Targeted Food Assistance in the Context of HIV/AIDS

Better Practices in C-SAFE
Targeted Food Programming
in
Malawi, Zambia and Zimbabwe

A Study Published by the C-SAFE Learning Center

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Executive Summary

As a regional program implemented by a consortium of sixteen NGOs, C-SAFE presents a wealth of opportunities for both reflective learning within the consortium and dissemination of better practices and lessons learned to a broader stakeholder audience. This study reviewed C-SAFE's targeted food assistance programs in order to better understand the opportunities, constraints and better practices associated with targeted food assistance with particular with emphasis on HIV/AIDS-affected individuals and households.

The findings are presented in two sections:

Section 1: Targeted Food Assistance (for non-medical interventions) describes five thematic areas of programming. Each theme is analyzed, case studies depicting better practices are provided and key learning points are summarized. Topics such as beneficiary targeting and selection, and the development of graduation and exit strategies are widely applicable (to any type of food programming), while the specific challenges and lessons from working in an HIV/AIDS context are also drawn out. Creative initiatives to provide complementary programming and appropriate food rations are particularly relevant to country programs with a high prevalence of HIV/AIDS.

Section 2: Linking Targeted Food Assistance with Medical Interventions is distinct from Section 1 because although linking food support to medical interventions is a relatively new area of programming for C-SAFE members, there has been a clear demand for direction about how to link food assistance with TB, PMTCT, & ART programming. This section comprises a brief background statement followed by guidance notes derived from existing technical literature and interviews with C-SAFE technical staff and stakeholders. These guidance notes will be updated as better practices emerge and empirical evidence begins to inform programming.

The onus is clearly on the southern Africa region to intentionally document and disseminate learning on the use of food assistance where HIV prevalence is high. This study is intended to provide a springboard to further discussion and much-needed research that will drive decision-making and programming here and around the world.

Contact Information

The key findings from this document were presented at dissemination meetings in Harare, Blantyre, Johannesburg and Lusaka on the 13th, 15th, 17th and 20th of September respectively. Feedback was provided (by C-SAFE members and other stakeholders in attendance) both verbally and in writing and was incorporated into this final version. If you have comments or questions on this document, please send them to: kara_greenblott@c-safe.org

Authors: This document was co-authored by C-SAFE (Kate Greenaway and Kara Greenblott) and Tango International (Clara Hagens).

Reviewers: Special thanks to the following representatives from C-SAFE members for taking time to carefully review various drafts of this document and making significant recommendations towards its improvement: Emily Movall (CRS Malawi), Greg Bastian (CRS Zimbabwe), Patrice Charpentier (CARE Zambia), Krishnan Unny (CRS Zambia), Thomas Mugala (CRS Zambia), Lilembalemba Lilembalemba (WV Zambia), Michelle Parke (WV Zambia), Jamo Huddle (WV Zimbabwe), Felix Phiri (Africare Malawi), Paulo Chiziwa (SAVE-US Malawi), Matilda Nangoma (Malawi Red Cross Society), Shannon Senefeld, (CRS SARO), Dr Jay Buensuceso (CARE Zambia), Gertrude Kara (WFP Malawi), and Michka Seroussi (C-SAFE RPU). Also thanks to Dr. Mugo Muita for his inputs on the clinical section of the document; and to John Service (CRS Zambia) for his help in finalizing the document.

Funding: This document is a product of the C-SAFE Learning Center. The Learning Center is funded by USAID's Office of Food-for-Peace, WFP Headquarters HIV/AIDS Unit, and private funding from CARE, CRS and World Vision.

Introduction

Background on C-SAFE: The Consortium for the Southern Africa Food Security Emergency (C-SAFE) is in its second year of implementation for a coordinated 'developmental relief' program in Malawi, Zambia, and Zimbabwe. The Consortium implements relief and recovery programs to 1) improve nutritional status, 2) protect productive assets, and 3) support households and communities to strengthen their resilience to current and future food security shocks. C-SAFE consists of three core members, CARE, Catholic Relief Services (CRS), and World Vision (WV), with each taking the lead in one country. The Malawi consortium has six additional members: Africare, Emmanuel International, Malawi Red Cross, Salvation Army, Save the Children UK, and Save the Children US. ADRA joined the C-SAFE Zambia consortium in Year 2. The regional program unit (RPU) is located in Johannesburg, South Africa.

C-SAFE's program was designed with the understanding that the severity of the 2002 food security emergency reflected the fragility of livelihoods throughout southern Africa and that any strategy seeking to successfully reverse this trend must address both the 'acute' *and* the underlying 'chronic' food insecurity. C-SAFE was thus founded on a broader and more diversified understanding of livelihood and safety-net recovery, and was intended to complement the ongoing developmental programming that C-SAFE members have undertaken in this region over the last several decades.

Learning Spaces: Given the novel approach of a regional NGO consortium and the application of the "developmental relief" strategy, C-SAFE presents a wealth of opportunities for both reflective practice within the consortium and dissemination of best practices and lessons learned to a broader stakeholder audience. In order to provide a forum for reflective practice and capture learning, C-SAFE developed the Learning Spaces initiative. The initiative engages in learning activities around themes such as working as a consortium, development relief, targeted food programming in the context of HIV/AIDS, adapting Food For Assets to an HIV/AIDS context, and others that have been prioritized by C-SAFE membership.

Objective of this Study: This study – Targeted Food Programming in the Context of HIV/AIDS – is a product of C-SAFE's regional Learning Spaces initiative. The document is divided into two distinct sections:
Section 1: Targeted Food Assistance (for non-medical interventions). This section is structured as follows *1) context for each theme and description of C-SAFE's experience in relation to that topic*, including the specific challenges the consortium members have faced due to the unique operating context (i.e. high HIV/AIDS prevalence and other related factors); *2) presentation of cases studies depicting better practices* which have been identified in C-SAFE programming in relation to the respective theme; and finally, *3) a brief summary of what C-SAFE has learned* from these case studies and programming experiences across the consortium in general.
Section 2: Linking Targeted Food Assistance with Medical Interventions. This section is distinct from the previous section because linking food support to medical interventions is a relatively new area of programming for C-SAFE members. In response to the members' expressed need for direction and consistency in this area, C-SAFE has developed guidance notes based not only on experience, but on existing technical literature (cited in the document) and interviews with C-SAFE technical staff and stakeholders to gather a consensus of opinion on appropriate practices. These guidance notes will be updated as better practices emerge and empirical evidence begins to inform programming.

Methodology: This study was developed with input from C-SAFE programming staff and stakeholders such as WFP and UNICEF in Malawi, Zambia and Zimbabwe as well as regional offices in South Africa. Where necessary the authors incorporated current thinking drawn from existing medical literature, especially with regard to the sections on TB, PMTCT and ART. The authors interviewed both program managers and field staff in order to gather a range in perspectives with respect to better practices in food programming. A semi-structured questionnaire was used during the initial fieldwork, in addition to follow-up interviews to gather detail on specific case studies. The questionnaire queried the participant's perception of the program objectives; the details of program implementation within his/her NGO; successes and problems cited; and feedback from communities and beneficiaries.

C-SAFE Targeted Food Assistance: Each C-SAFE country consortia provides food rations to commonly agreed upon targeted vulnerable groups. At its inception, the consortium identified four groups which would be prioritized for food assistance which include the following: 1) households affected by chronic illness; 2) pregnant and lactating women; 3) orphans and vulnerable children; and 4) malnourished children under five. Chronic illness is used as a proxy indicator for AIDS throughout C-SAFE programming and literature.

In years two and three of the three-year program, the consortium members are also implementing transitional (recovery oriented) programming under Objective 2 (building productive assets) to complement the targeted direct distributions, and to provide graduation strategies for those beneficiaries who, due to improvements in household food security (for example), no longer meet the criteria of the above listed vulnerable categories.

Establishing the Program

Terminology

Differences in terminology across the C-SAFE countries, as well as the C-SAFE NGO membership were evident at the early stages of the program. Assisting targeted vulnerable groups such as 'households affected by chronic illness' requires a common understanding of the terminology to ensure consistency in programming, comparability when analyzing data with respect to the beneficiary groups, and facilitation of learning.

As a regional consortium, C-SAFE experienced significant challenges in finding a common language, while simultaneously respecting the autonomy of individual NGO members and the pre-existing (or emerging) protocols of individual country governments where C-SAFE works. While variations in interpretation continue to occur in some cases, the commonly accepted definition of **'chronic illness'** -- *persistent and recurring illness lasting three months or more, which has decreased an individual's productivity* – was developed in C-SAFE's design phase. The definitions in the box to the right are used in C-SAFE programming and literature. It should be noted, however, that there is still some variation in application at the operational level due to varying NGO and country protocols as mentioned above.

It has been valuable for C-SAFE staff to refine their thinking of 'HIV and AIDS' in order to better understand the needs of food-aid recipients. Differentiating between 'HIV' (a long-term, asymptomatic illness) and 'AIDS' (a cluster of concurrent symptoms and illnesses) was a crucial step in this process. One practical application of that understanding has been C-SAFE's policy of providing food rations to the latter, and not to the former (except for specific cases such as HIV+ Pregnant/Lactating Women).

Pregnant and lactating women (PLW): *Women identified as pregnant by the health center or at community level, up to six months after delivery*[1]*.* ***Malnourished*** *PLW are pregnant as identified by health center or at community level, up to six months after delivery, with (MUAC) of under 21cm (or consistent with national guidelines).*

Malnourished children under five years of age: *Moderate acute malnourished children aged 6-59 months, <-2z score or between 70% and 80% weight for height; or, mid upper arm circumference (MUAC) <12.5cm (if no height boards)*

Orphans: *Single Orphan: A child up to 18 years of age who has lost one parent due to death. Double Orphan: A child up to 18 years who has lost both parents due to death.*

Chronically Ill (CI) Individual: *An individual experiencing persistent and recurring illness lasting three months or more, which has reduced that person's level of productivity.*

Admission criteria: *The vulnerability characteristics (demographic, health-related and other) that allow an individual or household to become eligible for targeted food assistance as identified by C-SAFE. Admission criteria generally include food security criteria which are used to prioritize vulnerable individuals or households for enrollment into the program (i.e. asset wealth ranking, food stocks, etc.)*

Effective Dependency Ratio: *C-SAFE uses a modified version of the Dependency Ratio called an* ***Effective*** *Dependency Ratio. The formula used is (total household members – productive members) / productive members. This is modified from the standard Dependency Ratio (which is purely age-based) to reflect more accurately the context where adults between 15-64 may in fact be dependent*[2]*. The larger the Effective Dependency Ratio, the greater the challenge of the household to cover its basic needs.*

Discharge criteria *The point at which individuals or households are discharged (or de-selected) from the targeted food assistance program due to changes in vulnerability characteristics; improvements in health, nutritional status or household food security; or, completion of medical treatment (in the case of TB patients).*

Graduation strategy: *The specific plan describing* ***how*** *the beneficiary will be discharged from targeted food assistance while assuring that achievement of the program's objective (with regard to that beneficiary) is not jeopardized, and that further progress toward that objective will be made. The goal of the graduation strategy is to ensure sustainability of impacts after the beneficiary has been discharged from the program.*[3] *It normally involves facilitating access or 'graduating' a beneficiary to other food security interventions to ensure that the beneficiary's food security and livelihood status continues to improve following his/her discharge from targeted food assistance.*

Exit strategy *is the specific plan describing how the program intends to withdraw from a program area while assuring that the achievement of the program's goals is not jeopardized, and that further progress toward these goals is made. The goal of an exit strategy is to assure sustainability of impacts and activities after the program has departed.*[4]

[1] *This timeframe is applied in order to position food assistance during the most vulnerable period of lactation although it is clearly acknowledged that many women breastfeed beyond six months.*

[2] *Save the Children UK. Food Security, Livelihoods and HIV/AIDS, August 2004*

[3] *While FANTA describes a graduation strategy as the withdrawal of resources from a program site, C-SAFE prefers to apply the term to the beneficiary level with the focus being on ensuring that a plan exists to graduate a targeted food assistance beneficiary to another food security strategy/program upon discharge from the program.*

[4] *"FANTA. Program Graduation and Exit Strategies: Title II Program Experiences and Related Research April 2004*

Understanding the HIV and AIDS Operating Environment

It is widely understood that HIV, AIDS, nutrition, and food security are inextricably linked. HIV/AIDS and food insecurity are mutually reinforcing, and the nutritional needs of people infected/affected by HIV are dynamic, changing with time and eventual disease progression. While food aid provides a much-needed short-term safety net, it is only one piece of a much larger food security challenge. The challenge lies in identifying the most appropriate food or nutrition intervention, targeting the right individual / household / community, and providing it at the right time (and for the right duration) for maximum effect. C-SAFE's experience with the drought of 2001-2002 highlighted the complexity of designing food aid/security programming in the context of high HIV prevalence rates.

To ensure effective and appropriate food programming, it is necessary to step outside the traditional practices and mechanisms of emergency relief and recovery operations (procurement, logistics, crop assessments, etc.) to discover how food programming could / should interact with HIV and AIDS in the targeted communities. This means doing research, developing new partnerships, bringing new skill sets to the staff team and providing training to staff and partners. It means finding ways to address HIV/AIDS in the workplace in order to prepare staff for the multifaceted challenges this programming will present.

It is not enough to simply identify HIV as a 'cross-cutting theme' and expect that relevant strategies will emerge spontaneously. 'Applying the HIV/AIDS lens' to program design requires that an HIV/AIDS analysis must be purposefully undertaken at the outset and relevant, practical strategies/mechanisms must be woven into the project framework. It is necessary to deliberately (and continuously) solicit input from key stakeholders and technical advisors in the HIV/AIDS field. A solid understanding of relevant government strategies[5] and aspirations regarding prevention, care and support and impact mitigation is essential. The planned involvement of people living with HIV/AIDS will guide the development of a credible, effective strategy. Strong leadership and commitment are required to give 'HIV mainstreaming' the high profile and resources it deserves.

CI Children Ages 6-18 Defy C-SAFE Assumptions

When C-SAFE was designed it was assumed that there would be very few children between 6 and 18 years of age with HIV/AIDS since it was believed that most children (who contracted HIV from their mothers) did not survive beyond the five-year mark. WV Zambia opted to include them as indirect beneficiaries through either OVC feeding or CI feeding for one of their caretakers. WV has learned during the course of program implementation that our initial assumption was not correct, and a considerable number of primary CI beneficiaries are in fact children between 6 to 18 years of age: 8.9% in Choma and 6.3% in Kalabo. It is likely that similar situations exist elsewhere in Zambia as well as in other C-SAFE countries. As disaggregated information is collected and analyzed for the CI beneficiary group, C-SAFE hopes gain a better understanding of this demographic trend and how best to support this group.

Supporting Existing Programming

C-SAFE NGO members have extensive food security experience throughout the southern Africa region and have made a concerted effort to integrate C-SAFE interventions into existing programming where possible, as opposed to introducing the C-SAFE pipeline independently. This includes integration with programs implemented by both C-SAFE members as well as non-C-SAFE members to assure a holistic approach to programming.

C-SAFE interventions often occur in the same communities as previously existing programs, and in many cases, are able to complement these efforts programmatically. C-SAFE programming also serves to strengthen current relationships with communities and local structures, as well as to establish *new* community relationships where C-SAFE has expanded an NGO's coverage area. The diverse NGO membership has integrated the C-SAFE pipeline into existing programming using a variety of approaches based on each NGO's particular programming and partnership niche.

C-SAFE Zimbabwe members also emphasize assistance to institutions supporting vulnerable groups, particularly orphans. To receive support, an institution must be registered, provide complementary services, demonstrate need and support vulnerable groups. While it is understood that communities and extended families generally provide the most appropriate (and most sustainable) care, institutions may be the last resort for the most vulnerable, even if only for a short-term stay. Targeted institutions may include: Orphanages; Rural and Urban Child Daycare facilities; Hospice Care facilities for Adults and Children; Schools/Homes for the Disabled; Skills Training Centers; Homes for Elderly; Centers for Street Kids; OVC Support programs (i.e. Masiye Camp).

[5] *World Food Program.* *Programming in the Era of AIDS: WFPs Response to HIV/AIDS, WFP Policy Paper, January 2003*

While this 'diversity' in approach has offered a plethora of opportunities for learning, it has not been without its challenges since the lack of standardization across the C-SAFE membership has made monitoring, evaluation and reporting more difficult. These brief case studies exemplify some of those approaches used by the NGO members to integrate C-SAFE interventions into existing programming.

Community Counseling Experience Provides Foundation for Launching C-SAFE

The Salvation Army (TSA) Malawi used USAID funding via a SAVE-US sub-grant to pave the way for community-based food aid targeting. TSA strengthened an existing strategy by training community counselling teams, equipping them with skills much like a standard counsellor, but with the intention of using their skills with small groups and families where a 'shared confidentiality' model was more culturally congruent that one-to-one counselling. This provided a very strong foundation for the community to assist households with chronically ill members and paved the way for targeting C-SAFE food distributions.

ADPs Provide Entry Point for C-SAFE Programming

WV Malawi was working in three districts with established Area Development Programs (ADPs) when C-SAFE targeted food assistance became available. Each ADP covers several communities composed of 4,000 to 6,000 households within a certain geographic area. As is typical with the ADP approach, WV had committed to assisting these communities in integrated development programming for 10 to 15 years. The ADPs provided an ideal structure through which to introduce the C-SAFE initiative since they had an ongoing working relationship with those communities, as well as extensive statistics available on food security vulnerability within those communities to assist in identifying C-SAFE's target groups.

When initial assessments showed significant numbers of vulnerable individuals and households falling outside the ADP boundaries, WV decided to extend C-SAFE's coverage to those communities as well. And later, when WV began planning its exit strategy for the C-SAFE program, the ADP model once again provided a practical solution since complementary ADP programming provides a natural graduation strategy for C-SAFE beneficiaries, and those communities that fell outside the boundaries were integrated into neighboring ADPs thereby also benefiting from the long-term ADP interventions.

C-SAFE Links with CoGuard in Malawi

CoGuard was the Malawi-based, consortium-wide supplementary feeding program, in which all C-SAFE members participated under the leadership of Africare. The aim of CoGuard was to rehabilitate moderate acute malnutrition among children under five, and among pregnant and lactating women. CoGuard, funded by OFDA, provided training to partner and health center staff under the Government of Malawi's newly established supplementary feeding protocol. C-SAFE provided the food commodities for the CoGuard program, which were distributed through participating health centers. C-SAFE's Malawi program therefore met its objective of improving nutritional status of targeted groups by direct integration into a pre-existing nutritional rehabilitation program, with staff training and nutritional monitoring supported by other donor funding.

CRS Integrates C-SAFE with its HBC Programming

Access to food has been a long-standing, serious gap in the delivery of Home Based Care (HBC) services, and is often cited as the most significant contributor to attrition among HBC volunteers who feel discouraged by their inability to assist clients in meeting such basic requirements. HBC programs continue to be a strong mechanism for targeting households with chronically ill members or where households have recently experienced the death of a productive adult. In all three C-SAFE countries, CRS links very closely with the Catholic Diocesan structures that support HBC and OVC activities. With strong referral mechanisms between hospitals/clinics and community-based HBC volunteers, this mechanism provides C-SAFE with direct access to some of the most disadvantaged households in the region. Similarly, C-SAFE's food programming has been welcomed with enthusiasm by both HBC and OVC partners as it adds value to those programs. The relationship is mutually beneficial since C-SAFE strengthens HBC programming while HBC programming allows C-SAFE to target more effectively.

SCUK Nutritional Monitoring Leads to Relief Efforts

The international humanitarian community first took note of the brewing crisis in Malawi early 2002 when Save the Children-UK alerted the donors to rising rates of malnutrition in specific areas of the country. The NGOs in Malawi formed a consortium (JEFAP) with resources provided by WFP in response to the crisis, with a general food ration distributed in each of the NGOs' operational areas. C-SAFE's program followed JEFAP and was implemented by nine of the 12 original members of the consortium. The program began in early 2003 with a complementary pipeline that focused on targeted vulnerable groups (in contrast to the general food distributions under JEFAP).

Support to Staff: Training and Workplace Policy

Member NGOs recognize that adequate support and training for NGO (and NGO partner) staff members is a necessary step towards providing effective HIV/AIDS programs to C-SAFE communities. The development of NGO Workplace Policies are an essential step in protecting and enhancing the investment made in staff capacity building, while purposefully preparing staff to undertake the complex challenges of programming in this context. C-SAFE has supported several agencies in their development of 'HIV/AIDS Workplace Policies.' Learning from the experience of CARE Zambia, CARE Malawi and CARE Zimbabwe have launched their policies; while Malawi Red Cross, Emmanuel International in Malawi, and CRS in all three countries have initiated policy development processes.

A Guidelines Document on the process of policy development has been developed by C-SAFE based on the above-cited experiences, and circulated to all members and posted on the C-SAFE website. Other means of support include regular training events to facilitate networking, sharing better practices and providing technical updates, as well as promoting the exchange of information through other means such as newsletters, circulation of literature and informal discussions around issues.

A *designated* staff position mandated to spearhead, guide and document HIV/AIDS-related activities in food aid programming is a crucial member of the team in high prevalence countries. Technical assistance and leadership is required to inform targeting decisions, guide commodities choices/ration sizes, support the staff development required to effectively manage programming and ensure collaboration with key stakeholders (Ministries of Health and AIDS Service Organizations). See a sample job description attached (Annex 2).

C-SAFE Newsletter Promotes Learning

The C-SAFE HIV, AIDS and Nutrition Newsletter has been produced and circulated on a bi-monthly basis to a wide audience with an enthusiastic response. Informal reactions from readers indicate that the material is stimulating and relevant to their programming environment. C-SAFE staff have used the crossword puzzle to foster learning through various group and individual events although field staff initially complained that the puzzle was too difficult. Once amended to an easier level, the puzzle drew many responses from within the region and beyond! The newsletter features success stories from the field; technical updates; a regular section on HIV and AIDS related terminology; and recently announced events and released publications.

Shifting Staff Responsibilities to Mainstream HIV/AIDS

In a workshop held in March 2004, CARE Zimbabwe trained 24 carefully selected Focal Point Persons (FPPs) in the fundamentals of HIV and AIDS. To kick-start integration efforts, FPPs committed an agreed percentage (from 20 – 50%) of their work week to HIV and AIDS issues over the subsequent three months in order to train their colleagues and begin the process of identifying and implementing appropriate HIV and AIDS integration strategies. This program addresses mainstreaming not by simply adding responsibilities for HIV/AIDS to overburdened staff but by shifting existing responsibilities of select staff members and setting realistic goals over a short, well-defined period.

Networking and Cross Learning Brings C-SAFE Staff Up to Date on HIV/AIDS Technical Issues

"HIV and AIDS: Opportunities for Food Security Programming" workshops were held in Zambia, Malawi and Zimbabwe between March and May 2004. Over 100 participants committed themselves to action plans for staff support and development, as well as food security programming. The training aimed to provide technical updates on HIV, AIDS and nutrition that will influence and inform future programming; facilitate internal networking and information-sharing within and between Consortium members; provide insight into existing capacities and expertise; and facilitate external networking and information-sharing to connect C-SAFE managers with relevant government strategies and the work being implemented by other stakeholders. For many participants, this workshop was their first opportunity to learn about the interactions between HIV/AIDS and Nutrition, and their exposure to the information prompted both personal affirmations and professional commitments that strengthened current programming and future planning. Equally important, at each workshop, at least two representatives from the other two C-SAFE country consortia were invited to participate, with the goal of facilitating communication and sharing of better practices not only within each country, but across the region.

Sensitization of Communities

Each C-SAFE NGO holds community sensitization meetings prior to food distributions (and sometimes at various points throughout the program) to discuss the objectives and basic procedures of the targeted food assistance program, and to provide updated information at later stages of the program. The sensitization meetings are usually conducted by field staff, involve the entire community (beneficiaries and non-beneficiaries alike), and are scheduled around other community events in order to maximize attendance.

C-SAFE NGOs across the three countries include similar topics in the sensitization process. They are:

- objectives of the program, both short-term and long-term
- duration of program
- definitions of targeted vulnerable groups
- rationale for targeting these vulnerable groups
- means of prioritization within those groups (food security criteria, etc)
- selection mechanisms and process (i.e. community selection committees)
- ration scale
- verification AND re-verification system, including objectives and frequency
- graduation strategies, if any
- complementary activities, if any
- cooking demonstrations and nutrition information, where new commodities were introduced
- 'help desk', or protocol for filing complaints or problems

The sensitization process is most effective, will reduce duplicity and increase collaboration when it reaches a broad audience, including village leaders, local health center staff, local NGO/CBO staff, community committee members, potential beneficiaries and non-beneficiaries, and any additional relevant stakeholders. It is useful for the sensitization process to include a component on roles and responsibilities for all involved, as well as for communities to fully understand the objectives of both verification and re-verification processes to ensure their full support and cooperation in the process.

The sensitization meetings are best conducted in a neutral area, clear of health centers and churches, to avoid creating false impressions of any political or religious affiliation with either the source of the food or the selection criteria.

C-SAFE members also noted that is useful to provide *on-going* sensitization to beneficiary communities and stakeholders to provide up-to-date information on various changes in C-SAFE programming. In general, C-SAFE has found that the more thorough the sensitization process, the smoother the implementation of the program, with greater satisfaction on the part of the beneficiary population.

Traditional Healers to Assist with Targeting in Zambia

CARE in Zambia has initiated an innovative strategy to target potential food aid beneficiaries who may not be captured through standard mechanisms. CARE recognized that in rural settings, many individuals with chronically illness seek assistance from Traditional Healers rather than government health services, especially where government health services are seen to have 'failed'. Many Traditional Healers in Zambia are organized, formally registered and trained in HIV and AIDS, and have expressed an interest in establishing a referral mechanism through which their clients could access food aid. In year three of C-SAFE, CARE plans to formalize this mechanism in order to include THs in their referral network.

'Indunas' Help Sensitize Communities

CRS Zambia conducts community sensitization activities through traditional leaders called 'Indunas'. Indunas are an important entry point into communities as they are respected authority figures that historically retain the trust and confidence of their communities. Since the program began, all CRS activities have been introduced through these traditional leaders and their communities have responded favorably. When problems did arise, the Indunas were able to assist the program in finding practical solutions and then sensitizing their communities as to the way forward. In one instance, bulgur wheat was to be provided but the communities were not familiar with this type of food. CRS Zambia's implementing partner worked with the Indunas to explain the dietary benefits, as well as different options for preparing the new commodity. Once the leaders accepted the commodity, and were comfortable with the information, they facilitated the sensitization process for the community.

ADRA Builds on Health Programming

ADRA joined C-SAFE in Year 2 with experience in relief, agriculture and health programming. ADRA had ongoing programs to build health posts and train community health workers and recognized the need to link C-SAFE's program to their existing programming and expertise. Under C-SAFE, ADRA targets 5,000 CI beneficiaries in collaboration with the MoH through the District Health Management Team and the Ministry of Community Development and Social Services. C-SAFE food distributions are conducted at the Health Centers where nutrition is monitored, and health workers trained by other ADRA programs give talks on health and nutrition issues.

Summary of Learning- Establishing the Program

Terminology:

- A common understanding of the terminology is essential to ensure consistency in programming; comparability when analyzing data with respect to the beneficiary groups; and to facilitate communication and learning across stakeholders.

Understanding the HIV/AIDS Operating Environment:

- It is necessary to deliberately solicit input from key stakeholders and technical advisors in the HIV/AIDS field. A solid understanding of relevant government strategies[6] and aspirations regarding prevention, care and support and impact mitigation is essential.
- Targeted food programming in a high prevalence context requires doing the research, developing new partnerships, bringing new skill sets to the staff team and providing training to staff and partners.

Supporting Existing Programming:

- Targeted food assistance programming has been more effective in reaching its goals when integrated into pre-existing relief and/or developmental programs and infrastructures, as opposed to establishing an independent pipeline.
- Integration into pre-existing programming allows C-SAFE food to complement existing relief/developmental efforts, and can serve to strengthen current relationships with communities and local structures. It can also help to establish new relationships where C-SAFE expands an NGO's coverage area.

Support to Staff – Training and Workplace Policies:

- An HIV/AIDS Workplace Policy, including a comprehensive and on-going staff training program, is an integral aspect of adapting food programming to an HIV/AIDS context. A well-designed and fully implemented policy serves to protect and enhance the investment made in staff capacity building, and to purposefully prepare staff to undertake the complex challenges of programming in this context. Find C-SAFE Guidelines for developing HIV/AIDS Workplace Policies www.c-safe.org.
- A *designated* staff position mandated to spearhead, guide and document HIV/AIDS-related activities in food aid programming is a crucial member of the team in high prevalence countries. (sample job description in Annex 2).
- Regular training aimed at staff from all sectors and sections (both developmental and relief) is essential to ensure that food programming benefits from cross-sectoral exchange and learning in relation to HIV/AIDS. Training should provide technical updates, facilitate internal networking and information-sharing between NGO staff, provide insight into existing capacities and expertise, and facilitate external networking and information-sharing to connect NGO managers with relevant government strategies and the work being implemented by other stakeholders.

Sensitization of Communities:

- Sensitization is most effective in reducing duplicity and increasing collaboration when it reaches a broad audience of village leaders, local health center staff, local NGO staff, community committee members, potential beneficiaries and non-beneficiaries, and any additional relevant stakeholders.
- Important themes to include in the sensitization process include: objectives and duration of program, definitions of targeted groups, reasoning for targeting these groups, means (criteria) of prioritization within those groups, selection mechanisms and process, ration scales, verification AND re-verification system graduation strategies, complementary activities, and a 'help desk' or protocol for filing complaints or problems. (see complete list under Sensitization).
- Sensitization meetings are best conducted in a neutral area, clear of health centers and churches, to avoid creating false impressions of any political or religious affiliation with either the source of the food or the selection criteria. It is also useful to provide *on-going* sensitization (throughout the program) to up-date communities on changes in the programming.

[6] *World Food Program. Programming in the Era of AIDS: WFPs Response to HIV/AIDS, WFP Policy Paper, January 2003*

Targeting

The operating context in the C-SAFE countries is characterized by widespread and chronic vulnerability to food insecurity, often making it difficult to distinguish between the vulnerable and the 'most' vulnerable members of the population. Additionally, donor resources are declining and do not meet overall requirements exerting additional pressure on NGOs to allocate resources wisely. And finally, the high HIV/AIDS prevalence context introduces the added complication of stigma and a paucity of lessons to draw from in terms of identifying who is most vulnerable, how to identify them and how to provide the most appropriate support. The multiple pressures for effective targeting have presented unique challenges to the C-SAFE members, as well as unique opportunities for learning.

The simultaneous use of a range of targeting mechanisms is required to ensure that the most appropriate individuals/households are identified and selected for provision of food rations or participation in other food security interventions. Finding the right balance between rigor and cost-effectiveness is a challenge. It is important to cast the net widely by explicitly involving community structures, HBC providers, Traditional Healers, etc. using criteria and systems adequately **sensitive** (to avoid the exclusion of those who should be eligible) and **specific** (to ensure that those deemed not eligible are, in fact, excluded)[7]. This is especially true in southern Africa where stigma and denial can confound transparent, explicit targeting. Working with all of these groups requires dedicated investment in relationship development and capacity building. Fortunately, C-SAFE's membership is diverse, allowing for wide range of approaches to targeting, depending on pre-existing programming and local partnerships.

In a high prevalence context where adults (rather than children) comprise the primary target group, traditional targeting methods (especially those using anthropometric measures such as weight-for-height and BMI), may not be appropriate. When assessing chronically ill adults, the attribution of results is often obscured by multiple simultaneous interventions. Equally important, staff are generally uncomfortable collecting this data, especially from adult beneficiaries who may continue to decline in spite of intervention. Targeting based on anthropometry, if applied at all in this context, must be used only in conjunction with other criteria.

While referrals from HBCs, health clinics and hospitals may include those who are vulnerable due to their poor health or nutritional status (chronic illness, malnutrition, etc.), the application of ***multiple vulnerability criteria*** ensures that from those referred (i.e. those that meet general selection criteria for the targeted vulnerable groups), the 'most' vulnerable within each group is served. Multiple vulnerability criteria can be in the form of demographic characteristics which are known to reflect vulnerability (such as a child-headed household or household with high dependency ratio); or alternatively, in the form of food and livelihood security criteria (such as asset wealth ranking or household food stocks). This strategy also reduces the risk that short-term food aid will create false incentives (i.e. families taking in orphans in order to quality for food aid, without making a long-term commitment to the child).

C-SAFE's baseline survey (April 2003) and Community and Household Surveillance (CHS) system findings emphasize the point that multiple vulnerability criteria are necessary to identify the most vulnerable households in a given community. The 2003 C-SAFE baseline survey found that vulnerability was most highly correlated with those households falling into two or more of C-SAFE definitions of vulnerability. For example, the presence of orphans alone was not a determinant of vulnerability for a household. The presence of orphans was a determinant of vulnerability when other criterion, such as a female- or elderly-head of the household, were met. Based on this information, C-SAFE recognized the necessity of utilizing multiple targeting criteria to identify the most food insecure beneficiaries and has changed targeting procedure accordingly.

In both Malawi and Zambia, C-SAFE does not have the resources to meet the overall need under each vulnerable group category. To ensure the most judicial use of resources, all individuals who are eligible (i.e. meet the vulnerable group criteria) undergo a second screening based on food security criteria. This acts to reduce the numbers (given resource constraints), and more importantly, to ensure that the most vulnerable individuals within each vulnerable category are the ones that eventually receive food.

[7] *Taylor, Anna and Seaman, John. Targeting Food Aid in Emergencies (Save the Children UK) ENN Special Supplement Series, No. 1, July 2004.*

C-SAFE Zambia uses the following food security criteria to prioritize individuals and households within each vulnerable group criteria:
Ownership of shops, businesses, ox-carts, etc, which generate income
Employment: formal, informal, temporary and part time,
Cattle/livestock ownership
Amount of land cultivated
Amount of food harvested versus the household requirements (both consumption and income generation are considered)
Household items owned, i.e. farming implements, etc.
Amount of support available from extended family and community, including remittances
Presence of productive adults in the household and number of dependants

The C-SAFE Zimbabwe program used similar criteria for its General Food Distributions (recently phased out due to government opposition to food aid). And as C-SAFE moves to its third year, the Zimbabwe consortium's more targeted Vulnerable Group Feeding program will apply an even more sophisticated system of analysis for ranking the vulnerability of the beneficiary households using Multiple Vulnerability Criteria (see case study under *'Selection Process and Criteria'* for details).

The following pages will discuss the various aspects of targeting including knowing the program objectives, dealing with stigma, the selection process, establishing criteria for admission and discharge, and graduation strategies.

Understanding the Program Objectives

A clear understanding of the purpose of an intervention is an essential first step in designing a targeting strategy. The objectives of individual interventions vary widely across C-SAFE's diverse regional program. For some interventions, project proposals and staff reported multiple objectives. The following examples demonstrate the diversity in types of programs for interventions that fall under C-SAFE's Objective 1: Improve Nutritional Status of Targeted Vulnerable Groups.

CoGuard Food Component (C-SAFE Malawi): Nutritional rehabilitation of moderate acute malnutrition of children under five and pregnant and lactating women.
Rations to Households affected by Chronic Illness (C-SAFE Zambia): Protect food security and livelihood status of vulnerable households; mitigate the impact of AIDS on vulnerable households; provide nutritional support to chronically ill members and their family members.
Supporting TB patients on DOTS: As a short-term adjunct to clinical treatment to improve uptake of TB control programs; to restore health and foster weight gain; to support treatment adherence and completion.
Nutrition Education: Support the longer-term food security and nutritional status of the vulnerable groups receiving food rations. Encourage dietary and crop production diversification impacting health and nutrition in the longer term.
Rations to Pregnant Women in conjunction with PMTCT programs: Encourage the uptake of emerging PMTCT services by using food to draw women to participating antenatal clinics; to protect the HIV-positive mother's ability to resist opportunistic infections during pregnancy (thus reducing orphan-hood).
Rations to HIV-positive Lactating Women in conjunction with PMTCT programs: Protect the mother's ability to resist opportunistic infections during lactation (thus reducing orphan-hood); support the mother's efforts to exclusively breastfeed for up to six months after delivery; encourage the mother's ongoing engagement with PMTCT staff following rapid weaning, until the infant is 12 months old.

For a given intervention, the objective should be clear to the NGO staff, the beneficiary population, and the community at large, in order to facilitate an understanding around *who is eligible* and *at which point the beneficiary should be discharged* from the program.

Dealing with Stigma

The stigma attached to HIV and AIDS continues to hinder the transparent and direct targeting of AIDS-affected households, and demands the use of proxies and other creative approaches to compensate. It is encouraging, however, that several NGO members in all three C-SAFE countries report that stigma is diminishing, especially in the rural areas where C-SAFE works. The level and nature of stigma around AIDS varies considerably from one community to another and is dependent on each community's experiences and leadership. While on one hand the fear of being labeled as HIV-positive discourages some people from registering with C-SAFE, some agencies have discovered that through careful entry to communities and working through knowledgeable and established partners on the ground, individuals and communities are increasingly open volunteering for testing, disclosing their status, discussing and learning more about HIV and AIDS.

Staff sensitization and training sessions have been very influential in breaking down stigma-related barriers. C-SAFE discovered that, in some instances, the desire to be prudent or sensitive actually perpetuated stigma, as project staff fail to recognize or respond to opportunities for open discussion. Workplace training programs presented opportunities for staff to openly discuss their observations, experiences and fears about HIV and AIDS, giving them new skills and confidence with which to approach communities. The phenomenon of stigma and its influence on targeting will require more investigation before it is fully understood by C-SAFE.

Staff Training Tackles Stigma

In June 2004, CARE Zambia began a comprehensive training process for all of its C-SAFE staff as well as selected personnel from CARE partner organizations. The aim of the training was to increase staff awareness of HIV/AIDS information and make plans to apply learning to programming. The training is held monthly and themes include: 1) fundamentals; 2) positive living, wellness and opportunistic infections; 3) treatment options; 4) mitigation activities; and 5) sensitization, skills and culture. Stigma and discrimination were themes within sensitization, skills and culture, and C-SAFE staff had stated that following the training, they had more confidence in handling stigma and discrimination. Simple, practical strategies were presented and staff were encouraged to speak openly of their personal experiences with each other, giving them confidence to interact more freely with beneficiaries.

Selection Process and Criteria

The target group is defined based upon the objective of the intervention, and through the use of selection (admission) criteria. While clear selection criteria are vital to the effective implementation of the intervention, of equal importance is a rigorous and transparent process of selection.

Below are a variety of innovative practices in beneficiary selection and 'verification', all of which involve the community (in different forms) in the identification and registration of beneficiaries. A verification process is crucial to ensuring that those households (or individuals) who have been referred and/or identified by community level institutions/groups are in fact eligible based on an objective and separate verification of their vulnerability characteristics and food security status. The verification process acts as a second screening, often through vigorous house-by-house visits to counter possibilities for nepotism, and to ensure that scarce resources are indeed allocated to the most vulnerable members of each target category. Where community or clinic-based referrals are used, household verification visits by C-SAFE staff play an important (and time-consuming) role in ensuring legitimacy of beneficiary lists.

Use of Community Selection Committee Empowers Communities to Care for Vulnerable Members

As a first step in the selection process, Emmanuel International (EI) field monitors meet with village chiefs to describe the program and solicit their interest and consent for moving ahead. Field monitors then meet with the entire community to describe the program and explain the targeting criteria and process. The community nominates a selection committee to work with the field monitors towards beneficiary selection. The committee members are trained by the field monitors to ensure consistency and transparency. Once selection is completed, the committee members notify the beneficiary households of their selection and explain the reasons that they qualified, what the food basket includes, and how often it would be provided. EI found that by involving communities extensively in the selection process community self-reliance improved and community members felt more empowered to care for their more vulnerable members.

C-SAFE Zimbabwe Fine-Tunes Targeting with Multiple Vulnerability Criteria

C-SAFE Zimbabwe is planning to use multiple and weighted criteria to select beneficiaries in Year 3 of its program. Individuals from within the category of households targeted for Vulnerable Group Feeding (VGF) will be selected based upon the following criteria:

> Chronically ill without means of support [8]
> Widows/widowers without means of support
> Elderly headed households without means of support
> Orphans and vulnerable children without means of support
> Female-headed of households without means of support
> Disabled without means of support

C-SAFE members will maintain a beneficiary database on the vulnerability characteristics of the targeted individuals and households. Through the registration process, individual members of households will be assessed based upon the vulnerability categories listed above. A coding system will be used to reflect their individual vulnerability status. The coding incorporates a weighting for vulnerabilities, giving a higher vulnerability score for individuals with multiple vulnerabilities or heads of households with vulnerabilities. A composite score will then be calculated for each household based upon the status of the household members. Households with the

[8] The term 'without means of support' refers to the food and livelihood status of the household. At the verification stage (house -to-house), C-SAFE plans to assess asset levels, food stocks and other food and livelihood security indicators to determine the household's existing 'level of support'. It should also be noted that VGF program has not yet been approved by the Government of Zimbabwe and will not begin until approval is secured.

highest composite score will be considered most vulnerable.

Following registration, house-to-house verification will be conducted for all registered households to validate vulnerability status and household composition. During verification, food security and livelihood indicators including household income, food stocks, productive assets, land holdings, etc... will be assessed for each household to determine which households are in fact most vulnerable.

This rather complex registration and verification methodology enables C-SAFE members to rank households by vulnerability and, in a context of limited resources and pipeline uncertainties, to ensure that only the most vulnerable are prioritized.

Village Action Committees (VACs) Assisting Beneficiary Selection

Consortium members in Malawi have relied heavily on Village Action Committees[9] (VACs) to assist with beneficiary selection. This innovation was primarily the work of Save the Children US who worked to facilitate the development of the VACs and build their capacity. These committees were developed and strengthened over the past several years with assistance from several current C-SAFE members and are now part of the national structure for coordinating and supervising all HIV/AIDS assistance provided at the village level. Thus, pre-existing linkages and working relationships provided C-SAFE with a natural mechanism through which to identify vulnerable individuals in their communities and ensure that duplication in the provision of rations was prevented. Given their intimate knowledge of the AIDS affected households in their communities, they were well positioned to carry out this mandate.

The food aid mechanism has provided a tangible purpose and function for VACs that has enhanced their credibility with their own communities, further strengthening these much-needed structures for a community-based response to HIV and AIDS. The partnership with C-SAFE has also served to strengthen their position with Ministry of Health (MoH), as Malawi decentralizes its health services. The VACs were able to show concrete results regarding their support to vulnerable households, thus strengthening their request to MoH to entrust them with greater responsibility vis-à-vis managing local public health initiatives.

Color Coding Verification System Ensures C-SAFE Assists the Most Vulnerable

CARE Zambia utilizes a color-coded system for verification for targeted food assistance beneficiaries. Each household referred for food aid is first assessed by a trained partner staff (i.e. a HBC provider or health) and is assigned a white card for 'yes', a blue code for 'no', or a pink code for 'maybe' according to the level of confidence the assessor has about the fit between the beneficiary and the admission criteria. Through follow-up household visits, CARE staff then assess 100% of the 'maybe' households to identify appropriate beneficiaries and conduct spot checks on 10% of both the 'yes' and 'no' households to identify targeting errors. Verification teams have found that this process is more difficult and time-consuming in rural areas where villages are more dispersed and health center personnel may be less adept at assisting with the initial screening of chronically ill beneficiaries. *(More details are provided in Annex 1)*

Social Mapping Supports Effective Targeting

CARE Zimbabwe, with funding from DFID, has piloted a 'social mapping' methodology in two non-C-SAFE districts. Social mapping is a participatory information-collection methodology that supports communities' efforts to elucidate and examine sensitive targeting related issues, and generate information required for intervention. CARE's experience has shown that this method provides a wealth of both demographic information and anecdotal commentary on households and the community, as well as an actual 'map', which eventually translates into a very specific targeting tool. While labor intensive and expensive at the outset, social mapping supports regular updating of beneficiary lists as communities are able to undertake the process independently. *(More details are provided in Annex 1)*

[9] *Formerly known as Village AIDS Committees*

C-SAFE

Establishing Criteria for Admission and Discharge

The development of criteria for selecting (and de-selecting) beneficiaries was – and continues to be – one of C-SAFE's biggest challenges. While community-driven targeting mechanisms, conceived differently by individual NGOs, have made it difficult to achieve strict consensus for the admission and discharge of Chronically Ill and OVC beneficiary households, food aid support to medical interventions is more easily standardized, at least at country level.

The Zambia consortium was able to design a set of shared criteria for food linked with medical interventions for Year 3 of the C-SAFE program, an excerpt of which is shown in the table below.

A full explanation of C-SAFE's links with medical interventions can be found in the section entitled 'Linking with Medical Interventions.' As noted in the section on Graduation Strategies, C-SAFE encourages the establishment of both admission *and* discharge criteria for non-clinical interventions as well. Where possible, clear discharge criteria related to changes in vulnerability (i.e. pregnancy status, health status, etc.) as well as improvements in food security status (listed under 'Targeting') are a realistic means of measuring a household's preparedness for being discharged from the program.

Admission	Purpose	Discharge
• TB patient registered with clinic/health centre • Individuals starting antiretroviral treatment • HIV+ pregnant or lactating women	• To enhance uptake and adherence with TB treatment • To enhance uptake and adherence with ART • To enhance uptake and adherence with PMTCT strategies	• Completion of TB treatment • Completed six months of ART and is established on treatment • Default from free medical treatment • Following delivery and six months of lactation • Death of primary beneficiary (one month's grace given to household)

NB: Beneficiaries who remain chronically ill following these interventions should be reassessed for eligibility under another targeted food assistance category, such as ' CI '.

Graduation strategies

C-SAFE refers to a 'graduation strategy' as the specific plan describing how an individual beneficiary will be discharged from targeted food assistance while assuring that achievement of the program's objective (with regard to that beneficiary) is not jeopardized, and that further progress toward that objective is made. The goal of the graduation strategy is to ensure sustainability of impacts after the beneficiary is discharged from the program.[10]

There is a tendency to view targeted food assistance as an interminable prospect for the chronically ill and other vulnerable categories in this region. However, some C-SAFE members have shown this not to be true. Food assistance linked to TB treatment and PMTCT has clear and fixed discharge criteria as should other targeted food assistance programming. C-SAFE Zambia has learned that by establishing clear discharge criteria (based on treatment completion or measurable improvement in food security status), individuals and households can and do graduate from direct food assistance to other longer-term food security and livelihood interventions.

Conducting **RE-verification** (similar to verification but conducted on an ongoing basis throughout the program life) on a regular basis to re-assess the food security status of vulnerable households is an integral aspect of this process. RE-assessing household food stocks, land cultivated, asset levels and other food security criteria (under 'Targeting') allows a household to be de-selected from direct distribution, and/or graduated to a more sophisticated food security strategy. It also promotes the idea that direct food distributions are not indefinite and that graduation to a more sustainable strategy is a viable goal.

For C-SAFE, developing a graduation strategy for beneficiaries exiting the program is an evolving process. In many cases, it is seen as graduating beneficiaries who meet the discharge criteria under the targeted food assistance program (an SO1 activity), to an SO2 activity that involves a deliberately designed (and sustainable) food security strategy rather than receiving direct distributions. Where appropriate, 'graduates' might have access to Food For Assets programming—which ranges from training in Positive Living to developing kitchen gardens to conservation farming or rehabilitating feeder roads and other community infrastructure. CRS Zimbabwe is currently piloting the distribution and training on the use of home drip irrigation kits to those beneficiaries that are discharged from their hospital feeding program (see below). This and other strategies seek to ensure that the beneficiary's food and livelihood security status continues to improve following his/her discharge from targeted food assistance.

It is important to consider HIV-positive beneficiary graduation strategies in conjunction with the development of community level safety nets. While safety nets are an essential feature of a self-reliant community, we are beginning to see that C-SAFE's HIV-positive beneficiaries (who overcome opportunistic infections and regain productivity)—with the right support at household level (i.e. interventions such as kitchen gardens and positive living) – can graduate from a short-term food aid intervention to a long period of self-sufficiency and productivity.

Drip Kits Given to Graduates of Zimbabwe Hospital Feeding

In Year 2 of C-SAFE, CRS Zimbabwe initiated a pilot distribution of irrigation drip kits as part of a graduation strategy for chronically ill (CI) beneficiaries who were in the process of being discharged from the hospital feeding program. Approximately 20 participants were selected from each of 18 affiliated hospitals for receipt of a drip kit.

CRS's community extensionists were trained in the installation and use of the drip kits, and subsequently worked with the 'graduates' to set them up and understand their benefits. The drip irrigation system requires minimal labor while allowing household to irrigate a garden up to 100 square meters in size and producing much needed vegetables and herbs for the household, and potentially, surplus produce which could be sold to augment household income. This graduation strategy seeks to assist graduates of the CI hospital feeding program towards improving their ability to meet their household food security requirements.

[10] *While FANTA describes a graduation strategy as the withdrawal of resources from a program site, C-SAFE prefers to apply the term to the beneficiary level with the focus being on ensuring that a plan exists to 'graduate' or transition a targeted food assistance beneficiary to another food security strategy/program upon discharge from the program.*

Linking with Agricultural Programs in Mzuzu Diocese

After attending the "HIV and AIDS: Opportunities for Food Security Programming" workshop in Malawi, CRS Malawi took lessons learned from C-SAFE NGOs in Malawi, Zambia and Zimbabwe to begin identifying opportunities for improving integration of HIV/AIDS and food security in existing programs. Implementing partners in Mzuzu Diocese linked with Ministry of Agriculture extensionists and HBC projects to support people affected by and infected with HIV/AIDS to begin developing small-scale household gardens. CRS Malawi has contacted FAO to support the households with seed purchases. Crisis Corps Volunteers from US Peace Corps with nutrition / HIV/AIDS / agriculture backgrounds will be placed with implementing members to advise on the creation of these gardens. CRS is also developing a partnership with IFDC and VSO, which would not only allow for the provision of quality, drought-resistant seed varieties to households affected by HIV/AIDS, but would bring a VSO volunteer to Mzuzu Diocese to support implementing partners staff and communities in creating and maintaining gardens. During the implementation of the DAP, CRS Malawi intends to extend this strategy to create closer linkages with food aid beneficiaries.

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Africare Promotes Labor-Saving Technologies

Africare[11] promotes the use labor-saving technologies to reduce the burden of work on vulnerable households. The Ripper is one such device that has proved easy to use and extremely effective in saving time (and money) of farm families in land preparation and harvesting of their crops.

A Ripper is a sharp, rod-like piece of equipment that is attached to an ox-drawn plough and opens the soil in a very limited space (i.e. only rips the soil in the space required for planting) thereby saving energy. The ripper makes land preparation faster and less costly than it would ordinarily be with a regular plough.

Selina is a farmer living in Kalomo district in Zambia. She attended Africare's field demonstration and recently started using the Ripper on her fields. Selina explains that by using the Ripper, she has managed to increase her harvest by ripping a wider area of soil within a short period of time (since the Ripper only opens the amount of soil necessary to plant). She is now able to cultivate one hectare in one day, whereas previously she required a whole week. This dramatically decreases her work burden and improves her chances of having her land prepared before the onset of the rains.

Using the Ripper has created time for Selina to engage in other farm activities, as she does not feel overworked by land preparation. In her experience, most farmers overwork themselves due to the multiple pressures of land preparation and other farming tasks, and then resort to late planting once the rains come. In addition to using the ripper for planting, Selina has also used this simple technology to harvest her groundnuts, a task that is mostly done by women. It is very laborious and involves long hours (sometimes days) of work. Selina explains that the Ripper has cut the time she spends harvesting groundnuts by almost 80%! Whereas it took two weeks in the past, it now takes her only two days to harvest the same field. It also saves her money since in previous years she had to hire help to harvest the groundnuts over the two weeks, and now she can do it herself with the Ripper.

CI Beneficiaries Graduate to Small-Scale Irrigation in Zomba Diocese

CRS Malawi, in partnership with the Zomba Diocese, has provided targeted food assistance to 2,050 households affected by HIV/AIDS in Zomba District. In an effort to graduate beneficiaries to more sustainable food security strategies, and in preparation for the exit of C-SAFE, CRS and its partner have linked food aid beneficiaries with small-scale irrigation activities, utilizing the dams and rivers that were excavated through FFW activities.

In addition, CADECOM (CRS' implementing partner) solicited 50 treadle pumps from the Ministry of Agriculture that are used by individual households to irrigate their plots. One pump is used by 10 households, and crops grown include vegetables, beans and maize. Realizing that there are some households that do not have the energy and manpower to effectively manage their own plots, CRS and its partner assisted communities to establish communal gardens, which will support those who were not able to establish their own. Households secure their own seeds and pesticides, and rely on compost/manure to improve soil fertility. As some chronically ill beneficiaries could not afford the high cost of these inputs, CADECOM also obtained seeds and other necessary agricultural inputs for use in the communal gardens. These graduation strategies have the ultimate goal of continuing to improve nutritional and food security status of the beneficiaries beyond their participation in the targeted food assistance program. *(More details are provided in Annex 1)*

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[11] *At the Zambia dissemination of this study, Africare noted the importance of promoting labor-saving technologies to graduates of targeted food assistance. This case study on the Ripper was contributed by Africare staff in Zambia.*

Summary of Learning - Targeting

Understanding the Program Objectives:

- A clear understanding of the purpose of an intervention is an essential first step in designing a targeting strategy.
- For a given intervention, the objective should be clear to the NGO staff; the beneficiary population, and the community at large, in order to facilitate an understanding around *who is eligible* and *at which point the beneficiary should be discharged.*

Dealing with Stigma

- While stigma continues to hinder the transparent and direct targeting of AIDS-affected households, it does appear to be diminishing, especially in the rural areas where C-SAFE works;
- The level and nature of stigma around AIDS varies considerably from one community to another and is dependent on each community's experiences and leadership;
- Through careful entry to communities and working through knowledgeable partners on the ground, individuals and communities are increasingly open to volunteering for testing, disclosing their status, discussing and learning more about HIV and AIDS.
- Targeting in the context of HIV/AIDS continues to require the use of refined proxies and other creative approaches to reach those marginalized by stigma;
- Staff sensitization and training sessions have been very influential in breaking down stigma-related barriers and giving staff new skills and confidence with which to approach communities.

Selection Process

- The simultaneous use of a range of targeting mechanisms is required to ensure that those most in need are identified and selected for provision of food rations. It is important to cast the net widely by explicitly involving community structures, HBC providers, traditional leaders, health center staff, etc.
- The application of 'multiple vulnerability criteria' (and weighting of criteria) ensures that from those referred (i.e. that meet general selection criteria for the targeted vulnerable groups), the 'most' vulnerable within each group is served. Multiple vulnerability criteria can be either in the form of demographic vulnerability characteristics or food security criteria such as asset wealth ranking, household food stocks, etc.
- Where community or clinic-based referrals are used, household verification visits by C-SAFE staff play an important (and time-consuming) role in countering nepotism, establishing legitimate beneficiary lists, and ensuring that scarce resources are indeed allocated to the most vulnerable members of each target category.

Establishing Admission and Discharge Criteria

- While admission and discharge criteria for food adjuncts to medical interventions are more easily standardized, C-SAFE encourages the establishing of both admission *and* discharge criteria for non-medical interventions as well. Where possible, clear discharge criteria related to changes in vulnerability (i.e. pregnancy status, health status, etc.) as well as improvements in food security status (listed under 'Targeting') are an important measure of a household's preparedness for being discharged from the program.

Graduation Strategies

- By establishing clear discharge criteria (based on treatment completion or measurable improvement in food security status), individuals and households can and do graduate from direct food assistance to other food security and livelihood interventions, where these are available.
- Conducting **re-verification** on a regular basis to re-assess the food security status of vulnerable households (taking into consideration variation due to seasonality) is an integral aspect of graduating beneficiaries from targeted food assistance. This includes re-assessing household food stocks, land cultivated, asset levels and other food security criteria allowing a household to be de-selected from direct distribution and/or graduated to a more sophisticated food security strategy.
- While safety nets are an essential feature of a self-reliant community, C-SAFE's HIV-positive beneficiaries (who overcome opportunistic infections and regain productivity) — with the right support at *household level (i.e. kitchen gardens and Positive Living)*---can graduate from a short-term food aid intervention to a long period of self-sufficiency and productivity where a community-held safety net will not be required.

C-SAFE

Appropriate Rations for Chronically Ill

The dual crises of food insecurity and HIV/AIDS, though exacerbated by the drought in 2001-2002, is not a traditional emergency: southern Africa is experiencing a 'protracted emergency' that started before the drought and will likely continue for several more years. The long-term and complex nature of this situation often (though not always) calls for not only the re-design of food programming, but also a review of the traditional food basket ration choices, amount, and relative proportion of components.

The complex dynamic of HIV/AIDS as both a cause and product of food insecurity must not be underestimated. Analyzing HIV/AIDS as a continuum that unfolds over time, rather than an event that occurs in isolation, can provide a framework for more holistic and appropriate decision-making. While we are still learning about the specific nutritional requirements of people living with HIV or AIDS, there are certain well-understood facts that guide our programming. It is clear, for instance, that people living with HIV require a minimum increase of 10% in energy intake to maintain nutritional status and avoid weight loss. While food aid is clearly not the most appropriate way to meet these nutritional requirements on a large scale, food aid organizations are often mandated to support the development/management of social safety nets for households in crisis and the standard food basket may not be the most optimal in this context. Where chronic poverty is compounded by a heavy reliance on cereals and sub-clinical micronutrient deficiencies are endemic, evidence to support fortification and supplementation initiatives are urgently needed. As Gillespie and Kadiyala put it, a shift from 'food delivery' to 'nutritional adequacy' is now required[12].

Targeted food assistance generally focuses on those most vulnerable in a community, including those with AIDS-related illnesses. Having progressed through the asymptomatic phase of HIV infection, these individuals now need a minimum of 20% increase in energy intake, and (although this is still controversial) as much as more 50% protein[13]. In the context of poverty and food insecurity, chronically ill adults, HIV-positive pregnant or lactating women, and children failing to grow need a nutrient-dense, highly fortified, easy-to-prepare and palatable commodity. Palatability is especially important in a high HIV prevalence context where primary beneficiaries are not simply hungry, but often experience mouth ulcers, nausea, diarrhoea and lack of appetite. Ease of preparation must also be considered, as small, frequent meals are often required and caregivers are generally over-burdened. Finally, the weight of ration packages (to accommodate the strength of those who collect it) or the frequency/location of distributions may need to be re-considered[14].

It is not, however, simply a matter of providing a supplementary ration to selected beneficiaries. When chronic illness strikes the primary bread-winner and/or caregiver, other members of the HH (especially children) become susceptible to malnutrition. There is consensus among members that in areas affected by both food insecurity and high HIV prevalence, a household ration (which should include a nutrient dense commodity such as CSB) is preferable to individual supplementation to "ensure that the most nutritionally-vulnerable family members actually receive their share of food and that the effects of HIV on family members (even those uninfected) are mitigated"[15].

GMO Ban in Zambia Limits Ration Size and Mix

The ban on Genetically Modified commodities for the Zambia consortium resulted in the elimination of vegetable oil and Corn-Soya Blend from the Zambia commodities list. Without these key commodities, C-SAFE Zambia was unable to address the nutrient requirements of the chronically ill adults it was intended to serve, a constraint that caused real concern among consortium members as the needs of their targeted beneficiaries become more clear. Aspiring to implement WHO recommendations[16], the consortium held several meetings in 2003 to review the ration mix and size but in the end, declined making any alteration. With only a household ration of cereal and beans, there was no justification for adjusting the food basket (which is planned for a family of five) for the one or two of the family members who were chronically ill. Nor was it practical to determine how many additional members of the family might be HIV-positive though asymptomatic. In the end, the ration size and mix was not altered.

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[12] *Gillespie and Kadiyala. Rethinking Food Aid to Fight HIV/AIDS. IFPRI, 2003.*

[13] *Piwoz and Preble. HIV/AIDS and Nutrition: A Review of the Literature and Recommendations for Nutritional Care and Support in Sub-Saharan Africa. AED, 2000.*

[14] *Save the Children UK. Food Security, Livelihoods and HIV/AIDS, August 2004*

[15] *Preble, E. Developing Approaches for WFP to Support Households of HIV-infected Women Enrolled in PMTCT and MTCT Plus Programs, WFP, 2003*

[16] *Increase energy intake by 10% for HIV-positive asymptomatic adults, 20-30% for HIV-positive symptomatic adults and 50% for HIV-positive symptomatic children.*

HEPS Production in Zambia Helps Overcome GMO Constraints while Providing Income to Communities

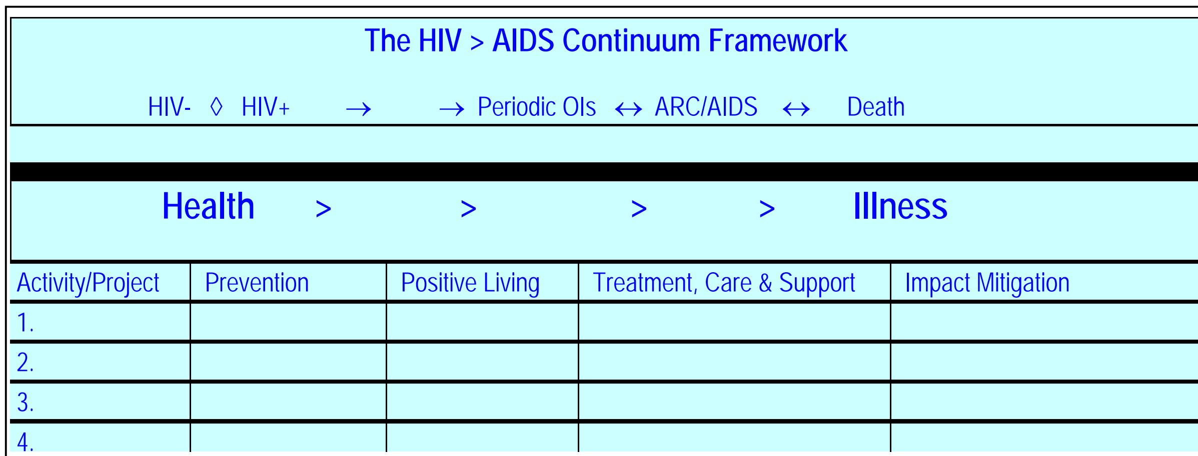
CRS Zambia began working with the widows and orphans in the Mongu Diocese who had lost spouses and parents to chronic illness to produce High Energy Protein Supplements (HEPS) in 2000. The aim of HEPS production is two-fold: the proceeds of HEPS sales provide income for participating widows and orphans and the HEPS provides an affordable nutritional supplement for community members, many of whom are chronically ill. The Mongu Diocese provided a grant to purchase the necessary ingredients and the widows and orphans are fully in charge of the HEPS production and sales. A major challenge in the process is that many of the widows and orphans who participate in the production are chronically ill themselves and are often unable to fully participate in HEPS production.

HIV > AIDS Continuum Used to Strategize Towards Comprehensive Programming

CRS Zimbabwe is using the HIV > AIDS Continuum framework (see below) to analyze the breadth and scope of food security programming in relation to HIV and AIDS, looking for gaps and opportunities for new interventions. While it was clear that projects are likely to address many points on the HIV>AIDS continuum, the CRS team noted that the highest level of activity was directed toward enhancing long-term food security for AIDS-affected households and supporting Positive Living. They also observed a strong focus on Care and Support, while interventions supporting HIV Prevention, Treatment and Impact Mitigation had a lower profile. This exercise was useful as a starting point for thinking more strategically in the planning of more comprehensive, holistic programming.

Summary of Learning-Appropriate Rations for CI

- Given the dual crisis of food insecurity and HIV/AIDS, a comprehensive review of the traditional food basket ration choices, amount, and relative proportion of components is needed.
- A minimum increase of 10% more energy intake is required to maintain nutritional status and avoid weight loss of asymptomatic individuals living with HIV.
- Targeted food assistance often includes individuals with AIDS-related illnesses, whose nutritional needs include a minimum of 20% increase in energy intake, with as much as 50% higher protein requirements[17].
- When chronic illness strikes the primary bread-winner and/or caregiver, other members of the HH (especially children) become susceptible to malnutrition.
- In areas affected by both food insecurity and high HIV prevalence, a household ration (which should include a nutrient dense commodity such as CSB) is preferable to individual supplementation.
- Both NGOs and donors have failed to devoted adequate time or resources to identifying, developing or sourcing appropriate commodities for chronically ill individuals and affected households. This is especially problematic where GMO constraints exist.



The HIV > AIDS Continuum Framework

HIV- ◊ HIV+ → → Periodic OIs ↔ ARC/AIDS ↔ Death

Health > > > > Illness

Activity/Project	Prevention	Positive Living	Treatment, Care & Support	Impact Mitigation
1.				
2.				
3.				
4.				

[17] Piwoz and Preble. HIV/AIDS and Nutrition: A Review of the Literature and Recommendations for Nutritional Care and Support in Sub-Saharan Africa. AED, 2000.

Complementary Rations

Unique access created by C-SAFE's food pipeline to a vulnerable, underserved population provides an opportunity to deliver health and agricultural messages, promote important events, and provide other valued services.

Although C-SAFE's single donor funding source has presented significant constraints to conducting 'non-food' related programming, the consortium members have been successful complementing food programming with health, education, social service and agricultural interventions **funded with private and/or other government resources.** These complementary activities are often implemented by the C-SAFE member itself in conjunction with partner agencies who specializes in a particular service area.

Linking with partners has proven to be a very effective way of enhancing C-SAFE's primary (food-related) activities, while providing the specialist organization with a pre-arranged venue and ready audience for its services. World Vision's partnership with PSI provides an example of a partnership with an international specialist in behavior change communications (see below), where WV allows those who specialize in BCC to do what they do best, as opposed to overextending the WV's capacity. Other local partners, such as TB focal point persons from Ministries of Health or resource people from relevant AIDS Service Organizations have also taken advantage of this privileged access to vulnerable populations to communicate vital information / messages.

PSI Delivers HIV Messages at C-SAFE Distributions

In Zimbabwe, an exciting new partnership was formed between World Vision and Population Services International (PSI) to bring PSI sensitization activities to Food Distribution Points (FDPs). PSI and WV agreed on key messages that included STI prevention and treatment, HIV transmission and prevention, voluntary counseling and testing, and mother-to-child transmission. These messages were relayed to beneficiaries in the form of short dramas and discussions.

WV & CARE Conduct Mobile Videos with WFP

In Zambia, World Vision and CARE collaborated with WFP to conduct mobile video shows in several C-SAFE districts in Southern Province. The mobile video van was rented from the Zambia Information Service and a local language video Musinsimuke ('Wake Up') was shown at FDPs where leaflets were also distributed.

Youth Alive Brings Awareness Activities to CRS Food

When C-SAFE resources became available, CRS Zambia took advantage of two pre-existing partnerships to establish a comprehensive assistance package to targeted OVCs and HBC beneficiaries in rural Zambian communities. CRS Zambia had been working with the provincial Dioceses to establish OVC and HBC assistance for their vulnerable and HIV-positive populations in vulnerable rural communities. Since 1989, CRS had provided funding to the Lusaka-based youth focused NGO called Youth Alive. Youth Alive promotes youth forums, concerts and debates around issues related to HIV/AIDS and gender, and delivers empowerment messages for (mostly) urban audiences in Lusaka. CRS coordinated with the Dioceses to bring periodic Youth Alive awareness activities to their targeted OVC and HBC beneficiaries, while CRS introduced C-SAFE food assistance to improve beneficiary nutritional status. In addition, the Diocesan OVC and HBC workers provided regular nutritional education. Together, the three initiatives combined to enhance the desired impact on these vulnerable and often HIV/AIDS-affected groups.

Heath Tables Provide Advice on Health Issues at FDPs

CARE Zambia obtained ECHO funding to initiate 'health tables' at all of their 68 C-SAFE distribution sites (30 in Kazungula and 38 in Kalomo). The tables are set up at the distribution sites to facilitate the communication of important health messages to members of the community. Pamphlets are distributed and discussions are held for all interested regarding a variety of health issues, i.e. HIV/AIDS, PMTCT, exclusive breast-feeding, condom usage, dangerous cultural practices, safe water and nutrition. Non-beneficiaries also frequented the health tables on distribution days raising questions and seeking practical advice to health concerns. Health table staff also offered free condoms to beneficiaries and non-beneficiaries alike. For those members of the community unable to access the health tables, CARE community extensionists (Community Health Workers and Neighborhood Health Committee members) provide similar services within the communities.

Candlelight Vigil Promotes Dialogue on HIV and AIDS

The International Candlelight Vigil (held annually on May 24th) provided an opportunity for CARE Zambia to profile HIV/AIDS and encourage dialogue in C-SAFE districts. From a photo exhibition funded previously by CARE Canada, CARE had developed a photo gallery 'newspaper insert' with relevant captions as part of a stigma reduction strategy. With funding from ECHO, the captions were translated into local language (Tonga) and 5,000 copies, with candles and red ribbon, were distributed to beneficiaries at final distribution points (FDPs).

Malawi Red Cross Uses Theater to Provide Info on HIV

Malawi Red Cross (MRC), for instance, accessed funding from the National AIDS Council to organize existing RC volunteers and drama groups, reaching an estimated 35,000 beneficiaries with important information about HIV/AIDS prevention and care. Drama presentations, lasting approximately an hour, were performed for audiences at FDPs prior to the actual distributions. Sessions were participatory and the audiences were encouraged to ask and answer questions, and included condom demonstrations and the distribution of six sets of IEC materials. Approximately 30 volunteers per event/distribution, drawn from within or nearby the target communities, were involved in the performances. Topics included basic facts, nutrition and HIV/AIDS, PMTCT, stigma and discrimination, care and support of PLHA, ABCs of prevention and sexual exploitation.

Health & Nutrition Education Complements C-SAFE Food

In June 2002, Africare Malawi obtained USAID and OFDA funding to initiate a health and nutrition education program to complement their existing targeted food programming. The strategy was to train government Health Surveillance Assistants (HSAs) and community volunteers (Growth Monitoring Volunteers (GMVs) and Village Health Committee (VHC) members) to deliver health and nutrition messages in the communities targeted for food assistance. When the C-SAFE pipeline came on line in those areas later in the year, the health education program was already in full swing. Education activities were conducted (to beneficiaries and non-beneficiaries alike) at all FDPs prior to each distribution. The established network of GMV and VHC members provided an ideal vehicle for delivering health messages at in conjunction with the food programming, as well as for follow to monitor the extent of behavior change impact.

C-SAFE Members Promote World AIDS Day

In spite of hectic project schedules, C-SAFE members in all three countries put on a huge effort for World AIDS Day 2003. Starting November 23rd and running through December 5th, 2004 C-SAFE members pulled out all the stops to organize and participate in a huge range of activities, including:

- *facilitating video shows and discussions with staff and partners; distributing red ribbon badges;*
- *hosting a photo exhibition at a shopping mall, with information about VCT and peer counselors on hand;*
- *distributing brochures and flyers with information about HIV and stigma at food distribution points;*
- *posting red ribbons and banners with stigma-reduction messages in prominent locations*
- *participating with partners in candlelight services and marches,*
- *wearing t-shirts with messages like 'My friend with AIDS is still my friend'; and*
- *organizing poetry readings, prayers and staff memorial services to help colleagues and families remember those who have passed away.*

Stigma and Sexual Exploitation are Discussed at Food Distributions

Since the end of 2003, CARE Malawi has been conducting education activities in conjunction with CI and FFW programming in 24 FDPs. Topics discussed include sexual exploitation and HIV/AIDS, including positive living and how to address stigma and discrimination. Pamphlets are distributed and discussions are held prior to food distributions. CARE Malawi staff have noticed that the audiences have become more open to discussing these themes over time, with group discussions becoming increasingly participative and animated. In addition, village chiefs who were initially dubious about targeting CI members of the community (because they felt that these members would not be able to contribute to the development of the village) have since become supportive of the program.

Summary of Learning - Complementary Activities

- Tapping into private (and other donor) funding has been an effective way of allowing C-SAFE to conduct complementary programming that was not allowable under C-SAFE's single donor funding source (USAID-FFP).
- Linking with partners, both local and international, has brought specializations / expertise in various sectors and added value to C-SAFE's targeted food assistance programming.

Exit Strategies

As defined in the 'terminology' section of this document, an 'exit strategy' is the specific plan describing how the program intends to withdraw from a program area while assuring that the achievement of the program's goals is not jeopardized, and that further progress toward these goals is made. The goal of an exit strategy is to assure sustainability of impacts and activities after the program has departed.[18]

As a 'developmental relief' program, C-SAFE's SO 2 (increasing productive assets) combined with SO 3 (building community resilience) intended provide a smooth exit from emergency programming by assisting communities to become better able to cope with future food security shocks. Donor support, however, for these latter objectives has not been sufficiently forthcoming, which has left the overall framework compromised.

As C-SAFE prepares for its final year, SO 2 has been partially funded and now contains many of the activities oriented towards building a community's 'capacity to care' for its vulnerable groups. SO 3, which contained activities oriented towards community resilience (including disaster preparedness and mitigation) remains un-funded.

FANTA describes three types of program exits: **phase-down, phase-over, and phase-out**, which are used in combination in C-SAFE.

In all three C-SAFE countries there has been a gradual decline in resources as the program enters its third and final year (**phase down**). Community take-over (a form of **phase-over**) by means of a community group is the most commonly documented exit approach,[19] and indeed this is one of the primary approaches being used by C-SAFE members for exiting C-SAFE program areas. C-SAFE Zambia, for example, will rely heavily on monetization funding in year three to ensure that community-level institutions are strengthened and have the 'capacity to care' for vulnerable groups in communities where C-SAFE resources are withdrawn.

A second type of **phase-over** strategy engaged by C-SAFE is the transfer of responsibility for C-SAFE activities to another program with a different funding source. In both Malawi and Zambia, the consortium members will transition from C-SAFE to a Development Assistance Programs (DAP), whereby a limited number of communities previously served by C-SAFE will continue to be served by the same NGO members but under the DAP mechanism. In this case, the DAP serves as a form of an exit strategy for C-SAFE. If a DAP is approved in each of these countries, there is a strong possibility that some of the targeted food distributions to PLHA, (i.e. through home-based care groups) will be carried over into subsequent years under the DAP budget and other funding mechanisms.

Lastly, a **phase-out** strategy refers to the withdrawal of resources from a program, where the change brought about may be permanent and self-sustaining and eliminates the need for further inputs. Nutrition and crop diversification education, where successful, seeks to eliminate the need for further program inputs by improving a household's capacity to meet its food security needs independently. It is recognized, however, that reaching this level of self-sufficiency via behavior change activities requires a long-term investment and cannot be counted in the short term to eliminate food insecurity of vulnerable households. This is especially true in high HIV prevalence countries where macro-level systemic erosion and human resource constraints may compromise a community's ability to fully implement planned activities or where the scale of the demand may outstrip the ability to deliver services.

HBC groups and ASOs Receive Capacity Building as Part of C-SAFE's Exit Strategy

In Zimbabwe, exit strategies involve working with and building the capacity of home-based care groups and AIDS service organizations, as well as food support to livelihood skills training intended to build the capacity of communities to support chronically ill individuals. Where possible and necessary, the formation of new home-based care and support groups will be encouraged and food for training will be implemented for staff.[20] Support groups/clubs, where they exist or emerge, will be targeted for food for work micro-projects aimed to create income generation activities for HIV and AIDS affected individuals and households. This strategy strengthening HBC and support groups will allow C-SAFE to exit program areas knowing that care of vulnerable groups will continue.

[18] *FANTA: Program Graduation and Exit Strategies: Title II Program Experiences and Related Research; April 2004*
[19] *ibid*

[20] *C-SAFE . Adapting FFA Programming to an HIV/AIDS Context, October 2004*

Community Nutrition Groups take on Role of Supporting Communities after C-SAFE

WV Zambia has established and trained volunteer community nutrition groups in C-SAFE communities. Improved nutrition practices, HIV/AIDS prevention messages, home gardening techniques, Home-Based Care support and income-generating activities for group members were among the topics covered. The members now take responsible for training community members, both beneficiaries and non-beneficiaries, and provide on-going support after the cessation of C-SAFE. WV Zambia currently supports these groups by providing vegetable seed for the group's gardens, and is working to link them with various local NGOs and government programs to improve their training and resource base. *(More details are provided in Annex 1)*

EI Emphasizes the Need for Strong Exit Strategies in Communities where the DAP will not Follow C-SAFE

Emmanuel International (EI) held a workshop with field staff to brainstorm, discuss and plan exit strategies for C-SAFE communities that would not receive follow up support under the Development Assistance Program (DAP). The workshop began with a discussion around various aspects of the current program, which would potentially lead to increased dependency and the different ways to mitigate this outcome.

Some of the issues raised and suggestions made around exit strategies were:

- Letting chiefs, communities, committees and beneficiaries know from that beginning that the food distribution would end in September 2004.
- Encouraging communities to provide resources for the most vulnerable households, in the form of community gardens or pooled financial contributions for affected households.
- Providing cooking demonstrations and nutritional information sessions to encourage consumption of nutrient-rich vegetables.
- Training growth monitors to train and encourage mothers to monitor the nutritional status of their children.
- Working with communities (especially via community committees) to assess their strengths, skills and capacities for caring for the vulnerable. Some communities have over ten functioning committees, many of which are unknown to the broader population.

Since this workshop, EI has successfully worked with various groups to create community gardens, small livestock schemes and low-labor kitchen gardens. While some of these activities required cash inputs, others called only for additional staff effort and a shift of focus. C-SAFE Malawi held a field trip for all consortium members to visit these programs and, as a result of the visit, each implementing partner agreed to conduct sensitization meetings with community members to identify the most appropriate exit strategies.

C-SAFE Malawi Transitions to DAP

The Malawi consortium will continue a similar targeted food assistance program under the DAP, but on a smaller geographic scale and many C-SAFE communities will no longer receive support (eight of the 23 will continue under the DAP). For the DAP, community committees will select beneficiary households based on food insecurity within the same four target groups. The food rations will be placed on a finite fifteen-month cycle. After the first cycle is complete, the community committee will again prioritize the most vulnerable households. The DAP will include multiple livelihood interventions, such as village savings and loan opportunities and training through farmer field schools, to boost the food security of beneficiary households while they receive food rations. Thus, it is unlikely that a household would continue to be vulnerable enough to be selected for two consecutive cycles, although this is not prohibited. The Malawi DAP NGOs decided to place each household on a standard cycle, instead of discharging beneficiaries based on improvements in food security status, as it may reduce disincentives for a household to work towards improving food security. This approach is different to the one taken by C-SAFE Malawi, Zambia and Zimbabwe and will be monitored for lessons learned.

Positive Living Training is Rolled Out for Malawian NGOs

After participating in a Positive Living training conducted in South Africa in February 2004, three members of C-SAFE Malawi (SAVE-US, CRS and American Red Cross) teamed up to replicate the training for UMOYO Network of Malawian NGOs. The training was designed as a Training of Trainers so that the participating NGOs could then further replicate to their targeted communities. The Positive Living curriculum was adapted slightly to fit the Malawian context, taking into account specific details such as which types of foods were easily available, but it covered the standard Positive Living feature topics: HIV as a Chronic Illness, Clean Stomach/Clean Water, Good Food, Home Gardens, Home Remedies and Psycho-Neural Immunology (PNI)/Attitude. The training was conducted in April 2004 and feedback from the participants has been positive. UMOYO NGOs are currently in the process of training their target communities so that PLHA in those communities can begin to apply the Positive Living principles. SAVE US, CRS and Malawi Red Cross are seeking funding from MSH to further refine the training curriculum.

C-SAFE Zambia Builds the 'Capacity to Care'

During the third year and final year of C-SAFE, some households benefiting from Strategic Objective 1 (SO1) activities (which seek to improve nutritional status of targeted groups), will graduate to the livelihood strengthening activities of SO2, (which seek to increase productive assets). While some beneficiaries will not require further assistance and will leave the program altogether; others are categorized as "chronically poor" and will not have the capacity to attain a satisfactory level of food security during the final year of the project. The exit strategy for this group will depend upon the success of C-SAFE Zambia in strengthening the capacity of the affected communities to care for the most vulnerable as detailed in the exit strategy section.

Efforts will focus on strengthening "community capacity to care" by facilitating the livelihood recovery with those households who have that capacity; by implementing mitigation measures such as the nutrition education and the changes in crop choices; by building community assets such as water harvesting or market linkages that benefit many households; by developing community gardens for produce that can be used by community groups that serve the poor; and by creating building strategic partnerships with other programs – OVC, HBC, or TB programs for example, that address psychosocial, health, legal and other needs in addition to the economic.

Communities Provide Input on Exit Strategies

C-SAFE Malawi conducted a qualitative survey of beneficiary communities, including focus groups with both beneficiaries and non-beneficiaries, to gain a greater understanding of targeted food assistance programming that was actually carried out in C-SAFE communities. The survey also asked respondent groups how they would improve the program. Outside of standard answers, such extending food aid to all community members, many respondents suggested that C-SAFE provide resources to start small-scale businesses in beneficiary communities and farming inputs, such as fertilizer and seed, to beneficiary households so they can improve or sustain agricultural production and decrease their reliance on food rations.

Summary of Learning – Exit Strategies

- Exit strategies need to be developed at the beginning of the program; they should be integrated and multi-sectoral with a flexible and responsive funding base;
- Exit strategies should be developed jointly with the community;
- Exit strategies require extensive discussion; capacity and role assessment; clearly defined responsibilities for all parties, and strategic planning;
- A phase-over exit strategy will only be effective when the community is strong enough and motivated to care for itself and its vulnerable households.

FANTA provides the following additional guidance in its document 'Program Graduation and Exit Strategies: Title II Program Experiences and Related Research:'

- Develop specific criteria for exiting a program area
- Develop specific and measurable benchmarks for assessing progress towards meeting the criteria
- Identify action steps to reach stated benchmarks
- Develop a time-line, recognizing the need for flexibility
- Develop mechanisms for periodic assessment of progress toward the exit criteria and for modification of that exit plan.

As C-SAFE approaches its final year, NGO members struggle to obtain adequate cash resources to ensure that communities level institutions are sufficiently prepared and empowered to assume the responsibility of caring for the most vulnerable. The following are examples of some of those strategies.

Linking TB, PMTCT and ART Programming

Across the region, there has been a steady rise in the provision of medical services aimed at treating HIV and related illnesses, or at reducing transmission of the virus. Unprecedented levels of funding have placed these efforts under tremendous public scrutiny and demand that every effort be made to achieve positive outcomes.

While there is no empirical evidence that confirms that targeted food assistance increases the cure or success rate of these interventions, food and nutrition support clearly play a significant role in enhancing program uptake and adherence. This has led many food aid organizations to re-think the purpose of food support in a shift away from previously-held beliefs and assumptions. For instance, while traditional indicators may not support a food aid intervention for pregnant and lactating women, it may be appropriate to provide a supplementary ration through MCH mechanisms in order to increase the uptake of PMTCT services. While food aid is often seen as an adjunct to clinical services, it is important to understand the cost-benefit of using this expensive resource. Food aid interventions to support medical interventions must be carefully designed with a clear understanding of expected outcomes and a rigorous monitoring and evaluation protocol that enable us to assess the impact of this costly 'adjunct'.

Tuberculosis

In Southern Africa, HIV is the most powerful known risk factor for reactivation of latent TB into latent disease, making TB the leading cause of death among PLHA.[21] C-SAFE has identified TB patients undergoing treatment (directly-observed therapy short-course or 'DOTS') for food assistance in its coverage areas. Multiple sources are used in targeting these patients, including clinic and home-based care referrals, self-identification, community health workers and DOTS treatment supporters. Based on interviews with stakeholders for this study, linking food programming with TB treatment has achieved several successes including the following:

- Very high TB adherence through the full DOTS cycle
- Reduced default rates
- Increased case identification
- Observed improvement in well-being including weight gain
- Return to work / productive activity

GUIDANCE: Based on staff input during this study, and a review of existing medical literature, C-SAFE has formulated the following guidelines for the use of food aid for TB patients in high HIV/AIDS prevalence areas:

- Work closely with all levels of the National TB Control Program to strengthen both referral mechanisms/case-finding and the monitoring and evaluation of food recipient outcomes;
- Ensure that patients receiving food for the purpose of TB treatment support are in fact adhering to treatment plans. Checking DOTS cards and spot-checking with clinic records should be included in the beneficiary verification protocol;
- Provide food aid to eligible TB patients who are adhering to treatment for the entire length of the treatment;
- Ensure provision of nutrient-dense, fortified commodities in food ration for at least the first two months of TB treatment (or entire treatment period if possible);
- Discharge beneficiaries who fail to adhere to treatment plans;
- Ensure that staff are well-informed about TB and are able to provide beneficiaries with simple advice, information and encouragement;
- Use every possible opportunity to disseminate information on TB to communities to encourage early case identification, treatment adherence & HIV testing;
- Deliberately link TB patients to long-term food security initiatives (internal or external to C-SAFE), including FFA programs, once they regain sufficient strength;
- Discharge TB patients from the food assistance program upon completion of treatment, unless they remain chronically ill (in which case they should be transferred to another category);
- Develop a recording system that identifies TB patients separately from other chronically ill beneficiaries in order to track the success of this initiative;
- Refer individuals to a different beneficiary category (chronic illness, high dependency ratio, etc.) on a case-by-base basis as required.

[21] *WHO. Guidelines for Implementing Collaborative TB and HIV Programme Activities. 2003.*

TB Treatment Enhanced with C-SAFE Food

CARE Zambia specifically targets TB patients, providing a household ration as an adjunct to treatment. Drawing on the experience and relationships of an existing TB project, CARE has developed a close relationship with the District Health Management Boards. This has facilitated CARE's access to the TB registers at clinic level, making it possible to identify potential beneficiaries who require additional support. Since TB infection so often co-exists with HIV, and management of TB is much more likely to be successful when there is adequate nutrition, CARE's aim is to increase the lifespan of HIV-positive wage-earners and parents.

Prevention of Mother to Child Transmission of HIV

Due to a combination of biological and sociological factors, girls and women are disproportionately affected by HIV/AIDS. In addition to the increased nutritional requirements associated with pregnancy and lactation, HIV-positive pregnant and lactating women have extra energy needs due to HIV infection (as described above). An investment in mothers during this time is intended to assist them in delivering a normal birth-weight infant and support the production of breast milk throughout the duration of lactation. Many HIV-positive women are the heads of households and the survival of other household members depends on her well-being.

The majority of HIV-positive children acquire the infection through mother-to-child transmission (MTCT), which can occur during pregnancy, delivery, or breastfeeding. The use of antiretrovirals (ARVs) around and after pregnancy is effective in reducing the transmission of HIV from an infected mother to her child. Programs to provide ARVs to mothers are getting underway in all three C-SAFE countries though the roll-out is slow and coverage remains very poor. To reduce the risk of MTCT during labor, the most commonly used protocol involves the use of a single dose of Nevirapine to the mother during labor and a single dose to the infant within 72 hours[22].

C-SAFE has identified HIV-positive pregnant and lactating women as a particularly vulnerable group for whom food assistance can be highly beneficial for improving long-term household food security, especially when offered in conjunction with emerging PMTCT initiatives. While a certain degree of stigma does exist and may interfere with effective targeting of HIV-positive women, feedback from field staff suggests such targeting has also had significant success.

In areas of chronic poverty and food insecurity, HIV-positive women endeavoring to exclusively breastfeed for six months are unlikely to have fully recovered from pre-pregnancy food inadequacies, including micro-nutrient deficiencies.[23] This is especially true where food aid rations do not include a fortified or nutrient-dense commodity (like corn-soya blend), as is the case in Zambia (due to GMO constraints). C-SAFE experience clearly indicates the importance of providing not only an individual ration (optimally nutrient-dense) but a ration to the household.

C-SAFE members are also concerned that up to 20% of infants born to HIV-positive women acquire infection through breastfeeding[24]. In resource-poor environments, WHO recommends that HIV-positive mothers practice exclusive breastfeeding during "the first months of life" and discontinue breastfeeding as soon as it is feasible[25]. While this advice presents many challenges, C-SAFE's experience has been that mothers struggle to implement these recommendations not only because of inadequate knowledge and support but because of the lack of weaning foods that fully meet the nutritional requirements of a very young infant.

C-SAFE Proposes Food Support to PMTCT Programs

Working with local partners and line ministries, in Year 3 of C-SAFE, Consortium members propose to support the promotion, expansion and ultimately adoption of PMTCT where opportunities for food assistance exist. If successful, C-SAFE would provide food support, in selected operational areas (where HIV prevalence and food insecurity coincide) to pregnant and lactating women accessing antenatal services at hospitals with established PMTCT programs.

Initially, to enhance PMTCT program uptake, C-SAFE proposes that all pregnant women would receive food support from 16 weeks of pregnancy through until delivery. Under this scenario, support would take the form of take home rations; for high-risk mothers staying in waiting shelters, daily dry rations would be distributed. As stigma reduces and PMTCT programs become stronger, the program will transition to providing food only for HIV-positive women.

Women who have tested HIV-positive through VCT and are participating in PMTCT programs would continue to receive food support until 12 months post-delivery. Providing food assistance to the mother aims to support the exclusive breast-feeding and rapid weaning of the child and facilitate the mother's continued contact with the health services.

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[22] *Republic of Zambia Ministry of Health. Integrated Prevention of Mother to Child Transmission of HIV/AIDS Protocol Guidelines, April 2003.*

[23] *WHO. Nutrient Requirements for People Living with HIV/AIDS. Report on a Technical Consultation. Geneva 2003*

[24] *WHO. HIV and Infant Feeding: A Framework of Priority Action, 2003*

[25] *ibid.*

GUIDANCE:

Based on field experience and a review of existing literature, C-SAFE promotes the following practices for providing food rations to pregnant and lactating women where there is a high HIV/AIDS prevalence:

- Make every possible effort to work with and support emerging PMTCT programs especially in food-insecure districts;
- Provide food assistance to pregnant HIV-positive women from the earliest opportunity during pregnancy;
- Undertake a more formal investigation to understand how stigma interacts with the targeting of HIV-positive pregnant and lactating women;
- Extend food assistance to HIV-positive lactating women from the current six months to twelve months (consistent with new WFP guidelines[26]);
- Provide a fortified nutrient-dense commodity (CSB) as well as a household ration wherever possible;
- Ensure that lactating mothers receiving food assistance are encouraged and supported to follow recommended infant feeding guidelines related to exclusive breastfeeding and abrupt weaning;
- Support rapid weaning with a palatable, nutrient-dense and ready-to-use commodity suitable for infants from three months of age;
- Provide food assistance to symptomatic HIV-positive mothers who elect to use breastmilk substitutes (rather than breastfeed) until health is restored;
- Ensure that staff are well-trained on PMTCT and are able to provide beneficiaries with simple advice and information;
- Use every possible opportunity to disseminate information about PMTCT to communities to encourage safe motherhood and infant feeding practices, and uptake of emerging PMTCT services;
- Work with clinical service providers, WFP and other stakeholders to determine a practical methodology for measuring the impact of this intervention;
- Refer individual mothers to alternate beneficiary categories (chronic illness, high dependency ratio, etc.) on a case-by-case basis as required.

Weaning Commodity for HIV-positive Mothers

In Year 3, C-SAFE Zimbabwe hopes to support mothers through the period of abrupt cessation of breast-feeding with the provision of a weaning commodity. PMTCT counselors at affiliated hospitals would assess readiness to abruptly wean and women identified by the counselor will be referred to C-SAFE for receipt of a weaning commodity. C-SAFE envisions using a pre-mixed commodity, which would be distributed specifically to support abrupt weaning. This could be Corn-Soya blend +Dried Skimmed Milk +oil, CSB+Dried Whole Milk, or Corn-Soya-Milk, depending on practicalities of procurement and pipeline. C-SAFE staff will be responsible for mixing, bagging and distributing the commodity.

Antiretrovirals

In Southern Africa, several governments and agencies are in the early stages of rolling out low-cost access to treatment and responding first to those who need treatment most urgently. WHO treatment guidelines recommend that an individual start ARV treatment when they are confirmed to be HIV-positive and conditions such as weight loss, diarrhea, loss of appetite, mouth ulcers, fatigue, chest infections, and low-grade fever are present (WHO 2003). While some individuals may begin ARV treatment prior to the appearance of these conditions, they are likely to be self-funding. C-SAFE beneficiaries, if they have any access to ARV treatment, are most likely to be captured by government or faith-based initiatives.

Response to treatment will vary depending on the stage of disease, clinical management of both the HIV and concurrent infections, and availability of complementary support mechanisms. Many patients, however, experience a dramatic recovery especially when adjunct measures (nutrition and psychosocial support in particular) are available: they regain lost weight, other symptoms disappear and productivity returns within a few months of starting treatment.

Where ARVs are being introduced in C-SAFE operational areas, C-SAFE will make every effort to support individuals accessing these medications to ensure adherence and treatment efficacy. Not only is it crucial that the treatment be effective, it must be *seen* by communities to be effective in order to encourage treatment uptake and adherence and to restore hope.

Many people on ARVs in resource-limited settings are not able to follow food and nutrition guidelines due to lack of access to the food required, which can lead to exacerbated drug side effects, reduced drug efficacy, and compromised

[26] *Historically, in emergency programming, C-SAFE had provided food to PLWs (whose status was unknown) for a period of six months.*

adherence to treatment[27]. Targeted food assistance therefore has the potential to fill a significant gap in the provision of comprehensive HIV/AIDS care and treatment, especially during the initial stage of ARV therapy.

For the purpose of establishing a food assistance protocol, C-SAFE categorizes people on ARVs into the following two categories:

a) Those on ARVs ***with symptoms and related complications*** (at the early stages of treatment) who require not only 20-30% additional energy intake but likely need a nutrient-dense, palatable commodity while appetite and absorption are restored;

b) Those on ARVs ***without symptoms and related complications*** (well-established on treatment), who still have increased energy requirement (10%) and require a high-quality balanced diet.

Those without symptoms and/or complications would normally have responded well to treatment and other support. While nutritional support is still indicated in this group, these individuals would not fit in a C-SAFE food assistance program. *The key assumption here is that this group is essentially health and is engaged in or has the potential to participate in productive livelihood activities*. Where applicable, these individuals should be directed to sustainable livelihoods/food security initiatives.

On the other hand, those on ARVs with symptoms and related complications are often unable to participate in productive livelihood activities. This group would require immediate food assistance (in addition to other support).

GUIDANCE:
Based on these findings, C-SAFE recommends the following practices for providing food aid for individuals on ARVs in the context of food insecurity:

- Food aid should be provided for the first six months of ARV therapy;
- Ensure that staff are knowledgeable about ARV therapy and are able to provide beneficiaries with simple advice, encouragement and information;
- Use every possible opportunity to disseminate information about ARV therapy to communities to encourage uptake of emerging services;
- Deliberately link individuals on ARVs (once they regain adequate strength) to longer-term food security initiatives (internal or external to C-SAFE), including Food For Assets programs;
- Develop a recording system that identifies those on ARVs from other chronically ill beneficiaries in order to track the success of this initiative;
- Refer individuals to a different beneficiary category (chronic illness, high dependency ratio, etc) on a case-by-case basis as required, following the initial six months of food assistance.

Supporting Antiretroviral Therapy in Malawi

WV Malawi, in collaboration with local health officials and Medecins Sans Frontieres (MSF), is contributing to a comprehensive program serving individuals with AIDS and their families. While MSF provides medication to the individual and capacity-building support to the government health services for monitoring of health status, C-SAFE offers food assistance to the household (maize, beans and vegetable oil) and a nutrient-dense supplementary ration (CSB[28]) to the individual, and home-based care groups provide counseling services. WV Malawi has found that the community appreciates the transparent nature and medical basis for beneficiary selection and that more community members are now interested in voluntary counseling and testing. Although no beneficiaries have been discharged from this program so far, it is anticipated that beneficiaries will be discharged based on significant improvements in health status. *(More details are provided in Annex 1)*

[27] *FANTA. Recommendations for the Nutrient Requirements for People Living with HIV/AIDS. January 8, 2004.*

[28] *Called 'likuni phala' in Malawi*

CARE Zambia Color-Coded Re-verification *

In Year 2 of C-SAFE, CARE Zambia (and the other members of the Consortium) experienced a reduction in resources and an intentionally moved towards more targeted interventions. In order to target only the most vulnerable households in an effective and transparent manner, CARE developed a re-verification system involving local leaders and a system of color-codes.

CARE initially solicited lists of potential beneficiaries for Year 2 (targeted food assistance) from community-based organizations, home-based care groups, and community leaders including village headmen and church staff members. CARE then trained 'verification aids' on the selection criteria, registration forms and process and a questionnaire for a wealth ranking exercise. The 'verification aids' visited and assessed all households on the preliminary lists based on CARE's selection criteria and a wealth ranking questionnaire, and completed a registration form for each household. The 'aids' completed a white registration form if the household clearly qualified for targeted food assistance, a pink form if the household's qualification was at all questionable, and a blue form if the household clearly did not qualify.

CARE staff then re-verified, or re-assessed, the qualifications of 100% of the households with pink forms (who potentially qualified for food assistance), and 5-10% of both the households with white forms (who clearly qualified) and blue forms (who clearly did not qualify).

During the re-verification process, CARE found that the use of chronic illness as a proxy indicator resulted in the inclusion of individuals with asthma and epilepsy, which CARE did not intend to be in the target group. Based on this exercise, CARE did not register these households and was better able to focus resources on the intended beneficiary households.

Recently, CARE decided to start re-verifying a greater percent of the white forms (representing households that definitely qualify for food aid) due to corruption during the initial assessment. CARE found that some 'verification aids' had intentionally included friends or relatives who did not qualify, knowing the white forms would not be thoroughly checked. Another challenge with the initial assessment was that the 'verification aids' eventually began to demand incentives due to the excessive time involved in the re-verification process. At the time of this presentation, CARE was still deciding how to address this issue.

In general, CARE found the re-verification exercise to be successful in targeting the most vulnerable households in a transparent and equitable manner. Community feedback suggested that communities were satisfied with the process based on their understanding of the targeting criteria and mechanisms, the involvement of community leaders and the thorough nature of the verification.

** This and the other case studies that appear in Annex 1 were presented by the implementing NGO at the disseminations of this Study. The details of each presentation were documented and annexed to this Study as shown above.*

CARE Zimbabwe Social Mapping *

CARE Zimbabwe piloted a social mapping exercise amongst more than 2,000 households in two districts. Neither district was covered by C-SAFE activities, yet the exercise has provided great insight into targeting practices that will inform future approaches in C-SAFE targeting.

Social mapping is principally a participatory rural appraisal tool. CARE used the social mapping exercise to reorient current and future programming by identifying vulnerable households and groups, as well as community needs and gaps in support. Social mapping collects information on community welfare, social networking systems, wealth ranking and the actual geographic location of vulnerable groups. Prior to the exercise, CARE staff met with councillors and chiefs to sensitize them as to the objectives and methodology, and to solicit their active participation and support. The mapping exercise relies heavily on focus groups with key informants and involves community and local leaders to produce a series of maps: a community map, providing information on demographics, wealth, health, and economic activities of particular households, as well as the location of community infrastructure; a social network map which shows the links and social support networks between households; and an institutional map based on an institutional analysis that shows differential access to institutional support by household characteristics. After creating the maps, CARE staff conducted a follow-up livelihood survey of 5-10% of the identified vulnerable households.

CARE Zimbabwe found the social mapping exercise to be highly informative despite the challenges associated with an assessment of this scope and scale. The exercise required considerable time, both in collection of the data and in its analysis. The exercise takes 4-6 hours per community and has led to community fatigue, with participants anxious to return to their daily routines. The time required to organize the exercise, including training time, was also considerable. In the future, CARE would like to restructure the organization of the exercise, allowing more time for training and a focus on quality, and utilizing local field staff to incorporate their knowledge of participating communities.

CARE can conduct both micro- (community), and macro-level analyses with the social mapping data. The social mapping information belongs to the communities, and in order to further the sense of ownership, the community-level data was quickly analyzed to provide community members with timely feedback. The macro-level data, however, has been slow to process and may take several more months to analyze. The large sample size will support more traditional quantitative livelihoods analysis, including a closer look at the accuracy of current proxy indicators for AIDS-affected households.

The key informant focus groups revealed a local reduction in AIDS-related stigma. While discussing amongst themselves, the key informants referred openly to households hosting PLHA and the details of their situation. C-SAFE targets chronically ill individuals (as a proxy for AIDS) and has avoided making direct reference to PLHA in relation to targeting food assistance. Some C-SAFE members have noted a reduction in stigma in the three countries where C-SAFE works, and it is hoped that a continued reduction will open avenues for more direct discussions and targeting mechanisms.

CARE staff reported that the social mapping exercise itself built and strengthened networks among community members, often revealing an absence of support (via social network maps), and prompting members to discuss how this might be resolved. CARE staff noted that the exercise improved the level of trust and ownership among participants by actively soliciting their input on sensitive targeting and programmatic issues. It is hoped that these and other benefits will be revealed as participants and communities update these tools independently in the future.

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CRS Malawi Zomba Diocese *

Catholic Relief Services (CRS) implements programs through the Catholic Development Commission (CADECOM) in Malawi. In the district of Zomba, CRS and CADECOM have partnered with the Zomba Diocese to link C-SAFE targeted food assistance beneficiaries with longer-term food security interventions. The food security interventions are intended to prepare households for the exit of C-SAFE activities in September 2004, with the ultimate goal of continuing to improve the nutritional and food security status of the beneficiaries post C-SAFE.

The food security interventions include community gardens (designed to assist chronically ill affected households), small-scale irrigation activities, and communal seed banks. CADECOM has supplied garden seeds and other inputs, while CRS and the Diocese have promoted compost manure making to improve soil fertility and garden production. The small-scale irrigation activities utilize the dams and rivers excavated through C-SAFE Food for Work activities and will benefit household plots and winter cropping practices. CADECOM has solicited 50 treadle pumps from the Ministry of Agriculture and Irrigation (MoAI) as an additional irrigation method for households with sufficient levels household labor. Communal seed banks assist households to secure a supply of maize, bean, and vegetable seeds for winter cropping. CRS and the Diocese are also encouraging communities to plan ahead for the hungry season by setting aside food from the harvest for the leanest months.

CRS and partner staff identified several challenges in the process of launching these food security activities. The initial challenge resided within the communities, who based on previous experience with similar interventions, exhibited considerable doubt as to the potential success of these activities. Staff members have since restored trust to the extent that community members are fully engaged and actively participating in the projects.

Working closely with the MoAI also proved to be more complex than anticipated. CRS and CADECOM felt under pressure to provide support to MoAI staff in the form of allowances and transportation costs, which created tension with the groups. CRS and CADECOM have since shifted the primary relationship to be between the communities and the MoAI, with the communities seeking services directly from MoAI staff. This shift has eased tension and strengthened the working relationship between CRS/CADECOM and the MoAI.

An additional challenge related to land access. Many of the AIDS-affected households did not have access to land for activities such as winter cropping. CRS and partner staff met with local leaders to negotiate the use of communal land for gardens and small plots for these households. And lastly, a common difficulty in implementing food security programming was the aspect of targeting. Both the recent food security crises and the AIDS pandemic have affected entire communities, leaving most households vulnerable to some degree and eager for assistance. Yet, the limitation in resources stipulates that these interventions can target only the most needy. Many participating communities also received assistance in the form of food aid under the Joint Emergency Food Aid Program (JEFAP) and many households expected C-SAFE to provide the planned interventions with minimal expectations of community input and participation. Through the sensitization process, CRS and CADECOM were able to familiarize communities with the importance of targeting the 'most' food insecure, and involving the community in caring for these households.

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WV Zambia Nutrition Groups Case Study *

World Vision (WV) Zambia has established and trained several community nutrition groups which will continue to support community health and improved nutritional practices after the cessation of C-SAFE. The groups are composed of volunteers who received extensive training from WV on basic nutrition, growth monitoring, vegetable gardening, and home-based care (HBC) for people living with HIV/AIDS (PLHA). WV Zambia started training the nutrition groups in Year 2 of C-SAFE in order to allow adequate time to train and support the groups before exiting, or withdrawing programmatic support, at the end of Year 3 (the final year of C-SAFE). WV has allocated significant time and effort to building community capacity through training and technical support – key aspects of a successful exit strategy.

The nutrition group activities include growth monitoring and promotion, vegetable gardening, health education, home-based care, and organizing drama groups. Growth monitoring is conducted among children under 5 and will be used for the admission and discharge to a local nutritional rehabilitation program. Data will also be used to identify trends in malnutrition rates. The vegetable gardens will support chronically ill-affected households through the provision of nutrient-rich produce and seed to selected households, and the groups will sell surplus produce from the gardens to provide income for nutrition group activities. The dissemination of health and nutrition messages to community members is also part of the program and many groups have begun dissemination sessions without any input from WV. The home-based care activities include nutritional care and support for PLHA, while group members conduct home visits to chronically ill-affected households to provide counselling on nutrition and health issues. The drama groups, organized by the nutrition groups, educate communities on nutrition and health issues, HIV prevention, opportunistic infections related to AIDS, and cholera prevention and care.

WV Zambia has encountered logistical challenges in establishing the nutrition groups. Each nutrition group has quite a broad coverage area that requires volunteers to travel long distances for many of the home visits. The scales and height boards related to growth monitoring are in short supply, leaving many groups to share supplies and delaying the growth monitoring process. WV Zambia is currently promoting the idea that community groups use profits from the sale of vegetables to procure additional scales and height boards.

WV is encouraged by the successes exhibited by the program in its initial stages. They reported that communities have already increased capacity and commitment to monitor the nutrition status of their children. Communities have also markedly increased their capacity to care for chronically ill-affected households through provision of vegetables and seed, increased health and nutrition knowledge, and home-based care services.

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WV Malawi Supporting Anti-Retroviral Therapy in Thyolo District *

WV Malawi has partnered with Medecins Sans Frontieres (MSF) Luxembourg to enhance the food security situation of AIDS-affected households and communities in 11 Traditional Authorities (TAs) in Thyolo by providing food assistance and additional support to AIDS-affected households. MSF Luxembourg supports individuals with AIDS by providing anti-retroviral (ARV) treatment, and building community capacity to care for these individuals. MSF directly supports government health services for monitoring health status, including CD4 counts, of individuals with AIDS; trains home-based care (HBC) volunteers in psycho-social counseling services; and supervises the treatment of opportunistic infections and reproductive services. WV Malawi, through C-SAFE, provides food assistance to households with individuals receiving ARV treatment in the form of food rations consisting of maize, beans, vegetable oil, and a fortified corn-soya commodity.

WV Malawi approached the targeting for this program with great caution, unsure of the current level of stigma surrounding AIDS in Thyolo District. Based on this concern, WV conducted the targeting through existing structures, such as HBC groups, District AIDS Coordinating Committees (DACCs), and Area Development Boards (ADBs), which were able to identify the most affected TAs and households in the district without an intensive survey process. The actual targeting of the individuals is based on CD4 counts which relies on medical testing facilities.

C-SAFE believes that, where food insecurity abounds, targeted food assistance is a crucial component of successful ARV treatment, especially during the initial stages of therapy. For individuals whose health and nutritional status has been severely threatened by the dual epidemic of AIDS and food insecurity, food aid rations help reduce drug side effects, improve drug efficacy and facilitate adherence to treatment. This WV-MSF partnership is an important innovation and the lessons learned from this activity will guide similar interventions in other C-SAFE countries as the ARV rollout gathers momentum.

WV Malawi found that participating communities appreciate the transparent nature of the medical basis for this program. It is anticipated that beneficiaries will also be discharged on a medical basis and that the marked improvement in health status of this first cohort in each community will build community confidence in the effectiveness of ARV therapy and, ultimately, fuel interest in voluntary counselling and testing (VCT) services.

The program has already bolstered the health status of individuals with AIDS and improved the quality of life for many beneficiary households. C-SAFE staff have observed dramatic recoveries among individuals who have regained lost weight and returned to productive activities within a few months of starting the treatment-plus-food intervention. Anecdotal evidence also suggests that interest in VCT services has increased due to the community's awareness of the success of ARVs and food aid. Unfortunately, despite these successes, WV Malawi reports that many beneficiaries were simply too sick to respond to this joint intervention, and have died.

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Job Description for C-SAFE HIV/AIDS Country Focal Point

Program Development / Networking

- represent C-SAFE with MoH at district level on the more sophisticated targeting issues: lactating women/PMTCT, TB control and identification of chronic illness/clinical vulnerability
- develop a database of and linkages with ASOs (AIDS Service Organizations) operating in C-SAFE districts
- contribute to mission-level, country-level and regional technical and practical discussions in relation to HIV/AIDS, food and nutrition
- identify opportunities in the field where food, nutrition and HIV/AIDS programming could be initiated or enhanced, with either in-house expertise or through partnership, creating stronger links between C-SAFE and other development projects
- liaise closely with the HIV/AIDS Advisor at the RPU (regional program unit)

M&E

- provide documentation of HIV/AIDS activities within C-SAFE
- assist in assessing the impact of programming on AIDS-affected individuals, HHs and communities
- provide input into the development and interpretation of M&E mechanisms
- liaise closely with the C-SAFE M&E regional technical advisor and Learning Centre coordinator to identify, document and disseminate lessons learned and better practices

Staff development

- disseminate information from Head Offices and the RPU to field staff, and mentor their use of new information
- identify staff training and support needs in relation to food/nutrition and HIV/AIDS programming
- assist Management in supporting staff to uphold SPHERE standards and organizational codes of conduct in the field, anticipating and mitigating potential risks

Annex 3

Contributors to the Study

Regional	
Michka Seroussi	C-SAFE
Marumbo Ngwira	C-SAFE
Kristy Allen	C-SAFE
Mugo Muita	Consultant
Shannon Senefeld	CRS SARO
Nina Bowen	CARE SWARMU
Dan Mullins	CARE SWARMU
Malawi	
Helen Jones	Emmanuel International
Paulo Chiziwa	SCUS
Henry Khonyongwa	CARE
Maggie Mazungu	Africare
Felix Phiri	Africare
Duncan Kochelani	CARE
Chris Mhone	CARE
Sophex Chimphonda	WV
Jane Jere	MRC
Matilda Nangoma	MRC
Emily Movall	CRS
Timothy Singano	TSA
Gertrude Kara	WFP
Zambia	
Catherine Lowery	CRS
Krishnan Unny	CRS
Thomas Mugala	CRS
John Service	CRS
Susan Chabala	CARE
Patrice Charpentier	CARE
Dr Jay Buensuceso	CARE
Emmanuel Chigogora	ADRA
Michelle Parke	WV
Lilembalemba Lilembalemba	WV
John Parmar	WV
Imelda Ruim	WV
Simasiku Veronica	WV
Martha Muswell	District Health Office
Viala Myambe	District Health Office
Sibi Lawson	WFP
Chansa Kampamba	CRS
Joseph Ng'ambi	CRS
Thomas Mugala	CRS
Steven Madaliso M'Tamira	Diocese of Ndola (CRS ptr)
Zimbabwe	
Greg Bastian	CRS
Margaret Kariuki	CRS
Thelma Bamhare	UNICEF
Mumtaz Osman	WFP
Kudzai Akino	WFP
Jamo Huddle	WV
Admore Mawere	CARE
David Majagira	CARE
Swedi Phiri	CARE
Trust Mlambo	CARE

The views and opinions expressed in this document represent those of the authors and not necessarily of each C-SAFE member agency or the donors

Africare

Save the Children