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Social Protection in the Era of HIV and AIDS

Examining the Role of Food-Based Interventions

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TABLE OF CONTENTS

1. Introduction **4**

2. What is social protection? **5**

Breaking down the terminology

Safety nets. What are they and where do they fit in?

Social protection systems in developing countries

Flexibility and reliability

Who should be responsible for social protection?
Coherence under a national framework

3. Why is social protection important and how have perspectives changed? **9**

Old views, new views

A human right or humanitarianism?

Key Issues: Conditionality **12**

4. Social protection in the context of HIV and AIDS **13**

The impact of HIV and AIDS

A question of supply and demand

What are the considerations?

1. Reinforcing community safety nets may not be enough
2. Promotion of livelihoods: not just protection
3. Accepting increased numbers of social welfare cases
4. An integrated strategy that supports the continuum of care
5. Putting transformational thinking into action

Key Issues: Dependency **18**

5. Food, HIV and AIDS and social protection **19**

The special role of food

1. Clarify the specific objectives of the intervention
2. Understand the way that HIV, food and nutrition security interact
3. Consider the context for food versus cash

6. Targeted social transfers in the context of HIV and AIDS **24**

Nutrition, health care and treatment

Livelihood support and asset creation

Education and support to vulnerable children

Operational considerations

7. The challenge of targeting **32**

The use of proxies

Key Issues: Equity **34**

Key Issues: Predictability **35**

8. The role of WFP in social protection for HIV and AIDS **37**

Knowledge orientation

Policy and strategy orientation

Programme orientation

Acronyms **40**

References **41**

Endnotes **42**

Box End Notes (BEN) **43**

1. INTRODUCTION

The concept of social protection has become the subject of ardent debate among international policy-makers and global think tanks. But what exactly does the term social protection mean? Is it different from social welfare or social safety nets? How and why have perspectives changed over the past decade? And finally, how is all this relevant to development practitioners who are implementing programmes on behalf of the poor?

Social protection is a relatively new and evolving area. Certainly, it owes much of its recently-gained attention to the HIV and AIDS pandemic, which has forced a re-think on 'what works' in support of protecting and promoting the livelihoods of poor and vulnerable people.

> Social protection could reasonably be described as **'safety nets for the new millennium'** – broader in its scope and ambition, better conceptualized, politically more acceptable, and with greater potential to achieve sustainable impact on poverty.
>
> *Devereux, 2002*

This document attempts to break down the terminology and conceptual thinking around social protection (Section 2); examines changes in perspectives over recent decades (Section 3); looks at implications and opportunities for social protection in light of the HIV and AIDS pandemic (Section 4); and examines possibilities for the use of food-based approaches within these scenarios (Section 5).

While it is widely recognized that food assistance alone will not address the complex needs of people living with HIV and AIDS – and affected households and communities – food and nutrition support do have an important role to play within an integrated framework of social protection. For example, in the struggle to provide the poor with unconstrained access to anti-retrovirals, positioning food support within a comprehensive package of care, treatment and support is essential in order to optimize treatment outcomes and overall investment returns on the global roll-out. Using food as part of asset creation and the promotion of livelihoods is also extremely relevant in an HIV and AIDS context where human assets such as health, knowledge, skills and awareness can improve livelihood opportunities for those affected by HIV and AIDS (Section 6).

The subject of social protection has gained prominence in international policy-making circles, but the debate at this level has been fuelled mainly by discussions within developing countries. A WFP review of social protection systems in four southern African countries noted that ministries of social welfare, health and education, and other local stakeholders, struggle to meet increased demand for services mainly due to the impact of HIV and AIDS, while facing severe capacity and resource limitations (also due mainly to the impact of HIV and AIDS). The study also suggests that there is broad recognition of the need to build bridges horizontally (across sectors) and vertically (between informal, semi-formal and formal social protection actors) to form a more holistic and cohesive response[1].

This document is written for a dual audience. First, it is geared towards WFP staff and other food-based actors such as international and local non-governmental organizations (NGOs) and government partners. It aims to introduce various aspects of the social protection debate and encourage examination of new and existing food programming through the lens of that debate. And secondly, it is written for non-food actors within governments, United Nations agencies and NGOs as a means of encouraging the integration of food-based initiatives (where appropriate and relevant) into the emerging social protection agendas in developing countries.

More generally, the document seeks to stimulate discussion, raise questions and encourage links

between new thinking in social protection and programming in support of the poor and vulnerable, with a special focus on individuals and households affected by HIV and AIDS.

2. WHAT IS SOCIAL PROTECTION?

Breaking down the terminology

The terms social protection, social welfare and social safety nets are often used interchangeably. In conventional terms, they describe transfers of food, cash or other in-kind contributions to poor and vulnerable groups, in response to poverty or threats to their livelihoods. New thinking, however, has emerged which broadens the notion of social protection. "Social protection is more recently conceptualized as an 'overarching framework' that goes beyond mere transfers and towards comprehensive policies."[2] Along these lines, safety nets and welfare mechanisms are not equal to social protection, but are rather considered components of a social protection framework.

It is important to recognize that social protection means different things to different people; there is no commonly agreed definition. A common purpose across most definitions, however, is to protect society's most vulnerable members through the provision of certain goods and services, including health, education and social services that provide financial, material, social or psychological support to people who are otherwise unable to obtain it through their own efforts.[3]

Whereas social protection approaches have traditionally sought to protect the livelihoods of vulnerable groups, recent debates have focused on the need to advance the concept beyond protection and towards actively promoting livelihoods using a framework that draws on various types of mechanisms. This expanded perspective has implications in the context of the HIV and AIDS pandemic, particularly with reference to food assistance and food aid, and will be discussed throughout this paper.

Definitions of Social Protection

WFP Integrated systems of institutionalized national measures, which may include contributory pensions, insurance schemes and safety nets. Safety nets are further defined as the social protection component targeted at the most vulnerable sections of a population.

Overseas Development Institute (ODI) A range of processes, policies and interventions to enable people to reduce, mitigate, cope with and recover from risk in order that they become less insecure and can participate in economic growth.

Institute of Development Studies (IDS) and the **United Nations Children's Fund (UNICEF)** All public and private initiatives that provide income or consumption transfers to the poor, protect the vulnerable against livelihood risks and enhance the social status and rights of the marginalized; with the objective of reducing the economic and social vulnerability of the poor, vulnerable and marginalized groups.

Governments and donor agencies increasingly recognize the need to provide protection for the poor against income fluctuations or livelihood shocks. In this context, 'social protection' is an umbrella term covering a range of interventions, from formal social security systems to ad hoc emergency interventions to project food aid *(e.g. school feeding, public works, etc.).*

Devereux, 2002

Social protection mechanisms may include anti-discrimination legislation, contributory insurance schemes, pensions for the elderly and disabled, grants to orphan caregivers, food stamp programmes, school feeding, anti-stigma campaigns and a litany of other interventions. In a recent working paper[4], the Institute of Development Studies (IDS) categorizes these measures into four groups, which helps to reveal their purpose:

- protective – providing relief from deprivation;
- preventive – seeking to avert deprivation;
- promotive – aimed to enhance real incomes and capabilities; and
- transformative – addressing social equity and exclusion.

Safety nets. What are they and where do they fit in?

As noted above, safety nets may be described as one piece of the social protection picture, which usually include some type of targeted social transfer of cash, food or other inputs. In older literature, safety nets are seen as protecting the chronically poor and most vulnerable members of society, though some would say they can also act in a preventive manner for those who have the potential to fall into poverty if conditions deteriorate. Some emphasize that safety nets not only ensure that livelihoods are not lost, but are also built upon while assisting those in need. And in most cases, they are characterized by their predictable and institutionalized nature. Some prominent thinkers on the topic make a further distinction between safety nets and welfare mechanisms, noting that safety nets are aimed at the 'poor but able', while welfare mechanisms are aimed at the 'poor and unable' (e.g. disabled, chronically ill, etc.).[5] Again, there is little agreement on these distinctions, although the terminology is frequently used.

Safety nets are also defined as tools that governments, United Nations agencies, international NGOs and other partners in development can use to preserve opportunities and give hope to the poor. When properly designed, safety nets offer an institutionalized set of mechanisms to help households in distress cope with shocks and meet their minimum consumption requirements.[6] Food-based safety nets are a subcategory of safety nets that provide food to beneficiaries either directly or indirectly through food stamps, vouchers and coupons.

Safety Nets

WFP defines safety nets as a component of social protection systems. When properly designed, safety nets provide a predictable set of institutionalized mechanisms to help households in distress cope with shocks and meet their minimum consumption requirements.

Social protection systems in developing countries

Social protection systems can be elaborate and based on a fairly sophisticated infrastructure, such as the provision of social security or food stamps in the United States. Even in some moderately developed countries such as South Africa, Namibia and Botswana, systems can be well established and play a particularly important role in reducing poverty.[7]

However, the vast majority of social protection systems in developing countries, where they exist at all, are not designed to be comprehensive. At a minimum, they provide limited support to existing coping strategies so that risks are more manageable and livelihoods do not suffer dramatic setbacks when faced with shocks.

Most systems are under-resourced and susceptible to environmental shocks, currency fluctuations, corruption, mass population movements and emergencies in general. They also face communication constraints, especially with rural populations. Many people don't know how to access services, or they have to travel so far to receive them that they become ineffective, or they are not even

aware of the services to which they are entitled. Finally, limited infrastructure and human resource capacity are common problems and are discussed in more depth later in this paper. In short, in shock-prone, chronically poor countries, social protection is often equal to ill-equipped social safety nets.

The United States Food Stamp Program provides low-income households with coupons or electronic benefits that can be used like cash at most grocery stores to ensure they have access to a healthy diet. The Food Stamp Program is the cornerstone of the federal food assistance programmes, and provides crucial support to needy households and to those making the transition from welfare to work. Eligibility is based on means testing for resources and income of applicant households. *(BEN1)*

Old-age pensions in South Africa and other middle-income countries are frequently shared within households and can have a significant impact on poverty for the elderly and their dependents. In South Africa, an estimated seven to nine dependents are supported by each social pension. In drought years, this income is redistributed to food-insecure relatives; in 'normal' years it contributes to reducing child poverty by paying for the education and child-rearing costs of pensioners' grandchildren. Increasingly, as grandparents become unpaid caregivers for orphans, the social pension is a vital source of support for orphans and other vulnerable children and for HIV-infected adults. *(BEN2)*

Flexibility and reliability

Effective social protection measures are flexible and available to the poor in a reliable manner. Studies of transitory vulnerability, in contrast to chronic vulnerability, suggest that some individuals (or households) are more or less vulnerable to shocks depending on the time of year (e.g. point in the agricultural season) or their stage in recovery from a previous shock. To protect and promote their livelihoods, social protection measures should consider the ebbs and flows in capacities of those individuals and provide assistance accordingly. Likewise, specific measures need to be available to the chronically poor and vulnerable, defined as those who have never recovered from a severe shock such as a debilitating illness or loss of assets. Similarly, effective measures should also be available on a consistently reliable basis so that candidates for assistance can manage their risk based on the knowledge that safety nets and other measures are readily accessible in times of need.

Who should be responsible for social protection?

There are a variety of actors that play a role in providing social protection to the poor and vulnerable. These actors can be broken down into three categories: informal (families and communities); semi-formal (United Nations agencies, NGOs and community- or faith-based organizations (C/FBOs)); and formal (government).

The institutional capacity of these groups can vary greatly in developing countries. In the WFP review of social protection systems in southern Africa, families and communities were able to provide the highest quality support and had the most impressive outreach and array of services. They were also the ones with the lowest levels of resources and management capacity. Furthermore, their capacity to cope and provide necessary resources was deteriorating rapidly due in large part to the impact of the HIV and AIDS pandemic.

Conversely, United Nations agencies and international NGOs, which had the highest levels of resources, had a limited outreach and range of services. The study noted that the semi-formal system is often characterized by incoherence and lack of stability, with the formal system holding the official mandate, but with the lowest capacity to implement.

Assessment of Capacity of Social Protection Actors in Mozambique[8]

Provider	Outreach	Array	Quality	Resources	Management
Informal					
Families	Very high	Very high	Very high	Very low	Medium
Communities	Very high	High	High	Very low	Medium
Semi-formal					
WFP	Medium	Very low	High	High	High
UN agencies	Low	Low	Medium–High	Medium–High	High
Int'l NGOs	Medium	Medium	High	High	High
National NGOs	High	Medium	Medium	Low	Low
Faith-based org's	Medium–High	High	High	Low–medium	High
Formal					
INAS*	Very low	Medium	Low	Low–Medium	Medium
MISAU**	Very low	Medium	Medium	Medium	Medium

* National Institute for Social Action
** Ministry of Health

Considering that the protection mandate typically sits with the national government, international organizations are advised to engage with the relevant government institutions in order to create a conducive policy environment for social protection mechanisms to be implemented. Implementation, however, is often beyond the ability of the national authority, unless in partnership with other actors such as international and national NGOs. Similarly, these NGOs rely on partnerships with the community to judge the nature and severity of the need, and to ensure that benefits are well targeted. Clearly, the successful provision of social protection relies on a myriad of partnerships. To be effective, the mandates, strengths and weaknesses of each group should be carefully considered and maximized.

Coherence under a national framework

A particular challenge in developing countries is ensuring coherence between national policies, strategies, programmes and activities in promotion of social protection. WFP's review of systems in Malawi, Mozambique, Swaziland and Tanzania emphasized the need to formulate a national policy on social protection, as well as an overarching strategic framework to guide the provision of resources from various actors in terms of both geographic and technical coverage. It is especially important that the framework recognizes the cross-sectoral nature of social protection and the importance of working towards common goals irrespective of sectoral biases.

Building mechanisms under the umbrella of a common strategic framework can facilitate improved integration of the various development and relief interventions that exist (often side by side) in a given country. The increasingly popular developmental relief approach, which evolved from the more rigid relief-to-development continuum of the early 1990s, is facilitated where there is cohesion under a common framework.

WFP's draft policy and guidance for country offices will assist staff for engaging in national Poverty Reduction Strategies. This is intended not only to

Sierra Leone Laying the Groundwork for National Safety Nets

Sierra Leone had just emerged from over ten years of civil conflict that ravaged the country. The new government was committed to the development of a social protection strategy as part of its wider poverty reduction strategy. WFP took on three important roles in assisting the government and civil society in this transition. First, it served as an advisor in the development of the Poverty Reduction Strategy Paper (PRSP) and an advocate for food-based safety nets and was involved in the development of the first National Food Security Strategy document, which highlights the value of food-based safety nets. Second, it used vulnerability analysis and mapping (VAM) as a tool for analysing a national household survey. And third, it began developing a country programme that included safety-net interventions implemented in partnership with the government, which serve as models and build capacity for future institutional safety nets.

Malawi Food-based Interventions in the Context of a National Safety Net Strategy

In Malawi, the WFP country office was involved in the planning and implementation of the country's National Safety Nets Programme. In response to the country's worsening economic conditions and high HIV prevalence, in 2003 the WFP country office helped to develop a Joint Integrated Food-Based Safety Net Programme. The country office was instrumental in building a coalition of government ministries, donors and NGOs in support of the programme and in developing many of its components. WFP has since implemented several activities under the safety net programme, including a targeted nutrition intervention. WFP's involvement in Malawi's national safety net is an example of how food-based interventions can be integrated into coherent national strategies for livelihood protection and promotion.

promote food security, nutrition security and emergency preparedness within national agendas, but also to ensure that WFP's programmes are aligned and integrated within the strategic frameworks set out by the national governments and their partners in development.

WFP's 2004 paper on food-based safety nets describes how WFP has engaged in the development of national policy for social protection by establishing and/or strengthening food-based safety nets in a variety of countries, including Sierra Leone and Malawi (WFP, 2004b).

3. WHY IS SOCIAL PROTECTION IMPORTANT AND HOW HAVE PERSPECTIVES CHANGED?

Our understanding of poverty has evolved considerably over the last several decades. One of the important lessons from the 1980's and 1990's was that the problem of poverty is not solved by focusing exclusively on economic growth, because the opportunities that growth provides are not always equitably distributed. Even worse, as happened under structural adjustment policies, growth can exacerbate disparity and leave the poor unprotected. In promoting 'Pro-Poor Growth' combining social protection with policies that boost economic growth, it is necessary to ensure that the poor share access to some of these

benefits which enable them to manage their risk and reduce their vulnerability more effectively.

There are persistent attitudes that social protection systems are costly, inefficiently-managed state mechanisms that do little more than breed idleness and dependency. However, there is mounting evidence to the contrary. When they are well designed, managed by institutions with adequate capacity and placed within a broader strategic framework, social protection systems can be affordable and not only save the poor from destitution, but actually empower them towards self-reliance. The table below depicts how views have begun to change in recent years.

In addition, old views tended to provide social protection measures as projects instead of working to institutionalize their benefits. Measures were often seen as external and ad hoc to national systems,

Old Views	New Views
Social protection is primarily a form of welfare transfer, with little or no impact beyond **immediate consumption.**	Social protection schemes also **have longer-term impacts** that are not immediately visible.
School feeding is a short-term means of **protecting the nutritional status** of the child.	When provided early in the school day, school meals **enhance learning**, and over the long term **increased attendance** in school may lead to a **healthier, more educated and productive** generation of adults. Take-home rations also act as an income transfer, **preventing families from facing the purchasing dilemma** between food and other essential costs such as education, medical care, agricultural inputs, etc.
Social protection mechanisms are a humanitarian gesture that can be provided to destitute individuals/families as a last resort. They **breed idleness and dependency,** and leave recipients once again vulnerable after assistance is withdrawn. Social protection mechanisms may be deployed on a short-term basis to **'protect'** livelihoods.	To be effective, social protection should provide coverage to both those who are unable to support themselves and those who are 'able but vulnerable', with different types of interventions geared towards each. Effective social protection not only serves the **humanitarian imperative** but protects health and productivity, especially through **reducing reliance on negative coping strategies** that put people at risk. Social protection can go beyond simply protecting livelihoods to the **promotion** of livelihoods. When designed properly, it can facilitate asset accumulation (including human assets such as health, knowledge, skills, etc.), **building household resilience** to withstand future shocks. Ideally, it also helps households to begin **saving and investing.**
Public works/food-for-work (FFW)/food-for-assets (FFA) projects provide **temporary work** for otherwise unemployed individuals. The food ration provides **short-term support** to food-insecure families and also serves to diminish the risk of dependency or the appearance of 'free food handouts'. The choice of work project is secondary to the primary consideration of providing food to the worker and his/her family.	These programmes prevent food-insecure households from selling off their household assets. The physical infrastructure created by the intervention (e.g. a kitchen garden, a seed bank, feeder roads to markets, etc.) represent **newly-created** (or **rehabilitated) productive assets** that are intended to make households/communities **more self-reliant in the future.** And finally, the **newly-created human assets** (knowledge and skills) better prepare them to be productive in the future.

whereas new thinking places them prominently within national frameworks.

A human right or humanitarianism?

What is new about today's concept of social protection is the link it makes between social assistance and wider objectives relating to vulnerability, growth and rights. "Today the challenge is whether… a narrow approach to social protection (developed in the 1990s and designed predominantly to prevent the poor from becoming destitute) can also play a role in creating conditions for persistently poor people to emerge from poverty and even interrupt some of the structural patterns which maintain people in poverty."[9]

The ethos underpinning social protection in developing countries is one of charity rather than entitlement – humanitarianism, not human rights.

Unlike social security benefits, targeted transfers are not guaranteed in developing countries (citizenship does not confer an entitlement to minimum income security)…

IDS Working Paper 142: Social Protection for the Poor

This relatively new aspect of social protection thinking is referred to as transformational. It looks at issues related to equity, empowerment and economic, social and cultural rights, rather than limiting the discussion to income transfers. Using rights-based approaches, transformational social protection focuses on social equity and encourages responses that reduce prejudice and the stigmatization of vulnerable groups. It attempts to change the understanding of social protection as charity or humanitarianism, putting it in the context of human rights and entitlements.

Economic growth is an important aspect of the debate. In many poor countries, social protection continues to be viewed as fiscally unsustainable and a wasteful diversion of public resources that are better spent on economic growth initiatives. Recent research, however, indicates that social protection measures can contribute to poverty reduction and economic growth, and may be more affordable than previously thought. A recent IDS paper[10] notes two ways that social protection contributes to economic growth: **1) directly** – via redistributive transfers that raise the income of the poor and smooth their consumption, allowing them to engage in moderate risk-taking and protect (rather than erode) assets when facing livelihood shocks; or, **2) indirectly** – through asset creation (e.g. infrastructure through public works, school feeding to increase human capital) and income or employment multipliers.

Without social protection, households engage in risky behaviour – negative coping strategies such as selling off their assets, taking children out of school, engaging in transactional sex, etc. – which is inevitably very costly to any household. On a macro level, mounting food or livelihood insecurity can eventually require an expensive relief effort. While developed countries have long incorporated social protection mechanisms into

In three southern African countries, poverty headcounts among beneficiary households fell significantly for as long as income transfers continued. The higher the value and longer the duration, the more the households were able to acquire productive assets, invest in farming and informal economic activities, save, and provide assistance to their relatives. Secondary benefits of these safety nets included not only the participants' immediate and extended families, but also local traders and others who benefited from income multipliers generated by spending.

(BEN3)

Zambia is piloting a social cash transfer scheme (at a cost of 0.5 percent of gross domestic product) targeted at the poorest 10 percent, those with no able-bodied labour and high dependency ratios. **Mozambique** is trying out a food subsidy programme for citizens unable to work and with no income, in urban/peri-urban areas. Eligibility is based on means testing, proxy indicators (age, disability) and health status (chronically ill). Expansion to rural areas is planned.

Both countries are hopeful that these social protection mechanisms will have lasting effects on poverty at a relatively lower cost than relief responses, which have become a regular feature in their national portfolios.

(BEN4)

national strategies, some countries with fewer resources have also begun to experiment with this. However, most social protection programmes are too piecemeal and ad hoc to have such far-reaching effects as livelihood promotion and economic development.

Those with the highest likelihood of success are flexible and accessible in a reliable manner – two features that often conflict with the formats of international assistance packages when implemented independently.

Key Issues: Conditionality

Is it appropriate for conditions to be placed on the receipt of basic entitlements? Don't material benefits such as food, shelter and health care constitute basic human rights? Conversely, do material benefits that come unconditionally work against principles of self-sufficiency, and even worse, foster dependency? How can the poor be expected to take initiative if they continually receive hand-outs?

'Unconditional' benefits: While social security benefits in industrialized countries are often provided unconditionally to principle care-givers (in support of the care/development of their children) this kind of support is viewed by many as promoting idleness and dependency and undermining the work ethic.

Some argue that developing countries have neither the administrative infrastructure nor the budgets to create nationwide social protection mechanisms. Others, however, point out that a predictable and permanent safety-net mechanism would be less costly than repeatedly mounting relief efforts when communities lack resilience to withstand shocks.

'Conditional' benefits: Placing conditions such as active participation (e.g. FFW/assets schemes) on the receipt of material benefits (food or cash) is generally considered appropriate in relation to able-bodied individuals. But when dealing with the exceptionally vulnerable (e.g. young children, elderly or pregnant/lactating women), should conditionality be removed altogether? Or should it be modified to softer, self-care-oriented conditions such as requiring use of health services or sending children to school?

It is important to consider the availability and quality of social services. While placing conditionalities on social transfers is far more popular in Latin America than in Africa, this may be due (at least in part) to the fact that there is little advantage in requiring children to attend schools or clinics where public services are insufficient.

Food aid agencies often attach conditions of active participation to the receipt of food rations. Food is seen as a powerful incentive towards the creation of productive assets –- from community infrastructure (physical assets) to education and skills (human assets), which ultimately improve productivity and promote livelihoods. Conditionality is also used in the context of HIV and AIDS. Food is attached to prevention of mother-to-child transmission of HIV (PMTCT); to Directly Observed Treatment, Short-course (DOTS) for tuberculosis (TB) programmes (encouraging uptake and adherence to services); and to anti-retroviral therapy (ART), promoting adherence to treatment regimes.

A government-run programme in **Mexico** entitled *Oportunidades* provides transfers for each child on the condition of consistent school attendance and uptake of basic health services. Placing responsibilities on the beneficiary (or his/her care-taker) is increasingly popular in Latin America, and influenced by welfare thinking in the United States and Western Europe.[11] The overall cost is only 0.32 percent of Mexico's GDP.

In **Zimbabwe and Zambia,** rations of corn-soya blend (CSB) are linked to adherence to the TB DOTS and ART treatment regimes. In a study conducted by C-SAFE in February 2005, a commonly mentioned impact of the food assistance was an increase in treatment acceptability and ease of adherence with drug regimens (for TB and ART). One study has shown that among a small sample of treatment interrupters, lack of money for food was seen as a barrier to treatment adherence.[12]

4. SOCIAL PROTECTION IN THE CONTEXT OF HIV AND AIDS

The impact of HIV and AIDS

The impact of the HIV pandemic on household vulnerability is extensively documented. Communities and households already living on the edge have been made more vulnerable by the complex consequences of HIV and AIDS. Below are some of the most commonly cited impacts:

- reduced household labour capacity, affecting agricultural production at the household and community levels;
- household income diverted from investment, savings and spending on basic essentials and instead used to cover medical expenses, funerals and other illness-related costs;
- time and effort dedicated to care-taking instead of household production or income;
- intergenerational knowledge (life skills, agricultural techniques, etc.) not passed down since parents are ill or dying before children come of age;
- children withdrawn from school to help with household chores and care-taking;
- increasing number of orphans and extra burden placed on the households that host them;
- increased demand on health systems because of the greater number of chronically ill; and
- reduced capacity of health systems because health practitioners (and their families) are also directly affected by the disease.[13]

This picture, already disheartening, is incomplete without the added complications of food and nutrition insecurity. HIV has particular relationships to each of these, which are becoming clearer as the body of research and documentation grows.

A question of supply and demand

Considering the vast and dramatic impact of HIV and AIDS on communities, households and individuals living with the virus, the aspects of demand and supply merit further examination when we discuss social protection in a high HIV prevalence context.

Informal Safety Nets in Malawi Strained from Impact of HIV Pandemic

The combination of poverty and HIV and AIDS in Malawi has severely strained the resources of kinship-based safety nets due to the sheer numbers of HIV-affected and poor households. Caregivers of ill family members are increasingly resorting to *ganyu*, or informal wage labour, for their cash needs. Traditionally *ganyu* has been a common form of informal social protection, as better-off households both needed and were expected to provide agricultural employment for the less wealthy. As *ganyu* has become a central coping strategy for HIV-affected households, growth in the labour supply has lowered wages and increased competition for employment. This competition reduces the bargaining power of already vulnerable casual labourers, particularly women, to the extent that transactional sex is increasingly being incorporated into *ganyu* contracts in exchange for a chance to work.

(BEN5)

Demand (for social protection): Traditional shocks to livelihoods such as natural disasters generally run a predictable course, with the impact and recovery trajectories experienced similarly across affected communities and geographical areas. These shocks are typically resolved in a single season, with most of the affected population recovering (albeit with assistance) to pre-shock levels of productivity. Individuals and households affected by HIV, however, are significantly more vulnerable to

external shocks than their neighbours, and thus further disadvantaged and less able to recover from them. The consequences of Alex de Waal's "new variant famine" hypothesis[14] are by now widely publicized: there is asset erosion, increased vulnerability and a new category of poor and vulnerable people not seen before. The implications for social protection systems are equally alarming: "Relatively minor shocks may be greatly magnified and require much larger humanitarian responses" due to the fact that "HIV-affected households and communities have increasingly less capacity to cope." People affected by HIV are more vulnerable to livelihood shocks; and even worse, since entire communities are affected, "People living with HIV may lose this informal assistance precisely when they need it most."[15] Finally, health care systems, which were often inadequate to begin with, are overwhelmed with increased numbers of sick people, and must assume the added burden of the anti-retroviral rollout.

Supply (of social protection): Many contend that informal safety nets are over-stretched, and even near collapse. There are fewer care-givers available (in both informal and formal health systems), since they themselves are either ill or caring for their own family members affected by the virus. "The immediate effect of the influx of financial resources has been to illuminate the precarious state of health systems in many developing countries. In the face of new health crises, some of these systems are either contracting or collapsing."[16]

Furthermore, rural families who once depended on remittances from urban kin may now bear additional burdens as those afflicted by illness return to their home areas.[17] "Vertical transfers" (from rich to poor) are disappearing in Africa, whereas "horizontal" redistribution (among the poor) remains widespread but usually has nominal impact on livelihoods. "While informal safety nets might be expected to increase in significance during economic crises, in practice, the ability of the poor to draw on informal support networks is weakest precisely when it is most urgently needed."[18]

> Supporting children affected by HIV and AIDS in the longer term will not be best served by increasing the burden on already overburdened families and communities. It calls for an urgent reappraisal of approaches to social welfare of the state.
>
> UNICEF, 2005 *(BEN6)*

With this abbreviated supply and demand analysis, how well can we expect existing social protection systems to absorb the current and future impact of HIV and AIDS? Are they showing signs of strain, or even collapse? Is a dramatic infusion of support warranted? If so, where do we start, and what are the considerations?

What are the considerations?

1. Reinforcing community safety nets may not be enough

The emphasis on community structures, community support and community-based interventions dominates policy thinking around HIV and AIDS.[19] Current levels of household poverty and vulnerability, however, should challenge our assumption that communities can be expected to extend safety nets to people living with HIV and affected households. A kind of fatigue has developed in recent years where families, neighbours and community members shun or neglect those living with HIV not due to ignorance or spite, but because they are no longer capable of lending a helping hand.[20] Families who have already experienced losses due to AIDS may have little left to offer to the friend or relative that comes seeking support or refuge. Having exhausted their resources (both emotional and financial), they have no spare capacity to cope.

According to UNICEF's recent review of social protection, "It is vitally important to expand social protection interventions to a national scale." The same study notes that requirements for expansion should include delivery systems, long-term reliable financing, the active involvement and participation of communities and avoidance of unrealistic time estimates.[21]

Mozambique – Food as Incentive for Home-Based Care Providers

In many countries, the Home-Based Care (HBC) network is considered the backbone of care and support for people living with HIV. HBC workers, however, experience a high turnover and are increasingly unable to dedicate time to volunteering due to the direct impact of HIV on their own families. In fact, a recent assessment of social protection by WFP noted that "burnout and dropout of trained activists frequently pose setbacks to safety net activities."

The provision of food assistance to HBC workers is supported by some NGOs while others believe it sets a dangerous precedent as it may discourage volunteerism and is unsustainable. WFP-Mozambique is experimenting with the use of food as an incentive, while looking at adopting other ways to compensate HBC providers. WFP, the National AIDS Council and several NGOs are lobbying the Ministry of Women and Social Action to have the government provide a standardized-rate monetary incentive.

(BEN7)

Zimbabwe – Food for Cooks

Like HBC volunteers, school cooks (who are normally parent volunteers from the community) are increasingly unable to dedicate time to cooking for school feeding because of the added burdens of care in their own homes caused by HIV and AIDS. Some NGOs in Zimbabwe are experimenting with providing food rations to support these volunteers.

(BEN8)

2. Promotion of livelihoods: not just protection

If we are to pursue recent perspectives in social protection theory, we should not be content with protection of livelihoods, food security, health, education and other entitlements. Instead, our goal should be to consider how to promote livelihoods and contribute to economic growth. Social protection's ability to make direct and indirect contributions to growth should be at the forefront of our thinking, irrespective of the modality (cash, food, agricultural inputs, etc.). FFA linking food to ART, and even school feeding can help to achieve these results when planned in an integrated manner, combined with concepts such as graduation of beneficiaries from food and nutrition support to longer-term livelihoods strategies.

The use of admission and discharge criteria is common for food programming in clinical interventions; it is less common (although equally important) to establish these criteria for non-clinical interventions. Where possible, clear discharge criteria related to changes in vulnerability (e.g. pregnancy status, health status, etc.) and improvements in food security status are realistic means of measuring a household's preparedness for being graduated from the programme, and where necessary, transferred to another form of assistance.[22]

3. Accepting increased numbers of social welfare cases

A "promotion, not just protection" approach may facilitate transformation, empowerment, poverty reduction and economic growth under normal developmental circumstances. But in a context of high HIV prevalence, if we accept the radical picture painted by new variant famine theory, "the scale of the HIV and AIDS pandemic challenges whether social protection can actually contribute to economic growth." [23]

With improved food and nutrition security, ART, management of opportunistic infections and 'positive living,' people living with HIV can often lead relatively healthy and productive lives. However, there may always be a portion of this population which is unable to stay (or become)

healthy and contribute to economic growth and recovery. Governments and donors need to recognize that while some people living with HIV may be able to graduate to self-reliance upon return to better health, others will not recover and will require long-term assistance.

4. An integrated strategy that supports the continuum of care

An understanding of the evolving needs of individuals, households and communities affected by HIV is a crucial foundation for effective planning of social protection. The needs of people living with HIV are dynamic, changing with time and disease progression. Likewise, the impacts of the disease (and consequent needs) vary depending on the level of beneficiaries targeted: individual, household or community. In the context of HIV and AIDS, flexibility and reliability (noted earlier as critical features of social protection) help provide the right intervention to the right person at the right time and for the right duration.

Analysing HIV and AIDS with a timeline framework can foster more holistic planning and the integration of responses across institutions and sectors; it facilitates the identification of appropriate responses when the participant is ready to graduate to more livelihood-oriented interventions. One example might be providing food linked to ART when the person is symptomatic and access to micro-credit once health is regained. Conversely, it facilitates an appropriate response if and when an individual's condition deteriorates and requires more intensive care and support.

Organizational linkages and well-functioning referral mechanisms are absolutely critical to optimizing the continuum of care. Connecting the various service delivery channels will help provide an integrated and comprehensive support system to the client. For example, a TB patient identified by a doctor or nurse as needing nutrition support – nutrition assessment, counselling and possibly food rations (to increase weight and support the recovery process) – is referred to an appropriate provider, who can furnish necessary nutrition services and, upon confirmation of need (based on means testing), deliver food rations and access to other longer-term, livelihood support. The WFP review of social protection systems (Tango International, 2005) found that while linkages between sectors, departments and agencies are usually desired by all parties, in practice they are difficult to maintain due to time pressures, workloads, inadequate resources and competing agendas.

South Africa's Treatment Action Campaign

The Treatment Action Campaign (TAC) was launched on 10 December 1998, International Human Rights Day. Its main objective is to campaign for greater access to HIV treatment for all South Africans, by raising public awareness and understanding about issues surrounding the availability, affordability and use of HIV treatments. It also promotes and sponsors legislation to ensure equal access to social services for and equal treatment of all people with HIV and AIDS.

TAC is managed by – and on behalf of – people living with HIV throughout South Africa. It is a model for them to take the lead in shaping the HIV and AIDS social protection agenda rather than accepting an agenda set by others.

(BEN9)

5. Putting transformational thinking into action

A first step towards putting transformational thinking into action is giving people living with HIV a voice in the design of social protection systems. This complies with the UNAIDS commitment to the GIPA (Greater Involvement of People living with/affected by HIV and AIDS) principle, to which WFP also subscribes.

Providing a Continuum of Care[24]

The needs of people living with HIV change with time and eventual disease progression. An understanding of those needs is a crucial foundation of effective planning for social protection. Visualizing needs across a "continuum of care" can help in planning appropriate interventions in an integrative and holistic manner.

The HIV/AIDS timeline tool[25] was developed by CARE and Catholic Relief Services (CRS) to provide a starting point for analysing this complex problem one stage at a time. By looking at the stages as they unfold, programmers, policy-makers and community members can begin to identify the needs of particular target groups and understand how those needs evolve. The timeline prompts us to consider the potential interventions relevant to individuals, households and communities in crisis because of illness, and also to those who are HIV negative but food-insecure and at risk, those who are HIV positive but asymptomatic, and those who are affected by the illness and death of others.

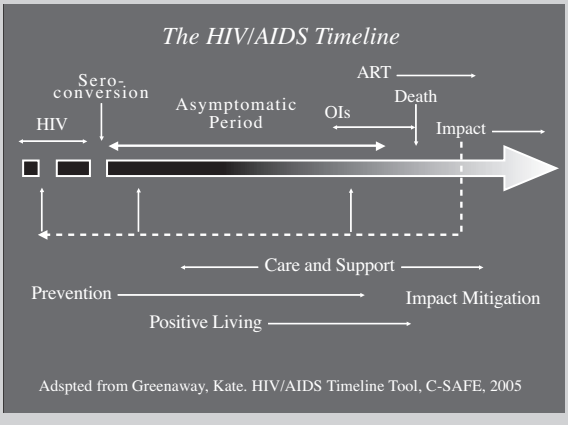
The challenge lies in identifying the most appropriate intervention (whether it be food security, nutrition, livelihoods or other), targeting the right individual/household/community and providing it at the right time for the right duration. This is the essence of providing a seamless continuum of care for individuals, families and communities throughout their entire experience of HIV and AIDS. For example, to effect a lasting change, people infected with HIV but not yet symptomatic need more than information about good food choices and many need assistance in developing their production or purchasing power. At this point in the HIV to AIDS timeline people do not need food handouts, but rather a long-term food and livelihood security strategy that provides resilience against the shocks of both external economies and climate.

There is a tendency to think of food aid as a palliative/end-stage measure, but it is equally important to identify the opportunities where food aid can assist in preventing HIV transmission. Support to PMTCT programmes, for instance, can improve maternal/infant delivery outcomes and encourage safer breastfeeding for HIV-positive mothers. To offset the nutritional drain of pregnancy and lactation, women in food-insecure households can benefit from appropriate food support for six months during pregnancy and six months during lactation. Encouraging exclusive breastfeeding and rapid weaning is crucial to reducing HIV transmission, and can be further supported by the provision of a suitable weaning commodity for the baby for 12 months after breastfeeding ends. Keeping the baby satiated reduces the temptation to intermittently breastfeed. Keeping mothers well nourished delays the onset of illness and, ultimately, orphanhood.

We know that the best HIV programming is holistic and multi-sectoral. In food-insecure and resource-poor environments, social safety nets for high-dependency-ratio households (i.e. those with several orphans and few productive adults) should include short-term food assistance but must be linked with agriculture and income-generation strategies at both household and community level. Assisting health sector efforts, with the provision of short-term food assistance with clinical TB treatment, for instance, generates a synergistic effect that far out-performs a single intervention.

ART is likely to be more effective when presented as part of a holistic package. For food-insecure and malnourished clients, a suitable food adjunct should be provided alongside the first few months of ART to ease early side effects and increase compliance, with a transition to an independent food security/good nutrition strategy as health and strength return. And as with all programming, appropriate HIV information and sensitization should be integrated into each intervention, capitalizing on the access the interventions provide to this uniquely vulnerable population.

Well-designed food-based interventions can help prevent HIV transmission, reduce morbidity, delay orphanhood and prolong health and productivity. Towards the end of the timeline, food can also be used to ease suffering. Thoughtful programming has the capacity to restore hope and empowerment to communities devastated by multiple losses. The extent of the challenge is equalled only by the plethora of opportunities and the scale of the need.



KEY ISSUES: DEPENDENCY

FROM HARVEY, P. AND LIND, J. 2005. DEPENDANCY AND HUMANITARIAN RELIEF: HPG REPORT 19. A CRITICAL ANALYSIS. LONDON, ODI.

- **Dependency** is generally seen as something negative.
- **Dependency** is associated with the provision of relief and contrasted with development approaches.
- **Dependency** is seen as undermining people's initiative.
- **Dependency** is contrasted with a variety of positive values or terms – notably independence, self-sufficiency, self-reliance, and sustainability.
- **Dependency** is seen as a particular problem when relief assistance has been provided over a prolonged period.

Common uses of the term dependency:
Relief creates a dependency mentality and undermines local economies, trapping people in chronic states of dependency on external aid. Dependency is one of the features of extreme poverty and associated with shame or defeat. Governments, warring parties and aid agencies are all vulnerable to dependency on relief resources.

The ODI's July 2005 HPG report, like others before it, finds that "people depend less on relief than is often assumed. There is little evidence that relief undermines initiative, or that relief is delivered reliably or transparently enough for people to depend on it."

According to the report, "In practice, many concerns about dependency seem to stem from a preoccupation with the disincentive effects of food aid. Framing these real concerns in terms of dependency is unhelpful because this can provide an excuse for cutting back relief for people who may still be in desperate need. The more important question is what forms of assistance are most appropriate to prevent hunger, save lives and alleviate suffering."

While the ODI report focuses on relief settings, one might argue that many of the issues related to dependency also apply for social welfare programmes in development settings. For example, the report notes, "In situations where people's lives and livelihoods are under threat and local capacities to cope with crisis are overwhelmed, being able to depend on receiving assistance should be seen as a good thing. The focus should not be on how to avoid dependency, but how to provide sufficiently reliable and transparent assistance so that those who most need it understand what they are entitled to, and can rely on it as part of their own efforts to survive and recover from crisis." These concepts are equally vital to the successful functioning of social protection systems as they are to relief responses.

The report also notes, "It is important to situate debates around dependency within a wider literature around livelihoods, social protection and coping strategies in response to crises. This stresses the point that people affected by emergencies are not passive recipients of aid, but use it as one of many livelihood strategies for survival and recovery. Aid assistance is therefore better seen as one of a range of options that people may be able to draw upon in their struggle to deal with crisis...It is equally possible, for example, to see relief as having the potential to reduce dependency, by enabling people to conserve productive assets that they would otherwise have had to sell."

The report finds that given renewed interest in social protection and the growing acceptance of the need for long-term welfare provision, there is an opportunity to rethink the concept of dependency. "If assistance is required over the long term, ways need to be explored to link this with states' responsibilities to provide social protection and basic welfare for their citizens."

Finally, the report concludes that, "Rather than seeing depending on relief in negative terms and as unsustainable, being able to rely on relief could be regarded as a positive objective of assistance, with the possibility that social protection measures have a realistic chance of providing some form of transition between relief and development."

AID IS A SMALL PERCENTAGE OF OVERALL COPING STRATEGIES

Evidence from the 1998 floods in Bangladesh found that food aid was quite a small input relative to households' needs and other coping mechanisms. Household borrowing was six to eight times the value of all transfers to poor, flood-exposed households. Findings from the 2000–2001 drought in the Horn of Africa were similar.

(BEN10)

South Africa's Treatment Action Campaign (TAC) provides a role model for people living with HIV in influencing the agenda for social protection. Most countries with high HIV and AIDS prevalence have national associations and networks that raise awareness and advocate for improved access to services. These should be sought out and engaged in the design of social protection provision to ensure that the voice of people living with HIV plays a part in emerging policy.

Using an HIV and AIDS lens at the design stage (whether developing a nationwide strategy or an individual intervention) can also facilitate this process. Like a gender analysis tool, this is a checklist of questions prompting practitioners to be more inclusive of people living with HIV at all stages of the project cycle, and suggesting ways of modifying traditional programmes (without invoking stigma) so that those living with HIV and affected households are empowered to participate and gain full benefits. Providing stigma-reduction training for staff and communities and conducting anti-stigma campaigns can also contribute to transformational efforts.

5. FOOD, HIV AND AIDS AND SOCIAL PROTECTION

The special role of food

The HIV and AIDS timeline illustrates that to achieve a continuum of care, a comprehensive package of services should be made available in a reliable manner based on the stage of disease progression and the level being targeted (individual, household or community). Social protection policy needs to consider the entire spectrum of prevention, care/support, treatment and mitigation, to ensure that appropriate modalities for social transfers (cash, food, counselling, medication, etc.) are carefully selected for each intervention. Food has a special role to play, but it is important to note that it is but one part of the social protection package. In analysing what type of social transfer is most appropriate, the following guidance may be useful:

CLARIFY the specific objectives of the intervention within the context of the overall social protection framework.

UNDERSTAND the way that HIV and food and nutrition security interact.

CONSIDER the context for food versus cash decision factors.

1. CLARIFY the specific objectives of the intervention

While the overall goal of social protection may be to reduce poverty while contributing to economic growth, individual measures are context-specific, relating to the immediate needs of the individual (or household) and their access to relevant social services. A young girl, for example, may be returned to school by her parents due to incentives provided by a school feeding programme in her community (which has the specific objective of improving school attendance among girls). Her improved educational and employment opportunities, her increased understanding of HIV and risk-reduction strategies and the increased food security of the household which may result from that intervention, will contribute to the broader social protection goals of reduced poverty, protection of health and increased economic development. Likewise, a TB patient who receives food rations as an adjunct to treatment (with the objective of improving his adherence and efficacy of the treatment) will contribute to the larger social protection goals if treatment completion also allows the patient to regain health, strength and

productivity and fulfil parenting obligations.

An effective referral system connects the multiple purposes of different interventions. For example, an orphan receiving meals at school may be referred to a community care programme (where support is conditional on school attendance) aimed at improving food security at the household level. Although the activities are linked, and may have in common the goal of improving the welfare of vulnerable individuals and households, they are distinct in terms of their specific objectives.

It is important to clarify the specific objectives of an intervention. They should be explicitly stated to the client community, not only to ensure an appropriate match to its needs and expectations, but also to facilitate the development of the larger framework of social protection policies and systems. A clear understanding of the objective is also crucial for establishing the appropriate type and size of food support, duration of assistance and selection criteria. The WFP review of social protection systems in four southern African countries (Tango International, 2005) revealed frequent tension between the overarching goals of social protection and the specific objectives of individual interventions, and emphasized the need to create a careful balance of each in the design of social protection systems and measures.

2. UNDERSTAND the way that HIV, food and nutrition security interact

Food insecurity can prompt risk-taking behaviour related to sexual exploitation and transactional sex, increasing the likelihood of exposure to HIV. HIV-negative individuals with poor diets, which compromise their immune system, are more susceptible to contracting the virus when they are exposed. HIV-positive individuals with declining health (i.e. symptomatic) are more likely to become food insecure, since they are physically less able to produce income and have less access to a nutritionally adequate diet. They may also have physical constraints to eating well (e.g. mouth sores) and benefiting from the food that they do eat (e.g. diarrhoea). They may also fail to receive a fair share of available food if distribution arrangements within the household or community shift and (intentionally or unintentionally) sideline them. Negative coping strategies follow, such as the sale of productive assets and other behaviour that exacerbates vulnerability. The combination of challenges facing people living with HIV places them in a

Food Security Versus Nutrition Security

It is important to distinguish between food security and nutrition security, two quite different terms often used interchangeably.

Food security, important for improved nutrition outcomes, is concerned with physical and economic access to food of sufficient quality and quantity in a socially and culturally acceptable manner.

Nutrition security is an outcome of good health, a healthy environment, and good caring practices in addition to household-level food security. For example, a mother may have reliable access to the components of a healthy diet, but because of poor health or improper care, ignorance, gender, or personal preferences, she may not be able – or may choose not – to use the food in a nutritionally sound manner, thereby becoming nutritionally insecure.

Nutrition security is achieved for a household when secure access to food is coupled with a sanitary environment, adequate health services, and knowledgeable care to ensure a healthy life for all household members. A family (or country) may be food secure, yet have many individuals who are nutritionally insecure. Food security is therefore often a necessary, but not sufficient, condition for nutrition security.

World Bank, 2006

deleterious cycle that is difficult to reverse.

Nutrition security: Adequate nutrition cannot cure HIV infection but it is essential for maintaining the immune system, physical stamina, and optimal quality of life. Adequate nutrition is also necessary for ensuring optimal benefits from the use of ART, which is essential to prolong the lives of HIV-infected people and prevent transmission of HIV from mother to child.[26]
It is important to note that while many people in developing countries subsist on a diet that falls below the recommended daily allowance, WHO states that energy needs increase by 10 percent in asymptomatic HIV-infected adults and children, and by 20 to 30 percent in adults with more advanced disease – a challenge even for those residing in relatively food-secure households.

According to WHO, "These targets should be achieved through food-based approaches whenever possible."[28]

Energy requirements[27]	Asymptomatic	Symptomatic
Adults and adolescents	10% increase	20–30% increase
Children	10% increase	50–100% increase (in cases of weight loss and/or growth faltering)

For someone living with HIV, nutrition security may be compromised not because food is lacking, but because stigma, lack of knowledge and cultural norms can have a significant influence on food choices. Illness itself affects appetite, nutrient needs and the ability to absorb nutrients. While precise

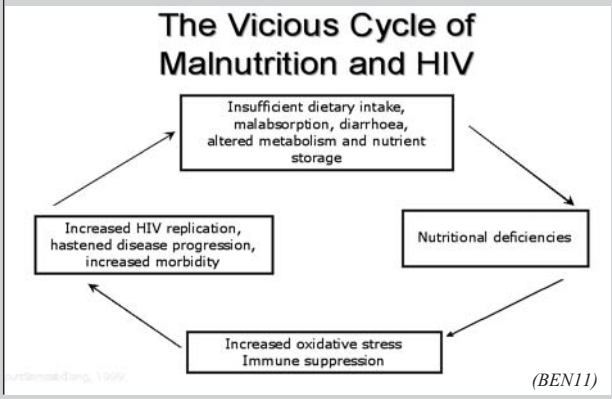
The Vicious Cycle of Malnutrition and HIV

Even for people without HIV, immune functions are undermined by malnutrition. But malnutrition is significantly more complex for people living with HIV and AIDS because of the added stress placed on an already weakened immune system.

HIV and AIDS diminish nutritional health in three, mutually-reinforcing ways[29]:

- Reduced food intake: Individuals with HIV and AIDS often consume less food due to loss of appetite, mouth or throat sores, pain and nausea, side effects of medication or as a result of worsening household poverty and food security.
- Altered metabolic processes: HIV and AIDS change the body's metabolism so that more energy is demanded, as well as protein (if opportunistic infections are present) and micronutrients (if intake or absorption are inadequate).
- Impaired nutrient absorption: Nutrients are poorly absorbed because of diarrhoea and vomiting, damaged intestinal cells and other effects of opportunistic infections. This may also complicate treatment by affecting the intestinal tract's ability to absorb drugs and nutrients.[30]

Unfortunately, these processes occur precisely when the body requires the best possible nutrition. When they occur simultaneously they can rapidly accelerate weight loss, malnutrition and wasting. Malnutrition directly influences survival, and significant weight loss in HIV-positive individuals has been associated with increased risk of opportunistic infections, complications and early death.[31] Replenishment of macronutrients and micronutrients is an essential intervention for people living with HIV and AIDS to mount an effective immune response to fight opportunistic infections.[32] Furthermore, micronutrient deficiencies are common in people living with HIV, a situation which accelerates the death of immune cells and increases the replication of HIV.



(BEN11)

nutrient considerations continue to be studied and debated, there is already general consensus regarding the importance of good nutrition for people living with HIV. "They need to maintain an optimal nutritional status at the time when their immune system is being undermined by the virus. Without early nutritional intervention, weight loss and other complications are bound to follow."[33]

3. CONSIDER the context for food versus cash

Both food and cash are legitimate modalities for social transfers and need to be carefully considered in the context of a social protection package for individuals, households and communities affected by HIV. The choice between food and cash is an old debate found in nearly all social protection discussions and literature. As always, practitioners need to consider carefully the needs of the group being targeted and the local operating environment (e.g. access to markets, etc.) when deciding on an appropriate modality. While there is no "one size fits all" solution, it is imperative to consider the special relationship between people living with HIV and nutrition security when looking at the cash versus food decision. It is also important to consider that food assistance does not necessarily mean external food aid. There are many examples where nutrition and food security programming draws on local food reserves or locally purchased commodities.

Where markets are weak or not functioning, as was the case in Zimbabwe in 2003, food transfers may be the only alternative since food is not available locally. When the objectives are specifically nutritional, such as providing food as an adjunct to

The cash vs. food debate[34] *(Items in bold are particularly relevant in the context of HIV and AIDS)*

FOOD	CASH
Advantages	**Advantages**
• Immediately addresses food availability and access issues • **Can directly address nutritional deficits** (less prone to diversion from non-food objectives) • **Can be self-targeting** (e.g. CSB is usually for children and sick people) • **Usage favours/empowers women, children and elderly** • Lower security risk • Donor food surpluses are more readily available than cash • **Can be fortified or enriched with nutrients**	• Cost efficient • **Allows more beneficiary choice** • More fungible than food • Encourages production • Stimulates the market • **More discreet than a food ration, minimizing stigma and discrimination**
Disadvantages	**Disadvantages**
• High transport costs • Losses from spoilage and theft • Less easily exchanged than cash • Imported food aid may act as a disincentive on production and compete with local markets and trade • **Restricted commodity choices may limit nutritional value** • **Dry rations difficult to conceal, and may expose recipients to stigma**	• Prone to inflation • Can be used for non-food consumption • More difficult to target • Usage favours men • Heightened security risk • Limited donor resources available • When used to purchase food, diet may not meet diversity or micronutrient needs

treatment or ART in a food-insecure environment, the direct provision of food rations is the best option. There is a tendency to presume that food is more appropriate to a relief environment, while cash should be used for development. This, however, is not necessarily the case and the decision needs to be carefully considered for the specific context of the recipient community. In Malawi, for example, it was shown that the most appropriate modality changed with the seasons. This shows that the desires of the participants should be factored into the equation.

There are also other, less frequently used modalities to be explored, such as the use of food stamps, coupons or vouchers, each of which has its respective advantages and disadvantages. Other novel means of improving access of vulnerable groups to food include making use of commercial markets.

Local Purchases in Southern Africa

By early 2003, WFP had purchased 45 percent (332,000 tons) of its food commodities in the southern Africa region (as opposed to using in-kind contributions). In emergencies elsewhere in the world, local purchases usually account for up to 30 percent of the overall volume. *(BEN12)*

Locally-Produced Commodities used for Food Programming in India

In India, a food-surplus country, WFP does not contribute significantly to the amount of food supplied, but instead focuses on providing operational and technical support to food-based safety nets, which are implemented using locally-produced commodities. WFP pilots and models new programming for improving safety net features, and has a strong advocacy role, speaking out for the poor who are affected by hunger and ill health. *(BEN13)*

Traditional Support via Untraditional Means

In 2003, commercial markets in Zimbabwe had ground to a halt, and in urban areas such as Bulawayo, grocery shelves were bare. The urban working poor were still earning wages, but foodstuffs were largely unavailable. The limited maize that did exist was completely unaffordable to most people.

The Market Assistance Pilot Program (MAPP) was designed by C-SAFE and piloted by CRS in Bulawayo, Zimbabwe. It aimed to address the needs of urban working poor people who possessed regular (off-farm) income but who lacked the buying power to purchase sufficient food to meet their daily requirements. The MAPP's commodity of choice was sorghum, less popular than the staple (maize), making it self-targeting to poorer segments of the population.

The sorghum was milled by local Zimbabwean millers, and then sold at a subsidized price via small-scale retailers throughout Bulawayo. In this way, the project also contributed to revitalizing the local economy by providing business opportunities to local millers and retailers who had suffered enormous losses due to market distortions and ultimately, a collapse of the commodity market.

Through MAPP, these international NGOs used commercial channels for the first time to target food aid to poor and vulnerable households.

MAPP set the price of sorghum by determining how much the local population was paying for specific commodities when the markets were functioning efficiently. It then took into account the income and expenditure of more than 800,000 targeted households (captured via weekly monitoring) in the Bulawayo area. Early estimates suggested that the sorghum meal prices allowed the majority of poor families to purchase sufficient food to feed all family members three meals per day for the six-month duration of the pilot programme. Given the high HIV prevalence in urban areas, MAPP inadvertently captured a large proportion of HIV-affected households. By modifying commodity choice, MAPP could also be designed to address the specific nutritional needs of people living with HIV.

This USAID-funded project is currently being considered for replication in other countries where market failures exist, such as post-conflict countries like Liberia and Somalia.

(BEN14)

Let the People Choose![35]

Evaluations of public works programmes in Malawi found that participants' preferred mode of payment varies seasonally, geographically and by gender. "Before harvest, participants want maize and after harvest they are interested in other items, especially seeds and fertilizer." A majority of cash-for-work participants surveyed on Malawi's Social Action Fund expressed a preference for payment in cash around harvest time, in agricultural inputs around planting time and in food during the hungry season (Zgovu *et al.* 1998). Women were more likely than men to request food as payment; most men favoured cash. Communities further from roads and towns were more likely to request food, while those closer preferred cash. A fully responsive public works programme would provide cash for work after the harvest, inputs for work during the planting season, and food for work in the hungry season.

6. TARGETED SOCIAL TRANSFERS IN THE CONTEXT OF HIV AND AIDS

Social protection interventions are ideally designed to help vulnerable individuals and households cope with shocks (e.g. natural disaster, loss of income, illness, etc.). They not only safeguard but also promote the accumulation of productive assets (including human assets such as health, education and skills). They allow the poor and vulnerable to manage their risk and prevent negative coping strategies that can lead to destitution and further spread the HIV virus.

There is increasing recognition that the HIV pandemic has created a long-term humanitarian crisis, not only for those affected, but for children, households and communities more generally. This has prompted the need to look at regular, predictable transfers. Social transfers constitute a crucial aspect of the response to rising dependency ratios and other implications of the pandemic.

Social transfers target specific groups and their respective needs. Those commonly highlighted as exceptionally at risk in an HIV context include orphans and other vulnerable children, people living with HIV and households disproportionately affected by HIV and AIDS (e.g. those caring for orphans or chronically ill members, those with high dependency ratios, etc.).

Households that are disproportionately affected by HIV and food insecure can also benefit from short-term food assistance which is linked to longer-term livelihood support (e.g. agricultural or micro-credit programmes).

It should not be assumed that all members of these groups are poor and vulnerable. As with all effective social protection mechanisms, some form of means testing should be incorporated into targeting mechanisms.

Cash Transfers in Support of Children

In Botswana in 2000 the government introduced a package of subsidies-in-kind for orphan children worth US$60 per child/month. South Africa has instituted a child support grant, a foster care allowance and a care dependency grant for children with severe problems.Thailand has developed a mixed system in which temple- and community-based transfers are accompanied by interventions originating from the central government and targeting children. Even financially-stretched countries such as Zambia have considered a modest transfer system (at a cost of US$500,000 per year) to offset school costs of children orphaned by AIDS.

(BEN 15)

Nutrition, health care and treatment

While there are clear links between HIV, food and nutrition, it is obvious that not everyone affected by HIV is food-insecure, and not all food-insecure people are directly affected by HIV or AIDS. HIV positive individuals are, for the most part, asymptomatic and while they need to increase their daily caloric intake, they do not typically need food assistance simply because they are HIV positive.

WHO Consultation Participants Call for Integration of Nutrition into Package of Care

The HIV and AIDS epidemic is increasingly driven by and contributes to factors that also create malnutrition – in particular, poverty, emergencies and inequalities.

In urgent response to this situation, we call for the integration of nutrition into the essential package of care, treatment and support for people living with HIV and AIDS and efforts to prevent infection.

(BEN16)

Good nutrition, on the other hand, can delay the progression of HIV to AIDS, reducing health care costs and allowing people living with HIV to remain productive as they pursue their livelihoods and continue parenting. Introducing nutrition education and protecting nutrition security early in the disease process – while people living with HIV are still asymptomatic – is a natural entry point for programming for "positive living" and treatment literacy. It supports a gradual adjustment to new lifestyle practices and behaviours, and paves the way to a successful transition to ART when the time is right, before the onset of end-stage disease and wasting.

"The life-saving benefits of antiretroviral therapy are clearly recognized. To achieve the full benefits of such treatment, adequate dietary intake is essential."

WHO, 2005a

Symptomatic people living with HIV who are food insecure often do, however, require short-term nutrition support, in addition to other essential services, in order to emerge from the vicious cycle of HIV and malnutrition. Community-based targeting of people living with HIV using proxies such as Chronically Ill (CI)[36] has often been used to reach symptomatic people living with HIV to avoid provoking stigma.

In the context of HIV and AIDS, food aid is being used in new and creative ways to improve nutritional and health status, uptake of services, adherence to drug regimes and improved treatment outcomes for people living with HIV. Attaching food assistance as an adjunct to TB DOTS, ART and PMTCT programming shows great promise, yet remains under-used. Currently, food is linked to these interventions on an ad hoc basis, mostly by WFP and NGOs, and has yet to be comprehensively integrated into these types of interventions on a nationwide scale.

PMTCT: Linking food to prevention of mother-to-child transmission programmes can increase the use of these services among mothers, encourage safer breastfeeding for HIV-positive mothers, and ultimately improve maternal and infant health. Encouraging exclusive breastfeeding and rapid weaning is crucial to reducing HIV transmission, and can be further supported by providing a suitable weaning commodity for the baby.

TB DOTS: In southern Africa, 40 to 70 percent of all TB patients are HIV-positive. Someone who is HIV-positive is approximately 20 times more likely to develop TB than someone who is not, and an AIDS patient is 100 times more likely to contract the disease.[37]

Patients are more likely to drop out of TB treatment than other medication regimens. When a patient with TB does not finish the full course of treatment, he or she can develop and spread drug-resistant strains of TB that are much harder to treat and up to 100 times more expensive to cure.[38] Providing food as an

adjunct through the entire course of TB DOTS increases adherence to the drug regime, and ultimately enhances the patient's recovery and return to productivity.

ART: It is generally accepted that anti-retroviral therapy is most appropriately delivered as part of an integrated and coordinated HIV and AIDS plan which includes voluntary counselling and testing (VCT), PMTCT, diagnosis and treatment of opportunistic infections, lifestyle counselling and a range of prevention, care and social support services. Nutrition assessment, counselling and weight monitoring are also critical components of the overall support package and will help maximize use of available resources.

Good nutrition helps reduce side effects and improves tolerance to the drugs, especially at the initial stages of treatment. For clients from food-insecure households, experts are beginning to advocate for a short-term nutrition/food assistance adjunct (e.g. first 6 to 12 months of treatment) to assist the reversal of wasting and help patients adjust to the medication.

Food and nutrition interventions for people living with HIV are believed by many to be a critical aspect of the treatment package, with some suggesting that "clinical standards of care that include nutritional services will soon be the foundation for HIV disease management." [39] In the context of the increasing availability of ART, it is becoming clear that reaching the right beneficiary with the right food and nutrition at the right time can not only optimize treatment, but maximize investment returns on the massive cost of global coverage.

Documenting and evaluating the impact of food on people living with HIV: Despite our understanding of the role that food plays in curbing malnutrition, the precise impact of food on people living with HIV is still not well documented. A recent study by C-SAFE on the impact of food on CI, TB DOTS and ART patients and PMTCT participants strongly recommends the piloting of eight categories of indicators including anthropometrics, quality of life and adherence to drug regimes.[40] The lack of empirical evidence remains a significant barrier to broad-based donor and government support to linking food to services for people living with HIV in a comprehensive manner. While a handful of research and pilot initiatives are in place, more (and better coordinated) exploration of various impact indicators is crucial to moving this agenda forward.

ART Patients Wait for Food to Take with their Medications

Clinic personnel in Uganda have reported to WFP food monitors that ART patients decide not to start their treatment until they receive food due to the side effects of the medication when taken on an empty stomach.

(BEN17)

Malawi Hospital staff cite food as a "powerful incentive" for uptake and adherence

Anecdotal reports from St Gabriel's mission hospital programme (for PMTCT and ART) and the University of North Carolina's PMTCT programme at Bottom Hospital in Lilongwe indicate that food is a powerful incentive to begin ARV therapy and to stay in treatment.

(BEN18)

Husband and wife on ART in Thyolo, Malawi

Both husband and wife receive ARVs from MSF and food support from World Vision.

"Before food aid I had many challenges. I was sick, had stomachaches, heart palpitations, headaches and pneumonia. [After starting on ARVs and receiving food aid] my physical problems decreased, I had less diarrhoea, I gained a lot of energy and could move around and get involved. I had enough strength to mould bricks, construct a house and do some gardening. [Since the food has been stopped] I have increased problems taking the medications and my weight has decreased."

(BEN19)

WFP and Good Shepherd, Swaziland pilot project to link food with ART

Good Shepherd Hospital, a private facility in Swaziland, is one of two hospitals in the country that provide ART daily. Patients receiving ART are supplied with individual rations of corn soya blend by WFP as part of a pilot project that aims to gauge the feasibility of distributing food supplements at clinics in support of the nutritional requirements of ART patients. The hospital's home-based care staff monitor patients within a 40 km radius. The hospital provides a small storage room and WFP supports the salaries of two staff who distribute the food, a financial cost that the hospital cannot assume at this point. This and other models are being explored as possibilities for a comprehensive scale-up.

(BEN20)

Livelihood support and asset creation

In an era of HIV and AIDS, there is a general perception that public works, and the food-based equivalents (FFW and FFA) do not pertain to people living with HIV since the labour requirement is considered beyond their physical capabilities. More recently, however, ways are being found to adapt programmes involving work to an HIV and AIDS context.

Public works programmes dominate social protection agendas in developing countries

Historically, one of the most common forms of social protection is public works programmes, which target poor households with able-bodied members. In South Africa, public works forms one of the principle social protection interventions for the working-age poor, and in Ethiopia, it is mandated that 80 percent of relief resources are used as payment to workers on labour-intensive public works, with what the government calls 'gratuitous relief' allowed only for needy households that lack able-bodied labour.

(BEN21)

Just as using a gender analysis tool became popular in the 1980s and 1990s (and is now standard procedure in effective development programming), applying an "HIV and AIDS lens" is currently gaining recognition as a way to promote the inclusion of people living with HIV in all stages of programme development, and to find ways to adapt projects to their specific needs and concerns. This is particularly true for FFW and FFA projects.

Similar to a gender analysis tool, the HIV and AIDS lens is basically a checklist of questions that ensure opportunity and that people living with HIV benefit from the asset and participate in decisions related to how it will be used and maintained. One such tool is being used in Zimbabwe and Zambia, and has been particularly helpful in identifying ways to find tasks that are less labour-intensive and adjust work norms to facilitate the participation of people living with HIV and affected households.[42]

Other recent innovations in public works programmes include the introduction of contracts with households (instead of with individuals) so that if a worker falls ill or dies, other family members are entitled to substitute for him or her; and dedicating a portion of public work benefits to labour-constrained households (10–20 percent of the amount transferred).[43]

Shifts in terminology are also gradually taking place. While the term food for assets is not often heard in social protection circles, it is pertinent to social protection thinking. As noted earlier, social protection can contribute to economic growth in two ways: indirectly, by protecting household assets and allowing families to manage risk more effectively; and directly, through asset creation. The terminology and the thinking behind FFA came into being in the late 1990s, shifting the focus from the employment creation aspect of FFW, to an emphasis on the assets being created and the contribution those assets can

Public works, food for work and food for assets through an HIV lens

An HIV and AIDS lens[41] helps us adapt public works, FFW and FFA programmes to contexts of high HIV prevalence. The lens, which can be applied to any type of project, is intended to:

- **PROMPT** us to be more inclusive of people living with HIV in our approach to FFA selection, design, planning and implementation of community works projects, thus gaining access to the communities' full potential;
- **REMIND** us to invite those most affected by HIV and AIDS to become active players in creating community responses to current and future shocks, enabling them to be part of the solution;
- **HELP** us to identify the key steps in adapting our projects to this challenging context;
- **STIMULATE** thinking about actively mitigating the impact of HIV and AIDS;
- **INSPIRE** proactive approaches to building community resilience to the shocks of HIV and AIDS;
- **INFORM** our thinking about potential risks and threats of failing to adapt FFA programming to a high HIV-prevalence context; and
- **ADVANCE** the regional goal of a multi-sectoral response to HIV and AIDS. (While public works, FFW and FFA projects are just one piece of this, they can help link together various sectors.)

make to household and community resilience to future livelihood shocks.

Even more relevant to social protection, FFA broadens the concept of assets beyond the creation or rehabilitation of physical assets (e.g. infrastructure projects such as roads and dams) to also capture the notion of human assets (e.g. health, education, skills and awareness) and social assets (e.g. family, friends and social networks) and the role that these categories of assets can play in enhancing household and community resilience to shocks.

FFA is especially useful in the context of HIV because the enhancement of knowledge, skills and social networks are all relevant to mitigating the multiple impacts of HIV and AIDS. For example, FFA might include training (also known as food for training [FFT]) on a variety of thematic areas such as conservation farming, positive living, labour-saving technologies, and even home-based care of chronically ill persons – all seen as constructive activities in areas with high prevalence of HIV and AIDS.

FFA programming can strengthen social assets by providing food to HBC providers and Early Childhood Care and Development (ECCD) workers.[44] Physical assets or infrastructure in support of people living with HIV or orphans and other vulnerable children might include the rehabilitation of clinics and schools or the creation of a community or hospital garden. The deliberate inclusion of asymptomatic people living with HIV, where possible, can be an extremely effective way of engaging them in asset creation, and can also inspire support group formation and elevate them from the role of beneficiary to that of participant.

What is food for assets?

FFA has its origins in the experiences, lessons and better practices of the emergency FFW activities implemented in Ethiopia during the great famine, and in many countries in southern Africa affected by the droughts of 1992, 1995/96 and 1998. A transition from FFW to FFA was initiated by WFP through its Food Aid and Development Policy "Enabling Development" adopted in 1999. This policy introduced a paradigm shift from emergency-driven employment creation and income transfers to a new emphasis on community-managed asset accumulation and human capital development. FFA strategies emphasize the creation of productive assets that are owned, managed and utilized by the household or targeted community.

(BEN22)

Food for assets projects can help mitigate the impact of HIV and AIDS

FFA has the potential to mitigate one or more of the impacts of HIV and AIDS on communities and households. These interventions go some way to address the need for better nutrition, better health and hygiene conditions, agricultural recovery, restoration of coping strategies, improved income and protection or recovery of productive assets, intergenerational transfer of knowledge and economic recovery of communities affected by the pandemic.[45]

Food for developing 'key hole' gardens Lesotho

In Lesotho, CARE and local partner TEBA have developed a nine-month training curriculum for food-insecure households on how to build and maintain a 'keyhole' garden (named because its shape resembles a keyhole).

With sustainability in mind, the construction of the garden uses readily available and affordable components (e.g. manure, bones, stones and aloes), and emphasizes water conservation in its maintenance. The gardens are resistant to dry weather conditions, and provide high yields of vegetables year-round using only waste water (reducing stress on household water supplies). And given their height and circumference, the gardens are easy to manage and maintain, even for the elderly and infirm.

The assets gained are two-fold: the garden, and just as importantly, the knowledge / skills to construct and maintain it. Households are able to graduate only once they have a functioning garden with skills to maintain it and hence no further need for NGO inputs.

Food for housing of CI households Zimbabwe

In Zimbabwe, the World Vision (WV) team together with targeted communities identified the need for improved housing for households headed by the elderly and chronically ill.

Using the FFA mechanism, WV assisted communities in providing decent and affordable accommodation for the households headed by the elderly and chronically ill in disadvantaged communities. Under the programme, community members identified deserving beneficiaries and pooled local resources to assist in the construction of small houses. As a food-for-assets project, the community workers received food rations at the end of each month. In September 2004, 15 houses had been completed and 23 were under construction.

Food for training teen orphans Mozambique

The death of young parents has led to their children facing social exclusion as well as the loss of local knowledge of agro-ecology and farming practices.

In response, FAO and WFP in Mozambique have developed Junior Farmer Field and Life Schools to bridge the intergenerational knowledge gap for youths who have lost their parents and care-takers to AIDS.

Orphans and other vulnerable children (aged 12 to 17) are trained for one year using a combination of traditional and modern agricultural techniques. An equal number of boys and girls learn field preparation, sowing and transplanting, weeding, irrigation and pest control, resource conservation, processing of food crops, harvesting, storage and entrepreneurial skills, and receive food for their participation.

Educational drama explores sensitive issues around health and nutrition, psycho-social problems, gender roles and HIV.

Education and support to vulnerable children

Children made vulnerable by HIV and AIDS can be targeted either directly or indirectly (via orphan allowances, foster care allowances, basic pensions for elderly or through chronically ill people caring for orphans). Such transfers can be in kind (e.g. food or clothing), in cash (e.g. for books, school uniforms or transport allowances) or exemptions from school and medical fees.[46] Elements of such schemes exist in several AIDS-affected countries.

There is growing evidence of how long-term cash transfers, such as social pensions to the elderly, can mitigate the impact of HIV and AIDS.[47] Grandparents are taking on more and more responsibility in caring for the chronically ill and their dependents, as well as taking over as heads of households when those who are ill die. In this context, pensions are used to pay school fees, especially those of orphans, and to purchase food for the rest of the household.[48]

Education, especially for girls, is one of the most effective ways to improve food security for the long term and strengthen coping strategies for times of crisis. It has a positive effect on girls' economic opportunities and on their participation in community decision-making, and leads to reduced child malnutrition in the next generation. Studies have shown a steep decline in HIV infection rates among women who have received secondary education. Women with education are more likely to send their own children to school.[49]

A recent UNICEF review of social protection with respect to the education sector points to the crucial need to get children into school (access) and to keep them there (retention), particularly those who are "educationally marginalized".[50] This is particularly true in an era of HIV and AIDS given: 1) the valuable role that schools can play in the care, support, protection and development of marginalized youth; 2) the loss of trans-generational influence on knowledge, attitude and behaviour development that occurs when the parent–child relationship is interrupted; 3) the unique opportunity afforded by the education system for early identification and appropriate referral of children at risk; and 4) the role the sector has to play in replacing vital human resources lost to the pandemic.

Kenya cash transfers for orphans and other vulnerable children

In 2004, the Ministry of Home Affairs and the National AIDS Control Council set out to develop a cash transfer scheme for orphans as an integral part of its strategy to encourage foster care in families. UNICEF and SIDA have funded a small pilot to assess the feasibility.

The households care for 500 children in total, and each receive every month, the equivalent of US$0.50 per day; a similar amount for each child is given to community-based initiatives.

Initial assessments suggest that the money has been spent on food, clothing, shoes, medical expenses and other minor household purchases. School attendance has increased and some children have been able to obtain ART. The project is receiving strong political support and plans to scale up to reach 2,500 orphans.

(BEN23)

Lesotho Social Pension for Elderly

A social pension in Lesotho began at the end of 2004, the sixth in sub-Saharan Africa, following South Africa, Botswana, Namibia, Mauritius and Senegal. The cost of the pension programme is approximately 1.4 percent of GDP and 7 percent of recurrent expenditure. The age for receiving a pension is currently 70, but there are plans to lower it to 65.

(BEN24)

In this context, school feeding has received renewed interest. Food assistance provided in the form of morning or lunchtime meals or as take-home rations can play an important role in attracting students, especially girls, to school and improving their attendance. Unlike other social transfers, school

meals also have the added benefit of enhancing students' capacity to learn.

Both unconditional (e.g. food rations for orphans and other vulnerable children) and conditional (e.g. school feeding or food for training to teenage orphans) social transfers have the potential to protect and promote livelihoods via the accumulation of physical, social and human assets. It is important, however, that they are planned in an integrated manner, and available on a regular and predictable basis, so that participants in these programmes can use them to manage risk and improve their livelihood opportunities.

School Feeding has Secondary Benefits

In fiscal year 2005, C-SAFE began an emergency school feeding programme in Zimbabwe. Focus groups with children found that those who received rations at school were receiving fewer meals at home, leading one to assume that the food aid was simply displacing a home-provided meal (substitution effect) and of no added value to the child.

However, upon closer investigation, it was found that the savings afforded by not feeding the child a meal at home was allowing the family to pay for other necessities, such as health services, soap and other commodities, and was furthermore encouraging parents to keep the child in school despite financial difficulties at home.

(BEN25)

Millions of children worldwide have been orphaned or made vulnerable by AIDS. Sub-Saharan Africa has been most heavily affected, where over 11 million children have already lost at least one parent – a number that will continue to rise over the next decade as adults with HIV become ill and die of AIDS. Being orphaned is not the only way children are affected by HIV. They may live in a poor household that has taken in orphaned relatives; they may be caring for a sick parent; they may be experiencing stigma related to the illness of a family member; and they may be infected with HIV themselves. The social, economic and psychological impacts of AIDS on children combine to increase their vulnerability to a range of hardships including HIV infection, lack of education, poverty, child labour, exploitation and unemployment.[51]

Operational considerations

The delivery of social protection in developing countries is frequently by limited by poor infrastructure and human resource capacity. As noted earlier, this is magnified in recent years by the strain that the HIV and AIDS pandemic has placed on health providers (and social services in general) at all levels: informal, semi-formal and formal.

In some countries, there is no shortage of funding for scaling up where there is a national (or global) priority, such as the roll-out of ART. However, the limited capacity on the ground presents an equally frustrating barrier to meeting targets.

Any increase in the provision of social transfers entails considerable investment in delivery infrastructure, whether it be to make psycho-social support more widely available to orphans and other vulnerable children or providing nutrition support in combination with anti-retroviral drugs. Various tasks such as harmonizing targeting strategies and criteria, mapping institutional actors and enhancing referral systems, installing procurement, logistics and monitoring and evaluation systems are all required. These are daunting tasks, although there is existing expertise in most countries that can be used in the form of international NGOs, United Nations agencies and local private sector specialists.

Scaling up a food delivery system can be particularly challenging, with food-specific issues arising such as limited shelf life, the need for appropriate transport and storage facilities and the need for staff with strong commodity management and accounting skills. WFP's examination of social protection in Mozambique showed transaction costs to be excessive for each partner due to separate agreements with service providers and the need to establish separate, in-house systems for managing

the commodities – often with little expertise to do so.

Furthermore, investment in more automated systems is not warranted given the limited size of each organization's food programme. The complex task of food allocation planning and distribution is burdensome and distracting to some actors, whose expertise lies in other aspects of community development. In considering increasing food delivery, these constraints may be overcome by creating a joint operational infrastructure – one that handles the logistics across various partners, allowing them to enjoy economies of scale while permitting them to retain their focus on what they do best: providing quality services to communities.

A strong referral system plays a critical role in ensuring integrated and holistic social protection. It is important that as the needs of individuals or households change, the system facilitates a more appropriate intervention. If, for example, a chronically ill person gains strength, but still needs livelihood support, it should be easy for the person to be referred. These connections are crucial to the successful implementation of the overall social protection framework, and building links between various players is critical to making scaling up affordable.

It is worth noting that the advantages of local engagement mentioned earlier (such as quality, outreach and array of services) are difficult to replicate when scaling up to a national level. The trade-off between community outreach and wider coverage needs to be carefully examined. The scaling up of service provision does not necessarily mean increased volume of inputs. Enhanced cooperation between informal, semi-formal and formal actors to make better use of their respective strengths can itself overcome many difficulties.

7. THE CHALLENGE OF TARGETING

Targeting for social protection is never simple, but it is certainly made more complicated in the context of HIV and AIDS. A broad range of targeting and verification mechanisms is required to ensure that the most needy individuals/households are identified and selected, whether for food, cash or transfers of other material benefits. Finding the right balance between rigour and cost-effectiveness is always a challenge. It is important to cast a wide net, explicitly involving community structures, HBC providers, traditional healers, etc., using criteria and systems that are adequately sensitive (to avoid the exclusion of those who should be eligible) and specific (to ensure that those deemed not eligible are excluded).[52] This is especially true in a high-HIV prevalence context because stigma and denial can confound transparent, explicit targeting and self-identification.[53]

Targeting should be understood at two levels:

1. **Macro level:** Groups are selected based on:
   a) geographic profile – areas most affected by a particular crisis, or areas that experience high levels of poverty, food insecurity, malnutrition, etc.); and/or
   b) social demographic profile – prioritization of one group over another (e.g. people living with HIV, orphans and other vulnerable children, etc.) often due to global or national strategies or funding mechanisms.
2. **Micro level:** Individuals and households (within the groups selected through macro-level targeting) are assessed for particular vulnerabilities. Micro-level targeting is generally called beneficiary selection.

There is no standard method for targeting. The targeted groups (macro level) are based on factors such as a programme priorities, needs assessment, access to funding for particular purposes and global or national strategies. Targeting mechanisms and procedures applied vary according to capacity, skills, access to information, partnerships with groups in the community, etc.

The use of proxies

While HIV and vulnerability to food and nutrition insecurity are very often linked, not all people living with HIV are vulnerable. The use of proxies for individuals/households affected by HIV – such as chronic illness (CI) and households hosting orphans – has become a popular means of targeting in high-HIV prevalence contexts. However, proxies should not be used in isolation to determine eligibility, as they have a tendency to be crude and often inaccurate indicators for food insecurity and poverty.

A recent WFP document, *Thematic Review of Targeting in Relief Operations (WFP, 2006),* points out that while socio-demographic targeting may be easier to use, proxy indicators of social or health status may correlate poorly with food insecurity.[54] In Uganda, the profile 'female-headed household' had often been used to target vulnerability, but an analysis of household income and expenditure data found no correlation between gender of household head and the probability of being poor.[55] An analysis by the International Food Policy Research Institute (IFPRI) revealed that households caring for one orphan exhibited less food insecurity than households with no orphans; while for households caring for more than one orphan, food insecurity was significantly greater.[56] These findings have significant implications for targeting, such as the need to consider the number of orphans in a household and to incorporate multiple targeting criteria to ensure that resources are going to the most vulnerable.

Targeting in a high-HIV prevalence context requires identifying the most at-risk in the midst of broad-based vulnerability. Whether targeting is based on geographic or demographic profiles, there will always be certain individuals and households with similar vulnerability who are excluded from support because they are outside the defined target group or defined target area. In many communities, every household is in some way affected by HIV and AIDS; multiple criteria are necessary in order to discern the most vulnerable. The use of multiple vulnerability criteria is relevant for all forms of social protection, including food assistance programming.

Most social protection mechanisms include some form of means testing (i.e. use of economic criteria) to determine eligibility for benefits. While some focus on income, others look at wealth and assets, ensuring that the recipients of benefits (food, cash or other) are not selected solely on the basis of geographic location and/or social category, but also on their capacity to cope (as indicated by their asset portfolio).

Showing preference for one group over another raises issues of equity and social justice. "Initial efforts, for example, to target AIDS orphans in Africa have given way to targeted support to all orphans and to families caring for orphans, rather than denying benefits to the carers' biological children."[58]

Effective targeting is challenged by limitations in mandate, skill, capacity and outreach to communities where services are delivered. Clinical health service providers, for example, cannot be expected to conduct extensive household vulnerability assessments to determine if a patient should be eligible for food supplements as an adjunct to treatment. Strong referral mechanisms must be in place to link services and make relevant assessments in an efficient manner.

In an environment of broad-based vulnerability, where differences in means are subtle, some programmes have opted for universal coverage once

Key Issues: Equity

There is ample evidence that HIV and AIDS have had an unprecedented impact on household vulnerability to food and livelihood insecurity. In response, humanitarian actors have developed targeting mechanisms designed to identify and reach out to those affected by HIV and AIDS without involving stigma (e.g. by using proxies such as chronic illness and dependency ratios).

But can we assume that proxies for AIDS reliably demonstrate increased vulnerability? Should a child who lost her parents due to conflict, disease other than AIDS or even an automobile accident be excluded from the same benefits awarded to a child orphaned by AIDS? Is a household caring for orphans necessarily more vulnerable (and therefore in need of more social protection) than a household with no orphans that is poor or vulnerable for other reasons?

How do we ensure that individuals and households (that are at least as vulnerable as those affected by HIV and AIDS) are not overlooked? In one extreme case of perceived inequity, individuals in Uganda (in the early days of HIV and AIDS) prayed to become HIV-positive in order to receive some of the benefits that their HIV-positive neighbours were receiving.

There is growing evidence that targeting based on social demographics alone (e.g. female-headed households or households with orphans) is inadequate. Asset ownership has been found to be the best indicator of vulnerability, suggesting that a combination of economic and social demographics should be used where possible.

A 2003 C-SAFE survey in Malawi, Zambia and Zimbabwe found that vulnerability was most highly correlated with households that fell into a minimum of two (preferably more) vulnerable group categories. The application of ***multiple vulnerability criteria*** increases the probability that those selected are indeed the most vulnerable.[59]

The ability to provide services to people of equal need irrespective of their location poses operational and logistical challenges particularly where the need is thinly spread across a vast geographic area (low need density). In this context, prioritization of funds and efforts towards areas with higher need-density is often inevitable.

> There is a danger in considering the broader impacts of HIV and AIDS on livelihoods of "AIDS exceptionalism", privileging AIDS over other disease in health systems or focusing unduly on the impact of AIDS in food security programmes.
>
> *Harvey, 2004*

Are Households With Orphans More Vulnerable?

A 2005 report, *Food Aid and Chronic Illness*[60] (based on data collected from six southern African countries), concluded that **household asset ownership is the strongest indicator** of food security compared to other targeting variables such as chronic illness, presence of orphans and gender of the head of household. Asset ownership was found to be highly correlated with the Coping Strategy Index and the Food Consumption Scores (dietary diversity), suggesting that the effectiveness of food aid targeting could be improved by first differentiating households according to their wealth category.

Evidence to suggest that "orphan households" are more vulnerable to food insecurity remains mixed. The Comprehensive Household Survey (CHS) data showed no correlation; however, a recent study by IFPRI cites evidence that while households with one orphan may be less food insecure, those with multiple orphans appear to experience significantly more food insecurity.

Key Issues: Predictability

To be effective, social protection needs to be transparent, reliable and **predictable.** If a community knows what it is entitled to and can expect to have access to it in a reliable manner, it can exploit these benefits to their fullest, taking calculated risks to enhance livelihood opportunities. This is not possible if entitlements are unclear, or if it does not have sufficient confidence in the receipt of those benefits to engage in long-term planning.

Predictability, reliability and sustainability are not terms commonly associated with food aid or foreign aid projects. Food aid programmes usually have a short lifespan (one to five years maximum), with budgets subject to the whims of donor interest or competing priorities from year to year. Furthermore, pipeline challenges can cause food rations to vary in composition, size and timing, making it difficult for recipients to depend on them enough to engage in planning. Often, due to fears of dependency, timeframes are kept short intentionally.

The routing of social protection benefits through programmes with long-term vision, planning and budget cycles is crucial for establishing trust and reliability for targeted recipients. This trust allows households to make decisions based on the expectation that they will receive the benefits in a reliable manner. Trust may require several years of uninterrupted support, with both the content of the support and its quality being predictable and guaranteed. For example, a farmer who knows that he will receive seeds from the government for several upcoming agricultural seasons will have the confidence to invest his limited resources in capital equipment and other agricultural inputs. Without that trust, however, he will refrain from investing, keeping his livelihood options limited and stagnant.

Given the uncertainties of funding for externally-resourced programmes, is it ethical for external agencies to provide social protection? What should their role be? Should alternative roles be considered (e.g. support to government-managed mechanisms)?

Predictability, reliability and other such concepts are challenges to external food aid programmes, and suggest that channelling resources through more permanent conduits may be more effective. A shift towards long-term, national safety net programmes is an option that is gaining popularity. It requires donors to finance national budget line items and support the mandate of national governments to protect and promote the rights of their citizens to certain entitlements.

Alex de Waal argued in 1997, “The internationalization of responsibility for fighting famine is not a positive development.” International relief risks undermining political contracts between the state and its citizens, and “it is only through popular accountability and political contract that famine will be conquered.” [61] One might make a similar argument for social protection.

Ethiopia undergoes strategic shift

Ethiopia is introducing a five-year social protection scheme entitled **Productive Safety Nets Programme (PSNP).** Ethiopia’s leading bilateral and multilateral donors have played an important role in driving the current debate and advocating new strategies to assist chronically food-insecure households. Relief provided on an emergency basis has barely kept the poor above water. At best, it has simply kept them treading water. It has not built assets nor has it secured livelihoods. The PSNP represents a significant institutional transformation of the aid system in Ethiopia. One critical design feature is multi-annual funding commitments by donors, which will enable the government to provide predictable resources to targeted chronically food-insecure populations. There is broad donor support for the government’s decision to address chronic food insecurity through a budget line, rather than through the annual appeal.[62]

Mozambique develops multiple vulnerability criteria and comprehensive targeting procedures[57]

In 2004, the National AIDS Council of Mozambique commissioned the Technical Secretariat for Food Security and Nutrition (SETSAN) to develop procedures for identifying groups that were vulnerable to food insecurity and malnutrition due to the impact of HIV and AIDS. SETSAN set up a multi-sectoral working group to draft procedures for institutionalized mechanisms to identify geographic priority areas, specific beneficiary groups from within the general target group and criteria for selecting beneficiaries within these groups. The procedures included common criteria for beneficiary selection and standard means for verifying eligibility for support, as well as guidance for cross-referral between the various actors.

Cumulative criteria	Infected household member	Affected household member
Clinical criteria +	• HIV+ (tested), asymptomatic (Stage I); or • HIV+ (tested), asymptomatic, unintentional weight loss < 10% (Stage II); or • HIV+ (tested), symptomatic, partially and fully bed-bound (Stages III and IV); or • partially or fully bed-bound due to chronic illness (adult 15–59 years old too ill to work or to perform normal duties for a total of 3 months during past 12 months); and • moderate or severe malnutrition.	(no clinical criteria)
Socio-economic criteria +	Income level of household is insufficient to meet the additional food and non-food needs brought about by the demands of chronic illness. Taken into consideration: • income from formal employment and other sources; • income from crop production; • income from sale of livestock; • other locally important sources of income; and • other criteria (no able-bodied working adult, high effective dependency ratio, assets, housing conditions, etc.).	
Socio-demographic criteria	Sex Age: <17 years (child) >55 years <> 6 months < 5 years pregnant or lactating	Relation to people living with HIV: spouse, child, parent; Sex Age: <17 years (child) >55 years <> 6 months < 5 years pregnant or lactating

Malawi DAP Opts to Rotate Coverage Rather than Means Test for Improvements in Food Security Status

In 2004, a consortium of international NGOs in Malawi entered a five-year Development Assistance Programme (DAP) entitled I-LIFE.

One aspect of their portfolio of development interventions was to place food rations to vulnerable households on a 15-month cycle. After the first cycle was complete, a community committee prioritized the most vulnerable households for the subsequent rotation.

The decision to use a standard cycle, instead of discharging beneficiaries when their food security status improved, was done to reduce disincentives for households to improve their food security. (I-LIFE's predecessor C-SAFE had discharged beneficiaries when their food security status had improved sufficiently.)

(BEN27)

targeting has been conducted at a macro level (i.e. there is no additional criteria at the beneficiary selection phase). This ensures that people will not distort their behaviour in order to gain entry into the programme – such as families who take in orphans in order to qualify for food aid (but do not make a long-term commitment to the child) or who defer the purchase of productive assets (knowing that "limited or no assets" is one targeting criteria for food rations).

Finally, it is important to assess the costs and benefits of targeting strategies since the more sophisticated the targeting (i.e. the more sensitive and specific), the greater the administrative costs. While there is a widely recognized need to improve targeting and assessment capacity with respect to food security, nutrition and HIV and AIDS, there has been a reluctance to provide adequate resources to support such a labour-intensive undertaking. In collaboration with government counterparts, entities such as FEWS NET, WFP, national vulnerability assessment committees (VACs) and international and national NGOs have a role to play in providing technical support and building local capacity to assess vulnerability.

8. THE ROLE OF WFP IN SOCIAL PROTECTION FOR HIV AND AIDS

Given the multiple challenges for social protection in the era of HIV and AIDS and the role that food assistance can play as part of the overall social protection framework, WFP has begun to rethink its own institutional role and consider opportunities for sharing its expertise.

Externally sourced and managed food aid programmes represent a small portion of the social transfers required to meet the overall need, and most will never be sustainable in a developing country context. While food aid programmes serve an important purpose, effective social protection policies must be of a more permanent, reliable and sustainable nature. And just as importantly, they should be accessible to citizens of developing countries irrespective of their geographic location or social demographic profile – i.e. they should be based on need. This may mean significantly increased services in some countries where the impact of HIV and AIDS has been substantial, so that quality services are available nationwide. To this end, there are several areas in which WFP can consider making a contribution.

Knowledge orientation

Evaluate the impact of food on people living with HIV: There are major gaps in knowledge regarding the impact of food on people living with HIV (in particular CI, PMTCT, TB and ART). While practitioners in the field and beneficiaries are convinced of the critical role that food plays in the maintenance and recovery of the health status of people living with HIV, documented, empirical evidence is necessary to convince donors and governments of that need. Linked to this, it is important for WFP to understand the possible effects of improved health and social outcomes on livelihood promotion and economic growth. WFP has a potential role in enhancing the knowledge base in this area via operational research and piloting of various options.

Provide leadership in vulnerability assessment and targeting: There is a clear role for WFP to play in enhancing the capacity of governments and local partners to conduct vulnerability assessments and to develop effective targeting strategies, mechanisms and criteria. WFP can make known *better practices* and *lessons learned* from its ample experience with VAC assessments, community and household surveillance (CHS) monitoring and targeting in high HIV prevalence contexts. In a collaborative process, WFP might also use the results of vulnerability assessment reports to develop recommended eligibility, admission and discharge criteria for food assistance programmes, and provide training in their application.

A comprehensive understanding of vulnerability with respect to particular target groups (such as ART clients, women in PMTCT programmes and orphans and other vulnerable children in care and support programmes) is increasingly required by practitioners in order to guide the design and implementation of interventions for these groups. A vulnerability profile can contribute to improved services delivery and projections of need for the future.

Policy and strategy orientation

Advocate for social protection and promote national strategies: WFP can help lobby local and donor governments on the benefits of social protection in the HIV and AIDS context, and can promote promising practices from countries such as South Africa, Namibia and Ethiopia. It can encourage donors to provide much-needed support to social protection agendas and assist national budgets to underwrite these policies.

Support social protection delivery systems: Social protection delivery systems (informal, semi-formal and formal) are heavily strained by increased poverty and the impact of AIDS. The ART rollout has put particular pressure on health care delivery systems at a time when they were already under stress from increased demand. Where food assistance is appropriate and warranted (and irrespective of whether it is internally or externally sourced), WFP can facilitate a scaling-up of delivery systems from a provincial or regional orientation, to one where there is integrated, national coverage. Linking nutrition support to the ART rollout is one area with immediate potential. Various tasks must be undertaken, such as harmonizing targeting criteria and strategies, mapping institutional actors and enhancing referral systems, installing procurement and logistics systems, and establishing monitoring and evaluation systems to ensure accountability. This is an obvious area where WFP can contribute, given its mandate to ”strengthen the capacities of countries and regions to establish and manage food-assistance and hunger reduction programmes” (Strategic Objective 5).

Promote links between policy frameworks, governmental coordinating bodies, international agencies and local service providers: Recognizing the strengths and weaknesses of informal, semi-formal and formal actors in the provision of social protection, WFP can facilitate links between these actors and promote a national framework that exploits the strengths of each to their fullest. As we

have seen, while organizations operating at the community level have strong outreach and high quality programming for the poor and vulnerable, geographic coverage and mandate is lacking. Forming links between these local actors, international agencies operating on district or regional levels, national coordinating bodies and a national policy framework is imperative. Given WFP's close ties (and cooperating agreements) with the range of actors, it has a potentially important role to play in facilitating these links and scaling up systems to achieve expanded, universal coverage.[63]

Programme orientation

Promote an integrative strategy that supports the continuum of care: Social protection needs to be available across the entire spectrum of prevention, care, support, treatment and mitigation. WFP can promote the use of the social protection model in order to encourage practitioners to design new, more holistic responses and to re-examine existing portfolios. In the language of WFP, while conducting an integrated vulnerability analysis, and moving step-by-step through the project design process, a social protection analysis would encourage building links between activities, objectives and goals within the food programming portfolio. WFP would also promote that portfolio as part of a larger social protection framework, emphasizing the need to connect activities horizontally across sectors and vertically between informal, semi-formal and formal social protection partners – an approach that may ultimately serve as a model for national social protection frameworks.

The mapping of institutional actors and available services is a crucial step towards the goal of strengthening referral systems. This will ensure that the system can easily identify a provider to meet the needs of an individual or household. And similarly, as needs change (i.e. a people's or households' condition improves or deteriorates) they can be matched with interventions that address those changes. For example, as a woman receiving food rations while on ART begins to regain her strength and stamina, she graduates from short-term nutrition support and is referred (possibly across sectors) to a longer-term livelihoods programme such as FFA, or to a micro-credit facility. A comprehensive model should facilitate cross-sectoral referrals where necessary, and may even consider cross-sectoral conditionality (e.g. linking receipt of micro-credit or agricultural inputs to school attendance or participation in water and sanitation activities).

Apply an HIV lens for food for work and food for assets: Given the obvious and continued popularity of public works as a form of social protection, as well as the growth of food for work and food for assets as food-based mechanisms, it is important that these programmes be made more inclusive of people living with HIV and be adapted to consider and intentionally mitigate the impacts of AIDS. WFP's vast experience implementing FFW and FFA in high HIV-prevalence contexts makes it a strong candidate for promoting this approach.

ACRONYMS

ART	anti-retroviral therapy
ARV	anti-retroviral
C/FBO	community/faith-based organization
CHS	Community and Household Surveillance
CI	chronically ill
CRS	Catholic Relief Services
C-SAFE	Consortium for Southern Africa Food Security Emergency
CSB	corn-soya blend
DAP	Development Assistance Programme
ECCD	Early Childhood Care and Development
FAO	Food and Agriculture Organization of the United Nations
FEWS NET	Famine Early-Warning System Network
FFA	food for assets
FFW	food for work
GIPA	Greater Involvement of People Living with HIV and AIDS
HBC	home-based care
HIV/AIDS	human immunodeficiency virus/acquired immune deficiency syndrome
IDS	Institute of Development Studies
JFFLS	Junior Farmer Field and Life Schools
MAPP	Market Assistance Pilot Programme
MOHA	Ministry of Home Affairs
NGO	non-governmental organization
NVF	new variant famine
ODI	Overseas Development Institute
PMTCT	prevention of mother-to-child transmission
PRSP	Poverty Reduction Strategy Paper
PSNP	Productive Safety-Net Programme (Ethiopia)
RDA	recommended daily allowance
SIDA	Swedish International Development Cooperation Agency
TAC	Treatment Action Campaign
TB DOTS	Tuberculosis – Directly Observed Treatment, Short-course
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VAC	vulnerability assessment committee
VAM	vulnerability analysis and mapping
WFP	World Food Programme
WHO	World Health Organization
WV	World Vision

REFERENCES

Bennett, J., Forced Migration Review (FMR) 18, Food aid logistics and the southern Africa emergency, September 2003.: 28–31

Bishop, C.; Greenaway, K.; Kruse-Levy, N.; Weinhauer, K.; Senefeld, S. Catholic Relief Services. Nutrition and Food Security for People Living with HIV and AIDS, 2006.

C-SAFE, MAPP Fact sheet, 2003.

C-SAFE, Food-for-Assets Programming through an HIV and AIDS Lens – Manual and Checklist, C-SAFE Learning Spaces, April 2005.

C-SAFE, Food-for-Assets: Adapting Programming to an HIV and AIDS Context, C-SAFE Learning Spaces, September 2004a

C-SAFE, Targeted Food Assistance in the Context of HIV and AIDS – Better Practices in C-SAFE Programming from Malawi, Zambia and Zimbabwe, C-SAFE Learning Spaces, 2004b

Caldwell, R, Food Aid and Chronic Illness: insights from the Community Household Surveillance Surveys. Tango International on behalf of WFP and C-SAFE, 2005.

Devereux, S., Social Safety Nets for Poverty Alleviation in Southern Africa, ESCOR Research Report, R7017, London, DFID, 2000.

Devereux, S., Institute of Development Studies (IDS), Working Paper 142, Social Protection for the Poor: Lessons from Recent International Experience, January 2002.

Devereux, S., Institute of Development Studies (IDS), Policy Options for Increasing the Contribution of Social Protection to Food Security, September 2003

Devereux, S. and Sabates-Wheeler R., IDS Working Paper #232, Transformative Social Protection, October 2004.

Devereux, Steven and Sabates-Wheeler R., Institute of Development Studies, AIDS and Vulnerability Workshop, AIDS, Vulnerability and Social Protection, 23-24 June 2005.

De Waal, A., Famine Crimes – Politics and Disaster Relief Industry in Africa, African Rights and Indiana University Press, 1997.

De Waal, A. and Whiteside, A., 'New Variant Famine': AIDS and Food Crisis in Southern Africa, The Lancet 2003, 362: 1234-37 (11 October 2003).

DFID, Social Transfers and Chronic Poverty, Emerging Evidence and the Challenge Ahead, A DFID Practice Paper, October 2005.

Egge, K. and Strasser S., C-SAFE, Measuring the Impact of Food on HIV/AIDS – Related Beneficiary Groups, With a Special Focus on TB, ART, CI and PMTCT Beneficiaries, M&E Indicators for Consideration, November 2005.

Erdelmann, F., WFP, private correspondence, 2006.

FANTA, HIV & AIDS: A Guide for Nutritional Care and Support, October 2004.

Gentilini, U., Mainstreaming Safety Nets in the Social Protection Policy Agenda: A New Vision or the Same Old Perspective? Journal of Agricultural and Development Economics, Vol. 2 No. 2, 2005.

Gillespie, S. and Kadiyala, S., IFPRI, HIV/AIDS and Food and Nutrition Security: From Evidence to Action, 2005.

Green, M., UNICEF, Strengthening National Responses to Children Affected by HIV/AIDS: What is the Role of the State and Social Welfare in Africa, Background Paper for Wilton Park Conference, 14-16 November 2005.

Greenaway, Kate, HIV consultant, private correspondence, 2006.

Greenaway, K. and Mullins, D., The HIV/AIDS Timeline as a Program Tool: Experiences from CARE and C-SAFE, April 2005.

Greenblott, K., Focus group conducted with school children at WV school feeding in Zimbabwe, 2005.

Harvey, P., HPG Research Report #16, HIV/AIDS and Humanitarian Action, April 2004.

Harvey, P. and Lind, J., Dependency and Humanitarian Relief, Overseas Development Institute (ODI), HPG report, July 2005.

Meyer S, Nutritional Care and People Living with HIV, Arizona Dietetic Association, as reported in Nutrition and HIV/AIDS Research Abstracts, 2000.

Nyangara, F. Sub national distribution and situation of orphans: an analysis of the president's emergency plan for AIDS relief focus countries, Washington DC, USAID, 2004.

Rivers, J., Silvestre, E., Mason, J. IFPRI, Nutrition and Food Security Status of Orphans and Vulnerable Children, 2004.

Rockefeller Foundation, Human Resources for Health and Development -- A Joint Learning Initiative, 2003.

RuralNet Associates, World Vision HIV/AIDS, Food and Nutrition Operations Research Proposal, January 2005.

Slater, R., ODI, The Implications of HIV/AIDS for Social Protection, September 2004.

Tango International. 2005. Linking HIV/AIDS Responses with Food-Based Social Protection Systems, An Appraisal of Social Welfare Systems in Malawi, Mozambique, Swaziland and Tanzania. Rome, WFP.

Taylor, A. and Seaman, J., Save the Children UK, Targeting Food Aid in Emergencies, ENN Special Supplement Series, No. 1, July 2004.

Treatment Action Campaign (TAC), TAC Website, http://www.tac.org.za/index.html, 2006.

UNICEF Summary Report, Innovations in Social Protection in Eastern and Southern Africa, Reaching the most vulnerable children in the context of HIV/AIDS, An Integrated Summary Report on Education, Public Works and Cash Transfer Programs, 2005.

World Food Programme (WFP) 2002, WFP Gender Policy (2003-2007): Enhanced Commitments to Women, October 2002.

WFP 2004a, HIV/AIDS & Tuberculosis. Addressing co-infection, July 2004.

WFP 2004b, WFP & Food Based Safety Nets: Concepts, Experiences and Future Programming Opportunities, October 2004.

WFP 2006, Thematic Review of Targeting in Relief Operations: Summary Report, February 2006.

World Health Organization (WHO) Consultation on Nutrition and HIV/AIDS in Africa, Participants Statement, Durban, South Africa, 10-13 April, 2005A.

WHO, Executive Summary of a Scientific Review, Consultation on Nutrition and HIV/AIDS in Africa: Evidence, lessons and recommendations for action, Durban, South Africa, 10?13 April 2005B.

World Bank, Repositioning Nutrition as Central to Development, A Strategy for Large Scale Action, 2006.

Zgouv, E.K., Mvula, P.M., Kunkwenzu, E. and Potani, M. 1988. A review and evaluation of the MASAF safey net programme. Lilongwe, Malawi Social Action Fund.

ENDNOTES

1 Tango International, 2005.

2 Gentilini, 2005.

3 Tango International, 2005. This description of a common purpose of social protection was adapted from the source noted, with one change. The word ‘public’ was intentionally removed from ‘public goods’ to recognize the importance of public and private goods within the realm of social protection.

4 Devereux and Sabates-Wheeler, 2004.

5 Gentilini, 2005.

6 WFP, 2004b.

7 Slater, 2004.

8 Tango International, 2005.

9 Gentilini, 2005.

10 Devereux and Sabates-Wheeler, 2004.

11 Green, 2005.

12 Egge and Strasser, 2005.

13 Brainstorming list produced in plenary by participants at C-SAFE workshop on Exit Strategies, April 2005 in Harare, Zimbabwe. Participants included staff from CRS, CARE, WV, WFP and several donor representatives.

14 De Waal and Whiteside, 2003.

15 Devereux, 2005.

16 Rockefeller Foundation, 2003.

17 Nyangara, 2004.

18 Devereux, 2002

19 Green, 2005.

20 Greenaway, 2006.

21 UNICEF, 2005.

22 C-SAFE, 2004.

23 Slater, 2004.

24 Greenaway and Mullins, 2005.

25 This tool was developed by Kate Greenaway (C-SAFE and CRS) and Dan Mullins (CARE US) as a training and mainstreaming mechanism for C-SAFE and CARE staff in southern Africa.

26 WHO, 2005a.

27 FANTA, 2004.

28 WHO, 2005b.

29 Greenaway, 2006.

30 RuralNet Associates, 2005.

31 Gillespie and Kadiyala, 2005.

32 Bishop, 2006.

33 RuralNet Associates, 2005.

34 Devereux, 2002. This table was adapted, adding factors particularly relevant to an HIV and AIDS context.

35 Devereux, 2002.

36 A chronically ill (CI) individual is defined as "An individual experiencing persistent and recurring illness lasting three months or more, which has reduced that person's level of productivity".

37 WFP, 2004a.

38 WFP, 2004a.

39 Meyer, 2000.

40 This comment refers to Egge and Strasser, 2005.

41 The lens described here was designed by C-SAFE for adapting FFA programming to an HIV context and is detailed in C-SAFE, 2005.

42 This comment is in reference to C-SAFE, 2005.

43 UNICEF, 2005.

44 Examples taken from C-SAFE, 2004.

45 UNICEF, 2005.

46 Slater, 2004.

47 Slater, 2004.

48 Slater, 2004 and UNICEF, 2005.

49 WFP, 2002.

50 Children who for one reason or another, have difficulty accessing primary education, or who drop out prematurely, or have been pushed out of formal education system by the system itself, or who fail to learn, despite being in school.

51 Greenaway, 2006.

52 Taylor and Seaman, 2004.

53 C-SAFE, Targeted Food Assistance in the Context of HIV/AIDS, 2004.

54 WFP, 2006.

55 Devereux, 2002.

56 Rivers, Silvester, Mason, 2004.

57 Tango International, 2005.

58 Devereux, 2002.

59 C-SAFE, 2005.

60 Caldwell, 2005.

61 de Waal, 1997.

62 Harvey, 2004.

63 WFP, 2004b.

BOX END NOTES (BEN)

BEN1: USDA Food Stamp Program website, 2006, http://www.fns.usda.gov/fsp/

BEN2: Devereux, 2003.

BEN3: Devereux, 2000.

BEN4: UNICEF Summary Report, 2005.

BEN5: Tango International, 2005 (Malawi).

BEN6: Green, 2005.

BEN7: C-SAFE, 2004a.

BEN8: C-SAFE, 2004a.

BEN9: Treatment Action Campaign, 2006.

BEN10: Harvey and Lind, 2005.

BEN11: Gillespie and Kadiyala, 2005.

BEN12: Bennett, 2003.

BEN13: WFP, 2004b.

BEN14: C-SAFE, 2003

BEN15: Slater, 2004.

BEN16: WHO 2005b.

BEN17: Erdelmann, 2006.

BEN18: Tango International, 2005 (Malawi).

BEN19: Egge and Strasser, 2005.

BEN20: Tango International, 2005 (Swaziland).

BEN21: Harvey and Lind, 2005.

BEN22: C-SAFE, 2004a.

BEN23: DFID, 2005.

BEN24: UNICEF, 2005.

BEN25: Greenblott, 2005.

BEN26: Tango International, 2005.

BEN27: C-SAFE, 2004b .

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