School Feeding in Zambia

PMTCT in Rural Malawi

Targeting Food in Western Kenya

Participatory Approach in Uganda

Special focus on Food Aid and HIV/AIDS

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Acronyms

APPLE Aids Prevention and Positive Living Programme
ART Anti-retro viral therapy
ARV Anti-retro viral
CCA Community Counselling Aide
CBO Community based organisation
CHBC Community Home Based Care
CHS Community Household Surveillance
CHW Community Health Worker
CI Chronically Ill
CMC Community Management Committees
C-Safe Consortium for the Southern Africa Food Emergency
CST Coping Strategy Index
CTC Community Therapeutic Care
DOT Directly Observed Therapy
EMOP EMOP Emergency Operation
FPW Food for work
HBC Home based care
HEA Household Economy Approach
HH Household
HIV/AIDS Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
IGAs Income generating activities
INGOs International NGOs
IP Implementing partners
JETFAP Joint Emergency Food Aid Programme
MT Metric tonne
NAC National Aids Commission
NGOs Non-governmental organisations
NGOs National NGOs
NRUs Nutrition Rehabilitation Units
OI Opportunistic infections
OTP Outpatient Therapeutic Programme
OVC Orphans and Vulnerable Children
PLWHA Persons living with HIV/AIDS
PMTCT Prevention of Mother-to-Child Transmission
PRRO Protracted Relief and Recovery Operation
RSA Rapid Situation Assessment
SC Stabilisation Centre
SF Supplementary Feeding
SFP Supplementary Feeding Programme
SLA Sustainable Livelihoods Approach
TA Tribal area
TA Traditional authority
VCT Voluntary Counselling and Testing
UN United Nations
VAC Vulnerability Assessment Committee
VDC Village Development Committee
VAC Village Action Committee
VRC Village Relief Committee

From the Editor

This special issue of Field Exchange focuses on the food aid component of HIV related programming and was made possible through additional funding from DFID RSA. How the ENN have gathered field material for this issue marks a significant departure from our usual approach, in that a consultant (Mary Corbett) was taken on as a kind of roving researcher/ correspondent. Mary visited five countries over the course of six weeks (Malawi, Zambia, Kenya and Uganda and South Africa) to meet with a wide variety of agency staff implementing HIV programming with a food aid component. Her brief was to describe these programmes and, where possible, identify lessons learnt. She was also asked to identify significant related research initiatives or findings in the countries visited. An account of the experience is captured in her editorial (page 17).

The rationale for this special issue was primarily that HIV-related programming involving food aid has been increasingly rolled out over the past few years, with a view to achieving a variety of objectives. Since much of this programming is ‘cutting edge’, many of the objectives have not been properly tested. Hence agencies are, effectively, learning by doing. The ENN (along with others) believes it important to document these new programming experiences to support a process of learning. Although the production of this special issue, based on 18 programme experiences, cannot be described as a comprehensive overview, it is, at least, a snap-shot of what is going on. The ENN believe that some of the lessons and cross-cutting issues to emerge from this special issue are important and indicate priorities and strategies for the future.

The agency field experiences documented are based on programmes implemented by a wide spectrum of agency types, i.e. UN, INGO, local NGO and CBO. Some of the CBOs literally started out as spontaneous community initiatives, led by a few dynamic individuals affected directly or indirectly by HIV. Over time, these organisations have professionalised, expanded, and achieved a significant profile and status with international agencies who now collaborate with them, and often provide resource support. The food aid and nutritional compo-
There are a number of key findings from this snapshot of agency programming:

**Objectives and evidence of impact**

Multiple objectives for the food aid element of programming are invoked. For example, the 18 month food aid package as part of the PPTCT programme at St. Gabriels Hospital in Malawi (by Gertrude Kasa and Mary Corbett) is meant to encourage compliance and ongoing educational support, support abrupt weaning, ensure full infant immunisation, ensure VCT for infants on reaching 18 months and provide an opportunity to target IGA. The community school feeding programme in Zambia (by Kate Vorley and Mary Corbett) is aimed at improving enrolment and strengthening longer term food security. Generally, there has been insufficient attention given to impact assessment methodology for emergency related programming. Apart from the methodological challenges, there are also difficult ethical considerations in impact assessment. Given the large numbers of individuals affected by HIV, nutritional support in the context of HIV programming, there is an urgent need to strengthen the ability of implementing agencies (especially CBOs and local NGOs) to undertake impact assessment.

Anecdotally, IP staff and beneficiaries indicate enormous value of food aid as a component of the many types of HIV related programming. The interest and attention is focused on specific objectives, e.g. weight gain, improved well-being, decreased mortality, improved programme compliance, long-term food security, well-functioning ARV/dote/OPAT clinics. It is hard to disbelieve these findings, especially when one considers that much of the targeting is to the poorest of the poor (see section on targeting). However, rather than rely on anecdotal reports of programme benefits in order to strengthen understanding of how programmes are working (what is the process underpinning impact) so that programme design can be strengthened, and so as to increase belief in this type of programing - particularly in an environment where donors are increasingly sceptical of the benefits of food aid/HIV programming.

**Targeting criteria, stigma and resources**

A great deal of food aid targeting within HIV programming currently takes place on the basis of proxy indicators, i.e. chronic illness, orphan containing households, single parent/widow headed households, elderly-headed households, child headed households (with less than 18 years old children) and households with deceased HBC clients. These categories have been employed partly to address issues of stigma which is still a major problem – particularly in Africa. However, there are also difficult ethical considerations around the use of proxy indicators. For example, what is the inclusion error if the purpose is to target those with HIV? Do such indicators really address issues of stigma (people aren’t stupid and quickly realise that chronic illness probably means advanced stages of AIDS). Furthermore, and perhaps more significantly, many argue that HIV/AIDS cuts across all income classes so that targeting the chronically ill or orphan containing families is not the best use of targeting resources. Although this is somewhat contradicted by the CRS Dedza research in Malawi (see page 7), it is supported by other studies, e.g. Seaman/Petty (Field Exchange 23/SIAT/Watkins (WFP /REEP, this issue). In a pilot programme in Malawi (Fisher and Munk), ACF employed a food requirement/density ratio indicator, which the authors argued is more equitable than focusing on CI or OVC. Another difficulty with the proxy indicator approach has been that, in the face of limited food aid resources, many programmes have had to make tough choices on the number of CI or orphan containing households at village level has exceeded food supply, e.g. this has created tensions and conflict for village committees charged with targeting responsibilities and implementing agencies. Furthermore, scales down food aid programming during the hunger gap period. Some agencies, recognising the inequity of targeting on the basis of proxies for HIV – especially in extremely food insecure and chronically poor areas - have used a two tier system, i.e. classification according to level of vulnerability adjusted for individual status. Relying on the community is, clearly, key for economic or food security based targeting. Generally, in the programmes reported here, the community does target the poorest of the poor.

Targeting food aid to PPTCT/ARV/DOT programmes is, undoubtedly, an efficient means of providing nutritional support to the HIV infected. However, although consensus regarding the differential nutritional requirements and rationing for those infected with HIV has not been reached, there is some agreement on the need for differentials based on patient status - particularly in Africa. For example, it is believed that a 10% increase in energy intake is required to maintain nutritional status and avoid weight loss of asymptomatic individuals living with HIV, while those with AIDS related illnesses require a minimum of 20% increase in energy intake. Further research is needed on optimal protein requirements during the course of HIV disease, which may be...
increased due to nitrogen loss associated with opportunistic infections (for the moment, current guidelines (WHO, FANTA) advise at least the meet protein intake required of a balanced diet). Agencies like WFP need to monitor emerging consensus and expert opinion on this and adjust rations accordingly. At the same time, implementing ration differentials will be extremely challenging from a logistical perspective.

Finally, despite the concerns that targeting PLWHA will cause problems of stigmatisation, the evidence does seem to show that CBOs and NGOs that invest in community sensitisation manage to reduce stigma. Agencies like REEP appear to have done an extraordinary job in building self-esteem of those infected and enabling them to speak freely about their status. The increase in numbers of those coming to be HIV tested in REEP programme areas is testimony to this.

Exit criteria

Providing of food aid within the context of HIV programming brings with it the enormously challenging issue of when to stop giving out food. Many of the programmes described have not invoked exit criteria, (e.g. REEP and Shoham J) and some beneficiaries have been food aid recipients for almost three years, e.g. Reach Out. Although there has been much discussion in the literature, and within implementing agencies, about exit criteria and discharging recipients on achieving a level of food security, the reality is that there are no simple tools to assess when that has been achieved. The only food security assessment tools widely employed are HEA and, more recently, CSI. Although HEA appears a promising tool in food security impact assessment, the approach requires extensive field based training and cannot be rolled out rapidly and on a large scale, especially if the status of individual households is to be assessed. Furthermore, as many beneficiaries are extremely poor (indeed they are targeted on the basis), the time-scale for achieving a level of food security may be entirely unrealisable and certainly, as yet, untested. There are also challenges about nutrition al entry and exit criteria for this type of programming. Thus, in Malawi, MSF have been feeling their way with BMI cut-offs for ARV/nutritional support and have adjusted these on the basis of experience during the programme. However, MSF readily acknowledge that newly planned programmes for 7-14 year olds on ARV will raise fresh challenges in terms of identifying appropriate anthropometric-based entry and exit criteria. We still lack experience of adult feeding programmes targeted at HIV infected individuals, especially with regard to length of time it takes for improvement, proportion expected to improve, optimal rate of improvement. This is even true for malarious HIV positive children. Work by ACF in Malawi shows that not only were 30% of children admitted to NRUs HIV positive, but their outcome was poor, with almost half discharged failing to respond.

Integrated programming

Providing of food aid on its own to PLWHA is unlikely to have a marked impact on nutrition, morbidity, survival, food security, and general quality of life. Although this is understood by most agencies, there are still a large number of food aid and nutritionally focused HIV programmes where integrated programming is proving very difficult, (see Shoham J, CRS Malawi, Oxfam Malawi, MSF Luxembourg) Research summarised in this issue (CTC/VALID) shows the needs of PLWHA and HIV affected households were found to cover ten different categories. These categories were ranked by participants under two groups, primary (nutritional, material, medical, economic, psycho-social, spiritual and patient care) and secondary (food security, knowledge on prevention and vocational skills). The ranking of needs reflected a prioritisation of immediate over long-term needs. More experienced and better resourced agencies like Oxfam have successfully established linkages with other programmes, e.g. IGA, but have still found it hard to strengthen linkages between HBC and health infrastructure. More medically focused agencies like UNICEF and WHO through health care infrastructure, have struggled to integrate longer-term food security initiatives. What is clear is that fully integrated programming, whereby the multi-sectoral needs of PLWHA are addressed in a coordinated fashion, is something that can be established easily.

While scepticism still abounds regarding the role of food aid in HIV programming, there is a need for well conceived and implemented pilot studies/programmes of multi-sectoral programming which can demonstrate how effective food aid can be within an integrated package. These experiences should next allow for analysis of how to effect integration and in which contexts good integrated programming can take place. Guidance material for implementing agencies should then follow. It may be that some form of mapping can subsequently take place at country level, to determine where integrated programming is feasible and to target resources (including food aid) on this basis. The need to rationalise food aid and nutritional support programming is evident where there can be a significant and sustainable impact (i.e. where a level of integrated programming can be assured) is key, given the logistical challenges posed by the upsurge of this type of programming in sub-Saharan Africa. The fact that this type of programming is so decentralised i.e. implemented through small CBOs, schools, health centres, means that costs per tonnage of food delivered is relatively high compared to more traditional types of food aid programming, e.g. general rations or supplementary feeding. Economies of scale no longer apply. Therefore, targeting food aid and nutritional support resources to locations where there is most likely to be an impact (where programming is integrated) will reduce inefficient logistics. It is also likely to have a greater influence in convincing donors that this type of programming is worthwhile.

This special issue also carries a large number of research summaries (published and grey literature) on topics related to food aid, nutrition and HIV programming. Subjects range from the impact of food aid on survival in HIV/AIDS affected adults, to the role of community based technology to combat the impact of HIV/AIDS on food security and livelihoods. Other subjects include the impact of food aid on survival and nutritional status in Bangwe, Malawi and the prevalence of HIV in children admitted to NRUs in Malawi comparing their recovery performance to HIV negative children.

The range of research is a stark reminder of how much we don’t know, as well as how many people/institutions are doing research out there. A lot of this research may not make the published literature. Indeed, the recent IFPRI conference in Durban (11th-13th of April) received an enormous number of abstracts of ongoing research. Clearly, many of those who submitted these abstracts will need support and funding to ensure that correct research protocols are followed and that findings can be written up and disseminated.

Conclusion

There is an argument that “while there is little empirical evidence regarding the effec-
WFP Recipients’ Weight Gain at Reach Out Clinic

By Antonia Torreblanca and Eileen Kim

This report outlines the weight progress of clients attending the Reach Out clinic of Mbwaya parish clinic in 2002, who were receiving WFP food (see field article p28).

Both Antonia Torreblanca (MD, MPH) and Eileen Kim (MD) worked as physicians at the Reach Out Clinic, Kampala, Uganda in November 2003. They are currently working as attending physicians at the Kaiser Permente Medical Centre, California, USA.

In October 2002, the medical records of 100 clients who were registered to receive World Food Programme (WFP) food through the Reach Out Clinic-Mbwaya Parish HIV/AIDS Initiative were reviewed. The programme was based in Kampala, Uganda.

The food disbursed was based on a family size of 5, and was intended to comprise 50% of the food needs of the family. It consisted of maize meal (25 kg every 24 days), beans (25 kg every 45 days), corn-soya blend flour with micronutrient fortification (25 kg every 3 months), and cooking oil (4 L every 2 months).

Table 1 outlines the baseline characteristics of clients enrolled in the WFP-Reach Out programme. Of the 100 clients that began receiving food in October 2002, 85 were alive at 1 year. Of those 85 clients, 35 (41%) had HIV, 49 (58%) had HIV and TB, and one person (1%) had TB alone.

Table 2 reflects the trends in their weight prior to receiving food, and at 3 months, 6 months, and 12 months after joining the programme. During the four months prior to receiving WFP food, clients’ weights remained stable (average change of +0.25 kg, P=0.47). At 6 and 12 months, patients had statistically significant weight gains (+2.3 kg, P<0.001 and +2.4 kg, P=0.001 respectively). Although all groups demonstrated weight gain, the most marked gains were in the clients with both HIV and TB (see figure 1).

Conclusions

Although average weight gains were modest, at 6 and 12 months nearly 50% of clients had significant weight gains of 3 or more kilograms (6.6 lbs). Weight gain in the ‘HIV alone’ group peaked at 6 months and then began to decline. This may be secondary to the progression of their HIV infection. This study demonstrates a positive outcome from WFP food disbursements and proves the provision of food to patients with HIV and/or tuberculosis in impoverished nations should be supported.

For further information, contact: Antonia Torreblanca and Eileen Kim, The Permanente Medical Group, 220 West MacArthur Blvd, Oakland, CA 94611, USA. email: and Eileen Kim, email: antonia.torreblanca@kp.org and eileen.kim@kp.org

<table>
<thead>
<tr>
<th>Table 1</th>
<th>Baseline characteristics of clients enrolled in the WFP-Reach Out programme</th>
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<tbody>
<tr>
<td>A. Characteristics of the 85 clients alive at 12 months</td>
<td></td>
</tr>
<tr>
<td>Characteristics</td>
<td>HIV/TB N=80</td>
</tr>
<tr>
<td>Mean age, yr (SD)</td>
<td>36 (+9.6)</td>
</tr>
<tr>
<td>Female, no. (%)</td>
<td>38 (79%)</td>
</tr>
<tr>
<td>Mean wt, kg (SD)</td>
<td>54 (+9.7)</td>
</tr>
<tr>
<td>Started on HAART</td>
<td>11 (23%)</td>
</tr>
<tr>
<td>B. Characteristics of the 15 clients deceased at 12 months</td>
<td></td>
</tr>
<tr>
<td>Characteristics</td>
<td>HIV/TB N=13</td>
</tr>
<tr>
<td>Mean age, yr (SD)</td>
<td>36 (+6.7)</td>
</tr>
<tr>
<td>Female, no. (%)</td>
<td>8 (62%)</td>
</tr>
<tr>
<td>Mean wt, kg (SD)</td>
<td>57 (+13.2)</td>
</tr>
<tr>
<td>Started on HAART</td>
<td>3 (23%)</td>
</tr>
</tbody>
</table>

* Highly Active Antiretroviral Therapy

<table>
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<tr>
<th>Table 2</th>
<th>Weight change according to disease status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disease Status</td>
<td>Wt change, 4 months to start</td>
</tr>
<tr>
<td>HIV/TB</td>
<td>+0.40 kg (P=0.40)</td>
</tr>
<tr>
<td>HIV</td>
<td>+0.07 kg (P=0.90)</td>
</tr>
<tr>
<td>Overall Average</td>
<td>+0.25 kg (P=0.47)</td>
</tr>
<tr>
<td>HIV/AIDS</td>
<td>+0.07 kg (P=0.90)</td>
</tr>
<tr>
<td>TB</td>
<td>+0.40 kg (P=0.40)</td>
</tr>
<tr>
<td>Neither HIV nor TB</td>
<td>+0.07 kg (P=0.90)</td>
</tr>
</tbody>
</table>

Any contributions, ideas or topics for future issues of Field Exchange? Contact the editorial team on email: office@emonline.net

Notes:
1. See http://www.sahims.net/archive/specialfocus/specialcoverage_who_consultation2.htm
The second section asked for demographic information, including the age of the head of household and the number of children and orphans within each household. This section specifically requested information on HIV/AIDS within the surveyed households. The final section was a Quality of Life Index (QLI), which was selected due to its comprehensive psychosocial nature. The QLI is a standardised measure, developed by Ferrans and Powers\(^2\). While this measure has been standardised among various populations around the world, it has not been used before within Malawi. However, psychometric research revealed that among the sample population, the QLI performed similarly to past performance with other populations.

Results

A total of 301 household surveys were analysed in the results. The sample represents 20 villages randomly selected from three deaneries. The average age of the head of household was 45.7 years. Female head of households constituted 40.1% of the households. Approximately 3.4 children were reported, on average, for each household, while an average of 5.6 people were reported as residing in the households. Just under half (49%) of households reported that an orphan resided in their homes, but only 23.2% of households reported the presence of AIDS orphans in their households.

Of the sample, only 12.9% of the households reported having someone who was living with HIV/AIDS within their households, but 45.5% reported benefiting from a home-based care programme. While home-based care programmes also contribute to an increase in OVC, the primary service delivery is around HIV/AIDS related illnesses. This suggests that the sample either did not know their family members may have been infected, or they did not reveal their family member’s status to interviewers. However, more than 65% of the sample indicated that they knew where they could access voluntary counselling and testing services, and that they would welcome and care for a family member who was infected. Further data analyses revealed a negative relationship between households that reported the presence of someone infected with HIV/AIDS and household willingness to discuss such a status variable (p = 0.05).

More than one-third (37.7%) of households reported selling assets in the last three months. Of the 107 households that reported selling assets, the primary reason for doing so was to meet household food needs (76.7%), followed by personal daily household expenses (29%), and the need to cover hospital and doctor bills (11.2%). On average, households reported that in a non-drought year, they would have access to sufficient food for 4.5 months with their current harvest (SD = 2.7).

There was a significant difference (p = 0.05) in reported food security between households that reported having a household member living with HIV/AIDS and non-affected households. A relationship (p = 0.01) also emerged between the presence of AIDS orphans within the household and a reduced number of months per year the household could meet its food needs. In addition, the number of months that households could meet their food supply with their current harvest was correlated significantly with the participation of the households in the HBC project (p = 0.05).

Analyses demonstrated quality of life was predicted by whether or not the household had sold assets in the previous three months (p = 0.001) and whether their current harvest food supply was above or below average supplies (p = 0.017). Decreased quality of life scores were also significantly associated with the presence of persons living with HIV/AIDS (PLWHA) (p = 0.05) and the presence of orphans (p = 0.05) in the household.

Computing a two-way analysis of variance for main effects of asset sales and the presence of an HIV household member on quality of life, demonstrated that there was no interaction effect between asset sales and PLWHA presence on quality of life of the head of household. However, a significant main effect on quality of life emerged within the variable of asset sales.

Limitations

One of the main limitations with most of the research focusing on HIV/AIDS is the inability to appropriately and correctly identify people living with HIV or AIDS. Most research now uses ‘chronically ill’ as a proxy indicator for HIV infection. Initial analyses from some researchers have indicated that this proxy indicator over-exaggerates the cases of HIV infection. Barrère (2005)\(^3\) examined the use of this proxy indicator in a survey in Malawi and found that only 54% of a chronically ill sample was likely to have HIV or AIDS based on national infection rates.

As such, the survey used in this study specifically asked if anyone in the household was infected with HIV or AIDS. A total of 12.9% of the households replied affirmatively. According to the National AIDS Commission in Malawi (2003)\(^4\), the infection rate among rural households is estimated to be 10-15%. Thus, the 12.9% of affirmative responses would fall as projected within the infection rate estimates. However, it is possible that some households answered negatively to this question due to stigma concerns or lack of knowledge of HIV/AIDS. The lack of household member’s status, which could result in a higher HIV positive population than the one presented here.

Finally, this is a relatively small sample and cannot be applied broadly to the larger rural population in Malawi in other districts. These data were obtained from a specific geographic location for the purpose of an impact evaluation, thus the results are not necessarily applicable to a broader area.

Discussion

The results demonstrate that the presence of PLWHA and OVC (orphans and vulnerable children) at the household level also impact the level of food security, which is highlighted by whether the households have access to sufficient food to meet their needs. This relationship is further compound when households, lacking this supply, cope with their situation by selling their assets. These variables, in turn, affect the overall quality of life of the heads of households.

The data from this evaluation highlight the need to engage in holistic programming. Traditional mitigation responses, such as emergency food aid, cannot respond to the overall stress placed on the household in terms of food insecurity. Psycho-social interventions will also be hampered without addressing the basic food needs, as quality of life is likely determined alongside assets and basic food security. In addition, given that these data demonstrate a link between the presence of OVC in the household and the quality of life and food security at the household level, programming will need to address these findings in future OVC programming.

Given these results, programming will need to fully address mitigation of HIV/AIDS at the household level. While many theories have abounded regarding the importance of household food security, this evaluation confirmed this link in rural, central Malawi, while uncovering the psychosocial impact of this relationship on the households.

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Integrating CTC and HIV/AIDS Support in Malawi

By Saul Guerrero, Paluku Bahwere, Kate Sadler, and Steve Collins, Valid International

Saul Guerrero is a Social and Community Development Advisor. Dr. Paluku Bahwere (PhD) is a medical doctor. Kate Sadler is a Public Health Nutritionist. Dr. Steve Collins (MD) is a medical doctor and Director of Valid International.

The authors regularly work as CTC programme advisors with Valid International, and were involved in the coordination and conduct of the CTC and HIV/AIDS study in different capacities. The authors would like to thank Food and Nutrition Technical Assistance (FANTA) and the SARA project for financial and technical support, and Concern Worldwide and Ministry of Health and Population (MoHP) in Dowa District for facilitating the conduction of the study.

Locally produced RUTF is provided to beneficiaries in the CTC programme

This article describes the research findings of the first phase of a two-part study in Malawi by Valid International, which is exploring how existing CTC programmes can be adapted in the context of HIV/AIDS.

Over the last five years, Valid International has spearheaded the development and implementation of the Community-based Therapeutic Care (CTC) approach for the treatment of acute severe malnutrition. The CTC model is designed to provide timely, effective and cost-efficient assistance in a manner that strengthens and empowers the affected communities and creates a platform for longer-term solutions to the problems of food security and public health. In practical terms, the combination of its three core components (Stabilisation Centre (SC), Outpatient Therapeutic Programme (OTP) and Supplementary Feeding (SF)) with food security and health education programmes, offers a more holistic approach to the treatment of malnutrition.

CTC was first implemented in Malawi as a joint pilot programme between Valid International and Concern Worldwide during the 2002 nutritional emergency. The focus of the CTC programme in Malawi has, since the end of the emergency period, shifted to a more long-term integration with local health structures. The programme has been successful, with over 3,000 severely malnourished children admitted since 2002, and a 69.4% recovery rate as of early 2004. In spite of the encouraging results, and the support that the approach has gained within the country, the impact of HIV/AIDS in Malawi has forced a more in-depth re-examination of the aptitude of the current CTC model to face the so-called ‘New Variant Famine’ and the HIV-fuelled increase in food insecurity and malnutrition rates in Africa.

Since January 2004, Valid International, in collaboration with Support and Analysis for Research in Africa (SARA) and Food and Nutrition Technical Assistance (FANTA), has been conducting a two-part study to explore ways in which existing CTC programmes can be adapted to provide community-based care and support to HIV-affected individuals, households and communities. The findings of the first, more qualitative part of the research are presented in this article. The second stage, phase B, aims to establish whether HIV positive children can recover from severe acute malnutrition when given a standard CTC protocol. The findings outlined in this article relate exclusively to phase A of the study.

Aims and objectives of the research

The research study is divided into two phases. The first, phase A, examines the use and appropriateness of CTC as an entry point for providing longer-term HIV-related care, treatment and support in the community. The second stage, phase B, aims to establish whether HIV positive children can recover from severe acute malnutrition when given a standard CTC protocol. The findings outlined in this article relate exclusively to phase A of the study.

The aims of phase A are three-fold:

a) to examine the effectiveness of the CTC programme in Dowa district for identifying households affected by HIV/AIDS
b) to examine the relationship between the perceived what is being provided for, People Living With HIV/AIDS (PLWHA) and HIV affected households in Malawi, and
c) to examine how well the CTC programme in Dowa district meets both the perceived and actual needs of PLWHA and HIV affected households.

The research focused primarily on Dowa district, but activities were also conducted in Lilongwe, Blantyre and Nkhotakota districts.

Given the qualitative nature of this part of the study, the methodology relied heavily on Focus Group Discussions (FGDs), Semi-Structured Interviews (SSIs), Questionnaires and Surveys. Participants included support agencies (e.g. non-governmental organisations (NGOs), Community-Based Organisations (CBOs), governmental groups, community support groups, etc.) beneficiaries of HIV support programmes, members of HIV affected households, traditional health practitioners, agricultural extension workers, Ministry of Health (MoH) staff and traditional local leaders, among others. Planning, conducting and analysing the results of this first phase of the study extended over a six-month period.

General findings

The majority of the support programmes for HIV affected households surveyed during this study were found to rely on proxy indicators for identifying beneficiaries. Of these indicators, the most commonly used are chronic illness (i.e. 3-12 months), households looking after orphans (both parents deceased), single parent/widow headed households, elderly-headed households, child headed households (child less than 18 years old) and households with children of deceased HIVB clients.

The needs of PLWHA and HIV affected households were found to cover ten different categories. These categories were ranked by participants under two groups, primary (nutritional, material, medical, transport, psychological, primary and secondary education) and secondary (food security, knowledge on prevention, and vocational skills). The ranking of needs reflected a prioritisation of immediate over long-term needs, as well as the gaps in the support available in the research area.

The support available to PLWHA and HIV affected households was found to come from both formal (e.g. international NGOs, CBOs, governmental structures) and informal sources of support (e.g. community initiatives and groups). Formal sources were most effective in providing nutritional, medical, food security and educational support. Informal sources, on the other hand, were most successful at addressing the spiritual, psycho-social and patient care requirements of PLWHA and HIV affected households. Together, both informal and formal sources engage with all but one of the primary areas of need and one of the three secondary needs. Evidence collected during the study, however, suggests that the provision of support by formal sources – such as NGOs – has led to the weakening of informal support mechanisms within the communities. In Malawi, the support of community members is often crucial in dealing with illness and death in the household. One of the study participants said: “I have been sick for three years and the assistance I have received has been enough, given that the people who assist me are themselves poor but spare something for me, they wash my clothes, beds and give me other things that I need in my household”. The availability of external formal support, however, is weakening this community approach and assistance. In the words of one respondent, “some people in the community say that we get a lot of money from [the NGO] so they refuse to assist us”. The effect of formal support programmes has also been felt in NGO initiatives to strengthen food security in the communities at large. The study found evidence that the singling out of individual households for HIV related support, leads to dissatisfaction and decreasing levels of community participation in other programmes aimed at the community at large.

Although formal and informal sources of support jointly take on most need areas of PLWHA and HIV-affected households, the study concluded that the appropriateness of the assistance available to these households is limited by inadequate engagement between support providers - to reduce replication - and between providers and beneficiaries. Initial engagement - in the form of needs assessments, for example - was inadequate, resulting in a poor under-
Future implications for the CTC approach

Although the results from the initial phase of the study shed some light on the changes required for the CTC to be used as an approach for the delivery of HIV support, the overall findings of the research – i.e. from phases A and B – will be necessary before conclusive steps are taken towards any adaptation of the CTC model. So far, however, the study has shown that in order to target a much greater proportion of HIV affected households, changes in the current targeting criteria of the CTC programme are required. CTC must expand its target group to include malnourished and chronically ill adults. Current anthropometric indicators for identifying malnutrition in adults and children must also be used alongside a combination of some of the proxy indicators identified in this study (and further explored in phase B). These changes would ultimately allow for more effective identification and the inclusion of a larger proportion of HIV affected households.

The findings also suggest that the CTC as an approach is suitable for providing longer-term care to HIV affected and infected individuals and households. CTC was found to be advantageous due to its minimal impact on the daily activities and resources of the enrolled households, and decreased risk of contracting opportunistic infections. The assistance currently provided under the CTC was reported as adequate to meet the needs of target children in these areas. The nutritional, medical, food security and material supports were deemed sufficient by participants and the mode of delivery and quality of the distribution process widely characterised as appropriate. The participants’ views regarding the appropriateness of the medical and nutritional care were substantiated by the high recovery and low non-response rates in the programme. In terms of the adequacy of the support for the household, however, the majority of the respondents felt it was insufficient to meet their household’s needs. This was a foreseeable conclusion, given that the current targeting criteria focuses on individual malnourished children and not on meeting the nutritional (or any other) requirement of HIV affected households as a whole.

Valid and MoH workers in Dowa District
The identification of basic prognostic indicators of HIV infection is essential before widespread antiretroviral therapy can be implemented in low-technology settings. A recent study assessed how well body mass index (BMIkg/m²) predicts survival.

BMI within 3 months of HIV diagnosis was obtained from 1657 patients aged >15 years, recruited in a seroprevalent clinical cohort in The Gambia since 1992, and followed up at least once. Baseline CD4⁺ cell counts and clinical assessment at time of diagnosis were collated. The mortality hazard ratio (HR) of those with a baseline BMI <18 compared with those with a baseline BMI > 18 was 3.4 (95% CI 3.0-3.9). The median survival time of those presenting with a BMI <18 was 0.8 years, in contrast to a median survival of 8.9 years for those with a baseline BMI >22. Baseline BMI <18 remained a highly significant independent predictor of mortality after adjustment for age, sex, cotrimoxazole prophylaxis, tuberculosis, reported wasting at diagnosis, and baseline CD4⁺ cell count (adjusted HR = 2.5, 95% CI 2.0-3.0). Sensitivity and specificity of baseline BMI <18 was comparable to that of a CD4⁺ count <200 in predicting mortality within 6 months of diagnosis.

BMI at diagnosis is a strong, independent predictor of survival in HIV-infected patients in West Africa. In the absence of sophisticated clinical and laboratory support, BMI may also prove a useful guide for deciding when to initiate antiretroviral therapy.

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Rethinking Food Aid in the Face of HIV/AIDS

Summary of published research¹

A recent detailed review of the relevant literature and the findings of a mission to eastern and southern Africa highlights the implications of the HIV/AIDS pandemic for food aid strategy and programming. The review examines experiences of using food aid within the context of Prevention of Mother to Child transmission (PMTCT) programmes, food supplementation in home based care, supplementary feeding for orphans and vulnerable children, food for education and training, food for work, and income generating activities and micro-credit schemes. A number of conclusions are drawn.

HIV/AIDS demands a multi-pronged response, grounded in an understanding of the susceptibility and vulnerability of people’s livelihoods. Food aid can strengthen care, mitigation and prevention activities. It is also relevant for the nutritional well being of vulnerable groups and for strengthening human capital, as well as for preserving assets and livelihoods. Food aid can enable the marginalised to take advantage of development opportunities. Those affected by HIV/AIDS are arguably among the most marginalised populations, both socially and economically. Not only does stigma foster exclusion, but progressive asset depletion may also render households destitute and unable to participate in the development process. There are opportunities for using food aid to enable these populations to avoid and escape such marginalisation. In addition, it will be important to seek opportunities for linking such initiatives to HIV-specific interventions whenever possible, thus potentially further reducing susceptibility to HIV.

But many challenges exist which will need to be dealt with dynamically through ongoing implementation, food monitoring, and timely focused operational research. Such challenges include how to target the vulnerable in the HIV/AIDS context, how to use food aid to leverage longer-term livelihood options, how to ensure complementary resources through appropriate partnerships and how to strengthen local capacity. Donor responses have been piecemeal to date, and the involvement of food aid organisations is fairly recent. The article concludes that, “there is little empirical evidence regarding the effectiveness of food aid in responding to HIV/AIDS currently, this should not forestall action. A well documented learning-by-doing approach is required, of building up, evaluating and disseminating experiences and lessons learned”.

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Early Exclusive Breastfeeding Increases HIV Survival

Summary of published paper¹

The promotion of exclusive breastfeeding (EBF) to reduce the postnatal transmission (PNT) of HIV is based on limited data. The recently published ZVITAMBO study in Zimbabwe has carefully measured associated infant infections and deaths. All infants initiated breastfeeding, Overall PNT (defined by a positive HIV test after the 6-week negative test) was 12.1%, 68.2% of which occurred after 6 months.

A total of 14 110 mother–newborn pairs were enrolled, randomly assigned to vitamin A supplementation, education and counselling about infant feeding and HIV was provided while information was prospectively collected on infant feeding practices, and measured associated infant infections and deaths.

A total of 4495 mothers tested HIV positive at baseline. Of these, 2060 of their babies were alive, polymerase chain reaction negative at 6 weeks, and provided complete feeding information. All infants initiated breastfeeding. Overall PNT (defined by a positive HIV test after the 6-week negative test) was 12.1%, 68.2% of which occurred after 6 months.

Compared with EBF, early mixed breastfeeding was associated with a 4.03 (95% CI 0.98,16.61), 3.79 (95% CI 1.40–10.29), and 2.60 (95% CI 1.21–5.55) greater risk of PNT at 6, 12, and 18 months, respectively. Predominant breastfeeding was associated with a 2.63 (95% CI 0.59–11.67), 2.69 (95% CI 0.95–7.63) and 1.61 (95% CI 0.72–3.64) trend towards greater PNT risk at 6, 12, and 18 months, compared with EBF.

The authors conclude that EBF may substantially reduce breastfeeding-associated HIV transmission.

Recently produced training materials (Module 2 for health and nutrition workers in emergency situations) detail support of exclusive breastfeeding in the challenging environment of emergencies. They support Module 1 material, both of which are available in print from ENN, and online at http://www.enonline.net

¹ Early exclusive breastfeeding reduces the risk of postnatal HIV-1 transmission and increases HIV-free survival. Peter J. Uff, Ellen G. Poetsch, Anne V. Tawney, Claire D. Zunpuza, Edmore T. Marinda, Kusum J. Nathoo, Lawrence H. Moulton, Brian J. Ward, the ZVITAMBO study group and Jean H. Humphrey AIDS 2005, 19, 69-708. The full text version of this article is available by joining the WABA HIV and Infant Feeding Yahoo Group (see news piece on this issue)

² Comments drawn from Pro-Nut HIV communication, Ted Greiner, 14 April 2005
Research

T he Bangwe project is a joint home based care (HBC) project run by the Salvation Army and the Department of Community Health, College of Medicine, University of Malawi. While providing a standard HBC service to a township of 40,000 adjacent to the city of Blantyre, data have been collected since January 2003 on health problems of patients, their response to treatment and their nutritional status. Antiretroviral (ARV) drugs have not been given during the study period.

Following a recommendation from the National AIDS Commission (NAC) that the project should assess the use of supplementary feeding to HBC patients, WFP began providing food in July 2003. Nutritional assessments were carried out at the time of initial assessment of the patient, and in June 2003, November 2003 and July 2004 on the members of the household of each patient.

Inclusion criteria

Inclusion criteria were adult patients (over 15 years of age) with chronic disease of more than one month and in need of home based care. The group of patients who were enrolled between January and June 2003, and their families, did not receive food in the first period of their home based care. They, and all subsequent patients, received the basic food package from July 2003 to July 2004. The effect of the food was measured by the difference in nutritional status of each patient, comparing the Body Mass Index (BMI)2 at the last survey assessment with the original BMI, expressed as the rate of change per 100 days.

The WFP supplement was targeted at households taking care of orphans and those with someone requiring HBC. Monthly rations were 50 kg of maize, 5 kg of beans and 7.5 kg of Likuni Phala (a Malawian fortified blended food). Four litres of oil were given to half of the households selected on a random basis.

The study was divided into three periods (January 2003 to July 2003, August 2003 to November 2003 when the second nutritional survey was implemented, and mid November 2003 to July 2004, when the third nutritional survey occurred). Results were analysed using SPSS.

Results

Between January 2003 and July 2004, 360 pregnant women were enrolled, of whom 59% were women. It appears that half of the chronically sick in the study area were enrolled at the time. The mean age of men was 38 years and women 30.9 years. Over the course of the study, over half of the patients (56%, 190/346) died. There was no apparent difference in case severity of patients enrolled in the different periods of the study based on symptoms of fever, cough, lower limb pain and thrush.

The majority of patients presented in an advanced stage of disease, with 70% in stage 4.

Change in BMI

The mean BMI at presentation was 18.5. Half of the patients were malnourished, with a BMI less than 18.5 on enrolment, and one quarter were severely malnourished (BMI=16). The nutritional status of the group presenting before July 2003 was similar to that of the group who presented during the second and third periods. During the first period, when none of those enrolled received food, nutritional status remained constant. By the second survey, the mean BMI of those still alive rose by 0.49 per 100 days per patient. By the end of the third period of the survey, the mean BMI had increased by 0.35 per 100 days. These increases were not statistically significant. For the small group of patients (n=22) who survived through all surveys, there was an increase in the rate of change of BMI between the patients who had received food before the third survey and the patients who did not receive food before the third period of the survey. The addition of oil to the food package had no effect on nutritional status, as measured by change in BMI per 100 days.

Survival

One third of patients died within four months of being first seen. Of those who survived 14 months there was no difference in the survival patterns of those who did not initially receive food compared to those who received food from the start. Survival was better in those allocated to receive oil and those who actually received oil compared to those who did not. Oil seems to have an effect, but only for those who survived six months from the time of initial assessment. The results show no statistically significant differences between the patients groups before and after food distribution, although there is a suggestion of improved survival in clinical stage 4 patients post food distribution.

Household nutrition

A household of patients enrolled between January and June 2003 (n=181) who survived to one of the follow up weighing surveys. The study concluded that training and supervision of programme staff may increase the likelihood of increased social support for women's participation these measures at programme level, by concentrating efforts to prevent transmission of HIV from mother to child. Outreach and mobilisation in communities that are served by prevention programmes may complement these measures at programme level, by concentrating increased social support for women's efforts to prevent transmission of HIV from mother to child. Involving women's partners in the prevention of child to mother transmission of HIV is widely recognised to be desirable, but this rarely occurs.

Discussion and conclusions

An observational study of this sort is difficult to interpret and there is much room for bias if similar patients are not comparable. However, the assessment of the presence and severity of presenting symptoms, the ‘before’ and ‘after’ food groups had similar mixes of case severity and comparable BMIs. The main difference between the groups was the presence or absence of food in the ‘after’ food group. It may be that males tend not to seek HBC until it is known that food is available. However, the severity of disease of those presenting when food was being distributed (n=181) is not clear as it does not differ significantly from that of those presenting before the food handouts started. Overall, it appears that the two groups, at first presentation, are comparable.

In this study, food supplementation seems to have no effect on survival, but does affect the nutritional status of those home based care patients who survived to one of the follow up weighing surveys. The result is not surprising, considering the late stage of disease in many presenting patients. A possible reason for the absence of effect on survival could be that little food reaches the terminally ill, due to problems of distribution in an urban area of Malawi - families may have no one to carry food home from the distribution point and many patients are too sick to get there. It is possible that food may have an effect on those patients who survive six months. This may be because it is a concentrated form of energy or because it is a saleable commodity and may therefore be more likely to be purchased by some poor families.

The food supplement did not help maintain the BMI in household members of HBC patients. The reduction in BMI of household members may be attributable to the socio-economic catastrophe of loss of income and increase in expenditure, due to chronic ill health of one or two adults in the family. The longer the adult remains alive and ill, the longer the loss of earnings, drain on resources and ensuing poverty. This may account for the reduction in BMI of HIV households of whose patients have survived for 12 months or more. Arguably, the situation may have been worse without the provision of food.
Modification of Complementary Foods in Zambia

By Victor Ochieng Owino

Victor is currently a PhD student at the Centre for International Child Health, University College London. A Food Science and Technology graduate, he has previously worked as a research assistant at the University of Nairobi and held a technical position at a Nairobi based food company.

The author wished to acknowledge the contribution of the Ellison Medical Foundation, Nutrition Third World and Score Africa to this work.

This article is an overview of an ongoing study in Lusaka, Zambia, which is working on modifying complementary (infant) foods with α-amylase. Given that high levels of malnutrition in children is especially true in the second semester of the first year of life in poor settings. Some of the approaches to improve the quality of complementary foods include fortification and the enhancement of energy density by the application of starch-breaking enzymes, such α-amylase.

A two-phased study has been undertaken in Lusaka, Zambia since 2003, to assess whether modification of complementary foods with α-amylase and multi-micronutrient fortification benefit infant growth and micronutrient status. The study also aimed to generate data on breast milk intake of nine month old infants, using a multiple micronutrient premix based on the latest WHO recommendations for infants 6 – 9 months old. The complementary blend, developed blend was widely accepted by mothers.

Methods

The study was based at Chilenje clinic, Lusaka, a middle-income urban area where most households have running water and flush toilets. Ethical approval was obtained from the University of Zambia Ethics Committee and Great Ormond Street Hospital, UK.

The first phase of the study, carried out in 2003/2004, comprised an assessment of complementary feeding practices among mothers of children aged 6–23 months old at Chilenje, Lusaka, and the development and assessment of the acceptability of an α-amylase-modified complementary blend made from locally produced cereals and legumes.

Complementary feeding practices were assessed by qualitative techniques using focus group discussions and formal interviews. Infants’ nutrient intake was assessed by 24h-recall and 12h weighed food records. Focus groups discussions were held with mothers, fathers and health workers at Chilenje clinic. A total of 34 mothers were interviewed, of whom 20 were observed at home to determine how they prepared food and fed their children. Data from 24h and 12h weighed food records were used to compute the amounts of energy, iron and calcium obtained from family meals by children aged 6 - 23 months old.

The acceptability of the developed porridge was assessed using sensory evaluation by 18 mothers at Chilenje clinic. A blend was developed using maize, beans, groundnuts and bambaranut and was treated with α-amylase after roasting and hammer milling. Porridge viscosity was measured at different slurry concentrations (9-20%) in order to determine the amount of additional dry flour possible without a notable change in porridge consistency. The viscosity of habitual porridges was determined after simulating mother-reported and observed recipes.

Acceptability of new blend

The results showed that maize (Zea maize) is the main cereal used in Lusaka. The available, and widely used, legumes are common beans (Phaseolus vulgaris), groundnuts (Arachis hypogaea) and bambaranut (Vorandza subterreneae). Although processed complementary foods are available in Lusaka, they are very expensive, with the lowest priced selling at US$4 per kg. Thus, lack of affordable complementary foods was found to be a major constraint on mothers’ feeding practices. On the contrary, the developed blend would cost only US$2.5 per kg. Treatment of porridge with α-amylase allowed for a 100% increment in porridge slurry concentration without a change in porridge viscosity. The study blend was widely accepted by mothers.

Micronutrient status and growth

It was observed that although children received the recommended amounts of energy from habitual foods, they received less than half of their daily requirements for iron and calcium. This highlighted the need to fortify complementary foods to meet the micronutrient needs of infants, and necessitated the second phase of work that is currently underway. This aims to assess the benefit of α-amylase-treated, multi-micronutrient complementary blend on growth and micronutrient status of infants aged 6 – 9 months old. The complementary blend, developed in phase one of the study, was industrially processed by extrusion cooking in collaboration with Quality Feeds Limited. The food was fortified using a multiple micronutrient premix based on the latest WHO recommendations for infants 6 – 9 months old. The fortified blend was either treated with α-amylase or not.

Mother-infant pairs, recruited at Chilenje clinic, were randomised when the child attained 6 months of age to either receive α-amylase treated fortified blend, or non-α-amylase treated fortified blend. The control group comprises mother-infant pairs who were recruited when the infant was 9 months old and were measured once, alongside mothers and children from the intervention groups.

Each infant in the intervention is provided with 2 kg of porridge flour per month, while those in the control group receive at least 4 kg (2 months supply) of porridge after all the measurements are made. Monthly anthropometric measurements (weight, length/height, body circumferences and skinfolds) are performed on both the mother and the infant. Haemoglobin is measured in the infant at 6 months of age and at 9 months. Monthly intake of non- breast milk foods is determined by 24h recall. A sample of both control and intervention mothers receive a dose of deuterium oxide when the infant turns 9 months, and urine samples are collected over a period of 14 days to determine infants’ breast milk intake.

Observations

The main strength of the project is the fact the main ingredients (maize, groundnuts, bambaranut and beans) are locally produced in Zambia. Maize and groundnuts are among the main crops grown in Zambia and are readily accessible from local dealers. Minerals and vitamins for fortification can be sourced regionally.

The main observation has been that the developed blend is widely accepted by mothers who report that their children like the porridge. Mothers have also expressed willingness to buy the porridge if it were to be available in the shops. This shows that future scale up of this work is feasible. The viability of this work also depends on the already established collaboration among government, research institutions and the private food industry.

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* Current WHO guidelines recommend that complementary foods be introduced in addition to breast milk from six months of age. For guidance and resources on complementary feeding, see http://www.who.int/chld-adolescent-health/NUTRITION/complementary.htm
Chronic illness is used as a proxy indicator for AIDS throughout C-SAFE programming and literature. The study is broken down into two key programming areas. The first area investigates targeted food assistance for non-medical programmes and looks at factors involved in establishing the program’s potential. Appropriate rations for the chronically ill, complementary activities and exit strategies. The second area reviews guidance on programming with TB treatment has achieved several successes, including:

- very high TB adherence through the full DOT (Directly Observed Therapy) cycle
- reduced default rates
- increased case identification
- observed improvement in well-being including weight gain
- improved return to work/productive activity.

**Prevention of Mother to Child Transmission (PMTCT)**

An investment in mothers during this time is intended to assist them in delivering a normal birthweight infant, and to support the production of breast milk through the function of lactation. Many HIV-positive women are the heads of households, and the survival of other household members depends on her well-being. C-SAFE members are concerned that up to 20% of infants born to HIV-positive women acquire infection through breastfeeding. In resource poor settings, the infant of HIV-positive mothers practice exclusive breastfeeding during the first six months of life and discontinue as soon as is feasible. While this advice presents many challenges, C-SAFE experience has been that mothers are most effective in reducing duplicity and increasing coverage and impact once, when the community is strong enough and motivated to take action. Targeted food assistance protocol, C-SAFE categorises people on ARVs into the following two categories:

a) Those on ARVs with symptoms and related complications (at the early stages of treatment) who require not only 20-30% additional energy intake, but probably need a nutrient-dense, palatable and culturally acceptable food source. While nutritional support is still advisable, these individuals should be directed to sustainable livelihoods/food security initiatives. The other hand, those on ARVs without symptoms and related complications (well-established on treatment) who still have increased energy requirement (10%) and require a high-quality balanced diet.

b) Those without symptoms and/or complications would normally have responded well to treatment and other support. While nutritional support is still indicated in this group, these individuals would not normally be included in a C-SAFE food assistance programme. The key assumption here is that this group is essentially healthy and is engaged in, or has the potential to participate in, productive livelihood activities. Where applicable, these individuals should be directed to sustainable livelihoods/food security initiatives. On the other hand, those on ARVs with symptoms and related complications are often unable to participate in productive livelihood activities. This group will require immediate food assistance (in addition to other support).

In conclusion, targeted food assistance has the potential to fill a significant gap in the provision of comprehensive HIV/AIDS care and treatment, especially during the initial stage of ARV therapy.

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1 C-SAFE (2004), Targeted Food Assistance in the Context of HIV/AIDS. Better practices in C-SAFE targeted food programming in Malawi, Zambia and Zimbabwe. A study published by the C-SAFE Learning Centre.
The WHO (2004) estimates that Pneumocystis carinii pneumonia (PCP) accounts for about 20% of cases of severe pneumonia in HIV infected children and over one third of all HIV related deaths in infancy. Severe malnutrition may predispose patients to PCP. PCP can be prevented by cotrimoxazole prophylaxis. Despite explicit guidelines from WHO/UNAIDS on prophylactic cotrimoxazole (see box), and near universal use in developed countries, usage of cotrimoxazole for prophylaxis against opportunistic infections in children was only 1% in Africa in 2001. A recent review, conducted by Action Against Hunger (AAH) in Malawi, has examined the evidence for using cotrimoxazole as a prophylaxis for HIV positive malnourished children.

**Evidence for the use of cotrimoxazole**

There is an increasing body of evidence of the benefits of cotrimoxazole prophylaxis. Studies of cotrimoxazole prophylaxis in African adults, and of the recent CHAP (Children with HIV Antibiotic Prophylaxis) trial amongst Zambian children aged 1-14 years, have shown improved survival in people with HIV infection. In Cote d’Ivoire, daily administration of cotrimoxazole to adult patients who were both HIV positive and smear positive to TB significantly lowered, by almost half, the rates of death due to PCP and mortality due to TB (p<0.001) and admission to hospital (43%).

The Zambian CHAP trial has observed an overall reduction in mortality of 43% in children receiving cotrimoxazole as part of a placebo controlled trial, and reduced hospital admission by 23%. This has led to WHO, UNAIDS and UNICEF modifying current recommendations for cotrimoxazole prophylaxis. Interim recommendations endorse continued cotrimoxazole prophylaxis (due for expert technical review in early 2005).

Amongst African adults, PCP may be a less important opportunistic pathogen than TB and other infectious diseases that feature at an earlier stage of AIDS disease progression. Cotrimoxazole can particularly reduce bacterial disease and malaria, with potential benefit to uninfected infants as well as infants with HIV infection.

**Problems and evidence of contraindications for cotrimoxazole**

There are a number of potential/hypothetical drawbacks to mass cotrimoxazole prophylaxis, which include:

- The efficacy of sulphonamide containing antimicrobials could be reduced by mass cotrimoxazole prophylaxis.
- Given its antimalarial activity, cotrimoxazole prophylaxis could impede the acquisition of natural malaria immunity by infants.
- Further investigation is required into whether or not extensive use of cotrimoxazole accelerates resistance to cotrimoxazole and resists as resistance to other drugs of some pathogens in the community and the complexities of any such interactions.

Cotrimoxazole prophylaxis based solely on HIV exposure, without confirmation of HIV infection status, is likely the only option in resource poor settings and remains a trade off between possible benefit to the infant, versus the risk of resistance to antibiotics and anti-malarials.

**Adaptations based on evidence for and against**

**Infants under six months**

The current guidelines in Malawi for the use of cotrimoxazole in children, recommend that cotrimoxazole prophylaxis should be administered to all infants born to HIV infected mothers from 6 weeks until 6 months of age (MOH 2004, based on WHO guidelines, 2002).

**Infants over six months**

Cotrimoxazole prophylaxis for HIV exposed and HIV infected children beyond age 6 months is a separate issue. PCP is less common in infants over six months and young children, and prophylaxis in this group might lead to substantial, and negative, effects on successful management of malaria and common bacterial infections. However due to difficulties with HIV diagnosis in infancy and the contributing risk of postpartum transmission of HIV, PCP could present before diagnosis of HIV can be confirmed. There is, therefore, a rationale for prophylaxis to all those who are HIV exposed.

**Influence of testing on prophylaxis**

CD4 testing, ideally used to decide on prophylaxis, is likely impractical in resource limited settings, while total lymphocyte count has not been proven as an accurate indicator of immune status in children. There is evidence that, in the African context, an HIV antibody test could be highly specific for infection as early as 6 months of age but this requires further research.

**Malnutrition**

No studies were identified by the review on the use of cotrimoxazole prophylaxis in HIV positive malnourished children. Follow-up anthropometric data collected in the CHAP trial has not yet been reported.

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1 Cotrimoxazole as prophylaxis for HIV positive malnourished children, Action Against Hunger, January 2005, Malawi. By Susan Thurstans. This research was funded by the National AIDS Control Programme of Malawi.


4 These have since been updated since the CHAP trial (ref:footnote 5).


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1 See footnote 5

2 At the time of writing this article (March 2005), the Malawi guidelines were in the process of change which should be in place at time of print (May 2005). The revised guidelines recommend that all HIV exposed and infected children will receive cotrimoxazole indefinitely from six weeks of age, or in the case of the exposed, until a negative HIV result >18 months of age. Adults will start cotrimoxazole indefinitely if HIV viremia (stage 3 or 4) or CD4 count <250.


4 Since the revised Malawi guidelines (see footnote 8) support treating all exposed infants, testing will not be so much of an issue for this age group in Malawi.
Research

Cotrimoxazole has long been recommended as a prophylaxis for HIV positive severely malnourished children who are susceptible to serious opportunistic infections such as PCP and are prone to broken down or infected mucocutaneous surfaces and skin areas (the latter in kwashiorkor, especially). However, cotrimoxazole is likely to benefit those in the earlier rather than advanced stages of HIV disease.

Current Malawian guidelines for the management of severe malnutrition include systematic antibiotic treatment but do not include cotrimoxazole – experiences have found it to be no longer effective against established serious infections. Resistance to cotrimoxazole is common, and bacteria causing small bowel bacteria overgrowth are better targeted by amoxicillin\(^{15}\). However, the reviewed evidence suggests that it may still work as a prophylaxis, even when ineffective as a treatment but should not replace the systematic antibiotics use in therapeutic feeding.

Discussion

In many areas where 3 by 5 is being implemented, children will have limited access to ARVs. Although for an individual patient, prophylaxis of opportunistic infections does not confer the survival advantage of antiretroviral therapy, prophylaxis could have an important impact because of its low cost and ease of implementation\(^{15}\).

From the CHAP trial and the Cote d’Ivoire study, there is a growing body of evidence that would suggest that all severely malnourished children who are found to be HIV positive should be on cotrimoxazole prophylaxis, and the child should remain on cotrimoxazole indefinitely after discharge from therapeutic feeding. However, it remains to be seen whether cotrimoxazole prophylaxis is still indicated since the child gain access to antiretroviral therapy (ART) and should show an improvement in their condition.

Recommendations

As ACF is a leading organisation in the fight against severe malnutrition, and evidence has shown that HIV and severe malnutrition are inextricably linked, they should take the lead initiative in the integration of HIV care into the treatment of severe malnutrition.

In resource limited settings, emphasis should be placed on the demonstrated benefits of cotrimoxazole prophylaxis. ACF-International should lead the push for the provision of cotrimoxazole to HIV positive malnourished children, through integrating HIV counselling and testing into TFCs and NRCs in high HIV prevalent countries. Cotrimoxazole plus continued HIV care, links should be established with local health structures for continued provision of this drug and other services for the prevention and treatment of HIV related infections and severe acute malnutrition. TFCs and NRCs as an entry point and strengthening referral systems, services such as prevention of mother to child transmission (PMTCT), ART provision and community home based care (CHBC) can be compared to maximum benefit to help prevent the vicious cycle of HIV infection and severe malnutrition.

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Summary of a qualitative study\(^{15}\)

By Pamela Fergusson

Pamela Fergusson is a dietitian/nutritionist whose research and practice areas include international community health, nutrition, food security and HIV. Pamela is currently working in nutrition and HIV in the UK and working on consultations and research in southern Africa.

The author would like to acknowledge the contributions of the WFP Zambia office and WFP headquarters to this work.

On the ground perceptions of WFP food assistance and PMTCT in Zambia

The deadly triangle of interaction among malnutrition, infection and poverty has long been recognised. Nowhere is this interaction more apparent than in southern Africa. According to the 2004 UNAIDS Global report on the AIDS epidemic, sub-Saharan Africa is home to only 10% of the world’s population, but almost two-thirds of all people living with HIV. The report also states that 57% of adults infected in the region are women, and 75% of young people infected are women and girls. This growing trend in the ‘feminisation’ of HIV represents an epidemiological shift in infection rates and modes of transmission, which has prevention, treatment and policy implications. As the prevalence increases among women, the risk of transmission from mother to child has become an important public health issue and is growing in significance as a route of transmission.

Research suggests that without interventions to prevent mother to child transmission, the risk of mother to child transmission in Zambia is approximately 40%. Considering the high HIV prevalence in Zambia, without intervention, about 41,000 babies annually will acquire HIV, which translates into about 112 new infections per day. The government of Zambia is rolling out services to prevent mother-to-child HIV transmission (PMTCT) across the country, and they are currently providing services at 83 sites with the cooperation of implementing partners.

Rationale for providing food and nutritional support through PMTCT programmes

In addition to their primary objective of preventing HIV transmission, PMTCT programmes also offer an opportunity to revitalise the broader system of antenatal care into which they are being integrated. With HIV testing facilities in place, health care providers have a unique opportunity to provide services to pregnant HIV positive women in the early stages of infection, and to reach their families. One of the main opportunities this early intervention provides is to establish positive dietary practices and mother to child nutrition to provide food to women at a particularly vulnerable period of their lives. Very little is known about the dynamics between pregnancy, nutritional requirements, and HIV infection. However, HIV infection is known to increase energy requirements\(^{1}\), and studies have shown beneficial effects on birth outcomes of HIV+ women associated with supplementation of certain micronutrients\(^{15}\). Although it is conceivable that under-nourishment may also reduce the efficacy of anti-retroviral drugs, there have been no studies to date of the relative efficacy of Nevirapine or AZT in preventing mother to child transmission in under-nourished populations. There is, however, some evidence that low birth weight is associated with increased risk of HIV transmission from mother to child.

As a pilot initiative, the World Food Programme (WFP) partnered with PMTCT programmes being implemented at seven sites by the Government of Zambia, to provide food assistance. There are three major goals associated with food support to this programme: (1) to enable women to participate in the programme, thus creating an entry point for prevention to prevent transmission, (2) to support women’s nutritional status at a particularly vulnerable period of their lives, and (3) to gather operational and experiential information on the feasibility and acceptability of such a programme when linked to ongoing PMTCT services.

WFP field study

At the beginning of 2005, as part of an internship with the WFP Zambia office, the author conducted an analysis of the role and impact of food aid in PMTCT programmes implemented at seven sites.

The analysis included evidence gathering through interviews, questionnaires, direct observation, document review and analysis of collected data. This article focuses on one part of the report, relating to the perceptions of beneficiaries, clinic staff and stakeholders of the role of food aid in PMTCT programming in Zambia.

Perceptions of beneficiaries

During clinic visits, beneficiaries were interviewed about their impressions of the impact of WFP food. Only one of the six beneficiaries interviewed was aware of food availability in the programme; the other five were completely unaware of this in instance, food was not perceived to be an incentive for testing. In some smaller communities in Zambia, however, awareness of food rations distributed through the programmes is reported to be higher.

WFP has a policy that food should not be provided specifically as an incentive for HIV testing. Providing food to somebody who is food insecure as an incentive for testing can be seen as coercive—an approach that might make it difficult for clients to disclose their status to the community and therefore place them at risk of stigma and abuse. The risk of abuse associated with HIV testing remains very real in such contexts: an abstract presented by Kusimba at the XV International AIDS Conference entitled ‘Community Perception of PMTCT Services: the Kenyan Experience’ found that the key barrier associated with non-use of PMTCT services was fear of
testing positive, and the potential consequences of HIV positive status. The authors recommended that community sensitisation, service integration, and women’s empowerment could help to minimise risks associated with PMTCT. These communication strategies are in place as part of this programme, however the issue of stigma must remain a consideration in programme planning.

Measures of food security include food adequacy and dietary diversity. Beneficiaries in the PMTCT programme said that WFP food was an important motivator in attending follow-up appointments. Women also reported that they were eating a greater variety of food, including more fruits, vegetables, soya beans, and eggs, and were eating more frequently. Although WFP was not distributing fruit, vegetables, meat or eggs, some beneficiaries said that the receipt of WFP food had enabled them to purchase some of these items themselves. This may have facilitated them to be able to take action on some of the nutritional education that they receive as part of services. One woman said, “We have been taught about a balanced diet. I make an effort to eat more green vegetables and beans.” Another woman said, “We know that we have food in the house. We used to think, if this mealie meal finished, where are we going to get the food from?” Four of the six women said they felt they had gained weight as a result of the food rations, and all of the beneficiaries said they felt healthier because of the food. This last response could indicate a perceived increase in quantity of food available due to the food. Pursuing further assessment of the impact of WFP support on quality of life, using qualitative research methods with beneficiaries, would be a good direction for further research.

Perceptions of PMTCT clinic staff

A workshop-based training session of staff members was carried out, involving nurses and nutritionists working directly with women and families involved in the PMTCT programmes at Zambian Ministry of Health, and several MTCT clinics in Lusaka. A ‘problem tree’ was developed on perceived problems related to nutrition and food security faced by women in the PMTCT programme (see figure 1). The participants wrote these problems on cards, and then arranged the cards on the wall with the problem they felt was most central in the middle. The staff chose poverty as the central problem. Problems below poverty in the problem tree are seen as root problems, or causes, and problems above poverty were branch or effect problems on the problem tree. Problems clustered around the problem of poverty were seen as most closely related to the central problem.

Participating staff were also asked, as part of a separate activity, to put forward open-ended questions about WFP food support of PMTCT programme. The objectives they suggested were:

- To promote good nutrition to all pregnant women in the PMTCT programme
- To provide knowledge about preparing nutritious food, eg. balanced diets
- To provide knowledge and skills to health workers in PMTCT programme
- To provide food security to all pregnant women in PMTCT programmes

- To help have healthy babies.

A questionnaire on the effects of WFP food support was returned by fifty-five staff members from WFP supported PMTCT clinics, or clinics where training was provided in preparation for starting food support. Of these:

- 86.3% felt that the women’s nutritional status improves because of the food assistance
- 86.1% felt that the food encourages women to return to the clinic for follow-up
- 62.5% felt that the women are less likely to sell off assets because they have more food available at home
- 58.4% felt that the food encourages women to come to get tested
- 54.7% felt that women have healthier babies because of the food
- 51.1% felt that women are less vulnerable to engaging in high-risk behaviours because they have more food available at home.

Additionally, the respondents provided their own ideas of the impact of WFP food. Some of those comments included:

- “It will help prevent early progression of HIV into AIDS”
- “If the mother is healthy, the chances of transmitting the HIV virus in uterus (while pregnant) to the baby will be minimised”
- “Since we always teach them about the importance of diet, with food being supplied it will be easy for the clients to understand the whole concept”
- “Because the people in our programme are vulnerable. Right now we only give a mother PMTCT drugs and forget about her nutritional status in pregnancy and after delivery now with food we can help the mother a lot more.”
- “Yes – most people in our community can not afford three meals a day. At least if they can have soup porridge in the morning, then they may be able to have their regular meal in the evening.”
- “For those who might be single, divorced or widowed and have no source of income, it could help in sustaining them and prevent them from inflicting others whilst engaging in activities like sex to buy food.”

Categorising clinic staff responses, 9% (4/44 points raised) were programme related, 14% (6/44) were HIV mitigation related, and 45% (20/44) were food and income security related.

The problem tree reflects that, for clinic staff, food and nutrition issues are complex, connected and far reaching. The questionnaire responses demonstrate that food assistance to PMTCT programmes can have a holistic impact, on clinical as well as social factors.

Perceptions of expert stakeholders

In order to access opinions from experts in the field of PMTCT both locally in Zambia and internationally, a questionnaire was sent to researchers, policy makers, clinical specialists, government officials and relevant UN employees. One of the four open-ended questions asked, ‘what impact do you think WFP food assistance could have on programmes to prevent mother to child transmission of HIV?’ Of the eight responses to this question received, five were directly related to impacts on maternal and child health, specifically on nutritional status and breastfeeding, and three responses were related to programming and food security.

The sample of responses below illustrate the broad range of impact that expert stakeholders feel food assistance could have in PMTCT programmes.

- “Lots of women are educated as to the importance of breastfeeding for the child’s health but a low percentage of women are exclusively breastfeeding until 6 months in Zambia, partly due to mother’s malnutrition. Food aid for lactating women coming from food insecure families can be an important factor contributing to promotion of breastfeeding.”
- “It is hard to convince people to take medicine and engage in health care if their basic needs are not being taken care of. When you are really sick with AIDS, your nutritional requirement goes up, you need more medicine and not food it won’t work. Before medicine has to come food, without food, medicine can only do so much.”
- “WFP food assistance supplements the women’s existing diet. A satisfactory diet contributes to good nutritional intake/absorption and satisfactory health throughout pregnancy. To further elaborate on this statement, WFP food assistance contributes to steady weight gain throughout her pregnancy, enables proper foetal growth and development and, ensures that she receives vital micronutrients. In addition, food encourages women to keep their families healthy.”
- “Women’s empowerment could help to minimise women coming from food insecure families can be an issue. Food also helps in exclusive breastfeeding until 6 months in Zambia, part of the programme to prevent mother to child transmission of HIV.”
- “The same time, WFP food assistance contributes to steady weight gain throughout her pregnancy, enables proper foetal growth and development and, ensures that she receives vital micronutrients. In addition, food encourages women to keep their families healthy.”

These responses show that stakeholders feel that through the receipt of food is having a direct impact, including improving rates of exclusive breastfeeding, improving health seeking behaviours amongst HIV infected people (such as intervention programme uptake and retention) as well as improving clinical outcomes for maternal and child health.

Conclusions

Through the perceptions gathered here from beneficiaries, staff, and expert stakeholders, we can see that food aid has a powerful potential for positive impact on prevention of mother to child transmission of HIV programmes. The impact of the food appears to be spread across the HIV response continuum of prevention, mitigation, treatment and care. There are potential risks, including food servicing and dependence on food assistance. These risks can best be addressed through integration with other programmes and services, including comprehensive maternal and child health programmes, health education and capacity building projects, and income generating projects.

One of the stakeholders spoken to in Zambia had attended the 2004 International HIV conference in Bangkok. She said she had not realised, until discussing it at the conference, that only a few countries had attended PMTCT programmes with food assistance. She said, “WFP Zambia is at the forefront of food support and HIV. WFP is not there yet on a global level, and they need to be.” Taking lessons learned from food supported PMTCT programmes, Zambian Ministry of Health, and several MTCT clinics in Lusaka, it appears to be spread across the HIV response continuum of prevention, mitigation, treatment and care. There are potential risks, including food servicing and dependence on food assistance. These risks can best be addressed through integration with other programmes and services, including comprehensive maternal and child health programmes, health education and capacity building projects, and income generating projects.

For further information on this study, contact Pamela Ferguson, email: p.fergusson@chester.ac.uk.

For more information on WFP PMTCT related programmes, contact Andrew Thorne-Lynam, Public Health Nutrition Officer, WFP, email: andrew.thorne-lynam@wfp.org

1. Report: WFP food support of PMTCT programmes in Zambia: a situational analysis of the needs, risk and benefits
2. Zambian Ministry of Health Prevention of Mother to Child Transmission (PMTCT) protocol guidelines
ENN in the Field

Mary Corbett is a food security and nutrition consultant who visited southern Africa on behalf of ENN in early 2005.

Editorial

When approached to be part of a team to collect material for a special edition of Field Exchange focusing on HIV/AIDS and nutrition/food security, I was extremely excited and felt it would be a great learning opportunity. At an ENN planning meeting, we decided to only attempt focusing on Africa and in particular, the Horn and Southern Africa. Again, we had to narrow this down to a small number of countries and try to pull out experiences from a manageable number of programmes, given a limited travel time of approximately six weeks. The initial planning started in late 2004 and involved contacting agencies and pencilling in meetings and potential projects to be visited.

The field trip started with regional meetings in Johannesburg in early January 2005. From here I moved onto Malawi for a very hectic two weeks, rounded off by a trip to the airport for a non-existent flight to Zambia. In some ways, an extra two days to tie down and write up findings from the Malawi trip was welcome, but it did mean the Zambian trip was shorter than initially planned. However, with good co-operation, I still managed to see quite a lot of people and some interesting programmes. On to Kenya and though a mere four day trip that included a week-end, was extremely fortunate to make it to western Kenya to see a very dynamic local organisation. This was largely due to the support of WFP. But, again, we had flight problems. As I rocked up for the Friday evening flight out of western Kenya, I found that it was over-booked by 29 people and I was rescheduled to the early morning flight on Saturday. I finished off my travels with two weeks in Uganda, again achieving a substantial amount due to all the support from implementing partners on the ground.

Working as an independent consultant meant that I missed the usual luxury of an agency picking me up from the airport, having accommodation organised for me, and my itinerary all planned. Basically, I had to organise my own itinerary within a very tight timeframe. Therefore I spent some time haggling with taxis, trying to book accommodation prior to arrival (some of the lodgings proving a bit dodgy), and actively locating people/agencies in order to set up meetings. However, thanks to a number of good friends in the region, my trip was made much more successful than it might have been. I really appreciate their support and hospitality in providing food and accommodation. Furthermore, WFP was extremely supportive in terms of planning, organising and taking time out to travel to the field with me. Many of the implementing agencies were also extremely helpful, very honest and openly discussed issues.

At times, people were a little surprised at my focus on HIV/AIDS and nutrition/food security. To many it seemed so logical that there should be integrated programming, and that this should be part of a programme approach, that there was really little need to discuss a rationale. However, in my fieldwork I found these assumptions not to be the case. In a region with very high levels of HIV prevalence - 10-20% in many countries and underlying poverty affecting between 40-60% of the population, food security in many households is currently a major issue. This places an extra stress on the household, already marginalised by HIV. Furthermore, many households are made even more food insecure as a result of hosting orphans from HIV affected families.

Although all the countries visited during this trip have many similarities, there are also significant differences. Generalisations about programme approach are, therefore, not wise. For example, in Uganda where there has been a culture of awareness and openness around HIV for almost two decades, prevalence is now down to around 6.2% and targeting is much easier (stigma is reduced but still present). Furthermore, there are more facilities for testing for HIV. Indeed some of the programmes will only admit beneficiaries if they have documentation to show they have been tested. This contrasts with other countries visited where testing is not available countrywide (e.g. Malawi) and stigma is more prominent so that proxy indicators, such as chronic illness, are used for programming purposes.

It is really very difficult to target ‘chronic illness’ and it probably leads to both high levels of inclusion and exclusion error. In one programme, where chronic illness was the initial criteria, beneficiaries were offered VCT due to the potential introduction of ARVs. Around 20% of these chronically ill tested HIV negative. Some were upset to know their status, as it meant they would lose the resources they were receiving. This seems amazing, as they should be delighted to be HIV negative. This suggests many of these people are living in a state of chronic poverty and need to be supported, even if not under this particular type of programme.

When visiting programmes, in particular those with HIV positive and TB affected benefi-
In the case of patients with TB, many present with moderate or severe malnutrition. A study completed in Malawi of 1181 TB patients found that 80% were HIV positive and that 57% of the cases were malnourished. Mortality was closely associated with severity of malnutrition, with higher rates in the moderate to severe group (early mortality within 4 weeks). This highlights the need for targeted nutrition support for this group. In general, once patients enroll on TB treatment, they report that their appetites improve rapidly. If they have little food in the household, it is a major problem for them and can result in failure to comply with the treatment. In some programmes, compliance has been noted to improve with food aid support.

Implementing partners are grappling with project inclusion criteria throughout the region. Some programmes use externally imposed targeting criteria for individuals, while others, particularly in rural areas, are more dependant on community targeting. The rural and urban context can be extremely different. However, in nearly all programmes, although exit strategies are recognised as necessary, they are only being discussed (rather than implemented) at present. In general, there is a feeling that there needs to be some sort of time frame for inclusion in a food assistance programme but at the same time, there needs to be flexibility, especially given the difference in vulnerability between beneficiaries.

For most implementing partners, the programmes are intended to be comprehensive; addressing immediate needs in the form of food assistance (safety nets), and then more long-term food security assistance in the form of income generation, loans and agriculture inputs. Implementing partners also recognise that the health component is essential, some agencies link in with either the MOH or other health focused implementing partners. There is continual learning with many innovative types of programmes being piloted. At the same time, many of the more traditional skill training programmes, such as tailoring and carpentry, are also in place. Projects aimed at strengthening marketing are also being looked at by some agencies, particularly those working in rural areas.

The introduction of ARVs is going to dramatically change the dynamics around HIV/AIDS. ARVs are already allowing people to live longer with AIDS. However, the rollout needs to be carefully handled. In many of these resource poor countries where the health infrastructure is extremely limited, adding the ARVs programmes to health care will stretch an already limited health care capacity. Other components of the care and support to PLWHA need to be in place in order to support compliance with ARV regimes. These components include basic health care, good nutrition support and food security. It is recognised that PLWHA require at least 10% more energy daily, but when sick with opportunistic infections, this requirement is increased even further. The opportunistic infections often reduce appetite and therefore can lead to rapid weight and weakening of an already weak immune system. Therefore good nutrition is a major factor in good health, particularly with this vulnerable group.

Recent studies in Zambia and Cote d’Ivoire have shown substantial reduction in mortality and hospital admissions for PLWHA after the introduction of cotrimoxazole as a daily prophylaxis. The objective of introducing cotrimoxazole is to reduce risk to opportunistic infections. The overwhelming evidence has led WHO/UNAIDS to provisionally recommend that all PLWHA in Africa should receive prophylactic cotrimoxazole as part of the minimum package. However this minimum package, in general, is not being offered. Some PLWHA, who are well informed and can afford the drug, buy it themselves. However, even at a cost of about a dollar a month, this is not affordable for many very poor people. Arguments for investing in prevention appear unchallengeable if one weighs up the cost of a prophylaxis against the benefits, i.e. improved well being of clients, fewer illnesses and less weight loss so that PLWHA remain well, and therefore productive, for longer. Also, infected individuals may not require ARV’s until much later in their illness, resulting in cost savings.

Where activities are being focussed on three by five initiatives (to have 3 million people on ARV’s by end of 2005), it is extremely important that this does not become the priority to the detriment of all other support to PLWHA and their families. It is important to adopt a holistic approach, supporting nutrition, food security and health care in conjunction with ARV rollout.

It is essential to keep people well for as long as possible so that they can support their families.

I had the privilege of meeting families where a member was HIV positive, who, with the many types of support being offered - food aid, spiritual/psychosocial support and food security activities - were actually “planning for the future”. One particular family we visited in Uganda, where both the mother and father were HIV positive, had enough cassava planted for at least a year and were proudly able to tell us that their eldest daughter was preparing to go to teacher training college. Their inspirational energy showed the power of a well targeted programme, offering a variety of support to keep a family unit intact and giving people hope for the future.

Mary Corbett

3 Anglaret X et al, 2003 Pattern of bacterial diseases in a cohort of HIV-1 infected adults receiving cotrimoxazole prophylaxis in Abidjan, Cote d’Ivoire, AIDS 2003,17:575-584
Impact of HIV/AIDS on Acute Malnutrition in Malawi

By Susan Thurstans, AAH and Mary Corbett, ENN

This article developed from an interview by Mary Corbett (ENN) with Susan Thurstans, Action Against Hunger, Malawi.

The authors would like to acknowledge the support of AAH and the contributions of the AAH staff in Malawi, the Ministry of Health and Queen Elizabeth Central Hospital, Malawi to the ongoing work.

In Malawi, chronic malnutrition (stunting) is estimated at around 50%, although recent studies suggest this has increased substantially and, in some districts, is now around 65%. Rates of underweight are at 25% and acute wasting around 6%. During the dry season, admissions to the nutrition rehabilitation units (NRUs) average between 20-25 children a month. During the hunger gap, this peaks at 40-60 children, with higher numbers in the southern region. Action Against Hunger (AAH) became operational in Malawi in 2002, in response to the food crisis. Initially the main programming focus for AAH was supporting the treatment of severe acute malnutrition, targeting the under five’s population through the Ministry of Health (MOH) supported NRUs. AAH are now operational in 48 NRUs scattered through northern, central and southern regions of the country.

Through a collaborative process between the MOH, UNICEF and many NGOs, national guidelines for the treatment of severe acute malnutrition have been developed in line with international guidelines. These include protocols on nutrition and medical care to deal with acute malnutrition. As part of the development process, admission criteria were changed from admission using weight-for-age (a measurement of chronic malnutrition), to weight-for-height, a measure of acute malnutrition. Training of the NRU health staff was one of the main components of this programme. Another key element was sensitisation of senior staff at district level regarding the importance of appropriate treatment and resources for this vulnerable group. Ongoing supervision in the NRUs was also a major component. In a short period, extraordinary gains were made in Malawi in standardising nutrition guidelines, due to extensive co-operation among all the players and an openness of the MOH towards changing practice.

Context of HIV/AIDS

As a result of the compliance with the new guidelines, training, availability of special diets (F75 and F100) and availability of medicines, the treatment of acute malnutrition improved significantly. With the use of weight for height as admission criteria, only acutely malnourished children were admitted, so that length of stay in the NRU decreased and better weight gains were achieved. However, as seen from figure 1, the mortality rate remained high. A high prevalence of HIV among those admitted to the NRU was suspected as a cause - two small studies, conducted in Malawi, indicated prevalences of 18.9% and 34%. Given this, a comprehensive study was undertaken to determine the prevalence of HIV in children admitted to the NRUs.

Method

The objectives of the study were:

- To establish the point prevalence of HIV sero-prevalence of children admitted to NRUs in Malawi
- To describe seasonal and regional variations in the proportions of HIV sero-positive children receiving care in NRUs in Malawi
- To describe clinical outcomes of HIV positive and negative children admitted with malnutrition
- To improve linkages with services providing support to PLWHA

The study was conducted in collaboration with AAH, the Malawi College of Medicine, MOH Malawi and UNICEF. It was a two-part study, carried out during both the dry and wet seasons in order to assess seasonal variations in HIV prevalence.

Twelve sites were identified, four from each region, in addition to the referral hospital from each region, and three rural hospitals. All mothers and children in the NRU over a two-week period were asked to participate in the study. Children less than 15 months were excluded, due to the unreliability of results in the absence of Polymerase Chain Reaction (PCR) testing methods. Of those mothers approached, 145 children were eligible and 143 mothers consented to Voluntary Counselling and Testing (VCT) for their children.

Results

The preliminary findings from the first part of the study, carried out during the dry season, indicate a prevalence of 30% (CI 22%-37%) countrywide. However, there were significant regional differences, with the highest prevalence rates in the southern region at 42%, 16% in the central region and 32% in the northern region. The study is being repeated in February 2005 (hunger gap) to provide a seasonal comparison.

Out of the sero-positive sample, 58% were admitted with marasmus, 30% with kwashiorkor and 12% with marasmic kwashiorkor. Weight for height z scores on admission are presented in figure 2. Of those enrolled in the study, 40% of HIV positive had been previously admitted to a NRU, compared with 29% of HIV negative children (p=0.18, not significant). Clinical condition on admission to NRU is shown in figure 3.

As can be seen from table 1, the outcome for children admitted to the NRU who were HIV positive is poor, with almost half discharged as failing to respond (discharged at below the target weight). This group also had a higher rate of defaults compared to those who were not HIV positive.

Conclusions

Although these results are not altogether surprising, it is extremely important to confirm the high HIV prevalence rates amongst this malnourished population group. Given this, specific nutritional and medical requirements need to be better addressed within the context of NRU and community programming. However, there remain many unknowns with regard to the treatment of severe acute malnutrition in conjunction with HIV positive status - particularly in children. Child friendly services are not available in many situations to deal with the issues around HIV/AIDS and children, particularly in the context of HBC programming.

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1 Rogerson et al (2000) conducted a study whereby new admissions to an NRU (Queen Elizabeth Central Hospital) were tested over a two week period. Of these, 18.9% were found to be HIV positive and almost 30% of these children died.

2 Kessler et al (2000), found a HIV prevalence of 34.4%, from a sample of 250 malnourished children. The overall mortality for this study was 28%.
The uptake of testing was high. However, it appeared that on occasion, health staff over-sensitivity regarding HIV/AIDS testing, particularly in relation to stigmatisation, may have adversely affected uptake of VCT.

Following on from this study, AAH plans to try to use the NRU as an entry point for the care of children with HIV/AIDS. A referral system is being set up to link the NRU to services providing care and support to people living with HIV, in order to provide a more holistic form of care. Services will include, VCT, PMTCT for mothers, ARV (mainly for adults) and opportunistic infections (OI) treatment where available, family planning and community home based care (CHBC). To support the role of NRUs, there is a need to:

- train NRU health staff to identify HIV symptoms and provide more appropriate support to VCT
- strengthen linkages with paediatric units and paediatric ARV provision as, presently, some NRUs are separate from paediatric wards, and
- improve NRU kitchen garden programmes so that these better support training in crop diversification and use of herbs, as well as improved food security activities for households of NRU patients.

The current Malawi nutrition guidelines for the treatment of severe acute malnutrition may need to be revised to address the special needs of children admitted with HIV/AIDS. AAH are currently conducting research to monitor the response of children to therapeutic feeding according to sero-status, in order to determine if there is a need to modify current guidelines.

Finally, nutrition guidelines relating to HBC and children need to be re-examined, in particular with regard to ‘positive living with HIV/AIDS’. A number of initiatives are afoot with regard to this.

For further information, contact: Action Against Hunger, PO Box 145, Lilongwe, Malawi, email: aah@globemw.net

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**Table 1** Cure rates amongst children enrolled in the study

<table>
<thead>
<tr>
<th>HIV Status</th>
<th>Cured</th>
<th>Death</th>
<th>Default</th>
<th>Discharge as non respondent</th>
<th>Lost to Follow up</th>
</tr>
</thead>
<tbody>
<tr>
<td>+ve</td>
<td>40</td>
<td>2.5</td>
<td>7.5</td>
<td>45</td>
<td>5</td>
</tr>
<tr>
<td>- ve</td>
<td>76</td>
<td>2</td>
<td>3</td>
<td>16</td>
<td>3</td>
</tr>
</tbody>
</table>

**Figure 1** Mortality rates (%) for all NRUs (Dec 2002 – Jan 2004)

**Figure 2**

- **Figure 3** Clinical presentation based on HIV status

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**Integrated PMTCT Services in a Rural Setting in Malawi**

By Gertrude Kara, WFP and Mary Corbett, ENN

Gertrude Kara is the Programme Officer responsible for HIV/AIDS programmes in WFP Malawi. She has wide experience in the area of sexual and reproductive health, population issues, HIV/AIDS, nutrition and food security.

The authors would like to acknowledge the contributions of Dr. Athanase Kiromera, Medical Director, St. Gabriel’s Hospital, and Miss Hilda Kamera, Matron, St. Gabriel’s Hospital, to this article.

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This article is based on interviews by Mary Corbett with Matron Hilda Kamera and Dr. Athanase Kiromera, and a project visit by Mary, accompanied by Gertrude Kara, WFP.

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**St. Gabriel’s Mission Hospital** is situated in Lilongwe district, about 45 minutes by vehicle west of Lilongwe, the capital. Although just off the main road and reasonably close to the city, it is a very rural location. The hospital services a catchment area of 15km radius and a population of 200,000 people who rely mainly on subsistence farming. Maize is the staple food, while tobacco is the main source of cash and is mostly cultivated in big estates where the majority of the poor work as tenants. Most of the people have inadequate land and cannot afford agricultural inputs and are thus, potentially more food insecure. In Malawi, health care is supported through a combination of facilities run by the MOH (Ministry of Health) and the CHAM (Christian Health Association of Malawi) - approximately 40% of the health care is primarily supported by CHAM, working closely with the MOH.

**PMTCT in Malawi**

Mother-to-child transmission (MTCT) is the second major mode of transmission of HIV in Malawi. Recent estimates show that MTCT accounts for 8 to 10% of all HIV cases in the country. Although 10 to 15% of perinatal HIV infections occur through breast milk, women, particularly from rural areas, regard breastfeeding as the natural and preferred means of feeding their infants due to high poverty levels.

The health staff at St. Gabriel’s felt that there was a need to support pregnant/lactating women living with HIV/AIDS. In particular, the health personnel were concerned at the outcome of mothers diagnosed with HIV/AIDS, especially those with borderline nutrition status, and the impact this would have on breast milk output. A study in Kenya had indicated that reduced nutritional intake leading to catabolism increased the speed of the disease process - it is clear that the death of a mother substantially increases the risk of death of the young infant.

Thus, following discussions with WFP, a proposal was developed with a very specific objective to support HIV-positive pregnant and lactating women and their families with nutrition support. In October 2003, in collaboration with WFP, a pilot nutrition intervention to support pregnant/lactating women with HIV/AIDS and their families was commenced.

**Intervention**

All pregnant women during antenatal visits were offered VCT (voluntary counselling and testing). Women tested positive for HIV/AIDS were counselled that by including a family basket, it might reduce sharing of milk and a family basket, it might reduce sharing of milk.
The nutritional wellbeing of a woman plays a key role in the overall status of her own and her baby’s health. Food support improves the energy and protein intake of mothers, helps build their reserves and reduces their vulnerability to opportunistic infections. Integration of a well-targeted nutritional support increases mothers’ and babies’ access to health services. Food support enhances male involvement in the programme and empowers women to face their HIV status positively.

In conclusion, the nutritional wellbeing of a woman plays a key role in the overall status of her own and her baby’s health. Food support improves the energy and protein intake of mothers, helps build their reserves and reduces their vulnerability to opportunistic infections. Integration of a well-targeted nutritional support increases mothers’ and babies’ access to health services. Food support enhances male involvement in the programme and empowers women to face their HIV status positively.
This article describes the evolution of Oxfam’s operations in Malawi, and touches on how Oxfam have been influenced by their regional experience of HIV/AIDS.

**Evolution of Oxfam’s approach**

Prior to 1996, Oxfam provided financial support from their Zambia based operation to a mixture of partner implemented programmes in Malawi. In 1996, Oxfam became physically operational in Malawi, embarking on direct programming as well as working through partners, and focusing on livelihood support. Key activities included on-farm production, off-farm production, supporting small businesses, and social mobilisation in the form of capacity building. In 1999, the programme approach changed within the Oxfam global organisation, with the focus more on strategies to change the lives of the poor. Consequently, this meant a shift towards policy and practice changes that impact on poverty. Within this broader programme framework, the Malawi country programme focused on food and income security for the poor, their right to be heard, and gender. In 2000, in response to a greater awareness of the impact that HIV/AIDS was having on communities they were working with, Oxfam Malawi changed strategy again, this time mainstreaming HIV/AIDS work in all their programmes.

Following on from the 2002 food crisis, there was a realisation that the effect of the countrywide food insecurity was particularly marked for those households affected by HIV/AIDS. In 2003, Oxfam decided that a new strategy was required specifically to deal with this problem since despite reaching the end of the drought assistance period, it was felt “it was not possible to pull out as people were too vulnerable”. This article outlines this new programming strategy for Oxfam in Malawi.

**Rationale of current approach**

Underpinning the new strategy was the Oxfam Malawi team’s feeling that food aid was essential, in the short term, to save lives. Without food aid, very sick people will not survive. Bridging the gap is also critical in order to support more long-term food security through strengthening food production. Food aid can break the cycle leading to individual and household crisis. However, strengthening food production to bolster longer-term food security is particularly challenging in Malawi, where agriculture is rain-fed and therefore highly dependent on rainfall and drought.

The need to support seriously ill patients with health care and medications is clearly a priority. Prescribing medicines on an empty stomach is not advisable and can influence tolerance to medication. Therefore it is important to have both a food aid component and more long-term food security measures to support patients’ health.

In order to have a significant impact, these considerations argued for an integrated approach to programming for the chronically ill and their families through provision of health care, meeting immediate food needs, and long-term food security initiatives.

Given the vulnerability of the chronically ill, an integrated approach to interventions was developed by Oxfam which encompassed:

+ Safety nets support in the form of food aid and free inputs.
+ Medications and health care with advocacy as a key strategy.
+ Support to longer term food security.

**Population**

Oxfam is operational in three rural districts, Mulanje, Thyolo and Phalombe, in the southern region of Malawi. The government is a key partner in all three districts, as are a number of NGOs. According to the 1998 population census, the population of Thyolo is 458,976 and that of Mulanje is 428,322. The 2001 integrated household survey showed that 71% of Thyolo and 60% of Mulanje populations lived in poverty. In Mulanje, Oxfam is targeting half the villages in the district while, in Thyolo, fewer villages are yet involved as it is a relatively new district for the programme. Since MSF-Luxembourg (MSF-L) is also operational in Thyolo, a working relationship has been developed to avoid duplication and ensure comprehensive support to the communities.

**Targeting**

All interventions are targeted through structures within the communities, mainly Village Development Committees (VDCs). For the safety nets and healthcare programmes, Oxfam works with home based care (HBC) structures, where these exist, and where there are no HBCs, with VDCs at a community level. Through the HBC structure, beneficiaries are identified, providing the vehicle for the Oxfam food aid and social support is given, and long term food security support is mobilised and supported. Beneficiary status is reviewed on a monthly basis.

**Programme**

At present, 3,500 households (HH) are receiving food aid from Oxfam, while an additional 5,228 HH are receiving food aid from WFP. A family basket of maize 50kg, oil, beans and Lukinski Phala’ are given on a monthly basis. This element of the programme comprises approximately 10% of the programme budget.

Oxfam recognises that there is a need to stimulate household and community production. At present this is taking place through training, distribution of seeds for communal gardens, distribution of fertiliser and development of village grain banks linking production to vulnerable households.

Health care is conducted through the HBC structure. In Thyolo, a Memorandum of Understanding with MSF-L is being signed to link programmes and prevent overlap. MSF has the capacity to test and treat tuberculosis (TB), have facilities for VCT (voluntary counselling and testing) and therefore highly dependent on rainfall and drought.

**Challenges**

There are a number of challenges for this programme. Food insecurity in the region is a longterm problem, and food aid is a costly and not sustainable longterm measure.

The challenges faced are a composite of addressing immediate needs and longer-term food security. However, without addressing both concurrently, it would be very difficult to make substantial progress. Although food aid has been very well received and appreciated, it is difficult to measure impact of this intervention. There is a need to develop tools to measure impact of this integrated approach.

Access to markets is a major constraint, and it may be necessary to consider ‘fair trade’ issues while attempting to strengthen markets. Also, linkages between HBC and the health infrastructure are very weak. While HIV/AIDS related needs will remain for many years, strengthening community mechanisms may help to ensure longer-term support for the chronically ill.

**Future plans**

In 2006, Oxfam plans to expand its present programme and work in another district, (likely Blantyre Rural) using the same approach with an expanded budget. Oxfam also plans to strengthen their work in the key areas of advocacy, emergency preparedness and mitigation and capacity building within the Ministry of Health.

For further information, contact Oxfam Malawi, P/B 213, Blantyre, Malawi.

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1 A locally produced fortified blended food
Kate Vorley has spent 12 years working in programme management at national and regional levels for international NGOs, faith based organisations and multi-lateral donors, with a primary focus on programmes working with OVC (under health care and education).

The authors would like to acknowledge the work of Project Concern International (PCI) as the implementing agency, and the World Food Programme-Zambia Country Office, as main donor to PCI/WFPs OVC Support Programme.

This article describes the experiences of a school-feeding programme supported by the World Food Programme through Project Concern International (PCI).

Zambia, with a population of under 10 million, is a highly urbanised country, with around 40% of the population living in the main cities. However, poverty remains a major problem and according to the living conditions monitoring survey of 1998, 73% of the population are considered to be living in poverty. The HIV pandemic, together with other public health issues, has exacerbated an already chronic situation. Currently it is estimated that 16% of the population aged between 15 and 49 years is HIV positive1. There is a significant gender difference, with much higher prevalence rates among females between 15-24 years compared to men of the same age group (ranges of 17-25% for women, compared to 6-10% for men). The impact of HIV on families is substantial, some are street children and a high proportion are affected by HIV (an estimated 40% per-sonal communication).

Community schools

Community schooling is a particular Zambian approach. Due to the lack of sufficient numbers of government schools for all school-going age children, communities have set up their own informal basic schools. Normally, land is donated by a local chief or church (or sometimes rented) and a structure is built. The community schools are run with the support of local community based, non-governmental or religious organisations. Over time, the infrastructure expands through a combination of community financial support and outside donor funding. Most of the community school teachers are not trained and come from the very same communities that initiated the community school. They use whatever limited building is available (even open space) and have limited resources (mainly books, desks, blackboards, etc). Some teachers in these schools are now receiving government salaries, indicating that the government is acknowledging and supporting this educational system. Many of the schools appear to also have support from church groups or religious affiliations. The community school movement is managed by the Zambia Community Schools Secretariat, a local NGO mandated by the Government in the management and development of community schools in Zambia.2

The urban intervention

The UN’s World Food Programme (WFP) first commenced food assistance to community schools in Lusaka district of Lusaka province in January 2003, with Project Concern International (PCI) as the implementing partner. After six months of successful implementation, the project was scaled up and is now in two additional districts of Lusaka (Kafue and Chongwe). It serves a total of 205 community schools, as well as nine residential centres that cater for street children. Over 67,000 children each month are being supported with school feeding3. Many of the children enrolled in these schools are very marginalised, some are street children and a high proportion are affected by HIV (an estimated 40% personal communication).

Curriculum

As many of these children have dropped out of the formal education system (and in some cases were never in it), older children of around 10-11 years of age often end up in grade 1. To try to deal with this, community schools follow an accelerated curriculum called SPARK. The SPARK curriculum allows for only four school years or grades, instead of the normal seven grades typically adhered to in the formal education sector. Thus, two years are conflated into one grade. There is also a focus on life skills. Uniforms are not mandatory in community schools and there are no school fees - thereby reducing obstacles to attendance. However, if students do well in the community schools, they have an opportunity to attend secondary, and even tertiary, level education.

Major components of the Urban Intervention

a) School feeding intervention

The school feeding intervention commenced in January 2003 in the aftermath of the food and drought crisis of 2002. It was felt that urban populations were as much affected by food insecurity as the rural population, hence the urban nature of this intervention. The project targets both community schools and centres that cater for street children. Each school has its own Parents Community School Committee (PCSC), which is selected by the local community and is responsible for the overall management and running of the school. Community schools are therefore considered a community-based organisation (CBO), and provision of food commodities to orphans and vulnerable children (OVC) through community schools is, in itself, a self-targeting mechanism. PCI works in partnership with these CBOs with the primary aim of increasing their capacity to manage school feeding programmes and overall, OVC programmes.

The main objectives of the programme are:

- To improve enrolment and attendance levels in target community schools.
- To increase the participation of HIV/AIDS affected households in activities that will improve their health and livelihood security.
- To improve HIV/AIDS-related knowledge and practices amongst the target OVC population and other household beneficiaries.
- To improve the capacity of PCI’s implementing partners (CBOs) to implement and manage the programme.

The impact of the programme (under objective 1) is assessed by monitoring the number of students on the school enrolment registers and daily attendance rates.

Wet feeding and dry rations

For most schools, the assistance is in the form of one cooked meal a day, consisting of a wet ration of High Energy Protein Supplement (HEPS) and vegetable oil, a locally produced fortified Soya blend donated by WFP and delivered by PCI and cooked on site by school volunteers. All Community School Coordinators have been trained in the various aspects of managing school based feeding programmes ranging from community mobilization strategies, food preparation and handling and hygiene issues as well as report writing skills. A project orientation guide was developed in early 2003 and has been continuously revised to reflect lessons learnt during project implementation.

Initially it was planned that the feeding would be at 08.00 a.m., so that children would not attend classes on an empty stomach. In reality, most community schools tend to feed the children at approx. 10.00 a.m., to allow the community volunteers, who are themselves wives and mothers, to finish their

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2 Estimated at over 2000 community school nationwide.
3 22 school days estimated for each month.
4 School, Participation, Access and Relevant Knowledge
5 10g of HEPS and 10g of oil is provided for each child/school day
6 A 50-kg bag of grain is provided to the center to facilitate lunch and/or supper meal preparation, in addition to the HEPS supplied.
households chores. All children in the target community schools are fed with the wet ration at the community school to avoid stigma. In addition, the school gardens involve the individual children identified as particularly vulnerable also receive a monthly family take home ration, consisting of a 50kg bag of grain. This targeting considers both economic and social status of households - child-headed households are considered particularly vulnerable, while the dependency ratio at the household level is also taken into account.

b) HIV/AIDS component

The project also has a Behaviour Change Communication (BCC) component and PCI has trained a group of 20 youth as trainers in theatre for development techniques. Technical assistance from the Zambia Open University. TFD involves the use of participatory assessment methodologies for qualitative and quantitative data collection and incorporation of key messages into drama, song and dance. It was used to strengthen the skills of local drama groups that work with schools and drop in centres to provide effective HIV/AIDS prevention for behaviour change and communication. The 20 TOFs in theatre for development skills have, in turn, trained a total of 144 OVC and 64 teachers in three districts.

For activities targeting OVC in the PCI supported residential centre for street children, a draft curriculum has been developed for HIV/AIDS education for this profile of OVC. This curriculum is complemented by appropriate Theatre for Development materials that were developed in collaboration with 30 street children (ranging from 9-20 years) from three of the residential centres benefitting from the PCI/ WFP project.

c) School Based Agriculture component-Pilot Project

A school based agriculture pilot project has been implemented in 10 sites under a pilot phase. The aim of the school garden project is to enable site management to produce or access resources (from the garden or sale of produce) to manage their own school feeding programmes. The school garden concept has the following objectives:

- To build the capacity of teachers to teach agriculture as a classroom subject under the approved Government syllabus.
- Supplement the material resources available to community schools under the feeding programme.
- Income generation in those sites that involve women’s cooperatives (to ensure that child labor is not used to generate income for teachers).

Two teachers from each of the 10 sites were trained in vegetable production, field crops, animal husbandry and fruit production. A training manual was used developed with support from a University of Zambia Consultant with input from key stakeholders, including the Ministry of Agriculture and Cooperatives.

All sites have been provided with in-puts to kick start the pilot in three main agricultural areas - vegetable production, field crops and fruit production as well as garden. Additional training has been provided in the areas of plant protection, safe storage of chemicals, planting of field crops and fruit trees as well as record keeping (physical and financial records).

Findings from the pilot areas will assist in developing a realistic implementation plan for the scale up of this component to other participating community schools/residential centres.

Ongoing challenges

At present, PCI is supplying WFP food to over 60% of children in 214 community schools and centres in three districts. Absolute enrolment and attendance rates have increased by 26.6% and 40% respectively but there remain numerous challenges. Increased workload

Many schools find it difficult to turn away students, putting strain on the physical school capacity, i.e. space in classrooms, class size, etc., and creating an additional workload for the teachers which may adversely affect the quality of teaching and record keeping. As a result, in some schools, the two-class rotation (whereby some students come in the morning while others attend in the afternoon) has been replaced by three sessions – especially for the junior classes. This means that the students have less contact time with the teachers in the school.

The reduced contact time and larger class sizes may have a serious negative impact on academic results. However, anecdotally, teachers feel that the school feeding has made a big positive difference with a reduced number of children dropping out. Also, many of the children no longer come to school hungry, so that concentration levels have improved. There are plans to formally measure the impact of learning achievement on OVC in the near future.

Monitoring

At the onset, monitoring daily attendance at the classroom level was poor. Strict monitoring and accounting of the food, record keeping and store capacity have also been difficult in some schools. However, measurement tools and training have since been provided by PCI, and attendance data are now available for all OVC and for low availability in numbers of children dropping out. This means that the children no longer come to school hungry, so that concentration levels have improved. There are plans to formally measure the impact of learning achievement on OVC in the near future.

Food Management

Due to the increased school numbers and rotation system for actual classroom sessions, the on-site cooking needs to be done more than once a day. Fuel for cooking is often a limitation, with charcoal not available or used up quickly (PCI plans to explore possibilities of an energy-saving cooking ‘jiko’ to address this concern). Also, securing community volunteers to do the cooking has occasionally been difficult, so that community sensitisation continues to be a top priority for PCI Food Aid Monitors.

There has been some abuse of food items, particularly in urbanized settings. In such instances, distribution of food commodities to sites (esp. grain) has had to be halted while PCI works closely with the school’s PCSC to put effective food control systems in place.

Since PCI and WFP cannot guarantee the continued availability of grain, the project now uses a specific targeting tool that aids identification of the most vulnerable households with OVC.

Water

Water availability has been an issue in some schools, and although UNICEF have supported certain schools with boreholes, lack of ownership of land in certain cases prevented some needy schools from benefiting from this component. Communities continue to be sensitised to the need for ‘go to market’ involved in revenue generating activities that will enable schools to own their own land.

In spite of the above, and in addition to the progress made towards key education indicators, it is worth noting that project has also been able to facilitate a considerable increase in parent’s participation in the education of their children in participating community schools. Anecdotal reports from the partners indicate a notable increase in community involvement in OVC school activities as a result of the Urban Intervention. High attendance levels by parents in community meetings to discuss community school plans and identify ways of remunerating teachers at the school have been reported to PCI. Mothers continue to be primarily involved in the wet ration preparation, as well as in collecting firewood to facilitate the same.

Future plans

School feeding will continue for a further one to three years (Jan 2005 to Dec 2007) under WFP’s “Protracted Relief and Recovery Operation” programme (PRRO). The programme will place more emphasis on ‘recovery’ than on ‘relief’, and focus on more sustainable measures to support OVCs at the community school level.

It is recognised that analysis enrolment and attendance data from all schools is important in order to better understand the impact of the programme. Daily attendance and student results have been analysed in June 2003 and July 2004. However, due to limited CBO capacity, these data have not been disaggregated on the basis of gender until recently. CBOs have now been trained to do this and gender based data is being gathered on a daily basis at the school level and submitted to PCI on a monthly basis.

PCI aims to put in place a more inter-sectoral approach to school feeding and it is envisaged that collaboration with other UN donor agencies will be increased realised. Also, additional stakeholders and funding sources will be identified to ensure a multi-sectoral and integrated support programme for OVC that access education through community schools.

For further information, contact Kate Vorley, OVC Support Programme (Urban Intervention)-Project Coordinator, P. O. Box 32320, Lusaka, ZAMBIA. Tel: 260 1 256735/6/8, email: kate@pcizambia.org.zm

1 In addition to the aforementioned bore holes delivered to 12 of the schools, UNICEF Zambia has also supplied a variety of teaching and learning materials to 100 of the schools whilst New Zealand Aid has provided similar support to one of the community schools in Kafula District.
ENN in the Field

CRS Dedza team teaching carpentry and building skills

George Luboobi, Concern Worldwide

A member of GOAL Uganda team

AMOS Zaidi and Andrew Nicholson, GOAL Malawi

Katie Cuming and Pajuku Bahwere, Valid Int, Malawi

Rodger Mathisen and Mary Corbett

Team working in school feeding in Zambia, PCI/WFP

Mary Corbett with a schoolgirl, Plan Int, Uganda

Reach Out staff Uganda

Mary Corbett with women’s support group in Uganda (Plan Int)

Mary Corbett with CRS Dedza team in Malawi

Staff from Matendo NRU, ACF, Malawi

Mary Corbett with a schoolgirl, Plan Int, Uganda
By Mary Corbett, based on an interview with Mary Makopkha, REEP

A communications graduate from Daystar University in Kenya, Mary Makopkha originally worked as a freelance journalist for several publications. She founded REEP (Rural Education and Economic Enhancement Programme) in 1997 to spearhead the fight against HIV/AIDS and other issues affecting her Butula-Busia community.

The authors would like to acknowledge the contributions of REEP staff and donor agencies that have supported the project.

Busia district, in Western Kenya, borders Uganda and Lake Victoria and has an estimated population of 369,209 (August 1999 national census). The district is subdivided into six divisions, three bordering Uganda, and includes the town of Busia, situated on one of the main trading routes between Kenya and Uganda. The HIV prevalence rate in Busia is one of the highest countrywide, with estimates of 15.5% from antenatal clinics in 2002. This is substantially higher than the national average tested in antenatal clinics (8.7% for rural and 12.4% for urban populations).

There are many factors contributing to this situation, the primary one being that Busia is the site of heavy border traffic and therefore hosts high concentrations of a mobile population, who tend to be linked to risky behaviour and increased sexually transmitted diseases such as HIV. There is a similar mobile population around the Victoria lakeside.

Origins of REEP

REEP (Rural Education and Economic Enhancement Programme) is a local NGO operating from Butula town, also in Busia district. REEP’s mission statement is “to improve the quality of life for marginalised groups in rural communities in Western Kenya”. It was set up by a feisty, dynamic local lady called Mary Makopkha who originally came from Busia District but left for some years to further her education. With a degree in communications under her belt, she returned to her native area and decided to start up her own local NGO. She set this organisation up over seven years ago and, in her own words, reckons that “the first three years were very difficult and they achieved very little”. However, to the outside observer, this seems a little overly critical - this period must have been an enormous struggle, laying the foundations of a now strong, grass roots level agency, focusing on community participation and working closely with local leaders.

Presently, there are eighteen staff working for REEP, and 40 community health workers (CHW) receiving some financial support.

Community support

REEP is a grass roots organisation, working with community management committees (CMC), which have been set up with total transparency, elected by the community. Many of the people within these committees are living with HIV/AIDS. The CHWs are the corner stone of the activities, and work under the supervision of the REEP Home Based Care (HBC) department. Training of the CHWs is arranged by the REEP office, in collaboration with Pathfinder International. A total of 40 CHWs are working in this programme, initially trained by the Ministry of Health (MOH) and Pathfinder International, with further ongoing training provided through the MOH. Income generating activities are initiated at two levels, firstly at REEP office level and secondly, at the support group level, with the assistance of the CHWs.

The CHWs are instrumental in supporting the care of patients. As patients are often very sick, depressed and angry, it can be difficult to look after them, “occasionally caregivers will run away”. Therefore it is important to have a support mechanism for the caregiver. At present, the CHWs look after around 3,000 persons living with HIV/AIDS (PLWHA). Many of these clients are well, but as they become very ill and possibly bedridden, the CHW will step in to help the carer with the nursing care.

In addition, 18 support groups have been set up for PLWHA. These groups support one another, organise meetings and plan activities. As they have openly acknowledged their HIV status, they are frequently an important resource in trying to reduce stigma within the community.

There are many other “off shoot” activities of this community based organisation, e.g. supporting orphan children with school fees, advocating for change in the widow inheritance custom, supporting families of people dying with HIV/AIDS, in particular protecting their assets (often family members of the deceased come to claim all the property).

Food aid programme

A baseline study was conducted prior to the food aid component of the REEP intervention, which started in 2003. The project goal was to “improve food security among vulnerable households, especially those headed by children and old grandparents”. The food aid component aimed to support PLWHA and their families during crisis periods. A family ration was given, with an extra individual ration of corn soya blend (CSB) and oil to the person infected with HIV/AIDS. The initial food was targeted at families identified by the CHW and the CMC, but due to resource constraints this has proved unsustainable. Plans are now in place to look at food being given for 4-6 months only, focusing on the hunger gap period. Although there is not a major focus on antiretroviral therapy within this programme, MSF is also working in the area and medicines are available free of charge for those identified as requiring them.

Income generation

Small scale income generating activities have been initiated, including community gardens and small livestock distributions. It is planned that the community gardens will be at village level. In the past, maize has been the main staple grown in the Busia area, however this does not grow well. Instead, initiatives are in place to plant more cassava, sweet potato and traditional vegetables, as well as more sorghum and millet. Some women were given a small sum of money to set up their own businesses, or to support already established businesses.

Impact

Although it is difficult to measure impact, the REEP team feel that there are far fewer deaths from HIV/AIDS since the food aid programme has been introduced. “As many as 15 people were dying a month, now some months go by without any deaths”. Mary Makopkha feels that many people died from starvation rather than opportunistic infections. At an ENN interview with a support group of PLWHA (approx 20 people), there was very vocal support for the food aid. They all claimed their health had improved substantially, they had physically gained quite a lot of weight, and that they “felt much better.” Many had gone back to work and all were mobile and looked healthy. Respondents also claimed that they were able to tolerate drugs better. As some drugs need to be taken on a full stomach, compliance is compromised with households, who are hungry and malnourished. The group said that the combination of the co-trimoxazole (Septrin) and food assistance had made a major difference in their well-being.

An impact study (still in draft form) suggests that the very poor households that receive the food assistance derive a large proportion of their diet from this food aid. In a community where 54% of the population are the absolutely poor category (WFP baseline study), it is difficult to target the most needy. However, it appears that by targeting through the CMC, the most needy were better targeted.

There is close monitoring of the programme - one CMC was disbanded for abuse of food aid - but despite strict targeting criteria, there is some redistribution of food due to the high levels of poverty. Awareness of the lack of sustainability of long term food aid assistance has given rise to income generating activities to address chronic food insecurity.

The WFP programme evaluation (draft) of all implementing partners suggests that, in general, the programme is very beneficial. Wasting in children aged less than 5 years amongst participant households has been reduced, compared to non-participants. Meetings with the REEP staff and support groups indicate that a strong grass roots NGO with a home based care component has contributed to the success of the programme. In particular, stigma and behavioural changes may have been more effectively addressed, as all the staff are local and well aware of the context of HIV/AIDS within the community. Further- more, strong community participation at all levels, with substantial female participation, has led to empowerment of women in the community, and better targeting of food support.

For further information, contact Mary Makopkha, REEP Programme Director, P.O. box 47-50405, Butula, Kenya. Tel: Kenya 0734-643846.
REACH OUT food assistance in Uganda

By Peter Paul Igu, Reach Out and Mary Corbett, ENN

Kampala, the capital of Uganda, hosts a population of around 1.5 million people. Located close to the shore of Lake Victoria, the city is built on a number of hills, giving it a somewhat unplanned, scattered appearance. The infrastructure struggles with the expanding population, leading to major congestion on the roads, in areas where electricity is available, frequent interruptions in power supply due to ever increasing demands.

Mbuya parish is situated a few kilometres from the city centre. Based on the work of a number of small Christian communities, ‘Reach Out’ was established in the parish in May 2001, to support people living with HIV/AIDS (PLWHA) and their families. Initially, Reach Out activities mainly involved visiting chronically ill persons in their homes. Then, in January 2002, a clinic at Our Lady of Africa Church was established and over the last three years, has grown to become a vibrant organisation, providing families of PLWHA with a holistic support mechanism. Dr Margrethe Juncker, one of the founding members, works tirelessly in the care and support of all the beneficiaries, and her energies have been instrumental in the growth of this project.

Reach Out activities

Reach Out operates the clinic four days a week. On the fifth day, patients are visited in their homes and training is conducted. Clinic activities include counselling and testing for HIV/AIDS (same day results, to reduce defaulting), clinical examination, and medical support for opportunistic infections. TB treatment and antiretroviral (ARV) support are part of the service. People can also meet with a micro-finance team and receive loans for business plans.

The project expanded substantially in 2004, with client numbers up by 68.8%, from 860 clients at end of Dec 2003, to 1452 by the end of 2004. During 2004, a total of 140 clients died, 22% within the first month of admission onto the project, 42% within the first 3 months, and over 60% within the first 6 months. These figures suggest many people come for help very late and are already extremely ill. Efforts are being made at a community level to encourage people to attend for testing earlier. Given the actual figures enrolled, it is thought that people are moving into the area so as to benefit from the services of this programme.

Medical care

In March 2004, Reach Out were recognised by the National TB programme and since then, a total of 464 patients have been enrolled in the TB programme. Free ARV treatment is also available for HIV positive clients with a CD4 count of <200. At the end of 2004, a total of 545 clients were receiving free ARV therapy. In order to support compliance for both TB and ARV treatment, a community network has been established to support people, with enrollees supporting one another. The team consists of two full time doctors, 12 nurses (one is involved in counselling), additional counsellors, and 230 volunteers - 77% of the volunteers are clients living with HIV/AIDS who, in turn, support new clients.

Nutritional support

Nutritional support, in the form of WFP food aid, commenced in June 2002, initially through AVSI1 (implementing partner), and later, through a direct agreement (MOU) between Reach Out and WFP. Since then, the numbers of people receiving food assistance has substantially increased from around 600 to 1,000 beneficiaries. Reach Out has also acquired two containers to store a quantity of food, which assists in better planning of food distributions. A total of 10 food monitors, an assistant and a clerk support this project.

Monitoring

At each clinic visit, all clients are weighed by a nurse/doctor and have counselling if necessary. Initially when clients are registered in the programme, they are encouraged to attend the clinic on a weekly basis, then fortnightly and, once stable, monthly. Monthly information is collected on all beneficiaries on the food assistance programme. Table 1 shows summary data from August 2004, based on WFP monthly reporting.

During August 2004, 56.7% of beneficiaries gained weight, 28.9% lost weight, and 14.4% had static weight. Table 1 further profiles those who had lost/had static weights according to treatment /infection.

Table 1  Profile of weight loss/static weight, August 2004

<table>
<thead>
<tr>
<th>Weight Loss</th>
<th>Static Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>TB treatment</td>
<td>15.4%</td>
</tr>
<tr>
<td>ARV/TB treatment</td>
<td>11.5%</td>
</tr>
<tr>
<td>ARV treatment</td>
<td>26.9%</td>
</tr>
</tbody>
</table>

Opportunistic infections 46.2%

\[1\] Associazione Volontari per il Servizio Internazionale

Weekly Reach Out meeting held in a local church

Clients and staff receiving lunch outside the Reach Out-clinic

By Peter Paul Igu, Reach Out and Mary Corbett, ENN

Peter Paul Igu has been a full-time volunteer with the organisation, Reach Out, since Jan 2002, and is the food programme co-ordinator in Uganda.

The authors would like to acknowledge the work and appreciate the support of Dr Margrethe Juncker, the WFP and the Reach Out medical programme staff in Uganda.
Plains regarding targeting

At the end of 2004, the WFP implementing partners (IP) convened to review the present programme. A multi-working group was set up to consider admission criteria. Existing questionnaires used by different IP’s were reviewed and a new questionnaire has just been completed and will be piloted in March 2005. This questionnaire has a ‘score weighting system’ which it is hoped will facilitate targeting of the most vulnerable members in a programme and reduce subjective decision-making. Instead of a cut-off based on the amount of food available, the cut-off will be based on the scoring system, which is based on a more comprehensive economic status appraisal.

However, as yet, no exit criteria have been developed. In general, beneficiaries are informed that the food assistance will cease at some stage, although, so far, some beneficiaries have been on food assistance for 2.5 years.

Income generating activities (IGA)

IGAs take a number of forms, the largest being the ‘Bread for Life’ micro finance programme. This activity has shown a four-fold increase from 154 loans in 2003, to 650 loans in 2004. Clients must submit a business plan before a loan is sanctioned by the committee. The size of the loans has increased, now up to 100,000 Ush ($60) and repayment takes place over a six month period. The average recollection of loans is 81%. In general, 75% pay well, 15% are slow payers and a further 10% don’t pay. The main activities in business plans include vegetable purchase and sale, stone quarrying, fish shelling, purchase and sale of second hand clothes, hair dressing and brewing. Clients may receive new loans once the old one has been paid off. Clients need to be registered in the programme for at least three months and attending clinics regularly before loans will be sanctioned.

Conclusions

It is felt that most people who attend Reach Out are poor or very poor. Initially there was some stigma around food assistance but after some time, it appears that food acted as an incentive for people to come to be tested for HIV/AIDS and receive assistance. For TB patients, in particular, once on medication, appetite increases and food assistance becomes essential to support well-being and compliance. Also, staff feel that TB patients are now recovering much better since the introduction of food assistance, and describe how “less TB patients were dying”. Similarly, it is considered essential for clients on ARVs to receive food assistance so that their general condition improves. A one year time frame for food assistance to clients on ARVs may be introduced, which, it is felt, should be flexible.

Reach Out has a significant amount of data collected on clients over the years, i.e. weight trends, morbidity and mortality rates. Unfortunately, due to the enormous workload of day-to-day project work, it has been impossible to analyse these data. Project staff would welcome both technical and financial support in order to make use of these data, which could be invaluable in answering some of the key questions around HIV/AIDS and nutrition support/food security.

The HIV/AIDS pandemic in Uganda has had a major social, economic and health impact on the population over the last 18 years. There has been large loss of life, leading to an estimated 1.7 million orphaned children. Property grabbing has further exacerbated the plight of extremely vulnerable women and children, in particular. Stigma over the years has been particularly problematic and difficult to address.

In Uganda, many national non-governmental or community-based organisations (NGNOs /CBOs) have emerged in response to the overwhelming problems created by HIV/AIDS in their communities. A good number of these indigenous organisations have grown substantially in strength and have the capacity to access international funds to fight HIV/AIDS and implement quality activities. However, many NGO/CBOs lack the organisational capacity to implement activities based on recognised best practice or to access funds that are available to stronger NGO/CBOs. Through support from international NGOs, small but committed organisations, often formed from PLWHA themselves, are able to access financial, technical and organisational support to assist them to implement appropriate and quality interventions.
Nutrition support and food security

WFP food assistance support to PLWHAs first became available in Hoima through a partnership with AVSI in April 2003. Meeting Point and AVSI work in partnership to identify beneficiaries and distribute monthly food rations to 500 PLWHAs and their families on PMTCT. The initial criteria for inclusion in the food aid programme was membership of Meeting Point (i.e. being HIV positive). However, as time went on, the criteria were modified to target the most vulnerable households within this group.

WFP is soon introducing an eligibility format. This tool will provide the possibility to phase out current beneficiaries whose household has reached food security otherwise than introducing criteria of selection. Moreover, when a primary beneficiary dies, the remaining family members will receive food for a further three months and then will be discharged from the programme.

To complement the existing food aid programme and increase longer term food security, GOAL, in partnership with Meeting Point, funds sustainable livelihood interventions, such as small-scale agriculture/animal initiatives. This is in the form of agricultural inputs and technical support to 150 families of the 500 beneficiaries currently receiving food assistance through AVSI and WFP.

Case studies

In a field visit in February 2005, four case studies of Meeting Point members were compiled, highlighting the unique problems created by HIV/AIDS, poverty, stigma, and in particular, female vulnerability.

Case Study 1

Mary, in her mid to late fifties, is a grandmother and a member of Meeting Point since 1992. In 1989, Mary's husband died, leaving Mary and three other widows widowed. At this time, Mary lost all her property and was forced to move with her four children to Kampala, where she resides with a friend and generated an income by selling tea. Through psychosocial support, food assistance and sustainable livelihood interventions, Mary is now food secure, living well, and in her own home with income generated from a variety of crops/vegetables growing in her garden, pigs and chickens. In 2003, Mary became a Community Counselling Aide (CCA) with Meeting Point Hoima where she supports other PLWHAs through her HBC visits. Mary pays for her own prophylaxis for opportunistic infections (Septrin), which costs about $1 a month, and does not require antiretroviral medication (ARVs), which costs about $1 a month per beneficiary, it is not currently part of any HIV/AIDS intervention in Hoima.

Case Study 2

Rose, in her late twenties, was widowed recently and has four children. Due to lack of support from her family, her main economic resource, Rose, chose to remarry. Since the death of her first husband, one of her children has died, two now live with her dead husband’s family and the youngest remains with Rose and her new husband. Since remarriage, the young Rose remained with Meeting Point/ AVSI Prevention of Mother to Child Transmission (PMTCT) programme in 2004 where she has been receiving a single persons food ration. She is raising a one-month old baby boy. Since delivery, Rose was sick and admitted to hospital with a fever. Rose was distressed at not having the funds to purchase milk for her baby, yet she is a healthy and well nourished baby (on breast milk only). She was urged to purchase milk for her baby, yet she is a healthy and well nourished baby (on breast milk only). She was urged to use local available foods to achieve a well balanced diet. Nutrition training through HBC increases the availability of vegetables growing in her garden, pigs and chickens. In 2003, Mary became a Community Counselling Aide (CCA) with Meeting Point Hoima where she supports other PLWHAs through her HBC visits. Mary pays for her own prophylaxis for opportunistic infections (Septrin), which costs about $1 a month, and does not require antiretroviral medication (ARVs), which costs about $1 a month per beneficiary, it is not currently part of any HIV/AIDS intervention in Hoima.

Case Study 3

Moses, in his mid to late fifties, is married with five children. Both he and his wife, Esther, are HIV positive. Since August 2004, Moses has been taking ARVs, Esther’s CD4 count remains high and therefore she does not require ARVs at present. Despite the relatively low cost of antibiotic prophylaxis, at around $1 a month, Esther is on Cotrimoxazole (Septrin). Since 2003, Moses and his family have been receiving WFP food rations. Through the Meeting Point sustainable livelihood initiative supported by GOAL, he has been growing more than enough cassava, beans and maize to feed his family.

Moses became a member of Meeting Point Hoima in 1999. Following CCA training in 2003, Moses now heads a team of motivated CCA’s in his local area that provide HBC activities to PLWHAs. The main activities encompassed in HBC include psychosocial and practical support to families struggling with the impact of HIV/AIDS on their lives. Although Moses is on ARVs, he is an extremely active member of the community. Through health care support, food aid assistance and sustainable livelihood support, Moses and his family are currently food secure. Due to this comprehensive package of support, Moses and his family are optimistic about their future and hope to support their eldest daughter through teacher training in the next few months.

Case Study 4

Sarah, in her late twenties, was deserted by her husband within the last year. She remains in the family home close to her own family with her three children. Sarah and her husband are both HIV positive. They live in a close knit rural community. It would appear that her husband left due to fear of HIV/AIDS stigma from the neighbours and he now lives in town with a new partner. He supports the family financially on an irregular basis. Sarah is just about to complete a full course of TB treatment and will start ARVs in the very near future. Throughout her TB treatment, Sarah did not receive any food aid support, and was very dependent from day-to-day on food support from her family. At present, Sarah’s health remains fragile and she is not well enough to prepare her garden for the coming planting season. Without any active adult members in the household, she and her three children will remain food insecure for at least the next year.

Lessons learned

Lesson 1

It is evident that women and children’s vulnerability increases when HIV affects the family unit and that vulnerability increases with poverty. It is not uncommon for women in such situations to be abandoned with children to support, divorced, widowed and disinherited.

Lesson 2

Food assistance supports the immediate needs of fragile families.

Lesson 3

Health care support such as TB treatment, prophylaxis for opportunistic infections, PMTCT and psychosocial support through HBC, are necessary along with food aid to support immediate recovery.

Lesson 4

In order to achieve more longer term food security at household level, it is essential to incorporate appropriate sustainable livelihood initiatives along with food aid.

Lesson 5

Nutrition training through HBC increases the knowledge around the use of locally available foods. Changing traditional cooking practices, particularly of vegetables, can increase the nutritional value of food and helps PLWHAs achieve a more balanced diet.

Lesson 6

A family ration would be more effective in sup-


This guide provides information for HIV/AIDS-affected households and communities on how nutrition can help HIV-positive people live healthier lives throughout the progression of HIV disease. The guide is an interpretation of the best available evidence to date from multiple sources, especially the World Health Organisation (WHO) and a broad range of experts. This guide was extensively revised from its earlier version and was peer reviewed.

The purpose of this guide is to assist programme managers and health workers make recommendations on food management and nutritional issues for households with members who are HIV-infected or living with AIDS, and for individuals, families, and communities affected by HIV. Food and nutrition recommendations are for both adults and children and emphasise the use of locally available food products, complemented by appropriate foods obtained through external donation programmes.

This guide is targeted primarily at four types of audience:

1. Programme managers and technical staff who work in food aid, food security, health, and nutrition programmes in HIV-affected areas
2. Local health workers in areas affected by HIV/AIDS
3. Community-based organisations working in high prevalence HIV/AIDS areas
4. Institutions caring for PLWHAs or orphans and other vulnerable children infected or affected by HIV/AIDS.

Six chapters deal with thematic issues related to HIV/AIDS, which are:

- Nutrition and HIV/AIDS: Basic Facts
- Managing HIV Disease Through Nutrition Interventions
- Nutritional Issues Associated With Modern and Traditional Therapies
- Nutritional Care and Support for Pregnant and Lactating Women
- Nutrition and Care Recommendations for Infants and Children
- A Food-based Approach to Support HIV/AIDS-affected Households and Communities

Copies of the guide can be obtained from:
Food and Nutrition Technical Assistance (FANTA) Project, Academy for Educational Development, 1875 Connecticut Avenue, N.W. Washington, D.C. 20009-5721. Tel: 202-884-8000 Fax: 202-884-8432 Email: fanta@aed.org. The guide is also available online, http://www.fantaproject.org


CRS Conference in South Africa

CRS held a Conference on HIV/AIDS and Food Security in Southern Africa from September 22nd-29th in Johannesburg, South Africa. The aim of the conference was to appreciate the progress to date, to generate more innovative and longer term HIV/AIDS and food security strategies, and to further increase the quality and scale of holistic and sustainable programmes that address food security, HIV/AIDS and social justice. The conference was a collaborative effort between the CRS Southern Africa Regional Office (SARO) and CRS headquarters in Washington, the Food Security Unit Development Support Department (FSUDD) HIV/AIDS Unit. The conference was made possible through the financial support of the Food For Peace Grant, the ‘Institutional Capacity Building’ (ICB) grant (AFP-A-00-03-0015-00).

Thirty-nine CRS staff attended the conference – 24 from country programmes (including three country representatives and three heads of programme), seven from SARO, five from FSUDD (one from OVC), and two advisors from other regions in Africa. In addition, 18 resource people representing CRS, donors, other NGOs, and people living with HIV and AIDS also contributed at the conference.

The conference began by taking stock of the impressive amounts of high-quality programming integrating HIV/AIDS and food security currently being implemented by CRS country programmes. Country programme presentations were made in the areas of Orphans & Vulnerable Children (OVC), Title II food aid, and on the use of frameworks in project development.

New frameworks and information were introduced to deepen country programme understanding of the linkages between HIV/AIDS and Nutrition, Livelihoods and Social Justice. A full day of in-depth training was conducted in each of these thematic areas. With the benefit of this new information and training, participants analysed a series of critical issues such as prevention, complex program design issues, new programming areas and donor resource allocation strategies.

Finally, participants established capacity building and learning agenda priorities for linking HIV/AIDS and food security in the coming years. By supporting the continued programme growth warranted by the humanitarian context, while at the same time deepening programme quality, it is hoped that this learning agenda will contribute to greater visibility of CRS leadership in this important field.

A report of the conference can be obtained from Krystin Weinhaus email: kweinhaus@catholicrelief.org
Community Based Technology to Combat HIV/AIDS

A new study on community based technology change to combat HIV/AIDS in Africa is underway, funded by the MacArthur Foundation. This project is being led by staff at Tulane University, with input from the Overseas Development Institute (ODI). The project seeks to learn about community-based efforts to adapt technologies (tools, devices, and systems of technical knowledge) to respond to the impacts of AIDS throughout rural sub-Saharan Africa. Eventually this will lead to recommendations for aid agency, NGO and governmental policies to support appropriate technology innovation, adaptation and dissemination to combat HIV/AIDS.

Right now, the research team are engaged in a ‘scoping’ exercise to identify a range of local, small-scale technology innovations and adaptations that merit more attention. Examples might include conservation agriculture techniques, preservation and processing of local plants for enhanced nutrition, and text-messaging for enhanced care of people living with HIV/AIDS (PLWHA). Also of interest are new technologies for income-generation activities for PLWHA and AIDS-affected households, and innovations in household water, energy, and transport. This project will conduct fieldwork in Eastern and Southern Africa to try to find out more about these innovative technologies at a local level. Many agency reports mention what community agents should do based on first principles and/or what is needed (‘labour-saving’ devices). Less common is news of adaptations and inventions by the blacksmiths, healers, farmers, rural women, youths, orphans, and other community actors or organisations who directly, and daily, face the epidemic and its cumulative burdens.

The researchers are requesting information on specific examples that could be investigated further. This might be in the form of reports, internal assessments or anecdotal stories. Information on key informants or essential places for the research team or would like further information for the research team would like further information regarding this study, please contact:
Paul Harvey, Research Fellow, Humanitarian Policy Group, Overseas Development Institute, 111 Westminster Bridge Road, London, SE1 7JE, Tel (UK): + 44 (0) 20 7922 0374, email: p.harvey@odi.org.uk

Local Resources for Supporting PLWHA

A series of publications have recently been developed to support those working with PLWHA, produced by the Regional Centre for Quality of Health Care (RCQHC), Kampala, Uganda. Technical input by Food and Nutrition Technical Assistance (FANTA) and Linkages projects were financially supported by REDSO/ESA (Regional Economic Development Service Office/East and Southern Africa) and USAID.

The series comprises of two booklets that accompany a series of counselling cards as a ready-made flip chart:

- Nutrition for PLWHA – Counselling cards
- Food and Nutrition Counselling for PLWHA on Antiretroviral Therapy - A job aid for counsellors and anti-retroviral therapy (ART) service providers
- Nutritional Care for People Living with HIV/AIDS – Answers to frequently asked questions

Fact Sheets on ARV Treatment for NGO/CBO Staff

The International HIV/AIDS Alliance is developing a set of fact sheets and participatory tools to support community engagement for antiretroviral (ARV) treatment. The materials are intended for use by non-governmental/community based organisations (NGOs/CBOs), training organisations and individual trainers, international NGOs and NGO support programmes, to enable staff to support PLWHA and their communities on ARV treatment. They are based on experience in supporting treatment programmes in several countries.

Information covered some so far by the fact sheets include:

- adherence to ARV treatment
- what side effects can be expected with ARV treatment
- interactions between ARVs and food, and how to cope with them
- how stigma can affect ARV treatment

Further fact sheets are in production covering other topics such as TB, prevention, monitoring treatment, palliative care and living with a chronic illness. Participatory tools and activities, drawn from Alliance workshops in several countries, will also be made available later in 2005 to assist in education about ARV treatment and in developing ways of supporting people and communities with treatment.

The fact sheets are only available on-line and are not in print. A series of 20 fact sheets are planned and each one will be published on the Alliance website as it becomes available. There are currently seven fact sheets on the website, http://www.aidsalliance.org/sw199985.asp.

For further information, contact:
Garry Robson, Communications Assistant, International HIV/AIDS Alliance, Queensberry House, 104-106 Queens Road, Brighton BN1 3XF, United Kingdom.

New e-Resources on HIV and AIDS

Five new Key Issue guides are now available at the HRC/Eldis' HIV and AIDS Resource Guide website. Topics, which include nutrition, AIDS communications and sexual and reproductive health, have been produced in collaboration with subject experts. These guides provide in-depth coverage of HIV and AIDS, highlighting important research and linking to summaries of documents, websites and other resources. All documents are open access.

To access these pages and more, visit:
http://www.eldis.org/hivaidss/keyissues.htm
HIV/AIDS and nutrition can be directly accessed at:
http://www.eldis.org/hivaidss/aidsnutrition.htm

*The Health Resource Centre (HRC) provides information support to the UK Department for International Development and its partners on public health and communicable diseases in low and middle income countries. Eldis is an electronic gateway to development information, hosted by the Institute for Development Studies, UK.

Invite to Join WABA HIV and Infant Feeding Group

An open invite is extended by Ted Greiner to join The World Alliance for Breast-feeding Action (WABA) HIV and Infant Feeding Yahoo Group.

The group is not a chat group, but a list maintained by Ted Greiner, in his capacity as coordinator for the WABA Research Task Force. Members have access to a private website with numerous links to key UN and other documents on infant feeding and HIV, as well as unpublished and recently published full-text journal articles.

Anyone who wishes to join should email Ted Greiner email: tedgreiner@yahoo.com
The treatment of severe malnutrition in adults is not as well researched and guidelines are less well defined internationally, compared to management of children. Severe malnutrition in adults is more rare and, as a result, less is known. Many severely wasted adult patients may not want to consume large volumes of milk. It is also possible that adult patients are too high and will lead to an excessive case load of malnourished people.

Staffing and health infrastructure capacity

Although training has been conducted with health personnel around ARVs, the training in associated nutritional care has yet to be carried out. The task is not easy, as human resource capacity within hospitals is severely stretched. Large hospitals requiring around 175 qualified trained nurses have, in reality, only recently received the recent food security emergency, it took a considerable time to introduce the guidelines on treatment of severe malnutrition in children in the NRUs, both in terms of substantial initial training and then ongoing monitoring.

The attrition of health staff is due to many factors, which include poor morale and working conditions, long working hours, low pay, lack of resources, such as equipment, and lack of uniforms. There is also a lack of awareness by many countries, a depletion of human resources due to emigration (brain drain to other African countries, Europe and the States) and the HIV/AIDS epidemic. It has only recently recognised that the health infrastructure in Malawi is at near collapse. A proposal has provisionally been funded by the Department for International Development (DFID-UK) to support reform of the health system, dependent on other funding from the global fund.

Bearing all this in mind, it is difficult to see how, with the best will in the world, the many challenges around the health/nutrition care of PLWHA’s will be managed.

PMCT programme

The PMCT programme is an integrated approach, working through the antenatal and postnatal clinics and offers a range of services. A large component of this is good nutrition education for all women. Furthermore, 90% of women choose to breastfeed as it is the cultural norm and there is stigma attached to not breast-feeding. It is proving difficult to get women to abruptly wean the infant off breastfeeding. It is recommended that non-breastfeeding women need to be supported to wean babies within 2-3 months. It was interesting to see how this was being managed, particularly in the HBC scenario, patients receive food (during crucial growth period) to draw attention to these beneficiaries, in a close link with chronically ill patients and PLWHA’s.

NCHOS’ response to the PMCT programme

The PMCT programme needs to be modified to meet the needs of PLWHA’s. The recent food security emergency, it took a considerable time to introduce the guidelines on treatment of severe malnutrition in children in the NRUs, both in terms of substantial initial training and then ongoing monitoring.

Conclusions and issues

Food insecurity households taking care of chronically ill patients are targeted for support, as are pregnant women. In Malawi, nutrition care has not been recognised of their higher nutritional requirements, particularly with regard to the need for adequate intake of high quality protein and iron supplementation. In the same context, support for HIV patients (based on clinical signs and symptoms) is also lacking in Malawi.

The challenge to impact on nutritional status is the equipment for measuring CD4 count is only available in six centres, the WHO algorithm (see box 1) is being used for identifying symptomatic HIV/AIDS patients. The Malawi MOH has added severe wasting based on Body Mass Index (BMI<16) as one of the main criteria for diagnosis of clinical HIV/AIDS, which is also indicative of clinical HIV/AIDS. The WHO algorithm combines the pres-
Large volumes of milk as a stand-alone nutrition supplement are consumed by adults, and in some countries, milk is considered as food for children only. A combination of foods may need to be considered, such as the addition of multivitamins to milk to address this area as there are many unanswered questions regarding the appropriate use of scarce resources?

Although nutrition has been identified as a key element of the response to PLWHA, it remains difficult to address this area as there are many unanswered questions regarding the appropriate use of scarce resources.

Malawi is probably one of the most advanced countries in the region in terms of programmed guidelines related to HIV/AIDS programming for different contexts. However, at a grass roots level where implementation occurs, there are significant constraints, in particular around human resource capacity and availability of equipment and materials. The major concern is the capacity at ground level to support this huge initiative, particularly as the health infrastructure is already completely overwhelmed.

For further information, contact Mary Corbett, email: corbettmary@eircom.net

South Africa HIV/AIDS Pandemic

By Mary Corbett
Mary Corbett is a food security and nutrition consultant who visited the region on behalf of ENN in early 2005.

This viewpoint is based on a series of meetings with key stakeholders in South Africa during Mary Corbett’s field trip earlier this year.

As the HIV/AIDS pandemic continues in the Horn and Southern Africa, the prevalence rates vary from place to place but the impact can be felt across the region. Although countries with small populations such as Swaziland and Lesotho are highlighted due to their high prevalence rates, countries like South Africa, with somewhat lower prevalence rates but a far higher population size, have far greater physical numbers of people living with HIV/AIDS – estimated at 5.9 million people infected.

The situation in South Africa is complex. It is a country with huge disparities of wealth. Although placed in the upper half of UNDP’s Human Poverty and Development Index, over 50% of the population live below the poverty line. The country has a two-tier health system with highly sophisticated hospitals and clinics in the cities but poorly resourced primary health care in remote rural areas.

Work on Nutrition and HIV/AIDS

Prior to 1994, nutrition activities in South Africa were not well resourced. Since 1994, the Ministry of Health (MOH) has been involved in developing an integrated nutrition programme, whose main strategies include:

- Micro-nutrient Malnutrition Control
- Food Service Management
- Contribution to household food security
- Disease specific nutrition support, treatment and counselling
- Growth monitoring and promotion
- Nutrition promotion, education and advocacy
- Promotion, protection and support of breastfeeding

The development and implementation of the strategy has been a multi-sectoral approach involving other ministries, such as the Ministry of Agriculture and Ministry of Education.

In April 2004, the South Africa National Guidelines on Nutrition for people living with HIV/AIDS were completed. These guidelines are clear and easy to understand. The main emphasis is on maintaining local well balanced diets to maintain weight and keep healthy for as long as possible. Tips and suggestions are given on how to deal nutritionally with complications such as diarrhoea, nausea, vomiting, and mouth ulcers.

Although nutrition has been identified as a key element in the support to PLWHA, it remains difficult to address this area as there are many unanswered questions including:

- What vitamin/mineral supplements to administer
- Which patients to give supplements to, and for how long
- Whether to give multivitamins as a blanket approach
- What is the impact of social services supplied food baskets and what should be included in the basket
- Disruptive in need

On the one hand, there is great interest in food supplementation and optimum multivitamin supplementation in South Africa. However, in a country where half of the population is below the poverty line, household food security and well-balanced nutritious foods are often not an option. Access to the basics such as clean drinking water, health care facilities and education remain out of reach for many. HIV/AIDS prevalence rates also vary considerably, in some ante-natal clinics, ranging from 27.9% to 50% within the same area. The impact of these high rates on the community is tremendous, and with vast populations faced with insufficient daily food intake.

The MOH in South Africa is striving to address the HIV/AIDS pandemic. Antiretroviral drugs (ARVs) are available free of charge in public hospitals and service points but have been identified as access to different districts to support ARV uptake. However, to date, the uptake has been surprisingly low. Although it was planned to have 50,000 people on ARVs by April 2005, by the beginning of 2005 this has only reached 15,000, despite an anticipated “rush to get free ARVs”. It is unclear why uptake is so low in the face of substantial media coverage, however stigma around HIV/AIDS remains a major issue in South Africa.

In spite of the considerable progress made to improve health care and nutrition support overall in South Africa, HIV/AIDS has led to a substantial deterioration in health indicators, such as infant and child mortality, over the last number of years. The most recent mortality figures (unpublished) indicate a serious increase, which is largely being attributed to the high incidence of HIV/AIDS. It looks like the challenging, and perhaps unique, context of the country, with varying and substantial needs of vast sectors of the population, may well be limiting the impact of mainstream developments in managing HIV/AIDS.

For further information, contact Mary Corbett, email: corbettmary@eircom.net

1 Body Mass Index (BMI) calculated as weight (kg) divided by height (metres) squared
2 Pumplus (produced by Nutriset)
3 See field article, Integrated PMTCT services in a rural setting in Malawi, in this issue for experiences from St Gabriels, Hospital, Malawi
4 See research article, Impact of HIV/AIDS on household food security and quality of life in Malawi, in this issue of Field Exchange

I’m sure that pre-packaged, sourced-from-far-away products have their place in wars, tsunamis, a few cities and other disasters, but the 750 million children in the developing world, their own indigenous foods would have just as much effect with a longer-term impact on the children’s nutrition and health. "We need to teach children to make their own sprinkles from local nuts, fruits, greens, oils, seeds, insects, fish, and the like. Instead of just sprinkling onto a bulky carbohydrate food, use the sprinkle as treatment along with teaching about planting and eating less of that bulky carbohydrate food in the first place."

The results could be just as immediate and dramatic as with other products that could last for generations to come. The organisations that support this type of permanent intervention could be mentioned during events, with the help of big banners and flyers that announced them as the inventors and / or supporters. Just imagine a few times where we heard that everyone can have on hand to improve their own nutrition without relying on a packet from an outside source that is manufactured and transported with all the costs involved.

When I saw the developer of this product do a presentation on it, he did include a sentence about diversifying diets as part of the whole project, but it was strongly overshadowed by bringing in external resources and experts. When I asked him about using the same resources that went into developing, manufacturing and transporting Sprinkles to create a local ‘sprinkle’ product with an emphasis on local diversified diets, he immediately responded that it wouldn’t work.

How do we know if no one really puts sprinkles to control childhood anaemia. PloS Med 2 (1): e1. Source: PloS MEDICINE, an open access, freely available international email: info@www.medicine.org

Dear Field Exchange,

In 2004 I attended a presentation on Sprinkles, a micronutrient powder that can be ‘sprinkled’ onto foods. The development of this product was supported by several large organisations in a not-for-profit manner over the past several years. It wasn’t the first time I’d heard about the product as the group approached some organisations in Malawi a year or two before to explore bringing the product here. Now, in 2005, a message was sent that HIV listserv - which links those concerned with nutrition and HIV/AIDS - that the product aims to make it into all the homes of vulnerable populations.

I’m not at all opposed to sprinkles-types of products or other nutrition pills for treatment (or in other special situations), as long as recipients are also educated about where the medicine came from in food. But once again, a message is being sent that nutrition comes from a pill / a packet, a foreigner, and all with money.

It is too bad that all that research, time, energy and money couldn’t teach people (or local manufacturers) how to make their own sprinkles from local nuts, fruits, greens, oils, seeds, insects, fish, and the like. Instead of just getting onto a bulky carbohydrate food, use the sprinkle as treatment along with teaching about planting and eating less of that bulky carbohydrate in the first place.

It’s hard to believe that such basic things that could last for generations to come. The organisations that support this type of permanent intervention could be mentioned during events, with the help of big banners and flyers that announced them as the inventors and / or supporters. Just imagine a few times where we heard that everyone can have on hand to improve their own nutrition without relying on a packet from an outside source that is manufactured and transported with all the costs involved.

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This article was written based on a WFP consultation to Malawi in February 2005.

The WFP Malawi HIV/AIDS project started in November 2002 as a pilot project in four districts, targeting 7,500 HIV/AIDS affected households per year. During EMOP (Emergency Operation) 10290, between July 2003 and December 2004, the project expanded into 14 districts to support 27,818 households caring for the chronically ill (CI) and orphans, and 10,000 individuals. In the current PRRO (Protracted Relief and Recovery Operation), the project will target 22,750 households taking care of the chronically ill and those keeping orphans and other vulnerable children, 1,250 TB patients, 3,450 HIV positive mothers enrolled in the Prevention of Mother to Child Transmission of HIV (PMTCT) programmes, and 5,300 chronically ill persons. Project support will be in 12 districts.

The overarching goals of the project have been to maintain the minimum acceptable nutritional and dietary standards of PLWHA and other vulnerable groups through provision of information and services on food aid and health. Specific objectives are to:

- Improve the nutritional status of CI persons, including patients on Directly Observed TB Treatment (DOT) and PLWHAs on antiretroviral (ARV) treatment.
- Improve the short-term food security of households with CI persons and those taking care of orphans.
- Strengthen the capacity of partner agency staff and community support groups to implement effectively comprehensive HIV/AIDS and nutrition related activities.

Programme targeting

The method of targeting for the programme was elaborated in guidelines produced by a consortium of INGOs, UN agencies and government ministries (JEFAP II). The Vulnerability Assessment Committee (VAC) report of February 2003 and National HIV/AIDS Surveillance report of 2001 were used to identify the most vulnerable districts in the country, meaning those districts with:

- High numbers of cases of HIV infection (above 4% according to the 2001 National HIV/AIDS Surveillance Report).
- High prevalence of AIDS cases.
- High incidence of TB.
- High numbers of orphans.
- Food insecurity and low mean calorie intake per person per day.
- Existence of an NGO capable of implementing HIV/AIDS activities and collaborating with other organisations in the district.

Priority Tribal Areas (TAs) were determined by the lead NGOs through meetings with district authorities and other organisations working in the districts, to avoid duplication of efforts. Food secure TAs were given priority, on the basis that these communities have fewer resources to care for the chronically ill.

Beneficiary enrolment criteria at household level included food insecure households that had limited or no source of income, and income within the lowest community category. Also identified by the community or community organisation as in need of food assistance were:

- Households caring for a chronically ill or bedridden patient (where chronically ill shall mean illness for one month or more).
- Pregnant or lactating mothers under the PMTCT programme and their babies.
- Households caring for orphans with special attention to elderly, child or single headed households hosting a large number of orphans (as defined by the community).

The monthly food basket for those on the HIV/AIDS programme is 10kg of corn soya blend/vegetable oil for the chronically ill, and 50kg of maize, 5kg of pulses and 3.7kg of vegetable oil for households with CI or orphans.

Targeting took place through existing community structures, such as Village Action Committees (VAC), Orphan Day Care Centres or other Community Based Organisations (CBOs) for the chronically ill or bedridden, and orphans. Targeting was also advocated through institutions such as hospitals or clinics for TB patients on DOT and pregnant or lactating mothers under PMTCT and their babies.

Establishing the targeting process involved a number of steps. Sensitisation meetings were held at TA and village level to introduce the programme, discuss targeting criteria, and select or introduce an existing committee. Orientation of committee members on their roles and responsibilities and identification and registration of beneficiary households followed. Verification of beneficiaries by NGOs in collaboration with the community or community organisations was conducted through community meetings or household visits.

Revision of guidelines

In light of experience gained during EMOP 10290, including analysis of Post Distribution Monitoring and Community Household Surveillance data and an evaluation conducted in April/May 2004 (Salephera Consulting LTD 2004), these guidelines were revised for the subsequent PRRO (JEFAP III). Key findings in the ‘Salephera’ evaluation were that guidelines on targeting chronically ill and orphans were followed in almost all areas visited. However, difficulties implementing the guidelines arose since there were more vulnerable people in the communities than the number actually covered by the programme. Community perception of the most vulnerable for food aid has included people who are not most vulnerable as defined in the guidelines, and there has been limited community involvement, sensitisation and verification during beneficiary targeting and selection. As a result, conflicts sometimes developed between those responsible for food distribution, beneficiaries, and those that believed they should qualify for food aid but were excluded.

The new JEFAP III guidelines have, therefore, strengthened guidance on community sensitisation, selection of committee members, development of community defined selection criteria, beneficiary selection and verification. It also made certain substantive changes with regard to how to target.

Programme observations

A number of observations were made, based on interviews with WFP staff and four site visits.

In the sites visited, those beneficiary chronically ill and orphan containing households interviewed...
were acutely food insecure and deserving of support. Although the programme for the CI and orphan containing households should be integrated with other HIV services (see JEFAP 11 and 111 guidelines), this was not possible. Hence, many beneficiaries of the CI and orphan programme receive food aid but no other resource or form of support. Households and Village Relief Committee’s (VRCS) prioritised the need for drugs for these individuals to complement food provision.

The ration provided for households with orphans was the same, irrespective of the number of orphans. Households selected with orphans tended to have multiple orphans, with an average of three.

None of the chronically ill or orphan containing households interviewed were aware of exit criteria, other than when the EMOP ended. It appears that, to date, there has been no graduation due to improved food security of the chronically ill or orphan containing households.

Most beneficiaries (individuals or households) indicated that there were many others chronically ill or households with orphans who were not enrolled on the programme but were equally needy. In a country where an estimated 65% of the population live below the poverty line and there is an HIV prevalence of 14.4%, this is unsurprising.

Out of those presenting for selection for the PRRO starting in January 2005, the number/ proportion of households selected was small/low (in some cases, each village was only able to select five households).

Ensuring that food commodities are delivered close to where beneficiaries live poses a considerable challenge of loading small tonnages for various locations, which is not cost-effective.

**Conclusions**

**Donor environment and availability of resources**

The current donor environment in the Southern African region is, at best, sceptical and, at worst, acutely sceptical of the potential role of food aid in supporting PLWHA – especially in non-emergency contexts. There are emerging views that such households and individuals urgently require medical intervention and safety net programmes as a priority, rather than food aid. The result has been a type of situation seen in Malawi, where scarce resources from donors have to be targeted to a very small percentage of those in need, creating enormous pressures on WFP, implementing NGOs and communities.

However, food aid may be well placed to be an integral component of what PLWHA require. There is emerging evidence that certain nutrients may halt progression of the disease, and adequate diet is essential for maximising the impact of ARVs. Food aid may assist compliance with treatment (ARV, DOT) and participation in programmes (such as PMTCT). Food aid may also be an important vehicle to allow acquisition of skills and community resources which promote longer-term food security amongst PLWHA.

Yet, before such programming can be fully supported and rolled out on a national scale, there needs to be proof that objectives can be met. Longer survival times, less morbidity, improved nutritional status and attainment of longer-term food security need to be proven. Objectives of programming need to be clearly articulated and credible monitoring established to show whether these impacts are achievable and what the role of food is in achieving these objectives. Perhaps key to proving a role for food aid is the axiomatic truth that food aid can only have a significant impact if well integrated with other services, including health care (for example, drug supply for opportunistic infection and where possible, rolling out of ARVs), health and nutrition education, psycho-social support, provision of adequate water and sanitation, etc. The institutional complexities of providing integrated programming in a country like Malawi is, however, poorly understood, both in terms of ‘how to make it happen’ and resources needed.

Rolling out a national programme before there is evidence that objectives can be met within an integrated programming environment, and how to realise this environment, may set back a realistic appraisal of the potential role for food aid in supporting PLWHA.

**Targeting**

It is extremely difficult to evaluate the success of targeting under the HIV/AIDS programme in Malawi and other countries in the region. While the Post Distribution Monitoring (PDM) examines inclusion and exclusion with regard to social and economic criteria, it is unable to do this with regard to HIV infection status. In Malawi. While targeting through DOT, ARV, PMTCT and HBC programmes can be assumed to result in high targeting efficiency with regard to HIV/AIDS infected individuals (over 70% of TB cases in Malawi are known to be HIV positive), targeting on the basis of chronic illness or having orphans in a household may be an extremely imprecise way of providing food security support targeted at the most vulnerable PLWHA.

Although the JEFAP guidelines go some way to addressing the above concerns in deriving and advocating complementary indicators for inclusion, e.g. economic indicators, there is clearly significant room for inclusion and exclusion error with respect to the chronically ill HIV affected and those households whose food security has been critically undermined by HIV/AIDS.

A recent study by AAH in Malawi drew the following conclusions regarding targeting vulnerable households within the context of HIV/AIDS:

- Is it a greater priority to improve the selection of the more vulnerable households within Malawi, within this context of HIV/AIDS, whether the vulnerability is rooted in HIV/AIDS or not? For methodologies intended to target food security input interventions, the degree of household vulnerability should take precedence over the cause of that vulnerability during beneficiary selection and should avoid reliance on simple proxy.

- Popular proxies used to detect vulnerable and/or HIV/AIDS infected/affecte hold, while theoretically indicative, are often practically imprecise with regard to identifying vulnerable households. Other proxies, such as the household food requirement/labour dependency ratio, should be piloted and developed.

**Recommendations**

Targeting food aid support to PMTC/ARV/DOT individuals is an efficient means of providing nutritional support (over). However, although consensus regarding the differential nutritional requirements and ration for those infected with HIV has not been reached, there is some agreement on the need for differential rations according to stage of disease. For example, it is believed that a 10% increase in energy intake is required to maintain nutritional status and avoid weight loss of asymptomatic individuals living with HIV, while those with AIDS related illnesses require a minimum of 20% increase in energy intake, with as much as 50% higher protein requirements. WFP will need to monitor emerging consensus on this subject and adjust rations accordingly. At the same time, implementing ration differentials will be extremely challenging from a logistical perspective.

There is an urgent need to pilot integrated programming in one or two districts. These pilots may be targeted using clear objectives (nutritional, health and food security) and establish rigorous monitoring. Such piloting was initiated in the WFP country programme before the emergency, but ceased with the advent of the EMOP 10200 as other more pressing needs took priority. WFP should also document the process and lessons learned regarding how to establish integrated programming and the costs and expertise required to bring about this. If the findings are positive, then donor organisations may be more supportive of this type of programming with positive implications for resources and future targeting.

If the decision is taken to continue with targeting on the basis of CI and orphan containing households, then this should only be implemented where fully integrated programming can be guaranteed. This is complemented by health service provision and effective and proven food security support initiatives. Future programming, therefore, should be based on a mapping exercise to determine where integrated programming can be guaranteed. This will lead to an overall smaller programme but should also make it possible to target food resources effectively. Furthermore, committees at those sites selected will not be required to make ‘difficult and politically sensitive’ household targeting decisions, as all CI and orphan containing households can be included. This type of ‘integrated and targeted’ programme would also substantially reduce logistical costs on a per tonnage basis.

Simultaneously, there is a need for pilot studies to test the targeting efficiency of using proxies such as CI. Thus, a pilot study checking the serum status of the CI and orphan containing households should be piloted and developed. If the decision is taken to continue with targeting on the basis of CI and orphan containing households, then this should only be implemented where fully integrated programming can be guaranteed. This is because these individuals are known to be HIV positive, tar-

1 For JEFAP guidelines, contact ALNAP Secretariat, ODI, 111 Westminster Bridge Road, London SE1 7DJ, UK Tel: + 44 (0)20 7922 0300, Fax: + 44 (0)20 7922 0399, Email: alnap@odi.org.uk or visit the weblink: http://www.alnap.org/pubs/pdfs/JEFAP_manual.pdf
Emmanuel International

By Andrew Mellen, Emmanuel International

Andrew Mellen has been the relief programme manager with EI Malawi since 2003. With a background in agriculture, he previously worked as an organic farm manager in the UK. He currently lives in Zomba, Malawi with his wife and three children.

Clients receiving HBC in Mbalika village

Field Article

In this article, EI shares their experiences of working with a community whose active involvement in relief has played a pivotal role in responding to chronic food insecurity complicated by HIV/AIDS.

Emmanuel International (EI) is a faith based international NGO, with its head office in Toronto, Canada. Emmanuel International is operational in 11 countries worldwide, with a major programme in Malawi. Other programme countries include Tanzania, Uganda, Sudan, Haiti, Brazil and the Philippines. Founded in 1975 in response to several disasters around the world, EI’s strategy has always been to work through local partners, strengthening the church to “meet the spiritual and physical needs of the poor in accordance with the Bible.”

Work in Malawi

Emmanuel International became operational in Malawi in 1986, after a request from the Evangelical Baptist Church of Malawi to help them respond to the Mozambique refugee crisis when over a million people crossed the border into Malawi to escape the war. EI assisted the church with resources and staff to help meet the needs of the refugees in one area, and then gradually began development and spiritual projects, working with the local population through the church.

After the war finished in 1992, the refugees returned home and EI continued its development work in Malawi, while also becoming involved in food relief work with WFP. The main development projects being implemented by EI are in the areas of food security, health and nutrition, water/sanitation and fertiliser for work. Currently EI is working in four districts of southern Malawi, namely Zomba, Machinga, Mangochi and Balaka. The head office in Malawi is in Zomba town, the former capital. Paul Jones, who is from Canada, is the country representative. Over the years, the projects have grown or shrunk, depending on opportunity and the availability of funding. At present, the workforce numbers around 160 national staff, assisted by eight international staff.

EI and relief work

During the 2002/3 food security crisis, EI became operational in relief once again, and was involved in the formation of the Joint Emergency Food Aid Programme (JEFAP) - a consortium of NGOs in Malawi working together on WFP’s EMOP (emergency operation) general distribution of food aid to vulnerable populations. EI also became involved as an implementing partner in the USAID funded C-Safe1 group of NGOs. While the large-scale general food distributions have been phased out, EI remains an implementing partner with WFP under their three-year PRRO (Prorogated Relief and Recovery Operation) in Malawi. EI has also ongoing partnerships with USAID and other NGOs in the new five year Development Assistance Programme (DAP).

Challenges of implementation

Malawi faces a complex mix of problems that reinforce poverty and inhibit development. A high population density - particularly in the south - together with depleted soils are, on their own, a recipe for chronic food insecurity. Other factors, like the prevalence of HIV and lack of crop diversification, exacerbate the problem. Dependency on aid is something all parties want to avoid, so all WFP’s partners in Malawi are encouraged to get maximum ‘added-value’ for the food given, by forging linkages between food-for-work (FFW) type projects and other interventions. In one example from EI’s projects, participants in FFW carried out the heavy work of cultivation on community gardens while other households, targeted for aid under orphans or chronically ill projects, assisted with light work. Thus both benefited from the food produced. The village chief has made land available to grow maize, cassava and rice, along with vegetables that are planted in the dry season.

Involving the community in the targeting has been essential to the acceptance of the programmes, particularly as resources can seldom meet the needs of every household that falls into the targeted category. With assistance from EI’s field staff, the committee in each village consider the following criteria to select households that receive assistance:

- Food insecurity, with a range of inclusion and exclusion criteria
- Income-generating capacity of the household
- Households caring for chronically ill persons
- Households keeping orphans or other vulnerable children.

In Mbalika village where EI are working, those interviewed stated that there were around 30 chronically ill HH (households) and over 40 HH with orphans and vulnerable children (OVC) out of a total of 378 HH in the village. However, they only had resources to support 10 chronically ill and 17 OVC households. The committee has had to make hard choices with regard to targeting the neediest, particularly as there is no home based care (HBC) system in the village, making decision making all the more difficult.

Pilot programme to support TB treatment

EI has also been part of a pilot project with WFP and the national tuberculosis (TB) programme, assisting people diagnosed with TB in four selected districts of Malawi. Patients diagnosed with TB at the Machinga District Hospital are placed on the routine 8-month directly-observed treatment (DOT) regime. WFP provides for each patient a 2.5 kg household food ration to each household with a TB patient, part of which is a nutritionally-dense corn soya blend (CSB) plus a vegetable oil mix intended solely for the patient. EI receives food from WFP, re-packages it into the exact ration sizes, and delivers it to the local health centres around the district. Thus, when the patient goes to collect his month’s supply of medicine and to be weighed, he or she also collects a monthly food ration.

This intervention is being tested to see whether it helps in two ways, first by encouraging patients to stick with the treatment regime until the course is completed, and secondly to see if the food reduces the high death rate previously experienced in the early months of treatment. Once the scheme has been operational for a period of time, a direct comparison can be made between a cohort of patients who have received the food aid, and another non-recipient group that has never received food as part of the programme. Anecdotal evidence from health centre staff indicates, so far, that the food aid is having two effects. Patients diagnosed are being retained in the treatment programme much better than before. Also, as news of the food entitlement has spread, more people with symptoms like long-lasting coughts are presenting themselves for diagnosis, in order to try and qualify for the food.

The collection and analysis of the data on deaths during treatment is still being carried out and a paper on this should be published later this year. Even if, as expected, a reduced death rate during the treatment period is found, it will still be necessary to conduct an investigation to discover exactly how the food has helped. Is there a direct benefit to the patient in terms of better nutritional status helping them to tolerate the drug treatment? Or is it simply a case of the food acting as an incentive which keeps the patient on the treatment? All that can be concluded, so far, is that both the health workers, and the 370 or so patients currently receiving food, are very happy to be involved in this project.

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* Consortium for the Southern Africa Food Emergency
HIV/AIDS and Food Security in Malawi

By Kathryn Lockwood, Martin Davidson Mtika and Richard Mmanga, CRS

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Malawi, a land-locked country in sub-Saharan Africa that is prone to food shortages, is bearing the full brunt of the African HIV/AIDS pandemic, while also struggling to strengthen its democratic institutions after 30 years under an extremely repressive dictatorial regime. In Malawi, where nearly 80 percent of households rely on agriculture as their major livelihood strategy, HIV/AIDS is having devastating consequences. However, by building on the existing capacity of local communities, Catholic Relief Services (CRS) programmes are creating positive changes in the lives of vulnerable Malawians.

In 1997, the Episcopal Conference of Malawi (ECM) extended a formal invitation to CRS to work in Malawi. With this invitation, CRS first responded to the needs of Malawians through small-scale initiatives addressing food insecurity. Since then, over 60 national and international staff members, located in the main office in Lilongwe and sub-office in Blantyre, have contributed to the expansion of programming. Developments include long-term sustainable interventions in agriculture, health and nutrition, HIV/AIDS, justice and peace. CRS’ primary implementing partners in Malawi include the Catholic Development Commission of Malawi (CADECOM) and the Catholic Commission for Justice and Peace (CCJP).

Context of programme approach

HIV/AIDS and related diseases are now the leading cause of adult mortality in Malawi. The National AIDS Commission (NAC) estimates that approximately 15 percent of Malawians among the most productive age group (15-49 years) are infected and, in urban areas, the level of infection in adults reaches 20 percent. Every year, as many as 100,000 new infections occur, and at least half of these are among people aged 15-24 years. The three greatest impacts of the HIV/AIDS pandemic in Malawi noted by NAC were:

- 800,000 of Malawian children under the age of 15 years have lost at least one parent to the disease
- the death rate has tripled since 1999
- the number of tuberculosis cases is three times higher than it would be without AIDS.

Households affected by HIV/AIDS - whether caring for and supporting orphans or a chronically ill relative or neighbour - represent a staggering 64 percent of the population in central Malawi. Loss of productive labour is the most direct and significant impact of HIV/AIDS on these rural households who rely on agriculture. Extremely poor and vulnerable households possess no excess capacity to survive additional burdens. HIV/AIDS is also diminishing the human capital of upcoming generations as children, particularly young girls, are taken out of school to care for sick family members or sent out to work in order to subsidise family income. This severely limits their ability to gain education and life skills. Intergenerational knowledge is also deteriorating as parents die before passing on wisdom and learning to their children.

Within this context, CRS/Malawi strives to support individuals affected by and infected with HIV/AIDS. The agency will continue to support initiatives that complement the goal of helping the people they serve to better cope with their situation through the following approaches:

- Improved quality and increased scope of community-based home care
- Increased support to orphaned and vulnerable children
- Empowerment for affected communities through integration of HIV/AIDS with other programmes
- Increased advocacy at all levels of society on addressing stigma and discrimination.

Dedza Integrated HIV/AIDS Project

A significant component of the CRS operation in Malawi is the Dedza Integrated HIV/AIDS Project. This has recently completed a three-year programme and intends to continue in the future with increased activities. The project is implemented in nine townships in Dedza, Ntcheu, and Salima Districts and strives to minimise the impact of HIV/AIDS within the Dedza Diocese. Through home-based care, volunteers, infected and affected persons receive care and support and communities receive messages regarding HIV transmission. Additional components of the project include income-generating activities (IGA), distribution of food commodities to people living with HIV/AIDS, promotion of community-based HIV/AIDS education, and provision of vocational training for older orphans. The project has indirectly touched 200,000 of the 900,000 people living in the Dedza Diocese and has 6,000 direct beneficiaries, including orphans, chronically ill persons, widows, and HIV/AIDS infected families.

Home based care

Home-based care (HBC) is the main component of the Dedza Project. It is a community-based approach to providing health care and support to chronically ill persons and people living with HIV/AIDS (PLWHA). The programme operates in three deaneries, with each deanery comprising one HBC provider, one medically trained project officer, and 90 volunteers. The community identifies volunteers for the programme. The volunteers are both women and men and usually work in teams of two. Each volunteer supports three to five clients and makes at least one visit per week to a client. During client visits, the volunteer educates clients and other members in a household on primary health care, good nutrition, and HIV/AIDS prevention and transmission. The volunteer also assesses the condition of the client and provides basic medicines and other items to provide comfort. These items include pain relievers, malaria treatment, oral rehydration salts, antiseptic ointment, bandages, plastic sheets, gloves, and disinfectant. The volunteers will also do household tasks if necessary (e.g. sweep, clean, cook, fetch water and or firewood) depending on the condition of the patient.

HBC volunteers regularly gather for refreshers on palliative and home-based care. At these meetings they have the opportunity to discuss any issue regarding their work and exchange ideas. Traditionally, volunteers are permitted access to small-scale income generating activities in return for participating in the programme. In addition, the volunteers maintain an elevated social status and are respected within their communities. As such, the retention rate for the volunteers surpasses 90 percent, which is quite high for a HBC programme. Lack of adequate food security and not having sufficient medicines are the main problems that the majority of volunteers report on behalf of their clients.

Targeting beneficiaries

Communities select the HBC beneficiaries for the project. In general, the first layer of targeting for the project is relatively easy, as the communities identify households that have chronically ill household members. The volunteers then visit the household to determine if that household genuinely does...
have a chronically ill household member, and not just an individual suffering from a short-term disabili- ty. Communities readily accept this aspect of target- ing in the project. However, it has become apparent that communities were unclear as to the targeting criteria surrounding the Orphan and Vulnerable Children (OVC) component of the proj- ect, which led to a low-level tension in the commu- nities between beneficiary OVC households and non-beneficiary households. Given this, in the future the project will hold community education and sensitisation meetings with each of the targeted communities to clarify targeting criteria.

Obviously, some clients did not survive the full length of the project, and additional new clients needed assistance. Therefore, the same HBC clients did not remain in the project the entire time. However, community HBC volunteers largely remained the same, and the same communities were targeted throughout the life of the project.

Food aid component
Local food, mainly maize, pulses, and fortified grains, is regularly made available to extremely vul- nerable households. HBC volunteers demonstrate meal preparation to households using these food items along with other locally produced foods. Soy milk and porridge preparation is a new activity for the project. Using approximately two kilograms of soy and nearly 2 litres of milk, enough porridge to feed a large household can be produced. Volunteers also prepare traditional meals with maize and show households how to increase nutrient values with locally grown items. Community gardens also con- tribute to the food supply for vulnerable house- holds.

Income generating activities (IGAs)
The project also supports income-generating activities for older orphans and vulnerable children and households supporting chronically ill persons. Orphans and vulnerable children learn vocational skills such as sewing, tin smithing, and carpentry. Upon completion of coursework, they receive mate- rials to get them started, such as basic tools and sewing machines. Household income-generating activities include rabbit breeding and agricultural production. The rabbits mainly serve as food and, as they reproduce, are distributed to other house- holds, however they can be used as assets if needed. Agriculture extension workers introduce time- and cost-saving mechanisms to help increase crop pro- duction. Beneficiaries learn how to use manure or their own compost for fertilizing, crop rotation tech- niques, multi-cropping (growing different crops together in one field), and how to grow kitchen gar- dens. In some areas they also receive treadle pumps for irrigation. Based on the experiences beneficiaries have had selling vegetables in markets, they have decided to form cooperatives to increase their prof- its by reducing competition and working together to set prices.

A noteworthy aspect of this activity due to start this year is honey production, which can be sold in the market and consumed by chronically ill persons as an alter- native to refined sugar.

Impact of programme
The end of project evaluation revealed that 43 percent of households in the target area reported benefitting from this project, an increase over the project’s initial objective percentage of at least 25 percent of people infected and affected by HIV/AIDS. The project also aimed to provide HIV/AIDS education in the targeted area. Household surveys during the project evaluation demonstrated that approximately 67 percent of the communities had benefited from education and pre- vention messages.

During the same evaluation, 95% of respondents reported that they required additional food security interventions. Specific needs articulated by PLWHA included increased agricultural inputs, additional income generating activities, augmented support for orphans, more access to medicines, and scaled- up psychosocial support.

Interviews conducted by ENN with HBC staff in the field supported many of the CRS findings. For example, the main challenges identified by HBC volunteers included:

- Lack of food and food security for clients
- Lack of medicines (although volunteers have been taught about use of local herbs for treatment of illnesses associated with HIV/AIDS)
- Lack of clothes
- Patient isolation
- Lack of transport

An interviewed HBC co-ordinator described elements of the programme considered to have worked well, in particular patient care, including medication, orphan care, skills training, educational support, community empowerment, and income generation.

Youth mobilisation remains a challenge, while forging linkages with health infrastructure although started late, has made some progress. Since a work- shop with staff from all the health institutions in operational areas to sensitize them to the work being carried out by the HBC teams, some of the health centres now have an official referral letter so that patients can access health care. However it was felt that these linkages need to be strengthened fur- ther.

Future plans
CRS/Malawi plans to continue supporting this project in the future and is currently adjusting their activity plan in conjunction with CADECOM based on the evaluation findings. CRS and CADECOM are in the process of developing a more integrated food security and HIV/AIDS project. In addition, the organisations are slightly modifying and scaling-up other interventions based on the results of the end-of-project evaluation.

One of the interventions the new project will scale-up is the OVC component of the project, which focuses on mitigating the impact of HIV/AIDS on OVC and their quality of life. CRS and CADECOM will integrate food security, protec- tion, and psychosocial activities into the OVC com- ponents. In addition, CRS and CADECOM plan to work closely with the Malawian Ministry of Health to ensure collaboration with the Government’s anti- retroviral therapy (ART) rollout for current HBC clients.

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Field Article

Food aid component

Income generating activities (IGAs)

Future plans

Impact of programme

Nutritional Support Through HBC in Malawi

By Mieke Moens, MSF

MSF in Malawi

The author would like to acknowledge the contributions of Dr. Roger Teck, Head of mission, Thyolo, Malawi and Pascale Delchevalerie, nutritionist at MSF-Belgium headquarters.

In common with other countries in southern Africa, the Malawian population is heavily affected by the HIV/AIDS epidemic. The most recent sentinel surveillance report revealed a national HIV prevalence level of 19.8% among antenatal care (ANC) attendants. Projecting these findings, the prevalence level for HIV infection in the adult population (15-49 years) is estimated at 14.4% (12-17%). Approxi- mately 110,000 new HIV infections occur annu- ally. In 2003, about 900,000 people were estimat- ed to be living with HIV/AIDS in the country, of whom close to 170,000 had advanced HIV/AIDS disease and were in need of life-sav- ing antiretroviral treatment (ART). Of these, 10% are children, the majority having been infected through mother to child transmission. With an estimated 80,000 adult and child HIV/AIDS related deaths annually, HIV/AIDS has become the most significant cause of death amongst adults - average life expectancy in Malawi has now dropped to below 40 years. Moreover, Malawi has, at present, approximate- ly 840,000 orphans, 45% of whom have lost one or both of their parents because of AIDS.

Fuelled by this epidemic, the annual case noticitation of tuberculosis has increased from 5,334 new cases (82/100,000) in 1985, to nearly 30,000 new cases (257/100,000) in 2003. This is coupled with a significant increase in mortality, to more than 20%, among tuberculosis (TB) patients under TB treatment. The situation is further complicated by food shortages, which Malawi is increasingly confronted with during the very dry hunger periods. It is feared that this precarious food security situation will lead eventually to a nutritional crisis situation, with high levels of acute malnutrition during the annual ‘lean’ season (rainy season) before the harvest.

At time of writing, the most recent report was HIV Sentinel Surveillance Report 2003, Ministry of Health & Population and National AIDS Commission, November 2003.


In Malawi, orphans are defined as children who have lost one or both parents (because of death) and who are still under 18 years old.
HIV/AIDS pandemic. The current MSF programme is based in Thyolo district, Malawi and comprises a number of components including:

- Prevention of HIV transmission
- Support to the district tuberculosis control programme
- Home based care (HBC) and social support for people living with HIV/AIDS and/or TB
- Hospital based care for patients with HIV/AIDS and/or TB
- Integrated antiretroviral treatment programme since April 2003
- Emergency preparedness and response to cholera outbreaks for the five most southern districts in the southern region of Malawi.

Nutrition programme, whose key activities include:
- Running a Nutrition Rehabilitation Unit (NRU) in Thyolo District Hospital
- Supervising the Supplementary Feeding Centres (SFC) of Thyolo District
- Orphan’s programme for infants up to 1 year of age
- Integrated nutrition support to malnourished patients in the HBC network
- Nutrition support to TB patients during the first month of treatment
- Nutrition support to malnourished patients registered with the ‘Continuum Care’ (HIV/ARV) Clinic
- Nutrition supplementation of malnourished patients hospitalised in Thyolo District Hospital

Operational research to document and adjust approaches, to prove feasibility and to provide evidence for dissemination and advocacy at national and international level.

The HIV/AIDS related targets (2003-2007) for Thyolo district are, access to a ‘continuum of care’ for at least half of the estimated 50,000 people living with HIV/AIDS, and access to ART for at least 50% of the estimated 7,000 – 8,000 people living with AIDS. The target groups are malnourished people with HIV/AIDS and/or TB, and people with a poor medical condition.

Integrating HBC and nutrition

MSF currently coordinates and integrates HBC and nutrition programmes in the district. The objectives of the programme are to reduce malnutrition amongst the chronically ill and to support malnourished AIDS patients during initiation of ART. MSF currently have 550 patients registered through HBC activities and 33 through the antiretroviral (ARV) clinic (Jan 2005).

Integrated activities have been taking place monthly over five days – a period that has recently been extended to 10 days a month. Each month, the nutrition team joins the HBC team and the patients are screened in their community (or the nearest community where this activity takes place), while they are waiting for treatment from the HBC nurse. Screening is carried out by trained HBC volunteers. The results (height, weight and MUAC) are written up in their individual health passport. The nutritional team then evaluates each individual by calculating the Body Mass Index (BMI), checking for oedema and evaluating the general health condition. Where individuals meet the entry criteria, the patient is admitted onto the programme (70% are admitted on the basis of BMI<17). Each patient receives a monthly ration of 10kg of Likuni Phala (Malawian fortified blended food).

Some of the ARV patients are not supported through HBC but by the nutrition team in Thyolo District Hospital. The same entry criteria apply for hospital nutrition support but patients are provided with Plumpy’nut (Nutriset) instead of Likuni Phala.

Initial discharge criteria were established as a weight gain of more than 10% during two consecutive visits, a BMI >17 (or MUAC > 185) and good general health condition. However these proved impractical, both in terms of calculating the 10% weight gain and the degree of weight gain, which sometimes took too long to reach. The criteria were subsequently revised to achieving a BMI >18.5 for two consecutive visits and a good general health condition. Generally, patients remain for a considerable time on the programme (average stay 2004 was 5.5 months). Table 1 shows progress of patients in one year period.

Table 1: Weight progress of those patients registered in nutrition programme

<table>
<thead>
<tr>
<th>Total number of patients evaluated</th>
<th>Number receiving ART</th>
<th>Number not receiving ART</th>
</tr>
</thead>
<tbody>
<tr>
<td>n 3294</td>
<td>325</td>
<td>2969</td>
</tr>
<tr>
<td>Weight gain 41.5 %</td>
<td>56%</td>
<td>40%</td>
</tr>
<tr>
<td>Weight static 29.5%</td>
<td>24.5%</td>
<td>30.5%</td>
</tr>
<tr>
<td>Weight loss 29%</td>
<td>22%</td>
<td>29.5%</td>
</tr>
</tbody>
</table>

Period: February 2004 – January 2005

The MSF team strongly believe that nutritional support for this vulnerable group is necessary, although it is difficult to measure the impact. Implementation of a double blind control study would be ethically difficult. The programme is also shifting slowly to using Plumpy’nut instead of Likuni Phala, as it is a more nutritionally complete supplement, more manageable in terms of carriage and storage, and is easier for beneficiaries to use.

This programme has many challenges. For example, there is currently a low attendance rate in some areas, especially when the weather is poor or when there is a planting or harvesting period. People who send relatives, instead of attending themselves, for three consecutive visits are not visited by the team or through HBC workers, to establish the reason.

It is important that the objectives of this type of nutritional support are realistically defined in relation to access to medical care and treatment. In Thyolo district, people often live far away from the health structures, so that transport is difficult. Consequently, monthly attendance is not always realistic. On the positive side, nutritional screening can contribute to the identification of HIV positive patients eligible for ART (a wasting syndrome occurs at stage 4 in AIDS). In conclusion, through this programme experience, we have demonstrated that integration of well targeted nutritional support for malnourished people with HIV/AIDS is feasible in a setting with community home based care.

For further information, contact: Mieke Moens, PMTCT and Nutrition programme, MSF Thyolo, email: MSFL-Blantyre@Luxembourg.msf.org

* Visits take place once a month.
Impact

An impact survey was conducted in 2004 in five operational areas. On both criteria, Butula Division had the highest target efficiency, i.e. the majority of the people receiving food assistance were clearly both HIV/AIDS affected and food insecure in the absence of food assistance. Only two percent of eligible people were excluded from the programme. The partner in Butula is the Rural Education and Economic Enhancement Programme (REEP), a CBO under the dynamic and inspired leadership of Mary Makokha. So what are the main ingredients of REEP’s success?

1. Community-driven and community based:
The food is provided through elected Community Management Committees (CMC), which are independent of the local political and patronage structures, and generally comprise affected or infected people. The steadfast independence of REEP ensures that, for the most part, food allocation is decided based on needs, and not on influence. REEP officers know the community intimately, well enough to be able to verify the CMC participant lists.

2. Women in the driving seat:
As with all WFP programmes, women’s participation was encouraged and facilitated in all the stages of the Busia project. Over two-thirds of the CMC members are women. Women tend to have better information on the relevant household characteristics, and most community members consider the CMC to be much fairer than the male-dominated local leadership structures.

3. Tackling stigma:
REEP has done an extraordinary job, building people’s self-esteem and enabling them to speak freely about their HIV status. When people are found to be HIV positive, they are referred to a support group headed by a community health worker, and their food security situation is assessed in order to determine their eligibility for food assistance. This improves the quality of the targeting, by encouraging more destitute and infected people to come forward.

With the right quantities of food getting to the right people, the impact of the food assistance has been very positive. The proportion of poor households consuming adequate kilocalories has doubled. Participants report a tremendous improvement in their health, self-confidence, and entrepreneurship.

According to Mary Makokha there have been “resurrections” among the bed-ridden patients receiving CSB rations from WFP. On visiting Butula with ENN, WFP met a woman who was bedridden before the project but is now farming her own land, and has even increased her plot size. Although the programme targets the poorest households in Butula, there were no children suffering from wasting among those surveyed.

While the REEP experience has encouraged WFP to expand the food assistance programme, the agency is aware of the need to complement short-term food assistance with longer-term food security initiatives. In Butula and other project sites, WFP partners are setting up income-generating projects, like poultry and pork raising. These activities do not require heavy labour, so they are appropriate for households affected by HIV/AIDS.

Of course, effective targeting is not enough. In Butula, food support is an essential tool for mitigating the food security impact of HIV/AIDS, but is only one input in the support package. REEP’s comprehensive home-based care programme offers targeted households a support package, which is complemented with WFP’s food assistance.

See related field article, REEP experiences in Western Kenya, p26

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By Erin Culbertson and Moses Kalyebara

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Moses Kalyebara, an agriculture graduate of Makerere University, Uganda, has worked for Plan for 7 years as the Country Agricultural Advisor. Before this, he was one of the managers of a British tea company and the national manager of agro-processing for an INGO called World Learning.

The authors would like to acknowledge the contributions of the following to the project in Uganda: David Kyejune, Project Coordinator for Food Security, Cassiano Kansime, Community Development Coordinator (CDC), Martin Nzabal, (CDC), and the communities of Kasana and Bumunanka in Luwere District.

WFP supports a project, Nutrition and Care of the People Affected by HIV/AIDS, implemented by the Government of Kenya, NGOs and community based organisations (CBOs), in Busia district in Western Kenya. Busia district was selected due to a high HIV sero-prevalence (over 15 percent) and relatively high rates of rural poverty. The project commenced in 2003 and provides a basic food ration to 24,700 food insecure and HIV/AIDS-affected households. This poses a targeting problem since WFP is committed to feeding only the hungry poor, and lacks the resources to cover all HIV/AIDS affected households in Busia. Thus, WFP has applied a dual targeting criterion, to identify households that are both affected by HIV/AIDS and are food insecure. This is challenging because targeting HIV/AIDS-affected households is very delicate, with a risk of creating stigma. In addition, it is costly and difficult to evaluate food security status at a household level.

Delicacy of targeting

A baseline survey, undertaken prior to implementation, found that the households that are most directly affected by HIV/AIDS, such as those with bedridden adults, with grandparent heads, or host-
Approach to in Uganda

Plan is an international, non-governmental, child-centred development organisation without religious or political affiliation (see box for the basis of the organisation’s operations). For more than 12 years, Plan Uganda has worked in partnership with Ugandan communities to establish family support groups and to properly manage natural resources, and to properly manage natural resources, and to support them in their basic needs. The project was developed and implemented in collaboration with local government structures, an NGOs called Joint Energy and Environment Projects (JEEP), and Ibero (U) Ltd. In this project, Plan is working in four districts in Uganda (Kampala, Luwero, Kamuli and Tororo), primarily located in the central and eastern regions of the country. Over 80% of families in Uganda rely on subsistence agriculture. Low agricultural productivity, degradation of natural resources, and limited access to modern agricultural technologies and markets are all factors that may reduce families’ household incomes. It is difficult for families to raise enough food for survival on this land, let alone additional food to create an income basis. Children suffer the effects of this poverty, as food insecurity leads to deficient diets and malnutrition.

Vision and basis of Plan’s work

Fundamental to Plan’s operations is the organisation’s vision of a world in which all children realise their full potential in societies that respect people’s rights and dignity.

Child sponsorship is the basic funding component of the organisation, with over one million children and families enrolled. Plan strives to achieve lasting improvements in the quality of life of deprived children in developing countries through a process that unites people across cultures and adds meaning and value to their lives by:

- Enabling deprived children, their families and their communities to meet their basic needs and to increase their ability to participate in and benefit from their societies
- Fostering relationships to increase understanding and unity among peoples of different cultures and countries
- Promoting the rights and interests of the world’s children.

Child Centred Community Development (CCCD) is Plan’s basis for planning, resource mobilisation, implementation, and monitoring and evaluation of all programmes. It is equity-based and requires a change in relationships between and among individuals and institutions at all levels – children and adults, the poor and the elite, females and males. CCCD emphasises inclusiveness, respecting, shared learning and the importance of actively engaging children and adults in matters that affect them. Plan has begun (and will continue) to shift its programme approach away from one based upon traditional top-down delivery of services, towards one that is more child-centred, participatory, and community-based.

The HIV/AIDS pandemic is one of the biggest obstacles to reaching poverty reduction targets and development goals in Uganda. The pandemic has resulted in the death and illness of men and women in their prime ages, thus reducing the productive labour force that is engaged in agricultural production and also creating a large number of orphans in Uganda. Some farming families affected by ill health and death from HIV/AIDS have stopped planting traditional food crops, such as nutritious beans, and have replaced them with less nutritious root crops that are easier to produce. When the primary breadwinner of a family falls ill, the entire family’s food security is threatened. Additionally, a person living with HIV/AIDS needs to maintain a balanced, adequate diet to boost her/his immune system. To make ends meet, many families are selling off livestock, crops their children should be consuming, and household assets. In order to address the impact of HIV/AIDS on agriculture, food security, and nutrition, crops and production technologies that require lower inputs, yet retain micronutrients, need to be promoted. Higher value food crops, such as coffee and vanilla, also will be promoted to improve nutrition and income-generating activities.

Food security project

In response to these factors, Plan developed the Strengthening Food Security for Children and Families Liveability Project. The project is being implemented in one district, Luwero, which is located about 45 km from the country’s capital. It began in January 2004 and is projected to end in December 2008. This project is being supported by funding from the Douwe Egberts Foundation.

The overall project objectives include:

- To enhance awareness of coffee as a cash crop and improve coffee quality through training and support to small coffee farmers, utilising techniques that require lower inputs, yet retain micronutrients, need to be promoted. Higher value food crops, such as coffee and vanilla, also will be promoted to improve nutrition and income-generating activities.
- To augment market efficiency and farmers’ incomes through development and empowerment of small groups of coffee farmers.
- To create and retain community participation through enabling families to make enhanced-productivity agricultural investments, to sustain efforts for environmental conservation, and to properly manage natural resources.
- To facilitate uptake of thorough farm management practices through the introduction of intensive farming techniques and income-generating activities.
- To maintain an outreach programme in schools to enable school children to improve their knowledge and skills in agriculture, environmental conservation and natural resources management.
- To promote childhood care and development in the context of the communities’ needs and resources, with the ultimate goal of enhanced food security and improved nutritional status.

In Plan Uganda’s new Country Strategic Plan, the Sustainable Livelihoods Approach (SLA) is used to understand and analyse the circumstances of vulnerable children and their families and to identify the families that qualify as ‘chronically poor’ and those that are ‘economically vulnerable’. Targeted livelihood interventions for the families will be used to improve the food security and household incomes only for those families identified as ‘chronically poor’. For the ‘economically vulnerable’ families, capacity-building exercises, agricultural training programmes, and income-generating activities will enhance their abilities to provide for their children’s basic needs.

The ‘chronically poor’ include the severely disabled, terminally ill, child-headed households, the unemployed and the landless. People living with HIV/AIDS and their families will also fall into this category, particularly as the parents become weaker and eventually die, leaving widows, orphans, and child-headed households in precarious situations. This category of people has difficulty participating in community-managed projects. Studies have shown that targeted transfers of agricultural inputs can increase the livelihoods of the poor, particularly if they utilise the transfers for investment and improved productivity.

The ‘economically vulnerable’ include cash crop farmers, orphans, informal sector workers, the elderly and widows. This group could potentially benefit from different interventions, such as micro-credit programmes, training in modern farming techniques, and capacity enhancing activities.

Community participation

After raising awareness in communities about the project, over 1,000 farm families were identified by their communities through the SLA. Using a participatory approach, a ‘social map’ was created which included the number of people living in houses, their livelihoods, and the heads of the family. Both the ‘chronically poor’ and ‘economically vulnerable’ were identified, as various project activities could benefit the different groups. These participants received training on project structure, management, documentation and objectives.

One quarter (25%) of the participants selected were women. This number is lower than targeted, because coffee is traditionally seen as a man’s crop and most women do not have ownership of the coffee gardens. Gender-disaggregated data was collected on women’s involvement in and control of coffee farming. The role of women in attaining food and nutrition security is extremely important, particularly because experience shows that women transfer improved food/nutrition security and income to their children.

The project was developed and implemented in collaboration with local government structures, an NGO called Joint Energy and Environment Projects (JEEP), and Ibero (U) Ltd. In this project, Plan is adopting a community-managed project approach for certain components, such as animal provision. The project has embraced the concept of farmer-to-farmer extension, in which model farmers voluntarily support approximately five other farmers.

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The model farmers receive special training in topics such as coffee agronomy, post-harvest handling, soil and water conservation, and internal control systems. They are also provided with necessary tools.

Project impact
By the end of the first year of the project (January 2005), a number of outputs and impacts have been realised:

• Over 1,000 farmers (chronically poor and economically vulnerable) were trained in coffee agronomy, post-harvest handling, and soil and water conservation techniques. One example of a coffee improvment intervention was the provision of drying materials to the farmers to dry their coffee off the ground, thus improving coffee quality.
• Twenty farmer promoters (six women) were trained in skills that could be transferred to their fellow farmers. Farmer groups were then formed around these promoters.
• Fifteen demonstration gardens, that are well located and easily accessible, have been established.
• Over 30,000 coffee seedlings were distributed to farmers (chronically poor) to replace the old coffee trees that had been affected by coffee wilt disease.
• A major focus is placed on linking farmers to appropriate market channels. The implement partner, Ibero Ltd, bought all the coffee from the participants at a premium price.

Eight communities developed proposals for agricultural training. The training included improved chicken rearing practices, horticultural training, and livestock management. Additionally, some chronically poor households received chickens, goats, and piglets.

Horticultural training was also conducted. Nearly all the households received direct inputs, such as vegetable seeds, fruit seedlings, and orange sweet potatoes.

Over 600 participants were trained in improved knowledge and skills in nutrition, specifically for children and people living with HIV/AIDS. Out of these, 120 community nutritional trainers were identified and supported. Informational materials about child nutrition also were developed and distributed to the communities.

The future
Key issues identified throughout the project will be addressed in the upcoming years. Seasonal changes and unreliable weather conditions have proved a particular challenge, since this delayed crop planting and so influenced the timing of seasonal harvesting.

More attention is needed on the gender aspect of the project. Community awareness sessions could address the involvement of women in coffee production and the production of other cash crops - particularly in the case of AIDS widows who are supporting their children. Additionally, more interventions are needed specifically to target and involve child-headed households in cash crop production.

Coffee production alone will not guarantee improved food security in households. For farmers with limited resources, food crop production for consumption and income generation remains vital for attaining food security. Integrated farm management, which does not focus on a single cash crop, is needed to sustain the farm’s natural resource base.

For further information, contact Moses Kalyebara, email: moses.kalyebara@planinternational.org and Erin Culbertson, email: erin.culbertson@planinternational.org

Field Article

The future

Project impact

Complementary activities

Fortified foods

Agriculture

Evolution of GOAL Activities in Malawi

By Andy Nicholson

Andy Nicholson is currently Country Director of GOAL in Malawi. He has been in Africa since 1990 working mainly in emergencies in Sierra Leone, Liberia, Rwanda, DRC, Burundi and now Malawi. Has worked for Lutheran World Federation, Christian Aid, Save the Children UK and now GOAL.

This article describes the evolution of GOAL HIV related programming activities in Malawi over the past three years, but does not describe the implementation of or lessons learnt from these programmes (Eds).

GOAL and JEFAP

GOAL became operational in Malawi in April 2003 and was involved in the formation of the Joint Emergency Food Aid Programme (JEFAP), a consortium of agencies, including WFP and 11 other NGOs, formed to manage the distribution of food on a national basis. Operational in two districts, Blantyre and Chiradzulu districts, GOAL distributed 2,300 metric tonnes (MTs) of food per month at its peak, before completing this programme phase in May 2003. Continuing with the consortium model for the second year under JEFAP 2, GOAL was engaged in food for work (FFW) and the direct transfer of food aid to People Living with HIV/AIDS (PLWHAs) and the chronically ill. This involved supporting over 9,700 households affected by HIV/AIDS, with over 750 FFW projects operating in Blantyre and Chiradzulu Districts of Malawi. This provided the basis for activities that were implemented under JEFAP 3 in Nsanje district, where GOAL relocated (funded by WFP) to operate in an area of acute need in the southernmost area of the country. FFW projects were implemented in all nine Traditional Authorities (TAs), with a range of activities designed to support communities in the medium and longterm. These included reforestation and community woodlots, rehabilitation of key roads, rainwater harvesting and soil and water conservation, along with other community based agriculture projects. Food to those affected by chronic illness (2,041 families) and to those looking after the chronically ill (360 families) was supplied in seven of the TAs. This programme finished at the end of December 2004, coinciding with the beginning of WFP’s Protracted Relief and Recovery Operation (PRRO) in January 2005.

Goal and PRRO

The WFP PRRO is scheduled to run for three years, with the initial three month programme running to the end of March 2005. During this period, 4,000MT of food was allocated to GOAL, for distribution through FFW (26,110 households), food to those affected by chronic illness (2,048 households) and those hosting patients (620 households). A total of around 160,000 will benefit in this blanket response to what is traditionally a period of acute hunger as people wait to harvest their crops in April. Additional funding from the Jesuits has been received to support food to the chronically ill in the two TAs not served by the PRRO, up to the end of February 2005.

Complementary activities

GOAL views these activities with WFP as the stepping stone to consolidating a variety of activities in Nsanje, with particular emphasis on food security, agriculture, drought and flood mitigation.

Fortified foods

During JEFAP 1, with funding from Development Cooperation Ireland (DCI) and in parallel to the general food distribution, GOAL distributed Corn Soya Blend (CSB) to the most vulnerable groups during the hungry season months of January to May 2003. Further DCI funding saw GOAL establish a supplementary feeding programme in 21 health centres and 63 outreach clinics in Blantyre District. This included the training of Ministry of Health staff in the national guidelines and protocols. This programme ceased in May 2003.

Agriculture

GOAL has had two programmes in the agricultural sector, both running during phases of JEFAP 1 and 2. The first entailed distributing seeds and cuttings of ‘non-maize crops’ to vulnerable rural families, to encourage crop diversification and the formation of community seed banks for sustainability. This programme, led by CARE and funded by the Office of US Foreign Disaster Assistance (OFDA), involved training on seed production, multiplication, storage and post harvest management, including food preparation techniques and organisational capacity building. This ran from late 2002 to June 2004.

A second programme, funded by the FAO, involved working at two established government run Nutritional Rehabilitation Units (NRUs), one in Blantyre and one in Chiradzulu. Based at the NRUs, GOAL trained two ‘Home Garden Managers’ in establishing vegetable gardens and livestock production, as well as training ‘carers’ in home garden technology to support malnourished children. In addition, 1,500 families were supplied with an FAO starter pack of seeds and tools to help support the recovery and sustain the health of the children attending the NRUs after their discharge. GOAL involvement ended in May 2004 when the programme was handed over to a committee at each of the NRUs for future development and functioning.
WFP Monitoring and Evaluation of HIV/AIDS Programming in Malawi

By Jeremy Shoham, ENN

This article was written based on a WFP consultation to Malawi in February 2005.

During 2003, WFP Malawi significantly strengthened the monitoring activities for all its programmes in Malawi. The Post Distribution Monitoring (PDM) and Community Household Surveillance (CHS) programmes implemented by WFP are most relevant to targeting in Malawi and provide invaluable insights regarding the role of using proxy indicators to target people living with HIV/AIDS (PLWHA).

Community Household Surveillance (CHS)

The CHS is a regional initiative in six EMOP (Emergency Operation) countries and was initiated in early 2003. CHS is based on sentinel site monitoring and has four main objectives:

- to monitor impact of food aid
- to monitor trends in food security
- to monitor links between food security and nutrition and/or HIV/AIDS, and
- to feed into early warning system information.

The two instruments for the CHS are a household questionnaire and a monthly focus group discussion. CHS is conducted by WFP field monitors, who hold questionnaire and a monthly focus group discussion.

CHS was initially piloted in Malawi in July 2003 in 30 sentinel sites. The first round took place in October 2003, with 30 sentinel sites in six randomly selected EMOP 10280 districts. Four Final Distribution Points (FDPs) per district were selected, with one village randomly selected from serving FDPs. In each village, 22 households were selected, comprising 11 beneficiaries and 11 non-beneficiaries. A second and third round CHS were conducted in February 2004 and October 2004 respectively, with a fourth round planned for February/March 2005.

The initial pilot CHS in July 2003 mainly collected information on the food security situation, including data on coping strategies and household perceptions on need for food aid. There was also some analysis of vulnerability. The first round of surveys collected and analysed data on food security and coping strategies but also focused on targeting. The first round report claimed that social targeting was successful, e.g. 37% and 27% female-headed households amongst beneficiaries and non-beneficiaries respectively. However, it stressed that the ‘asset very poor’ were less represented than richer households (see figure 1).

The second report, in February 2004, concluded that social targeting, i.e. female headed households, orphan containing households, elderly and disabled, etc. was successful. Success of 41% of beneficiary households were female headed compared to 37% non-beneficiary households, and 26% beneficiary households had chronically ill compared to 21% non-beneficiary. It also stressed that 9% of beneficiaries and non-social inclusion criteria, while 31% of non-beneficiaries had three or more social inclusion criteria. Furthermore, 54% of beneficiaries were asset poor, compared to 48% for non-beneficiaries.

Post Distribution Monitoring (PDM)

The main objectives of PDM are to monitor the use of food aid, satisfaction with food aid, and access to food aid (including targeting inclusion and exclusion). It involves a household questionnaire and focus group discussions and is conducted by NGOs and WFP field monitors. The first PDM report was compiled in December 2003, containing information for September – December 2003 (EMOP 10290 began in July 2003). There had been considerable work in the development of the PDM prior to this, as well as evaluation of its implementation. A consultant on monitoring and evaluation was taken on at country office level, and experiences of PDMs from other countries with similar programmes were drawn upon.

The first PDM narrative report was based on a total of 1196 households, with a relatively equal distribution between beneficiary and non-beneficiary. Beneficiary households were those receiving food aid through the new EMOP under Food for Work (FFW), or Vulnerable GroupFeeding (VGF), i.e. those infected or affected by HIV/AIDS, children, orphans, expectant and nursing women. Social vul-

![FFW bridge construction in Chiradzulu](image)

**Figure 1 Asset ownership categories by beneficiary status and gender of household head**

<table>
<thead>
<tr>
<th>Asset ownership (different assets*)</th>
<th>Beneficiary household</th>
<th>Non-beneficiary household</th>
<th>% of total households</th>
</tr>
</thead>
<tbody>
<tr>
<td>M F</td>
<td>M F</td>
<td>M F</td>
<td>M F</td>
</tr>
<tr>
<td>Asset very poor (0-2 assets)</td>
<td>12.9% 24.5%</td>
<td>22.8% 27.6%</td>
<td>18.6% 25.9%</td>
</tr>
<tr>
<td>Asset poor (3-5 assets)</td>
<td>38.7% 46.4%</td>
<td>37.4% 43.7%</td>
<td>37.7% 45.2%</td>
</tr>
<tr>
<td>Asset medium (6-9 assets)</td>
<td>35.5% 25.5%</td>
<td>29.1% 18.4%</td>
<td>31.8% 22.3%</td>
</tr>
<tr>
<td>Asset rich (9+ assets)</td>
<td>12.9% 3.6%</td>
<td>10.6% 10.3%</td>
<td>11.7% 6.6%</td>
</tr>
<tr>
<td>Total</td>
<td>100% 100%</td>
<td>100% 100%</td>
<td>100% 100%</td>
</tr>
</tbody>
</table>
The main findings of the first report were that targeting on the basis of social vulnerability was a good but weak respect with economic wealth indicators. It was believed to be due to a high level of inclusion errors. The report recommended refining inclusion criteria through systematic discussions with local communities and traditional chiefs, giving the opportunity to work out local checklists of social and economic indicators tailored to a given local context.

The January 2004 PDM report found a clear improvement of targeting with respect to social and economic welfare indicators following a beneficiary verification exercise in late 2003. The February 2004 PDM report stated that the VGF programme more frequently included households keeping orphans (73%), the chronically ill (31%) and FHH (24.4%) compared to FFW activities (45%, 19% and 43% respectively). It was felt that VGF targeting remained satisfactory with a predominant inclusion of beneficiary households with at least one social vulnerability criteria.

The March 2004 PDM introduced new analytical variables – overall inclusion and exclusion errors and targeting efficiency. The executive summary of the VGF report stated that the VGF programme more frequently included households keeping orphans (73%), the chronically ill (31%) and FHH (24.4%) compared to FFW activities (45%, 19% and 43% respectively). It was felt that VGF targeting remained satisfactory with a predominant inclusion of beneficiary households with at least one social vulnerability criteria.

The PDM has had a significant impact on the targeting system in EMOP 10290 and the current Protracted Relief and Recovery Operation (PRRO). Early findings, after the first report, led to an evaluation of targeting (Nsama report in March/April 2004) and an evaluation of the HIV/AIDS programme, with a particular emphasis on targeting in April/May 2004 (Selapera Consulting Ltd).

Findings from the PDM and CHS have also led to a number of revised monitoring initiatives, including where:

- Implementing partners were strongly encouraged to undertake systematic and re-iterated targeting and verification exercises.
- In May 2004, a collaborative process was initiated between WP and the JEFA* cooperating partners to review the targeting criteria. As a result, the final set of inclusion and exclusion criteria was thoroughly discussed, agreed, and later on included in the revised implementation guidelines (JEFA III).
- Implementation of the new set of criteria and plans to apply the new set of inclusion and exclusion criteria.

Conclusions

Although there was no rigorous monitoring of targeting during the initial EMOP (1200), partly due to the need to prioritise implementation of the general food distribution, the monitoring evolved rapidly into an extensive system which collected a variety of data needed to assess compliance with targeting. The system has compiled a large quantity of extremely useful data. The level of sophistication acquired both with regard to monitoring targeting as a tool and unique and could serve as a model for other programmes.

The findings of the monitoring, in particular the weaknesses of targeting on the basis of economic criteria, were rapidly identified and reflected in JEFA III guidelines.

Some of the claims regarding the success of social targeting may have been over-emphasised, i.e. the differences found between beneficiary and non-beneficiary groups were not statistically tested and almost certainly not of sufficient margin to make certain claims. Furthermore, there seems to have been an undue emphasis on inclusion criteria rather than exclusion criteria, which showed very high levels reflecting the large proportion of very poor and poor in Malawian communities. It can be argued that exclusion errors are more important than inclusion errors, because they are di
ductive at community level.

The monitoring has a number of methodological weaknesses:

- Comparing assets between beneficiaries and the non-beneficiary population is conceptually flawed, as one would expect non-

- Inclusion and exclusion criteria are normally calculated on the basis of proportion of beneficiaries out of total target population, rather than on the basis of households which meet inclusion and exclusion criteria. The adopted method may lead to an underestimate of targeting efficiency.

- The non-beneficiary and non-beneficiary inclusion/exclusion percentages are not compared statistically.

Recommendations

Given the lack of success of economic targeting, there is a clearly a need for more pilot and research to determine when and where such targeting is appropriate. For example, where a large proportion of the population are economically ‘poor’ or ‘very poor’, it may not be feasible. It may be that in such circumstances, social targeting is more acceptable at community level while economic based criteria will lead to conflict and disagreement. An implication of this may be that ‘the first cut’ of targeting should be social targeting, with economic targeting being subsequently invoked once these households have been identified at community level. In order to assess efficiency of economic targeting, it would have been better to carry this out at the onset of the programme or following new registrations as, during the programme, a process of equalisation is likely to occur and non-beneficiaries are forced to disinvest. Where possible, statistical tests (e.g. Pearson coefficients) to compare social inclusion/exclusion for beneficiary and non-beneficiary populations. Had this been done, the findings would have been more credible.

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The HIV/AIDS epidemic in Malawi is receiv
ing increasingly committed responses from its government, donors, religious institutions, the UN, and NGOs. Programmes addressing prevention, testing, treatment and vulnerability are gaining momentum. Currently many of these programmes aim specifically to target HIV/AIDS infected/affected individuals and/or households. While this may be an appropriate approach for many types of interventions (such as HIV-specific prevention, curative, medical, educational or nutritional programmes), for some food security inputs programmes this may not be the most effective approach. The majority of rural Malawians are chronically impoverished and malnourished; they exist on the edge, where a shock to, or within, an average rural household can push it to a degree of vulnerability that they may not be able to withstand.

Within this context, it may be more important to improve the selection of the most vulnerable households, whether the vulnerability is rooted in HIV/AIDS or not - first considering the degree and aspect of a household’s vulnerability, and then considering the HIV status of the beneficiaries when developing the most appropriate intervention. By accurately targeting the most vulnerable households in countries, like Malawi, with high rates of HIV infection, infected/affected households will necessarily be infected/affected households.

By Maja Munk and Dr. Neil Fisher

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The targeting of vulnerable households within the context of HIV/AIDS in Malawi

Summary of evaluation

The percentage of beneficiary households with access to livestock decreased from 30% to 21%. However, there was no improvement with regard to land access. The analysis of the proxy revealed moderate exclusions errors proposed by the JEFA monitoring working group. The panel states to livestock, access to credit and ownership of income as medium business and income as formal wage. There are six inclusion socio-vulnerability indicators. These are undernourishment (defined as fewer than seven persons in a HH, elderly headed, female headed, keeping orphans and keeping chronically ill. In order to assess the targeting efficiency, a targeting index is derived for each household, which is composed of the difference between the number of inclusion and exclusion criteria. For the purpose of simplicity, each exclusion indicator is given a negative one (-1) and each inclusion indicator a positive one (+1). When the two are aggregated, a deserving household is one that has a positive difference, i.e. more inclusion indicators than exclusion indicators. A negative targeting index will mean that the household has more exclusion criteria than inclusion criteria, and should be considered as food secure. It should be noted that there are different figures in the text of the report for inclusion and exclusion and efficiency (16% and 73% and 78% respectively). Joint Emergency Food Assistance Programme is a wide consortium of 12 international and local NGOs in Malawi.
Common proxies

In Malawi, like many other countries, there is fear, ignorance, a lack of accessible free and anonymous testing, and a common assumption that all people tested for HIV have AIDS. Many women need their husbands’ approval to be tested, and there is difficulty preserving privacy within the village context. Given the personal and social ramifications of knowing your status and/or being associated with the disease, few rural Malawians undergo voluntary counselling and testing (VCT) or will be willing to be identified as being HIV positive. Until the impact of the current investments in VCT and antiretroviral (ARV) treatment are felt by Malawi’s rural population, and the rural population is successfully sensitised to HIV/AIDS, identifying HIV infected/affected households remains problematic. Additionally, there may be negative ramifications for households associated with programmes specifically targeting HIV/AIDS infected/affected families.

Correctly targeting vulnerable households is difficult in most contexts, accurately targeting household members who are vulnerable directly or indirectly because of HIV/AIDS is, on any significant scale, not practically possible in rural Malawi. The substantial increase of ‘dead’ deaths due to AIDS through the period of time, it can be an imprecise proxy for capturing HIV/AIDS or its opportunistic illnesses. There are also many types of chronic illnesses historically existing in southern Africa that may not have any relation to HIV/AIDS or its associated diseases. However, the presence of a family member who has been unhealthy for a specific period of time, it can be an imprecise proxy for capturing HIV/AIDS or its opportunistic illnesses. There are also many types of chronic illnesses historically existing in southern Africa that may not have any relation to HIV/AIDS or its associated diseases. However, the presence of one or both parents dead irrespective of the support the child receives from its remaining family; or an orphan is a child who does not have access to basic necessities, whether its parents are alive or not, and may rely on other people than its parents to satisfy those needs. Even within a household, there can be different options regarding the status of a child. A woman’s second husband may consider the children from his wife’s first marriage to be orphans, the wife may or may not consider her own children as orphans.

If an orphan is defined by the death of one or both parents, there is also the question: once an orphan always an orphan? That is, if a child is considered an orphan because one parent died, does it remain an orphan after the remaining parent remarries? Does an orphan after they get married or on their 16th or 18th birthday? Or is being an orphan restricted to a state of being dependent on others for your needs? If a grandchild is taking care of his grandparent, how do we in practice determine whether the child is responsible for, before the child is considered an orphan? While the answers to these questions may, on an abstract level, seem straightforward, at the field level they are often complex.

The presence of ‘orphans’ in a household is not necessarily a reliable proxy for HIV/AIDS in Malawi. While governmental and non-governmental actors are using orphanhood as an indicator of HIV infection, often these definitions do not translate into field realities. It should not be automatically presumed that the absence of one or ‘orphans’ necessitates a death in the child’s family. The definition of orphan in Malawi might be defined as ‘the child whose parent(s) have died’, or that the presence of the ‘orphans’ necessarily indicates a long-term economic burden on the hosting family (as the child may be receiving no other support). However, the number of ‘orphans’ may represent a positive or neutral contribution to a household, or the child may be hosted for a short period of time. However, the hosted orphan may be receiving a higher level of care for childhood (the care of the child before and after the remaining parent remarries) than the remaining children in the household. That said, specifically targeting the orphan, as opposed to the household as a whole, may further marginalise the child.

The proxy for ‘female-headed households’, as opposed to male-headed, assumes the absence of an active adult male contributing to the household. The absence of a male-head has a compounded effect: it puts more of a burden on the female-head as the primary primary proxy for household vulnerability and operates on the environment where women have fewer income generating opportunities than men. AAh surveys in central Malawi have found that polygamy in rural central Malawi is practised communally. The scope of polygamy does not readily present itself, as the polygamy practised in central Malawi is matrilocally in this setting, implying a causal relationship between the households of his co-wives, as opposed to sharing a common compound with them. In this structure, each co-wife’s house lacks the contribution of the husband or the support of the other co-wives.

Interviewed households have identified that three households can be classified as male-headed, as the wife has to provide for the household with, most commonly, ‘Elderly’ and ‘child-headed’ households are like- ly to be male-headed, and the woman likely to be the active contributing adult. The degree of their vulnerability lies both in the household head’s ability to contribute to the household. The presence of a gener- nation gap in a household is not unusual where middle aged women migrate to the city. This can be a particularly important resource for eld- erly-headed households. Often the elderly live in close proximity to their adult children, however, the adult children may not be technically child-headed, yet also leaves the elderly with the responsibility for their household. These households may have to rely on a smaller family support structure (as they have no adult children to rely on). It is also important to remember that the threshold for childhood varies culturally in Malawi, it is not uncommon for teenagers to marry and establish their own households before their 18th birthday. While these households may be technically child-headed, to successfully target the ‘child-headed’ households with children are frequently associated with HIV/AIDS, the presence of a genera- tion gap in a household is not unusual where middle aged women migrate to the city. This can be a particularly important resource for eld- erly-headed households. Often the elderly live in close proximity to their adult children, however, the adult children may not be technically child-headed, yet also leaves the elderly with the responsibility for their household. These households may have to rely on a smaller family support structure (as they have no adult children to rely on). 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Dependence /Poverty Score

The score took values from 1 (least vulnerable) to 19 (most vulnerable). After this score was ascertainment, one point was added for each orphan in the household. Two points were added to households that had elderly people caring for children. Households that scored 11 or more points were chosen as beneficiaries.

A short, ten-minute, targeting questionnaire capturing the essential data needed (household structure, mortality/morbidity, assets, and land holdings) for the targeting methodology was conducted in four health centres and their surrounding villages, within the catchment. Of the 3,500 people interviewed with the questionnaire, 64% of the total number of households qualified under the criteria used in the targeting methodology. Due to time constraints, the remaining 36% of beneficiaries were selected through local leaders using defined criteria: female-headed households, elderly-headed households with children, households with more than 4 orphans. Household characteristics determined the inputs received: vulnerable households with sufficient land and labour received crop inputs, vulnerable households with insufficient land or labour received chickens and feed.

Evaluation of the methodology

Constraints

The effect of the piloted targeting methodology was diluted, and AAH’s ability to evaluate it was somewhat limited, as, due to time constraints, not all beneficiary households were targeted through the food /labour dependency ratio. Additionally, AAH liaised with local leaders to inform selected households and ensure that they collected their beneficiary cards at designated points before the distribution. Follow-up visits to these households were given to people other than the intended beneficiaries.

During the monitoring and evaluation process, it was not possible to determine under which methodology a particular household was targeted. It was, therefore, not possible to ascertain during the evaluation process if incorrectly targeted households were selected by the piloted methodology or selected by local leaders. As an unknown third of the beneficiaries were not selected through the piloted methodology, properly evaluating its ability to correctly identify vulnerable households was difficult.

Selected households

Of the surveyed beneficiary households, 65% qualified on one criteria count and 17% qualified on two criteria counts. No one household had qualified on all three criteria, as they were in the richest two quartiles and in the two quartiles with least dependency.

Despite the fact that the potential effectiveness of the food/labour dependency ratio may have been diluted as 36% of the beneficiaries were selected via local leaders, the methodology was able to proportionally select more of these high dependency households towards the higher food/labour dependency households when compared to the base population. The only exception was the proportion of beneficiaries selected in the >8000kcal group, which is slightly less than the base population. This under-representation may be caused by these disenfranchised households not accessing health structures and not having choice in the community and therefore less likely to be picked up during the selection process.

In the food/labour ratio (figure 1), the threshold for vulnerability is calculated at 5800kcal per man equivalent. The targeting methodology was able to select proportionally more households that have a high food/labour dependency. In the dependency ratio, household vulnerability increases as the ratio increases from 1 to 10. The methodology was able to proportionally select more of these high dependency households as well (see figure 2).

Households which were not selected by the questionnaire had a food/labour ratio of 4,825kcal per man equivalent. The 17% of targeted households who should not have qualified had a food/labour ratio of 5.056kcal per man equivalent. Qualifying households had a food/labour ratio of between 6,321 and 8,000kcal per man equivalent.

There were statistically significant demographic differences between targeted households and the base population. Comparing Malawi’s DTFI food security methodology and the piloted targeting methodology picked up proportionately more households headed by persons aged 31 years or older, headed by women, and/or headed by widows/wvers. These households had fewer productive and non-productive assets than the base population. The presence of orphans in targeted households was between 2% and 4% higher than the base population. The poorest and most dependent 17% of the sample was more likely to be female-headed households with orphans; if these households had orphans they were more likely to have a higher number of orphans per household than the other segments of the sample.

Estimates of inclusion/exclusion errors

The piloted methodology had an estimated inclusion error of between 21% and 38% and exclusion error of <4%.

The inclusion errors appear to be better than those for Malawi’s DTFI funded Targeted Input Programme (TIP) in 2000-01. There are a number of possible reasons for this large inclusion error: the 36% who were selected through local leaders, rather than through the targeting interview, may not have conformed to the dependency/poverty criteria that were used for the 64% selected by the piloted methodology. People were interviewed for the beneficiary profile survey, but they gave different answers to the household structure and asset questions during the survey than during the targeting interview; some beneficiary cards were misallocated. If these assumptions are true, then the true inclusion error lies somewhere between 21% and 38%, as the portion attributed to households given food by local leaders is generally such a low error rather than a real inclusion error. While the inclusion error of the piloted methodology is the same or worse than the exclusion error, AAH’s distribution in Ntchisi’s neighbouring district of Kasungu (see table 1), where a traditional method of targeting through local leaders was used, the exclusion error is better. This is important as exclusion errors are arguably more important than inclusion errors, as they can trigger resentment within the concerned communities.

The quantitative inclusion and exclusion errors, as well as the qualitative input of the enumerators and AAH food security staff who carried out the evaluation, indicate that within Malawi’s context of widespread endemic poverty, it is difficult to differentiate the subtle degrees of poverty or dependency amongst poor households to find the most vulnerable. However, as most interventions do not have the capacity or mandate to target all of Malawi’s impoverished households, selection criteria are necessary for the identification of people in the remaining 70 to 80% of households.

Conclusion

It is not HIV/AIDS itself that threatens a household’s livelihood, but the ramifications of the disease that make the household increasingly vulnerable as their income and expenditure are skewed. The ratio of active members to dependants shifts. Within Malawi’s context of widespread chronic poverty, it is less essential for NGOs implementing non-HIV specific food security interventions to find households infected/affected by HIV/AIDS than to identify households that are vulnerable. The nature of HIV/AIDS vulnerability should be taken into account when designing programmes. One of the most vulnerable households have been correctly identified, the specific stresses of HIV/AIDS can be considered. Due to the limitations of proxies being applied practically in rural Malawi, humanitarian actors should not use them as the simple solution to identify beneficiary households and should question if using them is, in fact, appropriate for the identified vulnerability. While piloted methodology developed by AAH was a forward move, methodologies to improve identification of the most appropriate vulnerable households to target should be further developed and explored.

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References


2. For the questionnaire, ‘chronically ill’ was defined as ill for more than three months

3. For the questionnaire, orphan was defined as under 18 years old with both parents dead

4. UK Department for International Development

5. Targeting interviews were not conducted in the home, impact assessment interviews were

The Emergency Nutrition Network (ENN) grew out of a series of interagency meetings focusing on food and nutritional aspects of emergencies. The meetings were hosted by UNHCR and attended by a number of UN agencies, NGOs, donors and academics. The Network is the result of a shared commitment to improve knowledge, stimulate learning and provide vital support and encouragement to food and nutrition workers involved in emergencies. The ENN officially began operations in November 1996 and has widespread support from UN agencies, NGOs, and donor governments. The network aims to improve emergency food and nutrition programme effectiveness by:

- providing a forum for the exchange of field level experiences
- strengthening humanitarian agency institutional memory
- keeping field staff up to date with current research and evaluation findings
- helping to identify subjects in the emergency food and nutrition sector which need more research.

The main output of the ENN is a tri-annual publication, Field Exchange, which is devoted primarily to publishing field level articles and current research and evaluation findings relevant to the emergency food and nutrition sector.

The main target audience of the publication are food and nutrition workers involved in emergencies and those researching this area. The reporting and exchange of field level experiences is central to ENN activities.

The Team

Jeremy Shoham (Field Exchange technical editor) and Marie McGrath (Field Exchange production/assistant editor) are both ENN directors.

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