programme (and % of planned) • No. of people trained and/or supported to conduct HIV/AIDS prevention/IEC activities with caretakers at the TFP site (and % of planned)	• % of therapeutic feeding centres conducting HIV/AIDS prevention/IEC activities on site (and no. of activities conducted by type of activity) • No. of condoms or educational materials distributed at TFP site (and % of planned) • % of therapeutic feeding programme participants/ caretakers reporting exposure to HIV/AIDS education as part of the TFP (and % of planned)	• % of feeding programme participants and caretakers who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	• % of people aged 15-24 who are HIV infected • % of infants who are HIV-infected

Experiences from the field…

Palorinya settlement, Uganda. At Kali clinic, one severely malnourished young girl was brought to the therapeutic feeding centre by her mother, a young widow with several children at home. Discussions between the mother and the TFP nursing staff revealed that the death of the father from illness had left the household struggling to make ends meet. TFP staff reported preparing feeds according to international guidelines to nutritionally rehabilitate the child. However, if HIV/AIDS was an underlying cause of mortality and malnutrition in the family, then discussing HIV/AIDS with the mother, referring the family to a VCT counsellor (based at the same clinic site), and arranging for needed long-term care and support may have improved the health and nutritional outcomes of family members, including the malnourished child's siblings.

Integrated Programme Strategy 4: Incorporation into a school feeding programme of activities designed to promote knowledge and engagement around HIV/AIDS among young people

School feeding programmes aim to promote school attendance by at-risk children and improve the ability of children to concentrate and learn. School feeding programmes should be considered where there is evidence that food would be an effective incentive to promote attendance by at-risk children, and where complementary longer-term food security interventions are in place. Where a school feeding programme is in place, participatory activities using non-stigmatizing communication techniques can encourage young people to share their knowledge, concerns and attitudes regarding HIV/AIDS. They may also be made aware of locally available youth-friendly HIV/AIDS prevention services, such as VCT, condom availability, peer counselling and post-test clubs.

What does this integrated programme strategy aim to achieve?

The school feeding programme is used as an opportunity for interactive discussions among young people around HIV/AIDS, focusing on their concerns, beliefs, attitudes and information needs. Because of the stigma associated with HIV/AIDS and sexuality in many communities, communication techniques should be interactive and youth-friendly to encourage active participation and learning.

Young people then work with programme facilitators to implement activities designed to directly address HIV/AIDS in their lives and the lives of family, friends and the community. Young people are a vital, often underestimated resource in the fight against HIV/AIDS. Participatory discussions can serve as a springboard for peer education programmes using young people as educators and social mobilizers, or for the formation of centres where young people can confidentially receive education, counselling, condoms and referrals.

Post-test club with high youth involvement, Palorinya, Uganda

E. Mathys Kirkcaldy

How would this integrated programme strategy be implemented?

Institutional collaboration and coordination. Teachers, agency staff or community resource persons may facilitate participatory discussions. The Ministry of Education should collaborate with agency staff to agree upon a school feeding policy and core HIV/AIDS curriculum. All efforts should be directed towards strengthening the development of national HIV/AIDS curricula rather than creating parallel curricula in externally supported schools.

Emphasis on participatory and community-led approaches. Youth leadership in AIDS-related activities should be promoted as a key ingredient to achieve social and behavioural change among young people.

Logistics of implementation. Reasons for low or declining school attendance must be identified to determine if school feeding is an appropriate response. School feeding may be implemented on a continuous or seasonal basis, depending on school attendance patterns. Youth participants should take the lead in identifying other potential activities (e.g., a post-test club).

How would this integrated programme strategy be monitored?

Programme-level indicators		Population-level indicators	
Input/process	*Output*	*Outcome*	*Impact*
• No. of IEC materials available in local language of refugees for use in schools (and % of planned) • No. of people trained and/or supported to conduct HIV/AIDS prevention/IEC activities in schools (and % of planned)	• % of schools conducting HIV/AIDS prevention and IEC activities in conjunction with school feeding programme(and no. of activities conducted; ages of target children to be identified) • % of schools with teachers who have been trained in life-skills-based HIV/AIDS education and who taught it during the last academic year (and % of planned) • % of schools incorporating HIV/AIDS into youth-friendly activities, such as school-based sports, youth centres, skills building centres, post-test clubs and peer education programmes (and % of planned)	• % of schoolchildren who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission (and % of planned) • % of children in target age group(s) exposed to school-based HIV/AIDS prevention/IEC activities (and % of planned)	• % of people aged 15-24 who are HIV-infected • % of infants who are HIV-infected

Experiences from the field…

Palorinya Refugee Settlement, Uganda. In 2003, the NGO ADEO facilitated the establishment of a post-test club in the area surrounding Kali clinic, which offers VCT to people above the age of 16 (Photo 3). Everyone who undergoes a VCT test can join the post-test club, regardless of HIV status. The 70 participants, many of whom are young people, plan to conduct HIV/AIDS activities in the community, including music, dance, drama, sports and home-based care. These young people, empowered with life skills and leadership skills, can then be engaged as peer educators in HIV/AIDS activities undertaken in the school setting, including in coordination with a school feeding programme.

3.3 Integrated programme strategies that incorporate care and support activities for HIV/AIDS-affected and vulnerable groups into food and nutrition programmes (Strategies 5-12)

Refugee food and nutrition programmes aim mainly to prevent excess mortality and malnutrition. Malnutrition and HIV/AIDS are interrelated on many levels. People living with HIV/AIDS face an increased risk of malnutrition for several reasons. HIV infection can cause lack of appetite and difficulty with eating, resulting in decreased food consumption. HIV infection also causes metabolic changes that alter how the body absorbs and uses food. Finally, the enormous burden of supporting the body's immune response to HIV infection and opportunistic infections increases nutritional needs. Thus nutritional status is affected not only by the presence of HIV infection, but by the stage of the disease, the incidence and severity of opportunistic infections, and treatments undertaken. Conversely, malnutrition is associated with a faster progression of HIV infection to AIDS and death through several mechanisms: wasting, metabolic changes and micronutrient deficiencies.[27] Consumption of adequate energy, protein, vitamins and minerals is thus essential for people with HIV/AIDS to support their immune function and slow progression of the illness. Box 3 summarizes what is known about how HIV/AIDS affects nutritional needs.

It is important that HIV-infected refugees consistently consume adequate energy, protein and micronutrients to prevent wasting and nutrient deficiencies, and to prevent or manage opportunistic illnesses. Food and nutrition programmes can provide critical support to the health and nutrition of refugees living with HIV/AIDS. These programmes may involve the direct distribution of food, as in the general ration (Strategy 5), supplementary feeding (Strategies 6 and 8) and school feeding (Strategy 7). Food and nutrition programmes may also be used to assist refugees to earn food or income, such as through agriculture (Strategy 9), income generation, microcredit and training (Strategy 10) and food-for-work (Strategy 11). Strategy 12 promotes community structures that can provide many types of support to PLWHA.

Refugees should be enabled to establish livelihoods during displacement. For refugees in flight, the aim should be to settle the population in a safe location with adequate supplies of water, firewood, construction materials and land for cultivation. From a programming perspective, if refugees are able to farm, keep animals and participate in markets, fewer external resources should be required from the international community. By producing food and earning income, they are better able to supplement the food ration with nutritious foods such as fresh fruits

[27] Fawzi W. Micronutrients and human immunodeficiency virus type 1 disease progression among adults and children. *Clinics in infectious diseases* 2003:37 (Suppl 2), pp. S112-S131.

and vegetables, dairy products, meat, eggs and fish. UNHCR and WFP work to reduce and phase out the GFD in refugee communities when they have shown that they are able to be self-sufficient. The close collaboration of UN agencies with national and local governments can assist in establishing livelihood-friendly policies.

Strategy 5 *Modification of a general food distribution programme to better meet the needs of people affected by HIV/AIDS*

Strategy 6 *Modification of a supplementary feeding programme to better meet the needs of population subgroups affected by HIV/AIDS*

Strategy 7 *Support for HIV/AIDS-affected families and children through a school feeding programme*

Strategy 8 *Support for HIV/AIDS-affected families and children through provision of a supplementary ration to foster families and orphanages*

Strategy 9 *Support for the establishment of home gardens and agricultural plots for PLWHA and HIV/AIDS-affected families*

Strategy 10 *Support for income-generating activities, microcredit and community banking, training and other capacity-building activities for PLWHA and HIV/AIDS-affected families*

Strategy 11 *Support for food-for-work (FFW) projects that employ or directly assist PLWHA and HIV/AIDS-affected families*

Strategy 12 *Support to enable and encourage participation by HIV-infected individuals in community groups formed by PLWHA*

Integrated programme strategies 5–12 should only be considered under the following conditions:

1. **The feeding programme itself is justified.** Implementation of the underlying feeding programme (Strategies 5-8) or food security programme (Strategies 9-12) is justified by epidemiological nutrition or food security assessments.
2. **A monitoring and evaluation system is in place.** Measurable objectives, monitoring and evaluation and exit strategies have been put in place; this is particularly important to build up the evidence base on effectiveness of these interventions.
3. **The programme is organized for maximum impact.** The programme is of adequate length and intensity to be reasonably expected to bring about the desired behavioural changes or other intended impacts.

Box 3. Changes in dietary requirements due to HIV/AIDS

Nutrient	*Population group*	*Recommendation**
Energy	Asymptomatic HIV-positive adults (including pregnant/ lactating women)	Increase of ~10%
	Adults with symptomatic HIV infection or AIDS (including pregnant/lactating women)	Increase of ~20-30%
	Asymptomatic HIV-positive children	Increase of ~10%
	Children who are losing weight (regardless of HIV status)	Increase of ~50-100%
	Children with severe acute malnutrition WHO guidelines	No change from
Protein	All population groups	No change (10-12% of total energy intake)
Fat	Individuals who are HIV-negative or HIV-positive but not taking antiretroviral drugs	No change (17% of total energy intake)
	Individuals who are taking antiretroviral drugs or have persistent diarrhoea	Specific recommendations should be provided by care providers
Micronutrients	Intake of vitamins and minerals should reach recommended dietary allowance (RDA) levels through a healthy diet. Consumption of RDA levels may not correct micronutrient deficiencies in ill individuals. Current protocols for micronutrient fortification of blended foods and therapeutic products are inadequate to correct micronutrient deficiencies, even in non-HIV/AIDS-infected people. Micronutrient fortification of food aid commodities should be complemented by terventions that help households to purchase other foods to diversify their diet.	
Hygiene	To maintain hygiene, hands should be washed before and after cooking. Fresh fruits and vegetables should be washed in clean water. Other foods should be cooked thoroughly.	
Illness	Emphasize foods that patients find easy to eat when they are sick, or when they have pain or difficulty with chewing and swallowing, nausea, vomiting or diarrhoea.	
Water	Patients should drink plenty of clean water every day.	

Sources: WHO. *Nutrient requirements for people living with HIV/AIDS.* Geneva: WHO, 2003.
FAO, WHO. *Living well with HIV/AIDS:a manual on nutritional care and support for people living with HIV/AIDS.* Rome: FAO, 2003.

* For the most up-to-date recommendations, see the WHO Website, www.who.int.

Integrated Programme Strategy 5: Modification of a general food distribution programme to better meet the needs of people affected by HIV/AIDS

In populations that are highly affected by HIV/AIDS, it is especially important that energy, protein, fat, and micronutrient intake is sufficient to help prevent weight loss and to help patients cope with opportunistic infections. In refugee settings, this means that the ration should meet international standards (for a population fully dependent on food aid the average need is often 2100 kilocalories per person per day), with 10–12% of total energy coming from protein and 17% from fat.

A stable supply is critical to prevent interruptions in food access, which may be particularly devastating for people who are ill. Depending on the estimated HIV prevalence, the energy content of the general ration and the absolute protein and fat content may be increased to reflect increased needs. RDA levels of micronutrients should be ensured through fortification of commodities in the food basket, complemented by consumption of fresh foods. Blended foods (e.g., corn–soya blend) should be included to provide an energy- and nutrient-dense, easily prepared food.

Where blended foods are distributed according to World Health Organization recommendations (40–50 g/day), an additional 20–30 g may be considered to support PLWHA. Cereals and grains should be milled and fortified prior to distribution, until reliable on-site fortification systems can be put in place. Families affected by HIV/AIDS may need assistance with milling and transport of the ration.

What does this integrated programme strategy aim to achieve?

Good nutrition is necessary for health and survival. For people living with HIV/AIDS, good nutrition (including access to adequate food and clean water) can play an important role in slowing disease progression, fighting off illness, and maintaining quality of life. People living with HIV/AIDS are nutritionally vulnerable and have heightened energy requirements. It is therefore particularly important to ensure access to adequate foods in high HIV prevalence settings. In some settings, it may be possible to help meet needs through targeted feeding programmes (see Strategy 6). However, it may be more feasible to make changes in the general food ration for the entire population than to try to reach HIV/AIDS-affected individuals with targeted supplementary feeding.

No evidence-based guidance exists on how to adjust the energy content of the general ration in light of HIV/AIDS. The SPHERE handbook and the interagency document, Food and nutrition needs in emergencies,[19] recommend an increase of 100–200 kcals to the initial planning figure (2100 kcals) where the health or the nutritional status of the population is extremely poor; however HIV/AIDS is not explicitly mentioned. Clearly, for programmes that directly reach people with HIV/AIDS who know their HIV status, the recommendations in Box 3 regarding higher energy needs are directly relevant and should be strongly considered when designing the ration. Whether or not the energy content of the ration is adjusted, actions can be taken to protect the nutritional value of the general ration for an AIDS-affected population, such as ensuring the inclusion of fortified milled cereals, a fortified blended food, and assistance with distribution for those who need it.

There are three options to consider when deciding whether to adjust the energy content of the general ration in emergency contexts (see below). Each of these options has potential benefits

and drawbacks. Where the ration has been reduced due to an insufficient food supply, the main focus should be on restoring the supply to meet the estimated needs of the population before adjusting upwards based on HIV prevalence (or before establishing an SFP to target the chronically ill, which cannot adequately compensate for an insufficient general ration). The nutritional value of the general ration in terms of macronutrients (energy and protein) and micronutrients (vitamins and minerals) should be ensured to the extent possible or increased, depending on a needs assessment, to enable refugees living with HIV/AIDS to maintain their health and nutritional status and cope with opportunistic infections. Where energy content is increased, the absolute protein and fat content would be increased accordingly, to maintain the same recommended percentages of each (10–12% and 17% respectively).

Option 1: Increase the energy content of the initial ration planning figure (2100 kcals) by a percentage based on the estimated HIV prevalence in the adult population. Table 2 below shows the adjusted energy values for different levels of HIV prevalence among adults. These values have been calculated using the formula:

Adjusted ration = 2100 kcals + (2100 * HIV prevalence in adults * 10% adjustment * 50% adults in population)

i.e., = 2100 + (2100 * HIV prevalence * 0.10 * 0.50)

This option takes a similar approach to that taken when calculating the overall energy needs in a population of normal demographic composition. The higher energy needs of population subgroups (such as pregnant/lactating women and adolescent males) are weighted and incorporated in the overall calculation. For the purposes of calculation, it is assumed that adults comprise 50% of the population.

While Option 1 represents a valid attempt to account for the effects of HIV/AIDS on nutritional needs, it has three drawbacks. First, as shown in Table 2, when this strategy is used to adjust rations, the difference in the overall energy composition of the ration would be minor. It may be, therefore, that the administrative and logistic requirements of this option outweigh the nutritional benefits. Second, at household level, individuals with HIV would probably not benefit much from the increase, because food sharing among and within households may not be influenced by HIV status. Third, the 10% increase is based on the assumption that people with HIV are asymptomatic—an adjustment upwards of 20-30% for symptomatic people would raise the estimated population-level needs slightly higher.

Option 2: Increase the initial planning figure for energy by 10% for the entire population (e.g. raise it from 2100 to 2310 kcal). With such an adjustment, everyone, including people living with HIV/AIDS, would benefit from increased access to food. However, further research needs to be done to document the practical benefits of such a strategy compared with the significantly higher costs, particularly given that the percentage of the population living with HIV/AIDS would still be a minority. A good argument could be made to use the same funds to improve the quality of the food basket in the general ration, through universal inclusion of additional fortified blended foods (above the existing amount), or fresh fruits and vegetables.

Option 3: Leave the general ration unadjusted, and focus efforts on targeted feeding programmes for PLWHA. Such a strategy would have to either rely on proxy indicators for identification of households to be reached, or be linked with voluntary counselling and testing. Little

practical experience exists at present to guide such strategies. This option misses the opportunity to provide additional nutritional inputs to HIV positive people unaware of their status.

Table 2. Adjusted energy values of ration under options 1 and 2, according to HIV prevalence

HIV prevalence	OPTION 1: Adjusted energy value (kcals)*	OPTION 2: Adjusted energy value (kcals)
Unknown or 0% (normal ration)	2100	2310
10%	2111	2310
20%	2121	2310
30%	2132	2310
40%	2142	2310

* On the basis of a 10% increase for each percentage point of the population estimated to be HIV-positive.

In situations where refugees have achieved some level of self-sufficiency and the ration has been reduced to reflect this, research should be conducted to determine if HIV/AIDS-affected families have equally benefited before deciding which option to select.

Other steps can be taken to adapt the general ration to better meet the needs of PLWHA and their families (and to better meet the needs of the entire population), aside from raising energy content. Some of these recommendations apply to all refugee populations (regardless of HIV prevalence), but are often not implemented and assume higher importance in situations of high HIV prevalence. These include:

- providing milled and micronutrient-fortified staples rather than cereals;
- including fortified blended food in the ration;
- using social workers or community volunteers to distribute food directly to households with chronically ill members who would otherwise have difficulty collecting the ration.

When selecting food commodities for the adjusted food basket, the following should be borne in mind:

- The NutVal programme available from UNHCR or WFP can be used to simplify the process of calculating the nutritional content of the ration.
- Protein content should provide approximately 10–12% of the total kcals of the ration.
- Fat should provide approximately 17% of the total kcals of the ration.
- Care should be taken when choosing commodities so as not to raise the vitamin A content too high above the RDA, as there is evidence suggesting potentially negative effects of high vitamin A consumption among PLWHA.

How would this integrated programme strategy be implemented?

Institutional collaboration and coordination. HIV prevalence estimates will most likely be derived from proxy measures collected by the Ministry of Health, such as by antenatal sentinel surveillance. The Ministry of Health or other agencies running health facilities should collaborate with UN and agency staff in charge of food and nutrition planning to incorporate HIV prevalence data into GFD planning. Community development staff should assist in assessing whether the general ration is reaching HIV/AIDS-affected households, and in planning interventions to increase access where obstacles are identified.

Emphasis on participatory and community-led approaches. Provision of additional nutritional support through the general ration is unlikely to stigmatize people with HIV/AIDS, since everyone receives it. Alongside the general food distribution, community development programmes should be implemented for vulnerable households to enable them to diversify their diet, taking into account labour constraints.

Logistics of implementation. Generally, it is not feasible for a general food distribution programme to deliver different food ration baskets to different population subgroups. In high-prevalence populations it is important that the general ration approaches the nutritional needs of the affected community. Where the HIV prevalence is not known, it generally assumed that the prevalence equals that of the surrounding population.

Cooperating partner agencies should monitor the level of fortification at the mill and household levels. Given the difficulties of fortifying the ration at the distribution site, commodities should preferably be milled and fortified with micronutrients prior to distribution, in accordance with international standards. If milling takes place after distribution, opportunities for micronutrient fortification at hammer mill level should be explored. Operational factors to better meet the needs of HIV/AIDS-affected families include assisting with milling and distribution where needed (where milling is done after distribution).

To quickly raise the ration's nutrient content, additional corn–soya blend (CSB) should be considered. Commodities should be easy for beneficiaries to prepare and consume, as HIV often causes gastrointestinal problems, affecting the ability to chew, swallow and absorb foods. Commodities should also be culturally acceptable and diverse. Where a new food item has been introduced that is not familiar to the community, people should be shown how to prepare the food to retain its micronutrient content. Preparation skills must be ensured where fortified foods are prepared (how to prepare it, how to improve palatability, how to avoid overcooking it) to ensure micronutrient content is retained. Home-based care teams should know how to prepare nutritionally adequate meals for people with AIDS and HIV-related illnesses, to then teach the community to prepare meals using these commodities and locally available foods.

How would this integrated programme strategy be monitored?

The systematic collection of data for monitoring and evaluation is especially important with this strategy, because of the lack of an evidence base to inform programme planning in terms of morbidity, protein-energy malnutrition, micronutrient malnutrition and mortality.

Programme-level indicators		Population-level indicators	
Input/process	*Output*	*Outcome*	*Impact*
• Amount of each food commodity distributed to GFD beneficiaries (e.g., blended food) during each food distribution (and % of planned) • % of adequately fortified commodities distributed (e.g., blended foods, cereals, oil) through GFD (and % of planned)	• % of GFD beneficiaries receiving an adequate ration (e.g., meeting predetermined target levels of energy, protein, micronutrients) per month (and % of planned) • % of GFD beneficiaries categorized as "vulnerable" and needing assistance, receiving transport or milling services per month • No. of beneficiaries receiving target commodities (and amount received per beneficiary) by age group and sex (and % of planned)	• % of refugee population receiving an adequate ration per month (and % of planned) • % of "vulnerable" households in target population receiving support with transport or milling services per month (and % of planned)	• Incidence of opportunistic illnesses • Crude mortality rate (with age-related distribution if possible) • Prevalence of global acute malnutrition • Prevalence of severe acute malnutrition • Prevalence of micronutrient deficiencies

Experiences from the field…

Kala and Mwange Camps, Zambia. The estimated prevalence of HIV infection in Kala Camp is less than 3%. The prevalence for Mwange is unknown, but likely to be low as well. It was thus concluded that adjustment of the nutrient content of the general ration for HIV prevalence was unwarranted. Vulnerable households unable to collect the ration are eligible for HODI-supported assistance in milling and delivering the ration (Photo 4). Chronically ill individuals – those with TB or HIV/AIDS – are eligible to enroll in the HBC programme, which includes nutritional support (a take-home supplementary ration).

HODI-run hammermill, Kala Camp, Uganda

E. Mathys Kirkcaldy

Integrated Programme Strategy 6: Modification of a supplementary feeding programme to better meet the needs of population subgroups affected by HIV/AIDS

Supplementary feeding in normal camp contexts is usually triggered by a high prevalence of child malnutrition or other aggravating factors. Typically the supplementary feeding ration provides between 1000 to 1200 kcals per person per day in the form of a take-home ration, which is targeted to children, pregnant and lactating women, or other at-risk groups. In situations where supplementary feeding programmes are already set up, it may be useful to broaden eligibility criteria to offer nutritional support to people with HIV/AIDS, particularly those who are symptomatic. Where possible, the energy content of the supplementary ration for people with symptomatic AIDS should be raised to meet increased energy needs associated with HIV and opportunistic infections; absolute protein content should also be raised (to continue to account for 10–12% of energy) (see Box 3). Micronutrient content should be adequate to allow RDA levels to be met through micronutrient fortification and consumption of fresh foods. Blended foods should be emphasized where possible to provide an energy- and nutrient-dense, easy to prepare food in the ration.

What does this integrated programme strategy aim to achieve?

Population groups at risk of malnutrition (e.g., pregnant and lactating women, children under 5 years of age, people living with HIV/AIDS or TB) or with acute malnutrition (e.g., moderately wasted children) receive an enhanced supplementary ration, modified to account for increased nutritional needs associated with symptomatic HIV infection, opportunistic illnesses and AIDS. Where the energy content of the general ration has been increased to account for HIV/AIDS (see Box 3), an increase in the supplementary ration is not necessary. However if HIV prevalence is known to be significant and the general ration has not been modified accordingly, the supplementary feeding programme is the main way to target nutritional support to people living with AIDS.

How would this integrated programme strategy be implemented?

Institutional collaboration and coordination. Health staff should collaborate with UN and cooperating partner agency staff in charge of food and nutrition planning to make appropriate modifications to the supplementary feeding programme based on HIV prevalence data. Participation should be linked at the community level with health care and health education for the chronically ill, as well as with food security interventions.

Emphasis on participatory and community-led approaches. For the chronically ill, the supplementary ration should be presented as part of their health care rather than as an additional food ration entitlement to facilitate public acceptance of the programme.

Logistics of implementation. Additional commodities must be sourced and distributed to programme participants. Adjustments in the SFP should take into account any adjustments to the general food ration (see above), as well as whether the ration is consumed on site ("wet feeding") or at home ("dry feeding"). It is vital that stigmatization of AIDS-affected families is avoided in the targeting process.

How would this integrated programme strategy be monitored?

As with integrated programme strategy 5, systematic collection of data for monitoring and evaluation is especially important, because of the lack of an evidence base to inform programme planning in terms of morbidity, protein-energy malnutrition, micronutrient malnutrition and mortality.

Programme-level indicators		Population-level indicators	
Input/process	*Output*	*Outcome*	*Impact*
• Amount of food commodities distributed to SFP beneficiaries (and % of planned) • % of adequately fortified commodities distributed (e.g., blended foods, cereals, oil) through SFP (and % of planned)	• % of SFP beneficiaries receiving an adequate ration (e.g., meeting predetermined target levels of energy, protein, micronutrients) per month (and % of planned) • No. of people enrolled in SFP (by target vulnerable group) (and % of planned)	• % of intended SFP beneficiaries (target groups) in refugee population receiving enhanced SFP ration per month (and % of planned)	• Incidence of opportunistic illnesses in SFP target groups • Crude mortality rate (with age-related distribution if possible) • Prevalence of global acute malnutrition in SFP target groups[28] • Prevalence of severe acute malnutrition in SFP target groups • Prevalence of micronutrient deficiencies in SFP target groups

[28] Indicators for SFP and TFP start-up and closure may need to be adjusted where HIV prevalence is high.

Integrated Programme Strategy 7: Support for HIV/AIDs-affected families and children through a school feeding programme

Families struggling to cope with chronic illness may decide to withdraw children from school to earn money, help in food production, or assist in caretaking. When a needs assessment suggests that school attendance may have been adversely affected by food insecurity and the effects of HIV/AIDS in a refugee community, a school feeding programme should be considered. If food is provided at the school site, it should be given to all children to avoid stigmatization of those from affected households. HIV/AIDS sensitization and prevention activities should be integrated into the school feeding programme as well (Strategy 4).

What does this integrated programme strategy aim to achieve?

Children's ability to attend school throughout the year is important for their cognitive, social and emotional development, and should be protected in HIV/AIDS-affected populations. Girls may be particularly likely to be withdrawn from school to take care of ill family members. School attendance is vital for the development of life skills, including HIV/AIDS prevention, and may reduce engagement in unprotected sex. School feeding should not be the only response to evidence that HIV/AIDS in a household is associated with reduced school attendance; it should rather complement appropriately designed and targeted food security interventions that enable affected families to send children to school.

How would this integrated programme strategy be implemented?

Institutional collaboration and coordination. Educational facilities collect data on annual and seasonal trends in school enrolment and attendance. Community health workers and other cooperating partner agency health staff working directly with HIV/AIDS-affected households can monitor changes in school attendance among these households. Where either source of data indicates significant reductions in attendance as a result of chronic illness, and where a feeding programme is determined to be a suitable response, staff can collaborate to put a school feeding programme in place, with mechanisms to monitor attendance and assess programme impact.

Emphasis on participatory and community-led approaches. Before a school feeding programme is implemented, participatory research should be conducted with communities to determine if food is the right response to the problem. School feeding may help families to keep their children in school, but it does not address the issue of the caretaking burden or hunger in the household. Participatory research can also help to identify opportunities to assist AIDS-affected households in the care and nutrition of ill family members.

Logistics of implementation. School feeding programmes are likely to be inappropriate where school attendance rates are high, unless nutritional surveys indicate a high prevalence of malnutrition among school-age children. Reasons for declining school attendance, disaggregated by sex and age, should be identified. Where resources allow, follow-up may be conducted for children who do not attend school to determine the causes.

How would this integrated programme strategy be monitored?

Programme-level indicators		Population-level indicators	
Input/process	*Output*	*Outcome*	*Impact*
• Amount of food commodities distributed through school feeding programmes (and % of planned) • No. of schools involved in school feeding programme (and % of planned)	• Absolute enrolment: no. of boys and girls enrolled in primary school • No. of boys and girls receiving feeding through primary education (and % of planned)	• Net enrolment: no. of primary school age boys and girls enrolled in primary school • % of children of school age in AIDS-affected households benefiting from school feeding (and % of planned) • Attendance rate: % of boys and girls in primary schools with school feeding attending classes at least 80% of the school year	• Ratio of current school attendance among orphans to that among non-orphans, aged 10–14 (by sex) • Ratio of current malnutrition rate among orphans to that of non-orphans (by age and sex) • School enrolment and attendance/ retention, aged 10–14 (by sex) • Improved capacity of boys and girls to learn in schools with school feeding

Experiences from the field…

Kala and Mwange Camps, Zambia. In Mwange Camp, school attendance increased after school uniforms were distributed during 2003, confirming that the inability to afford uniforms was a barrier to school attendance. Additionally, attendance declines seasonally (particularly during the rainy season) as children join their families to farm in surrounding villages (one of the few sources of income available to the refugees). Despite this evidence of a decline in school attendance among poor families, it was concluded that school feeding would not be appropriate in the camps, based on data showing attendance rates exceeding 80% and very low prevalence of malnutrition. Assistance should be targeted instead to the poorest and most vulnerable households.

Integrated Programme Strategy 8: Support for HIV/AIDS-affected families and children through provision of a complementary ration to foster families and orphanages

While the placement of orphaned or unaccompanied children with local families is generally preferable to placement in orphanages, caring for an additional child can become an unmanageable burden where the fostering family is poor, headed by an elderly or ill person, or food-insecure. When supported by a needs assessment, the provision of a complementary ration to foster families can help maintain the food security of the household during short-term food crises, or hold them over until longer-term support is established. The needs assessment should determine whether the general ration is sufficient, or if an additional complementary ration is needed. For children in orphanages, external food support may be vital to their health and survival until the orphanage becomes self-sufficient or adequately supported from other sources.

What does this integrated programme strategy aim to achieve?

Material assistance for foster families can ease the collective burden of caring for orphans and unaccompanied minors and result in more families being able to take in such children. Placement of children with extended or foster families should be encouraged over placement in orphanages. In populations with high HIV prevalence or food insecurity, taking in an orphan can be an unmanageable burden for poor families. Food support to orphanages may be considered where the need has been sufficiently demonstrated.

How would this integrated programme strategy be implemented?

Institutional collaboration and coordination. Social workers or other staff conducting outreach activities with foster families or orphanages should collaborate with food distribution staff to ensure effective distribution of rations to participants. Collaboration is also necessary to identify the families or institutions to target, when to commence ration support, and when to phase it out. Where orphanages or other institutions are supported, identifying partners and activities that can supplement the fresh food supply should also be encouraged.

Emphasis on participatory and community-led approaches. Care must be taken not to undermine existing community structures that care for orphans and unaccompanied minors without outside incentives. Participatory research should assist in determining which families need assistance, and ensure that families are not taking in orphans solely in order to receive the ration. Caring for orphans and unaccompanied children should be seen as the responsibility of the community, rather than of external agencies, which is a short-term solution.

Logistics of implementation. Programmes aimed at improving the situation for orphans should not exclude children whose parents are still alive but sick. Assistance should be provided to the entire household, rather than solely to orphans in the household. Vulnerable foster families should also be included in income-generating activities to reduce dependence on external assistance and support their capacity to care for all children in the household. Exit strategies (including transition to sustainable, community-managed livelihood activities) are of the utmost importance, to avoid undermining pre-existing or potential local support mechanisms by over-reliance on external support.

How would this integrated programme strategy be monitored?

Programme-level indicators		Population-level indicators	
Input/process	*Output*	*Outcome*	*Impact*
• Amount of food commodities distributed to foster families and orphanages (and % of planned)	• % of feeding programme participants receiving an adequate ration (e.g., meeting predetermined target levels of energy, protein, micronutrients) per month (and % of planned)	• % of foster families and orphanages benefiting from programme (and % of planned) • % of orphans in population benefiting from programme (and % of planned)	• % of orphans living in households or in institutions that are food secure • Prevalence of global acute malnutrition in orphans • Prevalence of severe acute malnutrition in orphans

Experiences from the field…

Mwange Camp, Zambia. Foster parents in Mwange Camp who had taken in unaccompanied children before and during flight from the Democratic Republic of Congo were worried about their ability to meet the children's food, health and education needs. They received a general food ration, but no supplementary ration. HODI social workers provided counselling and assistance with medical care for the child. When asked for suggestions on how to support them, foster parents proposed a mix of supplementary rations and livelihood activities: "*If we could be assisted with a bit of food for the children, that would help us to feed them and to exchange with other food to improve the diet. And in case there is any [farm] piecework, it would be good if you could assist us as foster parents.*'

Children in Mwange Camp, Zambia

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Integrated Programme Strategy 9: Support for the establishment of home gardens and agricultural plots for PLWHA and HIV/AIDS-affected families

Where resources and national and local government policies allow, the establishment of gardens or agricultural plots for refugees should often be the first priority in a food security programme. People living with HIV/AIDS and their families should be eligible for gardening (horticultural) and agricultural programmes, taking their time and labour constraints into consideration. It is preferable that this programme is implemented alongside one for the entire refugee community, to reduce the risk of stigmatization. Gardening, particularly of fruits, vegetables, pulses and legumes, can increase the diversity of the diet, earn valuable income, and promote social and physical activity.

What does this integrated programme strategy aim to achieve?

Gardening or agricultural cultivation by HIV/AIDS-affected families should be viewed as an integral component of their long-term livelihood, nutrition, health and psychosocial support systems. For AIDS-affected people who depend on a general ration, fruits, vegetables, pulses and legumes from gardening projects can improve dietary diversity, increasing the levels of micronutrients (vitamins and minerals) and protein, which are vital to maintain the strength of their immune system. The physical activity of gardening helps maintain strength, body weight and mobility. Those who participate in communal gardening benefit from social contact, which can prevent isolation and depression.

How would this integrated programme strategy be implemented?

Institutional collaboration and coordination. People living with HIV/AIDS are often identified through confidential health services. To enrol them in an agricultural or horticultural programme, health staff should collaborate with community development staff who manage livelihood programmes. Nutrition staff may also assist in the selection and cultivation of nutrient-dense foods for participating families.

Emphasis on participatory and community-led approaches. Agricultural cultivation should be encouraged for all refugees, not just HIV/AIDS-affected households. The agricultural programme may be modified for PLWHA in several respects: they may need additional support with inputs, and the types of crops grown may reflect their ability to work and their elevated nutritional requirements. It may be preferable to involve vulnerable households in communal gardening projects to promote social integration and enhance the success of the project.

Logistics of implementation. Land allocation for refugees can be a delicate political issue, particularly where land is scarce or infertile. The closest plots, and those on flatter terrain, should be allocated to people with limited or declining mobility. Poorer families may need support to meet the cost of inputs (e.g., tools, seeds/seedlings, fertilizers, pesticides) for the first one or two seasons. Fast-growing, nutritious crops with low labour requirements should be the main focus.

How would this integrated programme strategy be monitored?

Programme-level indicators		Population-level indicators	
Input/process	*Output*	*Outcome*	*Impact*
• Total amount of land allocated for cultivation (and % of planned) • Total amount of agricultural inputs distributed to participants per type (and % of planned) • Number of people and households trained in agricultural techniques (and % of planned)	• % of targeted people or households successfully establishing home gardens (and % of planned) • Average amount of land cultivated and food produced per participating household (and % of planned)	• % of HIV/AIDS-affected households in population actively participating in programme (and % of planned)	• Household food security status, household income • Crude mortality rate (with age-related distribution if possible) • Prevalence of global acute malnutrition • Prevalence of severe acute malnutrition • Prevalence of micronutrient deficiencies

Experiences from the field…

Kyangwali Settlement, Uganda. The Ugandan Self-Reliance Strategy (SRS) encourages land allocation to refugees for cultivation, with the objective of food self-sufficiency. Congolese refugees who arrived in Kyangwali Settlement in 1997 are cultivating extensively (Photo 6), with some households selling the surplus in local markets. Only "vulnerable households" and new arrivals receive a food ration. The AAH Production and Environmental Protection Committee and Community-Based Extension Workers provide technical support and encourage each household to have an agricultural plot including fruits, vegetables, a wood lot and an orchard.

Refugee gardens, Uganda

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Integrated Programme Strategy 10: Support for income-generating activities, microcredit and community banking, training and other capacity building activities for PLWHA and HIV/AIDS-affected families

Many income-generating activities can be established to help HIV/AIDS-affected households be self-sufficient. When affected households are linked with community development programmes, they should be offered the opportunity to participate in economic activities that take into consideration their labour constraints. Involvement of healthy family members from affected households can increase their ability to care for their ill relative.

Microcredit and community banking projects build the capacity of participants to plan for and manage economic activities that use their specific skills and help them achieve their personal objectives. Unlike income-generating activities that are agency-managed, microcredit and community banking projects allow participants to invest their resources in various ways, after receiving training in book-keeping and planning. In many refugee communities, women have few opportunities to control and invest household income because of cultural constraints. Microcredit and community banking projects can be an invaluable way for women, including women with HIV/AIDS, to gain valuable business management skills. Additionally, the funds generated for a participating group be used to support the needs of members, a valuable benefit for PLWHA.

Where appropriate, food can be considered as a possible incentive to encourage participation by PLWHA and affected families in training and other local capacity development activities. As noted previously, it may be appropriate for PLWHA to be trained in different skills and trades than other families. To avoid stigmatization, their training should be integrated into training programmes open to the entire refugee community. PLWHA should be involved in identifying the skill areas in which they will be trained.

What does this integrated programme strategy aim to achieve?

Use of food or related resources to support income-generating activities for AIDS-affected families reduces their dependence on external assistance, and provides valuable income that may be used to purchase nutritious foods, pay for health services, pay for education for the children and meet other vital needs. Refugees living with HIV/AIDS may engage in tailoring, small-scale repair activities (e.g., shoes, radios) and small-scale trade. Their ability to participate in these activities can be facilitated by support with start-up costs, training, and formation of community groups to undertake the activity collectively.

Microcredit and community banking activities aim to improve the health, nutrition and food security of participating households through generation and investment of income. Added benefits for participants include development of financial management skills, available income for use in emergencies, and increased livelihood resilience. People living with HIV/AIDS can work closely with people without the disease – a source of social connectedness – to identify projects in which they are **able to actively participate.**

In addition to other material and cash resources, food may be used to support training activities that enable PLWHA and their family members to engage in economically productive activities. Training in appropriate skills – language, literacy, non labour-intensive

agriculture and horticulture, animal husbandry (particularly small animals), non labour-intensive trade skills – can promote self-sufficiency and reduce poverty during displacement, as well as build human capital (skills, knowledge and capacities) for repatriation. Host communities often provide many employment opportunities for skilled refugees. Development of skills among PLWHA, preferably in a training programme open to the broader community, can provide a valuable source of household income.

How would this integrated programme strategy be implemented?

Institutional collaboration and coordination. PLWHA identified by the health system can be referred to community development programme staff who oversee income-generating projects or who manage microcredit and community banking projects. Community development staff and the microcredit groups can liaise with banking institutions to make arrangements for opening and managing a bank account. Training programmes generally should not be targeted to PLWHA, to avoid stigmatization. However, agency staff can work to ensure that there are opportunities within existing training programmes that are accessible to PLWHA and their families.

Emphasis on participatory and community-led approaches. Successful income-generating activities are those that participants can engage in on a sustainable basis, and which earn significant income in accessible markets. At the outset, participants (including PLWHA) can work together to identify activities that can be supported by accessible markets. Both HIV-infected and non-infected people can participate in the same projects, but the specific needs of PLWHA should be taken into consideration. Community groups often form naturally within refugee communities, particularly among women who arrange for the rotation of small funds among families. Community development project staff can facilitate the involvement of PLWHA in these groups as they are formed. Training and income-generating activities should be geared to the capacities of PLWHA and their families, which should be identified through community

AAH-run model farmer plot for commercial food sale, Kyangwali, Uganda

E. Mathys Kirkcaldy

research. Refugees in Zambia, for example, consistently emphasized small-scale trade, radio repair, shoe repair, and other low labour-requirement activities as being appropriate for PLWHA.

Logistics of implementation. Once activities have been identified, plans must be put in place to find capital and funds for start-up costs, and for investment in management training. Community development staff should assess the financial feasibility of projects identified by the group, as well as providing ongoing supervision and support in financial management and reporting. Training for PLWHA should preferably be integrated into formal training services provided to the refugee community as a whole, to avoid stigmatization. Training itself should be recognized as an incentive to participate in programmes. This is likely to be achievable if participants feel that the training will contribute to their ability to get a job (a concern addressed when training participants receive a certificate to take home).

How would this integrated programme strategy be monitored?

Programme-level indicators		Population-level indicators	
Input/process	*Output*	*Outcome*	*Impact*
• Total amount of resources allocated per type of activity (and % of planned) • Number of people and households trained in appropriate skills for income-generating activities (and % of planned) • Number of people and households trained in appropriate skills for microcredit and community banking (and % of planned) • Number of people and households trained in target skills (and % of planned)	• % of targeted people or households successfully involved in income-generating activities (and additional activity-specific indicators) (and % of planned) • % of targeted people or households successfully involved in microcredit/ community banking activities (and % of planned) • % of participants able to access marketing system (and % of planned) • % of targeted people or households successfully completing training and demonstrating skills (and additional activity-specific indicators) (and % of planned)	• % of HIV/ AIDS-affected households in population actively participating in programme (and % of planned)	• Household food security status, income • Crude mortality rate (with age-related distribution if possible) • Global acute malnutrition • Severe acute malnutrition

Experiences from the field…

Kyangwali Settlement, Uganda. In 2001, AAH started a demonstration garden project in Kyangwali. Contact farmers were selected by the refugee community on the basis of their agricultural skills. The contact farmers were provided with sufficient financial and technical support to establish a series of income-generating activities at their homes, including intensive production of food and cash crops (Photo 7), and animal rotation involving the crossing of exotic breeds with local breeds (Photo 8). AAH staff provide training on crop management, post-harvest management (e.g., modern storage silos), marketing, and fuel-efficient stoves. AAH also provides seeds and helps with planting.

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AAH-run cattle rotation and model farmer project, Palorinya, Uganda

Palorinya Settlement, Uganda. AAH has established an admirable communitybankingproject in which refugee groups are provided with extensive training and initial capital to engage in economic activities that they themselves select. Participants are mostly women who learn for the first time how to engage in business (Photo 9). Each group is open to PLWHA, and participates in multiple economic activities depending on the skills of members and market availability.

Mwange camp, Zambia. The HODI-supported Mwange Skills Training Center provides certified training in plumbing, mechanics, tailoring, agriculture, electrical work, cookery, carpentry, and bricklaying. This service is free and available to both refugees and local community members. As a result of participation, some students had earned income working in nearby towns. In terms of providing an additional health benefit to PLWHA, the Mwange Skills Training Center cookery instructor volunteered to educate vulnerable families on nutrition, diet and chronic illness but requested formal training in nutrition to be able to provide this guidance. Instructors agreed that it would be valuable to research trade programmes in which PLWHA would want to participate, and to design the hours of the programme to facilitate their involvement.

Participants in AAH-run community banking project, Palorinya, Uganda

E. Mathys Kirkcaldy

Integrated Programme Strategy 11: Support for food-for-work (FFW) projects that employ or directly assist PLWHA and HIV/AIDS-affected families

Where appropriate, food for work (FFW) can be considered for vulnerable households, including those affected by HIV/AIDS. If PLWHA participate, the activities should not be labour-intensive. In order to assist PLWHA in the community, FFW activities may focus on the construction of health facilities, cultivation of agricultural plots or participation in other support activities.

What does this integrated programme strategy aim to achieve?

FFW projects can provide a safety net whereby vulnerable households, including vulnerable AIDS-affected households, receive food in exchange for services provided in the community. This ration should increase the nutrient intake of household members. FFW projects are intended to support the poorest households until livelihoods can be established.

How would this integrated programme strategy be implemented?

Institutional collaboration and coordination. FFW programme management staff should collaborate with health staff to ensure that AIDS-affected families participating in the programme are followed up.

Emphasis on participatory and community-led approaches. HIV/AIDS-affected households should participate in the development of FFW projects to ensure that they are able to perform the activities required. HIV/AIDS-affected households tend to be labour-poor, and this should be taken into account when the programme is designed). Members of AIDS-affected families who are able to engage in heavy labour (e.g., construction) may participate in community development projects and receive a family ration.

Logistics of implementation. In order to prevent stigmatization, FFW programmes should target all vulnerable households in the community, rather than only those with HIV-infected members. Where the FFW project is specifically intended for AIDS-affected households, management staff should conduct interviews with AIDS-affected participants to evaluate the project. Food should only be used as an incentive/enabler in FFW where food access is limited. Food rations (value, size) should be provided in accordance with the level of involvement in the various activities. the nutritional value of the rations can be considered where the diet has particular deficiencies. Large-scale sale of rations should be avoided, although limited amounts of food may be bartered for more appropriate or preferred food items. Participants in need of support but receiving a general ration may be paid with other essential commodities, such as non-food items. The appropriate payment is also determined by the availability of food and non-food items to refugees locally. FFW projects provide a temporary safety net until the poorest households can become self-reliant or community support restored. External support for such programmes may in some cases be necessary for the duration of displacement because of the limited number of opportunities to make a living. Development activities should be prioritized to prevent long-term dependence.

How would this integrated programme strategy be monitored?

Programme-level indicators		Population-level indicators	
Input/process	*Output*	*Outcome*	*Impact*
• Total amount of resources allocated per type of activity (and % of planned) • No. of people and households participating in asset- and income-generating activities (by sex) (and % of planned) • No. of projects established/ completed that benefit PLWHA (and % of planned) • No. of beneficiaries participating in income- and asset-generating activities from households affected by HIV/AIDS (and % of planned)	• % of targeted projects completed that employ or assist PLWHA (and % of planned)	• % of HIV/ AIDS-affected households in population actively participating in programme (and % of planned)	• Household food security status, income • Crude mortality rate (with age-related distribution if possible) • Prevalence of global acute malnutrition • Prevalence of severe acute malnutrition

Experiences from the field…

Kala and Mwange Camps, Zambia. Though FFW projects do not exist in Mwange or Kala, income-generating programmes prioritize groups that include "vulnerable" members, and vulnerable families are prioritized for casual labour and construction projects.

Kala Camp, Zambia. Agricultural extension workers with World Vision International assist "vulnerable" farmers, including those with TB or HIV/AIDS, with land preparation and cultivation.

Integrated Programme Strategy 12: Support to enable and encourage participation by HIV-infected individuals in community groups formed by PLWHA

HIV/AIDS can lead to tremendous isolation, disruption to family and social support networks, and fear. Refugees repeatedly report that HIV/AIDS leads to loss of hope, despair and social isolation. Where feasible and appropriate, food and related resources can be considered a possible incentive to support community groups formed by PLWHA, based on the recognition of their essential contributions to participants: acceptance and sympathy from members of the community, a source of hope, and practical life and health-related knowledge and skills to cope with the effects of the disease. These community groups can also serve as a springboard for advocacy for improved health care for PLWHA, and provide an entry point for training and capacity building activities targeted to group members.

What does this integrated programme strategy aim to achieve?

By providing food or related resources to community groups formed by PLWHA, this programme invests in the development of community-based support structures for people who are, or suspect that they might be, HIV-positive. The value of community groups formed by PLWHA cannot be overstated. Where HIV/AIDS services (e.g., VCT, ART, PMTCT) are not yet in place and stigma is widespread, these groups may be the only source of support available to people concerned that they may be infected with the virus. Peer support is crucial for people to have the courage to undergo VCT, accept their illness and begin "living positively". In its early stages, a group of PLWHA can provide confidential emotional and spiritual support to its members, who may have lost the support of family and peers. As the group develops, it can provide members with knowledge on how to protect their health, advocate for resources to address the needs of PLWHA, and serve as a springboard for outreach activities (e.g., public testimonies, HIV/AIDS sensitization).

How would this integrated programme strategy be implemented?

Institutional collaboration and coordination. Clearly, such groups would ideally be formed without the need for incentives, to reduce potential dependence. In some settings, however, food may be a helpful input in terms of facilitating attendance at meetings or group activities, and keeping group cohesion. Once a community group of PLWHA has been formed, relevant programme staff – particularly in the areas of health, social services, psychosocial support, and food and nutrition – should work with it to identify the most appropriate incentives to support its objectives.

Emphasis on participatory and community-led approaches. Community-based groups of PLWHA can serve as powerful agents of social change. They should be encouraged to be active partners in HIV/AIDS care, treatment and support programmes in the community. They are best placed to identify the issues that affect PLWHA locally, and to propose locally appropriate initiatives to address them.

Logistics of implementation. Incentives can range from the simple provision of food for group meetings, to interventions designed to enhance the health or capacity of the group such as training or income generating projects. Research can help identify what types of incentives would be most valued in a given situation.

How would this integrated programme strategy be monitored?

Programme-level indicators		Population-level indicators	
Input/process	*Output*	*Outcome*	*Impact*
• Total amount of resources allocated per type of activity (and % of planned) • No. of people and households trained in target skills (and % of planned) • No. of projects established/completed (and % of planned)	• No. of people participating in groups formed by PLWHA (and % of planned) • % of identified groups receiving support (and % of planned)	• % of HIV/AIDS-affected households in population actively participating in programme (and % of planned)	• Household food security status, income • Crude mortality rate (with age-related distribution if possible) • Prevalence of global acute malnutrition • Prevalence of severe acute malnutrition

Experiences from the field…

Hoima town and Kyangwali settlement, Uganda. In 1991, the CBO, Meeting Point, was established by 30 people who were living with HIV/AIDS (Photo 10). With 750 members in 2003, Meeting Point is a focal point for many AIDS-related services in the community. With financial support from the Association of Volunteers in International Service (AVSI), it pays the school fees of 500 orphans whose parents died of AIDS. In collaboration with AVSI medical staff, Meeting Point community counsellors (trained by the Irish NGO GOAL) conduct home visits and provide counselling to PLWHA as part of a home-based care programme, and advocate for home-based care in the final stages of the disease. Agricultural, horticultural and income-generating activities (poultry-keeping, bricklaying) provide some of the group members with a source of livelihood, while an arrangement with the World Food Programme allows food rations to be distributed to 500 PLWHA. Group members conduct personal "testimonies," dramas and education events to provide the community with accurate knowledge about HIV/AIDS prevention and transmission. The courageous woman spearheading the group said, "*When I met others with AIDS, I knew I was not alone, and that gave me the strength to cope with the situation and approach it courageously. This programme is very important for people living with HIV/AIDS, because self-stigmatization and isolation are enormous problems.*"

Meeting Point handicrafts for sale to support the group's activities, Hoima, Uganda

F. Abdalla

CHAPTER 4:

Incorporating food and nutrition activities into HIV/AIDS programmes in refugee settings

4.1 Introduction

This chapter presents an additional eight integrated programme strategies, each of which is based on an HIV/AIDS programme, enhanced to protect or improve the food security or nutritional status of people affected by HIV. The programme strategies are presented in three groups: strategies that incorporate food and nutrition support into *health care and treatment services for people living with HIV/AIDS* (section 4.2); strategies that use food and nutrition resources to support *training and capacity-building activities for clinic-based and community-based care providers* (section 4.3); and strategies that use food and nutrition resources to support the *establishment or continuation of community-level HIV/AIDS-related activities*

4.2 Integrated programme strategies that incorporate food and nutrition support into health care and treatment services for people living with HIV/AIDS (strategies 13-16)

Four programme strategies focus on integrating nutritional support into medical care and treatment services (Figure 6):

Strategy 13 *Establishment of an inpatient hospital/clinic feeding programme with nutrition education*

Strategy 14 *Establishment of a hospital/clinic demonstration garden with nutrition education*

Strategy 15 *Integration of a supplementary ration and nutrition education into a home-based care programme*

Strategy 16 *Integration of a supplementary ration and nutrition education into an antiretroviral therapy programme*

An inpatient hospital feeding programme may be appropriate in settings where at least the following two conditions are met: (1) a high percentage of hospital patients are seeking care for HIV/AIDS-related conditions, and (2) it is known or suspected that lack of food is adversely affecting the health outcomes of these individuals. Hospital feeding is a significant logistic and financial undertaking, in terms of securing adequate and diverse food commodities, and managing the associated preparation, delivery and disposal tasks. In most settings, it would be inappropriate to target people living with HIV/AIDS with food to the exclusion of other patients. Hospital feeding programmes, therefore, should generally include all inpatients, regardless of HIV status.

A complementary intervention is the establishment of demonstration gardens at health facilities. These can be used to demonstrate how locally appropriate and nutrient-dense food crops should be cultivated. The produce from demonstration gardens is distributed to inpatients of the health facility, thus supporting the inpatient feeding programme. This programme provides an additional benefit by educating the public about crops that grow well in the local environment, providing a reliable source of food and income for refugee families, and nutrient-dense foods for people suffering illness. Diverse crops should be cultivated, such as fruits, vegetables, legumes and cereals.

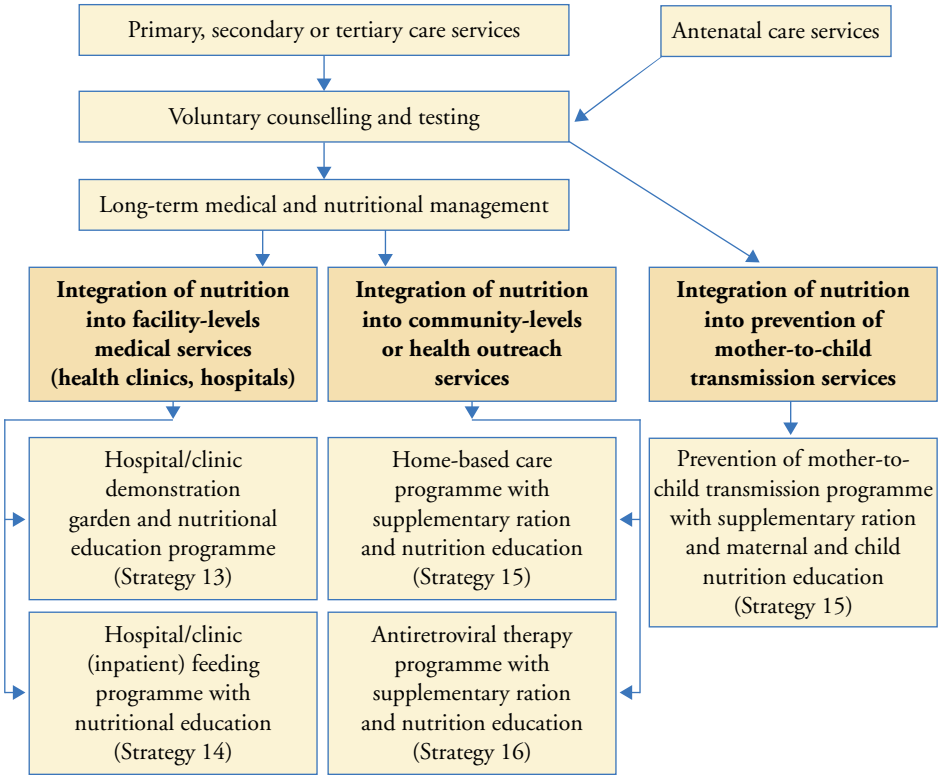
Both types of programme should ideally incorporate a nutrition education component that provides community members (particularly the chronically ill and their caretakers) with skills in food preparation and hygiene. HIV/AIDS sets in motion a complex struggle between the body's immune defences – which are affected by stress, nutritional status and other factors – and disease agents, including HIV and environmental pathogens. People found to be HIV-positive can stay relatively healthy by eating well, adopting healthy behaviours (e.g., hygiene, exercise, prophylactic treatment), and seeking medical care when health problems arise. For the majority of refugees living with HIV/AIDS in low-income countries, medical management of their disease is confined to primary care at the local health clinic. Antiretroviral therapy remains unavailable or unaffordable for the majority of refugee communities in low-income countries. Local health staff may be poorly equipped to identify and manage the opportunistic infections that frequently afflict those living with HIV, or to provide nutritional support or education.

In addition to providing nutritional care as part of routine activities, hospital and clinic (facility-based) services can be a springboard for better home-based nutritional management of people living with HIV/AIDS. For example, nutrition education and the involvement of family members during inpatient feeding can be used to relay useful information to households about care and support. Demonstration gardens at the hospital can be used to supplement the diet with fresh foods, while at the same time encouraging households to set up homestead gardens producing nutritious foods. Outside the facility setting, nutritional support can be incorporated into AIDS-related care through provision of a ration (and nutrition education), either as part of a home-based care programme for PLWHA, or to all participants in an ART programme. Finally, nutrition can be integrated into a PMTCT programme.

As illustrated in Figure 6, VCT is an entry point to prevention, care and support services for PLWHA, their partners and children. It is vital that the implementation of VCT services go hand in hand with the development of care, treatment and support programmes at the facility and household levels. The demand for VCT services is directly associated with the availability of treatment and management options. Health care services for refugees with HIV/AIDS should aim to provide facility-level medical and nutritional support, linked to longer-term community-level medical and nutritional support, ideally in combination with livelihood support interventions.

All camp-based health service providers, including agency staff and volunteers, should be given nutritional training appropriate to their responsibilities. Health service providers (e.g., traditional birth attendants, community health workers, community social workers, peer educators, traditional healers, clinic staff, home-based care staff) have frequent contact with vulnerable and chronically ill populations, and are in a position to provide valuable nutritional guidance. With training, health service providers could advise patients on proper preparation of foods, home gardening, and dietary diversification. Training should take into consideration locally available foods, particularly where a population relies on a general ration, and the financial constraints of the population. Where possible, training should be given on a continuing (rather than a one-off) basis. In Zambia, for example, community health workers received training on incorporating nutrition into their regular health education activities.

Figure 6. Integration of nutritional support into medical services for refugees living with HIV/AIDS



Integrated Programme Strategy 13: Establishment of an inpatient hospital/clinic feeding programme with nutrition education

In medical inpatient settings, particularly in environments with high HIV prevalence, the provision of meals to patients and the caretakers attending to them at the facility should be considered. Meal provision supports nutritional status and medical recovery, and may reduce the need for family members to bring food to the facility.

What does this integrated programme strategy aim to achieve?

Provision of meals to patients and their principal caretakers with them at the facility helps to ensure that ill patients receive adequate nutrition to support rehabilitation, and to reduce the impact of the caretaking burden on the rest of the household. In many refugee communities, family members must provide food to relatives in clinics and hospitals. In settings with high HIV prevalence, affected families may be struggling to meet basic needs within the household and may be unable to consistently commit the time and resources needed to support an ill family member. Additionally, patients with HIV/AIDS will have higher nutritional requirements than many patients without HIV/AIDS. A hospital feeding programme also provides the opportunity to provide nutritional education to caretakers on long-term nutritional care of the patient.

How would this integrated programme strategy be implemented?

Institutional collaboration and coordination. Planning an inpatient feeding programme requires discussions among representatives of the Ministry of Health, hospital/clinic staff and nutrition/feeding programme staff. Agreement must be reached on how the foods will be sourced, paid for, prepared and delivered, as well as on target guidelines for the nutritional content of the meals.

Emphasis on participatory and community-led approaches. The capability of the community to contribute to the feeding programme, particularly regarding fresh fruits and vegetables, should be assessed. Community members may also contribute to the maintenance of a hospital garden (see strategy 14).

Logistics of implementation. While not all inpatients will be HIV-positive, it is neither logistically feasible nor socially acceptable to provide inpatient feeding only to patients with HIV/AIDS. Meals should be provided to all inpatients, to avoid identifying specific ones as having HIV. Multiple micronutrient supplements and prevention/management of oral sores should be considered to help beneficiaries use the food received. The sustainability of the hospital feeding programme, or a phase-out strategy, should be considered from the outset.

How would this integrated programme strategy be monitored?

Programme-level indicators		Population-level indicators	
Input/process	*Output*	*Outcome*	*Impact*
• No. of hospitals/clinics with feeding programme-related facilities adequately constructed (and % of planned) • No. of staff adequately trained for feeding programme (per type) (and % of planned) • Amount of food distributed through hospital feeding programmes (and % of planned) • % of food distributed through hospital feeding programmes that is micronutrient-fortified (and % of planned)	• % of targeted facilities providing food to inpatients • No. and % of inpatients fed through inpatient feeding programme (and % of planned)	• % of inpatients participating and receiving adequate meals from inpatient feeding programme	• Clinical indicators of mortality, morbidity and recovery time

Integrated Programme Strategy 14: Establishment of a hospital/clinic demonstration garden with nutrition education

The establishment at a health facility of a demonstration garden where nutritious food crops are grown can be considered as a possible component of a facility-based nutrition education programme. Additionally, the produce from the garden can be used to support inpatient feeding or a home-based care programme for households affected by chronic illness.

What does this integrated programme strategy aim to achieve?

Demonstration gardens at health facilities present opportunities to educate families about how to grow productive and nutritious crops. Produce from demonstration gardens can be used to support an inpatient feeding programme, and to provide fresh foods to a home-based care programme. Refugees may need to adapt their cultivation patterns to local environmental conditions. Agricultural and nutrition staff can provide technical advice on cultivation and storage of specific crops, and guidance on how to prepare unfamiliar foods for people with illness.

How would this integrated programme strategy be implemented?

Institutional collaboration and coordination. This programme requires collaboration among health facility managers, agricultural staff and nutritional education staff for planning and management of the garden and nutrition education activities.

AAH demonstration garden that provides food to inpatients at Kala clinic, Zambia

E. Mathys Kirkcaldy

Emphasis on participatory and community-led approaches. Communities should be involved in establishing the garden, including identifying and preparing the site, and selecting crops to be grown (based on nutritional value, local suitability and cultural preferences).

Logistics of implementation. Once the site for the garden has been selected, materials (tools, seeds, inputs) must be obtained and allocated to those charged with maintaining the garden; supervision systems should also be established.

How would this integrated programme strategy be monitored?

Programme-level indicators		Population-level indicators	
Input/process	*Output*	*Outcome*	*Impact*
• No. of hospitals/clinics with demonstration gardens adequately established (and % of planned) • No. of staff adequately trained for demonstration gardens (per type) (and % of planned) • Amount of resources used (e.g., agricultural inputs, land) (and % of planned)	• % of targeted facilities conducting nutritional education through demonstration gardens (and % of planned) • % of facilities using produce from demonstration garden for inpatient feeding (and % of planned)	• % of population reporting adequate understanding of information provided through demonstration garden programme • Cultivation practices	• Clinical indicators of mortality, morbidity and recovery time

Experiences from the field…

Kala camp, Zambia. In Kala Camp, AAH established a UNHCR-supported demonstration garden at the Kala clinic (Photo 11). Produce from the garden, including fresh vegetables, is given to the inpatient feeding programme of the clinic.

Kyangwali Refugee Settlement, Uganda. In the Acholi-Pii section of Kyangwali settlement, agricultural staff of AAH are establishing a demonstration garden at the Rwenyewawa clinic. Land has been prepared and seedlings of micronutrient-rich fruit trees have been planted.

Integrated Programme Strategy 15: Integration of a supplementary ration and nutrition education into a home-based care programme

Home-based care (HBC) programmes for chronically ill refugees and their families often reach a population with a high prevalence of HIV. Blended foods (e.g., corn–soya blend) should be included where possible to provide a nutrient-dense, easy to prepare food, and cereals and grains should be milled and fortified prior to distribution wherever possible. Caretakers should be taught how to prepare the ration so that it is easy to consume, palatable and nutritious. The nutritional value of the supplementary ration is determined by whether it is intended to meet fully the nutritional needs of the patient (in which case it is affected by the age and sex of the patient), or to complement other sources as an additional dietary support.

What does this integrated programme strategy aim to achieve?

Through the outpatient home-based care programme, PLWHA and others who are chronically ill receive a regular food ration to ensure adequate nutritional intake and to increase their ability to benefit from certain medications. Households with chronically ill adults may be less able to purchase a diverse diet, because of reduced capacity to earn income or the increased health-related expenses in the household. According to WFP, key considerations when planning food rations for home based care programs include that the ration contains micronutrients, that it is energy dense, and if possible that it contains fresh fruits and vegetables. WFP often includes fortified blended foods or fortified cereals as part of a balanced food basket for such programmes.

By ensuring adequate nutritional intake, this integrated programme may reduce morbidity, extend life, enhance human dignity, and support the ability of PLWHA to care for their children. Patients in HBC programmes frequently include PLWHA, even where their HIV status is unknown (e.g., if they are enrolled because they have tuberculosis). These patients may therefore have increased nutritional requirements and require a nutrient-dense supplementary ration.

How would this integrated programme strategy be implemented?

Institutional collaboration and coordination. Health care staff involved in the HBC programme must collaborate with food and nutrition staff to acquire and distribute supplementary ration commodities. HBC staff should also work with community development staff to promote gardening and other food security interventions with participating families to diversify the diet.

Emphasis on participatory and community-led approaches. Care should be taken to ensure that the supplementary ration is diverse and palatable to programme participants. The ration should be easy to eat, since beneficiaries may suffer gastrointestinal complications that make eating difficult. HBC programmes in which participants visit the clinic to pick up the ration provide an opportunity to hold focus groups, where PLWHA can discuss issues that they face (e.g., discrimination, health needs, accessibility of food), identify solutions and establish action plans for advocacy and other projects. The Food and Nutrition Technical Assistance (FANTA)

Project has produced a valuable reference document summarizing the nutritional side-effects and food requirements of common antiretroviral and antimicrobial medications.[29]

Logistics of implementation. The whole family should be targeted when a dry ration is provided. If the SFP provides a "take-home" dry ration, then the activities must take place in the home when the ration is given, and health education may take place with the patient and/or the patient's family at the home.

How would this integrated programme strategy be monitored?

Programme-level indicators		Population-level indicators	
Input/process	*Output*	*Outcome*	*Impact*
• No. of HBC programme participants receiving rations (and % of planned) • No. of people trained to implement programme (and % of planned) • Amount of food distributed through health and treatment programmes (and % of planned)	• % of HBC participants receiving adequate supplementary ration and nutrition education (and % of planned)	• % of population eligible for programme actively participating in programme (and % of planned)	• Clinical indicators of mortality, morbidity and recovery time • Household food security status, income

Experiences from the field…

Kala Camp, Zambia. In Kala Camp, the SFP targets chronically ill individuals, particularly those on treatment for TB as well as those who have tested positive for HIV/AIDS. The supplementary ration currently includes only a blended food commodity called high energy protein supplement (HEPS) (at 5.8 kg per month per person). In the past, it has at times included sugar, milk and oil to improve nutrient density and palatability. Additionally, WVI provides other commodities (e.g., fresh vegetables) irregularly, from camp-based gardening projects.

Mwange Camp, Zambia. In Mwange Camp, the home-based care team conducts HIV/AIDS sensitization for chronically ill TB patients enrolled in the HBC programme. When the dry ration is brought to the patient's home by the HBC Team, the patient and other household members and caretakers are advised how to select and prepare foods to meet the nutritional needs of the ill person.

[29] Castleman T, Seumo-Fosso E, Cogill B. Food and nutrition implications of antiretroviral therapy in resource limited settings. Washington, DC: Food and Nutrition Technical Assistance Project, Academy for Educational Development, August 2003 (Technical Note No. 7).

Integrated Programme Strategy 16: Integration of a supplementary ration and nutrition education into an antiretroviral therapy programme

Refugee participants enrolled in an antiretroviral therapy (ART) programme may be poor and food-insecure, and unable to consume a nutritious diet, especially if they are not receiving a full ration. Refugees enrolled in a home-based care programme may already be receiving a supplementary ration (see integrated programme strategies 6 and 15). If they are not enrolled in a home-based care programme but are regularly taking ART, a supplementary ration combined with nutrition education may increase the effectiveness of the treatment.

What does this integrated programme strategy aim to achieve?

Provision of a supplementary ration to PLWHA taking antiretroviral therapy aims to increase the effectiveness of the treatment in suppressing the virus and promoting disease-free survival, by boosting the ill person's strength, nutritional status and overall health and immune function. In addition, a number of antiretroviral drugs must be taken with food. Common side-effects include nausea, vomiting, diarrhoea and appetite suppression. Antiwasting medications must be accompanied by increased energy intake. Inability to consume a proper diet while on ART can lead to painful side-effects, reduce the medications' efficacy, and promote drug resistance.

How would this integrated programme strategy be implemented?

Institutional collaboration and coordination. Health staff must collaborate with food distribution staff and government to develop protocols for supplementary feeding with ART. Options being considered by the international community include supplementary tablets, bulk commodities, prepared foods (e.g., biscuits or formula). Factors to consider in the decision include cost, likely adherence by participants and intrahousehold sharing.

Emphasis on participatory and community-led approaches. Refugee communities may have traditional beliefs about which foods an ill person should eat, and such beliefs may influence how nutritional supplements are perceived. Congolese refugees in Zambia and Uganda accurately identified foods rich in protein and micronutrients (e.g., eggs, fish, fresh fruits and vegetables) as those they give to friends and family who are ill. Nutritional support should identify and reinforce positive traditional practices about nutrition during illness.

Logistics of implementation. PLWHA taking ART should ideally be enrolled in a home-based care programme. Additional research is needed to determine the nutritional requirements associated with each antiretroviral drug regimen. Provision of supplementary rations to people on ART requires an extremely stable supply of food aid commodities, as any breaks could affect patients' health and may risk promoting drug resistance if adherence to the treatment protocol is disrupted. Although research is continuing to determine for how long supplementary food support may be necessary, many programmes currently being implemented are suggesting at least six months.

How would this integrated programme strategy be monitored?

Programme-level indicators		Population-level indicators	
Input/process	*Output*	*Outcome*	*Impact*
• No. of ART programme participants receiving rations (and % of planned) • No. of people trained to implement programme (and % of planned) • Amount of food distributed through health and treatment programmes (and % of planned)	• % of ART participants receiving adequate supplementary ration and nutrition education (and % of planned)	• % of population eligible for programme actively participating in programme (and % of planned)	• Clinical indicators of mortality, morbidity and recovery time • Household food security status, income • Incidence of side-effects • % of participants making a successful transition to ART

Experiences from the field…

Kala and Mwange Camps, Zambia. Antiretroviral drugs are not currently available in Kala or Mwange clinics, though they can be found at the referral hospital. The supplementary feeding programme run by AAH for the chronically ill in Kala Camp included only TB patients, as no one had yet "come out" to the programme staff as being HIV-positive. TB patients enrolled in the home-based care programme who experience weight loss receive 5.8 kg of High Energy Protein Supplement (HEPS, a corn–soya blend) per month as a take-home ration. HEPS has at times been accompanied by oil, sugar, and dry skimmed milk when these commodities were available. Participants admitted that the HEPS ration is sometimes shared with children in the family, particularly those who are malnourished or "hungry". TB patients also receive fruits and vegetables from a World Vision project, but the micronutrient content of this distribution varies by month, and the degree of sale of the ration is unknown.

4.3 Integrated programme strategies that use food and nutrition resources to support training and capacity-building activities for clinic-based and community-based care providers (strategies 17 and 18)

A comprehensive HIV/AIDS prevention programme requires the collaboration of many players: clinic-based health staff, traditional health care providers, staff of UN and cooperating partner (CP) agencies, and other community resource persons. Clinic-based staff must be trained to provide quality VCT and care. Traditional health care providers, such as traditional healers and traditional birth attendants, can play a vital role in HIV/AIDS prevention through consistent use of universal precautions in their practice as well as referral and care for people thought to be HIV-infected. UN and CP staff must be sensitized to report signs of abuse or exploitation of refugees. Finally, refugees who participate in HIV/AIDS prevention activities at the community level (e.g., drama, peer education) must be given the education and communication skills to do so effectively.

Everyone involved in HIV/AIDS prevention efforts may require training. As an added burden, HIV/AIDS undermines the foundation of skills and human capacity, affecting mainly the economically productive members of society. WFP recognizes the central role that food can play to "complement and scale up existing government, United Nations and NGO partner activities in prevention, mitigation and care for HIV-infected and -affected individuals and families."[30] WFP is committed to the use of food resources for training and capacity-building in support of HIV prevention programmes.

Food and related resources may be used to support training and other capacity-building activities in two main ways:

Strategy 17 *Support for training and other capacity-building activities for formal (clinic-based) and traditional (community-based) health care providers*

Strategy 18 *Support for training and other capacity-building activities for community resource persons who can play a vital role in HIV/AIDS prevention efforts*

Food may be provided on-site for training participants during short workshops. Longer-term training programmes, particularly for heads of households, may call for the provision of a household ration to enable the participant to take part. Decisions about how much food to give, and to whom, should take into account resource availability, household access to other sources of food, and local factors.

[30] Available online: http://www.wfp.org. Accessed July 2004.

Integrated Programme Strategy 17:
Support for training and other capacity-building activities for formal and traditional health care providers

Food and related resources can be considered a possible input to support training programmes for formal facility-based staff and traditional community health workers, to enable them to contribute effectively to HIV/AIDS prevention efforts. External food inputs should be phased out when community support is sustainable, and provisions should be sought from the outset to achieve such sustainability.

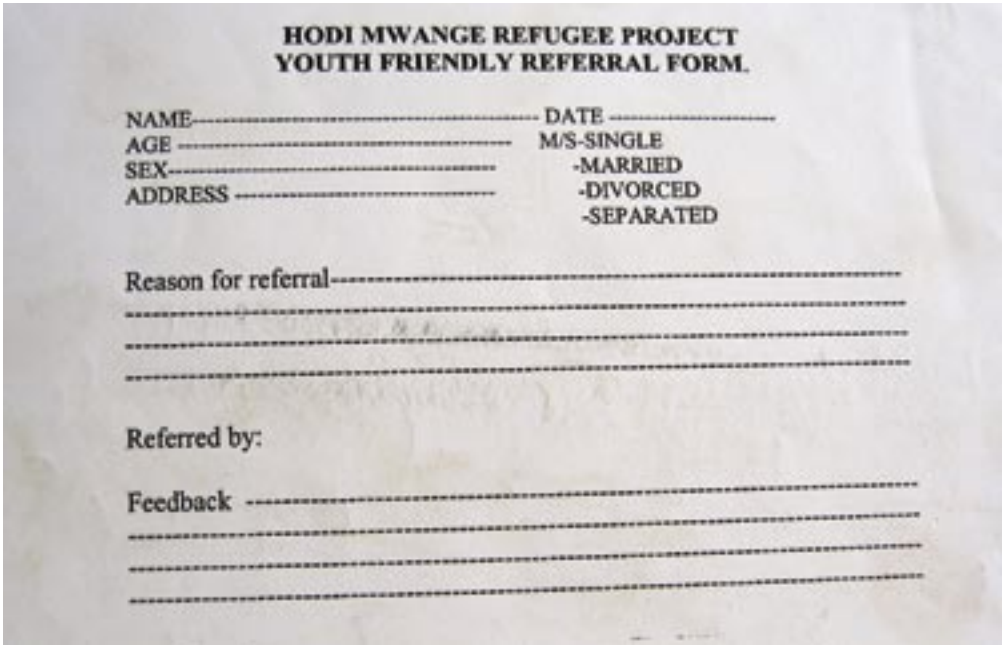
What does this integrated programme strategy aim to achieve?

Provision of food or related resources may enable and encourage health care providers to participate in training activities designed to provide the knowledge and skills they need to contribute effectively to HIV/AIDS prevention efforts. Refugee health facilities employ staff from the refugee and host communities with varying skill levels. Traditional health care providers will have varying degrees of HIV-related knowledge. Short workshops can provide training on specific issues, such as the use of gloves or the avoidance of high-risk cultural practices. Longer-term training programmes are a greater investment in developing the skills of selected key personnel.

How would this integrated programme strategy be implemented?

Institutional collaboration and coordination. Refugees typically use a combination of clinic-based and traditional health services. Partnership between facility-based staff and traditional care providers is essential to ensure that all care providers minimize the risk of HIV transmission in their own practice, and educate their clients on HIV prevention.

Referral form used by Red Cross health staff and traditional healers, Mwange Clinic, Zambia



HODI MWANGE REFUGEE PROJECT
YOUTH FRIENDLY REFERRAL FORM.

NAME---------- DATE ----------
AGE ---------- M/S-SINGLE
SEX---------- -MARRIED
ADDRESS ---------- -DIVORCED
-SEPARATED

Reason for referral----------

Referred by:

Feedback ----------

E. Mathys Kirkcaldy

Emphasis on participatory and community-led approaches. The cultural beliefs and practices of refugees may affect how they perceive issues such as HIV testing, condom use and care for HIV-infected patients. Collaboration among clinic-based and traditional health care providers requires mutual respect. Each must recognize the other's areas of expertise and potential contributions to community health.

Logistics of implementation. Facility-based and traditional health care providers should meet, possibly under the umbrella of an HIV/AIDS committee, to identify the relative strengths and weaknesses of the two types of service in HIV/AIDS diagnosis, treatment and long-term management. Together they should identify areas in which additional training and capacity-building are needed, and draw up a training action plan. A formal referral system may be established to ensure that patients receive appropriate care in a timely manner, drawing on the strengths of both types of service.

How would this integrated programme strategy be monitored?

Programme-level indicators		Population-level indicators	
Input/process	*Output*	*Outcome*	*Impact*
• No. of formal and traditional health care providers receiving HIV/AIDS and nutrition training (by type of caregiver) (and % of planned) • No. of training sessions conducted (and % of planned) • Amount of materials distributed (and % of planned)	• % of targeted formal and traditional health care providers adequately trained in HIV/AIDS and nutrition (by type of caregiver) (and % of planned)	• Reduction in high-risk practices by care providers (by type of practice) • Referral practices among providers • Caretaking practices for PLWHA within the home	• HIV prevalence • Crude mortality rate (with age-related distribution if possible)

Experiences from the field…

Kala and Mwange Camps, Zambia. The NGOs, Aktion Afrika Hilfe (AAH) and the Red Cross (ZRCS/ IFRC), took dramatically different approaches to working with traditional healers in Kala and Mwange Camps, respectively. Both are the types of health care provider training programmes that could be supported by use of food resources where appropriate.

In Kala, AAH participated in the Kala HIV/AIDS Task Force (chaired by the Zambian NGO, HODI), and successfully distributed large numbers of condoms at the health clinic. AAH also conducted training sessions for traditional healers on the risk of HIV transmission associated with traditional health practices, such as cutting and scarification. When interviewed, however, some of the traditional healers felt that their health care skills were not recognized by AAH, and that their relationship with AAH was competitive or non-cooperative rather than collaborative. As a result, some traditional healers were unwilling to refer clients to Kala Clinic, and were treating suspected HIV/AIDS cases with traditional treatments, involving in some cases several months of vomiting, diarrhoea and spiritual cleansing.

In sharp contrast, the Red Cross in Mwange Camp developed a highly collaborative and respectful relationship with traditional healers, with assistance from the Zambian NGO, HODI. A formal referral system was established between them, based on a shared understanding of the role that traditional and facility-based health care providers could play in supporting the health of PLWHA (Photo 12). Traditional healers were provided with a clinic office on the grounds of Mwange Health Clinic. Traditional healers also played an active role in the Mwange HIV/AIDS Committee. All parties felt that questions remained regarding the best way to treat specific health conditions faced by PLWHA (particularly given the lack of scientific research on the efficacy of traditional treatments), but nevertheless a constructive environment had been established among all caretakers, and clients were frequently referred in an effort to provide the best services possible. Similarly, traditional birth attendants received training on HIV prevention in their MCH practices, and were enthusiastic to become more involved in the camp-wide HIV prevention programme (Photo 13).

Traditional birth attendants developing an action plan for integrating HIV/AIDS prevention into their work, Mwange Camp, Zambia

E. Mathys Kirkcaldy

Integrated Programme Strategy 18:
Support for training and other capacity-building activities for community resource persons who can play a vital role in HIV/AIDS prevention efforts

HIV/AIDS prevention programmes must ultimately derive their support and momentum from the refugee communities themselves, who may bring numerous skills to AIDS prevention efforts. Food and related resources can be considered to support workshops and training for these people, to more effectively engage them in the effort.

What does this integrated programme strategy aim to achieve?

Food and related resources can be used to support workshops and training for community groups including religious leaders, traditional healers and birth attendants, youth and artists. Religious leaders can encourage abstinence and monogamy and, if they are willing, condom use; traditional healers can discourage or modify high-risk traditional practices; traditional birth attendants can educate pregnant women and their partners on mother-to-child transmission of HIV; young people can provide peer counselling; and those with creative talents can conduct drama, music and dance events to engage communities in dialogue about HIV/AIDS.

How would this integrated programme strategy be implemented?

Institutional collaboration and coordination. Food programme staff should collaborate with members of the HIV/AIDS committee and community leaders to identify key resource persons to be trained. Food programme staff can coordinate the provision of food.

Demonstration of proper condom use techniques by AAH community counselling aides, Kyangwali Settlement, Uganda

E. Mathys Kirkcaldy

Emphasis on participatory and community-led approaches. Workshops should be community-led and conducted in partnership, so that methods and messages are culturally appropriate. All activities should be participatory where possible.

Logistics of implementation. Food and other materials (e.g., training materials) must be procured for the training activities. In resource-poor or displaced settings, food may well be delivered as part of an assistance package including non-food items, particularly where participants in the programme are less able to benefit from other assistance programmes (because of time commitments, etc.).

How would this integrated programme strategy be monitored?

Programme-level indicators		Population-level indicators	
Input/process	*Output*	*Outcome*	*Impact*
• No. of community resource persons receiving HIV/AIDS and nutrition training (by type) (and % of planned) • No. of training sessions conducted (and % of planned) • Amount of materials distributed (and % of planned)	• % of targeted formal and traditional health care providers adequately trained in HIV/AIDS and nutrition (by type of caregiver) (and % of planned)	• % of people aged 15-24 who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission • Reduction in high-risk practices in population	• HIV prevalence

Experiences from the field…

Kyangwali Settlement, Uganda. In 2003, AAH supported the formation of a team of community counselling aides (CCAs) (Photo 14). Community volunteers such as CCAs are sometimes given incentives, which can include food resources. The enthusiastic CCAs work within the camp-wide HIV prevention and health outreach programme. They are trained to provide community members with accurate information on the use and disposal of condoms. The CCAs include both men and women, from both Congolese and Sudanese camp communities, to ease communication. Women's involvement in the group also serves to overcome cultural barriers regarding the engagement of women in explicit public discussions of sexuality.

4.4 Integrated programme strategies that use food and nutrition resources to support the establishment or continuation of community-level HIV/AIDS-related activities (strategies 19 and 20)

In stable communities, community health resource persons (such as traditional healers and TBAs) are rewarded with cash, labour or commodities for their services. These service providers can make a sustainable living because the community believes in the value of the services and is able to pay for them. The situation in refugee communities may differ in several ways. First, when refugees are struggling to meet their basic needs and establish livelihoods, they may not be able to afford to pay for health services. Community health service providers are often

expected to provide their services for free until the situation stabilizes, which can be difficult when they too are struggling to feed their families. Second, provision of health-related services may be hampered by the provider's need to devote time to activities that earn food or income. Third, the need for volunteers to address HIV/AIDS in refugee communities is new, and many such communities do not have people doing HIV/AIDS-related work. Agencies must build the capacity of community groups – often young people – to conduct AIDS prevention activities, and may need to provide temporary incentives to these people until the community itself understands the importance of the activity and is able and willing to support it financially.

Food and related resources may be used as an incentive to support HIV/AIDS prevention efforts in two main ways:

Strategy 19 *Support to community health volunteers engaged in HIV/AIDS prevention activities or in caring for PLWHA and HIV/AIDS-affected families*

Strategy 20 *Support to community awareness and mobilization activities of PLWHA by providing food for events*

The exact form that the incentive should take depends on the local context. The incentive selected should be valuable to the individuals being rewarded. Where access to food is limited, health volunteers may be happy to receive food. However, where access to food is adequate, because a full ration is distributed to the entire population, or because economic activities are well established, other incentives may be preferable. These could include eligibility for income-generating projects, agricultural projects, microcredit projects, community banking and animal rotation schemes. Groups to target include community volunteers and PLWHA engaged in HIV/AIDS prevention. Where resources allow, it is also possible to provide food to all participants in HIV/AIDS prevention activities as a way to promote community participation. Food should not be perceived as an alternative to cash payment of health workers where appropriate budgets exist.

Provision of incentives is a short-term intervention designed to allow vital health care to be delivered in the community. Just as incentives reward and motivate health volunteers engaged in HIV/AIDS prevention (e.g., peer educators, condom distributors), they can acknowledge the valuable efforts of community health volunteers who provide health, nutritional or psychosocial support to PLWHA. In all cases, developmental activities are preferable to short-term humanitarian assistance, and external incentives should be phased out with the establishment of community support mechanisms.

Agency staff should work with participants to identify appropriate incentives, being mindful not to undermine long-term commitment to the work, and to consider livelihood-based incentives where possible and appropriate.

Integrated Programme Strategy 19: Support to community health volunteers engaged in HIV/AIDS prevention activities or caring for PLWHA and HIV/AIDS-affected families

Food and related resources can be considered a possible incentive to motivate, support and reward community health volunteers engaged in HIV/AIDS prevention activities or in caring for PLWHA. Volunteers may include community health workers, community social workers, peer educators, drama groups, growth monitoring promoters, women's groups, TBAs, home-based care teams, and anti-AIDS and post-test club members. External incentives should be phased out when sustainable community support becomes feasible, and provisions should be sought from the outset to achieve such sustainability.

What does this integrated programme strategy aim to achieve?

Provision of incentives to community volunteers engaged in HIV/AIDS prevention acknowledges, supports, rewards and motivates skilled volunteers for their often time-intensive efforts (Photos 15 and 16). Health volunteers often cite the lack of incentives as a reason for low or declining numbers of volunteers, particularly in resource-poor settings where the pressure to earn food or income is considerable. Although activities should ideally be initiated and conducted on a voluntary basis for as long as possible, the provision of incentives often allows community-based HIV prevention activities to continue.

Provision of incentives to community volunteers engaged in caring for PLWHA and AIDS-affected families acknowledges, supports, rewards and motivates skilled volunteers for their often time-intensive efforts. With conflict and displacement, refugee communities can suffer from social fragmentation and psychosocial trauma that can interfere with traditional caretaking dynamics. Additionally, the heavy caretaking burden caused by AIDS puts considerable strain on affected families, making it more important to support caretaking systems in the community until the situation stabilizes. Community health volunteers can contribute enormously to empowering AIDS-affected families with skills to maintain the health and prolong the life of their sick member.

How would this integrated programme strategy be implemented?

Institutional collaboration and coordination. Health programme staff and social services programme staff typically identify, train and supervise community health volunteers. If food aid commodities are given to the volunteers as an incentive, food aid programme staff should collaborate with health programme staff to monitor the volunteers' activities and manage the provision of food. If volunteers are rewarded with participation in community development initiatives rather than food (e.g., income-generating activities), the community development or social services staff managing those programmes should collaborate with health staff in the same way.

Volunteers involved in providing health care and health/nutrition education to PLWHA – particularly community health workers and home-based care team members – will typically be supervised by government health staff or by the agency implementing the health programme. Volunteers involved in providing psychosocial support to PLWHA – such as community social

workers and community counsellors – may be integrated into a health programme or a community social services programme. The agencies overseeing these services must work closely with food programme staff to identify and arrange for appropriate incentives.

Emphasis on participatory and community-led approaches. Provision of incentives to volunteers may compromise participation in the programme after incentives are phased out. Ideally, volunteers should be supported by the community for their work. Similarly, care must be taken that using food aid as an incentive for selected volunteer groups does not undermine the motivation of volunteers in other, non-assisted programmes. Local support should be cultivated and relied on wherever possible, to enhance the sustainability of the volunteers' activities.

Community leadership in the support of care-giving structures for PLWHA is key in preventing stigmatization of PLWHA and their families. Community health volunteers providing care and health education to PLWHA should be trained to provide families with information on prevention and management of opportunistic infections (and on ART if available), hygiene, diet and mental health. They should transmit practical skills using locally available resources, making use of health-promoting traditional practices and sensitively addressing traditional practices that increase the risk of malnutrition, illness or HIV transmission.

Logistics of implementation. To be effective as a motivation tool, the incentive should be valued by the recipients. Food is likely to be less desirable where food needs are completely met by a general food ration, or where the refugees are self-reliant in food production. Provision of incentives to HIV/AIDS prevention volunteers does not necessarily need to be continuous. One-off (or periodic) gifts of food or non-food items may adequately acknowledge the considerable efforts and commitment of the volunteers, and motivate them to continue, particularly if this understanding is shared from the outset. Health care volunteers should be involved in the

Volunteer-based HIV/AIDS peer education and drama group conducting a drama on the health effects of HIV/AIDS, Mwange Camp, Zambia

E. Mathys Kirkcaldy

monitoring and assistance of affected families, facilitating their access to the support services that they need.

How would this integrated programme strategy be monitored?

Programme-level indicators		Population-level indicators	
Input/process	*Output*	*Outcome*	*Impact*
• No. of community resource persons receiving HIV/AIDS and nutrition training (by type) (and % of planned) • No. of training sessions conducted (and % of planned) • Amount of materials distributed (and % of planned)	• % of targeted formal and traditional health care providers adequately trained in HIV/AIDS and nutrition (by type of caregiver) (and % of planned)	• % of people aged 15-24 who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission • % of people aged 15-24 reporting the use of a condom during sexual intercourse with a non-regular sexual partner • Reduction in high-risk practices in population • Caretaking practices for PLWHA within the home	• HIV prevalence • AIDS-associated morbidity and mortality

Experiences from the field…

Mwange Camp, Zambia. Peer educators and growth monitoring promoters are highly active, but their numbers have dropped sharply in recent years, reportedly because of the low rewards relative to the tremendous time requirements of the activities. Drama, music and condom distribution undertaken by volunteer peer educators, for example, add up to more than a full-time job. Community members consult them during the day and evening, seven days per week, often visiting their homes at night to obtain condoms confidentially. HIV/AIDS drama participants in Zambia expressed a desire for items that identify them as part of the group and provide social status, such as t-shirts, caps and pins. Food resources were considered as a possible incentive, but in the presence of an adequate general ration, were not an appropriate incentive.

Drama group volunteer explaining modes of HIV transmission to women, Kyangwali Settlement, Rwenyewawa area, Uganda

E. Matthys Kirkcaldy

Integrated Programme Strategy 20: Support to community awareness and mobilization activities of PLWHA

Food and related resources are a possible incentive for PLWHA to participate in HIV/AIDS prevention activities, such as talking about their experiences or providing HIV/AIDS education. The active involvement of PLWHA in HIV/AIDS prevention events can increase their impact, as well as promoting optimism and a sense of purpose for the PLWHA involved. The food provided not only improves the strength and nutritional status of the infected person, but also affirms the value of his or her contribution. If food is not an appropriate input in the local context, non-food items may be used. Food and related resources can be considered a possible incentive to encourage community participation in cultural and educational events related to HIV/AIDS prevention.

What does this integrated programme strategy aim to achieve?

Active involvement of PLWHA in HIV/AIDS prevention programmes can raise awareness of the disease, decrease stigma and discrimination against PLWHA, counter myths about the disease, and empower PLWHA to live positively without hiding their HIV status. In many refugee settings, AIDS is believed to exist in the host community but not among the refugees, because of a lack of previous exposure or education among the refugees. Testimonies by local PLWHA can be a powerful force for raising HIV/AIDS awareness.

Provision of food at an HIV/AIDS prevention-related event may dramatically increase public participation in the event, and thereby promote community engagement and dialogue about HIV/AIDS. In most refugee settings, resource constraints do not allow food to be

MAHA group in Moyo, Uganda

E. Mathys Kirkcaldy

provided to all participants in every AIDS-related activity. One-off allocations of limited food resources can be used to support high-profile events such as World Refugee Day and World AIDS Day, or other events of high priority in the AIDS awareness effort. Provision of food to all participants at the event should increase attendance. Provision of food to contributors to the event (e.g., preparing a meal for speakers or performers) requires few commodities, builds rapport and acknowledges the value of their contribution.

How would this integrated programme strategy be implemented?

Institutional collaboration and coordination. PLWHA are often identified through confidential clinic-based VCT services. Some PLWHA may decide to contribute to public HIV/AIDS prevention efforts. Staff running the HIV/AIDS events (e.g., health staff) may contact food distribution staff to arrange for food to be provided to PLWHA on the day of the event. Health staff should also work with mental health staff (e.g., counsellors) to provide emotional support to PLWHA where desired. Food distribution staff should collaborate with individuals running the events to ensure that the food component runs smoothly and safely. If community groups contribute food (or other resources) to the event, they should take part in the planning process.

Emphasis on participatory and community-led approaches. For many refugees, facing the stigma of HIV/AIDS by living "openly" with the disease requires tremendous courage. Equally, discussing one's experiences with the disease in a public forum requires strength and support. Community-based groups formed by PLWHA can provide vital social, emotional, spiritual and material support to members, who can also draw upon their shared experience to develop testimonies and educational activities.

Local support should be encouraged wherever possible to enhance sustainability. Where refugees produce food locally they may contribute food to the event as a symbol of their commitment. Food provision should not undermine pre-existing incentives to attend, such as the innate desire to learn about HIV/AIDS. It is important to avoid creating the expectation that food will always be provided at community events. Food provision to selected programmes should not create tensions with other groups conducting events without incentives.

Logistics of implementation. Health staff can work with PLWHA and food distribution staff to decide which foods to use, the method of preparation and when to provide them. Food should generally be provided before or after, rather than during, the event to avoid disrupting the event itself. Planning should consider the need for serving materials and waste management.

Experiences from the field…

Hoima and Kyangwali Refugee Settlement, Uganda. Established in 1991, the Ugandan CBO, Meeting Point, grew to include 750 members living with HIV/AIDS by 2003. Meeting Point provides a range of AIDS-related services to the community: dance and drama events to sensitize people about HIV/AIDS and address stigma, condom distribution, distribution of food to PLWHA (with WFP support), HIV/AIDS counselling (with Irish NGO GOAL support), support to orphans, income-generating and agricultural activities for affected families, and home-based care. Meeting Point sensitization teams have visited nearby Kyangwali Refugee Settlement to talk about their experiences and meet HIV-infected refugees who were not yet living "openly" with their infection, because of stigma and inadequate access to medical treat-

ment. The group Madi AIDS Heroes Association (MAHA) in Uganda (Photo 17), serves similar functions for its members and for the community.

Mwange Camp, Zambia. The Zambian NGO, HODI, reported dramatic increases in event participation when lunch was provided during the day-long sessions. Voluntary participation in HIV/AIDS awareness events among men and women over 25 years of age (e.g. in dramas and peer educator-led discussions) was substantially lower than among those 25 years of age or younger. HODI suggested that the use of meals as an incentive would significantly increase participation by economically active adults (over 25 years) in such events, a valuable benefit obtained from relatively small food allocations.

How would this integrated programme strategy be monitored?

Programme-level indicators		Population-level indicators	
Input/process	*Output*	*Outcome*	*Impact*
• Total amount of resources allocated per group (and % of planned) • Total amount of resources allocated for community education and mobilization events (and % of planned)	• No. of people participating in groups formed by PLWHA (and % of planned) • % of identified groups receiving support (and % of planned) • No. of community education and mobilization activities conducted by PLWHA-based groups (and % of planned) • No. of people participating in programme-supported community education and mobilization events (and % of planned) • Total number of events supported (and % of planned)	• % of HIV/AIDS-affected households in population actively participating in programme • % of people aged 15-24 who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission • Reduction in high-risk practices in population	• HIV prevalence