Chapter 4: Adaptive and Integrated Programming

Program Design Steps

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Program Design Steps

Key Concepts

4.1 Program Characteristics

4.2 Food Security Program Design Considerations

4.3 HIV Program Design Considerations

4.4 Accounting for the Changing Needs of HIV-Affected Individuals and Households

4.5 Challenges and Considerations in Developing Integrated Programs

In This Chapter

This chapter discusses design considerations for the two types of programs that are the focus of this guide:

- Food aid-supported food security programs operating in areas that also have a high prevalence of HIV
- HIV programs operating in areas that have a high prevalence of food insecurity or in areas where overall food insecurity prevalence is not high, but there are a substantial number of food-insecure households participating in the HIV program activities

The chapter discusses how the core activities of each type of program should be adapted to account for the contexts in which they operate and presents design considerations for integrated programs that address both food insecurity and HIV needs in an integrated, holistic and comprehensive way.

More specifically, the chapter looks at the need to adapt food security programs in a high HIV prevalence context to explicitly address the constraints PLHIV and HIV-affected households face that may make it difficult for them to fully benefit from the food security program activities. The chapter also examines how HIV prevention, treatment, and care and support programs can utilize food and food-related activities to better achieve their HIV-related outcomes. Subsequent chapters provide greater detail on sector-specific interventions.

Where both food insecurity and HIV prevalence are high, the chapter discusses the primary challenges and the key considerations for integrating food security and HIV activities so that both food security and HIV prevention, treatment, and care and support outcomes are promoted. It also discusses the challenges to designing comprehensive HIV programs that address the needs of food-insecure HIV-affected households, where a lower overall prevalence of food insecurity may make it less likely that food assistance programs will be available.

4.1 Key Concept

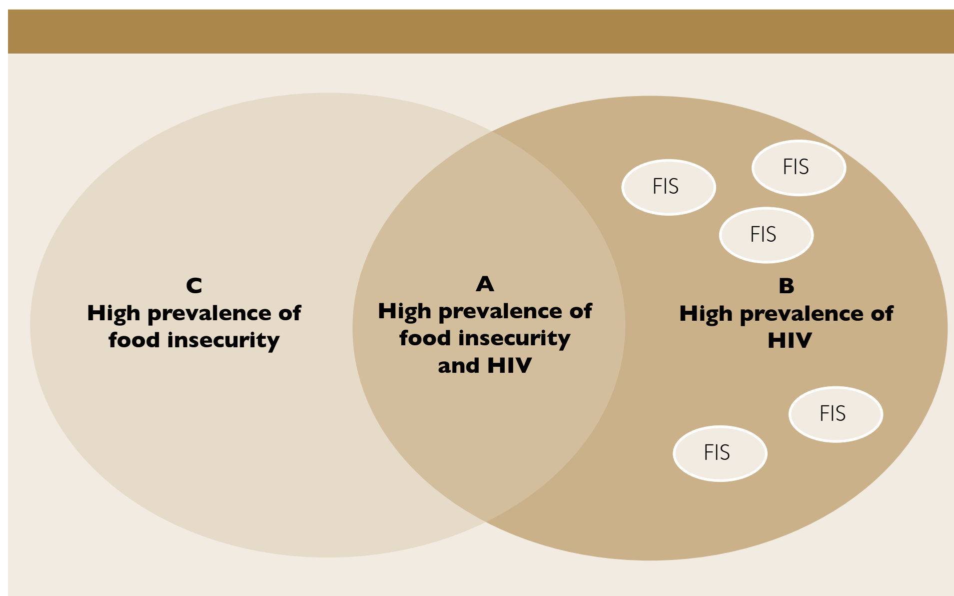
Program Characteristics

The information in this and subsequent chapters is relevant to two types of programs.

- Food aid-supported food security programs operating in an area that also has a high prevalence of HIV (area A in Figure 1). The program's core objective is to reduce food insecurity through improved availability, access and/or utilization of food and reduced vulnerability. The target population is the food-insecure.
- HIV programs operating in an area that also has a high prevalence of food insecurity (area A) or where food insecurity prevalence on average is not high, but there are many food-insecure households or individuals using HIV services (area B). The program's core objectives relate to prevention, treatment and/or care and support. The target populations are PLHIV, OVC and HIV-affected households.

The optimal approach for both program types involves using food assistance to support comprehensive and holistic programming so that objectives for both food security and HIV prevention, treatment, and care and support are achieved. Table 1 summarizes some of the program types' key characteristics.

Figure 1: Program Areas for Food Security and HIV Programming[A]



A While food security and HIV programs can have impact in areas in which high levels of food insecurity but low prevalence of HIV coincide (area **C** in Figure 1), such programs are not the focus of this guide. Still, the programming principles and approaches in this guide will also be useful in contexts where partnership and coordination among food security and HIV programmers are possible.

Table 1: Characteristics of Key Programs

	Core Objective(s)	Program Area (see Figure 1)	Target Population	Targeting Challenge	Design Modifications to Achieve Core Objective	Additional Programs to be Integrated/Linked
Food Security Program	Reduction of food insecurity	A	Food-insecure	Inclusive vulnerability criteria to ensure HIV-affected are included	Address constraints to participation of PLHIV and affected households	HIV interventions specifically targeting needs of PLHIV and affected households
HIV Program	Prevention, treatment and care and support	A or B	PLHIV, OVC and affected households	Identifying food-insecure individuals or households	Incorporate food and food-related interventions	Food security interventions to sustainably address broader food security needs of food-insecure PLHIV, OVC and affected households

4.2 Key Concept

Food Security Program Design Considerations

Achieving the food security objectives (improved availability, access and/or utilization, reduced risk and vulnerability) of food security programs in high HIV contexts requires two types of programmatic modifications.

- Food security activities must be adapted and modified to meet the special needs of communities experiencing high HIV prevalence. Without appropriate adaptations, some of the food-insecure will not be reached by the food security activities, and the program will be less likely to achieve its food security objectives.
- Programs should ensure that the HIV-specific prevention, treatment and care and support needs of the HIV-affected are addressed by incorporating HIV-related activities into the food security program and linking with HIV programs through partnerships and referral systems.

Adapting Food Security Program Activities

As discussed in **Chapter 1: Conceptual Framework**, HIV impacts households and individuals in ways that may prevent them from fully benefiting from food security activities in their communities. Food security programs in these communities should be designed to facilitate the inclusion of food-insecure households in the community.

This can be done by applying an "HIV lens" which can help program managers and field staff reassess food security program activities in light of HIV's specific characteristics and

the factors contributing to its spread. Used appropriately, the lens can help decision makers in all sectors reflect on how planned activities and ongoing interventions can be more inclusive of PLHIV and affected households, and how they might affect susceptibility to HIV and resiliency to its impacts on food and livelihood security.

Viewing current or planned food security programs through an HIV lens ***does not*** mean that activities are redirected toward HIV-infected individuals or affected households. Rather, it provides a way for programs to retain their primary goals and objectives of decreasing food insecurity among vulnerable populations while routinely considering the specific needs of HIV-affected households and communities during project planning and implementation. [1,2]

Questions to consider in applying an HIV lens include:

- What are HIV's impacts in the targeted communities?
- What constraints do HIV-affected households face that might limit their ability to participate? How might the project be modified to address these constraints and facilitate their participation?
- Can the activity itself (e.g., repairing roads to markets) increase the spread of HIV or increase risky behavior? How can this be mitigated?
- How will the project affect individual and household coping strategies in the context of HIV?
- How could targeting mechanisms and referral systems be adapted to ensure that PLHIV and affected households benefit from food security programs?
- Can current or planned food security projects contribute to or reduce stigma among HIV-affected households?
- How could PLHIV and CBOs with direct experience in HIV programming contribute to improved food-security activities?

Applying an HIV Lens to a Food for Assets Activity

An HIV lens could be used to adapt a FFA project designed to rehabilitate feeder roads to markets. For example, the project might:

- Ensure the greater involvement of people with HIV and AIDS (GIPA) in decision-making at all stages.
- Consider whether increased mobility of people using the roads increases the risk of HIV transmission and take action to mitigate this with HIV prevention activities, e.g., in the marketplace, en route to market, on buses, at bus stops.
- Help HIV-affected households who are food-insecure but cannot participate in the FFA project due to constraints such as labor shortages caused by the disease. For example, the project could be situated closer to the homes of people who are also working as caregivers. Daycare services could be made available for workers, or food payments could be made to temporary home-based caregivers so that able-bodied workers could be away from home long enough to participate in the project. The project also could let these households "recruit" a non-vulnerable relative or a neighbor to participate on their behalf.

A CRS HIV/AIDS Analysis Tool with an expanded example of the application of an HIV lens to food for assets programming appears in Annex 1.

Addressing HIV-Specific Needs

If the prevention, treatment, and care and support needs of HIV-affected households and individuals are not addressed directly, it is unlikely that the program's food security objectives will be met because HIV is likely to further worsen the food insecurity situation if not addressed directly. This highlights the importance of integrating HIV services into the food security program through direct provision by the food security implementing agency and/or through links with HIV-service providers (see **Chapter 7: Implementation Strategies** for a discussion of partnerships and effective referral systems). Food security programmers may be able to develop an integrated food security program by ensuring synergy and coordination among different aspects of the country program. For example, an agency may have programs in agriculture, HIV, health and nutrition, and water and sanitation, funded by a range of donors. However, many food assistance agencies will not have programs in all areas important for integrated programming. In this case, it is especially important to emphasize strong coordination, partnerships, the development of referral systems and collaborative planning. In all cases, it is imperative that government ministries/ departments, communities and other local service providers play a key, and often lead, role in coordinating and integrating food security and HIV programs.

It is important to recognize that integration is a process that entails careful consideration of the core objectives of both food security and HIV programming.The objectives of integrated programs should be a natural extension of the situation analysis and vulnerability and needs assessment, and should incorporate relevant stakeholders' input on prioritization of food security and HIV activities.

4.3 Key Concept

HIV Program Design Considerations

In contrast to the programs described in Key Concept 4.2, Key Concept 4.3 addresses programs with the core objective of improving HIV prevention, treatment, and care and support outcomes. These HIV programs incorporate food and food-related activities to support those outcomes. Program managers should answer these key questions to determine whether adding food and food-related resources would help achieve the program's HIV objectives:

1. Is lack of food interfering with optimal treatment by inhibiting or preventing people from starting or adhering to treatment regimes? Would food improve use of services?
2. Is lack of food reducing the effectiveness of care and support by inhibiting people's regular access to care and support services or by worsening functioning and quality of life? Is poor nutritional status aggravating symptoms or making it harder to manage symptoms? Is food likely to address the underlying nutritional issues? Would food increase use of care and support services?
3. Are there real or opportunity costs of program participation that a food transfer would help offset?

While lack of food can be an obstacle to achieving HIV objectives, incorporating food and food-related activities is likely to be a temporary solution. The longer-term food and

Table 2: Uses of Food to Support HIV Program Objectives

Intervention	Prevention	Treatment	Care and Support
Supplementary Feeding	Food for food-insecure vulnerable groups to prevent/reduce high-risk behaviors or reliance on negative coping strategies Food for replacement feeding or weaning food where mother is HIV-positive	Food for high-risk groups only (e.g. pregnant/lactating women who are HIV-positive, HIV-exposed, non-breastfed children) Food for replacement feeding or weaning food where mother is HIV-positive Food to support nutritional management of symptoms of opportunistic infections (OI), often using chronic illness as a proxy Food for persons who are losing weight and/or do not respond to medication Food to improve ART and TB treatment efficacy and help manage drug side effects Food to prevent nutritional deterioration for HIV-affected families who live in food-insecure communities and meet other vulnerability criteria	Food for use in home-, clinic-, hospital-, hospice-, and community-based care programs as a part of palliative care Food for high-risk groups (e.g., pregnant/ lactating women who are HIV-positive , HIV-exposed non-breastfed children < 2 years or HIV-exposed children with growth faltering) Food to protect the nutritional status of OVC and surviving family members when livelihoods are compromised because of HIV-related sickness or death Food for households affected by HIV that also exhibit other vulnerabilities such as food insecurity and asset depletion
Therapeutic Feeding		Therapeutic feeding of moderately and severely malnourished HIV-positive children and adults Nutrition management of HIV-related OI, symptoms, and ART (where applicable)	Therapeutic feeding for moderately and severely malnourished HIV-positive adults and children Therapeutic feeding to treat moderate/ severe malnutrition for children orphaned by AIDS and other high-risk groups (for HIV-exposed non-breastfed children < 2 years or children with growth faltering) Nutrition management of HIV-related OI, symptoms and ART (where applicable) in home-, clinic- and community-based palliative care
Food as an Incentive	Food as an incentive for participation in PMTCT Food as incentive to participate in HIV awareness, prevention, nutrition education and behavior change communication (BCC) programs FFT to support diverse, more resilient livelihood strategies that reduce the need to resort to risky livelihood strategies	Food as an incentive for participation in PMTCT Food as incentive for use of and adherence to OI treatment programs Food as incentive to improve adherence to ART Food as incentive to improve use of and adherence to TB directly observed treatment, short-course (TB-DOTS) Food as an incentive to participate in positive living training	Food for education (FFE) FFA to promote livelihoods FFT of OVC Food to support food-insecure households caring for orphans Food as incentive to improve adherence to ART

livelihood security needs of food-insecure beneficiaries of HIV prevention, treatment, and care and support programs should be addressed by linking to and integrating with food security programs (see Table 2 for uses of food to support HIV program objectives).

Three examples of this type of integration are:

- Integrating growth monitoring and promotion (GMP) activities into PMTCT services for HIV-positive mothers and their infants or establishing referral systems between PMTCT services and GMP activities
- Linking agricultural extension services and training for farmers with provision of agricultural skills in OVC support services and arranging for farmers in the extension program to mentor OVC
- Establishing linkages and referral systems between care and support services for PLHIV and OVC and activities that improve long-term food access, such as vocational training, microenterprise and other income-generation activities

When HIV programs are implemented in areas of high food insecurity prevalence, identifying food security programs to partner with and/or to refer food-insecure HIV program beneficiaries to may be relatively straightforward. HIV programs in areas where average food insecurity prevalence is lower will face greater challenges in finding both sources of food to incorporate directly into HIV programs as well as food security programs to which to link their program beneficiaries. These and other primary challenges and key considerations in developing integrated programming are discussed later in this chapter.

4.4 Key Concept

Accounting for the Changing Needs of HIV-Affected Individuals and Households

The needs of PLHIV and HIV-affected households change with time and disease progression. The challenge in designing appropriate interventions in the dynamic context of HIV lies in:

- Identifying the most **appropriate intervention**, whether it be nutrition, livelihoods or other
- Targeting the **right individuals**, **households or communities**
- Providing it at the **right time** and for the **right duration**

Visualizing beneficiary needs and program activities across a "continuum of care" can assist in planning appropriate interventions in an integrative, holistic and comprehensive manner. The ultimate goal is to provide a seamless continuum of care for individuals, families and communities throughout their entire experience of HIV. Potential interventions for addressing individual and household needs along this continuum are presented in Figure 2.[3]

To effect lasting change, people infected with HIV but not yet symptomatic need more than information about good food choices. For example, many need assistance in developing their production or purchasing power. At this point, households that are still food-secure do not need food assistance. And, chronically food-insecure households do not need food

in isolation from other forms of assistance. Rather, both would most clearly benefit from a long-term food and livelihood security strategy that provides resilience against the dynamic nature of both macroeconomic conditions and climate.

There is a tendency to think of food assistance as a palliative/end-stage measure, but it is equally important to identify the opportunities where food assistance can help prevent HIV transmission. Support to PMTCT programs, for instance, can improve maternal/infant delivery outcomes and encourage safer breastfeeding for HIV-positive mothers. Encouraging exclusive breastfeeding followed by rapid weaning is crucial to reducing HIV transmission, and can be further supported by providing suitable weaning food for the baby for 12 months after breastfeeding ends. Keeping the baby satiated reduces the temptation to intermittently breastfeed. Keeping mothers well-nourished also delays the onset of illness and ultimately, orphanhood. FFT and FFA can be used to support diverse, more resilient livelihood strategies that reduce the need to resort to strategies that may increase the risk of spreading or being infected by HIV.

Figure 2. Continuum of Care for PLHIV and Affected Households

HIV-free	HIV+/Asymptomatic	Chronically Ill	Time of Death	Survivors
PREVENTION				
	POSITIVE LIVING ········►			
	◄········	**TREATMENT SUPPORT**	········►	
		IMPACT MITIGATION	········	········►
Skills development/FFT for diverse and resilient livelihoods Provision of infant weaning foods FFA activities	Nutrition education Income-generation activities Training and inputs for gardening FFA	Nutrition education Access to health services Targeted food assistance Safety nets	Legal assistance Safety nets	Skills development/FFT for diverse and resilient livelihoods Income generation activities FFA Targeted food assistance

Adapted from Greenaway, K., and Mullins, D. "The HIV/AIDS Timeline Tool: Experiences from CARE and C-Safe (Draft)," paper presented at the IFPRI Conference on HIV/AIDS and Food and Nutrition Security, Durban, South Africa, April 14-16, 2005.

The best HIV programming is holistic and multisectoral. In food-insecure and resource-poor environments, social safety nets for high-dependency-ratio households (e.g., those with several orphans and/or few productive adults) should include short-term food assistance and must be linked with longer-term agriculture and income-generation strategies at both the household and community levels. Assisting health sector efforts by combining the provision of short-term food assistance with clinical tuberculosis (TB) treatment generates a synergistic effect that far outperforms a single intervention.

Similarly, ART is also likely to be more effective when it is part of a holistic package. For food-insecure and malnourished clients, a suitable food ration should be provided during the first few months of ART to ease early side effects and increase compliance. In keeping with the continuum of care, a transition to an independent food security/good nutrition

strategy should be encouraged among PLHIV if and when health and strength return. As with all programming in an HIV context, appropriate HIV information and sensitization should be integrated into each intervention.

By visualizing changing needs over time, holistically planned, food-based interventions can be integrated with other kinds of interventions to help prevent HIV transmission, reduce morbidity, delay orphanhood, and prolong health and productivity. When HIV has progressed to the point where health is not likely to return, food can also be used to ease suffering.

Using the Continuum of Care in Comprehensive and Holistic Programming

In a Specific Location

The continuum of care provides a framework for mapping out and reviewing programs and services implemented by all agencies, organizations, groups or departments working in a single community or district. This can enable them to better coordinate interventions with regard to:

- Interaction/referral between complementary programs
- Reach and coverage of various interventions within a community or district
- Opportunities for partnership, collaboration and learning
- Gaps in services and responses that require strengthening

By an Entire Agency or Government Ministry

The continuum of care can be used to help:

- Develop a strategy based on assessment of strengths, weaknesses, opportunities and threats
- Identify national or geographical gaps or niches
- Plan or enhance programs' complementarity
- Support fundraising and advocacy
- Identify options for the most strategic interventions
- Answer these questions:

  How can food help fill those gaps and/or strengthen existing responses?

  What programs can the food program serve or support?

  What programs can help target the food to the most vulnerable?

  What partners can the food agency link with to ensure complementarity and provision of non-food resources such as agricultural inputs, training, IEC and BCC in HIV prevention, etc.?

4.5 Key Concept

Challenges and Considerations in Developing Integrated Programs

Primary Challenges to Successful Integration

Implementing agencies will already be quite familiar with the challenges inherent in food and livelihood security programming in Africa. Poverty, disease, hunger, malnutrition and gender inequities are only some of the longstanding constraints faced every day. However,

the design, implementation, monitoring and evaluation of integrated food security and HIV programming present a new list of challenges, including:[4]

Lack of coordination and collaboration. Governments, donors and NGOs lack the mechanisms and intent for coordination and collaboration across sectors such as agriculture, health, emergency, education and social protection. Similarly, there is limited opportunity or demand for interaction or cross-fertilization within NGO, government or donor organizational structures.

Inadequate understanding. Knowledge of how to design programming strategies to address the known intersections between HIV and food security is often insufficient. Programmers are too busy "doing" their work to analyze and document their work. Networking and learning specifically about programming are generally underresourced.

Compartmentalized funding mechanisms. Where HIV and food security programming are not inherently complementary, funding mechanisms tend to be compartmentalized. It may be necessary to raise resources from multiple sources to fund integrated programming in areas such as Area B in Figure 1 where FFP and PEPFAR resources may not be simultaneously available.

Difficulty attributing results. As programs become better integrated, attributing results to any single intervention or investment grows more difficult.

Different objectives, different targets. HIV and food security programs have different objectives, which may complement and reinforce each other in some contexts but not others. This makes smooth integration of program interventions difficult. HIV and food security programs also have different target populations, which can overlap some but not completely. This can pose challenges for ensuring appropriate targeting and coverage in integrated programs.

Short-term horizons. The short-term nature of interventions leads to limited support for consultation or local empowerment, a prerequisite for creating or sustaining integrated programming.

Integrative programming should build on the comparative advantage of a program's core business, whether it is advancing food security goals and objectives, prolonging the period of healthy life for PLHIV or minimizing the impacts of AIDS-related illness and death.

Urgent nature of work. The intensity and urgency of HIV or food security programs often preempts even the best intentions for integration. This may be the most important and difficult challenge.

Key Considerations for Designing Integrated Programs

Some key considerations that are applicable across sectors and are necessary to address the primary challenges include:[5]

Developing assessment-based strategies. To design an appropriate strategy, programmers should begin with an assessment, establish priorities based on the assessment and set objectives stemming from those priorities. In addition to the traditional components of a food security assessment, these assessments should examine the prevalence and incidence of HIV within a community, the underlying causes, the effects on household food security and livelihood strategies and vice versa, and the ability of households and the communities to cope with the evolving impacts. These factors will help determine what type of integration strategy should be pursued.

Understanding current and planned efforts. It is important to have a solid understanding of current and planned food security and HIV prevention, treatment, and care and support efforts in a particular country, both nationally and locally. Connecting with key players, including UN agencies, donors, researchers, NGOs, CBOs, FBOs and relevant government bodies, will help develop this knowledge and build a network that may be useful later.

Identifying complementarities and entry points. Identifying where interventions may complement each other and where one set of services may provide a good entry point for another set of services is critical to designing integrated programs. Some HIV and food security interventions are well-suited for integration, while others are not. Similarly, some types of services are natural entry points or platforms for other services (e.g., PMTCT services as an entry point for nutrition counseling and GMP).

Ensuring that food is the appropriate input. Before any integrated program strategy is implemented, assessment results should be carefully examined to determine whether food is a needed and appropriate input in the local context. Food-based programming may be unnecessary—or even harmful—where food security is already established. Excess food distribution can undermine local production, disrupt food markets and/or impair coping strategies. Generally, food is an appropriate input only if assessments show that food is needed and valued by recipients and that food will have the intended effect (e.g., improve the nutritional status of HIV-affected individuals, increase use of PMTCT services or increase adherence to TB drug regimens).

The decision to implement integrated program strategies should be based on an epidemiological analysis of HIV (e.g., HIV prevalence, incidence, stage of the epidemic), malnutrition and food insecurity within the affected population (both displaced and resident communities) as well as other factors related to the population's vulnerability. [6]

Involving communities and government at every stage. The process of identifying and designing strategies and interventions should involve the affected households, communities and government representatives at every stage. Increasingly, programmers are developing food security and HIV activities jointly with communities and relevant government agencies. A participatory process establishes a relationship between programmers and these partners and facilitates a sense of empowerment that builds confidence, initiative and self-reliance. An inclusive and participatory approach is particularly important when food is used to complement and support existing services.

Making women a priority. Because of women's increased vulnerability and susceptibility to HIV infection and the negative effects of stigma and discrimination, all food security strategies should aim to increase the resistance and resilience of women to HIV. Other vulnerable groups, such as the elderly and children, should also be prioritized.

Situating the community in the progression from HIV to AIDS. To design appropriate strategies and interventions, it is important to recognize where the community lies within the progression of the HIV epidemic. A community with a low incidence of HIV infection but a high concentration of risk factors might require a strategy that emphasizes prevention, such as introduction of HIV-related messages into the agricultural extension program, promotion of alternative risk-reducing livelihood strategies or community-based contingency planning. A community with a high incidence of infection, morbidity and mortality might best benefit from the formation of community work groups or new skills training for HIV-affected households.

Building integration into staff work plans. Integration takes planning and intentional allocation of staff time to build skills and knowledge around HIV and food-based programming. Food security staff may need to expand their knowledge and skills on issues related to HIV, while HIV specialists may have to learn more about food programming.

Preventing stigma, abuse and harm. Risks such as creating stigma, increasing potential for abuse, encouraging dependency and providing inappropriate or unsafe rations or work conditions should be assessed, prevented and/or mitigated. There should be no discrimination against workers based on real or perceived HIV status. Discrimination is not merely unjustified; it contributes to stigma and persecution of PLHIV. Management must establish a climate of trust, understanding and freedom from fear of discrimination. Workplace policies and HIV-related information and education programs for staff are essential to promoting this climate (see **Chapter 9: Operational Modalities**).

Using participatory communication strategies. Effective community-level interventions should incorporate participatory communication strategies, community engagement and action supported by appropriate services and policies. Communications strategies should not focus on the transmission of messages, but rather the linkage of local dialogue to action, supported by accurate information services (e.g., VCT, PMTCT, ART, HBC) and policies.[7]

Building long-term food and livelihood security. Integrated food security and HIV-related programs should emphasize the use of food toward long-term food and livelihood security of affected households with seeds, tools, microcredit and income-generating activities rather than continuous direct distribution of food.[8]

Commitment to Program Integration at All Levels

At the *Africa Forum 2006* in Lusaka—designed in part to help change the way HIV and food security programs are conceived, managed and funded—delegates pledged to strengthen collective efforts to develop integrated programming and to inform policy decisions that inhibit effective integration. A number of concepts were agreed upon at this event.[9]

Institutionalizing collaboration and coordination at all levels to:

- Provide leadership and develop accountability mechanisms for harmonizing funding and systems that support integrated programming
- Ensure that projects in the same location use consistent, stratified approaches to targeting with well-articulated transition, graduation, re-entry and exit strategies
- Coordinate M&E systems that help capture project-level outputs and synergistic effects
- Devise tools that allow for integrated work planning across several related projects

Enhancing networks and referral mechanisms as close to the ground as possible to:

- Support or form interagency and multidisciplinary working groups
- Engage the most appropriate community structures as the driver of community-based referrals
- Capitalize on geographical overlap

One forum delegate likened the process of integration to applying mortar and plaster to a cinder-block house. Individual bricks (projects) can be well designed and even expensive, but may have gaps between them that allow beneficiaries to "fall between the cracks." Mortar and plaster will fill the cracks and help the bricks fit tightly together.[10]

Annex 1: CRS HIV/AIDS Analysis Tool: Checklist for Adapting Food for Assets Programming to an HIV/AIDS Context

Adapting Food for Assets Programming to an HIV/AIDS Context	
Programming Steps	**Key Questions to Ask**
Project Identification and Planning	1. What are the impacts of HIV/AIDS in the communities in which you are planning to work? 2. What resources are available that could help you integrate HIV/AIDS into your geographical targeting? 3. How are you involving community-level and district-level organizations who have experience, knowledge, or resources with HIV/AIDS issues? 4. How are you intentionally involving PLHA and households affected by HIV/AIDS in the identification and planning of the project? 5. Are there any assets included in your project that specifically aim to mitigate the impact of HIV/AIDS? What types of assets could you include that would do this? 6. What effect will the project have on traditional and existing coping mechanisms and strategies in the context of HIV/AIDS?
Building Staff and Community Capacity	7. What can be done to enhance the capacity of implementing agency to engage with the community regarding the inclusion of PLHA and affected households as planners, participants, and managers in FFA projects? 8. What can be done to enhance the capacity of the community and its leadership to support the inclusion of PLHA and affected households as planners, participants, and managers in FFA projects?
Beneficiary Identification	9. Will PLHA and affected households derive benefits from the assets being created? How could you modify the project to ensure that benefits are shared with the PLHA and affected households?
Identification of FFA Participants	10. Which targeting mechanisms have you included that seek to intentionally include PLHA as participants in the project? 11. Which organizations, institutions, and referral mechanisms could be approached for assistance in targeting able-bodied HIV+ participants? 12. Are there households that qualify yet cannot participate in the project? What are the precise reasons for their inability to participate? 13. How can the project be modified to accommodate those who are unable to participate for reasons identified above? 14. How can your work norms be adapted to enhance participation of PLHA and affected households? Are there aspects of the work that are less labor intensive and can be reserved for participants requiring lighter duties?
Implementation	15. Are there ways you could organize forms of compensation (food and in-kind) that do not rely on traditional person/hours worked, so as not to discriminate against PLHA or affected households? 16. How could you adapt the food ration to be more useful and appropriate for the needs of participant individuals and households?
Sustainability	17. How can you explicitly include PLHA and affected households in maintenance of the asset? 18. How have you adapted your maintenance plan to enhance sustainability in the context of HIV/AIDS?
Monitoring and Evaluation	19. How can existing FFA monitoring and evaluation tools be adapted to capture information measuring the community's response to HIV/AIDS-related shocks? 20. Does any aspect of the project have the potential to influence stigma?
Project Outcomes	21. Does the asset itself have the potential to increase the spread of HIV (or increase risk-taking behavior)? What ways can this be mitigated? 22. Does the process of creating the asset have the potential to increase the spread of HIV (or increase risk-taking behavior)? What ways can this be mitigated? 23. Will any stages of the project put people's health at greater risk, thereby hastening the progressing from HIV to AIDS? Will it have the potential to help slow progression of HIV to AIDS?

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Endnotes

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