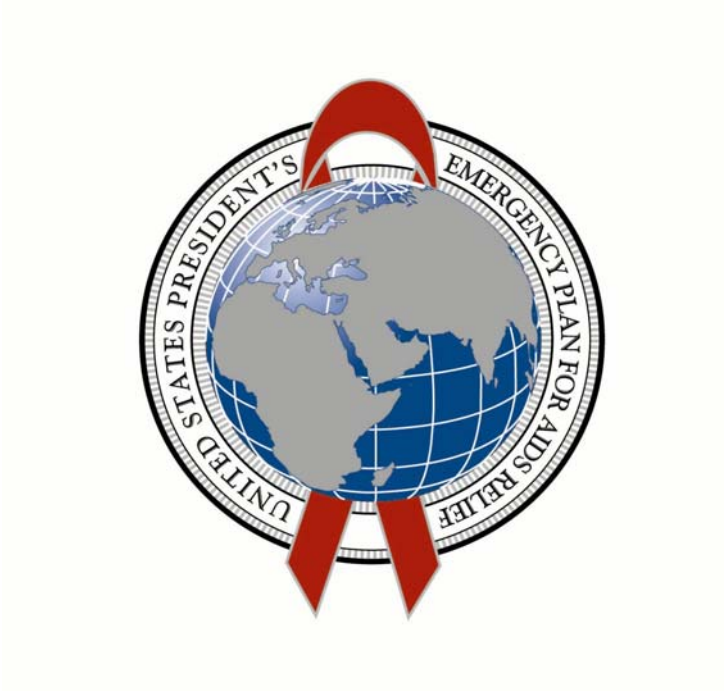
Report to Congress by the U.S. Global AIDS Coordinator on Food Security



May 2008

The Administration provides this *Report* pursuant to Report 110-197 of the 2008 State, Foreign Operations, and Related Programs Appropriations Bill, H.R. 2764: "Understanding that providing direct food aid does not fit within the immediate mandate or expertise of the Initiative, the Committee requests a report within 45 days of enactment of this Act that outlines the specific steps that the GHAI [Global HIV/AIDS Initiative] will take in fiscal year 2008 to work with other agencies, multilateral organizations, and the private sector to ensure that those served by the GHAI are food secure."

OVERVIEW

The linkage between food, nutrition, and long-term food security has been a longstanding concern of the U.S. President's Emergency Plan for AIDS Relief (Emergency Plan/PEPFAR). Steps have been taken by the Emergency Plan to address this important issue since 2005, and in Fiscal Year (FY) 2007, PEPFAR made major strides in its food and nutrition programming. Policy guidance released in late 2006 was revised in 2007 to broaden the parameters of food support for adult patients in care and treatment programs. Also of particular importance, PEPFAR improved its ability to report on how country teams are supporting food and nutrition activities within HIV/AIDS prevention, care, and treatment programs.

For the first time, PEPFAR used the Annual Progress Report process to capture information about food and nutrition programming in the field during FY 2007. In addition, new questions were incorporated into the FY 2008 Country Operational Plans (COPs) to gain better insight into planned programming for FY 2008.

PEPFAR also developed a concept paper in collaboration with U.S. Agency for International Development (USAID)'s Food for Peace Office (FFP) to provide a solid framework for strong collaboration in targeting our programs for the benefit of those infected and affected by HIV/AIDS. Efforts in providing longer-term food security support also continued through partnerships with a wide variety of programs including, but not limited to, microfinance, skills training, and household garden programs.

In FY 2008, PEPFAR's continued success in ensuring the food security of those served by the Emergency Plan depends not only on integrating PEPFAR-funded food and nutrition interventions into PEPFAR care and treatment programs for the benefit of HIV-positive people, but also on PEPFAR's ability to continue leveraging the work of its partners in the food and nutrition arena for the benefit of individuals, households, and communities. Therefore, PEPFAR's approach in FY 2008 will involve continued direct investments in food and nutrition activities as part of PEPFAR programs, as well as continued collaboration with key food and nutrition partners, including FFP, the United Nations World Food Program (WFP), the Global Fund for AIDS, Tuberculosis and Malaria (Global Fund/GFATM), and host-country governments.

Implementation of Food For Peace/PEPFAR Conceptual Framework

Within food and nutrition programs, PEPFAR continues to focus its resources on orphans and vulnerable children (OVCs), pregnant and lactating women in prevention of mother-to-child transmission (PMTCT) programs, and adult HIV-positive patients in care and treatment programs. However, the food security needs of these groups are much greater than those that can be served under PEPFAR's mandate alone. PEPFAR cannot and should not tackle these needs by itself. Leveraging and coordinating the resources and expertise of PEPFAR's food and nutrition partners, including linking people with longer-term food security programs, is central to success.

Given its mandate, FFP is a natural partner for PEPFAR in addressing broader community needs for food and nutrition support and linkages to livelihood assistance programs. There are challenges to this partnership, however. FFP primarily targets rural food-insecure communities, whereas PEPFAR works in areas of high HIV prevalence, many of which are urban and peri-urban.

To overcome this and other challenges of creating a seamless program to address nutrition, dietary supplementation, and food security needs of those infected and affected by HIV/AIDS, in 2007 PEPFAR and FFP collaborated on a conceptual framework to guide joint programming. This conceptual framework facilitates a programmatic continuum to address the nutrition, dietary supplementation and food security needs of HIV-infected and -affected populations and addresses the mutual objectives of FFP and PEPFAR.

Although the Conceptual Framework was not launched until FY 2008, both PEPFAR and FFP immediately began taking steps to ensure strong collaboration. For example, PEPFAR and FFP strengthened their guidance language for proposal submissions: PEPFAR through the FY 2008 Country Operations Plans (COPs) and FFP through its Multi-Year Assistance Programs (MYAPs). Several additional actions are planned or in process, including conducting joint PEPFAR/FFP/WFP planning in countries, establishing mechanisms to jointly fund and support local implementation partners, and working on common indicators and monitoring and evaluation systems to track support and outcomes for individuals and households. "Model" or "best practice" program approaches for joint programming are

being developed in a number of countries, such as Haiti and Ethiopia. These include mapping of current FFP, WFP and PEPFAR programs; standardization of eligibility and exit criteria for people who receive food support; development of tools and protocols for assessing household food insecurity among HIV-affected patients and families, particularly those who are identified through Food by Prescription and other clinical services; and establishing mechanisms for integrating HIV/AIDS and food security support at the community and household levels.

Revision of policy guidance

In late FY 2007, PEPFAR revised the policy guidance governing the parameters of adult patients eligible to receive food support using PEPFAR resources, likely leading to program shifts in FY 2008. Previous guidance specified three priority populations:

- Orphans and vulnerable children born to an HIV-infected parent (regardless of the child's HIV and nutritional status);
- HIV-positive pregnant and lactating women in programs to prevent the transmission of HIV to their children (PMTCT); and
- Adult patients in antiretroviral treatment (ART) and care programs with evidence of severe malnutrition, defined by a Body Mass Index (BMI) less than 16.

The policy regarding children and HIV-positive pregnant women did not change, and PEPFAR continues to encourage broad nutritional support for these groups. The significant change in policy relates to the guidance relative to adults in HIV care and treatment programs. While studies to determine the clinical benefits of food supplementation across the range of BMI in clinically malnourished HIV patients are not yet completed, PEPFAR has updated its guidance to allow country teams to provide food support to patients in antiretroviral treatment and care programs with a BMI lower than 18.5, replacing the BMI threshold of 16 in the earlier guidance. This revised policy is in line with World Health Organization (WHO) guidance and became effective for PEPFAR programs in FY 2008. Support for supplemental feeding programs ceases when the patient's BMI stabilizes above 18.5 for two consecutive months. PEPFAR will continue, where possible, to work with partners to help transition these 'graduated' patients into longer-term livelihood, income-generation and food security programs.

Given that the policy change became final after the submission of the FY 2008 COPs, PEPFAR has yet to see the full ramifications of the change in terms of country programming. Country teams that wish to expand their food and nutrition programs based on this new guidance will be able to do so as needed. While it is not yet clear how many countries will choose to do so and what effect any changes may have, PEPFAR anticipates this policy revision will result in further support for HIV-positive individuals before they reach the point of severe malnutrition, which will help to improve overall health outcomes. However, as with all program interventions, each country team will evaluate the use of this expanded food programming option against the competing needs of other program priorities.

Planning

As part of continued work to more fully integrate food and nutrition activities into country portfolios, PEPFAR collected baseline data from country teams to ascertain current financial commitments to food and nutrition. Countries reported that activities planned in their FY 2008 COPs include more than $93 million of food and nutrition-related activities. Over $90 million of these activities will take place in the fifteen severely-affected focus countries.

Given the complexity of food and nutrition support, it is important to note that the planned food and nutrition activities are for comprehensive nutrition programming – not just for food itself. (See Tab 1 for funding allocation by type of food and nutrition support.) Food itself is just one piece of a much broader intervention. Nutritional assessment, counseling, and other support (e.g. micronutrient supplementation where clinically indicated) are standard elements of HIV/AIDS care and treatment programs. Working with Ministries of Health and other partners, PEPFAR country teams support the development of national nutrition policies and guidelines that integrate food and nutrition activities into HIV/AIDS programs. Closely linked to this is the need to develop and roll out training curricula, counseling tools, job aids and other quality improvement procedures to be used at clinics and health centers by health care workers. The provision of food supplements requires providing anthropometry equipment and materials for food procurement, logistics and inventory control—all necessary for successful program implementation. Finally, linkages to long-term food security programs (e.g. support for community gardens, long-term sustainable agriculture, and vocational and job training) is essential for those

who receive nutritional support, especially "graduates" of food support programs.

At the country level, a combination of the components above translates into comprehensive nutrition programming, either with independent PEPFAR support or in tandem with other partners. For example, the National Food by Prescription Program in Kenya is supported by PEPFAR and the Global Fund in collaboration with Government of Kenya and WFP. Depending on the nutritional assessment of a clinician or nutritionist, HIV-positive patients in this program may receive a "prescription" for a fortified food product along with their antiretroviral drugs (ARVs) and drugs for treatment of opportunistic infections. This fortified food product, with the medicines, is dispensed at the clinic pharmacy. In addition to the actual food commodity, patients receive nutritional counseling about diet and health practices that impact on nutritional status, e.g. clean water, hygiene, and sanitation. In general, patients receive this feeding support until they are stabilized on their ART and adequate weight is reestablished. In Mozambique, the World Food Program collaborates with PEPFAR treatment partners to improve the provision of food and nutritional supplements to people living with HIV/AIDS (PLWHA) registered at treatment sites (including children) based on clinical and nutritional assessments. These activities also support the training of PLWHA and their families on the best nutritional practices using locally available products.

Monitoring and evaluation

Monitoring and evaluation is a key component of any programmatic intervention. In addition to collecting and assessing the baseline funding planned for food and nutrition within PEPFAR, additional steps are being taken to strengthen PEPFAR's ability to monitor the impact of its approach to food security for those it serves. For the first time, in FY 2007 PEPFAR collected information through the Annual Progress Report on numbers of people supported with a food intervention. This survey provided estimates that in FY 2007 in the 15 focus countries, PEPFAR provided food and nutritional supplementation to 50,000 HIV-positive pregnant or lactating women; 332,000 OVCs; and 20,000 people receiving ART (with evidence at entry of severe malnutrition per the guidance at the time). This was the first time PEPFAR requested this type of information from country teams, and the numbers under represent total PEPFAR support for food and nutrition-

related activities because only data for feeding support was requested. In FY 2008 PEPFAR is refining its indicators and data collection tools, which will result in improved and more comprehensive reporting on food and nutrition interventions.

Outstanding Challenges

Even as PEPFAR continues its work to address food and nutrition needs within the context of HIV/AIDS prevention, treatment, and care, it is clear that food insecurity cannot be tackled by PEPFAR alone. In communities where food insecurity is widespread, it is important that PEPFAR not inadvertently create an environment in which an HIV-positive status provides entitlement to programs and long-term food benefits that those who are HIV-negative cannot access. One way to ensure this is to continue to seek strong partnerships with other organizations with the mandate and expertise to address food insecurity at the household and community level. Strong linkages with WFP, FFP, private voluntary organizations (PVOs), and the faith-based community help ensure this. PEPFAR has built a solid base of experience working with this range of groups. In Ethiopia, PEPFAR partners with WFP not only to strengthen nutrition and food policies at the national level, but also to provide WFP commodities through PMTCT and palliative care services and develop longer-term food security and livelihood programs in communities impacted by HIV/AIDS. In Mozambique, PEPFAR is leveraging Title II and Public Law 480 (PL 480) resources to provide food support.

PEPFAR is also concerned with the well-being of rehabilitated patients who are stabilized on ART, have improved their health status, and feel healthier. Such patients, who often have limited or no means of income generation, particularly those who have "graduated" from food support, need to be linked to community livelihood programs and vocational and job training to strengthen the capacity of the household to meet their longer-term food and other basic needs. PEPFAR's extensive livelihood leveraging experience in Zambia demonstrates how this can be expanded in the future. A consortium led by World Vision provides agricultural inputs, seed, livestock, and small-scale irrigation equipment to OVC households and caregivers, accompanied by training in sustainable agricultural practices, food processing, and utilization. Christian Aid, another leveraging partner in Zambia, trains OVC caregivers in sustainable agricultural practices and also provides caregivers with high-quality agricultural inputs to improve food

security. This same program also involves a livestock multiplication project based on Heifer International's "Pass a Gift" model, which is implemented through neighborhood savings and loan associations.

In PEPFAR's recent data collection exercise, it was heartening to see the amount of funding provided for food and nutritional support to OVCs and patients in care and treatment programs. Clearly, OVC partners are taking advantage of PEPFAR's broad policy related to food support for OVC. Given similar broad guidance for HIV-positive pregnant and lactating women, PEPFAR is working to expand food and nutritional support within PMTCT programs.

Finally, the universe of food and nutritional support itself is quite broad and complex, and there are a number of questions that need to be answered through program experience and evaluation to guide programming in the future. How long should ART patients receive food support? How can PEPFAR ensure quality and safety of locally procured commodities? Is the Food by Prescription Program applicable and adaptable across all countries and programs? What are other emerging "best practices", particularly with regard to linking clinical services with short- and longer-term food security support to patients, their families and OVC? Addressing these and other questions will be a priority in FY 2008 for PEPFAR and its partners in both the governmental and private sectors.

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Tab 1. FY 2008 PEPFAR Country Planned Estimates in Food and Nutrition by "Type of Food and Nutrition Support"

1. Development of nutrition policies, guidelines, curricula, tools, and training.	2. Nutritional counseling, assessment and education	3. Commodities (food supplements, procurement)	4. PEPFAR-funded safe water initiatives	5. Long-term food security programs	6. PEPFAR-funded microenterprise, microfinance programs	7. Other (USG staff, M&E, etc)	Grand Total
$9,476,791	$21,822,448	$36,677,845	$6,449,426	$7,124,705	$8,756,476	$3,229,916	$93,537,608

1. Development of nutrition policies, guidelines, curricula, tools, and training;
2. Nutritional counseling, assessment, and education within standard PMTCT, care, OVC, and treatment service delivery programs;
3. Commodities, including food and micronutrient supplements (including for social marketing), equipment (e.g. scales), and procurement, logistics and inventory control costs;
4. All PEPFAR-funded safe water initiatives;
5. Long-term food security programs (except microenterprise), e.g. support for community gardens, long-term sustainable agriculture, skills and job training for those who are "graduating" from food support;
6. All PEPFAR-funded microenterprise/microfinance programs;
7. Other (including USG staff, M&E, etc).

(Please note that water and microenterprise are separated out because USAID has a separate earmark for this and needs the information on PEPFAR programs.)