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**RETHINKING FOOD AID TO FIGHT AIDS**

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## **Abstract**

HIV/AIDS is a slow-moving, devastating shock that kills the most productive members of society, increases household dependency ratios, reduces household productivity and caring capacity, and impairs the intergenerational transfer of knowledge. It is socially invisible, complicated by silence, denial, stigma, and discrimination. While it affects both rich and poor, it is the poor who are most severely impacted. Though it affects both sexes, it is not gender neutral.

Though AIDS is far more than just another health problem, many development organizations have yet to undertake thorough analyses of its impact on what they do and how they do it. Even fewer have actually changed their policies and procedures to adjust to the new realities.

In the era of AIDS, food and nutrition security is becoming even more of a priority for many households and communities. We know that food and nutrition are fundamentally intertwined with HIV transmission and the impacts of AIDS. Evidence of the ways in which food insecurity and malnutrition may increase susceptibility to HIV as well as vulnerability to AIDS impacts, and how HIV/AIDS in turn exacerbates these conditions is increasingly well documented. Food and nutrition security is fundamentally relevant to all four of the conventional pillars of HIV/AIDS response—prevention, care, treatment, and mitigation—and food aid can be an important addition to the arsenal.

This paper, based on a 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. By viewing food aid programs through an “HIV/AIDS lens” and in the context of a livelihoods approach, the authors argue that organizations can design effective interventions that reduce both susceptibility to HIV and vulnerability to AIDS impacts.

Though there is little empirical evidence regarding the effectiveness of food aid in responding to HIV/AIDS, the authors argue this should not constrain action. Using past experience as a guide, organizations can learn by doing, documenting, and continuously

reassessing their programs using the evolving HIV/AIDS lens. By doing so, they ensure maximal relevance and impact.

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## 1. Introduction

It has taken two decades for HIV/AIDS to be recognized as a serious threat to development and human security by governments and humanitarian and development agencies. Given the socioeconomic, cultural, and political underpinnings of the pandemic, there is an urgent need for all sectors to reassess their roles, both actual and potential, in combating HIV/AIDS. Such a response is critical if the Millennium Development Goal (MDG) of halving the spread of HIV/AIDS by 2015 is to be met, just as it is critical for the achievement of other MDGs, including poverty and hunger.

UNAIDS estimates 42 million people are living with HIV/AIDS (PLWHA), of which 29.4 million live in Sub-Saharan Africa, and 6 million in south and southeast Asia (UNAIDS 2002). The report suggests an additional 45 million people will become infected with HIV in 126 low- and middle-income countries between 2002 and 2010, if the response to the pandemic is not drastically expanded.

As the southern Africa food crisis continues, the impact of the AIDS pandemic is becoming ever more apparent (see, for example, United Nations 2003). These food emergencies highlight how vulnerable households, communities, and countries are to shocks that disrupt food production and consumption. Unlike earlier famines, e.g., mid-1980s Ethiopia, HIV/AIDS is now not only deepening vulnerability, but changing its nature in ways that have profound implications for response strategies.

We know that food and nutrition are fundamentally intertwined with HIV transmission and the impacts of AIDS. Evidence of the ways in which food insecurity and malnutrition may increase susceptibility to HIV as well as vulnerability to AIDS impacts, and how HIV/AIDS in turn exacerbates these conditions is increasingly well documented. The response to HIV/AIDS is conventionally disaggregated into the four pillars of prevention, care, treatment, and mitigation. Food and nutrition security are fundamentally relevant to *all* four strategies (Loevinsohn and Gillespie 2003).



Many policy and project instruments exist for tackling food insecurity, including measures to enhance agricultural productivity, investments in market infrastructure, and implementation of community-based nutrition programs. Given the interactions between AIDS, food, and nutrition, national AIDS policies are also important, not only for combating the epidemic, but for promoting food and nutrition security.

No one instrument can deal with the scale and many dimensions of food insecurity, now further exacerbated by HIV/AIDS. In this paper we consider whether food aid can be an effective weapon in the war against AIDS.<sup>1</sup> It has been argued that such a role might detract from preexisting food security goals. This, however, wrongly assumes that AIDS and food insecurity are unrelated. In fact, they are inextricably intertwined. Where food insecurity and AIDS coexist, proceeding with “business as usual” (where AIDS is often viewed as “someone else’s responsibility”) may compromise not only an organization’s ability to achieve its goals, but the very relevance of these goals as well.

To help practitioners understand the dynamic interactions of HIV transmission and AIDS impacts on different sectoral concerns, and to then identify appropriate policy and program modifications in the face of these realities, we propose the use of an “HIV/AIDS lens” (Loevinsohn and Gillespie 2003). The lens is essentially a metaphor for the approach of reviewing situations armed with the knowledge of the way HIV/AIDS interacts with another given problem.<sup>2</sup> A recent report of the January 2003 mission by two UN Special Envoys puts it, “United Nation agencies need to commit themselves to reviewing their emergency and development programmes in areas of high HIV prevalence through the ‘lens’ of HIV/AIDS” (United Nations 2003, 9).

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<sup>1</sup> In this paper, *food aid* and *food assistance* refer to targeted, in-kind transfers to vulnerable groups.

<sup>2</sup> For example, poverty may force families to split up temporarily as an adult goes in search of work. The *benefits* may include increased household income but—if we apply the lens—we may highlight some major *costs* if this dislocation leads to more frequent sexual interactions. There may be a significantly greater risk of the migrating individual (as well as his/her partner who remains) becoming infected with HIV. This is just one example of the changes to the policy context wrought by the various HIV risks and AIDS-related vulnerabilities.

In the case of food aid, we attempt first to assess current food aid programs in terms of their actual and potential effects in increasing or reducing household susceptibility to HIV and vulnerability to AIDS impacts. Second, we provide recommendations as to how food aid organizations may mainstream HIV/AIDS considerations into existing programming and/or embark on more targeted HIV-specific programs. Such a review of policies and programs precludes the common reflex of “new problems, new programs.” Clearly not everything needs to change because of AIDS, but it is important to have a mechanism for thinking through the various options. Should the program continue as before, should it change, or should it even be stopped? Targeting, intervention choice and design, and implementation issues all need reconsideration.

Our point of departure is thus the question of how best food assistance can be tailored to respond to the various impacts of HIV/AIDS.<sup>3</sup> Though there is no hard evidence yet showing the effectiveness of food aid in responding to HIV/AIDS, this should not constrain action. Guidance based on experience is becoming more available (e.g., WFP 2003). A learning-by-doing approach should be adopted, including the documentation and continual monitoring of program relevance and effectiveness so as to maximize impact.

The next section of this paper provides some background on the nature of the HIV/AIDS shock, its implications for people’s livelihoods and thus on the potential role for food aid, both in terms of preserving livelihoods and in terms of basic survival. We introduce concepts such as susceptibility/resistance and vulnerability/resilience. Section 3 then looks into the issue of targeting before analyzing in detail current food aid program types and their possible contribution to reducing susceptibility to HIV and/or vulnerability to AIDS impacts. This includes a section on the implications of HIV/AIDS for emergency response. Prior to concluding, Section 4 demonstrates how the HIV/AIDS

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<sup>3</sup> We do not intend to review the evidence on the effectiveness of food aid in meeting its current food security, nutrition, and development objectives.

lens can be applied to some crosscutting strategic issues relating to capacity, advocacy, implementation, monitoring, evaluation, and operational research.

## **2. What Is Different About AIDS?**

AIDS is a slow-moving, yet devastating, shock that is unique for the following reasons (Gillespie, Haddad, and Jackson 2001):

- It kills the most productive—and reproductive—members of society, thus increasing household dependency ratios, reducing household productivity and caring capacity, and impairing the intergenerational transfer of local knowledge and skills. The effect on the household may be permanent.
- Coping strategies are more likely to be irreversible, compared to those adopted to counteract other shocks. The very survival of the household unit may be threatened.
- HIV/AIDS is socially invisible. The private nature and divergent cultural attitudes toward sex lead to silence, denial, stigma, and discrimination at many levels. This makes effective prevention and mitigation difficult to implement.
- HIV has a very long incubation period between infection and full-blown AIDS, during which time individuals are infective. In the absence of routine HIV testing, infected individuals have less of an incentive to alter risky behavior and a long period over which to undertake those activities. Both invisibility and long duration increase chances of HIV transmission. Individuals who are unaware of their HIV status and their families cannot begin to alter livelihood strategies in anticipation of impacts.
- It has rural and urban dimensions. As with poverty, the death of one or more income earners in rural households often forces survivors to migrate to seek work in cities. The death of an urban worker may force survivors to send children back

to rural extended families to be cared for. Migrant workers who become infected in cities come back home to their villages to die.

- It affects both the rich and the poor, though it is the poor who are most severely affected. AIDS prolongs and deepens poverty, making it harder to escape.
- It affects both sexes, but it is not gender-neutral. To the extent that women are marginalized and powerless, they are more at risk of being exposed to HIV and less likely to seek health care. They are also more biologically susceptible to being infected in a given sexual encounter.
- Finally, one of the most disturbing facts of the pandemic is that, as it intensifies, the local capacity to respond is decreasing. Organizations located in areas that are experiencing a high HIV/AIDS prevalence are characterized by high absenteeism, high turnover, loss of institutional memory, and reduced innovation. As individuals in government and nongovernmental organizations continue to die, the gap between what is needed and what can be delivered is becoming an abyss.

### **Adopting a Livelihoods Approach**

To better understand how interventions may support people's livelihoods, it is useful to differentiate two important aspects of these livelihoods—their susceptibility to HIV and their vulnerability to AIDS impacts (Loevinsohn and Gillespie 2003).

Susceptibility relates to the chance of an individual, household, community, or livelihood system becoming exposed to HIV or to significant HIV infection rates. It essentially has two components: the chance of being exposed to the virus, which in turn relates to the risk environment of the person/workplace/community/system and to the riskiness of her/his behaviors (both of which may themselves be linked); and second, the chance of being infected with the virus, which relates to individual susceptibility. The positive converse of susceptibility is *resistance*.

Vulnerability is quite different from susceptibility. Vulnerability relates to features of the social, economic, cultural, and physical environment or process that make

it more likely that HIV/AIDS will have negative impacts at a certain level (e.g., individual, household, community). These impacts are not one-time events; they are *processes*, often hidden, slow-moving, but very destructive. These processes are punctuated by events, such as the sale of assets, some of which are irreversible, leaving the household—if it survives—significantly impoverished (see, e.g., Box 1). Much has been written about this in recent years (e.g., Barnett and Whiteside 2002; Haddad and Gillespie 2001) and more data are emerging from new studies (e.g., Yamano and Jayne 2002). The positive flipside of vulnerability is *resilience*, or the ability to bounce back after a shock.

#### **Box 1—HIV/AIDS strips assets**

HIV/AIDS may have the following negative effects on capital in livelihood systems (see Figure 1):

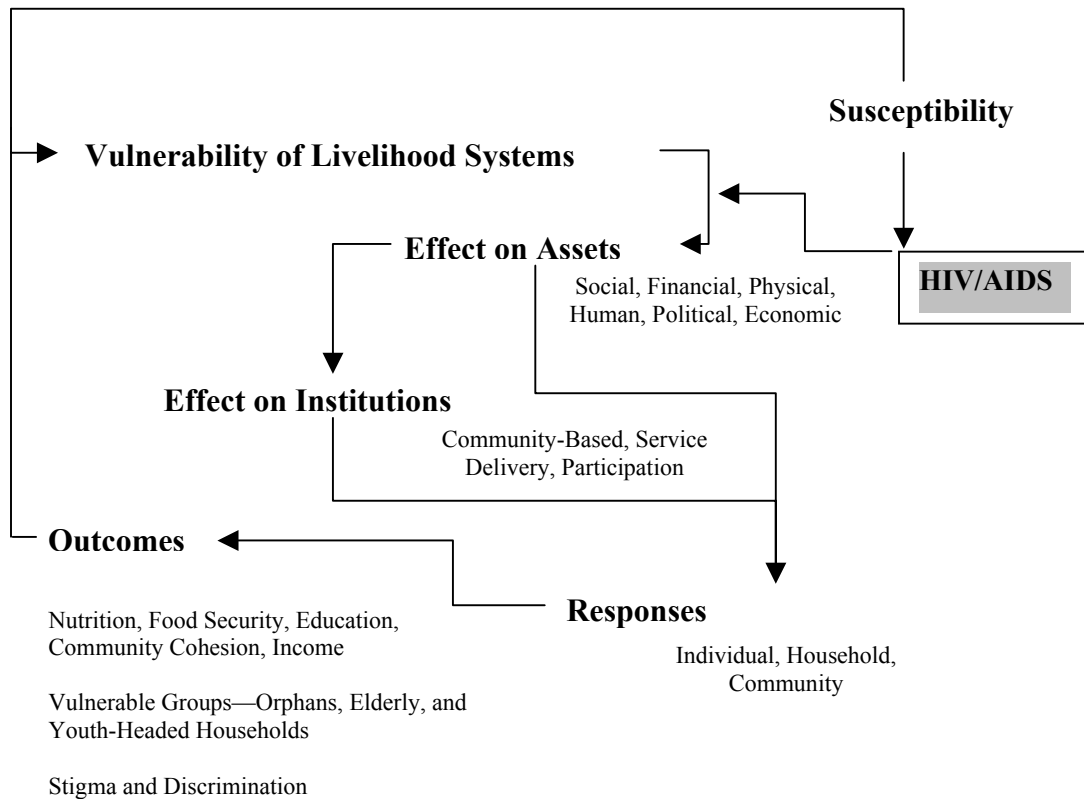
- **Human capital:** It decreases the productivity of household labor due to sickness and AIDS-related malnutrition and ultimately death. Children are forced to leave school early and there is a loss of indigenous knowledge transfer between generations. According to FAO, 7 million extension workers in 25 Sub-Saharan countries have perished. Sixteen million more will die in the next two decades.
- **Financial capital:** Medical costs and funerals are a major financial burden. AIDS-affected households are forced to sell assets to pay AIDS-related costs. Affected households cannot get loans from banks.
- **Natural capital:** Land is sold to pay for medical and funeral expenses. Land inheritance patterns can make widows in certain patrilineal systems more vulnerable. The productivity of land in AIDS-affected households has gone down considerably. Crop diversity has decreased, and cropping changes have favored less labor-intensive, less nutritious crops.
- **Physical capital:** Affected households are forced to sell productive assets and livestock, and the loss of productive animals for traction further reduces agricultural productivity.
- **Social capital:** The loss of labor is straining the capacity for a household to mobilize social capital. The system is overburdened with the demands for caregiving, cash, and labor.
- **Political capital:** Community participation of AIDS-affected family members is constrained due to the burden of illness and the lack of time. AIDS-affected families are often deliberately excluded from political meetings.

Most discussion of the role of food and nutrition security in the context of HIV/AIDS has focused on impact mitigation or vulnerability reduction, but far less on their relationship to susceptibility. An important response will be to develop strategies

that strengthen resistance *and* resilience, if possible simultaneously. And food and nutrition can play such a dual role.

Figure 1 places susceptibility and vulnerability to HIV/AIDS in a livelihood context. HIV/AIDS is likely to have an impact on the assets of households and on institutions, whether community-based or otherwise. The type and severity of these impacts will be conditioned by the vulnerability of the system, community, or household. These impacts will lead to strategic responses made at different levels, which in turn will lead to certain outcomes, e.g., on food security and nutrition. It is important here to realize that these outcomes themselves condition future susceptibility and vulnerability of livelihoods and the households and communities that depend upon them. This shows the interconnectedness and the intergenerational aspect of HIV/AIDS impacts.

**Figure 1—Understanding HIV/AIDS in the context of people’s livelihoods**



### 3. Rethinking Targeting

Targeting is a dynamic and iterative process that involves defining target groups (for example, the food insecure and the nutritionally vulnerable such as pregnant and lactating mothers), identifying individuals within target groups, and ensuring assistance reaches beneficiaries and meets their needs.

Normally, two targeting methods are used: one that defines large groups of intended beneficiaries and one that identifies members within target groups (Jackson and Wickrema 1998). Usually, a combination of these methods is used to identify who is most vulnerable and where in terms of risks to livelihoods, food insecurity, and nutrition. Most commonly, geographic targeting (to identify food-insecure regions) and institutional targeting (health-care centers, MCH clinics, schools) are used to identify physical location of groups. To select members within a defined target group, indicator-based targeting (such as anthropometric screening, population at nutritional risk such as pregnant and lactating mothers), community-based targeting (where the community screens participants), and self-selection are most common.

Many methodologies exist for geographic targeting. For example, the World Food Programme (WFP) uses its Vulnerability Analysis and Mapping system (VAM) and Save the Children UK uses a “food economy” approach to identify regions that are food insecure. In VAM, HIV/AIDS is considered one of the threats to food security. Seroprevalence data (both national and other data sets where available) and other proxies such as premature death rates of young adults, adult morbidity (particularly tuberculosis and sexually transmitted diseases), and household size or dependency ratios, are used in combination with other indicators to identify areas that are most vulnerable to food insecurity (Haan, Farmer, and Wheeler 2001). The Food and Agriculture Organization of the United Nations (FAO) and the Famine Early Warning Systems Network (FEWSNET) are trying similar approaches with their early warning systems. While such an approach is desirable in high prevalence countries, it presents some challenges. The dynamics of the spread, distribution, and impact of HIV/AIDS necessitate constant monitoring and

updating of databases for informing action in a timely fashion. This requires substantial resources, both financial and technical, at the local level.

In many instances, districts identified as food-insecure at any one time may not have high HIV prevalence rates and vice versa. This is the case in Kenya (e.g., in Garissa, a food-insecure district in the North Eastern province, UNAIDS reports only 6 percent of pregnant women testing HIV positive (Haan, Farmer, and Wheeler 2001; UNAIDS 2002). In food-secure Nyanza, however, 40 percent of pregnant women in Siaya District, and 27 percent in Kisumu District tested HIV positive. Nyanza and Siaya were found to be food-insecure, when HIV/AIDS relevant indicators were incorporated into VAM (Haan, Farmer, and Wheeler 2001).

Cross-sectional district-level data may be misleading if taken out of context; they represent a snapshot of the mean at one point in time, and say nothing about intra-district variation or about trends. There is evidence that HIV/AIDS is increasing income inequality and progressively worsening food security. For example, a recent WFP mission to Busia District in the Western Province—with a prevalence of around 30 percent among pregnant women (UNAIDS 2002)—found a large number of households with severely compromised access to food, and an unusually high number of orphans on the street (WFP 2002b). Even though affected households reside in food-secure regions, they are vulnerable to future food insecurity and other developmental impacts of HIV/AIDS. High prevalence rates have been found to severely strain traditional kinship mechanisms of social support, leading to a failure to cope and disintegration of certain households (Rugalema 2000; WFP 2002b). Mission members found some deserted houses of dissolved households, and many orphans and vulnerable children (OVCs) who had not eaten at least one meal the previous day and were out of school. Property grabbing was reported to be highly prevalent.

The effects of the pandemic at an aggregate level are not immediate, and their cumulative effect may not be seen for some time. A food-secure region may have a high prevalence of HIV because it has attracted people (“men, mobility, and money” conventionally viewed as being the first ingredients of an epidemic), but this does not



indicate what might happen in the future. Moreover, there is evidence of strong linkages between the HIV status of richer households and the food security of poorer households. A FEWSNET study in Makueni District, Kenya, has shown that as HIV-related expenditures of richer households increase, there is less money to hire labor from poorer households, who also suffer. In this way, food insecurity and HIV/AIDS may converge over time.

Within high prevalence regions it may be justifiable to target food assistance to vulnerable groups as defined by the communities, regardless of the food security status of the province as a whole. In Mbeere District, Kenya, which has an HIV prevalence rate of 26 percent, but is food secure at the district level, WFP Kenya aims to provide take-home family rations through the School Feeding Project as an incentive for labor-poor households to send children to school and to make it possible for foster families to absorb orphans (WFP 2002b; WFP 1999c). Involvement of the community in defining vulnerable households is critical in preventing stigma.

In community-based targeting, community members decide who participates and benefits from a food assistance project. Communities, however, are heterogeneous groups where discrimination, stigma, and social exclusion towards those afflicted by HIV/AIDS are still a serious problem. Targeting individuals or households affected by HIV/AIDS may exacerbate stigma and discrimination. To ensure that the most vulnerable households and groups are included in food assistance programs, implementing organizations need to establish a dialogue with the community to understand the level of stigma and norms and practices with regard to HIV/AIDS and to gauge the likelihood of HIV-related exclusion from the program.

### **Rethinking Interventions**

The choice of intervention can enable or hinder the participation of HIV/AIDS-affected populations. Food-assisted projects should be relevant to the needs and capacities (including labor, time, and risk-taking) of these populations. This section will

reassess some popular food assistance programs using an HIV lens. We suggest ways in which organizations can design programs that potentially reduce both susceptibility to HIV and vulnerability to its impacts. Box 2 provides a programming checklist to this end, while Table 1 illustrates the potential roles of food assistance in responding to HIV/AIDS.

**Box 2—Checklist for reviewing current food aid programming through an HIV/AIDS lens**

**Susceptibility**

Does the current program

- Increase traffic and transportation requirements?
- Increase physical market spaces (number and size)?
- Increase contact with markets?
- Encourage migration (temporary, seasonal, permanent, number of overnight stays per year, e.g., at markets)?
- Does the program include (especially if yes to the above) a prevention component, such as communications for behavior change and advocacy at the local level to discourage risky behavior?
- Does the program address the socioeconomic status of women?

**Vulnerability**

- ✓ Does the program cover most AIDS-vulnerable households both in food-insecure regions and high HIV prevalence regions, e.g., the chronically sick and their families, women-, child- and elderly-headed households, households fostering children, and OVCs?
- ✓ Does the program proactively take steps to prevent or reduce stigma and discrimination?
- ✓ Do the benefits of the program, e.g., food-for-assets, accrue to the community in general and the most vulnerable in particular? (For example, does a well constructed through a food-for-assets program substantially reduce women's work burden? Location of such assets is important.)
- ✓ Is the program labor- or time-intensive?
- ✓ Does the program facilitate sharing of knowledge, e.g., knowledge in preserving livelihoods, and in nutrition- and health-related practices across generations?

**Both susceptibility and vulnerability**

- ✓ Does the program preserve assets of the most vulnerable populations?
- ✓ Does it expand economic opportunities and allow diversification of risk sustainably?
- ✓ Does the program encourage formation or preservation of social networks/social capital?
- ✓ Is participation gender balanced?
- ✓ Does the program reduce gender discrimination (e.g., double take-home rations to girls)?
- ✓ Does the program provide nutritional support to pregnant and lactating women (potentially preventing mother-to-child transmission (MTCT) of HIVS as well as improving the health and nutritional status of the mother)?
- ✓ Does the program prolong life of HIV-positive parents and thus delay orphanhood?

**Table 1—What difference does HIV/AIDS make to food aid programming?**

Instrument objective	Design features in non-HIV context	Design features in heavy HIV/AIDS context
		<b>Livelihood support</b>
Income generation and microcredit	Mostly targeted to women's groups	Could be targeted to PLWHA associations, OVCs, and other vulnerable groups, such as elderly headed households and households taking in foster children
(To preserve or open up livelihood opportunities, prevent distress sales of assets and/or distress migration—thus strengthening household resistance and resilience)	Difficult in reaching ultra poor	Large proportion of HIV affected are ultra-poor and perhaps risk averse Longer initiation time (therefore longer period for food aid) to motivate Difficulties in loan repayment and further indebtedness Lack of trust regarding repayment in group-based lending in high HIV prevalent regions; greater stigma and social exclusion
	Addition of other services not considered cost-effective	Need to incorporate life-skills training and other HIV/AIDS management-related skills, particularly where IGA leads to more time away from community (e.g., marketing goods) Low input, low but quick return activities may be best suited
Food-for-assets/work	Based on the premise of labor abundance and self targeting	Labor may no longer be abundant and self-targeting will not work for PLWHA or child-headed and elderly-headed labor-short households who are often least able to undertake manual work
	Labor intensive works	Dissemination of labor saving technologies, promotion of labor and tool banks Crop diversification with an emphasis in labor-extensive and nutrient rich crops
	Decision on what to build may not be community's	Goods and services offered should relate to community felt needs Food for assets should ensure that the output benefits the vulnerable in the long-term, e.g., community gardens to feed the OVCs, community grain banks
	The output not necessarily community owned	Should facilitate community organization and community cohesion and strengthen community caring capacity
<b>Human capital development</b>		
Food-for-training	Often limited to training volunteers mostly health and extension workers	Should be continued but expanded to traditional birth attendants (on safe delivery to reduce MTCT), home-based care, and community-based childcare center volunteers; volunteer teachers in informal schools and for teachers to be trained in HIV/AIDS related issues
(To open up new livelihood opportunities and bridge intergenerational gap in knowledge/skills transfer)	Volunteerism seen as useful but not essential	Volunteerism is crucial element of community caring capacity
	Training of youth and women (through women's groups) in vocational skills	Should be expanded. New target groups would include PLWHA associations, youth clubs, OVCs, OVC mentors, elderly- and child-headed households, orphanages and other community-based centers for orphans
	No life-skills training	Life-skills training critical
	Mostly in food-insecure regions	Could be expanded to high prevalent areas (regardless of food security at the regional level)
Food-for-education	On-site school feeding or take-home rations in chronically food-insecure regions	Could be expanded to high HIV-prevalent areas (regardless of food security at the regional level)
	Extra take-home ration given to girls	Extra take-home ration to be given not only girls but also to OVCs. Involvement of the community is crucial to prevent stigma of OVCs.
<b>Vulnerable group support</b>		
Food-for-health	Supplementary feeding of pregnant women for nutrition and as incentive for antenatal care	Supplementary feeding of pregnant women to improve nutrition and reduce MTCT risk. Support transition to replacement feeding after 6 months exclusive breastfeeding (where chosen). Antenatal care critical for counseling on infant feeding. Supplementary feeding of HIV-positive mothers and their infants.
(To reduce MTCT and improve women's health)		Cover opportunity costs of seeking TB treatment (DOTS)

Instrument objective	Design features in non-HIV context	Design features in heavy HIV/AIDS context
		Design features in heavy HIV/AIDS context
Food-for-care  (To ensure care of particularly vulnerable groups)	Little support to orphan care, child or elderly headed households.	Food to support orphanages (on-site) and other forms of community-based orphan care including fostering. Conditional on school attendance  Food as payment for volunteers to manage care centers (who themselves may be HIV infected or affected, and have multiple demands on their time)  Food to households that are elderly- and child-headed
Food-for-life  (To prolong life of PLWHA)	Little support to the chronically ill	Increase and diversify support to PLWHA through home-based care including strong nutritional component.
<b>Emergency response</b>		
Food-for-life  (To reduce risk of HIV transmission and strengthen coping systems)	Often limited to distribution of relief food	Need for structural response to build capacity and livelihoods to strengthen resistance (through preventing survival sex and exploitative power relations) and resilience
	Characterized by food response	Need for nutrition response with special attention to chronically ill, pregnant and lactating women
	No special attention paid to chronically ill	Increased needs for macro and micronutrients. Guidelines to be drafted and strategies to be devised ensure that nutritional needs of PLWHA are met
	No special attention to youth	Crucial to contain the epidemic. Strategies to be devised to assist youth, especially girls in negotiating safe sexual practices and livelihood approaches
	Few partnerships with other organizations and advocacy	Essential for a holistic approach and resource-sharing and mobilization, e.g., links with counselors, traditional birth attendants (TBAs), camp health workers
	Little attention paid to often-dismal living conditions of host populations around refugee camps	Exploitation of refugees by host population and vice-versa is prevalent and fuels the epidemic. Investments in improving livelihoods and HIV-relevant education of <i>all</i> population groups should be given priority, including dissemination of information on human rights of refugees, IDPs, women, and children

The application of an HIV/AIDS lens highlights some of the crosscutting issues that should be considered in all food aid interventions:

- **First, do no harm.** As discussed in targeting section, stigma and discrimination faced by those affected by HIV/AIDS cannot be overstated. “Do no harm” should be the minimum standard on which *all* food aid should be programmed.
- **Revise the food basket.** The epidemic is drastically changing composition and size of households. There is critical need to factor the implications of these changes into the design of a family food basket.
- **Ensure nutritional quality of food rations.** Good nutrition is both the first line of defense and the first line of attack against the epidemic. PLWHA have increased nutritional needs of both macro- and micronutrients (Piwoz and Preble

2000). Requirements for protein increase by 50 percent and those for energy by 15 percent. Others affected by the pandemic are highly vulnerable to malnutrition. It is critical that the food baskets for populations in high prevalence communities provide adequate macro- and micronutrients. Special efforts should be made to fortify staple foods with multivitamins and minerals and to provide locally acceptable fortified and blended micronutrient foods in emergencies, protracted emergencies, and in development food aid (especially in high-prevalence communities). In addition, food assistance, to the extent possible, should be coupled with nutrition education, to make best use of locally available resources.

- **Focus on women.** Women are more susceptible to HIV infection for biological, socioeconomic, and cultural reasons. In Sub-Saharan Africa, 58 percent of infected people are women. They are also severely vulnerable to AIDS impacts. Once HIV/AIDS strikes a household, women and girls bear the double burden of not only producing food and domestic work but also taking care of the sick. Older girls are more likely to be withdrawn from school. In patrilineal societies, women may lose rights to land and property, rendering them more food insecure and more susceptible to HIV. *All* food aid interventions should aim to increase the resistance and resilience of women to HIV/AIDS.
- **Reduce susceptibility.** Whenever a food aid program is likely to increase the susceptibility to HIV, it is critical that such interventions be accompanied with effective prevention activities. In addition, food aid and its distribution points can provide the entry point for prevention activities. For example, food for training could be provided to teachers counseling students on safe sexual behavior; and food distribution sites in refugee camps could be used for disseminating information regarding HIV/AIDS, rights of children, encouragement of utilization of health services, etc.

### **Enabling Vulnerable Groups to Meet Nutritional Needs**

There is a need to expand and intensify food assistance to respond to the needs of groups who are at the risk of malnutrition in the dynamic vulnerability context of HIV/AIDS. Supplementary feeding interventions aim to improve the nutritional status of population groups that have special nutritional requirements. Interventions here include mother and child health (MCH) programs and therapeutic feeding programs (TFP). The ration provided typically consists of blended micronutrient-fortified foods. These programs aim to increase both access to food and its utilization.<sup>4</sup>

Besides improving the nutritional status of pregnant and lactating mothers through take-home food rations, MCH programs aim to increase antenatal care coverage among women, and their health and nutritional knowledge. TFPs target severely malnourished children with the aim of promoting weight gain through the use of food rations combined with medical care and supervision. Nutrition interventions are crucial to support the increasing numbers of affected populations including, but not necessarily limited to, PLWHA and orphans and vulnerable children (OVCs). They may also play an important role in reducing the risk of mother-to-child transmission (MTCT) of HIV.

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

Improved maternal nutrition combined with HIV testing, information, counseling, and antiretroviral drug provision is key in PMTCT. Research shows that maternal malnutrition increases the risk of MTCT (Piwoz and Preble 2000). Supplementary feeding can benefit not only HIV-positive women but also all those who are pregnant and lactating. Nutritional support to all pregnant and lactating women, through the usual MCH-type of activities, should therefore be expanded and intensified.

To reduce the risks of vertical transmission, UN guidelines advise HIV-positive mothers to exclusively breastfeed up to six months after delivery where safe alternatives

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<sup>4</sup> For a detailed discussion on ration size calculations and suggested modifications, see FANTA (2001), pp. 44–55.

are not “acceptable, feasible, affordable, sustainable and safe” (WHO 2001). After this time, the guidelines suggest that mothers switch exclusively to breast milk substitutes.

HIV-positive mothers in food-insecure households will often require support to enable this. Through the usual MCH channels or PMTCT initiatives, food aid organizations could consider providing take-home, micronutrient-fortified food rations to help the transition from exclusive breastfeeding to complete replacement feeding at six months. Such support could be extended until the infant is 30 months old. This is a difficult area in which our knowledge of risks, benefits, and operational feasibility is still evolving. Operational research here could shed some light on the practicalities of implementing current WHO guidelines and on where food assistance may be useful. Food assistance could be integrated with HIV testing of infants, referral services for children testing positive, child immunizations, and vitamin A supplementation programs. Wherever PMTCT interventions are ongoing (most are still under pilot stages in many countries), food aid organizations should explore the possibility of collaborating with other involved organizations, such as UNICEF and national governments, to maximize effective support.

#### *Food Supplementation in Home-Based Care (HBC)*

Nutritional support through home-based care is a major role of food aid, though efforts are still disjointed and inadequate. To date, a majority of HBC programs do not have a food component (WFP 2002a; Baylies 2002). Intensification and expansion of HBC programs offer one of the most direct options for addressing the challenges of the pandemic.

Although food assistance through HBC is mostly viewed from a humanitarian perspective, it has significant potential for reducing susceptibility to HIV and vulnerability to AIDS impacts. Research shows that adequate nutrition has multiple positive effects for PLWHA, including enhancement of the body’s ability to resist opportunistic infections, delaying the progression of HIV to AIDS, increasing the effectiveness of drug treatment, and improving psychosociological status and general

quality of life (FANTA 2001). Adequate nutrition can thus prolong economically active life of PLWHA and contribute to their “positive living,” enabling them to pass on important skills and knowledge to their children, plan for their children’s future, prepare their children psychologically, and delay their orphanhood. It enables PLWHA to remain active in family life and involved in socially productive labor, including childcare. Food indeed may very well be their most important medicine. Food aid organizations are well-placed to provide much needed empirical evidence on the role of nutrition in the socioeconomic and nutritional well-being of PLWHA and their families.

Food assistance support could take the form of dietary support to PLWHA as well as a resource transfer to prevent the sale of assets, to free time for providing care to sick members of the family, and to pursue other income-generating activities or vocational training. HBC should, as far as possible, be a holistic package that includes (1) health (basic drugs and hygiene), nutritional, and psychological support to the sick individual; (2) guidance to caregivers in taking care of the sick, HIV prevention, and nutrition education; and (3) linking household members to other types of programs, such as food for training and education, that could improve their income-generating capacity.

To address possible household food insecurity and child malnutrition within these households, a family food basket should be provided. The ration should also include blended micronutrient-fortified foods such as *lakhuni phala* or Unimix for PLWHA. These foods are easy to prepare, easy to swallow and digest, and are nutrient dense. In addition, in high prevalence areas, there may be a need to review the average household size, taking into account household composition changes due to AIDS.

There are no guidelines for exit strategies. A potential exit criterion could be the death of the PLWHA. Ideally, HBC interventions should link other family members to other programs that strengthen resilience through preserving livelihoods and/or building human capital. But in many cases, there may be no surviving adult members—just the elderly and children who may need continued assistance. Some children may be placed with extended families. There are many potential scenarios and, depending on local



realities, vulnerable members could be reached through other targeting and programming modalities.

HBC is often constrained by problems of inadequate resources, unreliable supply of basic medicines, and inconsistent volunteerism (Umoyo Network 2000). Although the idea of compensating volunteers has been debated for decades, it is worth recognizing that many of the volunteers may be HIV-positive, at risk, or affected by its impacts. With the burgeoning numbers of HIV/AIDS-affected, the spirit of volunteerism and the morale of volunteers are likely to dwindle. NGOs report consistently high dropout rates, often leading to compromised program quality and high recurring costs of training new volunteers. It is time to explore new mechanisms to reinforce volunteerism and self-reliance. An operational research question here would be: Can food be used to cover opportunity costs in high prevalence communities, and promote volunteerism, without undermining community self-reliance? Regular training and networking opportunities will enable volunteers to share their experiences, learn from each other, and support and motivate each other.

#### *Supplementary Feeding for Orphans and Vulnerable Children (OVC)*

One of the most disturbing long-term consequences of the AIDS pandemic is the growing number of orphans. The survival, food security, health, and development of many other children are also increasingly jeopardized due to the effects of AIDS on families and communities.<sup>5</sup> According to the most recent estimates, about 13 million children under age 15 have lost one or both parents to AIDS, with 11 million of them in Sub-Saharan Africa. In 2001, 10 countries in southern Africa had orphan rates higher than 15 percent, with two-thirds of them orphaned due to AIDS in Zimbabwe and at least half orphaned due to AIDS in Lesotho, Malawi, Botswana, Swaziland, and Zambia. Both

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<sup>5</sup> These children are referred to as vulnerable children. A recent WFP report cautions against treating OVCs as a homogenous group, as they face different risks. And boys face different risks from girls. These differences should be taken into account in designing policies and targeting programs (WFP 2002e).

the number and percentage of orphans due to AIDS are estimated to increase rapidly in the next decade (USAID/UNICEF/UNAIDS 2002).

Caring for orphans within the community is a challenge in areas with high prevalence of HIV. Orphans are particularly vulnerable to a range of problems, including early school dropout, malnutrition, and psychosocial deprivation. Community members themselves have constrained resources including food and time for childcare (Dienger et al. 2001). Property grabbing and abuse of orphans is not uncommon (UNICEF/UNAIDS 1999; Gilborn et al. 2002). Strengthening community capacity to care may permit the integration of orphans into mainstream society, reducing the chances of land grabbing and marginalization, and promoting their psychological and intellectual development (Subbarao, Mattimore, and Plangemann 2001).

Food aid has a role to play in enabling communities to care for their OVCs (see Box 3). Such strengthened capacity could reduce the vulnerability of OVCs to food insecurity, malnutrition, and school dropout. It may also reduce susceptibility by preventing adolescents from engaging in transactional or commercial sex to support families.

### **Box 3—Mentoring OVCS in Rwanda: *Nkundabanas***

Because of the social upheaval caused by the genocide and HIV/AIDS in Rwanda, there are an unprecedented number of child-headed households. CARE Rwanda is currently piloting projects where child heads of household (CHH) choose a person they trust within the community. This person acts as mentor or *nkundabana* to the child, which translates literally as “*one who loves children*.” CARE provides a family food basket to these households (covering 70 percent of their food needs) as well as to *nkundabanas*, who are trained in counseling, psychosocial support, and life skills (WFP 2002c). The food basket allows the CHH to participate in productive activities, such as skills training or income-generating activities, while the younger children continue formal education.

*Nkundabanas* hold regular meetings, either with individual CHH families to discuss specific problems and concerns, or with groups of CHHs to discuss issues common to all households for which they are responsible (on average, 4–10 households).

Freedom from Hunger International (FHI) also reaches CHHs in and around Gitarama with its *Nkundabanas* project. In addition to linking CHHs and training them in income-generating skills, FHI brings them together in mutual support groups (Crawley 2001).

Establishment of day-care centers (for all preschool children, not just OVCs) eases the burden of caring, permitting adults to be involved in economically productive activities. On-site feeding at these centers may ease household food security constraints and supplement the diets of preschool children. It also lowers the possibility of food aid leakages to other family members. Wherever feasible, communities should be encouraged to match the contribution for on-site feeding. These day-care centers should aim to be more than crèches, and maintain optimal health and nutritional status of children during this critical growth period. In addition to supplementary feeding, they should, as far as possible, act as conduits for complementary actions that enhance the benefits of supplementary feeding, such as growth monitoring (with referral services for severely malnourished), micronutrient supplementation, deworming, and immunization. Again, food aid organizations will need to form partnerships with government and other organizations in this effort. Food for training can be provided to health and nutrition workers who are responsible for growth promotion, immunizations, or other services, depending on the context. Such interventions are critical in an HIV/AIDS context where health centers may be overburdened and households impoverished and thus unable to afford the time, transport, or user fees to access health services.

Given the enormity of orphan crisis in Sub-Saharan Africa, the role of orphanages cannot be ruled out, especially in urban settings. Institutional care may be the only option for orphans in conflict and post conflict situations, where foster care is unfeasible (Subbarao, Mattimore, and Plangemann 2001). Community-based institutions such as small group homes and children's villages are also emerging in response to the burgeoning orphan population (WFP 2002d). Food aid organizations should carefully assess the pros and cons of food assistance to orphanages and other community-based institutions. Such interventions should, as far as possible, be conditioned on orphans' attendance at school or vocational training (see next section). Training of youth (especially in community-based care settings) in home gardening and raising farm animals to supplement income and diet has a potential to increase access to food and improve diet quality (WFP 2002d).

### **Strengthening Human Capital**

A recent comprehensive report by WFP on improving access to education for OVCs in Sub-Saharan Africa states: “everything—from the demand for education, the supply of education, the availability of resources for education, the clientele, to the actual process of education—is affected” (WFP 2002d). Education has been referred to as “the only vaccine that we currently have” by a delegate at the International AIDS Conference in Barcelona in 2002.

By receiving food rations, children from poor families may avoid being prematurely drafted into the family labor force. Food aid may be used as an incentive to encourage the poor to invest in their children’s future through education and training.

#### *Food for Education (FFE)*

Food for education may have an important role to play in combating HIV/AIDS in some of the following ways:

- In the long run, it has potential to increase household resilience by expanding economic opportunities that come with education.
- Educated children are more likely to internalize information on prevention of HIV, especially if education for behavior change is a part of the curriculum (see Box 4).
- Girls especially may become empowered, and therefore less susceptible to HIV.
- Hunger and malnutrition of school-going children may be reduced, particularly by school feeding, and thus their educability and ultimately academic performance.
- School enrollment, attendance, and completion rates may be increased.
- Gender disparity in educational attainment (exacerbated by HIV/AIDS) may be reduced.

FFE programs aim to reach school-going children in chronically food-insecure regions. Food is provided either as an on-site school feeding or as take-home rations. In

some regions, girls are provided a take-home ration as an incentive for families to send their girls to school—counteracting the common tendency to curtail girls’ education first (WFP 1999). Studies have shown that school feeding reduces hunger-related lethargy, improves academic performance, and provides an incentive for enrollment and attendance (Pillai 2000; Ahmed and Del Ninno 2002; Rogers and Coates 2002).

**Box 4—Comic books for HIV/AIDS education in Ethiopia**

WFP Ethiopia and the Ministry of Education are promoting HIV awareness through the existing program structure in five food-insecure communities. Recognizing that school children are potential channels of information, dissemination, and communication to other household members, WFP aims to mobilize resources to develop age—appropriate educational materials on HIV/AIDS, including comic books, leaflets, and posters in local languages to be distributed to children in formal and nonformal schools. Anti-AIDS clubs are being supported to provide peer group volunteers and community support groups.

In response to the crisis in formal schooling due to HIV/AIDS, communities have started addressing educational needs by starting informal community schools and other informal education modalities, such as interactive radio listening groups in Zambia. The teachers in these schools and groups are community volunteers.

Food has a role to make education more accessible to OVCs by

- continuing to support school feeding in formal schools in chronically food-insecure regions;
- expanding formal school feeding to high prevalence areas regardless of the food security (and vulnerability) situation at the district level to decelerate dropout of OVCs;
- expanding FFE to informal community schools in high-prevalence communities where the most vulnerable children tend to enroll;
- providing food to cover the opportunity costs of volunteer teachers and mentors in the informal education system, including for their training, so even the most vulnerable children could gain access to better education;

- providing food for HIV/AIDS training to all teachers and volunteers (both in formal and informal schools) to ensure that they have the necessary skills and information to communicate, guide, and counsel students; and
- supporting HIV/AIDS education in all schools through appropriate partnerships.

In food-secure, high-prevalence areas, a take-home ration for OVCs is less likely to be stigmatizing than is being singled out for on-site feeding. For example, in Malawi and Mozambique, in addition to on-site feeding of all primary school students (usually with blended micronutrient-fortified foods), WFP aims to provide take-home rations to girls and orphans (WFP 2001a; WFP 2001b). Where stigmatization may be an issue and wherever feasible, the family ration should be distributed to households through its implementing partners.

Food rations could be distributed directly to the vulnerable households (e.g., child-, woman-, and elderly-headed households, households with foster children, and other households that meet context-specific criteria), conditional on children within such households attending formal/informal school or vocational training (see below).

Many orphans and vulnerable children drop out or do not go to schools, owing to the prohibitive costs for many extended families of school fees, textbooks, or uniforms. Food aid organizations should thus work with other partners to provide such nonfood items, which are crucial for increasing enrollments and lowering the dropout rate.

### *Food for Training*

According to a recent USAID/UNICEF/UNAIDS report, children who lost one or more parents were less likely to attend school and more likely to be working more than 40 hours a week. In Kenya, 52 percent of orphaned children were not enrolled, as compared to 2 percent of non-orphaned children (USAID/UNICEF/UNAIDS 2002). Youth should be provided with opportunities for vocational training to offset the loss of intergenerational skills transfer when parents die prematurely. Food rations could provide an incentive to attend the training; they could be provided for the duration of

training and for a few months after, thus enabling beneficiaries to get a foothold in the market (see Box 5).

**Box 5—World Food Programme's strategy for training OVCs in Uganda**

WFP's training programs benefiting OVCs in urban areas of Uganda are designed to encourage at-risk orphans and street children to seek the shelter and care of orphanages and other reputable institutions; adopt sound hygienic practices and good health habits; and attend vocational training and participate in internships (WFP 1999b).

Training will be in construction, carpentry, tailoring, auto repairs, craft manufacture, and small-scale trading, dairy keeping, and agricultural activities. Literacy and numeracy programs will be offered to older children. The training achieved will, in turn, provide opportunities for the children to find employment or initiate their own business. There are a number of microfinance institutions that offer credit without collateral, and most of the children who graduate from the training and who are willing to establish their own business will be linked by the NGOs to such credit facilities.

For greater impact, WFP partners with other agencies and institutions that provide complementary tools, training aids, and other nonfood items. Finally, children will have the opportunity to adopt hygienic practices and other good habits.

WFP currently reaches 6,000 OVCs and aims to expand the program to reach 10,000.

**Source: WFP 1999b.**

Vocational training of youth may lead to urban migration and therefore increased susceptibility. It should therefore be combined with HIV awareness and life-skills training. Linkages to microcredit services or start-up financing schemes should be explored wherever possible, as is the case in Uganda (WFP 1999b).

Food for training could also be used as an incentive (and to cover the opportunity costs) to train peer support volunteers, home-based care, and other volunteers involved in prevention, education, and communication activities. Africare in Rwanda,<sup>6</sup> for example, proposes to use food to train and compensate the efforts of peer counselors at youth clubs. Traditional birth attendants could also be trained in improved delivery techniques that potentially reduce MTCT.

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<sup>6</sup> Personal communication with Africare staff.

### **Enabling the Poor to Preserve and Gain Assets**

As shown in Figure 1, asset stripping is a major destructive response to HIV/AIDS impacts at household and community levels. Food assistance has an important potential in buffering such impacts to the point at which assets may be preserved in the short term and even augmented over a longer period.

#### *Food for Work (FFW) Programs*

Food for work programs use food as an income transfer in exchange for work. They typically address chronic food insecurity by creating assets such as roads to improve access to markets, irrigation facilities, land terracing, or forestry. They seek to reduce income variability by providing slack-season employment. These programs tend to be well targeted via self-selection linked to food payment and the high labor intensity of the task (Box 6).

#### **Box 6—Innovations in FFW: Labor banks**

The neglect of farmland due to labor depletion may be one of the first household responses to HIV/AIDS. To counteract this, some agencies have started exploring the formation of labor banks, where willing laborers are engaged in working on individual plots of land owned by those who cannot tend them. World Vision in Rwanda is exploring the possibility of providing food aid to such laborers.

In Malawi, the COPE project by SAVE the Children US encourages the establishment and maintenance of cereal banks and community gardens so that communities can better withstand other shocks. Produce from the community gardens may be used to supplement the diets of OVCs.

In Zambia, to ease time constraints of women participating in their FFW project, CARE's PUSH/PROSPECT project has supported women to establish a crèche close to the FFW site. Through a lottery system, women take turns caring for children.

The effectiveness of FFW in improving livelihood security has been mixed. FFW programs aimed at guaranteeing employment to unskilled laborers in South Asia have, to a large extent, reduced income variability of laborers (Pillai 2000). In Africa, some studies show that FFW programs when expanded during short-term food shortages prevent distress migration. They have also been seen to reduce asset and savings depletion and enable the poorest to increase their asset base by freeing them from their



usual overriding preoccupation with meeting daily food needs (Pillai 2000; Webb 1995, 2001).

But many problems plague FFW programs. There is considerable controversy regarding the sustainability of assets created through these programs and the programs' ability to have an impact on longer-term food security and poverty reduction goals. Though FFW programs often go through the motions of community decisionmaking, the infrastructure built is often not a priority of the community, nor are the structures created necessarily beneficial to the communities. FFW projects aimed at increasing yield (land terracing, reclaiming swamps, etc.) often lack nonfood and nonlabor resources such as fertilizer and high quality seeds, limiting their impact. Weak administrative and technical capacity of the implementing partners may also be a constraint (Pillai 2000; Barrett, Holden, and Clay 2001). In addition to the problem of dependence on food aid for maintenance of the infrastructure created, lack of ownership and quality issues also constrain these programs. The long-term success of these projects depends on the rights of the beneficiaries to use the assets they have created and are expected to maintain. Clear tenure and use rights are rarely established beforehand, and it is not uncommon for assets to be appropriated by local elites.

What is the relevance of FFW programs in a high prevalence, chronically food-insecure area? Self-targeting for labor-intensive programs may leave out a large portion of the needy population, who are too weak or busy with intrahousehold caretaking to participate. Households headed by children and the elderly will also be excluded. The premises of labor abundance and self-targeting, on which FFW is based, are unlikely to apply in high HIV-prevalent areas (Barrett, Holden, and Clay 2001). There may well be skilled-labor shortages as a result of HIV/AIDS, and this will need to be addressed in the design and implementation of projects. It is critical, therefore, that small-scale infrastructure projects be based on a survey of local labor market conditions so as to ensure that requisite stocks of labor are available (and will not simply pull from existing productive use).

There is also a need for creative thinking about how labor-scarce households can be assisted at times of the agricultural year when labor is especially important, for plowing, for instance. For example, an FFW program could pay labor-surplus households to work the fields of labor-constrained households.

On the other hand, by ensuring food wages to other people in the community, FFW projects may indirectly enable communities to deal with the crisis. FFW projects aimed at reducing distress migration have a high potential to reduce susceptibility to HIV. Yet, it is important to understand how certain projects may also increase susceptibility to HIV. For example, Von Braun, Teklu, and Webb (1999) report multiplier effects of an FFW-built road in the Ethiopian lowlands, where resulting improved market access led to the establishment of water mills and fruit plantations and the revival of traditional spinning and weaving in the three years after the road was built.

Such projects that can “crowd in” private investment may also potentially increase risky behaviors, especially if they cause greater labor mobility, resulting in the formation of new sexual networks and an expansion of sex work (Cohen 2002). This is not to say that well conceived and managed FFW projects have no scope in improving the livelihoods of the affected populations, but it is vital to anticipate such potentially risk-increasing effects and address them in project design and implementation. Partnerships should be explored for linking to local community-based organizations and NGOs that can help to deliver complementary services, such as Voluntary Counseling and Testing (VCT), peer education programs, access to condoms, access to sexually transmitted infection (STI) treatment, and basic drugs.

### *Income-Generating Activities (IGA) and Microcredit*

Food rations may permit poor households to dedicate time and energy to developing and expanding income-generating activities. Target groups have conventionally been women’s groups with training in crafts such as basket weaving, knitting, etc. Food assistance is provided to cover the opportunity costs of learning new skills, as an income transfer (in that the women may use money they would have

otherwise spent on food) as startup capital. IGAs are most successful when there is good coordination between identification of activities, support structures, services, e.g., microcredit schemes, and market outlets.

Microfinance can be an important element in initiating and sustaining income-generating activity, though microcredit programs are often limited in reaching the ultra-poor, a group with high risk in loan default. Even when ultra-poor women were targeted, such as in the income generation for the Vulnerable Group Development Programme (IVGD) by the Bangladesh Rural Advancement Committee (BRAC) and WFP in Bangladesh, only about 29 percent of women were in a position to participate in the mainstream programs after phasing out of the program (RESAL 2001). In a recent report, Webb, Coates, and Houser (2002) report that many women feel that IGA investments are either too risky or too time consuming, thus limiting their participation. Risk-averse households—those that experience chronic sickness, have fewer assets, or have women over 50—tend to be excluded from these programs (RESAL 2001).

Microcredit is most useful to households before they are deeply affected by AIDS. Parker, Singh, and Hattel (2000) note that, as long as households undertake income-generating activities and are able to market their outputs, they can still make use of loans and save money. The inherent limitation of conventional microcredit is that it cannot serve the most needy, as the terms of loans tend to be inflexible. Indeed, Webb, Coates, and Houser (2002) report that sickness of the participating individual or that of other household members was cited as one of the primary reason for loan default in the IVGD program in Bangladesh. A survey carried out by CARE in Zambia showed that among the participants of PULSE microfinance project in peri-urban areas of Lusaka, death and illness of the family members were found to be major causes of loan default. As a result of high death rates among its clients, World Relief Rwanda decided not to target loans to PLWHA (Parker 2000). In places where women depend on men for marketing the outputs, HIV/AIDS poses particular problems, with men often being the first fatality of AIDS within households.

If microcredit activities are not sensitive to the dynamics of the HIV/AIDS shock at the household level, they may drive recipients into greater destitution (Baylies 2002). But there are some examples of innovations within microcredit (e.g., Opportunity International, serving 30,000 clients throughout Africa [Parker 2000]) that include provision of death insurance, health insurance for clients and families (including coverage for AIDS treatment), flexible savings plans, greater flexibility on loan sizes and payment schedules, the writing off of loan failures, emergency loans, and HIV/AIDS awareness training.

If successful, affected households can increase their resilience by diversifying their income (Box 7). Attention should nonetheless again be paid to the possible increase in susceptibility to HIV. Frequent contacts with markets to sell outputs could lead to increased adoption of risky behaviors. Vocational training of youth could lead to urban migration and increased susceptibility. Education for behavior change and life-skills training should thus be an integral part of all such programs.

**Box 7—Diversifying income in Zimbabwe: Labor-saving drip irrigation**

As rural families struggle to maintain their lives in the face of HIV/AIDS in Zimbabwe (where one-third of adults are HIV-positive), ongoing drought and economic crises also undermine families' ability to grow food for their own consumption or sale. A small USAID-funded pilot project—poised to expand rapidly across Zimbabwe—links AIDS-affected families to simple irrigation drip-kits for household gardens, giving them a chance to improve nutritional intake and increase their income by growing vegetables for consumption and sale. Working through 10 NGOs, International Development Enterprises (IDE) produces and distributes drip-kits that irrigate a household garden of up to 100 square meters, cutting irrigation labor requirements by one-half. This labor-saving kit allows orphans, grandparents, and those caring for the sick to continue to farm during and after the AIDS crisis. One irrigation kit with a stand, fencing for the garden, training, information, and follow-up support cost \$85. Six hundred kits have been installed thus far; 20,000 could rapidly be placed with AIDS-affected households through the existing NGO network. Other NGOs are petitioning to participate (Polak, no date; Parker, personal communication).

An understanding of how women and children women allocate their time and whether they can make time for additional activities should drive the IGA intervention. The activity chosen should be based on market analysis of activity outputs. Savings mobilization schemes with flexible savings withdrawals and links to innovative microcredit schemes for sustainability of IGAs in an HIV/AIDS context are crucial.

Often, the type of skills training offered to women and youth is limited by the implementing partners' capacities and expertise. Food aid organizations should seek to partner with organizations that have strong comparative advantage in microcredit activities. Capacity development of such organizations in food aid management and life-skills training should be a priority (this is much more feasible than training food aid managers in microcredit strategies that require market analysis, experience with credit schemes, and ability to reach markets.)

HIV/AIDS-related targeting mechanisms, such as PLWHA associations, youth clubs, and child- and elderly-headed households, should be used in addition to other traditional targeting groups and modalities.

The duration of programs that aim to reach the HIV/AIDS-affected may have to change. Rahman (2000) notes that longer time is required to motivate risk-averse hard-core poor to participate in microcredit activities and to ensure that they benefit from the services. Budgets should reflect this with increased administrative costs in the initiation phase of the project. This may also mean that food aid may have to be provided for a longer time. One approach could be an adaptation of the following phasing as suggested by Webb, Coates, and Houser (2002):

### *Phase 1*

- Initiate community mobilization and community participation in identifying the target groups, including PLWHA associations, child-, women-, and elderly-headed households and youth.
- Seek opportunities to raise awareness of HIV/AIDS. Issues of stigma and discrimination against participants will be an issue related to targeting. Instead of singling out specific groups, the services provided should be packaged in such a manner to attract other clients of interest (Parker 2000).
- Provide food aid as an income transfer. Microcredit services should provide flexible saving services.

***Phase 2***

- Food aid could be provided to train participants in new skills. Activities that require low mobility, low capital, and low labor should be explored.
- Quality and appropriateness of the training is key, and arguably the weakest link in IGA activities. The skills to be developed need to be based on the needs and capacities of the target population, and on market demand.
- HIV/AIDS education and life-skills training should be intensified.
- Encouragement of at least one more family member to be trained so that they could take over the activity if and when the current participant is no longer able to continue.

***Phase 3***

- Provision of loans along with other innovative financial and nonfinancial products.

**HIV/AIDS and Emergency Response**

In Sub-Saharan Africa, and in southern Africa in particular, HIV/AIDS is an increasingly prominent contributor to the development and persistence of humanitarian crises, along with other factors, such as conflict and natural, policy and/or market failures.

Famines occur where people's entitlements collapse (Sen 1981; Drèze and Sen 1989). An entitlement failure can result from either a fall in personal endowments, such as loss of labor and land, and/or because of unfavorable shifts in exchange entitlement, such as decline in employment opportunities, increase in food prices, and worsening terms of trade of the goods and services that people depend upon. It is increasingly recognized that HIV/AIDS may be a major factor in undermining entitlements, and thus contributing to or exacerbating the slide into famine (Haddad and Gillespie 2001; UNAIDS 2002).

A report of a late 2002 six-nation trip by UN Envoy and WFP Executive Director James Morris stated: “HIV/AIDS is a fundamental, underlying cause of vulnerability in the region [southern Africa] and represents the single largest threat to it people and societies” (United Nations 2002). Another more recent report of a January 2003 mission to southern Africa states: “The mission reasserted that HIV/AIDS is the most fundamental underlying cause of the southern African food crisis....The link between food security and HIV/AIDS must be fully recognized in all government, United Nations, international and NGO efforts to address food emergencies and in their support of HIV/AIDS-affected populations” (United Nations 2003, 6).

But how does HIV/AIDS interact with food crises? The term “new variant famine,” which has gained significant currency in recent months, is used to differentiate what, for example, is thought to be happening in southern Africa from famines in a pre-AIDS era. Though empirical evidence is still lacking, HIV/AIDS is likely to radically exacerbate food crises in the following ways. First, unlike “normal” famines, AIDS may drastically raise dependency ratios by killing proportionately more young adults, and thus significantly limiting famine management strategies that are ultimately predicated on labor power. In pre-AIDS famines, the dependency ratio did not change much, as children and the elderly would tend to die first. Households and societies were in this way far better adapted to cope and survive than in situations impacted by HIV/AIDS. The massive increase in numbers of dependent orphans, too, has not been a common characteristic of pre-AIDS famines. Second, women are more likely to be infected, being more susceptible and more vulnerable to HIV/AIDS than men, and it is women who have generally been more knowledgeable and adept at gathering famine foods and at nurturing social networks that may be required in famine situations. The death of an adult woman in a household may thus particularly affect household coping capacity. Third, AIDS may place a double burden of care on rural areas as more and more HIV-positive people are leaving urban areas and returning to their villages to die. Fourth, AIDS-driven reductions in life expectancy will have a major impact on the accumulation of both assets and skills and their transmission to the next generation. Fifth, the common “belt-tightening”

famine-mitigation strategy of reducing food consumption may have very serious consequences for HIV-positive individuals, who actually have higher nutrient requirements, likely hastening the onset of AIDS and death. And finally, the last resort for many women or adolescent girls has been to sell their bodies for food. What has been termed transactional or survival sex, may just as easily be called death sex—given the dramatically heightened risk of HIV infection for these women. This is the apex of the horror of the AIDS crisis, and the most profound illustration of the how AIDS and gender inequity fuel each other (De Waal and Whiteside 2003; UNAIDS 2002).

We have emphasized that relief and development lie on a continuum. This is nothing new, though it is a statement that is far more often stated than acted upon. Lip service alone will be lethal now. In the sections above we have shown how food aid can play an important role in preventing livelihood collapse due to HIV/AIDS. These are among the most important famine prevention measures in themselves. We should not lose sight of this when considering the response to current or future crises.

Let us now turn to how to deal with crises once they are underway. Emergencies are catalysts for changing sexual risks for men and women, and have been seen to raise HIV prevalence sharply, fueling the epidemic (Save the Children UK 2002; UNAIDS/WHO 2002). Against a backdrop of collapsing livelihoods, the breakdown of sociocultural value systems, widespread unemployment, destitution, insecurity, unsanitary conditions, and limited health care, refugee camps in particular are unusually fertile terrain for HIV spread. Young women are at greatest risk from transactional sex. HIV epidemics in refugee camps can also spread quickly into surrounding host populations.

The international community started to make the connections between HIV/AIDS and emergencies in the mid-late 1990s when guidelines were developed to respond to the epidemic during crises situations (UNAIDS 1996; UNHCR 1999; UNAIDS 2000; UNGA 2001). The SPHERE handbook is currently being revised to incorporate HIV/AIDS concerns in all aspects of emergency response. Implementation of these guidelines to date, however, has been piecemeal. In her analysis of current policies for responding to



the challenges of HIV/AIDS in emergencies, Smith (2002) concludes, “policies are mainly concerned with HIV prevention, with comparatively little attention paid to the needs of the people living with HIV or related to legal and human rights.”

How should agencies respond? Conventional emergency responses are typically characterized by (and often limited to) provision of basic needs such as food and shelter. Yet, given the essential qualitative difference between pre-AIDS and AIDS-affected famines, there is a need for responses to be far more structural than in the past. Relief needs to be more proactively linked to capacity strengthening and approaches to strengthening livelihoods (De Waal 2002).

Though notable improvements have been made in planning and delivering food assistance and in improving its quantity and quality in the 1990s, empirical evidence regarding its nutritional effectiveness is still weak. Some of the most important reasons include a shortage of rations, resulting in lower quantities distributed (with serious consequences for mortality rates); inadequate micronutrient density of general rations, linked to onset of micronutrient deficiency disorders; low acceptability of rations; and the fact that nutritional outcomes cannot solely be associated with quantity and quality of diet, given the critical roles of health and care factors (Shoham, O'Reilly, and Wallace 2000; Mason and Taylor 2002).

While these problems are not new, and food aid organizations have been struggling to come to grips with them, they assume a critical dimension in the context of AIDS. During pre-AIDS food (and food aid) shortages, adults waited out the crisis. But such strategies, as mentioned, may hasten the onset of AIDS and the premature death of PLWHA, who actually have increased requirements for both macro- and micronutrients (Piwoz and Preble 2000). Requirements for protein are increased by 50 percent and those for energy by 15 percent. Inadequate ration quantity and/or quality and unreliable delivery could further exacerbate the situation. While some people may be able to engage in camp microeconomies to acquire additional food, this may not be the case with PLWHA with advanced disease progression. While no data exist regarding the rate of progression of HIV to AIDS in an emergency scenario, it is likely to be high due to other

aggravating factors such as lack of health care, sexually transmitted disease (STD) treatment, and tuberculosis.

In a situation of high HIV prevalence, the size of the general ration may thus have to increase to account for the needs of PLWHA. The International Committee of the Red Cross (ICRC), for example, adopts an approach of providing 2,400 kcal/day to entirely food dependent populations, an energy level surplus to requirements, so that some of it could be sold for commodities that may diversify their diets (Shoham, O'Reilly, and Wallace 2000). Such options could be explored and expanded to enable general ration planning to take into account specific needs of PLWHA in terms of quality, quantity, and acceptability.

Quality, too, is crucial. While there are detailed guidelines for improving the delivery and targeting of generalized rations, there are few for improving micronutrient intakes of the refugee populations (Hansch 1999). Fortified foods such as corn soy blend (CSB) have been critical sources of micronutrients. But little progress has been made in exploiting opportunities for local food production and increasing market access. Data regarding success of such interventions, where they exist, are at best sketchy (Mason and Taylor 2002). Though we know, for example, that HIV-positive mothers who are deficient in vitamin A are more likely to transmit HIV to their infants than those who are not, vitamin A supplementation during pregnancy has not been linked with reduced MTCT (Dreyfuss and Fawzi 2002). In situations where there are virtually no facilities for testing or drugs, it is vital that all women maintain adequate micronutrient status.

It is imperative that the issues of quantity, quality, and reliability of rations are given top priority to effectively address the issues of HIV-related nutrition security in emergencies. Standards need to be reviewed from the perspective of state-of-the-art knowledge regarding the needs of PLWHA. Ultimately, a shift from “food delivery” to “nutrition adequacy” is required.

In protracted emergencies there is an assumption that self-sufficiency comes with time, with the size of the ration thus being decreased or limited over time. Targeting may often be tightened, based on inadequate information about who has become self-reliant

and to what degree (Shoham, O'Reilly, and Wallace 2000). The usual strategy is to switch from a general relief operation to FFW programs to discourage dependence. FFW programs, however, may have limitations in reaching PLWHA and others affected by the epidemic (as discussed earlier). Strategies for assistance during protracted emergencies therefore need to take account of the dynamics of the epidemic to make sure that those in greatest need are reached with appropriate modes of support.

In recent years there have been many attempts to support livelihoods in the context of emergencies. Peppiatt, Mitchell, and Holzmann (2001) examined a number of experiences of cash transfer programs to support livelihoods in nine countries. Their findings are positive and raise some questions that can only be addressed through carefully planned and monitored interventions. In Kenya, Aklilu and Wakesa (2001) found interventions of livestock (such as restocking, supplementary feeding for animals, etc.) to be promising. Such interventions may be crucial not only in expanding economic opportunities and improving access to food, but also possibly addressing the skewed power relationships that fuel the epidemic.

In addition to improving the quality and quantity of general rations distributed during emergencies, food aid organizations could play an important role in supporting HBC interventions to meet the special needs of PLWHA. For example, the AIDSCAP program in Rwanda recruited volunteers from the refugee community for their HBC intervention. The volunteers visited sick refugees, bringing water, firewood, and food. Various NGOs collaborated to provide complementary resources such as utensils. In one case, assistance was provided to a group of refugee women to help them start a kitchen (Pfeiffer 1999). Food for training could be provided for training HBC volunteers in counseling PLWHA, and in nutrition education and psychosocial support, and for training traditional birth attendants (TBAs) in STI management, safe delivery, and infant feeding practices to minimize the risk of MTCT. AMREF has established an effective syphilis screening programs in northern Tanzania, where refugee populations from Rwanda, Burundi, and Zaire were living. Local TBAs were trained in referring clients

for screening, providing education and counseling and training nurse staff in performing on-the-spot rapid syphilis tests (Pfeiffer 1999).

HIV prevention in emergency situations is also important and feasible. UN peacekeeping forces and truck drivers that transport food, for example, are at high risk of both transmitting and contracting the disease and represent a target group for education and prevention. WFP's HIV/AIDS training project for truck drivers, porters, and stevedores in Ethiopia provides an example of how organizations can seize opportunities to address the issues of HIV/AIDS in new ways (see Box 8).

**Box 8—Awareness-raising in the workplace**

WFP truck drivers are frequently on the road away from home and more likely to have multiple sexual partners. This puts them at high risk of contracting and transmitting HIV and other sexually transmitted diseases. In Ethiopia, WFP began a pilot project for its 2,300 drivers to increase their awareness about AIDS. In conjunction with private transport companies, an Ethiopian NGO provides the drivers with information and training about HIV/AIDS and how to prevent infection. Similar initiatives for other high-risk groups have been undertaken by WFP in other countries, such as in China.

**Source: WFP 2002e.**

Food aid organizations have the unique advantage of attracting large groups of people to their food distribution sites. Other organizations can be encouraged to use these sites to disseminate information regarding HIV/AIDS and human rights. There is a need for organizations to come together to create an enabling environment for children and youth to discuss issues of sexuality and HIV/AIDS. For example, WFP in Ethiopia aims to support “anti-AIDS youth clubs.” Provision of confidential counseling should also be a part of such settings. Again, peer group educators could be trained in the necessary skills using food aid. Apart from integrating HIV/AIDS in its general health education programs, the ICRC initiated the formation of voluntary after-school “health clubs” and Young Women Social Clubs that were involved in promoting reproductive and general health practices for Liberian and Sierra-Leonean refugees living in Guinea in 1994 (Pfeiffer 1999). Communications for behavior change has yielded positive results when it is based on a needs assessment of the population and the engagement of the target

population in program planning, implementation, and monitoring. Such interventions could be expanded to host communities that face an increased HIV risk due to the arrival of refugees, armed forces, increased truck traffic, and commercial sex work.

In sum, a major readjustment of thinking and action—fueled by a careful analysis of the costs of not addressing the epidemic—is required for all institutions involved in emergency response in high HIV prevalence areas.

#### **4. Ensuring the HIV-Relevance of Food Aid Strategy**

We have viewed interventions through an HIV/AIDS lens and considered options for increasing their relevance and effectiveness in the context of AIDS. In this section we consider some important crosscutting strategic issues. In order to ensure that development assistance of all types remains relevant and appropriate in the context of high HIV prevalence rates, organizations must review their mission, vision, objectives, timelines, and capacities, taking into account these new realities. This may entail restating organizational goals and, within the broad scope of the organization's mandate, embarking on new initiatives. In this section we apply an HIV/AIDS lens to some of these crosscutting issues, then suggest some possible responses.

##### **Capacity Development**

Rethinking the role of food aid in order to better respond to the changing needs of AIDS-affected populations is impossible unless modifications are made *within* organizations. Organizations need to facilitate a process of internalizing an understanding of the implications of AIDS for their work, and of harnessing and developing this understanding to respond at the broadest level. This is the essence of mainstreaming.

Recognizing that employees of organizations may themselves be HIV positive, may be at risk of HIV infection, or may be affected by the illness or death of others is a crucial first step. Employees may, moreover, be subject to discrimination within and

outside the workplace or be perpetrators of such discrimination. These personal impacts can severely compromise organizational ability to perform effectively and efficiently (see Box 2).

Employees need to be oriented to ask the question: “How does HIV/AIDS affect my work, both what I do and how I do it?” This demands an understanding of what AIDS is doing to their work, broadly defined, and ultimately the potential advantages and disadvantages of different programming approaches for combating its effects in different situations. To foster such understanding, staff need to employ an HIV lens for reviewing their core business and the way they undertake it. Staff need to be encouraged to think creatively and proactively about these relationships and how they could change their ways of working (see Box 9). Ongoing training and information exchange within the organization is crucial to sustain such efforts. Networking with partners and other organizations within the region to exchange ideas and best practices will increase motivation and can go a long way toward improving practice.

### **Advocacy**

Overriding strategy design and, linked directly with it, advocacy is crucial. Food aid organizations can and should play a major advocacy role for the following reasons:

1. They are on the frontlines, with firsthand experience of what’s happening.
2. They have the capacity to monitor, evaluate, and communicate widely, with regard to both the problem and possible solutions/interventions.
3. Food is an increasingly high priority for affected populations.
4. Food represents a major potential entry point for helping preserve and sustain livelihoods.
5. Economically, advocacy is necessary to raise resources and strengthen capacity to act on a scale commensurate with the epidemic.

6. Socially, advocacy is necessary to de-stigmatize the problem of HIV/AIDS, emphasizing its nature as a development problem affecting all aspects of a country's economy and society.

**Box 9—Checklist for organizational mainstreaming of HIV/AIDS**

- ✓ Has the organization reviewed its goals and objectives to take account of the reality of HIV/AIDS?
- ✓ Have employees been trained/oriented on the following:
  1. the implications of HIV/AIDS for themselves in the workplace (do staff understand basics of HIV transmission, risk situations, risk behaviors, progression from HIV to AIDS, living positively, etc.);
  2. the systemic nature of the HIV/AIDS pandemic, based on an understanding not only of the virus in its biomedical aspects, but of the socioeconomic and cultural context that fosters the spread of HIV (susceptibility) and aggravates its impact (vulnerability);
  3. use of an HIV/AIDS lens to help understand (in the context of [2] above), the role that food aid could play in either reducing susceptibility and vulnerability?
- ✓ Is there a staff health policy? Does it promote HIV education, prevention, management of ill health, and confidential HIV testing in line with national legal framework and good practice guides (including SADC Code on HIV/AIDS and Employment (SADC 1997) and the ILO Code (ILO 2001))?
- ✓ With regard to the performance management system, are candidates made aware of organizational commitment to HIV/AIDS issues, and assessed on their understanding of the issues? Do job objectives and reporting reflect HIV/AIDS-related aspects of the job?
- ✓ With regard to budgets and financial planning, are cost implications projected over 5–10 years? Do budgets address HIV/AIDS in terms of
  1. internal workplace: staff illness, health and life insurance, temporary cover for absent employees, additional recruitment processes, etc.?
  2. programs in all sectors?
  3. program budgets for focused HIV/AIDS interventions?
- ✓ With regard to human resources workforce planning, are human resource implications projected over 5 to 10 years, and are the following anticipated/planned for employee absenteeism, illness and death, demand on employee benefits, staff turnover, recruitment time, and costs?
- ✓ Does the organization have the capacity to monitor and evaluate the impact of its current programming on susceptibility and vulnerability? Has the monitoring and evaluation system taken into account the linkages and interactions between HIV/AIDS and original goals?
- ✓ Are there opportunities for networking and partnerships with other organizations to share experiences and best practices, and improve impact of operations? How successful has the organization been in leveraging nonfood resources when required?
- ✓ Is the organization active in advocacy and information dissemination regarding HIV/AIDS interactions and potential responses?
- ✓ Does it invest in developing the capacities of its partners either in food aid management or other nonfood-related technical capacities (e.g., counseling, monitoring, and evaluation etc.) when required?

Food aid organizations need to communicate the dynamic food-HIV/AIDS interactions and linkages to different fora, e.g., aid fora, emergency committees, as well as day-to-day policy dialogue with government counterparts. Such advocacy should be fueled by evaluations of successful initiatives as well as lessons learned from less successful endeavors.

### **Forging Partnerships**

In addition to advocacy and resource mobilization, the development of mutually supporting partnerships will be particularly important in the fight against AIDS (WFP 1999a; WFP 2003). Ultimately the most important partnership is with the community itself, particularly people living with HIV/AIDS.

Food assistance projects should also seek, wherever feasible, to link food assistance with enhancement of livelihoods of those most vulnerable (schooling, vocational training, income-generating activities, building assets, etc.) and, as far as possible, life-skills training that focuses on the targeted beneficiaries' motivation for change, their ability to try out and sustain new behaviors (this includes basic awareness and knowledge about HIV/AIDS as well as understanding of risk situations, self-esteem, assertiveness, negotiation skills, etc.). In Uganda, WFP aims to expand a project for orphans and street children that combines food assistance with vocational training and development of life skills and includes partners such as the Ministry of Gender and World Vision (WFP 1999b).

To enable such synergies, partnering with other organizations for nonfood components will be critical. While this is not unique in the context of AIDS, the issue of complementary resources becomes crucial and urgent as community capacity to contribute resources is highly weakened in high prevalence regions. In Malawi, for example, community members are no longer able to contribute food for on-site feeding of preschool children in childcare centers of the Community-Based Options for Protection and Empowerment (COPE) project by Save the Children US (WFP 2002a).



Fostering such partnerships both with people affected by HIV/AIDS and with professionals within other sectors should be built into strategy, not something undertaken on an ad hoc basis. In reformulating strategy, organizations need to go beyond their usual focus on those partners that have food management capacity to seek and identify partners with the capacity to bring to the project either the livelihood component, the life-skills development component, or both. Where capacities are weak, investments in developing the capacity of partner organizations, including, for example, providing links to technical support, should also be a part of the core strategy.

Mirroring the shift toward more comprehensive approaches with partners (involving nonfood items), there is also a need for a greater focus on achieving *outcomes*, not just food delivery outputs. This has implications for monitoring and evaluation systems, and for project timelines, which may need to be extended.

### **Monitoring and Evaluation**

Three forms of monitoring are required: geographic, and at the levels of project performance and capacity development.

A project monitoring system that is relatively simple but able to track the changing HIV/AIDS situation and its impacts on food and nutrition security, with the required accuracy and reliability to guide timely ameliorative action, is essential. The key data required to improve program decisionmaking in real time need to be generated by such a system and communicated to those who can use them. It will usually not be necessary to reinvent food and nutrition security indicators; rather, the HIV lens should be applied to existing ones. A balance has to be found between indicators that can be compared across communities and administrative units, and a community-driven process that can generate context-specific indicators.

Given the fact that this type of programming is relatively new, there is an urgent need to demonstrate what works. Evaluations of programs and projects will be key to

highlighting success and thus providing the fuel for advocacy to generate the resources to scale-up successful approaches.

Finally, there's a need to track the implementation and performance of such organizational capacity development initiatives as those highlighted in Box 9. Performance in this case relates to the enhancement of critical capacities (e.g., the ability to apply the HIV lens to different situations) at the levels being addressed by the initiatives.

### **Operational Research**

Operations research—which is critical for maximizing the effectiveness of interventions—should be directly linked to the monitoring and evaluation system in a dynamic manner. The monitoring system can highlight critical constraints or bottlenecks in the implementation of an intervention, which in turn should be addressed through operations research. Project budgets should include a non-earmarked portion that may be mobilized to support such essential work. In addition, there are certain general priorities that need further research, e.g., the continual development, refinement and application of the HIV/AIDS lens, the appropriateness of different indicators for targeting or monitoring, the nutritional composition of rations, and home-based care modalities.

Other key operational research questions include:

- What is the role of food aid in delaying the progression of HIV to AIDS? What composition of the food basket would best suit the nutritional needs of those living with HIV/AIDS?
- What is the exit strategy for HBC interventions and interventions to assist child- and elderly-headed households?
- What are the best practices in targeting without stigmatizing?
- What is the effect of HIV/AIDS on current southern African food crisis and vice versa?
- What are the best practices in tackling HIV/AIDS in emergencies?

- Does food aid have a role to play in fostering and sustaining volunteerism in high prevalence communities?
- What is the role of food aid in improving the survival of infants born to HIV positive mothers? Can food aid assist HIV positive mothers (1) who choose exclusive formula feeding or (2) in the transition from exclusive breastfeeding to replacement formula feeding after six months?

## 5. Conclusion

HIV/AIDS demands a multipronged response, grounded in an understanding of the susceptibility and vulnerability of people's livelihoods. Given the strong linkages between food insecurity, malnutrition, and HIV/AIDS, this paper has highlighted particular opportunities that food assistance may present—not only for care and mitigation, but also for prevention in a broad sense. Food assistance is relevant for vulnerable group nutritional well-being, for strengthening human capital, as well as preserving assets and livelihoods. Table 1 above summarizes the essential differences between food assistance in a non-AIDS context versus a heavily impacted situation.

Food aid can enable marginalized populations to take advantage of development opportunities. Those affected by HIV/AIDS are arguably among the most marginalized, 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 marginalization. In addition, it will be important to seek opportunities for linking such interventions to HIV-specific interventions wherever possible, thus potentially further reducing susceptibility to HIV.

But many challenges exist, which will need to be dealt with dynamically through ongoing implementation, good monitoring, and timely focused operational research. Such challenges include how to target the vulnerable, how to use food aid to leverage longer-term livelihood options, ensure complementary resources through appropriate

partnerships, strengthen local capacity, and mobilize communities, as well as required resources. Donor responses have been piecemeal to date and the involvement of food aid organizations is fairly recent. Though 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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