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THE DEBILITATING CYCLE OF HIV, FOOD INSECURITY, AND MALNUTRITION

INCLUDING A MENU OF COMMON
FOOD SECURITY AND NUTRITION INTERVENTIONS
FOR ORPHANS AND VULNERABLE CHILDREN

AIDSTAR-One
AIDS SUPPORT AND TECHNICAL ASSISTANCE RESOURCES

DECEMBER 2012

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AIDS Support and Technical Assistance Resources Project

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ACRONYMS

ART	antiretroviral therapy
CMAM	community-based management of acute malnutrition
FANTA	Food and Nutrition Technical Assistance
FAO	Food and Agriculture Organization
FFA	food for assets
FFT	food for training
FSN	food security and nutrition
IFPRI	International Food Policy Research Institute
NACS	nutrition assessment, counseling, and support
OVC	orphans and vulnerable children
PMTCT	prevention of mother-to-child transmission
UNESCO	UN Educational, Scientific and Cultural Organization
UNICEF	United Nations Children’s Fund
USAID	U.S. Agency for International Development
WASH	water, sanitation, and hygiene
WFP	United Nations World Food Programme
WHO	World Health Organization

INTRODUCTION

BACKGROUND AND PURPOSE

The impact of the HIV pandemic on children has been documented extensively. Roughly 17.1 million (15.4 million to 19.1 million) children under the age of 18 have lost one or both parents to AIDS, and millions more have been affected, with a vastly increased risk of poverty, homelessness, school dropout, discrimination, and loss of life opportunities. These hardships include pediatric HIV infection, illness, and death. Of the estimated 1.8 million (1.6 million to 1.9 million) people who died of AIDS-related illnesses in 2010, 250,000 (220,000 to 290,000) of them were children under 15 years old (United Nations Children’s Fund [UNICEF] 2011).

The purpose of this document is to provide an introduction to programming food security and nutrition (FSN) interventions for orphans and vulnerable children (OVC). It is written for development practitioners who have previous experience with OVC programming in an HIV context but do not necessarily have FSN-related experience.

Part 1 of this document examines the debilitating cycle of HIV, food insecurity, and malnutrition. It introduces two questions that can be used to help programmers better understand the dilemmas that result from the interaction between HIV and food insecurity and malnutrition:

- How does HIV contribute to food insecurity and malnutrition for OVC?
- How does food insecurity and malnutrition contribute to HIV and AIDS?

Part 2 builds upon the information presented in Part 1 and provides a menu of 20 common FSN interventions for OVC. The interventions are categorized by age and stage, and include a reference to the specific FSN-related factors (i.e., challenges) that the particular intervention seeks to address. This section also notes the ideal target group for each intervention, the aim of the intervention, age and stage, delivery mechanism, helpful notes regarding implementation of the intervention, a short list of relevant resources, and evidence regarding the efficacy of the intervention (where available). A list of resources on FSN programming for OVC, along with a list of common assessment tools are provided on page 28.

KNOWING WHAT IS RELEVANT TO YOUR CONTEXT

The answers to the two questions posed will vary from context to context. Every country, district, and community is unique, and not all of the factors contributing to HIV, food insecurity, and malnutrition will be relevant to your specific geographic area. Before deciding which type(s) of programmatic interventions to design and implement, you will need to assess your own situation. This may mean conducting an assessment/situation analysis to understand which aspects of the cycle apply to the communities where you are working. With regards to nutrition, there are well

established, global standards of care that your context and individual clients should be compared to. A few of the documents that detail these nutrition standards are listed on page 30.

In some instances, it may be necessary to conduct a comprehensive needs assessment, gathering both primary and secondary data about HIV, food insecurity, and malnutrition for the districts or communities where you work. Most often, program staff will rely on secondary data, but it may also be necessary to collect primary data to fill gaps where information is lacking. In many countries, OVC assessments are carried out by UNICEF, the United Nations World Food Programme (WFP), the host country government, and various nongovernmental organizations. These assessments may or may not include indicators related to HIV and FSN. If an OVC assessment is being planned, it is important to advocate for HIV and FSN indicators to be included; they are often forgotten. The results of these assessments will help determine the specific HIV-related factors that contribute to food insecurity and malnutrition in the communities in your geographic area. They will also identify the specific FSN-related factors that contribute to HIV where you work.

This document does *not* provide guidance on how to conduct an assessment. However, there are a wide variety of assessment approaches and methodologies in circulation, some of which may be used and recommended by your specific organization, donor, or host country government. Several suggested assessment resources are listed at the end of Part 2 of this document. Note that very few assessment tools include a review of HIV, FSN, *and* OVC-related issues, so a combination of tools may be necessary.

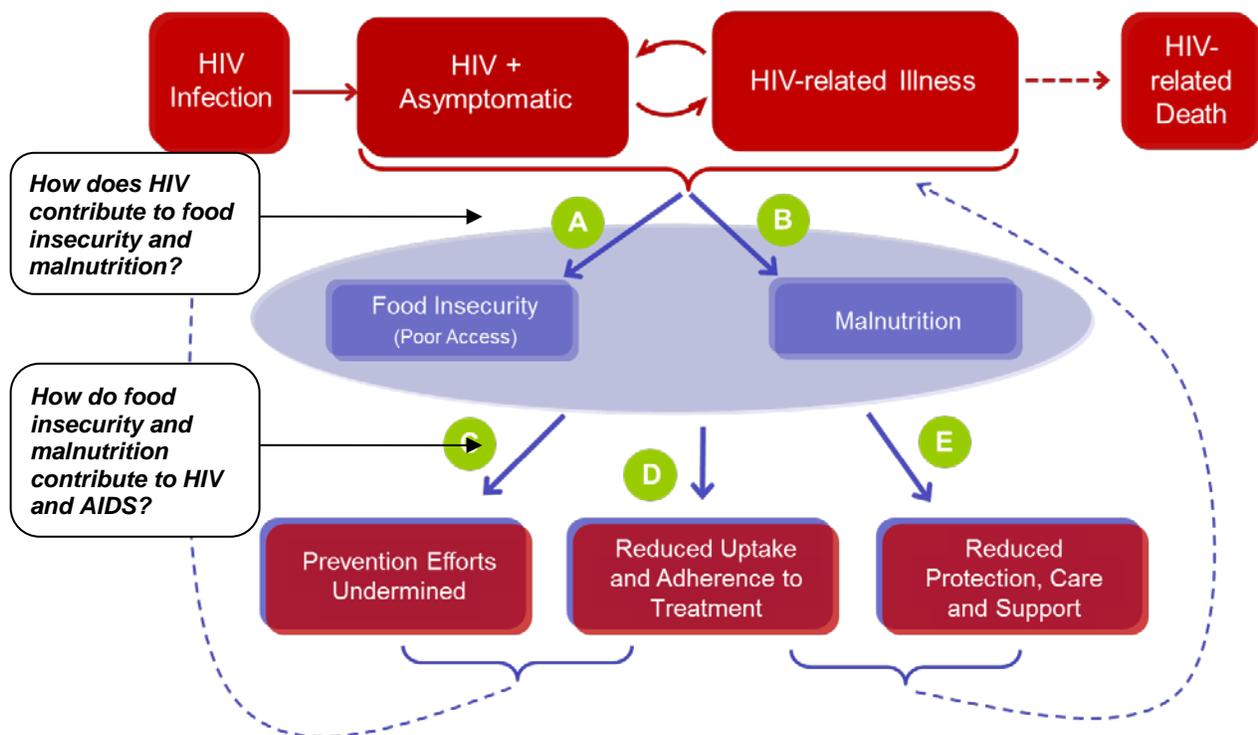
NECESSARY EXPERTISE

Food security and nutrition programming is a specialized area, so the level of expertise required to design and manage these interventions should not be underestimated. From establishing and managing a food commodity pipeline, to providing nutrition assessment, counseling, and nutritional support to each client, to training youth in agricultural techniques, FSN programming requires expert staff to design, implement, monitor, and evaluate interventions effectively. As with other program areas (e.g., education, child protection, psychosocial support), OVC program managers should either partner with organizations with experience in FSN programming or bring experts, such as nutritionists, commodity managers, and agriculture technicians, on staff before attempting to establish these programs in-house.

PART I: THE DEBILITATING CYCLE OF HIV, FOOD INSECURITY, AND MALNUTRITION

Figure 1 shows the debilitating cycle of HIV, food insecurity, and malnutrition to demonstrate how this cycle and the bi-directional relationship between HIV and FSN impact OVC and the families that care for them. More specifically, the graph demonstrates how HIV contributes to food insecurity and malnutrition among OVC and their families. It also shows that the reverse is true: Food insecurity and malnutrition contribute to the spread of HIV (Ngwira, Bota, and Loevinsohn 2001; Tsai, Hung, and Weiser 2012), and for those individuals who are HIV-positive, malnutrition hastens the progression from HIV to AIDS (Tang 2012).

Figure 1. The Debilitating Cycle of HIV, Food Insecurity, and Malnutrition



- A** HIV undermines access to food (food insecurity) for OVC and their families, leading to reduced food consumption and limited diversity in their diet.
- B** HIV can lead to malnutrition for HIV-positive children as *well* as HIV-negative OVC, especially those whose caregivers are HIV-positive and unable to provide nutritious food and appropriate caring practices.
- C** Food insecurity and malnutrition can undermine prevention efforts, leading to the spread of HIV.
- D** Food insecurity and malnutrition can undermine treatment outcomes, leading to death and viral resistance.
- E** Food insecurity and malnutrition within families can lead to reduced supervision of children, more expedient parenting, and compromised caring behaviors, thus leading to inadequate protection, care, and support.

The reasons that A, B, C, D, and E occur are described in detail in the following section.

UNDERSTANDING THE DEBILITATING CYCLE

The top row of Figure 1 illustrates the progression of HIV in an individual, from the time of infection to death.

With the advent of antiretroviral therapy (ART), people living with HIV, including children, are now living longer, healthier lives. People living with HIV on ART will therefore spend much of their time in the HIV-positive asymptomatic phase, with intermittent bouts of HIV-related illness.

Moving downward through the graphic, factors A and B indicate how HIV can contribute to food insecurity and malnutrition, respectively.

- A** HIV undermines access to food (food insecurity) for OVC and their families, leading to reduced food consumption and limited diversity in their diet.

Some of the reasons why HIV undermines access to food are as follows:

- Household purchasing power declines as productive adults become ill and can no longer earn income.
- Food is shared among more household members as orphans and foster children are taken in.
- Household labor supply and capacity to cultivate land declines.
- Productive agricultural assets are sold to cover costs of caring for the chronically ill or for funerals.
- Youth (especially girls) are taken out of school to help care for children and ill family members, undermining prospects for their long-term livelihoods.
- Agricultural and other livelihoods knowledge/skills are not transferred to children whose parents die prematurely of HIV-related illness.

- Stigma and the association of OVC with HIV results in isolation, marginalization, and “invisibility,” especially for children not in household settings.
- Relatives and neighbors appropriate productive assets (e.g., land, livestock, agricultural equipment) from widows and orphans when the father dies of HIV-related illness.
- Children may lose remittances and other forms of financial support from family and community members due to HIV-related illness and death.

B HIV can lead to malnutrition for HIV-positive children as well as HIV-negative OVC, especially those whose caregivers are HIV-positive and unable to provide nutritious food and appropriate caring practices.

Some of the reasons why HIV can lead to malnutrition are as follows:

- Mothers/caregivers with illness or those engaged in caring for ill family members are unable to provide nutritious diets and proper caring practices for their children.
- HIV-positive children reject food because of loss of appetite, side effects from ART, and physical discomfort.
- HIV-positive children experience impaired nutrient absorption.
- HIV-positive children have greater energy requirements to remain healthy.
- HIV-positive children with illness need additional nutrition-related care and support in order to meet “catch-up” growth requirements.
- HIV-positive children are sometimes neglected and inadequately fed due to the perception that they are doomed to die, and therefore feeding them would be an imprudent investment of a family’s limited resources.

The bottom half of Figure 1 shows that not only does HIV contribute to food insecurity and malnutrition, but that the reverse is also true: factors C, D, and E show how food insecurity and malnutrition contribute to HIV and AIDS by undermining three aspects of HIV programming: HIV prevention, ART, and protection, care, and support.

C Food insecurity and malnutrition can undermine HIV prevention efforts, leading to the spread of HIV.

Some of the reasons why food insecurity and malnutrition can undermine HIV prevention efforts are as follows:

- Adults and youth resort to transactional sex to obtain food.
- Youth migrate to urban areas in search of employment to feed themselves and their families. Urban areas tend to have higher HIV prevalence than rural areas, and given that migrants often resort to risky strategies to survive, they are more vulnerable to contracting the virus.

- Youth are taken out of school to obtain food/income and are overlooked by prevention programming.

D Food insecurity and malnutrition can undermine treatment outcomes, leading to death and viral resistance.

Some of the reasons why food insecurity and malnutrition can undermine treatment outcomes are as follows:

- Pregnant and lactating women and children on ART are hungry or have limited food choices. Thus, they have trouble adhering to their medication protocol.
- HIV-positive children who are malnourished require more specialized care and respond more slowly to treatment.
- Parents/caregivers are forced to choose between buying food and paying for transport for medication refills.
- Fatigue (from inadequate nutritional intake), anemia, and other debilitating conditions lead to skipping trips to the clinic for follow-up and medication refills.

E Food insecurity and malnutrition within families can lead to reduced supervision of children, more expedient parenting, and compromised caring behaviors, thus leading to inadequate protection, care, and support.

Some of the reasons why food insecurity and malnutrition can lead to inadequate protection, care, and support are as follows:

- Food-insecure households become preoccupied with efforts to obtain food, leaving OVC without adult supervision.
- Family and community safety nets are weakened by broad-based food insecurity, leaving people living with HIV and OVC without a secondary line of support (e.g., an increase in orphans living outside of family settings).

Finally, referring to Figure 1, the dotted arrow at the left of the graphic indicates that, by undermining prevention efforts and reducing uptake and adherence, food insecurity and malnutrition lead to the spread of HIV infection. Similarly, the dotted arrow at the right of the graphic indicates that reduced uptake and adherence, along with reduced protection, care, and support, lead to the progression of HIV to AIDS-related illness, and potentially death. The relationship between HIV and FSN is therefore described as “bi-directional” and creates a debilitating cycle of HIV, food insecurity, and malnutrition.

PART 2: FOOD SECURITY AND NUTRITION INTERVENTIONS FOR ORPHANS AND VULNERABLE CHILDREN

INTERVENTIONS BY AGE AND STAGE

Figure 2 lists 20 common FSN interventions for OVC, categorized by age and stage of the affected child. The figure also includes a notation explaining which factors that contribute to food insecurity, malnutrition, or HIV are addressed by that particular intervention. Factors are indicated by the letters A, B, C, D, and E, and relate to the letters in Figure 1.

The following is the delineation of the age and stages used in this document, as per guidance from the U.S. President's Emergency Plan for AIDS Relief (2006):

- Under 2 years (0 to 23 months): infancy
- 2 to 4 years old (24 months to 59 months): early childhood/toddler
- 5 to 11 years old (60 months to 143 months): middle childhood
- 12 to 17 years old (144 months to 215 months): late childhood/adolescence

NUTRITION ASSESSMENT, COUNSELING, AND SUPPORT

The 20 interventions listed on the next page represent a wide variety of FSN programming options. Nutrition assessment, counseling, and support (NACS) is an organizing framework that has emerged from within the HIV and nutrition communities as a way to align these interventions so that they work synergistically toward better nutrition and health outcomes for people of all age groups, including OVC. NACS has become an important feature of the nutrition landscape over the past several years. Although it was born from an HIV context,¹ the NACS framework has evolved into a

¹ Nutrition assessment, education, and counseling, combined with food by prescription, was the predecessor to NACS. Concern arose, however, that food was being overly prioritized within the care and treatment package, and that a more nuanced, balanced approach was required. NACS emerged in this context with "assessment" and "counseling" placed at the forefront and with food representing only one aspect of the "support" component (CORE Group 2012).

diverse portfolio of nutrition-related interventions for all, regardless of age, gender, and HIV status (see Figure 3).

Figure 2. Food Security and Nutrition Interventions for Orphans and Vulnerable Children

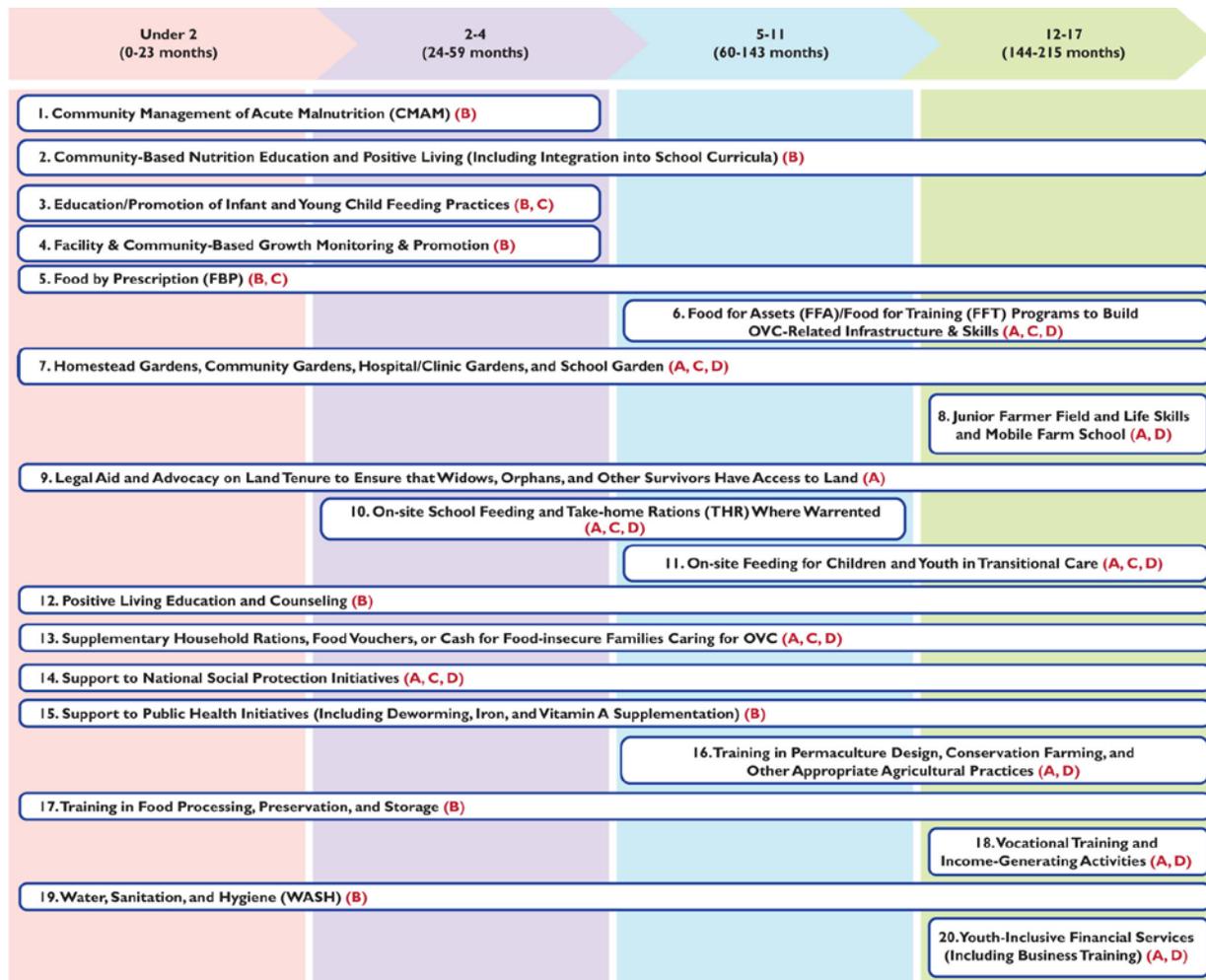
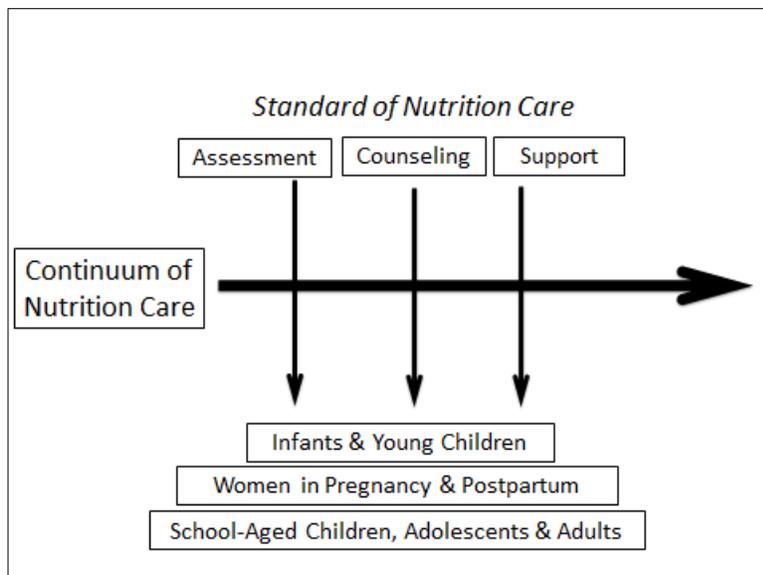


Figure 3. Nutrition Assessment, Counseling, and Support Framework



Some of the important characteristics of NACS are as follows:

- Nutrition assessment measures a client's nutritional status and dietary practices.
- Nutrition counseling refers to an interactive process between provider and client to assess nutritional status and needs; understand client preferences, constraints, and options; and plan a feasible course of action that supports healthy nutritional practices. Nutrition counseling includes nutrition education for groups of individuals.
- Nutrition support is the support provided based upon the nutrition assessment, and may include therapeutic or supplementary foods. Support may also come in the form of referrals to food security, livelihoods, and economic strengthening programs.
- NACS offers a unifying structure to help health facilities work in synergy with their communities toward better nutrition outcomes. It bridges the gap between facility- and community-based care, treatment, and support for malnourished clients, as well as for those at risk of malnutrition.
- NACS programming targets infants and young children, women in pregnancy and postpartum, school-aged children, adolescents, and adults. NACS is relevant to both HIV-positive and HIV-negative individuals.
- NACS not only addresses severe and moderate acute malnutrition, but it also emphasizes prevention of malnutrition within the NACS continuum of care.

A growing number of countries (15 at the end of 2011)² are applying a NACS framework to nutrition and food security programming. More information on NACS can be found in [Getting the Knack of NACS: Highlights from the State of the Art Meeting on NACS](#) (CORE Group 2012). Because the NACS framework is relatively new, there is no current guidance. Food and Nutrition Technical Assistance (FANTA)-3, however, is in the process of developing guidance, and it will likely be released in late 2012.

THE ROLE OF FOOD ASSISTANCE IN FOOD SECURITY AND NUTRITION PROGRAMMING

Some of the interventions listed in Figure 2 involve providing food assistance. It is important to note that the use of food assistance in FSN programming often has multiple objectives, some of which are not related to FSN.

On-site school feeding, for instance, typically aims to improve OVC enrollment and attendance at school in areas where there is underlying food insecurity and low attendance. Therefore, the stated objective of school feeding is to improve “access to education.” Similarly, while a supplementary nutrition ration may be delivered to malnourished mothers and children on ART (or pre-ART), the stated objective of providing food is not only to address malnutrition, but ultimately to enhance treatment outcomes by improving adherence to life-saving ART. Finally, a supplementary feeding program at a drop-in center for street children may have the desired objective of enrolling children and youth in healthy educational programs offered at the center, using food as an incentive for participation.

While the entry point for food assistance is generally the presence of food insecurity and/or cases of acute malnutrition, the actual role or objectives of providing food may vary from one intervention to another. Where food assistance is included in interventions detailed in the following sections, the intervention objective is listed under “Aim of the Intervention.”

EVIDENCE AND LESSONS LEARNED

At the end of each intervention description, evidence and lessons learned are provided. It is important to understand that causal attribution (i.e., attributing specific changes in health and nutrition status to FSN interventions) is generally not possible, even in non-HIV contexts. In HIV contexts, indicators such as morbidity, mortality, and even nutritional status are influenced by many program and non-program factors besides food assistance. Therefore, without a very rigorous evaluation design—which food security programs are not expected to employ—it is not possible to isolate how much of observed impact is due to food assistance. Donors generally acknowledge these limitations, and programs should still try to measure outcomes and impacts to the best of their ability, while examining and acknowledging any changes in assumptions regarding the operating environment (FANTA and WFP 2007).

Where peer-reviewed journal articles (using rigorous evaluation design) are available, carefully selected citations are listed for each intervention. Where articles are not available, an effort is made to provide lessons learned from practitioners, mostly in the form of PowerPoint presentations from conferences or other “grey literature” published by United Nations agencies and nongovernmental

² The 15 countries are Côte d'Ivoire, Democratic Republic of the Congo, Ethiopia, Ghana, Haiti, Kenya, Lesotho, Malawi, Mozambique, Namibia, South Africa, Tanzania, Uganda, Vietnam, and Zambia. In addition, Nigeria and Rwanda are in the early stages of designing NACS programming.

organizations. In many cases, evidence for the efficacy of FSN programming is qualitative and/or anecdotal and resides in donor reports and grey literature that is difficult to obtain.

LIST OF FOOD SECURITY AND NUTRITION INTERVENTIONS FOR ORPHANS AND VULNERABLE CHILDREN

This section contains detailed descriptions of 20 common FSN interventions for OVC within an HIV context. The descriptions detail the target group, relevant age and stage of the OVC, factors addressed (using letters A to E from Figure 1. The Debilitating Cycle of HIV, Food Insecurity, and Malnutrition), aim of the intervention, delivery mechanism, notes relating to implementation of the intervention, resources for learning more about the intervention, and evidence (where available) for demonstrating the efficacy of the intervention.

I. COMMUNITY-BASED MANAGEMENT OF ACUTE MALNUTRITION

Target Group: Community-based management of acute malnutrition (CMAM) typically targets children under five years of age, though in some countries—particularly those with a high prevalence of HIV—adults (both HIV-positive and -negative) have been included in CMAM protocols.

Age and Stage: Under 2, and 2 to 4 years old (up to 59 months)

Factors Addressed by this Intervention: B

Aim of the Intervention: Manage acute malnutrition through 1) community outreach, 2) outpatient care for children under five years old with severe acute malnutrition without medical complications, 3) inpatient care for children under five years old with severe acute malnutrition with medical complications, and infants under six months old with severe acute malnutrition (with or without medical complications), and 4) outpatient management of moderate acute malnutrition.

Delivery Mechanism: CMAM is a public health approach (treating as many clients as possible in outpatient care), compared to the traditional center-based approach (treating individuals in a 24-hour clinical setting). As such, it illustrates a shift from focusing on the individual to addressing the needs of the population.

Note: In high HIV-prevalence contexts, a large proportion of children with severe acute malnutrition in inpatient and outpatient care will be HIV-positive. Though not its primary purpose, CMAM has become an excellent entry point for identifying HIV-positive children and youth. Strong linkages between CMAM, HIV testing and counseling, and treatment services (i.e., antiretroviral and cotrimoxazole prophylaxis) are essential, and the majority of HIV-positive children with severe acute malnutrition will benefit from community-based treatment with ready-to-use therapeutic food.

Guidance: [Training Guide for Community-Based Management of Acute Malnutrition \(CMAM\)](#), FANTA-2, 2008

Evidence/Lessons Learned: The following workshop and conference materials provide case studies, lessons learned, and findings from research on CMAM programming in different countries.

- [International Workshop on the Integration of Community-Based Management of Acute Malnutrition, Washington DC, April 28–30, 2008, Workshop Report](#), Emergency Nutrition Network and FANTA, 2008
- [CMAM Conference 2011: Scaling Up Acute Management of Acute Malnutrition and Scaling up Nutrition \(SUN\)](#), (includes lessons from nine CMAM countries), Emergency Nutrition Network, 2011

2. COMMUNITY-BASED NUTRITION EDUCATION (INCLUDING INTEGRATION INTO SCHOOL CURRICULA)

Target Group: OVC, OVC households, and caregivers

Age and Stage: All

Factors Addressed by this Intervention: B

Aim of the Intervention: Provide context-specific and lifecycle-relevant information to aid in the preparation and consumption of diverse and nutritious diets and the practice of healthy lifestyles.

Delivery Mechanism: Nutrition education works best when linked with other services, such as growth monitoring and promotion activities, antenatal care, or formal education. Nutrition education (often combined with positive living education; see intervention 12) is ideally embedded in the national curriculum and offered, with increasing levels of complexity and application, to each age group or grade. Messages should be carefully (and professionally) designed and consistently supported through community radio and other media.

Note: Nutrition education and positive living should be core components of any food-based program. These programs must reach beyond traditional information sharing to include context-specific nutrition counseling and behavior change management, illness management, stress management, and more. Relatively inexpensive nutritional education and positive living programs can be successful in preventing morbidity and mortality among infants and children, regardless of HIV status (Interagency Task Team 2008).

Guidance:

- [The Essential Package: Twelve Interventions to Improve the Health and Nutrition of School-age Children](#), WFP and UNICEF
- [Repositioning Nutrition as Central to Development: A Strategy for Large-Scale Action](#), The World Bank, 2006
- [Partnership for Child Development](#) (website)
- [Food and Agriculture Organization \(FAO\) Nutrition Education and Consumer Awareness](#) (website)

Evidence/Lessons Learned: Community-based nutrition education comes in various formats and with a wide variety of curricula. The following articles suggest that gains in nutrition awareness, knowledge, and behavior can be achieved among children and their families with an actively implemented classroom nutrition program.

- [Developing a Nutrition and Health Education Program for Primary Schools in Zambia](#), Sherman and Muehlhoff, *Journal of Nutrition Education and Behavior*, 2007

- [Creating Health-promoting Schools in China with a Focus on Nutrition](#), Shi-Chang et al., Oxford Journals: Health Promotion International, 2004

3. PROMOTION OF INFANT AND YOUNG CHILD FEEDING PRACTICES

Target Group: Pregnant and lactating women and their infants and young children, as well as caregivers of orphaned infants

Age and Stage: Under 2, and 2 to 4 years old (up to 59 months)

Factors Addressed by this Intervention: B and C

Aim of the Intervention: Provide counseling (to groups and individual mothers) and other behavior change activities to promote optimal feeding of infants and young children in an HIV context.

Delivery Mechanism: Counseling on feeding practices should be integrated into nutrition assessment, counseling, and support (including food-by-prescription programming), and by extension should be part of all prevention of mother-to-child transmission (PMTCT) and mother and child health and nutrition programming.

Note: Infant and young child feeding is a rapidly evolving area of programming. In many countries, there remains significant confusion among health care providers about current infant feeding recommendations in an HIV context. It is crucial that the most up-to-date, accurate information be provided to pregnant and lactating women, empowering them to make the best decision possible for their given circumstances.

Guidance:

- [Guidelines on HIV and Infant Feeding](#), World Health Organization (WHO), 2010
- [Infant and Young Child Feeding List of Publications](#) (website), WHO, 2012
- [Infant & Young Child Nutrition Project Resources](#) (website), USAID, 2012
- [Infant & Child Nutrition](#) (website), FANTA

Evidence/Lessons Learned: A UNICEF programming guide provides a summary of evidence on the efficacy of infant and young child feeding interventions (p. 15 and throughout the guide). Additionally, a report from Malawi provides formative research on the barriers and facilitators to optimal feeding practices.

- [Programming Guide: Infant and Young Child Feeding](#), UNICEF, 2011
- [Consulting with Caregivers, Formative Research to Determine the Barriers and Facilitators to Optimal Infant and Young Child Feeding in Three Regions of Malawi](#), USAID, 2011

4. FACILITY AND COMMUNITY-BASED GROWTH MONITORING AND PROMOTION

Target Group: Children under five years of age

Age and Stage: Under 2, and 2 to 4 years old (up to 59 months)

Factors Addressed by this Intervention: B

Aim of the Intervention: Detect growth faltering early so that prompt action can be taken to prevent severe forms of malnutrition. Growth monitoring can provide an entry point to preventive and curative health care, contributing to significant reductions in malnutrition and mortality.

Delivery Mechanism: Facility-based growth monitoring and promotion take place at health facilities and at outreach posts as part of maternal and child health services.

Note: Community-based growth monitoring and promotion activities are relevant where there is low awareness of the causes of malnutrition and where families do not have the necessary information to help them protect and promote their children's health. Local-level ownership and responsibility are essential, along with a reliable referral system to ensure medical treatment for children when necessary. Horizontal integration with other local-level initiatives will help communities identify and implement actions that give them the highest gains in nutrition indicators (FAO 2005).

Guidance:

- ["Theme VI. Community-based Growth Monitoring and Promotion,"](#) in Protecting and Promoting Good Nutrition in Crisis and Recovery Resource Guide, FAO, 2005
- [Successful Community Nutrition Programming: Lessons from Kenya, Tanzania and Uganda,](#) The LINKAGES Project, 2002

Evidence/Lessons Learned: Evidence for the efficacy of growth monitoring and protection as a screening mechanism for malnutrition and for improving the nutritional status of children is mixed. To date, there is a lack of consensus on whether the benefits are worth the cost. The following resources reflect evidence both in favor and against the use of growth monitoring and protection.

- [Growth Monitoring and Promotion: Review of Evidence of Impact,](#) Ashworth, Shrimpton, and Jamil, Maternal & Child Nutrition, 2008
- [Growth Monitoring and the Promotion of Healthy Young Child Growth, Evidence of Effectiveness and Potential to Prevent Malnutrition,](#) Griffiths and Del Rosso, 2007
- [Do Growth Monitoring and Promotion Programs Answer the Performance Criteria of a Screening Program? A Critical Analysis based on a Systematic Review,](#) Roberfroid et al., Tropical Medicine & International Health, 2005

5. FOOD BY PRESCRIPTION

Target Group: Undernourished pregnant and lactating women and their infants; and undernourished OVC

Age and Stage: All

Factors Addressed by this Intervention: B and D

Aim of the Intervention: Improve the health and/or treatment outcomes of the client by providing short-term, individual nutrition supplementation with a specialized commodity in response to clinical malnutrition in the presence of HIV or other illnesses.

Delivery Mechanism: PMTCT and pediatric ART programs

Note: The WFP’s soon-to-be-released Food by Prescription Learning Modules suggest the following target groups: new ART clients, existing (malnourished) ART clients, pre-ART clients, HIV-positive pregnant/postpartum women (perhaps conditional on nutritional status), HIV-negative (malnourished) pregnant/postpartum women, other HIV-negative (malnourished) individuals, and tuberculosis patients. Food by prescription is still an evolving area of programming, with many aspects still in the experimentation phase. Strong nutrition assessment, education, and counseling are prerequisites for food by prescription programming, because the assessment of the client determines the need for the nutrition supplement, and because clinical care is a critical aspect of treatment for malnutrition.

Guidance: [GAIN Working Paper Series No. 2: Food by Prescription](#), Global Alliance for Improved Nutrition, 2009

Evidence/Lessons Learned: While evidence is still limited, the following research provides empirical and qualitative evidence linking food-by-prescription programming to increased adherence to ART, and relatively more rapid improvements in body mass index for the first three months on ART, when compared to people living with HIV on ART without nutrition supplements. The presentations by Tang and Manary provide a diverse range of evidence around therapeutic and supplementary feeding for people living with HIV, but are not child/youth specific.

- [Food by Prescription Pilot Project in Zambia](#), Catholic Relief Services, 2011
- [Food by Prescription in Kenya: An Assessment Conducted in 2009](#), USAID’s AIDSTAR-One Project, 2010
- [“Nutrition Implications of HIV and ART,”](#) Tang, presented at Getting the Knack of NACS conference, 2012
- [“Supplementary and Therapeutic Feeding in Adults Living with HIV,”](#) Manary, presented at Getting the Knack of NACS conference, 2012

6. FOOD FOR ASSETS/FOOD FOR TRAINING PROGRAMS TO BUILD ORPHANS AND VULNERABLE CHILDREN–RELATED INFRASTRUCTURE AND SKILLS

Target Group: Food-insecure OVC households and caregivers

Age and Stage: All

Factors Addressed by this Intervention: A, C, and E

Aim of the Intervention: Build human and physical capacity to provide relevant protection, care, education, and development of OVC while simultaneously improving access to nutritious food.

Delivery Mechanism: Household rations delivered to food for assets (FFA)/food for training (FFT) participants in exchange for labor or for construction of physical assets and infrastructure and/or to cover the opportunity cost (i.e., income lost) of participating in various types of training, or a combination of both. OVC-related FFA/FFT projects include rehabilitation of youth centers, feeder roads to market/health services/schools, community grain banks, community gardens, training in conservation farming, life skills training, stigma reduction training, and caregiver/teacher skill development that responds to the needs of OVC.

Note: FFA/FFT programs often include only able-bodied members of communities, largely because the construction work can be too physically demanding for those who are ill or need to avoid sun exposure (e.g., people living with HIV) and those with demanding work schedules. This presents a dilemma as it is often the families who are most in need that cannot participate, either because of their lack of physical stamina or because able-bodied family members must stay at home to care for those who are ill. FFA/FFT can be adapted to an HIV context by modifying certain tasks and taking into consideration the physical restrictions of people living with HIV and OVC caregivers. Some methods for modifying these projects are listed in the following resource.

Guidance: [Food for Assets: Adapting Programming to an HIV/AIDS Context](#) (draft), C-SAFE Learning Center, 2004

Evidence/Lessons Learned: FFA/FFT is a relatively new area of programming in comparison to its programmatic predecessor, food for work. The literature review for this intervention did not reveal any empirical evidence linking FFA/FFT to improvements in food security and/or nutrition status of youth participants, nor did it find any research examining changes in knowledge or skills due to FFA/FFT interventions. More generally, however, there is ample evidence that food transfers offer a protective role—improving welfare, access to food, and food security—for program participants and their families. One article by Gilligan and Hoddinott demonstrates this effect, though it is not OVC-specific. The UNESCO article discusses various types of FFA/FFT interventions and expected outcomes but does not provide empirical evidence to support these claims.

- [Is There Persistence in the Impact of Emergency Food Aid? Evidence on Consumption, Food Security, and Assets in Rural Ethiopia](#), Gilligan and Hoddinott, *American Journal of Agricultural Economics*, 2007
- “[Food for Education and Rural Development](#),” Haller, in *Education for Rural Development in Asia* (p. 125), UNESCO, 2002

7. HOMESTEAD GARDENS, COMMUNITY GARDENS, HOSPITAL/CLINIC GARDENS, AND SCHOOL GARDENS

Target Group: OVC households and caregivers, primary-school children, secondary-school youth, and OVC youth in general

Age and Stage: All

Factors Addressed by this Intervention: A, C, and E

Aim of the Intervention: Improve access to nutritious foods and increase dietary diversity. They also provide the possibility of generating income for the household.

Delivery Mechanism: A gardening curricula can be delivered via support and self-help groups for people living with HIV, home-based care groups, schools and/or after-school programs, youth groups, community groups, and other such programs.

Note: Backyard and kitchen gardens are extremely relevant to urban contexts, even where land is scarce. These gardens are not intended for growing staple crops, but instead aim to support dietary diversity by growing vegetables and fruits. Specific types of gardens, such as vertical or container gardens, require less labor to water and cultivate. Therefore, they are highly appropriate for people living with HIV who may be ill or incapacitated. Some methodologies, such as keyhole or trench

gardens, will be labor intensive initially (preparing the structure, soil, etc.), so families may need help from physically capable community members for the initial construction.

Guidance:

- [Homestead Gardening: A Manual for Program Managers, Implementers and Practitioners](#), Catholic Relief Services, 2008
- [Setting Up and Running a School Garden](#), FAO, 2005

Evidence/Lessons Learned: The following documents review results from a variety of research studies on gardening projects and agricultural programs more generally. The second document, in particular, concludes that dietary diversity, and in some cases anthropometrics, improve for participants in gardening projects when these programs include nutrition counseling/education components. Lessons learned are provided in both documents.

- [Opportunities to Improve Nutrition through Urban Gardens Program Activities in Ethiopia: Summary Report of Current Practices from Qualitative and Quantitative Research Studies](#). USAID's Infant & Young Child Nutrition Project, 2011
- [Nutrition and Food Security Impacts of Agriculture Projects](#), USAID's Infant & Young Child Nutrition Project, 2011

8. JUNIOR FARMER FIELD AND LIFE SKILLS AND MOBILE FARM SCHOOLS

Target Group: OVC youth

Age and Stage: 12 to 17 years old (144 months to 215 months)

Factors Addressed by this Intervention: A, C, and E

Aim of the Intervention: Provide agricultural and life skills to OVC youth. In situations where food rations are provided, the aim is also to improve short-term access to nutritious foods and to cover the opportunity cost (i.e., income lost) to youth attending the training. Rations are intended to increase program uptake, attendance, and retention of vulnerable youth.

Delivery Mechanism: Training can be delivered as part of school or after-school curriculum, or via church or community-based organizations for youth. When rations are provided, they are usually in the form of a snack or cooked meal at lunchtime.

Note: Evaluations of Junior Farmer Field and Life Skills to date indicate that it is critical for host country ministries (e.g., ministries of education, agriculture, or health) to be engaged in the delivery of these services in order to ensure sustainability. While these programs offer essential training for vulnerable youth, they are often expensive on a cost-per-beneficiary basis.

Guidance: [Getting Started: Running a Junior Farmer Field and Life School](#), FAO, 2007

Evidence/Lessons Learned: The following documents provide useful lessons learned as well as strengths and weaknesses of Junior Farmer Field programs. However, studies examining their contribution to the FSN status of OVC were not found during the literature review. This may be because these programs aim to improve long-term food security and livelihood prospects for OVC, which are difficult to measure within the purview of these projects.

- [“Junior Farmer Field and Life Schools: Experience from Mozambique,”](#) Djeddah, Mavanga, and Hendrickx, in *AIDS, Poverty and Hunger: Challenges and Responses*, IFPRI, 2006
- [Junior Farmer Field and Life Schools in Namibia and Swaziland,](#) FAO

9. LEGAL AID, SUCCESSION PLANNING, AND ADVOCACY FOR LAND TENURE RIGHTS FOR WIDOWS, ORPHANS, AND OTHER SURVIVORS

Target Group: Widows, orphans and other survivors

Age and Stage: All

Factors Addressed by this Intervention: A

Aim of the Intervention: Protect land and property rights of widows, orphans, and other survivors when the head of households dies.

Delivery Mechanism: Training for caregivers and OVC youth can be integrated into after-school programs, support and self-help groups for people living with HIV, youth groups, community groups, home-based care and PMTCT programs, and more. The need for improved laws and enforcement of those laws also points to the need for more uniform interpretation of existing laws, imperatives that can be approached in part by training judges, magistrates, court officials, and law enforcement officers on succession law, and use of standard training manuals for this purpose (Izumi et al. 2009).

Note: Access to land is a primary prerequisite for growing food. Therefore, advocacy regarding land tenure and legal aid for survivors is of critical importance to promoting the food security of widows, orphans, and other survivors. Ensuring the property and inheritance rights of women and children entails both preventing property grabbing and providing reliable legal recourse to those whose property rights have been violated. Women and children need to understand their rights and the resources available to them if those rights are violated; training on these topics can help to provide this knowledge and understanding.

Additionally, training caregivers in succession planning to provide for the future needs of surviving spouses and orphans is critical. This involves helping families obtain birth certificates and land titles, recording their oral or written wills, and making guardianship arrangements for their children to secure the verifiable rights of surviving family members.

Guidance: [Protecting Women’s Land and Property Rights in the Context of AIDS](#), Izumi et al., 2009

Evidence/Lessons Learned: The literature review for this document did not reveal any empirical evidence linking these types of interventions to the FSN status of OVC. However, the following document discusses how property and inheritance are enabling conditions for attaining food security, stating that secure access to land is an essential prerequisite for achieving diverse land-based livelihoods.

- [Gender, Property Rights and Livelihoods in the Era of AIDS: FAO Technical Consultation—Rome, 28-30 November 2007, Proceedings Report,](#) FAO, 2008

10. ON-SITE FEEDING FOR CHILDREN AND YOUTH IN TRANSITIONAL CARE

Target Group: OVC, with a particular emphasis on children who are living outside of family settings. This includes youth in transition shelters, foster family care, street kids projects, community-based early childhood care and development programs, after-school care, child camps and drop-in centers, children's care corners, and rehabilitation centers for formerly abducted children and child soldiers.

Age and Stage: 5 to 11 year olds (60 months to 143 months), and 12 to 17 year olds (144 months to 215 months)

Factors Addressed by this Intervention: A, C, and E

Aim of the Intervention: Improve access to a nutritious diet and increase OVC participation in programs that provide protection, care, and support. Early childhood care and development have particular potential for children living with HIV, who suffer from common childhood diseases more than other children. Single-parent families, households caring for orphaned children, or families busy with the care of a chronically ill member can benefit from having a safe place for small children to spend part of their days.

Delivery Mechanism: A biscuit or other fortified snack can be distributed in the morning and/or a cooked meal provided at lunchtime. A take-home ration also can be incorporated into on-site programming (see intervention for on-site school feeding). On-site feeding can be conducted via transition shelters, foster family care, street kids projects, community-based early childhood care and development programs, after-school care, child camps and drop-in centers, children's care corners, and rehabilitation centers for formerly abducted children and child soldiers.

Note: While there is broad consensus that institutional care has a negative effect on children (Save the Children n.d.), it is important to recognize that not all families are caring and protective of the children in their care. Inevitably, there will be cases in which children need protection but it is not in their best interest to stay with the family or extended family. There will also be children who have been separated from or abandoned by their families, and for whom institutional care (at least in the short-term) is the only option. Providing rations in institutional settings should be done only for carefully selected programs that provide care and protection to children who have no other options. A list of criteria for selecting appropriate institutional settings is provided in the following guidance document.

Guidance: [Getting Started: Programming Food Assistance for Orphans and Vulnerable Children](#), Greenblott and Greenaway, WFP, 2006

Evidence/Lessons Learned: No research studies were found examining the contribution of food rations to the FSN status of children in transitional care. There are at least two possible reasons for this dearth of research. The first is that due to the transient nature of their circumstances (e.g., living on the street, or in and out of institutional care), there may be inconsistent uptake of programming. This would make it difficult, if not impossible, to measure change associated with these interventions. The second is that other factors that affect FSN for these youth will be extremely dynamic (e.g., access to clean water, exposure to contagious disease, exposure to sexual violence), which also makes it hard to measure the effect of food rations on FSN.

II. ON-SITE SCHOOL FEEDING AND TAKE-HOME RATIONS WHERE WARRANTED

Target Group: Young, in-school children in geographic areas where high levels of food insecurity, high HIV prevalence, and poor school enrollment/retention rates coexist. On-site feeding in schools provides food for every child equally and does not single out individual students.

Age and Stage: 5 to 11 year olds (60 months to 143 months), and 12 to 17 year olds (144 months to 215 months), recognizing that many primary and secondary school children/youth are well beyond the age categories listed here.

Factors Addressed by this Intervention: A, C, and E

Aim of the Intervention: Improve and protect access to education (enrollment, attendance, and retention). On-site feeding for school-going children is thought to be the most straightforward mechanism for reaching vulnerable children on a large (e.g., district-level or national) scale. Take-home rations are dry food rations distributed to students and their families. The rations can provide income for particularly vulnerable families if they choose to sell the ration. Take-home rations can also provide an incentive to families with high childcare burdens (e.g., caring for or fostering non-biological children) to keep these children in their homes rather than placing them with other relatives or in residential care, or sending them elsewhere.

Delivery Mechanism: A biscuit or other fortified snack is distributed in the morning and/or a cooked meal is provided at lunchtime.

Note: Families may consume the take-home ration food, but they may also choose to sell or trade it to meet more pressing needs. Thus, take-home rations do not always ensure that the children themselves will consume more food. School feeding is widely thought of as one of the most successful models for reaching food-insecure children (and families) at scale. It does, however, overlook those food-insecure children and youth who, for one reason or another, are not able to attend school.

Guidance:

- [School Meals—Key Publications](#) (website), WFP, 2012
- [Rethinking School Feeding: Social Safety Nets, Child Development, and the Education Sector](#), Bundy et al., The World Bank, 2009

Evidence/Lessons Learned: The following resources show that school feeding has a positive impact on school participation rates where initial indicators of participation are low. Some of these studies also show that school feeding contributes to the cognitive performance of learners, although this is highly dependent upon the content of school meals. Generally speaking, school feeding programs no longer purport to improve nutritional status of learners, but instead focus on improving participation and cognition.

- [Realistic Review to Understand the Efficacy of School Feeding Programs](#), Greenhalgh, Kristjansson, and Robinson, British Medical Journal, 2007
- [How Effective are Food for Education Programs? A Critical Assessment of the Evidence from Developing Countries](#), Adelman, Gilligan, and Lehrer, IFPRI, 2008
- [School Feeding Programs: Evidence and Policy Lessons](#), IFPRI Seminar, 2009

12. POSITIVE LIVING EDUCATION AND COUNSELLING

Target Group: OVC, OVC households, and caregivers

Age and Stage: All

Factors Addressed by this Intervention: B, C, and D

Aim of the Intervention: Increase the quality of health through immune-strengthening and disease-prevention methods, thus extending the length of healthy living for people living with HIV.

Delivery Mechanism: Positive living strategies can be designed for the general population, or targeted specifically to people living with HIV. Population-based interventions are those generally considered good for everyone, reaching the maximum number of beneficiaries at the lowest possible cost, without the potential risk of stigmatizing the beneficiary. Targeted strategies are designed specifically to meet the particular needs of people living with HIV, and they can be integrated into a range of programming, including home-based care, PMTCT, ART, mother and child health and nutrition, the counseling component of NACS, and others.

Note: Positive living has evolved as a way to provide direction and a sense of empowerment to people living with HIV regarding how to manage HIV-related illness. It involves: 1) lifestyle management, psychosocial support, safer sexual practices, and reduced risk-taking; 2) good nutrition in health and illness; and 3) treatment literacy and access. As with nutrition education strategies, positive living relies on the participants being able to access a diverse and nutritious diet in order to follow the recommended strategies. This is often a significant challenge for food-insecure individuals.

Guidance:

- [Helping My Child Stay Healthy](#), Family Health International, 2009
- [Living Well With HIV/AIDS: A Manual on Nutritional Care and Support for People Living with HIV/AIDS](#), WHO and FAO, 2002
- [Positive Living: Food & Us](#), Francis and Rose, John Snow Inc., 2003

Evidence/Lessons Learned: No studies were found examining the contribution of positive living education to the FSN status of OVC. This is most likely due to the fact that positive living education is a set of strategies (rather than an intervention) that are context- and audience-specific, and are generally delivered through a wide range of program mechanisms (e.g., home-based care and PMTCT). As such, it may be difficult to measure their collective contribution to FSN for OVC.

13. SUPPLEMENTARY HOUSEHOLD RATIONS, FOOD VOUCHERS, OR CASH FOR FOOD-INSECURE FAMILIES WITH ORPHANS AND VULNERABLE CHILDREN

Target Group: Food-insecure OVC households

Age and Stage: All

Factors Addressed by this Intervention: A, C, and E

Aim of the Intervention: Reduce vulnerability to risky or unhealthy coping strategies, including taking children out of school, having youth resort to transactional sex, selling land or productive assets that might protect children from eventual destitution, or turning a blind eye to a child's efforts

to solicit food or money from strangers. Also, because food-insecure families become preoccupied with efforts to obtain food, supplementary rations can support caregivers' ability to be available and to supervise and care for OVC. Finally, where family and community safety nets have been weakened by the impact of HIV, supplementary rations can help shore up resources so that families can continue to take in OVC and keep children in safe and caring family settings.

Delivery Mechanism: Home-based care, community-based targeting (e.g., OVC committees or structures), PMTCT and other HIV-related programs.

Note: In places where the market is functioning, cash transfers or a food voucher system may be more appropriate alternatives to food rations because they can simultaneously stimulate the local economy by supporting local retailers. Food transfers will be more appropriate than cash where markets are not functioning or the risk of inflation is high.

Guidance:

- [Food Assistance Programming in the Context of HIV](#), FANTA and WFP, 2007
- [Food Assistance in the Context of HIV: Ration Design Guide](#), WFP, 2008
- [Guidelines for Cash Transfer Programming](#), International Red Cross and Red Crescent Movement, 2007
- [Getting Started: Programming Food Assistance for Orphans and Vulnerable Children](#), WFP, 2008
- [Cash and Vouchers Manual](#), WFP, 2009

Evidence/Lessons Learned: There is a large body of evidence covering this relatively broad category of interventions, and these interventions can be structured in a variety of ways (e.g., conditional versus unconditional transfers, cash versus food, targeted versus universal). The evidence base is generally positive, demonstrating that when well structured (i.e., appropriate to the context), these mechanisms can contribute to improvements in the FSN status of OVC.

- [Supplemental Feeding: Its Role in Large-scale Maternal and Child Nutrition and Health Program](#), CARE, 2008
- [The Impact of Social Cash Transfers on Children Affected by HIV and AIDS: Evidence from Zambia, Malawi and South Africa](#), UNICEF, 2007
- [Cash Transfers: Evidence Paper](#), UK Department for International Development, Policy Division, 2011

14. SUPPORT TO NATIONAL SOCIAL PROTECTION INITIATIVES

Target Group: OVC households and caregivers, the elderly

Age and Stage: All

Factors Addressed by this Intervention: A, C, and E

Aim of the Intervention: In conventional terms, social protection describes transfers of food, cash, or other in-kind contributions to poor and vulnerable groups in response to poverty or threats to their livelihood. According to contemporary interpretations of social protection, however, these

mechanisms strive to “promote,” not just “protect,” an individual’s livelihood, which is critical in the context of the OVC crisis. Some experts include a “transformative” component emphasizing “social equity” as well.³

Delivery Mechanism: Social transfers are a key social protection instrument that support the rights and needs of orphans and other children affected by HIV. OVC can be targeted either directly (e.g., on-site school feeding) or indirectly (e.g., orphan allowances, foster care allowances, basic pensions for elderly or chronically ill people caring for orphans). Such transfers can be in-kind (e.g., food or clothing), in cash (e.g., for books, school uniforms, or transport allowances), or in the form of exemptions (e.g., from school and medical fees).

Note: In some countries, including Mexico, comprehensive social protection has played a key role in improving the FSN of vulnerable children (Leroy et al. 2008). Affordability over the long-term (i.e., sustainability), however, remains an issue in countries that depend heavily on foreign support to national budgets to implement these programs. Additionally, no one model of social protection fits all situations; for each country, the specific context, including OVC-related priorities, government capacity, budget, local OVC service providers, and other contextual factors, must be considered. Working out the ideal model for each country through the use of pilot programs remains controversial.⁴

Guidance:

- [Taking Evidence to Impact: Making a Difference for Vulnerable Children Living in a World with HIV and AIDS](#), UNICEF, 2009
- [Social Protection in the Era of HIV and AIDS - Examining the Role of Food-Based Interventions](#), Greenblott, WFP, 2007

Evidence/Lessons Learned: The evidence base for social protection is generally positive with regard to the contribution that social protection can make to the FSN status of OVC. It is still questionable, however, whether successes in Latin America and other parts of the world are transferable to African countries, where national budgets depend heavily on short-term (and potentially unreliable) foreign aid for health, education, and other social services.

- [The Role of Social Protection in Achieving Equitable Reduction of Child Mortality](#), Hypher, 2011
- [Social Protection and Children: A Synthesis of Evidence from Young Lives Longitudinal Research in Ethiopia, India and Peru](#), Porter and Dornan, Young Lives, 2010
- [Scoping Study on Social Protection: Evidence on Impacts and Future Research Directions](#), Kabeer, UK Department for International Development, 2009

³ In 2004, the Institute for Development Studies published its landmark paper, *Transformative Social Protection*, arguing that social protection can empower marginalized people and be socially transformative. Anti-stigma campaigns that support OVC are a form of transformative social protection. The Institute for Development Studies describes four categories of social protection: protective, preventive, promotional, and transformative (Devereux and Sabates-Wheeler 2004).

⁴ Most of the pilot programs in Africa to date have been short-term and expensive (on a cost-per-beneficiary basis), both of which are counter to the goals of an effective social protection system (i.e., reliability and sustainability are key virtues of social protection).

15. SUPPORT TO PUBLIC HEALTH INITIATIVES (INCLUDING DEWORMING AND IRON AND VITAMIN A SUPPLEMENTATION)

Target Group: OVC, OVC households, and caregivers

Age and Stage: All

Factors Addressed by this Intervention: B

Aim of the Intervention: Improve nutrition and health via immunization campaigns; the provision of micronutrient supplements; systematic deworming; malaria prevention; water, sanitation and hygiene activities; and other relevant activities.

Delivery Mechanism: Public health initiatives are delivered using any and all delivery mechanisms listed in this guide, including priority mechanisms, such as schools, early childhood care and development programs and NACS.

Note: Public health initiatives such as these should always be performed in partnership with the local Ministry of Health and in support of the national OVC and/or public health strategy. Ad hoc initiatives can be detrimental and undermine local government initiatives.

Guidance: [Facts for Life](#), UNICEF, 2010

Evidence/Lessons Learned: There is a large body of evidence demonstrating the positive impact of public health initiatives on children's health and nutrition. The following are documents related to vitamin A supplementation, deworming, and iron supplementation.

- [Vitamin A Supplementation: A Decade of Progress](#), UNICEF, 2007
- [School Deworming at a Glance](#), WHO, 2003
- [Weekly Iron-Folic Acid Supplementation \(WIFS\) in Women of Reproductive Age: Its Role in Promoting Optimal Maternal and Child Health](#), WHO, 2009

16. TRAINING IN FOOD PROCESSING, PRESERVATION, AND STORAGE

Target Group: OVC, OVC households, and caregivers

Age and Stage: All

Factors Addressed by this Intervention: A

Aim of the Intervention: Improve dietary stabilization (i.e., increasing nutritional diversity year-round) and income generation by selling value-added produce and/or by storing produce until prices increase.

Delivery Mechanism: Training can be delivered at food distribution sites or as part of a wider community or school-based nutrition education campaign.

Note: To maximize efficacy, this intervention requires an understanding of local customs and practices. As a behavior change modification initiative, it also requires repeated follow-up and review of practices that have been successful in each context. This intervention is particularly relevant in communities able to produce more than they can consume at harvest time, but also experience debilitating periods of hunger, where food insecurity is transitory.

Guidance:

- “[Preparing Food](#),” in Setting Up and Running a School Garden, Teaching Toolkit, FAO, 2010
- “[Implementing Diet and Food-based Approaches](#),” in Preventing Micronutrient Malnutrition: A Guide To Food-Based Approaches, FAO and International Life Sciences Institute, 1997
- [Crop Drying, Preservation, and Storage](#), Village Earth website (contains an abundance of guidance on food processing, preservation, and storage)

Evidence/Lessons Learned: The literature review for this document did not reveal research examining links between these interventions and the FSN status of OVC specifically, although it does show the positive effect that they have on food security for vulnerable families and communities more generally. Lessons learned from experiences in different countries are provided in the following document, as well as in all of the guidance documents listed.

- “[Food Processing and Preparation Technologies for Sustainable Utilization of African Indigenous Vegetables for Nutrition Security and Wealth Creation in Kenya](#),” Habwe, Walingo, and Onyango, in Using Food Science and Technology to Improve Nutrition and Promote National Development, International Union of Food Science & Technology, 2008

17. TRAINING IN PERMACULTURE DESIGN, CONSERVATION FARMING, AND OTHER APPROPRIATE AGRICULTURAL PRACTICES

Target Group: OVC schoolchildren, OVC youth, and OVC households and caregivers

Age and Stage: All

Factors Addressed by this Intervention: A and E

Aim of the Intervention: Provide OVC and OVC households with long-term access to a diverse and nutritious diet. Permaculture also teaches children about their relationship to the environment and how to meet their needs in a responsible, eco-friendly manner.

Delivery Mechanism: Permaculture, conservation farming, and other appropriate agricultural approaches can be infused into the primary and/or secondary school curricula, or taught to OVC youth, households, and caregivers via after-school programs, support and self-help groups for people living with HIV, youth groups, and community groups.

Note: “Permaculture” is a framework for working toward greater sustainability of human habitats; it uses ecological principles to meet human needs for food, shelter, energy, and community. In the context of OVC programming, permaculture guides people toward sustainable FSN options that exist harmoniously within their environment. Training in these practices (permaculture, conservation farming, and other sustainable methods) takes time and physical effort, especially during the initial stages, when training takes place and soil preparation and irrigation methods must be established.

Guidance:

- [Permaculture Design for Orphans and Vulnerable Children Programming](#), Greenblott and Nordin, AIDSTAR-One, USAID, 2012
- [The Organic Classroom \(Grades 1 – 3\)](#), School’s Environmental Education and Development, 2004 (website contains many other useful permaculture resources)

- [Low Input Food & Nutrition Security: Growing & Eating More Using Less](#), Nordin, WFP, 2005
- [More and Better Food: Farming, Climate Change, Health and the AIDS Epidemic](#), Bayley and Nyika, Strategies for Hope Trust, 2011

Evidence/Lessons Learned: Empirical evidence linking permaculture programming to improvements in the FSN status of OVC is lacking. This may be because permaculture is better described as a design approach that informs the implementation of a range of interventions that are context specific. As such, it may be difficult to measure their collective contribution to FSN for OVC. The following document provides qualitative and anecdotal evidence of permaculture successes as well as useful lessons. All of the guidance documents also contain lessons learned from permaculture experiences with OVC.

- [A Food Centered Curriculum: How Permaculture Taught through School Kitchen Gardening can Lead to More Sustainable Schools and Communities and a More Sustainable Future](#), Gannon, Premier's Teacher Scholarship Reports

18. VOCATIONAL TRAINING AND INCOME-GENERATING ACTIVITIES

Target Group: OVC youth and OVC caregivers

Age and Stage: 12 to 17 years old (144 months to 215 months)

Factors Addressed by this Intervention: A, C, and E

Aim of the Intervention: Provide OVC youth and caregivers with marketable skills and potential for generating income in areas of demand in their communities. Ultimately, the intent is to increase their chance of developing a viable livelihood and long-term food security. When food rations are provided, the aim is to improve short-term access to nutritious foods and to cover the opportunity cost (i.e., income lost) to youth of attending the training. Rations are intended to increase program uptake, attendance, and retention of vulnerable youth.

Delivery Mechanism: Vocational schools/colleges or training curricula delivered via home-based care, after-school programs, support and self-help groups for people living with HIV, youth groups, community groups, private-public partnerships, and so on. When rations are provided, they are usually in the form of a snack or cooked meal at lunchtime.

Note: A comprehensive market survey is a mandatory part of any vocational training/income-generating activity. This helps ensure that youth are able to acquire jobs and/or viable income-generating opportunities upon graduation from the training. Like youth-inclusive financial services, this option offers more sustainable opportunities to OVC and OVC caregivers who have graduated from shorter-term food security interventions.

Guidance:

- [Children, Youth & Economic Strengthening Network](#) (website)
- [The Small Enterprise Education and Promotion Network](#) (website)

Evidence/Lessons Learned: The following evidence shows that vocational training raises earnings and employment when compared to youth that participate in training versus nonparticipants. Studies examining links to improvements in FSN status were not found.

- [Subsidizing Vocational Training for Disadvantaged Youth in Developing Countries: Evidence from a Randomized Trial](#), Attanasio, Kugler, and Meghir, 2009

19. WATER, SANITATION, AND HYGIENE

Target Group: OVC, OVC households, and caregivers

Age and Stage: All

Factors Addressed by this Intervention: B

Aim of the Intervention: Improve nutrition and quality of life through better hygiene practices, greater access to safe drinking water, and improved access to sanitation services. Water, sanitation, and hygiene (WASH) interventions also aim to facilitate access to deworming and distribute information about infant and young child feeding and care practices, good nutrition, and food preparation and safety.

Delivery Mechanism: WASH education and services can be delivered at food distribution sites or integrated into nutrition-oriented programming, including infant and young child feeding, mother and child health and nutrition, PMTCT, ART, and other services. WASH interventions can also be delivered in primary and secondary schools, delivering both improved infrastructure (e.g., latrines, washing facilities) and curricula.

Guidance:

- [UNICEF Publications on Water, Sanitation and Hygiene](#) (website)
- [Improving the Lives of People Living with HIV through WASH: Water Sanitation and Hygiene](#), AIDSTAR-One, USAID, 2012
- [Focusing Resources on Effective School Health](#) (FRESH website), UNESCO
- [Progress for Children: A Report Card on Water and Sanitation](#), UNICEF, 2006

Evidence/Lessons Learned: The following documents discuss the clear links between child health and nutrition and WASH. The HUNGaMA survey points to evidence from China, while the second document is a meta-analysis demonstrating clear links between WASH promotion activities and reduction in diarrheal disease among children.

- [The HUNGaMA Survey Report, 2011](#), HUNGaMA, Fighting Hunger and Malnutrition, 2011
- [Water, Sanitation, and Hygiene Interventions to Reduce Diarrhoea in Less Developed Countries: A Systematic Review and Meta-analysis](#), Fewtrell et al., The Lancet Infectious Diseases, 2005

20. YOUTH-INCLUSIVE FINANCIAL SERVICES AND BUSINESS TRAINING

Target Group: OVC youth and OVC caregivers

Age and Stage: 12 to 17 years old (144 months to 215 months)

Factors Addressed by this Intervention: A, C, and E

Aim of the Intervention: Expand access to financial service opportunities (savings, lending, and business training) for OVC youth and caregivers, and, by extension, promote livelihoods and long-term food security.

Delivery Mechanism: These types of interventions are most effective when savings and loan organizations, micro-lending groups, and other financial service experts collaborate directly with youth groups, self-help and support groups for people living with HIV, and other OVC and HIV service organizations.

Note: Youth-inclusive financial services can be an excellent option when OVC and OVC caregivers have graduated from shorter-term food security interventions and require more sustainable options. The provision of financial services is, however, a specialized area and should not be initiated without experienced staff and an established financial infrastructure.

Guidance:

- [Youth-Inclusive Financial Services Portal](#) (website)
- [Children, Youth & Economic Strengthening Network](#) (website)
- [The Small Enterprise Education and Promotion Network](#) (website)

Evidence/Lessons Learned: The literature review for this intervention did not reveal research that specifically examines links between youth-inclusive financial services and the FSN of OVC. The Youth-Inclusive Financial Services website includes case studies providing experiences and lessons learned from implementing these interventions, some of which had an impact on food security. The second resource reveals evidence of a positive relationship between women’s access to microcredit and young girls’ long-term nutrition status (height for age).

- [Youth-Inclusive Financial Services—Case Studies from the Field](#) (website)
- [Household Access to Microcredit and Children’s Food Security in Rural Malawi: A Gender Perspective](#), Guha-Khasnobis and Hazarika, United Nations University World Institute for Development Economics Research, 2007

OTHER RESOURCES FOR FOOD SECURITY AND NUTRITION PROGRAMMING FOR ORPHANS AND VULNERABLE CHILDREN

In many countries, context- and language-specific resources for FSN programming already exist. Some of the places to look for these resources include:

- The local food and nutrition council (or equivalent)
- The national network/society for people living with HIV
- The National AIDS Council
- [The FANTA Online Publications Catalog](#)

Some documents that provide general guidance on FSN programming for OVC include:

- [Food Assistance Programming in the Context of HIV](#), FANTA and WFP, 2007
- [Getting Started: Programming Food Assistance for Orphans and Vulnerable Children](#), WFP, 2008

- [Food Assistance in the Context of HIV: Ration Design Guide](#), WFP, 2008
- [Facts for Life](#), UNICEF, 2010
- [Building Blocks: Asia, Briefing Notes for Communities Working with Orphans and Vulnerable Children, Health and Nutrition](#), International HIV/AIDS Alliance, 2006

Websites that have publications and tools related to FSN programming for OVC include:

- [OVCSupport.net](#)
- [The Joint Learning Initiative on Children and HIV/AIDS](#)
- [Small Enterprise Education and Promotion Network](#)
- [Children, Youth & Economic Strengthening Network](#)
- [Regional Network on AIDS, Livelihoods and Food Security \(IFPRI\)](#)
- [Maternal, Newborn, Child and Adolescent Health: Documents on Child Health](#) (WHO)

Several tools for conducting FSN needs assessments include:

- [Integrating HIV/AIDS in Food Security and Vulnerability Analysis](#), WFP, 2008
- “Chapter 3: Needs Assessment,” in [Getting Started: Programming Food Assistance for Orphans and Vulnerable Children](#), WFP, 2008, pp. 16-24
- [How to Conduct a Food Security Assessment: A Step-by-Step Guide for National Societies in Africa](#), International Federation of Red Cross and Red Crescent Societies, 2006
- [Emergency Food Security Assessment Handbook, Second Edition](#), WFP, 2009
- [Emergency Nutrition Network Assessment Resources](#) (website)
- “[Food Security and Nutrition Assessment](#),” in Humanitarian Charter and Minimum Standards in Humanitarian Response, The Sphere Project, 2011, pp. 150–159
- [Nutrition Program Design Assistant: A Tool for Program Planners](#), The CORE Group Nutrition Working Group, 2010
- [Indicators for Assessing Infant and Young Child Feeding Practices Series](#), WHO, 2008

Examples of FSN assessments/situation analyses include:

- [Situation Analysis of Nutrition in Southern Sudan: Analysis Based on June 2009 Assessment](#), Ververs, FANTA II, 2010
- [Household Food Security and Nutrition Assessment 2009, in Bangladesh](#), WFP, UNICEF, and Institute of Public Health Nutrition, 2009
- [The Analysis of the Nutrition Situation in Uganda](#), FANTA II, 2010
- [Food Security Analysis Assessment Bank](#) (web-based database), WFP

NUTRITION STANDARDS OF CARE

Below is a list of key documents providing nutrition standards of care that apply globally to OVC.

GENERAL

The Sphere Project - Minimum Standards in Food Security and Nutrition

<http://www.spherehandbook.org/en/how-to-use-this-chapter-3/>

GROWTH STANDARDS

WHO Child Growth Standards (website list of publications)

<http://www.who.int/childgrowth/standards/en/>

WHO Growth Reference Standards for 5-19 years

<http://www.who.int/growthref/en/>

IYCF

UNICEF Programming Guide: Infant and Young Child Feeding

http://www.unicef.org/nutrition/files/Final_IYCF_programming_guide_2011.pdf

WHO Guidelines on HIV and Infant Feeding

http://www.who.int/maternal_child_adolescent/documents/9789241599535/en/

Guiding principles for feeding non-breastfed children 6-24 months of age

http://www.who.int/maternal_child_adolescent/documents/9241593431/en/index.html

Guiding principles for complementary feeding of the breastfed child

http://www.who.int/maternal_child_adolescent/documents/a85622/en/index.html

CMAM

Community Based Management of Acute Malnutrition: A Joint Statement by the World Health Organization, the World Food Programme, the United Nations System Standing Committee on Nutrition and the United Nations Children's Fund

<http://www.who.int/nutrition/publications/severemalnutrition/978-92-806-4147-9/en/index.html>

WHO Child Growth Standards and the Identification of Severe Acute Malnutrition in Infants and Children: A Joint Statement by WHO and UNICEF.

<http://www.who.int/nutrition/publications/severemalnutrition/9789241598163/en/index.html>

Since there are no WHO standards that incorporate CMAM, refer to the following FANTA documents:

FANTA generic guidelines and job aids for CMAM

<http://fantaproject.org/cmam/generic2010.shtml>

FANTA training materials for CMAM

<http://www.fantaproject.org/cmam/training.shtml>

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