

Technical Guidance Note for Global Fund HIV Proposals



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Food and nutrition

Note: This guidance note has been prepared in close consultation between the World Health Organization (WHO), the World Food Programme (WFP) and the Joint United Nations Programme on HIV/AIDS (UNAIDS) Secretariat.

Introduction

Recent years have brought increasing evidence on the relationship between the HIV epidemic on the one hand and malnutrition and food insecurity on the other hand [1]. As a result, several organizations and international initiatives advocate the integration of food and nutritional support as an effective investment in HIV programming, including the following:

- ◆ the Global Fund to Fight AIDS, Tuberculosis and Malaria [2];
- ◆ WHO [3];
- ◆ UNAIDS [4];
- ◆ WFP [5];
- ◆ the United States President's Emergency Plan for AIDS Relief (PEPFAR) [6];
- ◆ the Food and Nutrition Technical Assistance Project II (FANTA-2) [7].

Analysis of Global Fund grants from Round 5 (2005) to Round 10 (2010) shows that food and nutrition interventions have increasingly been included in proposals: Approximately 50% of HIV proposals in Round 10 included food and nutrition components [8].

This document provides basic guidance to countries wishing to integrate food and nutrition components into Global Fund proposals for HIV.

Rationale for including food and nutrition in the proposal

Approximately 1 billion people globally are undernourished [9], 195 million children aged under 5 years are stunted, and an estimated 26 million children are wasted [10]. The HIV epidemic is concentrated in geographical regions that already experience low dietary quality and quantity, particularly sub-Saharan Africa.

In the short term, HIV infection affects the person's appetite and ability to take in food and reduces the body's ability to absorb ingested nutrients, while metabolic changes actually increase the person's nutritional needs [11].¹ At the same time, increased morbidity and the related decrease in productivity often reduce food access [12]. This cycle is worsened by the impact of HIV on household food and nutrition security and the depletion of household resources. Tuberculosis (TB) is one of the most common coinfections in people living with HIV (at least one-third of people living with HIV are also infected with TB [13], further increasing metabolic stress for these individuals.

In the long term, HIV and antiretroviral treatment frequently lead to metabolic complications such as dyslipidaemia, obesity and insulin resistance [14]. People receiving antiretroviral treatment also have an increased risk of chronic conditions such as diabetes, cardiovascular disease, cancer and osteoporosis. Given the increased susceptibility to these conditions, healthy nutrition is critical to preventing or delaying their onset and to limiting their severity and impact on quality of life. Although people cured of TB do not risk similar conditions, evidence suggests they may struggle with regaining lean body mass and therefore also require a balanced diet [15].

¹ For people living with HIV, energy needs increase by 10% for asymptomatic adults, by 20–30% for symptomatic adults and by 50–100% for children with weight loss [10].

Most cases of HIV occur in low and middle income countries, where patients face limited dietary quality and quantity, leading to inadequate intake of the essential nutrients and energy required for a strong immune system. In addition to nutrition assessment, education and counselling, people living with HIV (and TB) may therefore require food supplements that complement their diet to enable them to meet their total micronutrient and macronutrient needs.

Evidence shows that people living with HIV who are malnourished when they start antiretroviral therapy are two to six times more likely to die in the first 6 months of treatment than those who have a normal body mass index [16–20].² Food insecurity is also associated with reduced levels of treatment adherence [22–25], with negative implications on individual health outcomes, programme outcomes and costs (e.g. through first-line treatment failure and the need to switch to more costly second-line drugs).

Therefore, food and nutrition interventions can contribute into protecting treatment investments by improving treatment success and mitigating the consequences that HIV (and TB) have on people's livelihood by:

- ◆ reducing early mortality of people on antiretroviral treatment;
- ◆ supporting nutritional recovery and offsetting treatment side-effects;
- ◆ to overcome barriers to treatment adherence and improving retention in care;
- ◆ mitigating the effects of infection on lost income and treatment expenses [5].

It is important to note that food and nutrition activities should not stand in isolation but rather should complement other interventions, at both the health sector and the community level. As part of a comprehensive package, food and nutrition activities are intended to support other interventions and make the overall response more cost-effective.

Situation analysis information

Applicants to the Global Fund are encouraged to conduct adequate situation analyses to develop appropriate food and nutrition programming. The goal of such an assessment is to understand the nutritional problems of people living with HIV against the background of the nutritional status of the broader population. This analysis can then be used to justify the proposed food and nutrition interventions in the proposal.

Examples of questions to ask when conducting an assessment:

- ◆ Are nutritional policies and guidelines in place? If so, are they up to date? Does the national HIV policy or strategy address nutrition? Does the national nutrition policy or strategy address the needs of people living with HIV?
- ◆ How high is mortality in the first 6 months of treatment? Is it higher than in comparable contexts?
- ◆ What proportion of people receiving HIV treatment are lost to follow-up or show poor adherence? What seem to be the main reasons for failure to adhere?
- ◆ Are areas of high food insecurity also areas of high HIV prevalence and TB incidence? If so, broader safety nets may be useful in slowing the spread of HIV and TB.
- ◆ What evidence is there that the livelihood of households affected by HIV deteriorates severely and leads to negative coping behaviours?
- ◆ What percentage of people living with HIV attending the health sector for the first time show signs of wasting or micronutrient deficiencies?
- ◆ Are any nutrition programmes already in place? If so, do they function at the health sector or community level? Are they integrated and aligned with the national HIV policy or strategy? What is their coverage? Who are the main implementing partners?

2 Studies have shown that a body mass index of less than 17 in people with TB is associated with an increased risk of early death [21].

Suggested activities

As part of the routine health assessment process, applicants are encouraged to include standard nutritional assessments for people living with HIV using anthropometric measurements, such as body mass index for adults or mid-upper arm circumference for children and for pregnant and breastfeeding women. People found to be malnourished should receive a time-limited nutritious food supplement to ensure their speedy nutritional recovery. Once they are sufficiently recovered (i.e. meeting nutritional assessment exit criteria), this supplementation should cease, but nutritional assessment and counselling (based on the individual's specific situation) should continue to address any potential nutritional issues that remain and prevent new issues from arising.

Comprehensive food and nutrition programmes should be funded from a range of sources and should leverage the strengths of the health sector and communities. Although the health sector can ensure that nutritional assessment and counselling become routine during treatment visits, nutritional assessment and counselling work best when complemented by the provision of nutritious food supplements through communities. This can happen, for example, through time-limited food assistance packages or a voucher system. Communities may also provide additional education and counselling, psychosocial support and referrals to livelihood activities.

Food and nutrition approach

A comprehensive food and nutrition approach includes the following:

- ◆ **Treatment, care and support, and the prevention of mother-to-child transmission of HIV (PMTCT):**
 - ▶ nutrition assessment, education and counselling for all people living with HIV, including infant feeding practices for pregnant and breastfeeding women who are living with HIV;
 - ▶ specialized food products for nutritional rehabilitation of people with malnutrition, including pregnant and breastfeeding women and their children attending maternal child health, nutrition or services to stop new infections in children services;
 - ▶ a finite income transfer in the form of food, vouchers or cash to the household, related to and in support of the individual ration that is provided to treat malnutrition, in order to compensate for the loss of income and to reduce sharing of the individual ration among family members.
- ◆ **Mitigation and safety nets:**
 - ▶ food or cash/voucher assistance for households affected by HIV, in particular when productive members of the household are sick, when the household is hosting orphans or other children made vulnerable by HIV, and when the household is headed by elderly people, women or children; this is especially suggested in contexts of high HIV prevalence and food insecurity;
 - ▶ peer support and community-based support to strengthen the linkages between the health sector and the community in order to guarantee a continuum of care.
- ◆ **Livelihood activities:**
 - ▶ activities such as farming activities, livestock activities, microfinance and vocational programmes to empower affected households to regain control of their food and nutrition security and to assist people living with HIV and their households to maintain or rebuild their income, savings and overall livelihood security.

Other important elements of a successful approach include operational research and a solid monitoring and evaluation system with good food and nutrition indicators. These are critical to assess the extent to which interventions contribute to addressing the problems identified during proposal development.

Focus populations

Careful consideration should be given to focusing the activities in order to ensure that finite resources are used in the most cost-effective manner [5].

- ◆ Nutrition assessment, education and counselling should be provided to all people living with HIV throughout life.
- ◆ Food supplements should focus on individuals with malnutrition until anthropometric criteria show recovery (regardless of their household food security status). Two subsequent monthly assessments above the predefined cut-off (e.g. the entry criteria) are sometimes used to determine exit from the food component of the support. In other cases, separate exit criteria are set for body mass index or mid-upper arm circumference. Some countries discharge patients once a certain percentage weight gain has been achieved.
- ◆ For households that care for a person receiving antiretroviral therapy in a low-income setting, applicants may propose income support activities for a finite period of time to prevent the development of negative coping behaviours and to support adherence. Although some implementers tie this household assistance to food security status, any indicator used for targeting will represent at best a proxy to assess past and present status and cannot fully predict potential deteriorations in food security status (which is often the objective of household components of such support). Instead, applicants are encouraged to ensure that any support is provided for a finite period of time, thereby ensuring effective use of resources. Support should not normally last for longer than the provision of the food supplement to the individual [7].
- ◆ Households otherwise affected by HIV, such as those headed by children and those hosting orphans or other vulnerable children, may receive longer-term support.

Although all people living with HIV (and those otherwise affected by HIV) face significant food and nutrition security challenges, such challenges are particularly detrimental for the development of children. In the HIV context, optimal infant feeding in line with WHO guidelines is necessary to reduce mother-to-child transmission of HIV, to maximize the infant's chances of HIV-free survival, and to optimize the growth and development of infants exposed to HIV and infants living with HIV [26].

Choosing the right food

The treatment of malnutrition involves treating infections so that the body can efficiently metabolize foods again and giving food support that provides the nutrients required for rebuilding tissues (such as muscle and fat mass) and restoring bodily functions [14]. Treatment initiation and adherence support may require specific foods in order to manage side-effects (such as nausea or a lack of appetite) in addition to a transfer (food, cash or vouchers) that offsets the out-of-pocket or opportunity costs associated with accessing treatment and compensates for the loss of income while the person is ill.

A number of special food products for treating severe or moderate malnutrition have recently become available for children, including spreads known as 'ready-to-use therapeutic foods' (RUTF) and 'ready-to-use supplementary foods' (RUSF). Although these may be good choices for children, they are often less acceptable to adults, in particular given the higher caloric needs of adults. Adults also have to consume more of these products, which they may find too sweet and monotonous. Fortified blended foods are sometimes used for adults instead of, or in addition to, RUTF or RUSF. There is no standard 'right food' – the choice depends on the patient's requirements, the patient's nutritional status, the availability and cost of different products, local food habits and preferences, and various programmatic requirements.

Malnourished people needs to be assessed carefully before a specific product or combination of products is selected. The product is meant to complement the existing diet of a target group with special nutritional needs. WHO guidelines should be referred to in order to determine the increased dietary needs of people living with HIV (and TB), taking into account whether they are asymptomatic, symptomatic or malnourished.

Suggested key indicators

Monitoring and evaluation is intrinsic to the Global Fund system of performance-based funding. Solid monitoring and evaluation is crucial to ensure cost-effective use of resources, to report on outcomes and to continuously improve programmes.

For food and nutrition actions in the context of HIV and TB, implementing organizations are currently using a variety of indicators. PEPFAR and WFP have developed extensive monitoring and evaluation guidance for HIV (PEPFAR) and HIV and TB (WFP; to be published on the WFP web site soon) [27]. In parallel, a series of multi-stakeholder consultations (including WHO, PEPFAR and WFP) are in the process of identifying a set of globally harmonized monitoring and evaluation indicators. These indicators measure whether nutrition assessment is carried out routinely, whether a food supplement is provided to people found to be malnourished, whether counselling is provided, and whether people who are malnourished recover from malnutrition. It is anticipated that this review will conclude in the autumn of 2011; as soon it is made publicly available, this note will be updated to reflect the new international consensus.

Approach to costing

For any Global Fund proposal to be approved, it is critical that the requested funds are based on a thorough assessment of the resources (quantity) and associated costs (price) required. Budgets need to be as detailed as possible and based on actual costs (e.g. through price quotations) or, where these data are not available, comprehensive and documented assumptions (e.g. through previous programme experience).

In a food and nutrition context, costs are dependent on the following factors:

- ◆ type of intervention (e.g. nutrition support for people on antiretroviral treatment, support for orphans and other vulnerable children, food and nutrition support in the context of PMTCT programmes);
- ◆ duration and entry and exit criteria;
- ◆ number of beneficiaries;
- ◆ distribution model (e.g. in kind or vouchers);
- ◆ existing infrastructure (i.e. foundation on which the food and nutrition interventions are implemented on, e.g. food distribution sites);
- ◆ local prices.

Given that the latter two factors are highly context-specific, costing needs to be approached on a country-by-country basis. There are, however, some common cost elements that may be involved in any food and nutrition intervention and that can serve as guidance in the budget preparation:

- ◆ Start-up costs:
 - ▶ infrastructure and equipment (e.g. storage facilities, administrative supplies);
 - ▶ staff recruiting and training (e.g. nutrition assessment, education and counselling, supply-chain management).
- ◆ Recurring costs:
 - ▶ human resource costs (e.g. salaries, per diems, training updates);
 - ▶ commodities (e.g. specialized food products such as RUTF or RUSF);
 - ▶ logistics (e.g. transport, distribution, customs);
 - ▶ operating costs (e.g. rental or premises, cost of utilities);
 - ▶ monitoring and evaluation (e.g. site visits, laboratory tests);
 - ▶ community outreach (e.g. communication of services provided).

It is noteworthy that the Global Fund usually does not provide funds for one-off capital-intensive infrastructure, such as the building of premises (under start-up costs). If such projects are included in Global Fund proposals,

detailed justification is needed; it may be beneficial to identify other funding sources (e.g. development banks) that specifically include such investments.

A recent assessment of 48 WFP programmes in 42 low- and middle-income countries gives reference points on the unit costs to provide food rations in the context of HIV and TB. Costs per person per day range from US\$ 0.43 (for orphans and other vulnerable children) to US\$ 0.83 (for PMTCT). Given that the programme duration will vary, the total costs of food and nutrition support can be between US\$ 115 (antiretroviral treatment for a child for 6 months) and US\$ 448 (PMTCT for 1.5 years). On average, commodities account for about 55% and logistics for about 30% of total costs [28].³

Common weaknesses identified in proposals to the Global Fund

Food and nutrition have increasingly been included in HIV (and TB) proposals to the Global Fund. Some weaknesses have been found in the design of food and nutrition components in these proposals, however, which have affected and limited the successful implementation of proposed activities.

Common weaknesses in past proposals submitted to the Global Fund [8]

- ◆ **Inadequate context**, policy frameworks and guidelines to support the implementation of the proposed activities.
- ◆ **Limited evidence**, which leads to poor justifications of the proposed activities. Information on the prevalence of malnutrition among people living with HIV, their food security status and vulnerability, and health system performance indicators such as adherence, mortality and survival rates are missing. Proposal components should be evidence-based and should be able to demonstrate that they are appropriate to the country and the epidemiological context.
- ◆ **Inadequate targeting** and poor prioritization of needs. Target populations are not well defined, and the size of the problems and target population may be under- or overestimated due to the lack of national evidence on the nutritional situation.
- ◆ **Weak monitoring and evaluation systems** in which technically sound nutrition indicators and dedicated monitoring and evaluation staff are lacking at all levels. As a result, the quality and accuracy of the product forecasts are poor and results cannot be documented.
- ◆ **Inadequate human resource capacity** at different levels. The workforce is often scarce and inadequately trained to implement the proposed activities. Many proposals do not include sufficient human resource and capacity-building activities (such as training) to ensure good-quality service delivery at all levels.
- ◆ **Inadequate infrastructure and tools** such as scales, measuring tape, reporting tools and others resources. The quality of service delivery can easily be compromised by a lack of appropriate tools, thus jeopardizing implementation of the proposed activities. Many proposals fail to plan and budget adequately for tools to implement the proposed activities properly.
- ◆ **Inappropriate choice and inadequate classification of products**. Due to budget constraints, some proposals substitute the most nutritionally suitable products with cheaper products or reduce ration sizes. Making such compromises may jeopardize the desired programme outcome. Moreover, nutritious food products prescribed for treating acute malnutrition should be classified as health products and should be dispensed after nutritional assessments as part of a comprehensive package of care.
- ◆ **Weak supply chains** may compromise timely procurement and delivery. Instead of merging a new supply chain with an existing national supply chain, many proposals have suggested the use of parallel systems, which can impact negatively on efficiency, cost-effectiveness and health system integration.
- ◆ **Inadequate budgets** often fail to consider the comprehensive costs not only for the food itself but also for all related operational costs, such as storage, transport, handling, training, human resources and equipment.

³ Note that this study focuses mostly on the costs of food distribution. Other food and nutrition interventions (e.g. nutrition assessment, education and counselling) are usually deeply interwoven with routine clinic processes and the related costs are, therefore, difficult to isolate.

References

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Additional resources

Websites

- ◆ *UNAIDS and WFP*: <http://www.unaids.org/en/AboutUNAIDS/UNAIDSCosponsors/WFP/>.
- ◆ *WFP's response to HIV and AIDS*: <http://www.wfp.org/hiv-aids>.
- ◆ *Nutrition and HIV/AIDS*: <http://www.who.int/nutrition/topics/hivaids/en/index.html>.
- ◆ *FANTA-2 focus areas*: http://www.fantaproject.org/focus/hiv_aids.shtml.
- ◆ *Global Alliance for Improved Nutrition (GAIN)*: <http://www.gainhealth.org/>.
- ◆ *Regional Network on AIDS, Livelihoods and Food Security (RENEWAL)*: <http://programs.ifpri.org/renewal/>.

Guidelines

- ◆ *Getting started: WFP food assistance in the context of tuberculosis care and treatment*. Rome, World Food Programme, 2007 (http://one.wfp.org/food_aid/doc/WFP_Getting_Started_2007.pdf).
- ◆ *Food assistance programming in the context of HIV: Ration design guide*. Rome, World Food Programme, 2008 (http://one.wfp.org/food_aid/doc/Brief_Ration_Design_Guide.pdf).
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