

# The development of programme strategies for integration of HIV, food and nutrition activities in refugee settings

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## Executive Summary

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In 2003, The United Nations High Commissioner for Refugees (UNHCR), United Nations World Food Programme (WFP) and United Nations Children's Fund (UNICEF) launched a joint effort to develop, through multi-site field research in refugee communities in Africa, a set of strategies for using food and nutrition-based interventions to support HIV prevention, care, treatment and support for people living with HIV. That initiative deliberately embodied a very high degree of collaboration, both among the agencies involved, but also with refugees themselves, to best capture lessons about how these sectors can be better integrated under the unique circumstances of refugee settings. This document discusses the process and findings of that initiative, whose value for best practices is found in the collaborative, field-driven methodology as well as in the findings and output.

The twenty integrated programme strategies explored through that activity were identified along the following two axes:

### HIV Interventions

- HIV prevention including prevention of mother-to-child transmission
- Care and support for people living with HIV and their families, and children affected by AIDS (including orphans and vulnerable children)
- Health care and treatment for people living with HIV and their families.

### Food and Nutrition Interventions

- Emergency food distribution and nutrition
- Food for training, capacity building and institutional support
- Household food and livelihood security

The main findings included the following points.

- 1. Though food is a blunt instrument for addressing the highly complex public health problem of AIDS, numerous opportunities exist to refine the use of food and nutrition-based programmes to support HIV prevention, care, treatment and support for HIV-infected and affected persons.** Implementation of these integrated programme strategies should be preceded by careful assessment to determine if food is an appropriate programme resource, as food-based programmes should be justified on the basis of nutrition and/or food security data first. Where such interventions are justified, programming flexibility and creativity reveal a range of entry points for modifying *how those resources are used*, to help prevent HIV transmission and mitigate the effects of the epidemic. Even where additional food is not justified, infant and young child feeding (IYCF) support or other communications activities can be linked to existing emergency response interventions. Infant and young child feeding counselling universally supports exclusive breastfeeding and appropriate complementary feeding when indicated.
- 2. Integration of refugees and surrounding host communities at assessment, programme and policy levels is vital for successfully addressing the epidemic.** Assessment for programme design in both refugees and host communities in an integrated manner is essential because the effects of displacement on the epidemic are determined in very large part on the frequency and nature of interactions among refugees and their hosts, as well as the levels of pre-conflict HIV prevalence. Interviews with refugees underscored the necessity

of conducting this assessment directly with the refugees and host communities, through a range of interviews designed to enable the exploration of policy and political, economic and sociocultural factors related to this interaction.

3. **Qualitative research, participatory communication strategies, community engagement and action should underpin programme development in stable refugee settings.** Most refugee communities are sufficiently established to transcend standard emergency programmes: over 60% of the world's refugees have been settled for at least ten years, which implies that the participatory engagement and action commonly used in community development programmes can be used in refugee settings as well.
4. **Refugees should play genuine leadership roles in refugee health programme design, implementation and evaluation.** Far from being passive recipients of humanitarian assistance, refugees possess skills to build more community-driven refugee health programmes to prevent HIV transmission and provide care, treatment and support. The coordination structure of the AIDS Committee, which should be a multisectoral and broadly participatory coordinating body for all HIV-related programmes for refugees, should interface with the Food Management Committee (e.g. via an HIV focal point on the Food Management Committee). Equally the AIDS Committee should include a Food and Nutrition Focal Point, charged with liaising with food and nutrition-related activities.
5. **The most commonly implemented refugee food and nutrition programmes —general food distribution, selective feeding and nutrition interventions for pregnant and lactating mothers, supplementary, therapeutic and school feeding programmes—can be instrumental to an HIV-prevention strategy by incorporating behaviour change communication, community engagement and action activities (Strategies 1–4)<sup>1</sup>.** Three elements are key to programme design: first, an HIV assessment should be conducted to determine approximate HIV prevalence and main routes of transmission among the general population (using proxy indicators if sentinel surveillance or population-based surveys have not been undertaken), pregnant/lactating women, as well as among groups highly likely to be exposed to HIV. Second, qualitative formative research should be conducted to develop appropriate HIV messages for the programme's target audience, which clearly differs enormously among these four types (strategies 1–4) of interventions. Third, an operations assessment should help to ensure that incorporation of HIV activities will not detract from the effectiveness of the food/nutrition programme itself, by considering key operational factors such as site planning and planning for adequate staff resources. Food/nutrition programme staff members will require additional training on AIDS if these activities are incorporated, even if HIV education is to be conducted by external groups. These programme strategies may be more effective if an epidemic is generalized (i.e. a population prevalence of at least 1%) than if only selected groups at high risk of exposure to HIV are affected.

The starting point for implementing these activities is the establishment of the AIDS Committee and Food Management Committee, to oversee programme development. It is important that these prevention-focused behaviour change communication activities are linked and coordinated closely with health (including voluntary counselling and testing, prevention of mother-to-child transmission, and treatment and care for opportunistic illnesses), social welfare and protection services. If the food/nutrition programme is a supplementary feeding programme, it can be linked to voluntary counselling and testing, and prevention of mother-to-child transmission, services. Behaviour change communication



initiatives should aim to address safe infant feeding in the HIV context. In emergencies, generally, replacement feeding does not meet UNICEF/WHO criteria of being “acceptable, feasible, affordable, safe and sustainable”, therefore support to help all women achieve exclusive breastfeeding for the first six months of life is vital. Engagement of community music, dance and drama groups helps to reduce risk of stigmatization associated with the illness and builds health education skills in these groups.

- 6. Food and nutrition programmes can support the objectives of providing care and support for people living with HIV and vulnerable groups through: modifying rations to better meet nutritional needs of people living with HIV and their families, modifying aspects of programme implementation to ensure that people living with HIV have access, and strengthening food and livelihood security of AIDS-affected households (Strategies 5–12).** HIV infection increases nutritional requirements by 10% in the case of asymptomatic HIV infection, and 20–30% in the case of symptomatic HIV infection or AIDS<sup>2</sup>. The importance of an adequate general ration is increased in AIDS-affected populations. Though evidence-based guidelines have not yet been established on how a general ration’s energy content should be adjusted in light of HIV, the cost of increasing a general ration for all beneficiaries to meet the increased nutritional requirements of people living with HIV would be considerable, while increasing the ration to meet the average nutrition requirements (including the HIV-infected and uninfected alike) would result in minimal changes to the ration. Highest priority should be given to ensuring that the full ration entitlement is provided without interruption, with 10–12% of total energy coming from protein and at least 17% from fat. There is no evidence that people living with HIV have increased protein intake requirements. A local assessment should be conducted to determine if additional resources should be used to increase the general ration or support targeted feeding programmes for people living with HIV.

Apart from increasing the general ration, operational changes can help to ensure that people living with HIV receive maximal benefit from the general ration, including: providing milled and micronutrient-fortified staples rather than cereals alone; including fortified blended foods; and engaging social workers or community volunteers to distribute the ration directly to members of households who, because of illness, may have difficulty collecting the ration.

Where the general ration has not been increased to account for HIV, targeted supplementary feeding programmes may distribute an increased ration, particularly where the eligibility criteria are broadened to offer nutritional support to people living with HIV. In this case, the supplementary feeding programme should be closely coordinated with health facilities. A critical constraint of targeted supplementary feeding programmes is the bias towards individuals who are seropositive, know their status and are willing to disclose it; the majority of the population living with HIV are therefore excluded.

Provision of a ration through school feeding programmes as an HIV intervention should only be considered where it is clearly demonstrated that a drop in school attendance of children from HIV-affected households can be reversed by school food distribution. This intervention should be considered a short-term measure until longer-term support measures can be implemented for HIV-affected households. Similarly, provision of a ration to foster families and orphanages can ensure that food needs are met for orphans and vulnerable children during food crises, but more comprehensive food security programmes are necessary in the long term.

Key food security programmes that should be considered include home gardens and agricultural plots (with appropriate support), income generating activities, microcredit and community banking, training and skills development. Food and food-related resources (e.g. seeds, tools) can be used as programme inputs as in the case of home garden projects; alternatively food can be used to enable people living with HIV to participate in certain programmes, such as training.

- 7. Nutritional support and nutrition education can be established as integral components of health care and treatment services used by people living with HIV, such as inpatient hospital services, home-based care and antiretroviral therapy programmes (Strategies 13–16).** The logistical and financial implications of a hospital inpatient feeding programme may be justified where a high percentage of hospital inpatients seek care for HIV-related conditions; and where the lack of food is known or suspected to result in adverse health outcomes in these patients. To avoid stigmatization, inpatient feeding would cover all patients, rather than targeting those people living with HIV. To enhance longer-term nutritional status, this programme should be accompanied by nutrition education. An activity that has demonstrated success in the field is establishment of demonstration gardens at hospitals which provide food for the inpatient feeding programme and enable education about cultivation and hygienic preparation of nutrient-dense crops for those with acute and chronic illness.

Equally, nutritional support can be integrated into community-level health care for people living with HIV. Home-based care programmes and antiretroviral therapy programmes can provide a supplementary ration with nutrition education. The ration should ideally include fortified blended foods and/or milled and fortified staple foods prior to distribution, as well as fresh fruits and vegetables if possible. Provision of the ration is designed to increase the effectiveness of the treatment in suppressing the virus, boost the person's strength and promote overall health and immunity.

- 8. Food and nutrition resources can be used to support training and capacity-building activities for clinic-based and community-based HIV-care providers and to support the establishment or continuation of community-level HIV-related activities (Strategies 17–20).** As with all food-based programmes, the use of food as an incentive must follow a careful assessment that determines that food is an appropriate incentive resource. Where this is assured, food can be used to support training for formal/clinic-based health care providers (e.g. nurses and assistants), traditional/community-based health care providers (e.g. traditional healers, traditional birth attendants) and other community resource persons who can play a central role in HIV-response efforts. Although stable refugee settings often exhibit better health service availability than surrounding host communities, refugees often use a combination of clinic-based and traditional health services. Enlisting health personnel in the HIV education, prevention, care and treatment effort requires building capacities of both clinic-based and traditional health personnel—in partnership whenever possible.

## Introduction

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Towards the end of the twentieth century, HIV joined a series of public health challenges so profound and far-reaching that major shifts in public health thinking and action were provoked. Perhaps more than most crises, the AIDS pandemic sharply contests the common bureaucratic, top-down, sector-driven nature of humanitarian and development assistance. The illness is a “long-term emergency... a cross-cutting issue in short-term humanitarian relief for acute suffering... [and] one of many contributory factors to long-term and chronic food insecurity, poverty and destitution”<sup>3</sup>. With an estimated 40.3 million (range 36.7–45.3 million) people living with HIV by the end of 2005, this pandemic is composed of many epidemics—each with its own patterns of infection and vulnerability<sup>4</sup>. For refugee communities, HIV joins forces with other factors such as conflict and displacement to bring about profound and often irreversible changes in people’s lives. For refugees as with all communities, effectively addressing HIV requires local assessments, partnerships and solutions.

Because of the magnitude and the unique nature of this crisis, the international community is compelled to implement responses based upon a partial, though growing, scientific and programmatic experience and evidence base. Rigorous monitoring and evaluation of HIV interventions as they are implemented will help to expand the evidence base and assist with the allocation of scarce programmatic resources. Recent efforts to elucidate evidence for these linkages between HIV and nutrition at the national level, such as the 2005 International Conference on HIV/AIDS and Food and Nutrition Security (Durban), are noteworthy, but too little light has been shed on these linkages in refugee settings, and more collaboration and research are necessary.

In 2003, the United Nations High Commissioner for Refugees (UNHCR), United Nations World Food Programme (WFP) and United Nations Children’s Fund (UNICEF) launched a joint effort to develop, through multi-site field research in refugee communities in Africa, a set of strategies for using food and nutrition-based interventions to support HIV prevention, impact mitigation, and care, treatment and support for people living with HIV. These highly collaborative initiatives grew out of the recognition at senior levels that refugee settings are unique. Specific research conducted among and with refugees is needed in order develop approaches using food and nutrition-based programmes more effectively to address HIV transmission prevention, care, and treatment, and support interventions in these settings. This document discusses the process and findings of this interagency initiative, whose value for best practices is as much in the collaborative, field-driven methodology as in the findings, which lie at the community-level intersection of HIV, nutrition and food security in refugee settings.

### **Justification for integrating HIV, food and nutrition programming**

Over the last few years, research has provided evidence of many linkages among food security (or related factors, such as agricultural production), nutrition and HIV, at both individual and population levels. Research on effective response options has not kept pace. Translation of these research findings to the refugee setting—to clarify how food and nutrition security and HIV are linked, and how to respond effectively—is for several reasons even more problematic. First, as a result of resource constraints and conflict-induced isolation, refugee settings (and more so, settings of internal displacement) are often data-poor. UNHCR and its partners are working to build the epidemiological data base, having conducted HIV antenatal

sentinel surveillance and behavioural surveillance surveys in 12 countries from 2001 to 2005<sup>5,6</sup>. Second, complex emergencies often bring about significant changes in many determinants of HIV prevalence, including exposure to the virus (through various patterns of population mixing, imbalances in individual powers and entitlements, and sexual and gender-based violence) and vulnerability to the virus (through malnutrition and untreated sexually transmitted infections)<sup>7,8</sup>. Third, the life cycle of a complex emergency exhibits enormous change in key health indicators, with high mortality rates in the acute phase falling to relatively low rates in long-established refugee camps<sup>9</sup>. Trends in HIV prevalence following displacement are therefore not consistent, as they are affected by factors that vary among refugee populations, such as the degree of interaction with host communities and HIV prevalence in both the refugee and host populations<sup>5</sup>. Fourth, response options in refugee settings are determined in a large part by host countries' national refugee policies, which vary greatly, as well as institutional frameworks<sup>10</sup>. National policies that allow extensive integration (including, for example, agricultural cultivation and freedom of mobility for trade and employment) enable a wider range of response options that may approximate those of stable non-refugee (civilian) settings.

A review of the literature on stable non-refugee settings in low-income countries suggests an association between increases in morbidity and mortality of household members, particularly adults, due to HIV infection in addition to numerous household-level outcomes related to food insecurity (outcomes varied by study site, but included livelihoods, including agricultural and off-farm economic activities and assets)<sup>11</sup>. AIDS-related mortality alters demographic household structure, and can frequently result in increased female- and child-headed households and an increased household dependency ratio. The relative impact of adult male and female death on household food security depends upon local sociocultural factors, in particular whether a widow retains rights to her land, her children and to other assets and whether she has economic opportunities after the loss of her husband; the extent to which support is given from family and community members; and the extent to which stigma constrains the ability of remaining household members to find work and engage in markets to earn a living. Research has demonstrated reductions in economically productive activities (e.g. food cropping, cash cropping, trade and other off-farm activities) depending on the age and gender of the deceased. In African countries where more lucrative economic activities are the domain of men (e.g. cash cropping, cattle keeping, access to credit), female-headed households face the daunting challenge of earning a living from far less profitable activities such as growing staple food crops and keeping small animals (e.g. poultry, goats, sheep).

Clearly in female-headed households cut off from their livelihoods, HIV can present particular challenges for the prevention and treatment of severe malnutrition in children at two levels: poverty and food insecurity at household level, and growth faltering for the infected child. In emergency settings, HIV exacerbates the risk of high acute malnutrition prevalence, which may have underlying causes in early weaning, poor diet and inadequate management of infection in the critical 6–24 month period. Poor growth is associated with increased risk of mortality, and good nutrition is critical to weight gain in children, particularly after opportunistic illnesses. (The issue of HIV and infant and young child feeding is, however, not dealt with in detail in this document.)

AIDS-related mortality is therefore associated with subsequent asset erosion, decreased household food consumption and increased stress on intra-community support mechanisms in non-refugee settings. It should be recognized that strong customary intra-community support mechanisms may prevent and even mask the effects of the epidemic (as they can mask

the effects of a developing large-scale food emergency) until these mechanisms are themselves over-stretched—and affected households dissolve, a demographic effect of the epidemic poorly measured to date. Though refugees tend to move as families and communities where possible, displacement remains highly disruptive to the family and community networks on which life for the most vulnerable rural African households often depends.

At the level of the individual, HIV infection is known to increase energy requirements by 10% for asymptomatic HIV-positive adults and 20–30% for those with symptomatic infection or AIDS<sup>12</sup>. While stable food-secure populations may be able to increase their food intake to meet this elevated requirement, this may be more difficult for displaced populations severed from their normal food access strategies (e.g. growing their own crops, earning income to purchase food), and relying on an increasingly limited supply of humanitarian food assistance. Opportunistic illnesses frequently faced by people living with HIV, such as those affecting the gastro-intestinal tract, can reduce appetite and consumption or decrease nutrient absorption.

Food insecurity can increase risk of HIV exposure through increased engagement in high-risk practices such as unprotected sex for food or income. Refugee settings are risky, particularly for women and girls, who face increased risk of sexual exploitation and gender-based violence. Protection systems by the host country government and international community (reporting, care and legal follow-up) are often poor to non-existent<sup>13</sup>. Significant reductions in donor food contributions in recent years have resulted in decreased food rations in many refugee camps around the world, with no evidence of a decrease in need; for refugee women struggling to feed themselves and their families, a worrying possible result is increased sexual exploitation and resulting HIV infection, sometimes even at the hands of the very humanitarian staff who are supposed to support and protect them<sup>14</sup>.

Interactions between pre-existing malnutrition and HIV are not yet well understood; though it is known that malnutrition impairs immune function at the individual level, available data documenting community-level linkages between malnutrition and HIV are somewhat scarce, and almost entirely country-specific to date. While this field of research is a relatively young one, interactions documented among HIV and food and nutrition insecurity are compelling enough to warrant changes in programming, alongside rigorous impact evaluation to draw lessons from field experience for future programme design. This recognition inevitably raises the question of how food aid—including the roughly six million tonnes of food aid distributed by WFP annually<sup>15</sup>—can contribute to HIV prevention, care, treatment and support in beneficiary populations.

In general, food aid should be prioritized for programmes designed to provide nutritional support rather than as a resource transfer<sup>16</sup>. Programming of relatively limited food aid resources to situations where cash or non-food programmes are the needed intervention can lead to negative effects such as undermining local production, disruption of markets, weakening of traditional intra-community support mechanisms and disruption of normal economic response strategies. With these considerations in mind, food aid must therefore be used cautiously also in refugee populations.

Where justified, humanitarian agencies (both UN and nongovernmental organizations) should consider seeking ways in which food resources can meet established food and nutrition-related objectives while simultaneously supporting HIV prevention, and care, treatment and support for people living with HIV. It is relatively straightforward to understand how food aid can save lives; the area where more programmatic research is needed is to achieve food aid's

second main objective—to build longer-term human and physical assets—through using food aid to address the causes and effects of the epidemic.

## Policy context: HIV and food/nutrition security for refugees

UN agencies and nongovernmental organizations have on the whole been quick to embrace HIV as a key priority issue, each through the lens of its own institutional mandate. The World Health Organization (WHO) Consultation on Nutrition and HIV/AIDS in Africa (2005) brought UN, nongovernmental organization, and government representatives from 20 African countries together to review synthesis findings from six technical reviews relevant to HIV, AIDS and nutrition, and identify key programmatic implications for national, community-level and emergency programming<sup>17</sup>. The Participants' Statement, which called for "the integration of nutrition into the essential package of care, treatment and support for people living with HIV/AIDS and efforts to prevent infection," was adopted by the World Health Assembly in resolution WHA57.14 (May 2005)<sup>18</sup>.

The UN General Assembly Special Session on HIV/AIDS *Declaration of Commitment on HIV/AIDS* (2001) made particular note of the need to extend the range of HIV-related measures to conflict and disaster-affected populations, including refugees, "as a matter of emergency," based upon the recognition that "populations destabilized by armed conflict... including refugees, internally displaced persons, and in particular women and children, are at increased risk of exposure to HIV infection"<sup>19</sup>. The *Declaration* asserts that the epidemic threatens national food security. Yet recommendations on HIV and nutrition in the *Declaration* are limited to two: to promote HIV prevention through nutrition (and other health/social) services, as well as to ensure good nutrition for orphans and vulnerable children.

HIV and nutrition only gained international prominence as a critical programming issue when the Southern African crisis of 2002-2003 generated questions about the contribution of high HIV prevalence to food insecurity, malnutrition and mortality. Unfortunately, until reliable population-level data are available on seroprevalence, acute and chronic malnutrition and household food insecurity, the "scale and severity of HIV/AIDS' contribution to both acute and chronic food insecurity is simply unknown"<sup>20,21</sup>.

The Joint United Nations Programme on HIV/AIDS (UNAIDS) was established in 1996 to serve as a focal point for policy and action related to AIDS in the UN system. UNAIDS aims for a broad set of goals: to lead, strengthen and support "an expanded response aimed at preventing the transmission of HIV, providing care and support, reducing the vulnerability of individuals and communities to HIV/AIDS, and alleviating the impact of the epidemic"<sup>22</sup>. Though UNAIDS is the UN system's main AIDS coordinating body, it is UNHCR, charged with the mission to "lead and coordinate international action to...safeguard the rights and well being of refugees"<sup>23</sup> that develops policies and interventions for refugees. UNHCR's *Strategic Plan 2005–2007: Fighting HIV and AIDS Together with Refugees* articulates 10 HIV policy and programme objectives (Box 1)<sup>24</sup>. Because UNHCR collaborates closely with the World Food Programme (WFP) on food distribution, use of food resources to combat HIV engages both UNHCR and WFP policy frameworks. For UNHCR, HIV food and nutrition interventions must be consistent with the core mission of refugee protection: interventions must broadly support the rights of refugees to live in dignity, free from discrimination, with their human rights respected. UNHCR became a cosponsor of UNAIDS in 2004.

### Box 1. Objectives related to HIV in UNHCR Strategic Plan (2005–2007)

1. **Protection:** To ensure that in relation to the AIDS epidemic, refugees, asylum-seekers and other persons of concern live in dignity, free from discrimination, and their human rights are respected.
2. **Coordination and mainstreaming:** To ensure that HIV policies and interventions for refugees are coordinated, mainstreamed and integrated with those at the international, regional, subregional, country and organizational levels.
3. **Durable solutions:** To develop and incorporate HIV policies and interventions into UNHCR's programmes for durable solutions and to mitigate the long term effects of HIV.
4. **Advocacy:** To advocate for HIV-related protection, policy and programme integration, and subregional initiatives for refugees and other persons of concern in a consistent and sustained manner at all levels.
5. **Overall level and quality of HIV interventions:** To ensure a satisfactory and appropriate level of HIV interventions to refugees, returnees and other persons of concern, in an integrated manner.
6. **Prevention:** To reduce HIV transmission and HIV morbidity.
7. **Support, care and treatment:** To reduce HIV morbidity and mortality.
8. **Assessment, surveillance, monitoring and evaluation:** To improve programme implementation and evaluation.
9. **Training and capacity building:** To improve HIV and related skills and capacities of UNHCR, its partners and refugees.
10. **Resource mobilization:** To increase funds and move beyond traditional donors to ensure HIV policies and programmes stated in UNHCR's strategic plan can be successfully undertaken.

In 2003, WFP adopted a policy on *Programming in the Era of AIDS* which articulated a commitment to incorporating HIV across its operations as a cross-sectoral issue<sup>25</sup>. Examples of how this would be achieved included: directly addressing food insecurity driven by HIV; using WFP activities as a “platform for other types of HIV/AIDS programmes”; adapting “programming tools such as needs assessments, vulnerability analysis, the design of rations and other nutrition-related activities” to take HIV into account; and ensuring that food is incorporated into HIV activities where and when appropriate<sup>26</sup>. WFP became a cosponsor of UNAIDS in 2003.

UNICEF was one of the original cosponsors of UNAIDS. UNICEF's commitment in the area of HIV is expressed in its Medium Term Strategic Plan (MTSP) 2006–2009. In this context, UNICEF's strategic focus is to put young children and adolescents at the centre of the AIDS agenda, and to build the capacity of state and non-state actors to halt and begin to reverse the spread of HIV among children. Two further documents elaborating on UNICEF's approach are *Fighting HIV/AIDS: Strategies for Success 2002–2005* (2003)<sup>27</sup>, and the multiagency *Framework for the Protection, Care and Support of Orphans and Vulnerable Children Living*

*in a World with HIV and AIDS* (2004), in which UNICEF played a lead role<sup>28</sup>. The *Fighting HIV/AIDS* document, which adapts UNICEF's action plan for armed conflict situations, places high priority on health and nutrition programming to protect the nutritional status of orphans and vulnerable children, pregnant and lactating women, and people living with HIV.

In terms of translating these commitments into guidelines for action, the Interagency Standing Committee Task Force on HIV/AIDS in Emergency Settings (IASC) developed the *Guidelines for HIV/AIDS Interventions in Emergency Settings* (2004)<sup>29</sup>. Building upon previous work of the Interagency Working Group and the Reproductive Health Response in Conflict Consortium<sup>30,31</sup>, the IASC Guidelines provide an invaluable blueprint for addressing HIV in acute emergencies, where such services are generally poorly implemented. Guidance for food security and nutrition interventions is provided in Sector five of the document. The document *Integration of HIV/AIDS Activities with Food and Nutrition Support in Refugee Settings: Specific Programme Strategies* (2004) complements the IASC Guidelines by focusing on the post-acute phase and discussing a broader range of intervention options.

Because HIV is ultimately addressed in specific countries and communities, the international community has recognized the necessity of establishing a coherent set of principles and policies to direct HIV-related activities in countries where national and multinational actors are working together. The "Three Ones" guiding principles, which grew out of international consensus at the International Conference on AIDS and STIs in Africa (ICASA) 2003, stipulated that countries should have "One agreed HIV/AIDS Action Framework that provides the basis for coordinating the work of partners; One National AIDS Coordinating Authority, with a broad-based multi-sector mandate; and One agreed country level Monitoring and Evaluation System"<sup>32</sup>. Though the importance of the "Three Ones" principles is indisputable for coordinating the often uncoordinated actions of the multitude of actors in this area, the important matter of HIV and refugees may be neglected if refugee policies are not fully integrated into national policies. The "Three Ones" fails to make specific mention of the need to programme at the intersection of nutrition, food security, and HIV. As long as refugee protection and service delivery continues to be relegated to a specific Governmental office or ministry, disconnected from national service delivery systems (e.g. AIDS, health, water and sanitation, education) and inhibiting integration into local communities, HIV among refugees will likely not be addressed adequately. Excluding refugees from national AIDS initiatives is imprudent for a number of reasons. The UN *Declaration of Commitment on HIV/AIDS* (2001) recognized the epidemic as a fundamental threat to human rights, life and dignity, with particular note of conflict and disaster-affected regions. Furthermore, the more than 35 million estimated refugees, asylum seekers and internally displaced people, including over six million newly displaced (in the same year, 2003), present a considerable challenge in terms of increasing population mixing<sup>33</sup>.

Many countries across sub-Saharan Africa have joined together to address the impact of migration and displacement on HIV within the region. These countries, with the help of donors and aid agencies, have come together to address the HIV-related needs of refugee and surrounding populations through the development of subregional plans. The creation of these plans makes it possible to provide HIV-related services to displaced persons who, in the past, may not have had access to them. The plans work to ensure continuity of care, by providing standardized protocols that reach across borders. This makes the introduction of antiretroviral therapy possible for these populations. Finally, not only do subregional plans help ensure that more comprehensive and better harmonized services are provided, they can also serve to improve programme efficiency and lower costs<sup>34</sup>.



As far as antiretroviral therapy is concerned, the World Health Organization/UNAIDS-led “3 by 5” initiative has seen considerable progress—by the end of 2005, more than 1.3 million people received antiretroviral therapy in developing and transitional countries<sup>35</sup>—but a very small proportion of these recipients, relative to their population size, are refugees, and antiretroviral therapy provision to conflict-affected and displaced populations is not a priority focus in this effort. UNHCR’s policy supports the provision of antiretroviral therapy to refugees when it is available to surrounding host communities<sup>36</sup>. Similarly, large-scale international programmes such as the United States-funded President’s Emergency Plan for AIDS Relief (PEPFAR), the World Bank’s Multi-Country AIDS Program (MAP) and the Global Fund to Fight AIDS, Tuberculosis and Malaria, primarily focus on responding to the epidemic in stable settings; although the World Bank is funding the Great Lakes Initiative on AIDS, an innovative cross-border subregional initiative. Additionally, achievements in antiretroviral therapy provision must be accompanied by increased nutritional assessment and monitoring of participants receiving therapy. Access to adequate and appropriate foods and consideration of a ration distribution to food insecure participants, will improve effectiveness of the treatment and prevent the weight loss associated with higher morbidity and mortality.

Policy frameworks on HIV that have begun to account for HIV and nutrition links have been in the area of treatment and care for people living with HIV who are now counselled to increase dietary energy intake. The effects of pre-existing protein-energy malnutrition (PEM) and micronutrient malnutrition on nutritional needs and health outcomes of people living with HIV in resource-limited settings are not yet well understood, with the scientific evidence still insufficient for the confident and comprehensive establishment of revised humanitarian response guidelines. Conflict-affected internally displaced populations and refugees in the acute phase (i.e. before a displaced community becomes stable with well established health and food access) are at high risk of acute malnutrition. Like HIV, malnutrition is a leading cause of reduced human development, reduced national productivity, and loss of life in children and adults worldwide. Malnutrition is directly or indirectly associated with 60% of all child mortality<sup>45</sup>, it is the main contributor to the burden of disease in developing countries<sup>46</sup>. Yet malnutrition has not triggered the policy or programme (public or private) response on the scale that AIDS has in recent years.

The humanitarian practice community—UN, nongovernmental organizations, and national actors alike—must draw reasonable conclusions from experience and the scientific literature to make rational changes in practice, documenting experience along the way to further the science. In the interagency initiative of focus in this document, three UN agencies joined forces with cooperating partner nongovernmental organizations and refugee and host communities to highlight lessons about how HIV, food aid and nutrition could be better integrated in refugee settings, drawing upon the ingenuity, leadership and partnership opportunities in refugee and host communities.

## **Objectives of the initiative**

The main objective of the UNHCR/WFP/UNICEF initiative was to identify priority entry points for HIV prevention, care, treatment and support through the integration of food, nutrition and HIV programmes in refugee settings. The main output of the initiative was the document entitled *Integration of HIV/AIDS activities with food and nutrition support in refugee settings: specific programme strategies*<sup>37</sup>. In 2005, UNHCR, WFP and UNICEF began testing and evaluating the strategies in diverse refugee settings in Africa, and this effort is ongoing.

Programme evaluation results will be used to further guide programme implementation strategies in these sectors for the UN and partner agencies.

## Methodology

To begin to build a research base on community-level HIV, food and nutrition interactions in refugee communities, this initiative conducted research directly with refugees themselves. From September to December 2003, following a literature review, interagency mission teams conducted field visits to four diverse refugee settings in sub-Saharan Africa. The missions, over two months in duration, examined two refugee camps in northern Zambia and two refugee settlements in western and northern Uganda. Site selection was designed to include populations with high variation in their degrees of integration with host communities, based upon the premise that integration can profoundly affect HIV risk and response options. Key informant and focus group participant selection was designed to enable the exploration of issues pertinent to specific risk groups and response opportunities, such as people living with HIV, participants in different types of nutritional and health-related programmes, community leaders, men, women and youth. The refugees frequently expressed appreciation for the opportunity to raise their voices on these issues, thanking mission teams for the decision to work directly with them and to explore the many ways in which they themselves could play important roles in addressing the problems they face.

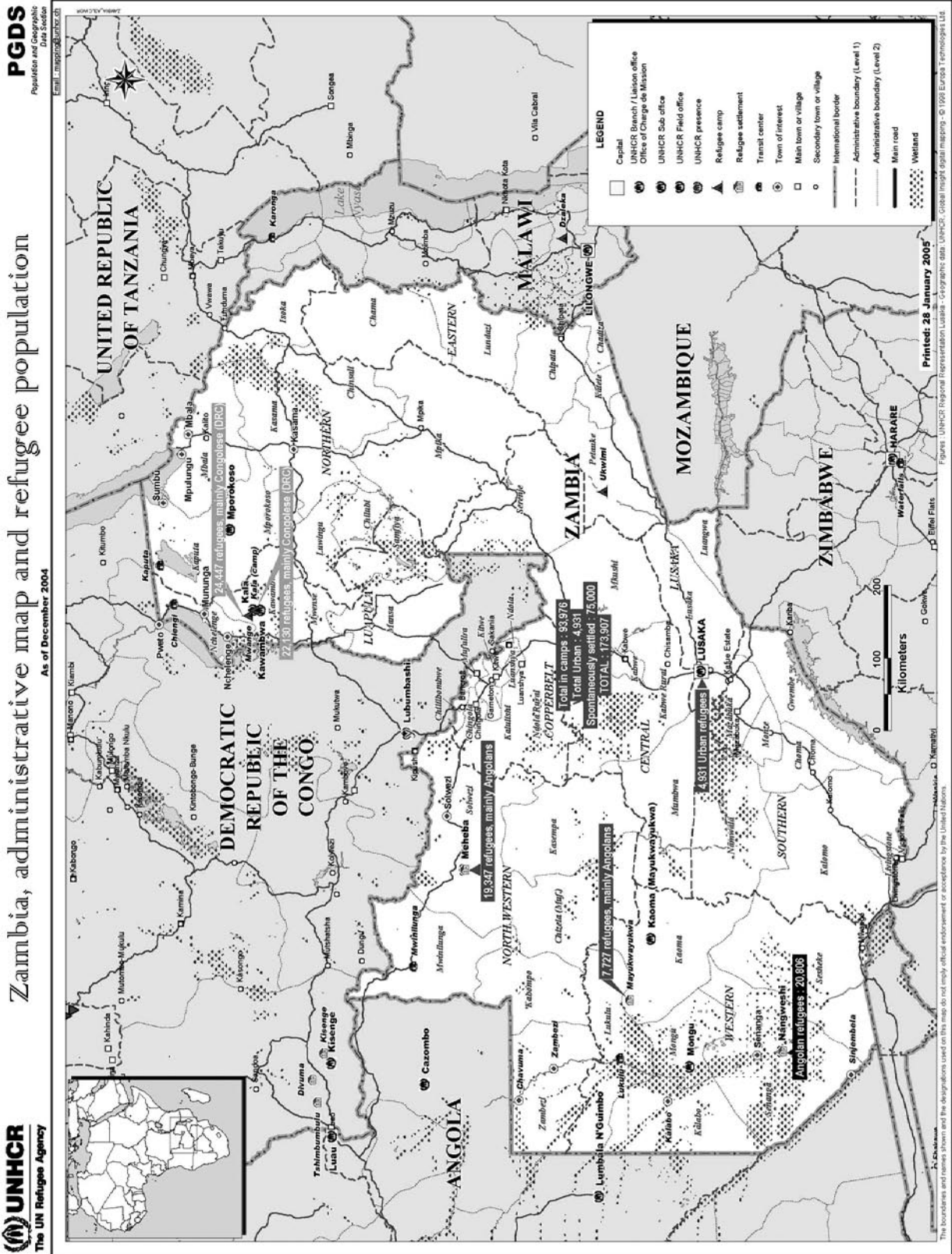
Despite superficial similarities between the Zambia Initiative and the Uganda Self-Reliance Strategy (the national refugee policies of the Governments of Zambia and Uganda), refugee populations studied in Zambia and Uganda varied starkly in the degree of integration<sup>38</sup>. Started in 2002, the Zambia Initiative aimed to promote community development among refugee and their host communities through activities such as small-scale poverty alleviation and income generation projects and education. By 2004 however, refugee populations in Kala and Mwanze Refugee Camps (see Map 1), who originate from the Democratic Republic of Congo, remained poorly integrated into the host population of northern Zambia (particularly in terms of land access), and thus are almost wholly reliant on external humanitarian assistance including general food distribution for subsistence. The poor integration in northern Zambia in 2004 may be in significant part explained by the Government of Zambia emphasis on implementation of the Zambia Initiative in Western Province rather than the north, with the result that economic development and livelihoods in the north between the refugee and host communities remained largely unconnected.

In stark contrast, the Government of Uganda's Self-Reliance Strategy (and since 2004, the associated Development Assistance to Refugees programme) strives to incorporate refugee assistance programmes and service delivery into national and local development plans and service delivery systems. As a result, the Sudanese and Congolese refugees in Kyangwali and Palorinya Refugee Settlements in Western Uganda (see Map 2) share highly developed social and economic links with surrounding communities, permitting a bigger toolbox of response options more closely approximating those available in non-refugee settings.

Mission teams conducted key informant and focus group interviews with over 800 refugees and host community representatives, health facility staff, government representatives, UN field staff, and local staff of 16 international and national partner nongovernmental organizations to investigate critical issues that required a flexible inquiry approach, such as percep-

tions of AIDS in the community, determinants and constraints to participation in humanitarian assistance programmes by vulnerable households, and opportunities to promote the role of refugees in designing, managing and evaluating assistance programmes. Findings were cross-checked across multiple interviews and against secondary data. Participants from the refugee and host communities included formal and traditional refugee and local host community leaders; health facility staff; traditional and agency-affiliated health extension workers; beneficiaries of relevant agency programmes; and people living with HIV (box 2). Table 1 presents core questions investigated in interviews with the target interview groups, with whom the mission teams met in both Zambia and Uganda.

Map 1. UNHCR Refugee Camps in Zambia, 2004 (UNHCR)

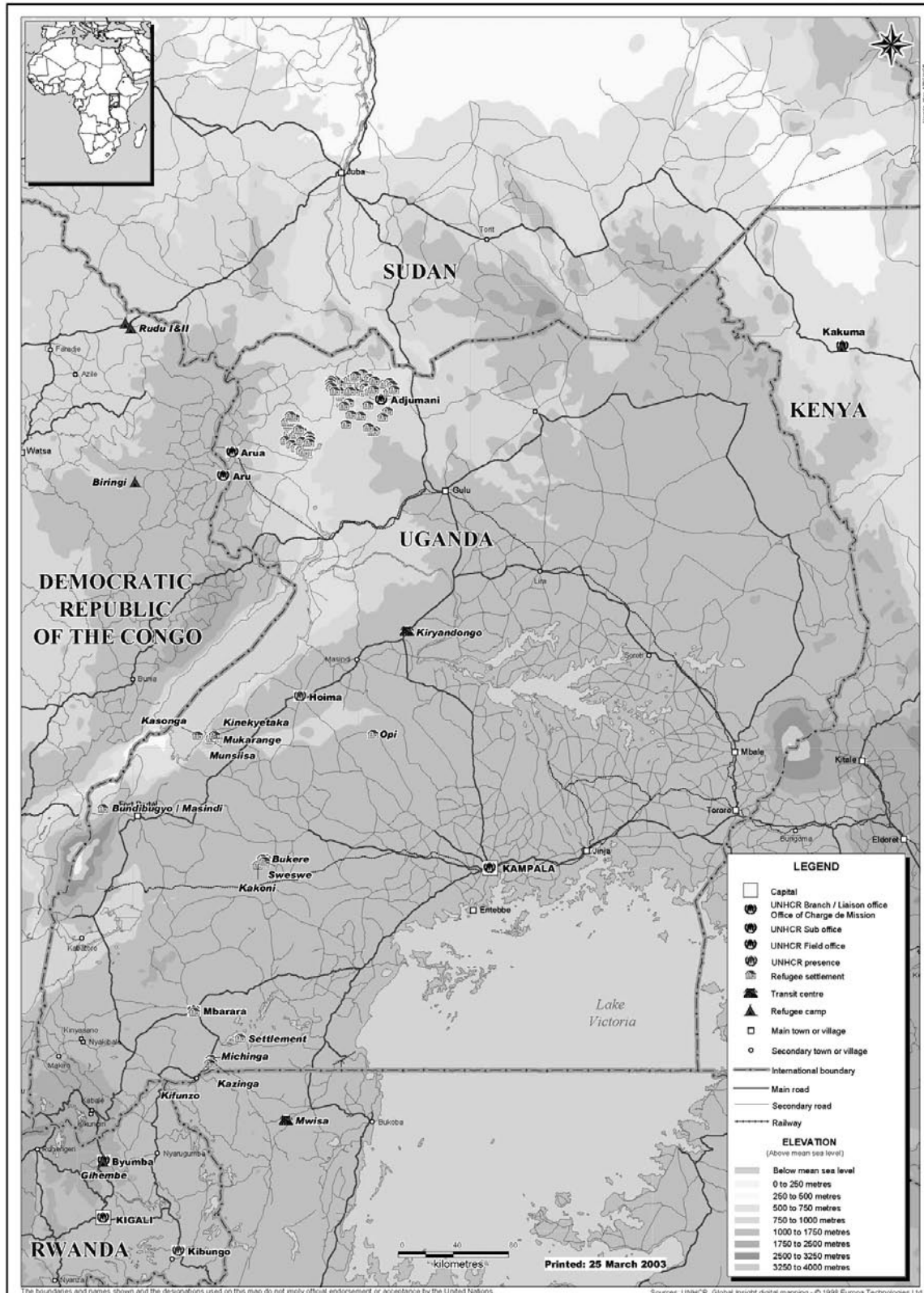


Map 2. UNHCR Refugee Settlements in Uganda, 2004 (UNHCR)



Uganda  
As at end of March 2003

**GIMU / PGDS**  
Geographic Information and Mapping Unit  
Population and Geographic Data Section  
Email: mapping@unhcr.ch



## Practice context for refugee settings

The 2004 *Interagency Global Evaluation of Reproductive Health Services for Refugees and Internally Displaced Persons* found that significant progress could be seen in the availability and use of reproductive health services in stable refugee settings worldwide in the last decade. Despite that, the area of HIV had seen one of the lowest rates of progress<sup>39</sup>. While condom availability, use of universal precautions and community-based AIDS education were implemented in over three quarters of sites studied, voluntary counselling and testing, prevention of mother-to-child transmission and home-based care were present in one third to one fifth of sites studied. After basic HIV interventions are implemented in the emergency phase in accordance to the framework articulated by the IASC Guidelines for HIV/AIDS Interventions in Emergency Settings, more comprehensive services of a similar level as those provided to the surrounding host population should be provided. That being said, HIV services in refugee settings during the post-emergency phase should strive to include, at a minimum, behaviour change communication strategies, voluntary counselling and testing, and prevention of mother-to-child transmission. However, significant progress has been made over the past few years. By the end of 2004, voluntary counselling and testing services were available in at least 27 refugee camps in 10 countries encompassing over 917 000 persons and prevention of mother-to-child transmission services were available in at least five countries in 15 camps encompassing over 580 000 persons. Furthermore, a very small number of refugees were accessing antiretroviral therapy in at least 13 countries in Africa and Asia by a variety of informal and formal mechanisms<sup>40</sup>.

A review of UNHCR's HIV programming for refugees in 2003 suggests that while no standard approach is followed by country offices, food and nutrition-based programming addresses HIV in two main ways: food can be provided to refugees living with HIV, including through a home-based care programme, alongside other chronically ill refugees; and food and nutrition support can be targeted to malnourished orphans and vulnerable children where the need is demonstrated<sup>41,42</sup>.

## Box 2. Methodology

### Zambia

- Field research dates: September-October 2003
- Refugee sites visited: Kala Camp, Kawambwa District (estimated population 25 000)  
Mwange Camp, Mporokoso District (estimated population 25 000)
- Research participants: 400 (estimated) including key informants and focus group participants
- Participating agencies: UNHCR/Zambia, WFP/Zambia, Zambia Red Cross Society, International Federation of the Red Cross, World Vision International, HODI, Aktion Afrika Hilfe, Right to Play

### Uganda

- Field research dates: November-December 2003
- Refugee sites visited: Kyangwali Settlement, Hoima District (estimated population 7000)  
Palorinya Settlement, Moyo District (estimated population 20 000)
- Research participants: 400 (estimated) including key informants and focus group participants
- Participating agencies: Aktion Afrika Hilfe, African Development and Emergency Organization, Agency for Cooperation and Research in Development, Meeting Point, Madi AIDS Heroes Association, Association of Volunteers in International Service, Hoima District Hospital, Moyo District Hospital, Health of Adolescents Program, Youth Anti-AIDS Services Association, AIDS Information Center, Traditional and Modern Health Practitioners Together Against AIDS

### All sites

- Focus groups conducted:
- People living with HIV: Participants in home-based care programmes; community groups of people living with HIV
- Gender: Women's groups; men's groups; mixed men's and women's groups
- Youth: Youth AIDS awareness groups
- Host community: Host community leaders (formal and traditional)
- Leadership structures: Refugee community leaders, food management committee members, health management committee members
- Service providers: Hospital and clinic staff; community health volunteers; community counselling aides; peer educators; traditional healers; traditional birth attendants
- Programme participants: Users of antenatal care services; general food distribution beneficiaries; users of supplementary and therapeutic feeding programme services; participants of income-generating activities targeting labour-poor and vulnerable households

*Table 1. Interview strategy: target interview groups and examples of focal interview questions*

Examples of focal questions investigated	
<b>Target group</b>	
<b>Government and agency</b>	
<b>District and local government and host community leaders</b>	<p>What are the host community policies regarding refugees, food security and nutrition, and HIV, particularly with regard to integration of services with the host community?</p> <p>What support does government give to refugee community groups working and living with HIV?</p> <p>How do local government, UN agencies and nongovernmental organizations coordinate on AIDS programming?</p>
<b>Refugee community leaders and refugee welfare council</b>	<p>What is the role of refugee leaders and representatives in supervising and monitoring agency programmes related to HIV, food and nutrition, and liaising between the refugee community and agencies?</p> <p>In what ways can refugees influence these programmes, and how much influence do they have?</p> <p>How transparent is information sharing between refugee community leaders, UN agencies and nongovernmental organizations?</p>
<b>United Nations agencies</b>	<p>How are "vulnerable" groups defined for targeting?</p> <p>What are the eligibility criteria for full and partial ration?</p> <p>What programmes are in place relevant to HIV, nutrition and food security, and what is their coverage?</p> <p>In what ways does nutritional programme design reflect concern for people affected by AIDS, for the major types of interventions?</p> <p>How is HIV articulated (e.g. as a human rights issue, protection issue)?</p> <p>How is stigma taken into account in programme design and implementation?</p>
<b>Nongovernmental organizations</b>	<p>For nongovernmental organizations working in the sectors of food, health, education, agriculture, community services, roads/construction, sexual and gender based violence (see Box 2):</p> <p>What services are provided to people living with HIV and orphans and vulnerable children, and how are these services delivered?</p> <p>How does stigma affect programme design and service delivery?</p>
<b>Socio-demographic groups</b>	
<b>People living with HIV groups</b>	<p>What is the role of groups of people living with HIV in referring people suspected to have HIV to voluntary counselling and testing and prevention of mother-to-child transmission services?</p> <p>What promising entry points exist for promoting food self-sufficiency in AIDS-affected households?</p> <p>What are the opportunities and constraints for AIDS-affected households to benefit from income generating activities and gardening projects?</p> <p>What are promising strategies to reduce stigma (e.g. testimonies) that people living with HIV can implement?</p> <p>What services are provided for people living with HIV and orphans and vulnerable children? What is the coverage of these programmes, and obstacles to use and effectiveness?</p> <p>What roles can people living with HIV play in promoting use and effectiveness of home-based care programmes?</p>
<b>Women</b>	<p>How do women perceive prevention of mother-to-child transmission?</p> <p>What are the traditional high-risk practices and perceptions of risk associated with these practices (e.g. removal of front teeth, breastfeeding, tattooing, pregnancy)? What promising strategies for reducing these risks are present in the refugee setting?</p> <p>What are the main determinants of willingness of women to reveal their HIV status to their spouse/partner?</p>
<b>Men and women (mixed group)</b>	<p>What are the perceptions of HIV risk between refugee and host communities?</p> <p>What support is available from the community for people living with HIV (especially with food preparation, personal care and household chores)?</p> <p>What are the main constraints to food security in AIDS-affected refugee families, and how could refugee communities be mobilized to better scaffold the food security of affected families?</p> <p>What are the determinants of willingness to use voluntary counselling and testing, prevention of mother-to-child transmission, antiretroviral therapy and home-based care programmes?</p>
<b>Youth AIDS awareness groups and post test clubs</b>	<p>What is the role of post test clubs in mitigating against stigma?</p> <p>What are the potential contributions of post test clubs to promoting the well being of AIDS-affected families in the community?</p>



<b>Examples of focal questions investigated</b>	
<b>Target group</b>	<b>Health care providers (facility-based and extension, including volunteers)</b>
<b>Government health directors, health facility staff (hospital, clinic)</b>	<p>What nutrition and HIV-related services are available to refugees?</p> <p>For voluntary counselling and testing programmes how do the counselling and testing services compare to practice standards? (Testing kits, protocols, reporting, confidentiality, supplies/equipment, screening test, confirmatory test and tiebreaker, quality control)</p> <p>For prevention of mother-to-child transmission programmes, how do the pregnancy counselling, testing, perinatal care, delivery and infant feeding counselling compare to practice standards?</p> <p>What are the key guidance messages given to people regarding HIV prevention (e.g. voluntary counselling and testing, prevention of mother-to-child transmission, and breast-feeding)?</p> <p>What training and supervision is given to different levels of health staff involved in food, nutrition, and HIV programmes?</p> <p>How available is antiretroviral therapy, and who has access?</p> <p>Are integrated health services available for refugee and host communities? Why or why not?</p> <p>What entry points are available to promote nutritional status of inpatients with HIV (e.g. demonstration gardens, hospital feeding)?</p> <p>What is the status of coordination with community health workers?</p>
<b>Community health workers (CHW)</b>	<p>What is the appropriate role of community health workers in addressing nutritional status and HIV infection in the community, including addressing nutritional beliefs (i.e. maternal and child nutrition)?</p> <p>How can food resources be programmed to promote the functioning and capacity of community health workers?</p>
<b>Community counselling aides (CCA), peer educators (PE), community reproductive health workers (CRHW)</b>	<p>What is the availability of local materials for reproductive health education (e.g. appropriate to local language, culture, risk factors)?</p> <p>How is education conducted: what are the key messages and materials (e.g. penis model, male condoms, female condoms)?</p> <p>How do the training and performance of reproductive health educators compare to practice standards?</p> <p>What entry points exist for promoting effectiveness of this intervention with youth in the community?</p>
<b>Health care providers (traditional)</b>	
<b>Traditional healers</b>	<p>What high risk practices for HIV transmission are practiced, and what priority entry points exist for reducing the risk associated with these practices?</p> <p>How can traditional healers be engaged to refer people suspected of being HIV infected so as to ensure a prompt offer of testing and of treatment, when indicated, through collaboration with integrated clinic-based health services.</p>
<b>Traditional birth attendants</b>	<p>What high-risk practices for HIV transmission are practiced, and what priority entry points exist for reducing the risk associated with these practices?</p> <p>How can traditional birth attendants be engaged to improve referrals for women or infants suspected of having HIV infection, and to increase collaboration with integrated clinic-based health services which can ensure a prompt offer of testing and treatment, when indicated, for people living with HIV?</p> <p>What are promising entry points for integration of HIV transmission prevention into their work?</p> <p>What are their skills and attitudes towards HIV awareness, towards infant feeding?</p> <p>What actions are taken if they suspect HIV?</p> <p>What are their services relative to HIV in women (e.g. information /education given on delivery, infant feeding, hygiene and rapid weaning)?</p> <p>What training did they receive, and what supplies do they use to reduce risk (e.g. clean delivery kits)?</p>

<b>Examples of focal questions investigated</b>	
<b>Target group</b>	
<b>Programme staff and beneficiaries</b>	
<b>Antenatal care (ANC) and prevention of mother to child transmission (PMTCT) staff and participants</b>	<p>What is the status of antenatal care and prevention of mother-to-child transmission in terms of availability and use of services?</p> <p>What information/education is given on infant feeding and HIV during antenatal care and to participants in prevention of mother-to-child transmission services? Does prevention of mother-to-child transmission include nevirapine, clean delivery, infant formula, counselling on breastfeeding, or antiretroviral therapy for the woman?</p> <p>What is the capacity of health care workers to undertake prevention of mother-to-child transmission counselling? Is counselling given for individuals or groups?</p>
<b>General food distribution (GFD) staff and participants</b>	<p>What entry points exist for modifying the design of general food distribution to better address the needs of families affected by HIV, including modification of the ration or modification of distribution factors?</p> <p>How can the general food distribution be used as an opportunity to conduct HIV prevention activities?</p>
<b>Supplementary feeding programme (SFP) staff and participants</b>	<p>What entry points exist for modifying the design of supplementary feeding programmes to better address the needs of families affected by HIV enrolled in the programme, including modification of the ration or modification of distribution factors?</p> <p>How can supplementary feeding programmes be used as an opportunity to conduct HIV prevention activities, and how can they be linked to appropriate follow-up care where the participant expresses interest in voluntary counselling and testing, prevention of mother-to-child transmission or antiretroviral therapy?</p>
<b>Therapeutic feeding programme (TFP) staff and participants</b>	<p>What entry points exist for modifying the design of therapeutic feeding programmes to better address the needs of families affected by AIDS?</p> <p>How can therapeutic feeding programmes be used as an opportunity to conduct HIV prevention activities, and how can they be linked to appropriate follow-up care where the participant expresses interest in voluntary counselling and testing, prevention of mother-to-child transmission or antiretroviral therapy?</p>
<b>Income generating activities programme (IGA) staff and participants</b>	<p>What are the impacts of participation in income generating activities on food security?</p> <p>What promising programme options exist for enrolling labour-poor households (e.g. households headed by women affected by AIDS)?</p>
<b>Home based care programme (HBC) participants</b>	<p>What are the criteria for eligibility (e.g. is it necessary to show proof of HIV status; is it necessary to be on TB treatment or to show other symptoms of HIV-related disease)?</p> <p>What food rations are given to patient and/or household, and what programmatic factors seem to be associated with success of this intervention?</p>
<b>Committees</b>	
<b>Sexual and Gender Based Violence Committee members</b>	<p>What seem to be the major risk factors for sexual and gender based violence in the community, especially related to humanitarian interventions?</p> <p>What factors seem to be associated with willingness to report an incident, willingness to pursue the legal process?</p> <p>What are the implications of reporting sexual and gender based violence on access to economic opportunities and social connectedness for victims?</p>
<b>Food Management Committee members</b>	<p>How can the committee become engaged in providing nutrition education, especially for households dealing with morbidity?</p> <p>What are the training received, knowledge levels, and perceptions within the food management AIDS committee?</p> <p>What priority entry points exist to be involved in home based care, drama groups, etc. incorporating HIV prevention?</p>
<b>Health Management Committee members</b>	<p>What is the capacity of committee members to bring about effective collaboration between facility staff, extension workers and volunteers?</p>

## Inter UN agency collaboration

The profoundly cross-cutting nature of the HIV epidemic challenges both the humanitarian and the development communities to join forces to a degree unseen in other sectors. This joint initiative united three UN agencies—UNHCR, WFP and UNICEF—towards the common goal of drawing upon field-level experience and insight to identify opportunities to support HIV prevention, and care, treatment and support for refugees.

The mission benefited from multiple levels of agency participation in fieldwork:

- senior technical advisors from headquarters level in areas of HIV as well as nutrition and food security;
- senior technical advisers from regional and country levels in areas of HIV including prevention of mother-to-child transmission, health, nutrition and communications; and
- agency staff in district and local offices and refugee camps/settlements

Following the fieldwork, central, regional and country level representatives contributed extensively to the development and review of the final manual. The document also profited considerably from the expert reviews of colleagues in academia, the UN system, nongovernmental organizations, and USAID.

UNHCR and WFP are new UNAIDS cosponsors; both focus primarily on humanitarian situations. UNICEF's continuing presence in 155 country offices worldwide—many established for more than 20 years—means that it is often on the ground long before, and after, the crisis or unstable situation occurs. The Joint Initiative has helped to advocate for and show the need for innovative and focused HIV programmes among these affected populations, both in-house as well as among the UNAIDS family as a whole. It has helped to define the interests and roles of the various cosponsors regarding HIV and refugees and set a model for future collaboration. Similarly, it established a model for research with a high degree of interaction with, and participation by, refugees themselves, which was an essential component of this activity.



## Findings of the interagency initiative

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The initiative identified 20 integrated programme strategies that should be considered part of the humanitarian agency's toolbox for responding to the epidemic. All 20 strategies involve linkages to food assistance in some way (food aid or food-related resources, such as seeds and tools). Selection of appropriate integrated programme strategies should be determined by the objectives of the agency, which are in turn based upon an epidemiological and situational assessment of the refugee population.

### Integrated programme strategies

The interventions are summarized on page 26 below. For convenience, each programme strategy can be classified into one of three categories along a food and nutrition intervention axis *and* an HIV intervention axis.

#### HIV Interventions

- HIV prevention including prevention of mother-to-child transmission
- Care and support for people living with HIV and their families, and children affected by AIDS (including orphans and vulnerable children)
- Health care and treatment for people living with HIV and their families

#### Food and Nutrition Interventions

- Emergency food distribution and nutrition
- Food for training, capacity building and institutional support
- Household food and livelihood security

The initiative explored each of these possible linkages—that is, how each category of food and nutrition intervention can be modified to promote HIV prevention, care and support, and health care and treatment in beneficiary populations. It found that although food aid is less flexible programmatically than cash in emergency response, where food aid is justified on the basis of food security and nutrition evidence (or in the absence of hard data, where the need is obvious), there are many ways in which food resources can be programmed to better address HIV in beneficiary communities. Each of the 20 integrated programme strategies in the final document integrates HIV intervention design components (at least one of the three categories above) and food and nutrition intervention design components (at least one of the three categories above) for refugee settings. For each strategy, the document summarizes the following points.

1. Evidence that should be sought indicating that the programme is justified, which is a precondition for success.
2. Specific objectives that each strategy aims to achieve.
3. Key factors that should be considered in implementing the strategy, specifically related to institutional collaboration and coordination, emphasis on participatory and community-led approaches, and logistics of implementation.
4. Selected process, output, outcome and impact indicators for monitoring and evaluating the strategy in the field.
5. For most of the strategies, experiences shared by refugees and partner agencies during the field mission, where the strategy was implemented or should have been implemented.

## Main findings

1. **Though food is a blunt instrument for addressing the highly complex public health problem of HIV, numerous opportunities exist to refine the use of food and nutrition-based programmes to support HIV prevention, care, treatment and support for the HIV-infected and affected.** Implementation of these integrated programme strategies should be preceded by careful assessment to determine if food is an appropriate programme resource, as food-based programmes should be justified on the basis of nutrition and/or food security data first. Where food is justified, programming flexibility and creativity reveal a range of entry points for modifying *how these resources are used*, to help prevent transmission and mitigate the effects of the epidemic.
2. **Integration of refugees and surrounding host communities at assessment, programme and policy levels is vital for successfully addressing the epidemic.** Assessment for programme design in an integrated manner in both refugees and host communities is essential because the effects of displacement on the epidemic are determined in very large part on the frequency and nature of interactions among refugees and their hosts, as well as levels of pre-conflict HIV prevalence. Interviews with refugees underscored the necessity of conducting this assessment directly with the refugees and host communities, through a range of interviews designed to enable the exploration of policy and political, economic and sociocultural factors related to this interaction.
3. **Qualitative research, participatory communication strategies, community engagement and action should underpin programme development in stable refugee settings.** Most refugee communities are sufficiently established to transcend emergency programmes: over 60% of the world's refugees have been settled for at least ten years, which implies that the participatory engagement and action commonly used in community development programmes can be used in refugee settings as well.
4. **Refugees should play genuine leadership roles in refugee health programme design, implementation and evaluation.** Far from being passive recipients of humanitarian assistance, refugees possess skills to build more community-driven refugee health programmes to prevent HIV transmission and provide care, treatment and support. It is recommended that where an AIDS Committee can be established in refugee communities, it should serve as the multisectoral and broadly participatory coordinating body for all HIV-related programmes for refugees. The AIDS Committee should coordinate with the Food Management Committee on issues related to food, nutrition and HIV. To facilitate this coordination, the Food Management Committee should include an HIV focal point; equally the AIDS Committee should include a Food and Nutrition Focal Point, charged with liaising with food and nutrition-related activities.
5. **The most commonly implemented refugee food and nutrition programmes—general food distribution, supplementary, therapeutic and school feeding programmes—can be integrated into HIV prevention strategies by incorporating behaviour change communication, community engagement and action activities (Strategies 1–4)<sup>43</sup>.** Programme implementation should build upon the three preceding steps. First, an HIV assessment should be conducted to determine approximate HIV prevalence in the population (using proxy indicators if sentinel surveillance or population-based surveys have not been undertaken) and in populations at higher risk of exposure to HIV to determine the main sources of infection. Second, qualitative formative research should be conducted to develop appropriate HIV

messages for the programme's target audience, which clearly differs enormously among these four types of interventions. Third, an operations' assessment should help to ensure that incorporation of HIV activities will not detract from the effectiveness of the food/nutrition programme itself, by considering key operational factors like site planning and planning for adequate staff resources. Food/nutrition programme staff members will require additional training on HIV if these activities are incorporated, even if the AIDS education is conducted by external groups. These programme strategies may have a larger effect if an epidemic is generalized (i.e. a population prevalence of at least 1%) than if only selected populations at higher risk of infection are affected

The starting point for implementing these activities is the establishment of the AIDS Committee and Food Management Committee, to oversee programme development. It is important that these prevention-focused behaviour change communication activities are linked and coordinated closely with health (including voluntary counselling and testing, prevention of mother-to-child transmission and care for opportunistic illnesses), social welfare and protection services. If the food/nutrition programme is a supplementary feeding programme, it can be linked to voluntary counselling and testing and prevention of mother-to-child transmission. Behaviour change communication initiatives should aim to address safe infant feeding in the HIV context. Where replacement feeding is not acceptable, feasible, affordable, safe and sustainable, exclusive breastfeeding for the first six months of life is vital. Engagement of community music, dance and drama groups helps to reduce risk of stigmatization associated with the illness and build health education skills in these groups.

**6. Food and nutrition programmes can support the objectives of providing care and support for people living with HIV and vulnerable groups through: modifying rations to better meet nutritional needs of people living with HIV and their families, modifying programme operation factors to ensure people living with HIV have access, and strengthening food and livelihood security of AIDS-affected households (Strategies 5–12).**

HIV infection increases nutritional requirements by 10% in the case of asymptomatic HIV infection, and 20–30% in the case of symptomatic HIV infection or AIDS<sup>44</sup>. The importance of an adequate general ration is increased in AIDS-affected populations. Though evidence-based guidelines have not yet been established on how a general ration's energy content should be adjusted in light of HIV, the cost of increasing the ration for all beneficiaries to meet the increased nutritional requirements of people living with HIV would be considerable, while increasing the ration to meet the average nutrition requirements (including the HIV-infected and uninfected alike) would result in minimal changes to the ration. Highest priority should be given to ensuring that the full ration entitlement is provided without interruption, with 10–12% of total energy coming from protein and at least 17% from fat. There is no evidence for increased protein intake requirements by people infected with HIV. A local assessment should be conducted to determine if additional resources should be used to increase the general ration or support targeted feeding programmes for people living with HIV.

Apart from increasing the general ration, operational changes can help to ensure that people living with HIV have access to the general ration, including: providing milled and micro-nutrient-fortified staples rather than cereals alone; including fortified blended foods; and engaging social workers or community volunteers to distribute the ration directly to households who, because of illness, may have difficulty collecting the ration.

Where the general ration has not been increased to account for HIV, targeted supplementary feeding programmes may be implemented, particularly where the eligibility criteria are broadened to offer nutritional support to people living with HIV. In this case, the supplementary feeding programme should be closely coordinated with health facilities. A critical constraint of targeted supplementary feeding programmes is the bias towards individuals who are seropositive, know their status and are willing to disclose it, and are physically ill, thus excluding the majority of the population living with HIV.

Provision of a ration through school feeding programmes as an HIV intervention should only be considered where it is clearly demonstrated that a drop in school attendance by children living in HIV-affected households can be reversed by school food distribution. This intervention should be considered a short-term measure until longer-term support measures can be implemented for HIV-affected households. Similarly, provision of a ration to foster families and orphanages can ensure that food needs are met for orphans and vulnerable children during food crises, but more comprehensive food security programmes are necessary in the long term.

Key food security programmes that should be considered include home gardens and agricultural plots (with appropriate support), income generating activities, microcredit and community banking, training and skills development. Food and food-related resources (e.g. seeds, tools) can be used as programme inputs as in the case of home garden projects; alternatively food can be used to enable people living with HIV to participate in training programmes and other activities.

**7. Nutritional support and nutrition education can be established as integral components of health care and treatment services used by people living with HIV, such as through inpatient hospital services, home-based care and antiretroviral therapy programmes (Strategies 13–16).**

The logistical and financial implications of a hospital inpatient feeding programme may be justified where a high percentage of hospital inpatients seek care for HIV-related conditions; and where the lack of food is known or suspected to result in adverse health outcomes in these patients. To avoid stigmatization, inpatient feeding would cover all patients, rather than targeting those people living with HIV. To enhance longer-term nutritional status, this programme should be accompanied by nutritional education. An activity that has demonstrated success in the field is the establishment of demonstration gardens at hospitals, which provide food for the inpatient feeding programme as well as enable education about cultivation and hygienic preparation of nutrient-dense crops for those with acute and chronic illness.

Equally, nutritional support can be integrated into community-level health care for people living with HIV. Home-base care programmes and other antiretroviral therapy programmes can provide a supplementary ration with nutrition education. The ration should ideally include fortified blended foods, with the cereals and grains fortified prior to distribution, as well as fresh fruits and vegetables if possible. Provision of the ration is designed to increase the effectiveness of the treatment in suppressing the virus, boost the person's strength and promote overall health and immunity.



**8. Food and nutrition resources can be used to support training and capacity-building activities for clinic-based and community-based AIDS-care providers, or support the establishment or continuation of community-level AIDS-related activities (Strategies 17–20).**

As with all food-based programmes, the use of food as an incentive must follow a careful assessment that determines that food is an appropriate incentive resource. Where this is assured, food can be used to support training for formal/clinic-based health care providers (e.g. nurses and assistants), traditional/community-based health care providers (e.g. traditional healers, traditional birth attendants) and other community resource persons who can play a central role in HIV efforts. Although stable refugee settings often exhibit better health service availability than surrounding host communities, refugees often use a combination of clinic-based and traditional health services. Enlisting health personnel in the HIV education, prevention, care and treatment effort requires building capacities of both clinic-based and traditional health personnel—in partnership whenever possible.

## INCORPORATING HIV-RELATED ACTIVITIES INTO FOOD AND NUTRITION PROGRAMMES IN REFUGEE SETTINGS

### Incorporating HIV prevention into food and nutrition programmes

- ✘ **Strategy 1** Incorporation into a general food distribution of activities designed to promote community engagement and action around HIV prevention
- ✘ **Strategy 2** Incorporation of AIDS awareness and HIV prevention activities into a supplementary feeding programme
- ✘ **Strategy 3** Incorporation of AIDS awareness and HIV prevention activities into a therapeutic feeding programme
- ✘ **Strategy 4** Incorporation into a school feeding programme of activities designed to promote knowledge/engagement around HIV among young people

### Incorporating care and support for HIV-affected, vulnerable groups into food and nutrition programmes

- ✘ **Strategy 5** Modification of a general food distribution programme to better meet the needs of people affected by HIV
- ✘ **Strategy 6** Modification of a supplementary feeding programme to better meet the needs of population subgroups affected by HIV
- ✘ **Strategy 7** Support for AIDS-affected families and children through a school feeding programme
- ✘ **Strategy 8** Support for AIDS-affected families and children through provision of a complementary ration to foster families and orphanages
- ✘ **Strategy 9** Support for the establishment of home gardens and agricultural plots for people living with HIV and for AIDS-affected families
- ✘ **Strategy 10** Support for income-generating activities, microcredit and community banking, training and other capacity-building activities for people living with HIV and AIDS-affected families
- ✘ **Strategy 11** Support for food-for-work (FFW) projects that employ or directly assist people living with HIV and members of AIDS-affected families
- ✘ **Strategy 12** Support to enable and encourage participation by HIV-infected individuals in community groups formed by people living with HIV

## INCORPORATING FOOD AND NUTRITION ACTIVITIES INTO HIV PROGRAMMES IN REFUGEE SETTINGS

### Incorporating food and nutrition support into health care and treatment services for people living with HIV

- ✘ **Strategy 13** Establishment of an inpatient hospital/clinic feeding programme with nutrition education
- ✘ **Strategy 14** Establishment of a hospital/clinic demonstration garden with nutrition education
- ✘ **Strategy 15** Integration of a supplementary ration and nutrition education into a home-based care programme
- ✘ **Strategy 16** Integration of a supplementary ration and nutrition education into an antiretroviral therapy programme

### Incorporating food and nutrition resources to support training and capacity-building activities for clinic-based and community-based AIDS-care providers, or support the establishment or continuation of community-level HIV-related activities

- ✘ **Strategy 17** Support for training and other capacity-building activities for formal and traditional health care providers
- ✘ **Strategy 18** Support for training and other capacity-building activities for community resource persons who can play a vital role in HIV prevention efforts
- ✘ **Strategy 19** Support to community health volunteers engaged in HIV prevention or caring for people living with HIV and AIDS-affected families
- ✘ **Strategy 20** Support to community awareness and mobilization activities of people living with HIV

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The Joint United Nations Programme on HIV/AIDS (UNAIDS) brings together ten UN agencies in a common effort to fight the epidemic: the Office of the United Nations High Commissioner for Refugees (UNHCR), the United Nations Children's Fund (UNICEF), the World Food Programme (WFP), the United Nations Development Programme (UNDP), the United Nations Population Fund (UNFPA), the United Nations Office on Drugs and Crime (UNODC), the International Labour Organization (ILO), the United Nations Educational, Scientific and Cultural Organization (UNESCO), the World Health Organization (WHO), and the World Bank.

UNAIDS, as a cosponsored programme, unites the responses to the epidemic of its ten cosponsoring organizations and supplements these efforts with special initiatives. Its purpose is to lead and assist an expansion of the international response to HIV/AIDS on all fronts. UNAIDS works with a broad range of partners – governmental and nongovernmental, business, scientific and lay – to share knowledge, skills and best practices across boundaries.

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- is a series of information materials from UNAIDS that promote learning, share experience and empower people and partners (people living with HIV, affected communities, civil society, governments, the private sector and international organizations) engaged in an expanded response to the AIDS epidemic and its impact;
- provides a voice to those working to combat the epidemic and mitigate its effects;
- provides information about what has worked in specific settings, for the benefit of others facing similar challenges;
- fills a gap in key policy and programmatic areas by providing technical and strategic guidance as well as state-of-the-art knowledge on prevention, care and impact-alleviation in multiple settings;
- aims at stimulating new initiatives in the interest of scaling up the country-level response to the AIDS epidemic; and
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In 2003 UNHCR, WFP, and UNICEF launched a joint effort to develop, through multi-site field research in refugee communities in Africa, a set of strategies for using food and nutrition-based interventions to support HIV transmission prevention, impact mitigation, and care, treatment, and support for people living with HIV. This important collaborative initiative grew out of the recognition that refugee settings are unique. It was recognized also that specific research is required conducted among and with refugees. This Best Practice document discusses the research process and findings of this interagency initiative.

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