Chapter 5: Targeting

Program Design Steps

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Key Concepts

In This Chapter

This chapter provides guidance on the critical issue of targeting food assistance in the context of HIV. It is intended to complement information in **Chapter 1: Conceptual Framework** and **Chapter 3: Vulnerability Assessments** by helping food assistance agencies identify the most vulnerable areas, communities, households and individuals while minimizing exclusion or inclusion error.

The chapter begins by reviewing several factors that will influence selection of food assistance beneficiaries in food security and HIV programs. For instance, in the context of HIV, the decision whether food assistance is best targeted toward entire communities, vulnerable households within the community or especially needy individuals will be influenced not only by the availability of resources and the capacity of participating institutions, but also on community perceptions of vulnerability within a given context and the level of stigma associated with HIV.

The chapter then discusses approaches to targeting and specific tools, as well as how they can best be adapted in the context of HIV. For example, given the dynamic relationship between HIV and food security, it is often essential to use multiple vulnerability indicators to identify those that stand to benefit most from integrated programming. In addition, in the context of HIV, many food assistance programs have found that using proxy indicators of vulnerability, involving HBC networks and working to reduce stigma are vital to targeting food assistance.

Finally, this chapter discusses the establishment of common vulnerability frameworks, the standardization of beneficiary selection criteria, processes of field-level verification and program referral mechanisms, each of which are promising practices in targeting food assistance in the context of HIV.

5.1 Key Concept

Targeting Food Assistance in Areas of High HIV Prevalence

The objectives and the scarcity of food resources dictate that targeting criteria for food assistance should include food insecurity or social welfare indicators to ensure that the most vulnerable individuals are reached. To reduce inclusion and exclusion errors, tools need to be introduced to objectively distinguish between households and individuals eligible for food assistance and households and individuals for whom food assistance may not be the most appropriate form of support.[A]

Food assistance must be carefully targeted to the most food-insecure to be the most beneficial and avoid disrupting local markets and creating disincentives to local food production.[1] The process of targeting food assistance in areas of high HIV prevalence is different for programs with food security objectives and those with HIV objectives. However, in both cases, food insecurity and vulnerability must form the basis for targeting food assistance. Targeting can take place at multiple levels: region, community, household and individual. Not all levels are necessary for all programs.

Programs With Food Security Objectives

To ensure cost-effectiveness and efficiency, food security programs must first target **geographic areas with the highest food insecurity**. Food-insecure areas should be selected based on an initial vulnerability assessment that includes data on food production, poverty, malnutrition and risk, including HIV prevalence rates (see **Chapter 3: Vulnerability Assessments**).

Because resources are rarely available to cover an entire population in a given area, food security programs usually will target specific districts within regions and communities within the districts. Finally, even in very food-insecure communities, there is often a need to target specific households within the communities for the program's food transfer component. Experience has shown that multiple indicators (multi-criteria targeting)—a combination of clinical, social, economic and demographic indicators—should be used to identify food insecure population groups or households within the targeted communities.

Targeting decisions should be integrated within a broader food security strategy that takes into account food insecurity and the underlying causes of poverty, as opposed to only HIV. Where food insecurity is broad-based, targeting choices can be controversial within a community. For example, targeting food assistance solely to food-insecure PLHIV for nutritional support is likely to create stigma and resentment when the entire community is food insecure.[2] Experience shows that, in a food security program, best practice is not to target only the HIV-affected because food insecurity is more generalized.

Even in areas highly affected by HIV, the main objective of food assistance interventions is to reduce general food insecurity. Accordingly, targeting in such areas should be based primarily on food security indicators, and if necessary, refined through the use of appropriate HIV-specific indicators. In most countries in southern Africa, initial targeting is done at the national level through vulnerability assessment committees.

A Inclusion and exclusion errors involve incorrect targeting of beneficiaries. In food assistance programs, inclusion errors are instances in which food-secure individuals or households are chosen to receive assistance. Alternatively, exclusion error occurs when needy, food-insecure individuals or households are ***not*** targeted for food assistance.

Geographic Targeting

When establishing new food security programs, agencies will target geographic areas based on food insecurity vulnerability assessments (see **Chapter 3: Vulnerability Assessments**). In many cases, agencies will have already established operational areas based on an analysis of need and their comparative advantage. In this case, targeting can be done within the context of existing programs where the characteristics of communities are already known.

In some countries, HIV prevalence is higher in some areas than others. The different HIV prevalence levels allow for clear geographic prioritization and targeting for HIV programming. However, areas with high HIV prevalence do not necessarily have high food insecurity prevalence. A combination of food insecurity data and HIV prevalence will locate areas with high or dual vulnerability as well as forecast future vulnerability.[3]

Community Targeting

While geographic targeting identifies areas with the greatest need, existing resources are unlikely to cover these regions entirely. It is necessary to target districts and communities with the greatest food security need in each area. Food assistance agencies can further refine their geographic target areas by compiling profiles to identify the most vulnerable food-insecure districts and communities, with criteria similar to those used in geographic targeting. Ideally such data will be overlain by community-level indicators related to food security and health outcomes to identify communities.[4]

Depending on the capacity of local and national government and participating NGOs, community-level data may be difficult to find or may not exist. In such cases, it is useful to conduct small-scale primary data collection exercises to produce current data for comparing communities within a priority region.

Household Targeting

In high-prevalence areas, HIV typically affects entire communities either directly or indirectly through increased dependency on households without infected members. However, vulnerability to HIV's impact is likely to be greater for poor food-insecure households, which are less able to absorb the loss of productive labor, increased costs related to illness and death, and higher dependency ratios. In addition, these households may be excluded from scarce or costly public assistance or services.[5]

For food security programs in high HIV contexts, the key challenge for targeting vulnerable households is to ensure that targeting criteria capture HIV-related vulnerabilities in addition to other food insecurity risks and vulnerabilities. Using multiple criteria for targeting is especially helpful considering the dynamic interaction between food security and HIV. For instance, multiple criteria using a range of social and economic factors may help identify needy households that do not have infected members but may care for OVC, support relatives who are ill or provide support to directly affected households through traditional community safety nets.[6]

Household targeting can be improved through community-based targeting (CBT), which draws on local knowledge about households.[7] By engaging community members in the targeting process, agencies may be able to increase awareness and understanding of HIV and promote a greater sense of ownership of the intervention. Although specific approaches will differ according to the local context, CBT involves:

- Community sensitization about the program, including identification of program objectives and methods of implementation

- Selection of committee members by the community, community groups, PLHIV associations and/or nearby clinics or ART sites
- Development of community-defined selection criteria with the support of an NGO or facilitating organization
- Beneficiary selection by the community at an open meeting using community-defined selection criteria, taking care to maintain confidentiality and avoid the stigmatization associated with HIV
- Verification of the list of selected beneficiaries by the NGO
- Communication of the list to the community at an open meeting
- Continual community involvement in regular updates of beneficiary lists

Household targeting can also be done by partnering with medical facilities offering ART or CBOs assisting PLHIV. Once particularly vulnerable areas or communities are identified, participatory techniques are often used to apply a combination of criteria to identify eligible

WFP Malawi's Approach to Community-Based Targeting[8]

In 2005, WFP Malawi, in conjunction with the Joint Emergency Food Aid Programme, developed HIV Targeting Guidelines promoting the use of CBT.

The guidelines state that after district executive committees, traditional authorities (including village headmen) and community groups are sensitized to the issues, community organizations—including VACs, HBC groups, orphan care centers, village relief committees, village development committees or other CBOs—should select food assistance beneficiaries, with WFP Cooperating Partners facilitating the targeting process. Beneficiary households should be enrolled in a transparent manner through village gatherings and told why they were selected. Cooperating Partners should work with the community organizations to continually verify beneficiary lists through regular community gatherings and random interviews of beneficiary and non-beneficiary households.

The guidelines provide several criteria to be used in combination with community-identified criteria to select areas of operation and beneficiary households, such as:

Geographic Targeting (district and community levels)
- High food insecurity as determined by the 2005 Malawi Vulnerability Committee Report
- High HIV prevalence based on the 2003 HIV/AIDS Surveillance Report by the NAC
- High population density

Household Targeting
(households must meet at least three criteria)
- Own less than two acres of land and be unable to hire it for food or cash
- Own no major common livestock (e.g., cattle, goats, sheep, pigs)
- Receive no formal wages
- Do not participate in a regular income-generating activities.
- Rely on piecework (ganyu) to meet daily food needs
- Have less than three months of food stock starting from harvest time

HIV-affected households targeted to receive food assistance must also meet these social criteria:
- Household must be caring for chronically ill member(s)
- Household must be caring for OVC

These households are prioritized in this order:
- Child-headed household with more than two orphans who have lost both parents
- Elderly-headed households with more than two orphans who have lost both parents
- Female-headed households with more than two orphans who have lost one parent
- Any other households with more than two orphans who have lost both parents

individuals or households. When using CBT, agencies should be careful to "do no harm" by avoiding stigma caused by public identification of HIV-positive beneficiaries.

Community-defined targeting criteria also should help identify characteristics of all food-insecure and vulnerable households, not just those affected by HIV. This is to avoid stigma and for several additional reasons:

- In food-insecure areas, targeting HIV-affected households alone would mean excluding other food-insecure households.
- HIV-affected households are not necessarily food-insecure.
- It is impossible to know for certain who is HIV-positive because testing facilities and reliable surveillance systems are lacking in most poor countries and, even if VCT services exist, many people are afraid to learn their HIV status.

Programs With HIV Objectives

Most HIV programs are implemented in areas and communities with high HIV prevalence. In many cases, areas with high HIV prevalence do not have populations who are the most food-insecure; the former tend to be in urban areas, while the latter are found more in rural areas. WFP and FFP prioritize food assistance to HIV interventions by focusing first on the most food-insecure areas that also have high HIV prevalence. WFP places second priority on areas that are generally food-secure but have high prevalence rates, with the expectation that they will become increasingly food-insecure due to the disease.[9]

Beyond prevalence rates, other factors that can help determine a community's needs include:

- Number of PLHIV
- Burden on services
- Community coping and care capacity

Individual Targeting

Food assistance programs may be explicitly designed to benefit PLHIV by supporting HIV or other medical treatment. This is usually done by targeting food-insecure individuals receiving TB and/or ARV treatment or participating in PMTCT or HBC programs.

The major targeting challenge food-assisted HIV programs face is identifying which PLHIV and HIV-affected households are food-insecure. In areas of high HIV prevalence but relatively lower food insecurity, where food resources to provide to food-insecure PLHIV and affected households are more limited, the targeting challenge is more sensitive and critical.

Clinical, social, demographic and/or economic criteria can identify food-insecure households and individuals affected by HIV. These indicators include direct measures of HIV infection and other clinical indicators, and food security indicators, including measures of household capital, nutritional status and income.

Clinical criteria assess HIV and nutritional status of the people receiving services. Where food assistance is provided through local clinics and community home-based care (CHBC) programs, food assistance targeting can be based on clinical criteria such as wasting or weight loss. However, this information is often not available where there are no testing facilities or stigma is severe.

Socioeconomic criteria assess whether a household has sufficient income to meet the additional food and non-food needs brought on by chronic illness. Socioeconomic indicators include assets, employment and income, food consumption patterns, diet quantity and quality, level of food production and levels of family assistance.

Sociodemographic criteria include household size, gender and age of household members, gender and age of household head, presence of OVC in the household, effective dependency ratio and recent death of an adult (age 18 to 59) in the household.

Using Multi-Criteria Targeting in an HIV Context in Zambia[10]

Using multiple clinical, social, demographic and economic criteria can help identify regions, communities, households and individuals most affected by the combined impact of HIV and food insecurity. These indicators include direct measures of HIV prevalence and other health data, as well as food security indicators such as measures of household capital and income. Below are examples of how some organizations use these criteria in Zambia (actual targeting tools used by WFP, C-SAFE and Project Concern International (PCI) in Zambia appear in Annexes 1-3). While each approach is useful, the differences between them highlight the importance of harmonizing targeting criteria, coordinating strategies and logistic systems, and enhancing referral and M&E systems to ensure transparency and accountability at the national level.

1) WFP targets vulnerable households identified by socioeconomic and demographic indicators. Specifically, WFP has been targeting nutritionally vulnerable women and children; PLHIV in PMTCT, TB and ART interventions; OVC; chronically ill households (used as proxy indicators for HIV); households that host OVC, are elderly-headed or care for chronically ill people; and school-age children in food-insecure areas.

WFP uses two tools for targeting in the context of HIV: a Food Security Screening Tool to assess potential beneficiaries and a set of food insecurity targeting criteria to select beneficiaries for individual and household ration distribution. The tools appear in Annex 1 of this chapter.

2) C-SAFE also used multiple criteria to identify households eligible for food assistance in Zambia. Targeted groups included extremely food-insecure households, ART patients, TB patients, HIV-positive pregnant and lactating women, HBC recipients or chronically ill family members, and OVC (which include child-headed households). Households had to meet at least three of these criteria to be eligible:

- Inadequate food production/income to meet household food requirements
- No liquid assets
- Presence of OVC
- Presence of chronic illness
- Headed by elderly or female or children
- Presence of nutritionally vulnerable women and children

C-SAFE found that tools such as questionnaires, when used alone for screening, did not help to accurately target food-insecure households over the life of the project. So C-SAFE conducted a comprehensive questionnaire-based household-level re-verification process every eight months. While it was more costly, the process became an integral part of graduating households from targeted food assistance, allowing households that regained viability to move into more sustainable livelihood activities. C-SAFE's Zambia Targeting Tools appear in Annex 2 of this chapter.

3) The Archdiocese of Lusaka, another WFP partner in Zambia, uses a socioeconomic assessment tool to select beneficiaries for food assistance and inclusion in its HBC program. Archdiocese staff noted that inclusion error can be reduced by visiting the individual household to get information to complement the medical screening done using a questionnaire.

4) PCI, in an urban program that provides wet feeding for OVC, uses a tool to identify beneficiaries for the take-home ration (THR). The tool includes the dependency ratio (targeting of larger families) and prioritizes female-, widow- and elderly-headed households affected by HIV. PCI also provides WFP food assistance through an urban clinic-based program that targets ART patients (identified in collaboration with district health centers) using multiple criteria including food consumption, coping mechanisms, income and food production levels, nutritional status and existence of other support systems. PCI's Zambia Targeting Form, Monitoring Form and Food Security Reassessment Form appear in Annex 3 of this chapter.

5.2 Key Concept

Adapting Food Assistance Targeting Approaches and Tools

While food assistance agencies have developed a range of tools for identifying households and individuals most vulnerable to food insecurity, these tools must be adapted in the context of HIV to account for the specific targeting challenges presented by the disease.

Adapt Targeting Criteria to the Purpose and Objective of Food Assistance

The targeting process depends on the type of program and the objectives of the food assistance. The selection of criteria to target food assistance in HIV contexts relies on several factors, including the purpose of the intervention and the stage of the epidemic in targeted individuals or households. For example, targeting criteria will differ when the focus is on prevention and vulnerability reduction compared with later efforts to mitigate the epidemic's impact on affected households.[11]

If the food assistance intervention's main objective is to reduce general food insecurity in areas highly affected by HIV, then targeting criteria should be based on food security indicators as opposed to more direct HIV indicators. It should be expected that households affected by HIV will also likely exhibit increased food insecurity and therefore qualify for food assistance. Using food security indicators to target HIV-affected communities and households is also likely to attach less stigma to beneficiaries than targeting approaches that directly identify HIV-affected households.[12]

An effective referral system among food aid agencies, health centers, community health workers, CBOs, and HBC groups helps to identify highly vulnerable PLHIV and ensure they are enrolled in a food-assisted treatment program.

Use Home-Based and Other Care and Support Community Groups

Household and invidividual targeting can be done in partnership with community health centers, HBC and support networks, PLHIV networks and facility-based care systems. Targeting through home-based and other care and support community programs usually follows two steps:

- First, clinics refer patients who test HIV-positive to an HBC program, or an HBC provider may encourage someone who is chronically ill to go to a clinic for VCT. Once a person tests positive, they voluntarily enroll in a HBC program. HIV-positive status is confirmed either by a clinic partner or test results presented by the patient.
- Second, the patient is assessed using socioeconomic and demographic criteria to determine eligibility for food assistance.

Tapping Community Home-Based Care in Kenya[13]

CARE expanded its livelihood security programming in the Rochounyo and Homa Bay districts of Kenya to support safety nets and strengthen community institutions caring for and supporting PLHIV, OVC and other vulnerable groups. In response to the increasing numbers of OVC, CARE identified community care and support groups to address needs of OVC and create effective referral mechanisms between OVC, CHBC organizations, and health and other social services providers. One CHBC partnering with CARE is the St. Raphael's Lombeni CHBC Program, which provides extended family support to OVC after parents die and cluster foster care services, in which a surrogate guardian cares for several OVC with community support. In the selection of CHBC beneficiaries:

- An initial village meeting is held with community leaders, ward councilors and village chiefs to endorse the targeting approach and the beneficiary selection criteria.
- Local leaders and community care and support groups conduct a needs assessment.
- Households are identified and targeted for food assistance. OVC age six to 18 are registered for apprentice training, and OVC up to age five are registered for supplementary feeding.
- CARE program facilitators work with community resource persons to confirm the beneficiary list and set an appropriate food ration size.
- An agreement on the food and distribution system is reached with CHBC.
- Beneficiaries are informed of ration entitlement, total amount of food to be delivered, arrangements for delivery and storage, and dates and time for food distribution or feeding.

Use of Proxy Indicators

In many areas, people do not know their HIV status. There may be limited clinical facilities to test for HIV or treat AIDS patients or a high degree of stigma that poses barriers to VCT. People may also simply choose not to know their status. In these environments, proxy indicators are used to target communities and households eligible for food assistance. However, this runs the risk of including households that are not food-insecure and excluding others who may qualify. To appropriately select and use proxy indicators for targeted interventions, program staff must have a clear understanding of critical distinctions between targeting food insecurity, targeting individuals and households affected by HIV, and using multiple criteria to identify the most vulnerable households and individuals.

One best practice for targeting is the development of standardized targeting procedures that:

- Use multiple criteria to assess socioeconomic and health status
- Incorporate a hierarchy of need that prioritizes the use of limited resources
- Are used by all government and non-government agencies in a location

Chronic illness is perhaps the most common proxy indicator used for identifying PLHIV.[14] As noted in **Chapter 3: Vulnerability Assessments**, chronic illness is generally defined as a condition, disease or disability that has prevented an individual from being fully functional for at least three months within the previous year.[15] However, chronic illness alone may not be a reliable indicator of HIV in communities that have a high rate of illness even without the disease. For example, many types of chronic illness, including cancer and asthma, are not associated with HIV.

Other proxy indicators measure changes and effects on household resources (assets and income) because of members' chronic illness. These indicators include:

- Loss of labor
- Delayed agricultural operations

CRS Zambia Fine-Tunes Chronic Illness Definitions[16]

The C-SAFE Program in Zambia found discrepancies in how program staff defined chronic illness. CRS developed this targeting tool to help field staff without any medical training identify patients' symptoms that are likely to be from AIDS so they can make program decisions and link people to medical services for testing and treatment.

Based on this checklist—which does not replace a formal diagnosis, a person is considered to be chronically ill with AIDS if he/she has two major and two minor conditions listed, or specific conditions like Kaposi's sarcoma.

1. Clients' Medical Condition/Illness (* = major conditions)

1a. Weight loss>10% from normal/regular weight	1=Yes	2=No	1h. Unexplained prolonged fever *	1=Yes	2=No
1b. Generalized lymph node enlargement	1=Yes	2=No	1i. Oral thrush *	1=Yes	2=No
1c. Skin infections	1=Yes	2=No	1j. Tuberculosis *	1=Yes	2=No
1d. Non-resolving herpes simplex	1=Yes	2=No	1k. Pneumonia *	1=Yes	2=No
1e. Herpes zoster within the last 5 years	1=Yes	2=No	1l. Kaposi's sarcoma *	1=Yes	2=No
1f. Recurrent upper respiratory infection	1=Yes	2=No	1m. Meningitis *	1=Yes	2=No
1g. Unexplained chronic diarrhea >30 days)	1=Yes	2=No	1n. Persistent confusion/dementia *	1=Yes	2=No
			1o. Other, specify:	1=Yes	2=No

- Land left fallow
- Changes in crop mixtures
- Changes in livelihood sources
- Increased dependence on casual labor opportunities

See **Chapter 3: Vulnerability Assessments** for a more detailed list of indicators that capture HIV's impact on assets.

Each indicator represents a trigger point that results in decreased agricultural productivity and the potential for decreased food security. By targeting households with these characteristics, food assistance agencies aim to reach the most food-insecure households affected by HIV.[17]

It should be noted that identifying vulnerable groups in terms of personal and household characteristics, such as people with disabilities or female-headed households, does not automatically identify the groups who require food assistance interventions.[18] Indeed, it would be unusual to find a context in which all members of these groups are vulnerable. In addition, many vulnerable individuals are not members of these groups. Thus targeting based exclusively on group characteristics may create considerable inclusion and exclusion errors.

Incorporate Stigma Reduction Measures

The level of stigma against HIV varies greatly; in general, it tends to be higher in rural than urban areas and lower in environments where HIV is talked about openly. In Zambia, stigma has been reduced considerably in recent years as prevalence rates have increased and as new services such as AIDS treatment services and social support (including food assistance) have emerged.[19] HBC providers credit ongoing sensitization, the feeling among people that "today it is you, but tomorrow it could be me," awareness raising and the willingness of some PLHIV to speak publicly for stigma reduction. Also, the advent of ART has helped reduce stigma because a positive diagnosis no longer necessarily means a long, steady decline into severe illness and/or death. Furthermore, the awareness created by institutionalization of HIV care and support and livelihood interventions within rural communities has a profound impact on stigma reduction and on promoting acceptance of PLHIV within the family and the community.

However, there are contexts in which stigma is still strong. For instance, in cases where food distribution points are established specifically for the HIV-affected, beneficiaries may be reluctant to personally collect food for fear of being publicly identified as infected. In addition, non-beneficiaries may grow resentful based on their perception that because PLHIV are going to die soon, they should not receive public aid.

Stigma can be a particularly significant issue in programs aimed at reducing mother-to-child transmission because it may follow a child throughout his/her youth. If adequate resources are available, it is preferable for PMTCT programs to target all pregnant and lactating women in food-insecure areas to avoid stigmatization.[20]

Guidance for Addressing Stigma[25,26]

Although health service providers and development practitioners have long been aware of the constraints presented by stigma, there have been few proven approaches to dealing with it. To address the urgent need for tools to address stigma, the International Center for Research on Women (ICRW) and the CHANGE Project developed an anti-stigma toolkit entitled "Understanding and Challenging HIV Stigma: Toolkit for Action." The toolkit's guidance is based on findings from four country studies and provides evidence-based guidance for stigma-reduction activities with key groups, including religious and political leaders, people living with HIV, and community members. The toolkit is designed to motivate and enable individuals to use these methods to address stigma in their communities, workplaces, organizations and households. Specific guidance in the toolkit is aimed at:

- Making stigma visible and helping resolve contradictions such as those between intentions and behavior
- Enhancing practical knowledge to reduce fear of casual transmission
- Providing a safe forum to discuss sensitive topics (sex, death, drug use, inequity)
- Finding a common language to talk about stigma
- Strengthening PLHIV capacity to challenge stigma in their lives
- Providing a process to determine appropriate and feasible individual and community responses to stigma
- Providing comprehensive, flexible tools for organizations to strengthen staff skills and develop or strengthen interventions to reduce HIV-related stigma

The toolkit is available at www.changeproject.org/technical/hivaids/stigma/StigmaToolkit.pdf.

Methods to Reduce Stigmatization

Given the stigma associated with HIV, food assistance programs specifically targeting infected individuals must take extreme precaution in controlling the use of targeting information. For obvious reasons, this is much more feasible for administratively targeted interventions than for those using CBT. Likewise, the degree of transparency in targeting is largely dependent on a program's objectives. A program with explicitly stated HIV objectives will necessarily target individuals based on HIV status, making it difficult for them to avoid stigma where it exists. However, food security programs may find it easier to avoid identifying beneficiaries as HIV-positive.

As discussed earlier, proxy indicators may be used to identify HIV-affected families. However, proxy indicators such as chronic illness should be used cautiously and should not be the sole means of identifying HIV-affected households. In addition, chronic illness may not be appropriate as a proxy indicator in areas where it has already become closely associated with HIV. In such cases, socioeconomic criteria may be a better alternative for reducing the risk of stigma.

CBT can reduce stigma in many cases.[21] It is most effective when the community has been fully sensitized to a program's objectives and targeting strategy. Social mapping exercises, which rely on community input and participation, can reduce stigma associated with food assistance in this context. Community participation in such exercises often helps to stimulate discussions about chronic illness, the situation for OVC and other vulnerable groups, the availability of community services and related community development projects. These discussions, in addition to other sensitization efforts such as discussions with local leaders, youth groups, women's groups and community groups, can directly contribute to stigma reduction in a community.[22] Findings from FFA programs in Zimbabwe indicate that food assistance in conjunction with community sensitization on HIV can reduce stigmatization of PLHIV beneficiaries.[23]

In many rural areas, people do not believe that others are dying of AIDS and instead attribute deaths to TB, pneumonia and other causes, hampering community targeting methods. Some agencies have made progress in addressing stigma by supporting community sensitization efforts and working to build the self-esteem of PLHIV. Experience shows that where HIV is openly discussed, stigma tends to decline as people learn more about the disease and become less fearful of associating with PLHIV, including their own family members.

Where feasible and appropriate, it is important to explicitly involve PLHIV, affected households and communities in each step of the targeting process to ensure equitable access to aid and services. While stigma remains an issue, the transparency of this process is important to avoid significant exclusion error.[24]

Gender and Targeting

For food assistance programs, consideration of gender is particularly important because of women's traditional role as household food managers and because of how gender influences household food production through small-scale agriculture. As discussed earlier, gender is also an important consideration in effectively targeting food assistance to reduce vulnerability to HIV. (See **Chapter 1: Conceptual Framework** for a discussion of gender and HIV, and **Chapter 3: Vulnerability Assessments** for an explanation of gender analysis and a gender analysis tool.)

For a more detailed discussion on the role gender plays in food assistance programs in the context of HIV, program managers can review ***Getting Started: HIV, AIDS and Gender in WFP Programmes,*** available at www.wfp.org/food_aid/doc/GETTING_GENDER7.pdf.

5.3 Key Concept

Promising Practices

Use a Common Framework of Vulnerability

Targeting requires a common definition of vulnerability to express the target population's immediate and long-term needs. A judgment has to be made as to whether food insecurity and HIV prevalence are homogeneous throughout an area or whether there are pockets of greater need and vulnerability that deserve specific attention. This judgment can be made only if there is a good understanding of food insecurity and HIV at the country, regional and district levels.

Furthermore, program managers will have to decide whether food assistance will be targeted specifically to food-insecure, HIV-affected people or will include other food-insecure households that are not directly affected by the disease. This is a delicate decision, especially in areas with widespread poverty and food insecurity. If the food assistance intervention's main purpose is to enhance general food security in areas highly affected by HIV, then targeting criteria should be based on multiple food security indicators that are likely to include direct and proxy HIV indicators.

Even in communities in the same food economy zones or livelihood zones, needs will vary among populations. Understanding who are the most vulnerable or most at-risk is a prerequisite for effective resource targeting.[27]

Standardize Program and Beneficiary Targeting Criteria

Standardizing targeting criteria is important for avoiding confusion at the community level, preventing competition among agencies for program participants and improving the quality of analysis. Developing a framework of analysis with standardized indicators allows for comparison of results, identification of cross-cutting issues and transferral of lessons on prevention, treatment, and care and support strategies across regions, countries and even communities in the same country. When developing such a framework, program managers should acknowledge that different funding sources may have a significant influence on the selection and application of specific targeting criteria, as is often the case regarding OVC.

Standardization does not imply a lack of flexibility. Criteria must be sensitive to the local context. For example, wealth ranking varies between communities; a person who owns one cow may be considered poor in one community and rich in another. Similarly, in highly food-insecure areas, households may take actions such as assuming care of orphans or the chronically ill just to become eligible for assistance. So while it is important to standardize criteria, community members should be involved in verifying eligibility criteria and, if necessary, changing them to ensure they are appropriate.

Conduct Field-Level Verification

Screening tools such as questionnaires alone are not sufficient for accurate targeting. Field-level verification, where staff periodically visits households to check information, is needed to avoid inclusion error, along with periodic re-verification to see if conditions have changed. Multiple means of verification improve the accuracy of targeting, helping to ensure that the

most vulnerable households and individuals are selected and that limited resources have the biggest impact.[28, 29] The best practice is multiple means of targeting with at least some levels of verification. Programs should include this as part of their budget.

Link Health Referral Systems With Home-Based Care Groups and Networks

Building strong links with community health centers, HBC and support networks, PLHIV networks, and facility-based care systems allows the benefit of community workers' knowledge about socio-economic factors, food insecurity and hunger in the community in the identification of the most vulnerable households and individuals to be referred for food assistance.[30] In addition, the use of health services outreach facilities that are linked to HBC, PLHIV networks, and other institutions providing treatment, support and safety nets enables programs to reach PLHIV and other vulnerable groups not accessible to centralized feeding programs.

Apply "Do No Harm" Principles

It is crucial to ensure that the targeting system adheres to the key principles of non-discrimination, impartiality and equity, and does no harm to the community. In particular, as an equity principle, targeting can be improved by involving women in the community at various stages of developing and applying the targeting system. Women caregivers as well as female-headed households should be given an opportunity to participate in food distribution activities.[32]

Zambia Case Study: Cross-Sector Referral Targeting Mechanisms Used to Guide Interventions[31]

In Zambia, whose national health care system tracks Zambians through an individual code connected to her/his medical records and local treatment facility, collaboration between hospitals providing ART, NGO-supported food assistance programs and HBC programs is strong. WFP Cooperating Partners in the same areas are beginning to exchange beneficiary lists to avoid targeting of the same beneficiaries. This is actively encouraged by WFP through district coordination mechanisms such as District Disaster Management Committees and District AIDS Task Forces. The District Development Coordinating Committee requires monthly updates and meetings so the Cooperating Partners are kept up to date.

Still, organizations are careful about how and with whom they share information. Due to stigma and other reasons, personal privacy is an issue, and ART patients do not like being identified on lists that may circulate in their communities.

Annex 1: WFP Zambia Targeting Tool: Food Security Screening Form

This form is taken from Fergusson, P. *Targeting Household Food Insecurity in the Context of HIV: A Report by WFP Zambia.* WFP Zambia, 2005.

WFP Zambia Food Security Screening Form	
Client Name:	Date: ____/ ____/ _____ Day Month Year
Client ID Number: (specify ID type)	
Client Sex: **(circle response)** Male Female	
School/HBCO/CBO Caregiver Name:	
Name of Respondent (if other than the client):	
Relation to Client:	
Client's Address:	

A. Demographic and Education		
A1	How many adults (19-59 years) stay in the household?	**Number of adults:**
A2	How many elders (60 years and older) stay in the household?	**Number of elders:**
A3	How many children (18 years or younger) stay in the household?	**Number of children:**
A4	Marital status of primary income earner	Married (1) Single (2) Separated (3) Divorced (4) Widowed (5)
A5	Sex of primary income earner	Male Female **(circle response)**

A6 In the following table, record the required information for all children in the household who are between 6 and 18 years of age.

	First name of the child (6-18 years only)	Age	Is the child currently attending school? **(circle response)**	1. Community school	2. Drop-in center	3. Government school	4. Fee-paying private school	5. Fee-paying tertiary education
1			Yes No					
2			Yes No					
3			Yes No					
4			Yes No					
5			Yes No					
6			Yes No					
7			Yes No					
8			Yes No					
9			Yes No					
10			Yes No					

B. Food Consumption

B1 How many bags of mealie-meal did the household consume in the last month?

Bag Size	Number Consumed
50 kg	
25 kg	
12.5 kg	
10 kg	
5 kg	
2.5 kg	
0.5 kg	

B2 Where did the food that you ate yesterday come from? **(check all that apply)**

	YES	NO		YES	NO
1. From own harvest			7. Food received—General food distribution/nutritional support programme		
2. Casual labour			8. Food received—Home-based care		
3. Borrowed			9. Food received—School feeding/OVC take-home ration		
4. Bartered			10. Food received—Food for work/food for assets		
5. Gift			11. Purchased (shop, market, kantemba)		
6. Gathered from wild			12. Other sources **(specify)**		

B3	In the last month, did anyone in the household cut the size of meals or skip meals?	Yes No **(circle response)**
B4	If yes, how often did this happen? **(circle one response)**	Daily (1) Every other day (2) Weekly (3) Once (4)
B5	How many meals does the household usually have in a day?	Yes (1) (2) (3) **(circle response)**

C. Food Aid

C1	Is the household currently receiving any donated food?	Yes No **(circle response)**
C2	If yes, from whom is the food received?	
C3	How much food is the household currently receiving each month?	

D. Household Income and Production

D1	Was the client the primary income earner in the household before becoming ill?	Yes No **(circle response)**
D2	What is the estimated household income (from salary, rental income, vending, gifts, etc.) per month? **(circle one)**	Less than K50,000 (1) K50,000 to K199,000 (2) K200,000 to K500,000 (3) Over K500,000 (4)

WFP Zambia Food Insecurity Targeting Criteria for Use in the Context of HIV

Section A: Basic Criteria Guidelines

Clients meeting any of the following criteria will be eligible for the individual ration:

1. Monthly household income of less than K50,000 per month

OR

2. The household consumes 25 kg of maize meal or less per month AND household size is more than five people

OR

3. The household consumes 50 kg of maize meal or less per month AND household size is more than 10 people

OR

4. The respondent reports that during the past month, members of the household cut the size of meals or skipped meals because there was not enough food, daily or every other day, and the household consumes less than three meals per day on average.

OR

5. The respondent reports that the food eaten yesterday in the household came exclusively from borrowing, bartering, and/or gathering in the wild AND at least one other criteria above is also met.

In accordance with WFP protocol, those meeting the following criteria will receive the household ration:

6. Client was the household's primary income earner AND the household's monthly income is less than or equal to K200,000

Clients will not qualify for food aid (either the individual or household ration) if they live in a household which:

- Has children in fee-paying private schools
- Is currently receiving donated food including at least all of the following:
  - 25 kg or more bags of maize meal per month
  - 25 kg or more bags of HEPS per month
  - 2.5 liters of oil or more per month
  - 5 kg peas/beans or more per month

Section B: Demographic Qualifiers

Number of children under 18 not attending school
1. 0 = 0
2. 1-2 = 1
3. 3 or more = 2

Household head:
Child-headed household = 5
Elderly-headed household = 3
Female-headed household = 1

Marital status of HH head
1. Married = 0
2. Single = 1
3. Separated = 1
4. Divorced = 2
5. Widowed = 3

Dependency ratio:
(number of adults in the home divided by the total household size)
= A1/(A1+A2+A3)

0	= 3
.001 to 0.33	= 2
0.34 to 0.66	= 1
0.67 to 1.0	= 0

Total possible score: 13

Annex 2: C-SAFE Zambia Targeting Tool: Household Food Security Appraisal Form

C-SAFE Zambia Household Food Security Appraisal Form

Date of Interview: / /

District: FDP / Site Name: Village Name: HH No:

Name of Respondent: *(Should be household head or spouse)* Sex: (Male = 1; Female =2)

Name of Primary Beneficiary: *(Would-be food aid recipient)* Sex: (Male = 1; Female =2)

A1	A2	A3	A4	A5	A6	A7	A8	A9	A10	A11
						0-17 YEARS OLD ONLY, ELSE GO TO A10	**6-17 YEARS ONLY, ELSE GO TO A10**		**MORE THAN 5 YEARS OLD ONLY, IF YES GO TO A11, ELSE GOTO B1**	
	Please give me the first name of each household member, starting with you	What is (NAME) relation-ship to head of house-hold?	Is (NAME) male or female? *MALE = 1 FEMALE = 2*	How old is (NAME)? *IN YEARS IF < 1, WRITE 0*	What is (NAME) health status?	What is the (NAME) parental status?	What is (NAME) school status: *ENUMERATOR TO READ ALL CATEGORIES IN A8 BELOW IF CURRENTLY ENROLLED=1 OR PRIMARY/ SECONDARY COMPLETED = 5, GO TO A10*	What is the main reason for (NAME) absenteeism/ dropped out/never enrolled?	Is (NAME) engaged in any activity that brings an income in cash or in kind?	Income received /earned in the last three months (amount in kwacha)
1	Household head	01								
2										
3										
4										
5										
6										
7										
8										
9										
10										

A3 -Relationship

1 = head
2 = head spouse
3 = child
4 = father/mother
5 = brother/sister
6 = other relative (grandparents, uncle, aunt, cousin)
7 = no relation
8 = adopted/foster or step child
9 = grandchild, niece, nephew

A6 – Health status

1 = good
2 = ill for < 3 months
3 = ill for 3 months or more
4 = physically or mentally disabled

A7 – Parental status

1 = both parents alive
2 = mother alive, father dead
3 = father alive, mother dead
4 = both parents dead

A8 – School enrollment

1 = enrolled
2 = enrolled but absent > 1 week in past month
3 = dropped out this school year
4 = dropped out before this school year
5 = primary/secondary complete
6 = never enrolled

A9 – Primary reason absent, not enrolled or dropped out

1 = illness
2 = working
3 = help with HH work
4 = care for ill member/younger sibling
5 = not interested in school
6 = distance to school far
7 = hunger
8 = expensive/no money
9 = child considered too young
10 = pregnancy/marriage
88 = other (specify_____)

A10

1 = yes
2 = no

A11

1 = > 50,000
2 = 50,001 – 100,000
3 = 100,001 – 200,000
4 = 200,001– 300,000
5 = 300,001 – 400,000
6 = 400,001 – 500,000
7 = 500,000 +

Section B. Household Income and Expenses

B1 During the past year, what were your household's three main sources of livelihood? (starting with the most important)

(1) |_____| (2) |_____| (3) |_____|

If no source of livelihood, write 15 and go to B2

CODES FOR B1

1 = remittance
2 = crop production/sales
3 = casual labour
4 = begging
5 = livestock production/sales
6 = skilled trade/artisan
7 = small business
8 = petty trade (firewood sales, etc.)
9 = brewing
10 = formal salary/wages
11 = sale of fish
12 = gold panning
13 = vegetable production/sales
14 = food aid
15 = no secondary source of livelihood
88 = other (specify) _____

B2 During the past month, what were your household's three main uses of your income? (in order of importance)

(1) |_____| (2) |_____| (3) |_____|

CODES FOR B2

0 = none
1 = staple foods
2 = non-staple foods
3 = HH goods
4 = education
5 = health
6 = funerals
7 = travel
8 = agricultural inputs
9 = other (specify) _____

Section C. Household Food Stocks and Sources

C1	How much cereal does your household have from own production? (If no cereal, go to C3)	_____(x 50kg bags)
C2	How many months do you think cereal stock will last?	_____ (# of months)
C3	At what time of the year did cereal from own production dry out?	_____ (indicate month)
C4	In the past three months, what were your household's three most important sources of cereal/staple food to eat?	

CODES FOR C4

1 = from own harvest, 2 = casual labour, 3 = borrowed, 4 = gift, 5 = food aid, 6 = food received from FFA/FFW, 7 = purchased, 8 = barter, 9 = no source of food, 88 = other source (specify)_____

Section D. Agricultural Production

D1	How much land did you cultivate this year? ***(1 hectare (ha) = 100x100m, 1 lima = 0.25ha= 50x50m, 1 acre = 0.4ha)*** **IF DID NOT CULTIVATE WRITE 00**	|__|__|. |__| Hectares **IF 00 MOVE TO D4**
D2	Compared to last season was the area of land you cultivated larger, the same or less	1 = larger 2 = same 3 = less **IF LARGER OR SAME, GO TO D5**
D3	What is the primary reason for cultivating less land?	Reason |____| **GO TO D5**
D4	What is the primary reason for not cultivating?	Reason |____| **GO TO E1**

CODES FOR D3 & D4

1 = planned fallow, 2 = weather related causes, 3 = could not access land, 4 = lack of seed, 5 = lack of fertilizer, 6 = lack of labour/insufficient manpower, 7 = pest problems, 8 = rented out, 9 = illness in the household, 88 = other (specify)_____

D5 Did you cultivate any of the following crops?

CODES FOR D5: Harvest Usage

1 = consumed
2 = sold
3 = bartered
4 = given out as gift
88 = other (specify)_____

Crop	YES	NO	How harvest was used
Maize	1	2	
Sorghum	1	2	
Millet	1	2	
Cassava	1	2	
Beans	1	2	
G/nuts	1	2	
S/potatoes	1	2	
Vegetables	1	2	
Cash crops	1	2	

Section E. Food Consumption

E1	How many meals did the adults in this household eat **yesterday**?	|___| NUMBER OF MEALS
E2	How many meals did the children (6-59 months old) in this household eat **yesterday**? **IF NO CHILDREN IN THE HH, WRITE 98 for N/A**	|___| NUMBER OF MEALS

Section F. Assets					
F1: How many of the following assets are owned by you or any member of your household? (indicate kwacha value where possible)					
Productive, Non-Productive & Transport Assets					
Asset	**No.**	**Asset**	**No.**	**Asset**	**No.**
Land (hectares)		Canoe		Radio	
Tractor		Harrow		DSTV	
Hand tractor		Plough		Fridge	
Hammer mill		Shops/kantemba		Fan	
Hand mill		Business		Sewing machine	
Treadle pump		Truck		Bicycle	
Fishing nets		Van/hilux		Other 1	
Ox cart		TV		Other 2	

G1 TO G4	**G1 How many of the following livestock does your household currently own?** **G2 How many livestock has your household purchased in past 3 months?** **G3 How many livestock has your household sold in past 3 months?** **G4 What was the main reason for selling this livestock?** **FOR EACH TYPE OF LIVESTOCK NOT OWNED, NOT PURCHASED AND NOT SOLD, WRITE 0**				
	Livestock	**G1** Currently owned	**G2** Purchased	**G3** Sold	**G4** Main reason for sale
1	Draught cattle				
2	Cattle				
3	Donkeys/horses				
4	Sheep/goats				
5	Pigs				
6	Chickens/ducks/other birds				
	Codes for G4	1. No longer needed 2. Pay daily expenses 3. Buy food for HH	4. Pay medical expense 5. Other emergency 6. Pay debt	7. Pay social event 8. Pay funeral 9. Pay school	88. Other (specify) _____ 98. N/A

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1. This part is to be filled in by the enumerator immediately after completing the appraisal form.

Based on answers to the above questions, in the enumerator's opinion, this household should be classified as:				
1 = Very eligible (Asset very poor, food insecure with hunger)	**2 = Eligible** (Asset very poor, food insecure with hunger	**3 = Moderately eligible** (Asset poor, food insecure without hunger)	**4 = Ineligible** (Asset rich, food secure without hunger)	**5 = Disqualify** (Asset very rich, food secure and not hungry

2. If ineligible or disqualified based on issues other than Food Security perception, please indicate these reasons:

1. _____

2. _____

3. _____

Name of HH head _____

Sign _____ Date _____

Annex 3: PCI Zambia Targeting Tools: Initial Home Visit, Monitoring Visit, and Reassessment Food Security Screening Forms

PCI Zambia Initial Home Visit Form	
Patient Name:	Date: / / (Day/Month/Year)
Patient ID Number:	Patient Sex: Male Female **(circle)**
HBCO Caregiver Name:	HH Head Profile: Male Female **(circle)**
Name of Respondent (if other than patient):	
Relation to Patient:	
Does the patient address match the locator form? Yes No **(Please circle your answer)**	
If not, please record the patient's address and any additional information required to locate the patient.	

A. Demographic and Education		
A1	How many adults (19-59 years) stay in the household?	Number of adults:
A2	How many elders (60 years and older) stay in the household?	Number of elders:
A3	How many children (18 years and younger) stay in the household?	Number of children:

In the following table, record the required information for all the children in the household who are between 6 and 18 years of age

	First name of the child (6-18 years of age only)	Age	Is the child currrently attending school? Yes	No	What type of school does the child attend? 1 = Community school	2 = Drop-in center	3 = Government school	4 = Fee-paying private school	5 = Fee-paying tertiary education
1			☐	☐	☐	☐	☐	☐	☐
2			☐	☐	☐	☐	☐	☐	☐
3			☐	☐	☐	☐	☐	☐	☐
4			☐	☐	☐	☐	☐	☐	☐
5			☐	☐	☐	☐	☐	☐	☐
6			☐	☐	☐	☐	☐	☐	☐
7			☐	☐	☐	☐	☐	☐	☐
8			☐	☐	☐	☐	☐	☐	☐
9			☐	☐	☐	☐	☐	☐	☐
10			☐	☐	☐	☐	☐	☐	☐

B. Food Consumption

B1 How many bags of mealie-meal did the household purchase for consumption in the past month?

Bag Size	Number Purchased
50 kg	
25 kg	
12.5 kg	
10 kg	
5 kg	
2.5 kg	
0.5 kg	

B2 Where did the food that you ate yesterday come from? **(check all that apply)**

	YES	NO		YES	NO
1. From own harvest	☐	☐	7. Food received—General food distribution/nutritional support programme	☐	☐
2. Casual labour	☐	☐	8. Food received—Home-based care	☐	☐
3. Borrowed	☐	☐	9. Food received—School feeding/OVC take-home ration	☐	☐
4. Bartered	☐	☐	10. Food received—Food for work/food for assets	☐	☐
5. Gift	☐	☐	11. Purchased (Shop, market, kantemba)	☐	☐
6. Gathered from wild	☐	☐	88. Other sources **(specify)**	☐	☐

B3	In the past month, did anyone in the household ever cut the size of meals or skip meals because there wasn't enough food?	Yes No **(circle response)**
B4	If yes, how often did this happen? **(circle one response)**	Daily (1) Every other day (2) Weekly (3) Once (4)

C. Food Aid

C1	Is the household currently receiving any donated food?	Yes No **(circle response)**
C2	If yes, from whom is the food received?	
C3	How much food is the household currently receiving each month?	

D. Household Income and Production

D1	Was the patient the primary income earner in the household before becoming ill?	Yes No **(circle response)**
D2	What is the household income (from salary, rental income, vending, gifts etc.) per month? **(circle one)**	Less than K50,000 (1) K50,000 to K199,000 (2) K200,000 to K500,000 (3) Over K500,000 (4)

E. Buddy

E1	Does the patient have a buddy?	Yes No **(circle response)**
	If no, the caregiver should: 1. Review with the patient the importance of having one, and 2. Review the characteristics of a good buddy and help the patient identify someone	

PCI Zambia Monitoring Visit Form	
Patient Name:	Date: / / (Day/Month/Year)
Patient ID Number:	
HBCO Caregiver Name:	
Name of Respondent (if other than patient):	
Relation to Patient:	
Has the patient's address changed since the initial home visit? Yes No **(Please circle your answer)**	
If yes, please record the patient's new address and any additional information required to locate the patient.	

A. Adherence Support		
A1	**(Ask)** Have you missed any doses of your ARVs since I last visited you?	Yes No **(circle response)**
A2	**(If yes)** How many doses have been missed in this period?	|_____| NUMBER OF DOSES MISSED
A3	Review the Patient Care Card. According to the card, how many doses have been missed?	|_____| NUMBER OF DOSES MISSED
A4	If the number in A2 and A3 are different, try to determine with the patient and/or buddy the correct number of missed doses.	|_____| NUMBER OF DOSES MISSED
A5	Record the number of days since the last visit.	|_____| NUMBER OF DAYS
A6	Record the total number of pills which should have been taken during this period.	|_____| NUMBER OF PILLS
A7	Use the figures in A4, A5 and A6 to determine the patient adherence during the period in question. (Refer to Table 5.5)	**Adherence is less than 95%** _____ **Adherence is more than 95%** _____

IF ADHERENCE IS LESS THAN 95%:

- **» Assess the reason(s) for missed doses**
- **» Assess barriers to adherence and suggest solutions**
- **» Review with the patient the importance of 100% adherence**
- **» Complete a Follow-Up Required Card and return it to the HBC Supervisor**
- **» Caregiver must begin doing daily visits until adherence improves**

IF ADHERENCE IS GREATER THAN 95%:

- **» Assess any potential barriers to adherence and encourage the patient and buddy to continue**

B. Buddy		
B1	Does the patient have a buddy?	Yes No **(circle response)**

C. Potential Problems with ARVs		
C1	Is the patient having any problems taking all their medicines?	Yes No **(circle response)**
	If yes, describe:	

C2	Is the patient experiencing any of the following? **Tick if response is yes**	
a	☐ Nausea	If causing minimal intake for more than 48 hours
b	☐ Vomiting	If severe, limiting food or fluid intake or ART and lasting 24 hours
c	☐ Diarrhea	If more than three times per day, or bloody, or if associated with fever or dehydration
d	☐ Persistent headache	If severe, requiring frequent painkillers, lasting over one week
e	☐ Rash	If severe, especially if associated with blisters or peeling and covering more than 50% of the body
f	☐ Severe leg pain	If new or worsening or impairs walking
g	☐ Fever	If lasting more than one day
h	☐ Difficulty breathing	Any difficulty breathing or shortness of breath, even if mild, especially if associated with abdominal pain, nausea or vomiting
i	☐ Itching	Or swelling all over the body
j	☐ Fatigue	If normal activity reduced by more than 50%
k	☐ Severe abdominal pain	If it is too painful for the patient to move
l	☐ Dizziness/lightheadedness	If preventing standing from a seated or laying down position
m	☐ Yellow eyes	
n	☐ Other unusual signs or symptoms (describe below):	

If the patient is experiencing any of the problems above, please:

» Encourage them to return to the clinic for evaluation
» Complete the Follow-Up Required form and submit it to the HBC Supervisor

D. Food/Nutrition		
D1	Is the patient receiving an **individual ration** from the clinic through PCI/WFP (HEPS and oil)?	☐ Yes ☐ No **» if no, go to D6** ☐ Don't know **» if don't know, go to D6**
D2	**(If yes)** Did the patient eat any of this food during the past 24 hours?	☐ Yes ☐ No **» if no, go to D5** ☐ Don't know **» if don't know, go to D6**
D3	**(If yes)** What did they eat?	☐ Only the HEPS ☐ Only the oil ☐ Both the HEPS and oil
D4	How much did they eat?	☐ Less than 2 banana cups porridge ☐ 2 banana cups porridge ☐ More than 2 banana cups porridge ☐ Other **(specify how much)** _____ **(for all responses, go to D6)**

D5	**(If no)** Why not?	☐ Food is finished ☐ Food was sold/bartered/given away ☐ Food was not enough for the patient/others ate it ☐ No fuel to cook the food ☐ Nobody to cook the food for patient ☐ Patient wasn't hungry ☐ Patient didn't want the food (yesterday) ☐ Patient doesn't like the food (at all) ☐ Patient was sick ☐ Patient has trouble swallowing ☐ Other (specify)_____
D6	Is the patient receiving a **household ration** from the clinic through PCI/WFP (HEPS, oil, mealie meal, beans/peas)?	☐ Yes ☐ No **» if no, go to next page** ☐ Don't know **» if don't know, go to next page**
D7	**(If yes)** Did the patient eat any of this food during the past 24 hours?	☐ Yes ☐ No **» if no, go to D9** ☐ Don't know **» if don't know, go to next page**
D8	**(If yes)** What did they eat?	☐ HEPS ☐ Mealie meal ☐ Oil ☐ Beans/peas **(tick all that apply, then go to next page)**
D9	**(If no)** Why not?	☐ Food is finished ☐ Food was sold/bartered/given away ☐ Food was not enough for the patient/others ate it ☐ No fuel to cook the food ☐ Nobody to cook the food for patient ☐ Patient wasn't hungry ☐ Patient didn't want the food (yesterday) ☐ Patient doesn't like the food (at all) ☐ Patient was sick ☐ Patient has trouble swallowing ☐ Other (specify)_____

Is the patient experiencing any problems related to food consumption and the ARVs? If so, please describe the problem below and alert the HBC Supervisor to the problem:

_____

_____

_____

Provide any comments in the space below related to the patient's condition, adherence, needs for follow up, etc.

_____

_____

_____

Make sure you have covered all of the items in this checklist before leaving the patient.

CHECKLIST FOR HOME ADHERENCE SUPPORT

1. **Ask the patient if they are having any problems with the drugs.**
2. **Ask the patient how many doses they have missed?**
3. **Review the DOT card with patient to check for signatures.**
4. **Assess the reason for missed doses.**
5. **Assess barriers to adherence and suggest solutions.**
6. **Review with patient the reasons that we need 95-100% adherence.**
7. **Review with patient that they must attend all appointments and should have a buddy to directly observe therapy.**
8. **If a buddy has not been identified review the characteristics of a good buddy, and help the patient to identify a good buddy:**
   - **should be a responsible person who cares about the patient's well being.**
   - **should live near or in the same household as the patient.**
   - **should be able to come to clinic appointments with the patient.**
   - **should be able to observe the patient taking his or her medicines every day.**
   - **should be able to help remind the patient to take all of their medicines at the correct times.**
   - **should be able to maintain the patient's confidentiality.**
   - **should be able to communicate with the clinical staff in case the patient becomes too sick to come for an appointment.**
9. **Talk to the patient about creating reminders when it is time to take the drugs (visual cues, alarm clocks, etc.).**
10. **Assess if there is proper storage of the drugs.**
11. **Help patient repack their weekly pill box.**

PCI Zambia Reassessment Food Security Screening Form	
Client Name:	Date: / / (Day/Month/Year)
Client ID Number:	Client Sex: Male Female **(circle)**
HBCO Caregiver Name:	HH Head Profile: Male Female **(circle)**
Name of Respondent (if other than patient):	
Relation to Patient:	
Does the patient address match the locator form? Yes No **(Please circle your answer)**	
If not, please record the patient's address and any additional information required to locate the patient.	

A. Demographic and Education

A1	How many adults (19-59 years) stay in the household?	Number of adults:
A2	How many elders (60 years and older) stay in the household?	Number of elders:
A3	How many children (18 years and younger) stay in the household?	Number of children:

In the following table, record the required information for all the children in the household who are between 6 and 18 years of age

	First name of the child (6-18 years of age only)	Age	Is the child currrently attending school? Yes	No	What type of school does the child attend? 1 = Community school	2 = Drop-in center	3 = Government school	4 = Fee-paying private school	5 = Fee-paying tertiary education
1			☐	☐	☐	☐	☐	☐	☐
2			☐	☐	☐	☐	☐	☐	☐
3			☐	☐	☐	☐	☐	☐	☐
4			☐	☐	☐	☐	☐	☐	☐
5			☐	☐	☐	☐	☐	☐	☐
6			☐	☐	☐	☐	☐	☐	☐
7			☐	☐	☐	☐	☐	☐	☐
8			☐	☐	☐	☐	☐	☐	☐
9			☐	☐	☐	☐	☐	☐	☐
10			☐	☐	☐	☐	☐	☐	☐

B. Food Consumption

B1 How many bags of mealie-meal did the household purchase for consumption in the last month?

Bag Size	Number Purchased
50 kg	
25 kg	
12.5 kg	
10 kg	
5 kg	
2.5 kg	
0.5 kg	

B2	Where did the food that you ate yesterday come from? **(check all that apply)**					
		YES	NO		YES	NO
	1. From own harvest	☐	☐	7. Food received—General food distribution/nutritional support programme	☐	☐
	2. Casual labour	☐	☐	8. Food received—Home-based care	☐	☐
	3. Borrowed	☐	☐	9. Food received—School feeding/OVC take-home ration	☐	☐
	4. Bartered	☐	☐	10. Food received—Food for work/food for assets	☐	☐
	5. Gift	☐	☐	11. Purchased (Shop, market, kantemba)	☐	☐
	6. Gathered from wild	☐	☐	88. Other sources **(specify)**	☐	☐

B3	In the past month, did anyone in the household ever cut the size of meals or skip meals because there wasn't enough food?	Yes No **(circle response)**
B4	If yes, how often did this happen? **(circle one response)**	Daily (1) Every other day (2) Weekly (3) Once (4)

C. Food Aid		
C1	Is the household currently receiving any donated food from other than PCI/WFP?	Yes No **(circle response)**
C2	If yes, from whom is the food received?	
C3	How much food is the household currently receiving each month?	

D. Household Income and Production		
D1	Was the client the primary income earner in the household before becoming ill?	Yes No **(circle response)**
D2	What is the household income (from salary, rental income, vending, gifts, etc.) per month? **(circle one)**	Less than K50,000 (1) K50,000 to K199,000 (2) K200,000 to K500,000 (3) Over K500,000 (4)

E. Buddy		
E1	Does the client have a buddy?	Yes No **(circle response)**
	If no, the caregiver should: 1. Review with the patient the importance of having one, and 2. Review the characteristics of a good buddy and help the patient identify someone	

F. Clinical Data		
F1	Is the client able to walk without assistance?	Yes, all the time (1) No, not at all (2) **(circle response)** Sometimes (3)
F2	Is the client suffering from chronic diarrhea? **(circle response)**	Yes (1) No (2) Don't know (3)
F3	If yes, how many months? **(circle response)**	Less than 6 months (1) 6 months or more (2)
F4	Is the client currently on TB treatment? **(circle response)**	Yes (1) No (2) Don't know (3)
F5	If yes, is client in intensive phase? **(circle response)**	Yes (1) No (2) Don't know (3)
F6	Is client receiving food ration as TB patient? **(circle response)**	Yes (1) No (2) Don't know (3)

Endnotes

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