Chapter 7: Implementation Strategies

Program Design Steps

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Program Design Steps

Key Concepts

In This Chapter

This chapter identifies several guiding principles for the step-by-step implementation of food assistance programming in an HIV context. It begins by highlighting the importance of encouraging community participation in implementation of food assistance programs, including the greater involvement of people with HIV and AIDS (GIPA). The chapter then provides guidance on identifying and supporting exisiting programs as well as on securing complementary non-food inputs.

Next, the chapter explores the development of various types of partnerships and the potential need to strengthen partner organizations' capacity. The chapter also underscores the need to develop intersectoral referral mechanisms in areas simultaneously affected by food insecurity and HIV, giving specific attention to ethical considerations involving the potential overlap of benefits while maintaining confidentiality of beneficiaries' HIV status. The chapter then discusses the importance of program scale up, and identifies several key factors essential for effective scale-up of successful interventions.

The chapter ends with a discussion of exit strategies and challenges that must be addressed to ensure sustainability of food assistance interventions in the context of HIV.

Key Concept

7.1 Implementing Food Programs in an HIV Context

Key Considerations for Implementation

The following are key guiding principles for implementing food programs in an HIV context, along with sources for more detailed information on challenges, design steps, lessons learned and better practices within this guide with respect to each step:

Encourage participation and community mobilization. Participation from partner organizations, government and the community should be encouraged at every step of designing and implementing the program—from needs assessment to carrying out the exit strategy. GIPA is crucial to meeting the specific needs of PLHIV, mitigating against stigma and normalizing discussion of the disease. See Key Concept 7.2 in this chapter.

Support existing programming and ensure complementarity and provision of non-food requirements. Food interventions that are integrated into ongoing programs are often more successful than independent food pipelines. Especially in an HIV context, where food is only one part of a comprehensive package of support, it is important to recognize and plan for the non-food requirements that contribute to HIV prevention, treatment, and care and support. See **Chapter 4: Adaptive and Integrated Programming** and Key Concept 7.3 in this chapter.

Develop partnerships and strengthen intersectoral linkages and referral mechanisms. HIV touches all aspects of life for affected individuals and households. Multi-sector linkages and connections between service delivery channels are critical to providing an integrated and comprehensive system of livelihood support to PLHIV. As much as possible, two-way referral systems between food security programs and HIV services should be maintained. See Key Concepts 7.4 and 7.5 in this chapter.

Plan, implement and monitor exit strategies. Scale-up of successful programs and effective exit strategies are critical to promoting sustainability of program outcomes. In an HIV context, many factors affect an organization's ability to graduate beneficiaries and conduct a successful program exit. Perhaps most important among these is the capacity of the community and/or partners to care for vulnerable groups and assume responsibility for ongoing program activities and outcomes. See Key Concepts 7.6 and 7.7 in this chapter.

Key Concept

7.2 Community Mobilization and Participation

Community-based safety nets have been an effective means of preventing individuals and households made vulnerable by HIV from falling into destitution. A community may be geographically based or may describe a group of individuals who come together around a religious affiliation, women's issues, or through CBO or NGO associations, shared health practices or other areas of common interest. Many groups and communities have organized their own grassroots responses to food insecurity among HIV-affected families. However, they are often constrained by limited resources and organizational capacity.

Community Mobilization in Ethiopia: The MERET Program[1]

The Managing Environmental Resources to Enable Transitions (MERET) program uses food assistance to restore the environment and enhance livelihoods in chronically food-insecure communities through soil restoration and conservation, rural infrastructure development and reforestation activities. One of the methodology's major strengths is its emphasis on building beneficiaries' capacity to participate in issue/problem assessments as well as to plan and carry out diverse and sustainable livelihood strategies.

The MERET program builds community capacity largely through two community-based structures, Local Level Participatory Planning Approach (LLPPA) teams and Community Conversation groups. First, the LLPPA teams, composed of representatives from distinct livelihood/wealth groups and locations, work directly with Ministry of Agriculture and Rural Development Agents to identify and prioritize constraints to local development. Teams then present issues to the wider community through the Community Conversation groups.

Community Conversation groups have shown great promise in raising awareness and increasing community mobilization around HIV. Because of the groups, men, women, community elders and youth are increasingly able to discuss issues of gender, sexuality, livelihood strategies and customary practices that influence vulnerability to HIV. More important, the participatory nature of the process enables individuals and groups to take greater responsibility for preventing and mitigating HIV within their communities.

Community Conversation groups, LLPPA teams and government agents appoint Community Facilitators, who mobilize the community in support of HIV activities and sustain linkages between local stakeholders. Community Facilitators' responsibilities include:

- Facilitating regular biweekly community conversations
- Participating in regular planning and documentation meetings
- Disseminating HIV messages through MERET work activities and local meetings
- Mobilizing the community to provide care for PLHIV and orphans
- Fostering linkages between communities and school anti-HIV clubs
- Promoting women's direct participation in conversation groups and other community development activities
- Submitting quarterly activity plans to LLPPA teams and Rural Development Agents

Community mobilization is a capacity-strengthening process that helps communities take responsibility for identifying and deciding on an effective, coordinated response to food insecurity and HIV. Community participation ensures that those most affected by HIV, including stigmatized groups, play an active role in these processes.

Rigorous participation, a sense of ownership and community cohesion are critical to successful and sustainable food security programs. Likewise, community resource mobilization is unlikely to occur until there is adequate community involvement in planning and implementing a proposed program.

Promoting the Greater Involvement of People With HIV and AIDS[2]

Many factors make GIPA a critical component of the response to the epidemic. At the social level, publicly acknowledged involvement helps reduce stigma and discrimination, and sends a signal to society about the acceptance and importance of PLHIV. At its most basic, GIPA means two key things:[3]

- Recognizing the important contribution people infected or affected by HIV can make in the response to the epidemic
- Creating space within society for their involvement and active participation in all aspects of that response

A primary reason for including PLHIV and affected households in project planning and implementation is that they best understand their own needs, constraints and opportunities regarding food insecurity, assets and livelihoods.

Program managers should ask at the design stage of any food security program how they can intentionally involve PLHIV and affected households in the program's design, management and decision-making. When answering this question, program managers should consider involvement as both the level of ownership PLHIV have over the project and their stake in the benefits that accrue from project activities, such as products, revenue, etc.

Two approaches are critical to GIPA:

- Identifying relevant organizations, such as community-level PLHIV and OVC groups, as well as religious institutions and schools
- Using existing targeting processes, including community action committees, HBC networks or other support groups

Promoting Community Participation

Community participation is vital to effective project design and implementation. The planning and implementation process has several key decision points that can serve as points of entry for community participation, including:

- Situation analysis
- Stakeholder analysis
- Food needs assessment
- Targeting
- Activity selection
- Implementation
- Monitoring and evaluation
- Sustainability and exit strategy development

While time will be a limiting factor in emergency situations, there are still opportunities to use participatory processes to design the modalities for the program. Recovery and development programs offer a breadth of opportunities for community involvement in selecting, designing and implementing activities.

It is important to reiterate two key points in community participation: Regardless of the specific context, if HIV prevalence is high, a concerted effort should be made to ensure that PLHIV have a voice. In addition, community participation must be carefully balanced with confidentiality (e.g., for HIV status) when community representatives are involved in targeting.

Tools for Facilitating Participation

Tools and their potential applications are described in detail in the WFP Guide on ***Participatory Techniques and Tools***[4] available at www.wfp.org or at

www.livelihoods.org/info/pcdl/self/self_instruction_materials18.html. The tools can help partners with information gathering and analysis. All of them are participatory, i.e., inclusive, interactive and iterative.

Two other approaches have proven effective in facilitating collaboration and community participation. Participatory rural appraisal (PRA) is used to gather and analyze information about a particular community where an organization intends to work. CBT is an approach to targeting interventions that maximizes input from the community.

Varying Levels of Participation

Participation can occur at several levels of intensity. The ideal level is self-mobilization, with external actors serving as catalysts of change. At minimum, food programming should engage in consultative participation.

Self-mobilization: Communities or local partners take initiatives independent of external institutions to change systems; external agents may play a catalytic role.

Interactive participation: Partners and communities participate in joint analysis leading to action, formation of new local groups or strengthening of existing ones; local stakeholders take control over local decisions, giving them an incentive to maintain structures and/or practices.

Functional participation: Communities form groups to meet a program's pre-determined objectives, driven by external stakeholders. Such involvement tends to occur after major decisions have been made; such groups may be dependent on external initiators but can also become self-dependent.

Consultative participation: Communities are consulted. External stakeholders consider their knowledge and interests; outsiders define both problems and solutions but may modify these based on local people's responses. But communities do not make decisions, and outsiders are under no obligation to act on local people's views.

Information-giving participation: Communities answer questions posed by external stakeholders or program staff; they do not have an opportunity to influence decision making because findings are not shared.

Passive participation: Only external stakeholders make decisions; local communities are told what is going to happen or has already happened.

7.3 Key Concept

Existing Programming and Complementary Inputs

Agencies often experience greater success when integrating food interventions into existing programming, as opposed to introducing the food pipeline independently. This includes integration with programs implemented by the agency itself or other organizations to ensure a holistic approach to programming.

Food-based interventions that are introduced to communities via ongoing programs and services can complement these efforts and strengthen relationships between those programs and target communities. For example, some agencies provide food to institutions supporting vulnerable groups, particularly orphans. In order to receive support,

an institution must be registered, provide complementary services, demonstrate need and provide support to vulnerable groups. While it is understood that communities and extended families generally provide the most appropriate and most sustainable care, institutions may be the last resort for the most vulnerable, even if only for a short-term stay. Institutions may include orphanages, rural and urban child daycare facilities, hospice care facilities for adults and children, schools/homes for the disabled, skills training centers, homes for the elderly, centers for street children and OVC support programs.[5]

Complementarity and Non-Food Inputs

As described in **Part III: Sector-Specific Program Design Considerations**, a variety of non-food activities and inputs are integral to sector-specific interventions. While food assistance alone may be provided, complementary interventions are necessary to ensure and expand its impact. However, multiple funding streams are often needed to cover a range of complementary inputs, so it is critical to identify and access potential sources of funding for non-food inputs at the earliest stages of program planning. Projects with single-source donors that primarily provide food often cannot implement integrated projects readily—or at all—without complementary funding. There are often limitations on what costs food aid donors can cover when an activity is not directly tied to the food, particularly in emergency programs.

Agencies should be realistic about the non-food inputs needed for comprehensive programming, especially when integrating HIV-related issues into programming, and should assess donors' capacity to cover those costs. Two common strategies for acquiring these resources are 1) supporting existing programming within the agency itself or by linking with partners who can provide the complementary resources, or 2) raising funds among other public and private donors.

Complementary Programming: Linking C-SAFE Food Pipeline to Existing NGO Programs in Southern Africa

Salvation Army Combines Food with Community Counseling

The Salvation Army (TSA) Malawi combined food with community counseling and paved the way for community-based food assistance targeting. TSA strengthened an existing strategy by training community counseling teams, equipping them with skills much like a standard counselor, but with the intention of using their skills with small groups and families where a "shared confidentiality" model was more culturally congruent than one-to-one counseling. This provided a very strong foundation for the community to help households with chronically ill members and paved the way for targeting C-SAFE food distributions.

Area Development Programs Provide Entry Point for Food Programming

When C-SAFE targeted food assistance became available, World Vision (WV) Malawi was working in three districts with established Area Development Programs (ADPs), with a commitment to assist communities in integrated development programming for 10 to 15 years. The ADPs—each of which covers several communities with 4,000 to 6,000 households—provided an ideal structure for introducing the C-SAFE initiative because WV had an ongoing relationship with those communities, as well as extensive statistics on their vulnerability to food security to help identify C-SAFE's target groups.

One controversial type of complementary resource is food incentives for home-based caregivers and other volunteers. Many PLHIV support programs would not exist without these volunteers, who have high dropout rates and who may be as food-insecure as their PLHIV patients who receive food assistance. However, some donors do not support volunteer incentives. Program designers should be aware of the issues surrounding volunteer incentives and explore creative ways to support volunteers without undermining community spirit or creating competition. This might include possible FFT-type programs for counseling or other types of FFW programs.

7.4 Key Concept
Developing Partnerships

Forming partnerships to deliver food security, livelihood and HIV programming is common and often imperative in the quest to provide comprehensive and holistic programming. Partnerships are typically formed between NGOs (international, national and local), UN agencies, government bodies, CBOs, FBOs and community leaders. As noted in **Chapter 2: Policy and Program Environment,** Key Concept 2.4, partnerships can take many forms, including cooperating partnerships, complementary partnerships and coordinating partnerships.

Aside from more formal contractual arrangements, good relationships are key to successful partnerships. Good practices in the partnership process include:[6]

- Recognizing that participation will not happen on its own and planning for the involvement of key stakeholders as early as possible
- Consulting people at the community level about who will best represent them in the planning process

Partnership at Work: NGOs and Cambodian Government[7]

Cambodia's Home Care Program is a partnership between the government and the country's HIV/AIDS Coordinating Committee, which groups together Cambodia's NGOs involved in HIV.

Home Care Teams provide palliative care, counseling, education and welfare support to the patient and family members. They foster contacts within the community, pagodas, hospitals and other institutions to help support their activities, thus creating a Home Care Network of partnerships.

The results have been promising and community response has been very positive:

- PLHIV receiving home care visits report that they feel better able to look after themselves. By focusing on better nutrition and early treatment of infections, they say they enjoy both better health and a more positive outlook.
- Family members report a better understanding of HIV and greater confidence in caring for patients; they also say the program has saved them time and money.
- Community leaders report reduced discrimination, fear and anger and an increased knowledge and support for PLHIV.

Integrating School Feeding and HIV Programming[8]

In 2003, as part of their global strategic partnership, WFP and World Vision (WV) acquired a USAID grant specifically supporting joint programming to benefit orphans and other children affected by HIV, and their families and/or caregivers. Based on an initial short list of 12 countries, WFP and WV jointly selected five countries (Burundi, Mauritania, Rwanda, Sierra Leone and Uganda) to participate in the pilot, in which WFP provided food assistance linked with complementary activities by WV to mitigate the impact of HIV.

The pilot partnership was directed by a joint Partnership Coordination Team led by two partnership coordinators based at WV in Johannesburg and WFP in Rome. The objectives of the pilot project were to:

- Develop a partnership of equals
- Build on comparative advantages
- Focus on complementary activities
- Apply lessons learned from the pilot project
- Provide feedback to improve strategic partnerships

- Understanding and clearly outlining each partner organization's policies on participation—particularly the participation of women and PLHIV—to other partners
- Recognizing that identifying relevant stakeholders is an ongoing process
- Working jointly to arrive at operational strategies
- Being realistic about each partner's strengths and weaknesses and recognizing that capacity strengthening may be required

Capacity Development of Partners

Understanding one another's strengths, weaknesses and capacity limitations is integral to any partnership. Joint planning among various partners should consider members' strengths and weaknesses and make this part of the baseline information used to design the program. Conducting a capacity assessment of partners will help to determine what type of training and capacity building will be required to implement program plans.

There are a variety of tools that can facilitate this process in a participatory manner, including WFP's Capacity Analysis Match, a highly interactive tool than enables partners to assess their capacities and resources, learn from and/or train one another, and determine when outside help is required (see Annex 1).

There are also other tools, such as PACT's organizational capacity assessment tools at www.pactworld.org/services/oca/index_oca.htm, that are easily adapted to various settings and contexts.

In a high HIV prevalence context, adequate staff support and training for NGO and partner staff are also critical to providing effective HIV programs to communities. Workplace policies and staff training on HIV-related issues are discussed in **Chapter 9: Operational Modalities**, Key Concept 9.6.

7.5 Key Concept

Intersectoral Referral Mechanisms

Multisector and multi-actor linkages, along with well-functioning referral mechanisms, are critical to optimizing a continuum of care for PLHIV and affected households. Connecting various service-delivery channels can create an integrated, comprehensive support system for beneficiaries. For example, if a doctor sees that a TB patient needs nutrition assessment, counseling and/or food rations to support recovery, the doctor can refer the patient to a facility that provides those resources. Conversely, a food security program could refer its clients for clinical assessment and treatment.

Comprehensive Referral Systems

A comprehensive referral support system should link PLHIV, caregivers, family members, communities and aid organizations into an integrated referral network. Referral networks should include organizations in a certain location that can address health needs, support food and nutrition requirements, assist with livelihood and social protection needs, and provide microfinance training and support, education services, and a variety of other services. In an HIV context, some of these will include:

Comprehensive mapping of service delivery agencies may be a necessary first step to enhancing multisectoral referral mechanisms.

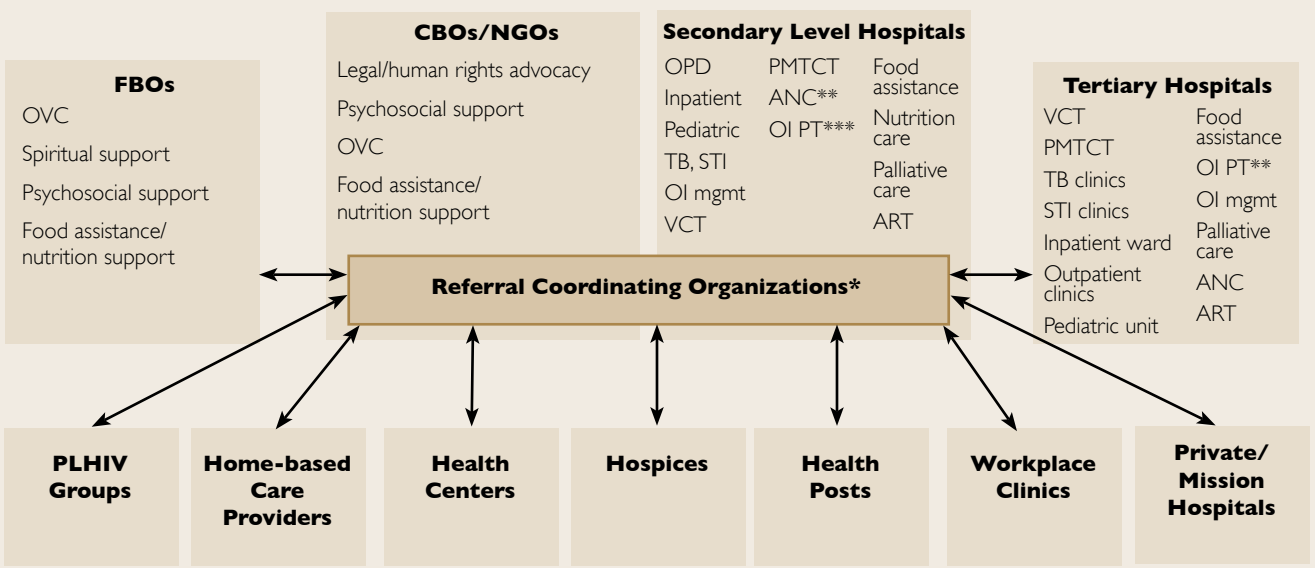
- VCT facilities, which often serve as a point of referral to health, physical, psychological and spiritual support programs
- ARV treatment programs
- TB treatment programs
- PMTCT programs
- HBC programs
- Youth associations and clubs, women's groups, FBOs
- Traditional healers and leaders
- OVC programs
- Food assistance programs

Ideally, a health facility or CBO would serve as the focal point and coordinate the services, as shown in Figure 1, adapted from Family Health International's (FHI's) Referral Network for Prevention, Treatment, Clinical Care and Support model.

FHI also has published a guide to creating referral networks, "Establishing Referral Networks for Comprehensive HIV Care in Low-Resource Settings" [9] and a companion toolkit. [10] These can be downloaded from FHI's website at www.fhi.org/en/index.htm.

Because of HIV's impact on pregnant women and their babies, strong referral systems should, at the very minimum, be in place to ensure that any HIV positive women seen at antenatal clinics are enrolled in an HIV clinic. PMTCT counselors should encourage family members to be screened for HIV and refer them when appropriate. Likewise, HIV clinic clients who become pregnant should be referred to the PMTCT programs. In these cases, programs should try to speed the process by sharing relevant medical records and follow up with referred patients who do not show up at either site within a reasonable period.

Figure 1: Referral Network for Prevention, Treatment, Clinical Care and Support



* Coordinating organization can be a health facility or CBO/NGO
** ANC=antenatal care
*** PT= prophylactic treatment

Family Health International (FHI). ***Tools for Establishing Referral Networks for Comprehensive HIV Care in Low-Resourcing Settings***, Arlington, VA: FHI, 2005

Primary Challenges to Developing Intersectoral Referral Mechanisms

While linkages between sectors, departments and agencies are usually desired by all parties, they are difficult to maintain because of time pressures, workload, inadequate resources and competing agendas. There are several other well-documented challenges to developing effective intersectoral referral mechanisms for food assistance in an HIV context.

Overlap of benefits. One primary challenge is that households may receive food assistance from multiple sources if they qualify under various categories, including OVC-targeted aid or as members of PLHIV groups. While local and international NGOs have resolved and managed overlap in some areas, others report significant overlapping of food benefits because of referral mechanisms that are not well-coordinated. Although field-level

Rural Health Motivators Play Key Role in Referral Systems

Rural health motivators (RHMs) support rural communities in high prevalence areas in southern and eastern Africa by assisting with local health matters and promoting healthy practices. RHMs, typically women selected by traditional leaders and community members, play a primary role in identifying the chronically ill and referring people to health centers for testing and treatment.[11]

verification should ensure that each household receives an appropriate level of assistance, limited staff capacity as well as poor coordination and follow-up hampers these efforts.[12]

Coverage of ART programs. Another challenge for targeting and referral is the typically urban bias of ART programs, whereas food assistance programming is more commonly focused on rural, food-insecure populations (see **Chapter 1: Conceptual Framework** for more on urban versus rural environments). Similar obstacles are evident when referral mechanisms are triggered by eligibility for ART regimens. Since targets for ART are typically able to serve only a fraction of those in need, there will be food-insecure people who are medically eligible but unable to receive assistance.[13]

A referral system that functions properly brings health, social and economic empowerment programs around the same table—an essential prerequisite to creating a continuum of care.

Confidentiality. Maintaining confidentiality in referrals between the health and social sector is a key challenge. A patient must be able to rely on the confidentiality of any health-related information, including HIV status, when a case is referred to a service provider. One option for food programming may be to use mechanisms that rely on self-identification and cross-reference these with permission against clinic records.

7.6 Key Concept
Scaling Up Programming

Bringing successful pilot or small-scale interventions to a larger number of people is a common challenge. Hundreds, perhaps thousands, of community-driven interventions serving one or a handful of communities exceed their expectations and inspire community members and other stakeholders to sustain them for many years.

Despite the success of many small-scale initiatives, it is impossible to achieve national or international goals for food security and HIV without effective large-scale action.[14] The many lessons learned and best practices in successful small-scale interventions have not been translated into bigger projects or wider coverage.[15] Unfortunately, when programmers try to expand or replicate the interventions, they often find that the success stemmed from a level of attention and inputs that are not feasible for serving greater numbers in new target areas. For these and other reasons, attempts to significantly scale up projects often falter.

Still, several small-scale interventions have been brought to scale successfully. This Key Concept reviews the lessons learned from some of these experiences.

Lessons on Bringing Community-Driven Development to Scale[16]

The International Food Policy Research Institute (IFPRI) reviewed five community-driven development (CDD) projects in Zambia, Malawi, Kyrgyz Republic, India and Nepal, examining conditions for a successful scale-up as well as limiting factors. Two key conclusions were:

- Capacity is a pivotal factor. Capacity goes beyond resources and includes motivation, commitment and appropriate incentives at all levels. An upfront and ongoing investment in capacity, with particular attention to facilitators and local leaders, is vital.
- "Learning by doing," as opposed to mere replication, should be fostered at all levels, with time horizons adjusted accordingly. A "learning by doing" culture values adaptation, flexibility, and openness to change. One World Bank review concluded that because the success of CDD is linked to local cultural and social systems, it is best done not with a wholesale application of best practices from projects that were successful in other contexts, but by careful learning by doing.

The IFPRI study encourages CDD donors and supporters to think of the process beyond the project and transformation or transition, instead of exit, once the project has ended.

Ultimately, the study found, bringing CDD to scale is not about projects per se, but processes and principles that must become anchored in national policy frameworks and embedded within the country's social, cultural and institutional fabric.

Key Considerations for Scaling Up

Below are some key lessons gleaned from a review of eight HIV initiatives on three continents. While the contexts varied dramatically, the lessons in scaling up were remarkably similar: [17]

Building bridges. While some successful partnerships evolve naturally without formal planning, contracts or Memoranda of Understanding (MOUs), these arrangements depend heavily on the interpersonal skills of staff and mutual goodwill. Most effective scale-ups are the result of carefully designed cooperation between services. The partners have similar goals and objectives in HIV responses or recognize the potential to capitalize on synergies and complementary expertise between HIV-related activities and those in different fields. Partnerships with government, GIPA and community involvement are all critical to scaling up activities.

Decentralization. National HIV responses cannot reach the necessary scale, maintain quality or provide flexibility by acting solely through centrally operated programs. A decentralized, participatory approach that involves all sectors is the only way for programs to scale up and increase coverage, particularly to those who are hard to reach.

Building management capacity. In many developing countries, HIV projects are held back by administrative challenges. Some are the legacy of colonial times, and some are of more recent origin. But most are not peculiar to HIV and are encountered in all aspects of public administration and governance. In general, there is a need to:

- Build institutional capacity, including training managers and strengthening administrative infrastructure to manage given projects
- Establish or update administrative procedures to promote initiative and improve effectiveness

TASO Shares Experience/Builds Capacity[18]

Some successful programs choose not to scale up. One example is The AIDS Support Organization (TASO) of Uganda, which is arguably one of Africa's most successful HIV NGOs and has served as a model for others. In 1995, TASO was operating in eight of Uganda's 49 health districts and was often tempted to expand to respond to the obvious need in other districts. TASO decided to limit its own growth because of fears of overextending itself and, instead, decided to help other NGOs who were attempting to do home care, providing the benefit of its experience to these newer organizations.

- Ensure transparency to prevent inefficiency and corruption from depleting scarce resources
- Encourage follow-up by building monitoring and evaluation into planning cycles

Scaling down before scaling up. Scaling down before scaling up is integral to reaching a larger beneficiary audience. To foster the expansion of a successful small-scale operation, it is often necessary to transfer management responsibility to the community, thus reducing the international development organization's control and involvement.

A review of the Scaling Up HIV Interventions Through Expanded Partnerships (STEPs) program in Malawi found several other key factors for facilitating a scale-up: [19]

- An enabling policy environment and a commitment by the government to a multisectoral solution to the pandemic
- Demand-driven processes using communities as catalysts for change
- Flexibility and an ability to adapt to new information and change
- Documentation and management information systems that collect and disseminate better practices to facilitate learning

7.7 Key Concept

Sustainability and Exit Strategies

Ensuring sustainability in an HIV context presents additional challenges to food assistance programs, especially where poverty, food insecurity and HIV prevalence are closely related.

Sustainable development programs support activities and behavior changes that will become permanent and self-sustaining, so progress toward overall development goals will continue after program support is withdrawn.

Sustainability is built on participatory and inclusive programs and requires an individual, community, local organization or government to be fully equipped to carry out the actions required to maintain or sustain achievements. This guide presents approaches—from community participation and partnerships to holistic and complementary programming that

integrates HIV services into food security programs—intended to help program managers meet these challenges to sutainability.

An integral part of ensuring sustainability is a program exit strategy, which should be built into a program's design from the beginning, monitored throughout implementation and, ideally, reviewed for effectiveness once the program is completed.

Developing appropriate exit strategies may also be more challenging for food assistance programs than for other programs and is likely to be even further complicated in a context of high HIV prevalence. The planning matrix in Figure 2 on page 154 provides guidance on designing an exit strategy in an HIV context. Some of the more basic concepts and terminology related to exit strategies are provided below:[20, 21, 22]

What Is a Program Exit Strategy?

A program exit strategy describes how the program intends to withdraw its resources while protecting the program's achievements and ensuring continued progress toward its goals. An exit strategy could be accomplished through staggered graduation from specific project areas, simultaneous withdrawal from the entire program area, or transitioning to associated programming in selected areas.

Why Are Exit Strategies Important?

Exit strategies, when planned with partners in advance of close-out, ensure better program outcomes and encourage commitment to program sustainability. In addition, good exit strategies can help resolve tension that may arise between a program's need to withdraw assistance and its commitment to achieve its outcomes.

Exit strategies also can help define a sponsor's role to host countries and local partners as being time limited, reducing the potential for misunderstandings and future dependency. In addition, they are critical to food assistance programming as they inform a program's plan for sustainability or planning for its next phase.

Graduation Strategy Versus Exit Strategy

While an exit strategy involves the withdrawal of a program from the entire area, a graduation strategy refers to a program's withdrawal from specific communities or a project site.

In an HIV context, a graduation strategy can also refer to a plan for how a beneficiary will be discharged from food assistance while ensuring that achievement of the program objectives regarding that beneficiary is not jeopardized and that further progress will be made.

Similar to an exit strategy, the goal of the graduation strategy is to ensure sustainability of impacts. When the intervention involves food assistance, beneficiaries can be graduated to other food security interventions to ensure that their food security and livelihood status continues to improve.

What Is a Program Transition?

A program transition is defined as the change from one type of assistance program to another. It may mean changing a program's emphasis from one type of food assistance to another (e.g., from general food distribution to more targeted assistance to vulnerable groups such as the chronically ill or OVC), and usually indicates the scaling down of resources. A program transition could also refer to changing from a food assistance program to another type of programming (e.g., non-food). A key question to be addressed in this process is whether to continue food assistance. If so, how should food assistance be continued and from whom would the resources come? If not, then what other activities should continue?

Three Approaches to Exit Strategies[23, 24]

1. Phasing down. This is a gradual reduction of program activities, using local organizations to sustain program benefits while the original sponsor, implementing agency or donor deploys fewer resources. Phasing down is often a preliminary stage to phasing out and/or phasing over.

2. Phasing out. This refers to ending a program without turning it over to another institution for continued implementation. Ideally, a program is phased out after permanent or self-sustaining changes are achieved, eliminating the need for additional external inputs. In a high HIV prevalence context, reaching a level of self-sufficiency through behavior change and asset creation activities (such as crop diversification and nutrition education) requires a long-term investment and is unlikely to be realized entirely during the term of a given project.

Donor support and funding cycles may impose artificial timelines on program phase-out. For instance, where harvest cycles may be an obvious choice for timing a program phase-out, the donor's fiscal year and other pre-determined timing requirements for grant closeout may not accommodate this.

An exit strategy is successful if:

- The program impact has been sustained, expanded or improved after the program ends
- The relevant activities are continued in the same or modified format
- Systems developed continue to function effectively

3. Phasing over. The third approach is phasing over, in which a sponsor transfers program activities to local institutions or communities. During program design and implementation, emphasis is placed on institutional capacity building so program services can continue through local organizations.

Of the three approaches mentioned above, phasing over is often the most feasible and effective exit strategy available. For food assistance agencies intending to pass significant responsibility for program management to local organizations, these questions should be carefully considered during the design phase:[25]

- How strong is the community's sense of ownership/commitment to continue activities?
- To what extent does the community value program activities? What is the level of demand for the phased-over services?
- Do community members, groups and service providers have the knowledge and skills to implement the program activities?
- Do the local organizations implementing the phased-over activities have sufficient institutional and human resource capacity?

Lesotho FFA Builds In Phase-Out With a Fixed Timeframe[26]

The C-SAFE Lesotho nine-month modular FFA program was designed with sustainability and program exit in mind. Implemented between 2002 and 2006, the program targeted able-bodied beneficiaries from food-insecure households for food assistance, offering a ration as an incentive for participating in a hands-on gardening curriculum with household-level asset creation. When households completed the curriculum, each had a functioning garden as well as some level of self-reliance.

- Are the organizations responsible for implementing phased-over programs resilient to shocks and changes in the political and social environment?
- Is there a viable plan to generate the consumable supplies (such as food or agricultural inputs) that are required to implement activities?

Exit Strategies In the Context of HIV

When developing exit strategies for food assistance programs in the context of HIV, it is important to assess and monitor how much the disease will affect community organizations' capacity to maintain adequate levels of care for affected households and individuals. Several factors must be considered to accurately assess the current capacity of service organizations, as well as predict their future ability to provide nutrition and other support to HIV-affected community members.[27] The characteristics of HIV-affected communities likely to have the most immediate influence on exit strategies include:

- Large and often increasing numbers of long-term chronically ill members, both adults and children
- Higher numbers of households headed by orphans, the elderly or single parents
- Decrease in services available in communities (e.g., government extension services)
- Increases in poverty and chronic malnutrition
- Increased food insecurity, particularly regarding diet quality and diversity
- Among PLHIV, increased nutritional requirements and increased importance of meeting RDAs for both macronutrients and micronutrients
- Increased need for foods that are nutrient-dense, easy and quick to prepare, and portable for people who need to eat small frequent meals and must carry the food to garden or work
- Increased incidence of acute malnutrition in children and adults
- Decreased transfer of knowledge and skills from adults to children
- Diminished household labor supply, at least temporarily or intermittently, resulting in less household income and food production
- More frequent conflict over land/asset ownership and inheritance when adults die without sorting out inheritance issues
- Change in the types of beneficiaries typically targeted for livelihood and asset creation activities when heads of household are dead or incapacitated

- Changing needs of PLHIV and those affected over time, contributing to a constant steam of new beneficiaries whose programming and service needs also change over time
- High staff turnover within NGO, CBO and government programs and resulting need to repeat training and capacity building efforts

Each factor reflects HIV's dynamic and progressive nature and its influence on food security within affected communities. Accordingly, developing exit strategies in areas highly affected by HIV involves a more concerted approach to assessment, planning and monitoring. One way of doing so involves establishing benchmarks to gauge the community's resilience with respect to food insecurity and HIV, including its capacity to care for potentially growing numbers of chronically ill and destitute individuals.[28] Benchmarks for gauging a community's preparedness to accept a phased-over food assistance program might include:

- Number of local organizations trained in all aspects of food assistance programming with adequate staff capacity and a food pipeline in place
- Sufficient community programs, such as irrigated gardens, to provide for the needs of food-insecure chronically ill or destitute households
- Sufficient number of food-secure, able-bodied individuals and households with sufficient resources and commitment to "adopt" chronically ill or destitute households
- Evidence that the intervention will be sustained over time
- Local organizations' ability to access external resources through proposal development, targeting and accountability capacities

Planning for exit strategies may also be hampered by a lack of economic opportunities and longer-term livelihood options for communities as they transition from food assistance.

Exiting from areas with a high prevalence of HIV may take more time and involve a longer phase-down or phase-over or additional funding to continue the program's unsustainable components. Given that little is known about HIV's long-term effects on livelihoods, it may not be possible to sustain program outcomes after an exit, especially in situations where phase-over or phase-out is premature or shocks occur.

TASO's Economic Empowerment Framework

TASO in Uganda addressed a lack of economic opportunities and livelihood options by developing an Economic Empowerment Framework to guide the interventions of partner organizations. It is aimed at helping a range of clients transition from short-term food interventions to longer-term livelihood support.

The framework includes the provision of food and care for the most acutely affected, "jumpstart" programs providing training and resources for livelihood recovery, and financial services for PLHIV groups geared toward livelihood recovery and expanding income-generating activities.

Figure 2: Planning Matrix for Exit Strategies in the Context of HIV

Questions:

1) What is your program's objective?

2) What parts of your program and which of its outcomes do you want to sustain?

Component	Key Questions	Guiding Principles	Challenges
1. Plan for exit from the earliest stages of program design	How will we "phase down" our program? Will we "phase out" activities or "phase over" to a local actor? What is the appropriate time line? How will we know we are on track for phase-out? What indicators or benchmarks will we use? How will we monitor them? What are the specific action steps to reach the benchmarks?	1. Flexibility: Consider the HIV timeline, i.e. the needs of HIV-affected and infected beneficiaries are not static 2. Ongoing program review and revision 3. Transparency: Especially regarding program limitations and funding cycle 4. Participation: Include HIV service organizations, PLHIV, Ministries of Health (MOHs), Community Development or Social Welfare, HIV-affected households	Balancing firm commitments with flexibility as conditions change; sometimes planning is necessary although future funding is uncertain Allowing adequate time to develop capacity, while working within the program funding cycle Responding to changing needs of HIV-affected and infected individuals and communities
2. Develop partnerships and local linkages	With what types of organizations should we partner? What will our partners bring to the partnership? What can we offer? How will the partnership prepare for exit? How can the partnership help facilitate a successful exit?	1. Diversity: Other program inputs may be needed as well as food assistance 2. Complementarity: Consider all possible partners, build in coordination and referral as it is critical when serving PLHIV and HIV-affected households 3. Clear and common goals	Aligning the needs and objectives of diverse stakeholders Supporting local partners without building dependency Increased numbers of "role players" in areas of high HIV prevalence; more time needed to identify, select and build partnerships
3. Build local organizational and human capacity	What capacities are needed? What capacities already exist? What indicators will we use to monitor progress in building these capacities?	1. Build on existing capacity whenever possible 2. Sponsoring organizations and partners model appropriate organizational and individual behaviors given the HIV context 3. Create new environments that support new behaviors and skills 4. Monitor progress	Designing a monitoring system to track capacity building Providing appropriate, sustainable incentives Retaining experienced staff in program areas with high HIV prevalence and/or job mobility

Component	Key Questions	Guiding Principles	Challenges
4. Mobilize local and external resources as an exit strategy	What inputs will we require to maintain services? Who can provide these inputs? To what extent are they available locally? Externally? Which benefits of the program can be sustained without continued inputs? To what extent can the benefits be sustained without ongoing inputs?	1. Continue to progress toward sustainability, e.g. support the production of local fortified commodities 2. Generate and procure resources locally where possible 3. Bring external resources increasingly under local control 4. Advocate for long term needs of HIV-infected and affected communities and indivuals	Difficulty in finding adequate or available local resources Sources of other funding may not buy-in to all of the original program's objectives Resisting the tendency to cover a lack of sustainability by simply finding a new donor to fund inputs Sustaining program impacts among HIV-infected and affected households
5. Stagger phase-out of various activities	What are the key elements of the program? Which elements are dependent on others? What are the graduation and exit plan and timeline for the program components? How will it be implemented? How will it be monitored?	1. Flexibility: the logical sequence for staggering phase out of various activities may change once activities have been implemented	Sufficient time in program cycle to start seeing the impact of activities other than direct food distribution in order to effectively transition to them when food distribution is ended Increased nutritional needs of PLHIV Difficulty identifying program activities other than direct distribution that HIV-affected households can transition to in a staggered phase-out
6. Allow roles and relationships to evolve and continue after exit	What types of ongoing support would be most useful (e.g. advice, mentoring, technical assistance)? How will such ongoing support be funded when the project finishes?	1. Prevent slippage of program's results by re-entering if necessary	Availability of funding for ongoing support Availability of program staff who can focus sufficient time and energy on ongoing support in an area where a full program does not exist

Source: Gardner, A., Greenblott, K., and Joubert, E. ***What We Know About Exit Strategies: Practical Guidance for Developing Exit Strategies in the Field.*** Johannesburg, South Africa: C-SAFE Regional Learning Spaces Initiative, 2005.

Annex 1: WFP Capacity Analysis Match

Description: This is a highly interactive tool, which enables stakeholders to determine whether they have the capacities, skills, resources, knowledge and/or experience amongst them. These stakeholder capacities are relative to the activities within each stage of the programme, and can be done in the preparation stage, or before entering each subsequent stage.

Possible applications: Assess the potential or capacity of partners to learn from each other, train each other and determine when outside help is required.

What you need: Flipchart paper, pens.

How to use:

- Explain the task that has to be accomplished.
- Brainstorm the skills, experience and resources that are needed to accomplish the task.
- Place each one of these skills in the Match grid on the flipchart, as shown in the example.
- Have partners put their names down in the places where they have the necessary resources, skills or experience.
- Discuss the results, with special emphasis on the areas where capacity is not fully met by the partners.

Examples of Food Needs Assessment

Program Stage Idea

	M	A	T	C	H
1	Do you have access to, and the ability to interpret, national-level nutritional information?	Do you have an understanding of micro-economics?	Do you have adequate staff skilled in participatory techniques?	Do you have logistical support for the field (transportation, field offices, etc.)?	Do you have financial resources?
2	Do you have a good understanding of the cultural and political climate at the national and local levels?	Do you have experience and connections to the poor and marginalized populations?	Do you have a good understanding of food insecurity coping practices at the community and household levels?	Do you have staff who know the local languages?	Do you have a good understanding of food strategies?

Program Stage Design

	M	A	T	C	H
1	Do you have staff trained in PRA techniques?	Do you have a broadbased (national and local) knowledge of natural resources (forestry, wildlife, parks, environment)?	Do you have broadbased (National and local) knowledge of health issues?	Do you have logistical support for the field (transportation, field offices, etc.)?	Do you have broadbased (national and local) knowledge of educational issues?
2	Do you have staff who know the local languages?	Do you have broadbased knowledge of infrastructures (roads, bridges, school buildings, clinics, etc.)?	Do you have experience in conducting community-based needs assessments?	Do you have experience in conducting participatory baselines?	Do you have a good understanding of food strategies?

Source: World Food Programme (WFP). ***Participatory Techniques and Tools: A WFP Guide.*** Rome: WFP, 2001.

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