Procedures for the identification of groups vulnerable to food insecurity and malnutrition due to the impact of HIV and AIDS, and mechanisms for beneficiary selection and eligibility for appropriate interventions

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Procedures for the identification of groups vulnerable to food insecurity and malnutrition due to the impact of HIV and AIDS, and mechanisms for beneficiary selection and eligibility for appropriate interventions.

1 Introduction

The National Council for the Combat of HIV/AIDS (CNCS) nominated the Technical Secretariat for Food and Nutritional Security (SETSAN) to host a multi-sectoral taskforce [1] to prepare procedures for the identification of groups vulnerable to food insecurity and malnutrition due to the impact of HIV and AIDS.[2]

Food and nutrition counselling care and support interventions may be necessary for these groups due to the linkages between food and nutritional security and HV and AIDS: HIV and AIDS can increase the risk of malnutrition and food insecurity[3]; and food and nutrition insecurity can increase susceptibility to HIV infection and hasten the progression from infection to symptomatic AIDS.

This manual is divided into two Parts: Part I is the Procedures, and Part II is a resource document which presents some options for food and nutrition counselling, care and support interventions in the context of HIV and AIDS.

Part I presents procedures for an institutionalised mechanism for target group identification and beneficiary selection. This includes a common set of criteria for beneficiary selection, and standard means to verify eligibility for specific support. The Procedures also propose a support and referral network between different sectors that may be providing food and nutrition support, such as social welfare, health, education, and agriculture and implementing partners.

The Procedures refer to the potential beneficiary group that either knows their HIV status and, or, are predominantly bed-bound in Stage III and IV of HIV

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[1] The members of the multi-sectoral taskforce are: CNCS, MMCAS, INAS, MISAU, MINED, SETSAN, MONASO, Rede Cristão, FAO, and WFP. Technical Assistance and financial support have been provided by FAO and WFP.
[2] The Procedures are supported by three other documents: a more general background document providing information on the justification for food and nutrition security interventions in the context of HIV/AIDS and the methodology used to develop the Procedures; "An Executive Briefing on the Procedures" and a "Proposal for piloting the Procedures".
[3] Food security exists when all people at all times have physical and economic access to sufficient safe and nutritious food to meet the dietary needs and food preferences for an active and healthy life (FAO 1996)

infection, or due to other chronic illness. This group will be self-selecting in that individuals have undertaken HIV testing, and, or have given informed consent to be assessed for entry into a support programme.

It is anticipated that the Procedures will be initially phased in under the following possible scenarios:

1. Localities where the *complete* Ministry of Health Integrated Network (MISAU-RI)[4] is operating in conjunction with a MISAU approved HBC programme[5].
2. Localities where a *partial* (Voluntary Counselling and Testing (VCT) Treatment of Opportunistic Infections (TOI,) Ministry of Health Integrated Network (MISAU-RI) is operating in conjunction with a MISAU approved HBC programme.
3. Localities where there is a Home Visit programme operating, and it is anticipated that this will be transformed into an MISAU approved HBC programme.

The needs of the general population who may be susceptible to HIV infection and the population group that is HIV positive, asymptomatic, but not tested, should be addressed through activities that mainstream HIV and AIDS impact mitigation into the policies, strategies and programmes of sectors that influence food and nutritional security.[6]

[4] The expansion of the RI is prioritised on the basis of two criteria: areas with high prevalence of HIV (the centre region, the commercial corridors, and the frontier areas), and areas where interventions would be more effective (i.e. where large scale health facilities already exist and where there is a higher population density). See annex ? for anticipated coverage.

[5] MISAU approve Home Based Care Programmes on the basis of a minimum standard of training and supervision. Home Based Care Programmes are differentiated from Home Visit Programmes, where volunteers or activistas have not received MISAU training and supervision.

[6] SETSAN is currently preparing a working document on "Mainstreaming HIV and AIDS into the National Strategy for Food and Nutrition Security", which will help to orientate food and nutrition security interventions to the general population in the context of HIV and AIDS.

PART I: The Procedures

1 Objectives

The Procedures have been developed in order to guide organisations working at the community level in the selection of households and individuals vulnerable to food and nutritional insecurity due to the impact of HIV and AIDS for appropriate interventions.

These organisations will be implementing programmes with food and nutritional security activities that provide counselling, support and care to people living with HIV and AIDS as well as activities linked to the mitigation of the impact of HIV and AIDS on the food security of other affected family members.[7] These activities may be short term or longer term and targeted at the individual or household level.

The Procedures provide a common basis for organisations to harmonise and institutionalise criteria and mechanisms used for beneficiary selection.

The objectives of the Procedures are to ensure that:

- Target groups have information about their rights and responsibilities with respect to entry into, exit from, and transfer/transition between different food and nutrition security support programmes in the context of HIV and AIDS.
- Organisations use common criteria and mechanisms for the identification of target groups and selection of beneficiaries for programmes aiming to alleviate and mitigate food and nutritional insecurity due to the impact of HIV and AIDS.
- The selection of beneficiaries is based on a participatory and transparent process at the locality level, which includes PLWA and community leaders;
- There is an adequate referral and communication system between the different types of support programmes that may be available at the Administrative Post and Locality Post levels.
- Existing institutions and mechanisms are used, so that there is a better management of resources, and that these mechanisms can be sustained in the long term.
- There is adequate and appropriate support and supervision from district, provincial and national levels.

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[7] Affected family members include family members of PLWA who during the period of chronic illness: may have increased caring demands made upon them, who may be vulnerable to current food and nutrition insecurity; and after a chronic illness related death may be vulnerable to future livelihood and food and nutritional insecurity.

The Procedures will contribute to efforts to ensure that PLWA and affected family members are aware of and if eligible, have access to the range of support services that are available to ensure their food and nutritional security.

2 Identification and prioritisation of geographical target areas

The priority target areas are those areas that have high levels of food and nutritional insecurity *together with* a high prevalence of HIV infection, and, or high AIDS related mortality.[8] Currently, the tools available to identify these areas are national level surveys or surveillance systems, e.g. the national household living conditions survey (IAF), the national demographic and health survey, (DHS) the food and nutrition insecurity vulnerability assessment, (VAC) and the MISAU national HIV/AIDS sentinel site surveillance system.[9] (See matrix 1).

2.1 Selection of Administrative Posts and Localities

This will be done by the multi-sectoral District CNCS nuclei. They will select priority localities: i.e. those localities that have high estimated HIV prevalence and or AIDS mortality and are food and nutritionally insecure. The selection will be based on Health Information System indicators for key illnesses and malnutrition; and information from key informants in the area of agriculture and food security.

3 Definition of target groups

The term target group refers to a population group that has the same characteristics or is facing a similar situation.

The general target groups that are addressed in the Procedures are those populations that are food and nutritionally insecure due to the impact of HIV and AIDS. Specific target groups could be food insecure and or malnourished:

[8] That is there may be areas where estimated prevalence of HIV infection is going down, but AIDS related mortality is going up.

[9] Target areas may not coincide with administrative units, e.g. districts. Target areas may be “corridors” along key transport routes, or important frontier posts, or “hot-spots” with concentrations of high-risk groups. WFP work on geo-spatial analysis cross referencing IAF poverty indicators with HIV sentinel site prevalence data will be used, but malnutrition data should also be incorporated. There are also issues with using the sentinel site data (36 sites)

HIV/AIDS-orphans, PLWHA, HIV/AIDS-widows, etc. (See Matrix 2 and 3). Organisations are most likely to be working with specific target groups depending on their area of expertise and interest.

The general target group is screened according to specific criteria in order to identify beneficiary groups.

4 Identification of beneficiary groups

Not all people infected or affected by HIV and AIDS will be food insecure, and not all food insecure households are infected or affected by HIV and AIDS. At the household and individual levels, vulnerability to food and nutritional insecurity also depends on the stage in the life cycle.

Some individuals infected with HIV, and, or affected household members may not be able to access sufficient income and food resources in order to meet their additional nutrient requirements and nutritional care needs,[10] due to poverty and, or their stage in the life cycle, and therefore require assistance.

Scarce resources should be targeted to the most needy and support should be appropriate to individual and household characteristics. Therefore, objective and standardised criteria need to be applied in a transparent way in order to select those that are most needy from the general target group.

All tested HIV positive individuals (i.e. stages I –IV), registered chronically ill patients and affected family members are *potential* beneficiaries.

In order to receive financial and or in-kind material benefits, HIV positive individuals and, or, their affected family members should meet economic and demographic criteria.

4.1 HIV positive individuals who are food insecure and, or malnourished

HIV positive individuals who are unable to meet their additional food and nutritional support needs will be identified on the basis of a combination of clinical criteria, *and*, socio economic criteria, *and* socio-demographic criteria

[10] See Part II for an explanation of the additional and different food and nutrition care and support requirements of PLWA.

Therefore a combination of the three criteria is needed to select this beneficiary group.

4.2 Affected family members of PLWA who are vulnerable to food insecurity and, or malnutrition

In order to help affected household members cope with the impact of chronic illness and death they may be eligible for means tested financial or in-kind material benefits.

In order to reduce vulnerability to current or future food and nutritional security, affected household members may be eligible on the basis of socio-economic and socio-demographic criteria for support to household food production and or income generation activities.

Affected family members of a person with HIV will be identified on the basis of their relationship to the chronically ill or deceased person as well as a combination of socio-demographic criteria *and* socio economic criteria.

5 Beneficiary selection criteria

In order to ensure that assistance goes to those that need it most, all three criteria (clinical, socio-economic and socio-demographic) must be met in the case of an individual infected with HIV. In the case of affected family members, both socio-economic and socio-demographic criteria must be met.

5.1 Clinical criteria

a. **HIV infection assessed according to the WHO guidelines:**

- Individuals who have tested HIV positive but are asymptomatic (Stage I)
- Individuals, who have tested HIV positive, are symptomatic and have unintentional weight loss of < 10% (Stage II)
- Individuals who have tested HIV positive and are symptomatic, and are partially or fully bed-bound (Stage III & IV)

b. **Other chronic illness assessed by the medical authorities[11]:**

- Individuals who are partially or fully bed-bound due to chronic illness. (DEFINITION: An adult (15 – 59 years) who has been too ill to work or perform their normal duties for a total of 3 months (i.e. illness could be persistent or recurring) during the last 12 months.

[11] In areas with no health facility registered traditional healers may be used

c. **Moderate or severe global acute malnutrition**
- Adults: Body Mass Index (or MUAC)
- Children < 5 years: weight for height or growth faltering
- > 5 years < ? years:

5.2 Socio-economic criteria

There are some types of food and nutrition interventions that all PLWA and their family members should be able to access and act upon, irrespective of their socio-economic status. These include information and nutrition counselling with respect to increased nutrient requirements, management of nutrition related disorders, and developing food and drug plans for maximum efficacy and adherence to drug regimes.

However, there will also be some food and nutrition interventions that require means testing to ensure that resources are targeted at the most needy individuals and households. These interventions may include cash, material and or food subsidies.

The socio economic criteria are intended to assess whether the income level of a household is sufficient to meet the additional food and non-food needs brought about by the demands of chronic illness. As the cost of living differs according to region and between urban and rural areas[12], the Procedures provide general parameters that will then be adapted to the local situation by the "community committee".[13]

a. **Income from formal employment and other sources**
- E.g. self-employment, crafts, petty-trading, remittances, pension

b. **Income from crop production**
- E.g. field crops, horticultural, fruits, nuts

c. **Income from sale of livestock**
- E.g. small-stock, poultry

d. **Other locally important sources of income**
- E.g. natural resource utilisation

[12] See MPF/IAF Regional poverty lines
[13] The idea is to use/strengthen existing committees at the locality level, and only if necessary establish new committees.

e. Other criteria

- Household has no able bodied working adult
- Household has high "effective dependency ratio"
- Assets
- Housing conditions etc.

Annex 2[14] provides guidelines for committees to develop community driven poverty criteria, and a mechanism to check that these are "reasonable", and feasible to implement.

5.3 Socio-demographic criteria

The socio-demographic criteria are applicable for both the person infected with HIV and also to their close affected family and dependents, e.g. spouse/partner, caregiver, child, dependent (i.e. elderly, or handicapped with no other source of income or support). The specification of the sex, age, social and biological status of the individual, and their family member/s helps to identify why they may be more vulnerable to food insecurity and or, malnutrition and to ensure an age and gender appropriate intervention. (See matrix 3).

a. PLWA

- Sex: male, female.
- Age: > 55 years (INAS) < 17 years> (definition) of child
- Biological status: < 6 months; >6 months < 5 years; pregnant, lactating
- Position in household: HHH, spouse, orphan (maternal, paternal, double).

b. Affected household member

- Relationship to PLWA: spouse, child, parent
- Sex: male, female.
- Age: > 55 years (INAS) < 17 years> (definition) of child
- Biological status: < 6 months; >6 months < 5 years; pregnant, lactating
- Position in household: HHH, spouse, orphan (maternal, paternal, double).

6 Verification of eligibility

[14] These are still to be developed based on TF experience

- **Clinical:** medical personnel in a health facility or in case of no health facility criteria of "chronic illness" applied by registered traditional medical practitioner.
- **Age:** identification document or testimony by community leader/committee
- **Residence:** > 6 months (INAS) implications for PLWA who have moved back to home area? Is residence eligibility necessary (to avoid double registration) testimony
- **Income:** assessment by community committee
- **Status:** (orphan, HHH) Community committee and/or home visit by focal point or professional (health, social welfare, agriculture).

7 Exit criteria

a. Graduation from means tested programme to livelihood programme

A household where an individual is eligible for, and receiving means tested cash or in-kind benefits (cash subsidy, non-food, food assistance), should also be registered in a livelihood support programme (e.g. income generation, home gardening, business skills). Means tested interventions should be designed and implemented in order to reduce expectations and dependency on welfare handouts.

Eligibility for means tested interventions should be reassessed annually or each 6 months. The timing of exit from a means tested programme should take into account seasonal patterns of production and income.

b. Death of primary beneficiary

On the death of primary beneficiary (AIDS related or chronic illness), specific benefits will cease (some months after the death) or with the payment of a funeral grant. The remaining affected household members are then reassessed for continued eligibility of existing benefits additional and or, different benefits.

c. Annual reassessment

The locality committee will reassess all beneficiaries on an annual basis, to verify continued existence and eligibility for benefits.

8 Steps for the selection of beneficiaries at locality level

8.1 Initial contact with referral network: information and counselling

At the community level, members of the potential target groups come into contact with various institutions, people and or programmes. Examples of these include: the health facility, the day hospital, a home-based care programme, and NGO, the school, and the religious centre. In addition various committees or community members (e.g. community leaders, religious leaders, traditional healers, neighbours, agricultural technicians or extension workers, activistas, teachers) will be aware of individuals or households who are part of the overall target group.

When an individual or household has the initial contact with an institution, they need to be able to obtain information[15] concerning their rights and potential eligibility for different kinds of support. They then need to be informed as to which institution should be their principal contact point for an assessment.

8.2 Referral for clinical assessment

a. **PLWA or chronic illness**

For an individual who is HIV positive or bed bound through HIV related or other chronic illness, the contact institution will be a health facility, or Day Hospital.[16] This facility or designated person will assess the individual against clinical criteria, for HIV infection and, or chronic illness and then carry out an assessment for malnutrition.

b. **Affected family member of PLWA**

- If VCT facilities are available: depending on the age of the affected family member and relationship to the PLWA, counselling should be provided for VCT and positive living;
- If VCT facilities are not available: counselling should be provided for positive living
- Affected family members should be referred for assessment of nutritional status.

8.3 Referral for socio-economic assessment

a. **PLWA or chronic illness**

b. **Affected family member of PLWA**

Spouse, single or double orphan of PLWA or chronic illness,

[15] Information on rights at the facility or institutional level will need to be complemented by a wider IEC campaign through different media and at different levels

[16] It is under discussion that in future trained traditional medical practitioners may also be part of the referral network.

With informed consent, the patient, and, or family members would then be referred to the focal point person of the locality level committee.

In the case of bed-bound individuals or minors, a responsible adult would be nominated by the individual, or identified by the institution (e.g. orphans with no adult relatives).

8.3.1 Completion of assessment form: Part I

The focal point person would assist in the completion of the first part of the assessment form, and carry out a home visit.

8.3.2 Case review and verification by locality committee

The locality level committee would comprise of a multi-sectoral team. The individual or household case would then be reviewed by using the socio-economic and socio-demographic criteria detailed above.

a. **Cases found eligible for means tested benefit**

Individual cases that were reviewed, verified and found eligible would then be provided with information and counselling with respect to the range of non-means tested and means tested support available locally.

i. An individual confidential referral form would be provided to the individual or his/her representative.
ii. A confidential case referral would be sent to the appropriate organisations for follow up.
iii. A copy of the confidential case referral would be sent to the supervisory institution (or CNCS Nuclei?) at District level.
iv. A copy of the confidential case referral would be maintained with the community level focal point for monitoring and follow up.

b. **Cases not found eligible for means tested benefit**

Individual cases that were reviewed, and not found eligible would then be provided with information and counselling with respect to the range of non-means tested support available locally.

i. An individual confidential referral form would be provided to the individual or his/her representative

ii. A confidential case referral would be sent to the appropriate organisations for follow up
iii. A copy of the confidential case referral would be sent to supervisor at District level
iv. A copy of the confidential case referral would be maintained with the community level focal point for monitoring and follow up.

8.3.3 Acceptance into programmes

Organisations in the referral network would rapidly review the case; provide programme specific information and request additional individual or household details as necessary. The rights and responsibilities of beneficiaries would be explained orally and written information provided as appropriate. These would include: programme participation and benefits, complaints mechanisms, graduation and exit criteria and annual reassessment.

9 Supervision mechanisms

9.1 Locality level

The Head of the Administrative Post or Locality Post would provide administrative oversight to the Locality Committee. This would include for example:

- Increasing awareness in the general population about the role and importance of the committee and referral network in helping to ensure that the rights of people living with HIV/AIDS and chronic illness and vulnerable to food and nutrition insecurity and their affected family members were being addressed.
- Increasing the communication and collaboration among different stakeholders in the referral network: government institutions, NGOs, CBOs, private sector.
- Ensuring that regular meetings are held and recorded.
- Ensuring that rules for confidentiality are upheld.
- Assessing and acting upon complaints received.

9.2 District level

At the District level the CNCS nuclei would be responsible for:

- Conducting a desk review of beneficiary lists to ensure agreed community criterion were being applied.
- A percentage random sample of lists for verification with locality committee and home visits on a quarterly basis.

10 Complaints mechanisms

10.1 Locality Level

- At the locality level, the Head of the Administrative or Locality Post would actively ensure that the mandate and responsibilities of the committee and referral network were being carried out in accordance with the guidelines. The Head of the Administrative or Locality Post would ensure that any complaints were heard and or received in confidentiality, and dealt with in a timely manner as appropriate.

- Organisations of PLWAs would be encouraged to disseminate information concerning the rights and responsibilities of beneficiaries and ensure adequate information about complaints mechanisms. Organisations of PLWAs or other CBOs and faith-based organisations would be encouraged to represent specific cases as necessary.

10.2 District level

- The quarterly supervision visit from the District CNCS Nuclei would programme time for confidential hearings of complaints.

11 Monitoring implementation of Procedures

To be included after piloting.

Matrix 1: Identification and prioritisation of target areas[17]

General description	Specific description of indicators	Means of identification	11.1.1.1.1 Examples
Area with high level of food and nutritional insecurity		Food insecurity vulnerability assessments	
	High rates of chronic malnutrition (< 5 years)	DHS	
	High rates of acute malnutrition (< 5 years)	DHS	
	High levels of poverty	IAF 2002	
	High incidence of drought or floods	Disaster profiles	
Area with high prevalence of HIV infection		MISAU Sentinel Site Surveillance System	
	High AIDS related mortality	Health information system	
	High morbidity among women of fertile age	Health information system	
Areas with high incidence of OIs			
	High incidence of STI	Health information system	
	High incidence of TB	Health information system	
	High incidence of malaria	Health information system	
Areas with high incidence of proxy HIV/AIDS impact indicators			
	High incidence of orphans & OVCs	MMCAS & MINED	

[17] Target areas may not coincide with administrative units, e.g. districts. Target areas may be "corridors" along key transport routes, or important frontier posts, or "hot-spots" with concentrations of high-risk groups. WFP work on geo-spatial analysis cross-referencing IAF poverty indicators with HIV sentinel site prevalence data will be used, but malnutrition data should also be incorporated. There are also issues with using the sentinel site data (36 sites)

Matrix 2: Potential beneficiary groups using clinical and socio-demographic criteria

	Age					Sex	Relationship to PLWA?[18]	Relationship to HHH?	Receiving Treatment
	0-5m	6-59m	5-14y	15-49	50+				
Tested individuals in Clinical Stage I	X	X	X	X	X	F M			
Tested individuals in Clinical Stage II	X	X	X	X	X	F M			N
Clinical Stage III	X	X	X	X	X	F M			N
Clinical Stage IV	X	X	X	X	X	F M			N
Registered chronically ill patients	X	X	X	X	X	F M			N
Unregistered (?) chronically ill patients									
Individuals on ARVs or TB therapy	X	X	X	X	X	F M			Y
People in registered HBC programme				X	X	F M			
Pregnant + b/feeding women on PMTCT+				X		F			Y
Infants and children infected through MTCT	X	X	X			F M			?
Breast feeding infants of HIV infected mothers	X					F M			N

[18] Self, spouse, parent, child, other relative, no relative

	Age					**Sex**	**Relationship to PLWA?**[18]	**Relationship to HHH?**	**Receiving Treatment**
	0-5m	6-59m	5-14y	15-49	50+				
Maternal orphans < 6 months	X					F M			N
OVC > 6 months		X				F M			N
Youth??			X						
Widow headed households									

Matrix 3: Potential beneficiary groups using clinical and socio-economic criteria

Criteria	**Relationship to:**		**Community identified poverty indicators**			
Target group	**PLWA**	**HHH**	**Income level**	**No able bodied working adult**	**"Declaration"?**[19]	**Others**[20]
Tested individuals in Clinical Stage I						
Tested individuals in Clinical Stage II						
Clinical Stage III						
Clinical Stage IV						
Registered chronically ill patients						
Unregistered (?) chronically ill patients						
Individuals on ARVs or TB therapy						
People in registered HBC programme						
Pregnant + b/feeding women on PMTCT+						
Infants and children infected through MTCT						
Breast feeding infants of HIV infected mothers						
Maternal orphans < 6 months						
OVC > 6 months						
Youth??						
Widow headed households						

[19] Declaration made by INAS permanent/bairro secretary etc?
[20] Others: < threshold of ag.production; land/cultivated area; livestock/poultry

Annex 1: Planned expansion of HBC/CD and Day Hospitals providing ARV Therapy

Intervention	2004		2005		2006		2007		2008	
	US	Cases	US	Cases	US	Cases	US	Cases	US	Cases
HBC/CD	60	11,355	120	27,582	200	67,371	250	107,238	250	143,776
HD-TARV-RI	17	7,924	24	20,805	112	57,954	112	96,418	129	132,280

Source: MISAU PEN (2004-2008) the expansion of the “integrated network”.

Annex: WFP GIS Maps on HIV prevalence and Poverty incidence
Annex: Diagrams and decision making trees

PART II: Options for food and nutrition security interventions in the context of HIV and AIDS

1 Justification for food and nutrition security interventions in the context of HIV and AIDS

While people with HIV and AIDS have special nutritional requirements, all people can benefit from adequate nutrition. Good nutrition increases resistance to infection and improves energy, thus making people, stronger, more productive and able to realize a better quality of life.

HIV positive individuals are at risk of malnutrition because the presence of the virus increases their nutrient requirements. The nutrient requirements will differ according to the sex, age and status of the HIV positive person. The nutrient requirements will also change with the progression of the illness.

As well as increased nutrient requirements, HIV positive individuals have different nutritional care needs. This includes knowledge as to how to prepare foods and meals that meet the nutrient requirements in different stages of the illness, and how to manage disorders that might affect consumption.

Individuals with HIV and the members or survivors of their households may also be vulnerable to food insecurity due to the following reasons:

- The illness or death of a household member may mean that labour is diverted away from productive tasks towards caring for the chronically ill household member. This may lead to a reduction in the levels of household income and, or food production.
- The household may draw down savings or sell assets to cover increased health and social expenditures.
- Surviving family members may not be able to protect their rights over resources, or have sufficient knowledge and skills to maintain the production and income levels of the household.

2 Interventions at the individual level for HIV positive individuals

The most appropriate food and nutrition intervention depends on the clinical stage of HIV infection[21], and the age, sex and status of the infected person.

All individuals should be able to access and act on information, education and communication concerning:

- Additional nutrient requirements for people infected by HIV,
- Nutritional care practices in order to maintain weight, and enhance the body's immune functions.
- Food hygiene and safety measures,
- Personal, household and environmental hygiene requirements in order to maintain health and avoid opportunistic infections.

3 Tested individuals in Clinical Stage I

These are individuals who have tested HIV positive, but have no symptoms and are able to conduct their normal daily work and family activities[22].

a. **Pregnant women on ARV drug treatment (PMTCT+):** information on macro and micro nutrient supplementation for nutritionally compromised women on ARV for prevention of MTCT.

b. **Breastfeeding women:** counselling[23] for informed choice on safe breastfeeding practices and safe and sustainable use of breast milk substitutes, for those unable to breastfeed.

c. **Infants and children infected through MTCT:** screening and assessment for malnutrition and special nutritional care and support needs.

4 Tested individuals in Clinical Stage II

These people are symptomatic, continue to be ambulatory, and have unintentional weight loss of <10%.

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[21] See glossary for explanation of WHO stages of HIV infection.
[22] Until VCT becomes more widely available and acceptable, this group of individuals who have tested HIV positive but are asymptomatic will remain relatively small. However it is important to provide interventions that allow this group to take control over their lives and life-styles and live positively.
[23] Counselling on individual and, or group basis

5 Individuals in Clinical Stages III and IV and chronically ill patients

These individuals are in one of the following categories:

- **Clinical Stage III:** symptomatic, are bed bound for less than 50%, of the time and have unintentional weight loss of greater than10%
- **Clinical Stage IV:** symptomatic, are bed bound for greater than 50% of the time and have HIV wasting syndrome
- **Chronically ill patients:** e.g. registered for TB treatment, and or, meet the criteria for chronic illness: "(DEFINITION: An adult (15 – 59 years?) who has been too ill to work or perform their normal duties for a total of 3 months (i.e. illness could be persistent or recurring) during the last 12 months. "
- **Individuals on ARVs or TB therapy:** nutritional counselling and planning to support adherence to food and drug regime and management of drug side-effects.

6 Interventions for other affected members of the PLWA's family

a. **Spouse or partner**
b. **Breast feeding** infants of HIV infected mothers: parental counselling
c. **Maternal orphans < 6 months:** counselling of caregiver for informed choice on safe wet-nursing, and safe and sustainable use of breast milk substitutes
d. **OVC > 6 months:** safe introduction of complementary foods. Growth monitoring and counselling

7 Interventions at the household level

These interventions may take place during the period when an affected household is coping with chronic illness, and, or, after the death of a household member.

Interventions during a period of chronic illness may benefit family members, such as the spouse or partner of the patient and, or the principle caregiver.

Interventions after the death of a household member may benefit the widow, widower and surviving children or other dependents.

Interventions can be broadly classified into two approaches:

I. Strengthening the ability of households to cope

These are activities that help the affected household members to cope with the food and nutritional implications of chronic illness and death.

a. **Information, education and communication**[24] on:
   - Additional nutrient requirements and nutritional support needs of HIV infected people.
   - Nutrient needs and nutritional support needs of other biological or socially vulnerable members of the household (infants, elderly, orphans).
   - Food hygiene and safety, and personal, household and environmental hygiene, to maintain health of all family members
b. **Financial and material support** that supplements the person's or household income and food situation (cash subsidy, clothes, bedding, utensils, cleaning materials, food basket, food supplement)
c. **Exemptions or subsidies** that reduce demands on household income and resources (exemption of school fees, health costs, school meals)

II. Reducing future vulnerability to food and nutrition insecurity

These are activities that seek to diminish the risk of current and future asset depletion through promoting production and income generation activities.

a. **Life skills and vocational training and material support for household level production activities** to improve availability of nutritionally adequate diet (e.g. crop and livestock productivity enhancement and diversification, home gardens, poultry and small-stock, food for assets/training/work)
b. **Life skills and vocational training and material support for household income generation activities** to supplement the household's income (credit or grant for small businesses providing goods or services)

8 Interventions at community level

These may include school and or community gardens, which while being open to everyone, are also intended to be accessible and bring direct benefits to HIV infected individuals, members and or survivors of their households.

[24] (e.g. as part of a home based care programme)

Acronyms

ARV	Antiretroviral
BMI	Body Mass Index
CBO	Community Based Organisation
CNCS	The National Council for the Combat of HIV/AIDS
DHS	Demographic and Health Survey
HBC	Home Based Care
HHH	Household Head
IAF	National household living conditions survey
INAS	National Institute for Social Action
INGOs	International Non-Governmental Organisations
MADER	Ministry of Agriculture and Rural Extension
MINED	Ministry of Education
MISAU	Ministry of Health
MISAU-RI	Ministry of Health Integrated Network
MUAC	Middle Upper Arm Circumference
OVC	Orphans and Vulnerable Children
PLWA	Person Living with AIDS
RI	Integrated (Health) Network
SETSAN	Technical Secretariat for Food and Nutritional Security
VAC	Vulnerability Assessment Committee

Glossary

WHO stages

WHO classifies HIV infection into four clinical stages:

- Clinical Stage I: asymptomatic, normal activity.
- Clinical Stage II: symptomatic, ambulatory, unintentional weight loss<10%
- Clinical Stage III: symptomatic, in bed <50%, unintentional weight loss>10%
- Clinical Stage IV: symptomatic, in bed >50%, HIV wasting syndrome

Annex: 3. Nutritional support as part of a HBC package

- Information on the additional and different nutritional requirements (including micro-nutrients) for various chronic illnesses (T. B. AIDS…)
- Nutritional support needs of other household members (orphaned babies < 6 months, HIV positive, care-givers)
- Nutrition promotion and education on the nutritional value and utilisation of locally available foods to meet the nutritional requirements of chronically ill household members
- Management of household resources to meet food and non-food needs
- Income, coupon or food subsidy to support the additional food needs of the chronically ill and their caregivers
- Nutrition information and education for foods included in any ration provision
- Food safety and hygiene
- Environmental hygiene
- Personal hygiene and management of disorders affecting food consumption and dietary intake (oral thrush, diarrhoea, malabsorption of fats)
- Nutritional literacy for care givers and affected household members, covering a range of cross-sectoral skills and knowledge around health care, food security production orientated activities, water and sanitation, HIV/AIDS and nutrition information.
- Monitoring and evaluating of nutritional support activities

Matrix 1a: Examples of options for food and nutritional security interventions in the context of HIV/AIDS at individual, household, community levels

	Prevention: Community and Household levels	Care support and treatment, phase III and IV	Mitigation for orphans, widow and elderly headed households	Mitigation at community level

Food Availability	o Protect and uphold rights to land and natural resources by men and women:
	  o Disseminate land law
	  o Develop widow and orphan case studies of implementation
	o Sustainable seed and input supply systems
	o Enhance productivity for diversified and nutrient rich food production (staples, legumes, vegetables, fruits, oil seeds, poultry, small-stock)
	o Production systems for cash crops that minimize risk of exposure to HIV infection
	o Small scale irrigation and water conservation methods
	o Home gardens
	o School gardens
		o Medicinal plant gardens
		o Home gardens
		o Food and micro-nutrient supplements for pregnant women
		o Food aid rations for food insecure
		o Food fortification
		o HBC programmes include productive support for other HH members:
		o Seeds and tools
		o Small-stock and poultry interventions
		o Fruit tree planting
			o Seed fair vouchers for orphan and widow households
			o Spread labour requirements in time and by family member
			o Review labour demands of technologies in relation to household characteristics
			o Small scale water and soil conservation practices
				o Systematic knowledge retention and transfer for local seed varieties and seed conservation practices (e.g. local curriculum).
				o Local seed multiplication plots (school-community linkages)
				o Group “pass-on-the-offspring” activities
				o Intergenerational knowledge transfer for production practices through formal and informal education system
				o Mechanisms for widow/youth partnerships for improved land access at household and community level
				o Community based natural management approach incorporates needs of youth and elderly
				o Link self reliance to safety net provision

Matrix 1b: Examples of options for food and nutritional security interventions in the context of HIV/AIDS at individual, household, community levels

	Prevention: Household and Community levels	Care support and treatment, phase III and IV	Mitigation for orphans, widow and elderly headed households	Mitigation at community level
Food Access	o Diversification and smoothing of income sources for men and women o Location and opening hours for markets to reduce risk exposure o Marketing systems for cash crops that reduce exposure to HIV infection (e.g. non-lumpy payments; use of bank transfers) o Product labelling with nutrition and HIV prevention messages (salt, sugar, soap) o Conservation and storage to maintain stability of food supplies o Training in development of business plans, feasibility studies, market demand surveys, budget (credit and debt) management	o Cash subsidy for resource poor HH o Appropriate size and packaging for food aid o Conservation and storage technologies o Training in diversified and flexible IGA for caretakers and other household members o Access to flexible savings and micro credit systems o Management and budgeting of household food and non food resources	o IGA for orphans, youths, widows, & caretakers o Funeral grants o Cash and food subsidies for resource poor HH o Criteria for savings and micro credit schemes enables access by youth and elderly	o Reassess physical access and location of markets o Community funds (cash, in-kind) to support needs of OVCs and elderly o Training of market inspectors (hygiene, opening times) o Training in proposal development for new IGA initiatives o Business Development Service Centres, in collaboration with schools

Matrix 1c: Examples of options for food and nutritional security interventions in the context of HIV/AIDS at individual, household, community levels

	Prevention: Household and Community levels	Care support and treatment, phase III and IV	Mitigation for orphans, widow and elderly headed households	Mitigation at community level
Utilisation and Caring practices: throughout the life cycle	o Reduce labour requirements for domestic tasks (water and firewood collection) o Train ACS/CHW in food and nutritional care and support for all population o Food and nutrition security lifeskills for boy and girl OVCs o Improve quantity and quality of water within accessible distance o Hygiene and sanitation to reduce food and water born diseases o Counselling parents on the promotion of exclusive breastfeeding to contribute to prevention of MTCT o Multi-vitamin supplements for nutritionally compromised women to contribute to prevention of MTCT	o Nutrition education and communication re increased and different nutrient requirements of PLWA o Food preparation methods for PLWA o Dealing with AIDS related feeding problems (ulcers, thrush, diarrhoea) weight loss o Improve quantity and quality of water within acceptable distance for PLWA o Acceptable hygiene and sanitation provision for PLWA o Fuel efficient stoves o Food safety o Processing technology (grinding) o Treatment of opportunistic diseases to avoid infection-malnutrition synergy o Dietary choices to manage side effects and promote ARV efficacy and adherence o Facility or home based therapeutic feeding for moderately and severely malnourished HIV positive children and adults o Assess transport options to health care facilities	o Nutrition education and communication re requirements for different hh members (< 6 months, infants, elderly) o Improve quantity and quality of water within acceptable distance for youth and elderly o Food preparation methods o Hygiene and sanitation o Food safety o Community level food processing and conservation facilities (hammer mills, driers)	o Improve access and coverage of health and social services o Training of community health and social workers o Strengthen and capacity building for informal and formal social networks (FBOs, CBOs)