

Real-time Evaluation of DG ECHO financed action of CARE International Deutschland in Zimbabwe

Contract N°: ECHO/ADM/BUD/2007/01214

for European Commission's Directorate General for Humanitarian Aid (DG ECHO)



Cover photo: Zimbabwe, Care Facilitators, Ward 11 "Cheshanga", Mberengwa District, 16th Nov. 2007

Final Report Phase II / II – April 2008

**submitted by Particip GmbH :
Ms Annemarie Hoogendoorn (TL)
Mr Munhamo Chisvo**

Report costs: € 124.150,00 - equivalent to 9% of the total Budget evaluated



This report has been prepared with the financial assistance of the European Commission. The views expressed herein are those of the consultants and therefore in no way reflect the official opinion of the Commission.

TABLE OF CONTENTS

TABLE OF CONTENTS	II
LIST OF FIGURES	III
LIST OF TABLES	III
ABBREVIATIONS	IV
EXECUTIVE SUMMARY	1
1. INTRODUCTION.....	6
1.1 Overall purpose and objectives of the RTE	6
1.2 Epidemiological update on the HIV/AIDS pandemic.....	7
1.3 International responses to the HIV/AIDS pandemic.....	8
1.4 DG ECHO responses to HIV/AIDS.....	10
1.5 Conceptual framework Integrated Home Based Care.....	11
1.6 Key conclusions and recommendations of the Zimbabwe case study	12
1.7 Methodological considerations for the RTE	14
2. KEY STRATEGIC ISSUES FOR DG ECHO FOOD AND NUTRITION SUPPORT PROGRAMMES ALONG HOME BASED CARE	15
2.1 Potential for use of DG ECHO food aid within HIV responses	15
2.2 Technical design considerations with regard to food / nutrition support alongside Home Based Care Programmes	18
2.3 Performance measurement for food/nutrition support alongside Home Based Care Programmes	22
2.3.1 Theoretical framework	22
2.3.1.1 Overview of performance measurement	22
2.3.1.2 Results to be measured in nutrition support to CHBC?	22
2.3.2 Recommended indicators for performance measurement in nutrition support to CHBC....	23
2.3.2.1 Core indicators for assessing impacts and outcomes of the nutrition support to CHBC	24
2.4 Cost implications for scaling up food / nutrition support alongside Home Based Care programmes in Southern Africa.....	26
2.4.1 Underlying assumptions	26
2.4.2 Costing the different options of the CHBC scaled-up operation	26
2.4.2.1 Option 1: CSB and nutrition, health and hygiene education only	26
2.4.2.2 Option 2: CSB, IEC on nutrition, health and hygiene; ART and Cotrimoxazole as antibiotic/prophylaxis for Opportunistic Infections.....	28
2.4.2.3 Option 3: CSB, Maize, Oil, IEC on nutrition	29
2.4.2.4 Other Options.....	32
3. CONCLUSIONS AND RECOMMENDATIONS	33

LIST OF FIGURES

Figure 1: Median HIV prevalence among women (15-49 years) attending antenatal clinics in consistent sites in Southern African countries, 1998-2006.....	8
Figure 2: Home Based Care Conceptual Framework	12

LIST OF TABLES

Table 1: Global HIV prevalence and AIDS deaths in 2007.....	7
Table 2: Indicators and the monitoring of results	23
Table 3: Estimated cost for scaling up CSB plus IEC on nutrition, health and hygiene.....	28
Table 4: Estimated cost for scaling up CSB; IEC on nutrition, health and hygiene; ART and Cotrimoxazole (at 70% coverage of ART and Cotrimoxazole).....	29
Table 5: Price ranges for maize in maize exporting countries in the SADC region, 2007/8 marketing season.....	30
Table 6: Estimated cost for scaling up CSB; Maize; Oil; IEC on nutrition, health and hygiene; ART; Cotrimoxazole; hygiene kits and other medical supplies.....	30

ABBREVIATIONS

ACP	Group of countries in Africa, the Caribbean and the Pacific that have signed a partnership with the EC (Cotonou Agreement)
AIDS	Acquired Immuno Deficiency Syndrome
ALNAP	Active Learning Network for Accountability and Performance in Humanitarian Action
ART	Anti Retroviral Therapy
AusAID	Australian Government Overseas Aid Program
BMI	Body Mass Index (Height / Weight ²)
CAP	Consolidated Appeals Process (for UN agencies, coordinated by OCHA)
CARE	Cooperative for Assistance and Relief Everywhere
CHBC	Community Home Based Care
CI	Chronically ill
CIDA	Canadian International Development Agency
C-SAFE	Consortium for the Southern Africa Food Emergency
CSB	Corn Soy Blend
CSP	Country Strategy Paper (EC)
DAC	Development Assistance Committee (part of the OECD)
DFID	UK Department for International Development
DG ECHO	The European Commission's Directorate General for Humanitarian Aid
DOTS	Directly Observed Treatment Schedule (TB treatment protocol)
EDF	European Development Fund
ESP	Expanded Support Programme
FANTA	Food and Nutrition Technical Assistance (USAID funded)
FAO	Food and Agriculture Organization
FY	Fiscal Year
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GoZ	Government of Zimbabwe
HBC	Home Based Care
HIV	Human Immuno Virus
HLSA	Household Livelihood Security Assessment
IEC	Information, Education and Communication
IFRC	International Federation of Red Cross and Red Crescent Societies
IOM	International Organization for Migration
JFSAM	Joint Food Security Assessment Mission (WFP/FAO)
KABP	Knowledge, Attitudes, Behaviour and Practices
LAMF	Locally Adapted and Manufactured Formulae
LRRD	Linking Relief, Rehabilitation and Development
M&E	Monitoring and Evaluation
MCT	Mashambanzou Care Trust (WFP cooperating partner for HBC)
MoHCW	Ministry of Health and Child Welfare
MOESC	Ministry of Education, Sport and Culture
MPP	Micro-Project Programme (EC)
MPSLSW	Ministry of Public Service, Labour and Social Welfare
MUAC	Mid-upper-arm circumference
NAC	National AIDS Council

NATF	National AIDS Trust Fund
NGO	Non Governmental Organization
NIP	National Indicative Programme (EC)
NPA	National Plan of Action (support to OVCs)
OCT	Overseas Countries and Territories (EC)
OECD	Organization for Economic Cooperation and Development
OIs	Opportunistic Infections
OVCs	Orphans and other Vulnerable Children
OVI	Objectively Verifiable Indicator
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission
PoS	Programme of Support (for OVCs)
PRP	Protracted Relief Programme (DFID funded)
QALYS	Quality of Adjusted Life Years
RSO	Regional Support Office (DG ECHO, based in Nairobi)
RTE	Real Time Evaluation
RUSF	Ready to Use Supplementary Food
RUTF	Ready to Use Therapeutic Food
SAM	Severely Acute Malnutrition
SIDA	Swedish International Development Cooperation Agency
SST	Sector Support Team (DG ECHO, based in Nairobi)
TA	Technical Assistance
ToR	Terms of Reference
UNGASS	Special Session of the United Nations General Assembly on HIV/AIDS
VCT	Voluntary Counselling and Testing for HIV
VGf	Vulnerable Group Feeding
WAAC	Ward AIDS Action Committee
WFP	World Food Programme
WHO	World Health Organization
ZDCP	Zimbabwe Decentralized Cooperation Programme (EC)
ZIMVAC	Zimbabwe Vulnerability Assessment Committee
ZNASP	Zimbabwe National HIV and AIDS Strategic Plan (2006-2010)
ZRCS	Zimbabwe Red Cross Society

EXECUTIVE SUMMARY

Overall purpose and approaches of the Real Time Evaluation

DG ECHO (the European Commission’s Directorate General for Humanitarian Aid) has contracted Particip GmbH to conduct a Real-Time Evaluation from 5th November 2007 to end of February 2008 focused on the “Food Support to Integrated Home Based Care Programme” which is implemented by CARE International in rural Zimbabwe. This food-based HIV response project is financed from the DG ECHO managed Food Aid Decision.

The purpose of the evaluation is (a) to feed into defining a possible medium term strategy concerning food assistance activities for HIV/AIDS affected households in the Southern Africa region (including contributing towards further development of DG ECHO funding guidelines on HIV/AIDS) and, where appropriate, serve as a basis for justifying follow-up financing decisions, and (b) to provide information about the implementation and impacts of this DG ECHO pilot financing and subsequently identify re-adjustments of the activities within the remaining implementation period.

As part of the Real Time Evaluation, the evaluators have developed a visualized conceptual framework on Integrated Home Based Care which integrates food security, health services and health environment and household care as the three cornerstone factors influencing the health and nutrition status of chronically ill patients. The evaluation has been based on a review of documents and publications, interviews, meetings and workshops in Zimbabwe, Johannesburg / Pretoria and Nairobi, and project visits in two of the three districts where the programme is implemented and some visits to some other relevant programmes in Zimbabwe.

Potential for use of DG ECHO food aid within HIV responses

The mandate of DG ECHO is geared towards providing a needs-based emergency response aimed at preserving life, preventing and alleviating human suffering and maintaining human dignity in respect of the “do no harm” principle, which is fully in line with the Principles and Good Practices of Humanitarian Donorship (endorsed by the 2003 Stockholm Conference) and the 2007 European Consensus on Humanitarian Aid. From a combination of humanitarian policy and technical perspectives, the evaluation has resulted in a prioritized listing of food and nutrition interventions within HIV responses that are pertinent to the humanitarian mandate:

- As DG ECHO is bound to the framework of natural or man-made disasters which involve multi-sector assistance with short timeframes and results-oriented approaches, it is clear that HIV/AIDS cannot be an entry criterion *per se* for DG ECHO. However, in any setting where HIV is a significant problem DG ECHO will need to incorporate a strong focus on HIV/AIDS in order to ensure the effectiveness of its funded programmes,. In all acute and protracted emergencies DG ECHO should make sure that HIV/AIDS prevention activities are mainstreamed in every financed project / programme (this is a priority 1 activity).
- For food assistance as part of humanitarian responses, the prime focus should be to address the food crisis while ensuring that general (targeted) food distribution programmes are also reaching food insecure HIV affected households. As part of the time-bound international response to a food crisis and depending on HIV prevalence figures and malnutrition levels among HIV+ individuals, there might be a need for DG ECHO to finance targeted nutrition support interventions geared to the needs of malnourished people living

with HIV/AIDS (priority 2 level). In these situations the food crisis is the entry point and not HIV/AIDS *per se*. These programmes could be piggybacked onto supplementary / therapeutic feeding programmes or to Home Based Care programmes. Just like for any other humanitarian assistance programme, beneficiary selection for these programmes should be needs-based (with the status of malnutrition indicating a need for nutritional rehabilitation). Individual targeting for such programmes should never be based on treatment status (whether the patients are on antiretroviral therapy or not), as exclusion of malnourished people with HIV from getting access to nutritional rehabilitation support would run across equality considerations.

- Other options for incorporation of food-based complementary programmes within humanitarian crisis response packages (in the context of a non-stabilized humanitarian crisis) are at priority 3 level primarily serving gap filling purposes (pointing to the need for sustainability after DG ECHO phase out) and/or for piloting of innovative approaches and documentation of lessons learned. E.g., DG ECHO could decide to fund food support to needy clients of Prevention of Mother to Child Transmission programmes, to socio-economically vulnerable or food insecure patients alongside Home Based Care (to be differentiated from the nutrition support for malnourished Home Based Care clients which is a priority 2 intervention) or for gap filling in year-round food support to vulnerable orphans and their caretakers (but emergency food assistance to these target groups preferably should be provided through inclusion in general food distribution programmes and emergency livelihood interventions), or as food support while starting up antiretroviral therapy schedules. Detailed decision-making on the use of the range of eligible options and on operational aspects for each of the interventions will have to be adapted to specific country contexts.

Technical design considerations with regard to food / nutrition support alongside Home Based Care programmes

Over the past few years, various practical guidelines have been published on nutritional care and support within HIV responses. The key programming recipes in these guidelines are that:

- For people living with HIV it is seen as essential to consume higher amounts of energy (10% more in stage 1 and 20% to 30% more in stages 2 and above) but otherwise the international opinion is now that requirements for protein and for micronutrients are not elevated.
- The technical design for food / nutrition support to Home Based Care programmes will need to be based on (a) clear situation analysis and targeting methods based on nutritional status; (b) assessment of the needs for support to community volunteers to the Home Based Care system; (c) strategic partnerships and integration with other social care programmes in the medical sector, food aid / food security sectors and the water and sanitation sector, including effective coordination with the Government and the main implementers of relief and development interventions; (d) specific feeding protocols based on appropriate and cost-efficient food rations including micronutrient fortification that are in line with existing national HIV/AIDS policies and response guidelines; and (e) inclusion of nutrition education as an essential element of food-based support programmes.

Performance measurement for food / nutrition support alongside Home Based Care programmes

It is now internationally accepted that comprehensive care for people living with HIV must include nutritional support when required. However, solid evidence on the effectiveness of

food and nutritional support to adult HBC patients is still being gathered. Most studies conducted so far have been small and not adequate for unequivocal scientific validation of results. A key limitation of many studies is the lack of information on viral loads to assess the response to therapy. An additional limitation is the lack of credible baseline data especially on mortality rates prior to the intervention, as well as the lack of effective control groups for tracking the counterfactual for ethical reasons.

There is a growing interest among humanitarian agencies to measure and document the effectiveness (outcomes and impacts) of nutritional support programmes based on Ready-to-Use therapeutic foods and Corn Soy Blend porridge for malnourished HIV+ adults. This presents an opportunity for DG ECHO to contribute to this global discourse of seeking evidence through its pilot initiatives. Additionally, there is a niche for DG ECHO to possibly take up a role to support development of explicit guidelines on integrating effective operational research into on-going pilot Home Based Care oriented nutrition interventions.

Cost implications for scaling up food / nutrition support alongside Home Based Care programmes in Southern Africa

A basic package of 25 kg of Corn Soy Blend would cost DG ECHO €12.94 per client per month or €155.25 per client per year. Assuming that DG ECHO will provide support only to malnourished HIV+ individuals who are in stages 3 or 4 of the disease, and only in those countries in Southern Africa that have frequent occurrence of humanitarian emergencies and that these countries meet all the necessary entry criteria for DG ECHO, it is estimated that in the worst case scenario, a total of 379,830 clients may be eligible for support in six countries (Lesotho, Malawi, Mozambique, Swaziland, Zambia and Zimbabwe). DG ECHO may anticipate the cost of scaling up food and nutrition interventions to reach this number of beneficiaries in these six countries to amount to about € 60 million per year.

Antiretroviral therapy and Cotrimoxazole can be added to this package at an additional cost of €114 and €8.16 per client per year, respectively, resulting in an annual programme budget of €91.5 million or (€241 per client) that covers both food and the drugs. If DG ECHO decides also to add hygiene materials such as gloves and other supplies for bed-ridden clients, this is highly recommended as this is in conformity with Priority 1 activities of the DG ECHO HIV/AIDS Guidelines which seek to reduce the spread of HIV/AIDS and related OIs. However, antiretroviral therapy, Cotrimoxazole as treatment/prophylaxis against opportunistic infections and hygiene materials would be long-term undertakings and alternative funding sources in the context of longer term social protection programmes should be mobilised for this cause first and DG ECHO only intervene with a clear exit strategy linked to well articulated strategy for handover to more sustainable funding instruments. As a general principle, inclusion of hygiene/other medical supplies should be conditional upon results of a proper study to evaluate the cost-effectiveness of these supplies which should be commissioned first. The study should culminate into the identification of a prioritised and properly costed set of essential items that should be included in the hygiene/first aid medical supplies kit.

Assuming the composition of the food package is diversified to 10 kg Corn Soy Blend, 1 litre cooking oil and 25 kg maize as recommended in a recent costing exercise by WFP, the direct cost of food only would almost double to €10.11 per client per month or €121 per client per annum. If ART and OI treatment are included the cost increases to €20.31 per client per

month or €243.73 per client per year, giving rise to a total regional programme cost of €79 million per annum.

Conclusions and recommendations

With regard to the potential for DG ECHO food aid as part of HIV responses the following main conclusions have been drawn:

A. Options for DG ECHO support

- The 2004 DG ECHO Model Guidelines provide a clear though not officially endorsed overall framework for decision-making including the position that HIV/AIDS will not serve as entry point *per se* and a prioritization of DG ECHO financing of HIV responses but a revision is needed (a) to work towards formulation of an official EC policy statement on DG ECHO funding of HIV responses within humanitarian assistance and (b) to work on further elaboration of practical guidelines for eligible types of interventions endorsing the hierarchy of priorities of the 2004 Model Guidelines.
- DG ECHO could play an influential and important role in the area of financing of pilot programmes of food assistance in relation to HIV responses in any emergency context where the organization is already present with other humanitarian interventions and where HIV a public health problem. It is particularly recommended to DG ECHO to finance pilot projects to test new programming approaches, e.g. on beneficiary targeting methods, efficient integrated intervention models and for development of effective and cost-efficient local production methods for fortified blended foods.
- Food support to vulnerable households affected by HIV/AIDS through a general (targeted) food distribution programme and targeted nutrition support interventions for malnourished HIV+ individuals (either through inclusion in supplementary / therapeutic feeding programme or through linking up with a Home Based Care programme) both fall within the Priority 2 in the 2004 / new draft Guidelines which are strongly recommended wherever appropriate and feasible. Beneficiary selection for these interventions should be irrespective of whether patients are on antiretroviral therapy and should be confined to the duration of the food crisis. Building on the experiences of the Zimbabwe case study and through collation of available practical guidelines, some general design outlines have been drawn for food / nutrition support alongside Home Based Care.
- Other options of secondary priority are only eligible in a non-stabilized humanitarian crisis and with preconditions of sustainability and existence of exit strategies. This e.g. pertains to food support alongside Prevention of Mother to Child Transmission programmes, food support to food insecure / socio-economically vulnerable Home Based Care clients and their households, food support to HIV+ patients while starting up antiretroviral therapy schedules, and food support to vulnerable orphans and their caretakers.

B. Performance measurement

- Performance measurement and evaluation should be at the core of any future “nutrition for Home Based Care” programming. The demand for such information is growing and a need specifically exists for DG ECHO to mainstream operational research as a core activity within its pilot nutrition interventions in support of Home Based Care. This will also strengthen accountability of DG ECHO’s partners. The process should start by carefully reviewing and reaching a consensus on a short list of core impact and outcome indicators sufficient to inform the collection and analysis of data on the effectiveness of these

interventions, then incorporating them into the guidelines for preparation and assessment of partner proposals.

C. Cost implications of scaling up in the Southern Africa region

- The cost per client for a more diversified food and nutrition package may be more expensive per beneficiary than providing one commodity. However, a more diversified package may be more effective in meeting the development objectives (impact) of the food and nutrition support as it provides a more nutritionally adequate diet.
- Given the short-term nature of DG ECHO funding in general, and the high cost nature of nutritional and medical support to PLHIV (Euro 157-209/client per year), DG ECHO funding should be considered only when there is a guarantee that the short term assistance will have demonstrable and sustainable impacts and there is a clear exit strategy linked to follow-on funding either by other donors, global funds or by government’s own resources (through the national budget instruments). For ART and OI treatment, these are clearly long-term undertakings where DG ECHO may not have a comparative advantage, vis-à-vis other EC instruments or bilateral and multilateral donors (such as DFID, World Bank, USAID, etc) hence DG ECHO should first seek to activate more appropriate longer-term sources and pipelines before mobilizing emergency humanitarian partners. Of priority would be European Commission instruments or other donors funding social protection programmes on a longer term basis in countries affected by humanitarian emergencies.
- Apart from cost-sharing arrangements with other development partners in the same sector, there is also the scope for cost-savings when food purchases are better planned for (e.g., maize purchases) and if funds can become more predictable so as to allow advance procurement, say using futures markets or if DG ECHO partners better manage transportation costs.
- It is evident that the cost of the food package is volume-driven and the size of the package is a key contributor to costs (both direct costs and overheads, especially transport). In the diversified package as recommended by WFP for Home Based Care, maize would account for (60%) the cost of the food package, whilst Corn Soy Blend would account for about 28% and oil 12%. If joint funding arrangements are not feasible and costs have to be reduced significantly to match available resources, the intervention would have to first scale down the protective household ration portion of the package, which is principally maize. Otherwise for impact, it would be better for DG ECHO to maintain the recommended more diversified package which clearly distinguishes the special nutritional needs of the malnourished HBC patients and the food supplementation needs of the other household members. Instead, it would be preferable to pursue other cost-cutting measures which do not entail compromising the ration package.

1. INTRODUCTION

1.1 Overall purpose and objectives of the RTE

¹ DG ECHO (the European Commission’s Directorate General for Humanitarian Aid) has contracted Particip GmbH to conduct a Real-Time Evaluation (RTE) of the “Food Support to Integrated Home Based Care (HBC) Programme” which is implemented by CARE International¹ in three districts in rural Zimbabwe. This project is a pilot financing as it was the very first time for DG ECHO to involve itself in a programme on HIV responses implemented by a Framework Partner with funding from the Food Aid Decision.

² As stated in the Terms of Reference (ToR, see Annex A), **the purpose of the RTE is twofold²:**

- 1. The RTE should feed into defining a possible medium term strategy concerning food assistance activities for HIV/AIDS affected households in the Southern Africa region, and, where appropriate, serve as a basis for justifying follow-up financing decisions.**
- 2. The RTE should provide information about the implementation and impacts of the DG ECHO financed activities and subsequently identify re-adjustments of the activities within the remaining implementation period.**

³ The assignment is meant to provide recommendations at two levels: (a) **at the operational level in order to suggest improvements as necessary with regards to the financed CARE project in Zimbabwe;** and (b) **at the strategic level in order to feed into the current process of redefining and elaboration of DG ECHO’s role and potential approaches as to HIV/AIDS,** including contributing towards further development of the DG ECHO’s HIV/AIDS model guidelines published in 2004 (PROLOG Consult, 2004a and 2004b).

⁴ The Terms of Reference specify that the RTE has to be structured in two phases which reflect the two different levels. The report for Phase I which comprises a detailed quality assessment of the CARE Food Support to Home Based Care programme has only been shared with the stakeholders that are directly involved in this project. The current (second) report is for Phase II which is meant to promote accountability and learning through an analysis at strategic level of DG ECHO’s possible role(s) in relation to food security and HIV responses building on the experiences of the financed pilot project in Zimbabwe. To make this report available for a much wider audience, it will be placed in the public domain on the Internet, with the intention to inform EU member states, DG ECHO’s operational personnel, other donors, and the humanitarian community in general.

¹ CARE International is a consortium of twelve national CARE members with a secretariat based in Switzerland. The acronym CARE stands for Cooperative for Assistance and Relief Everywhere. For background information on CARE International, see www.care-international.org.

² The Terms of Reference mention the following specific objectives for the RTE: (a) To review the partner’s baseline information; (b) To identify and appraise and analyse other ‘base-line’ information; (c) To evaluate the implementation of DG ECHO’s strategy in this action under the Food Aid Decision (both with regard to programme implementation quality criteria, and in the sense of ‘lessons learned’ during programme implementation); (d) To assess if DG ECHO’s HIV/AIDS guidelines are pertinent with regard to food aid interventions and/or identify areas where adaptation may be required and provide inputs to consider for eventual adaptations; (e) To assist DG ECHO to define a coherent and viable strategy regarding HIV/AIDS related food aid interventions, including alternative solutions; and (f) To provide conclusions and recommendations at both strategic and operational levels.

5. Within the Terms of Reference, some **specific areas of interest for DG ECHO** were highlighted. These have been taken by the evaluators as key questions at strategic and operational level that need to be answered by the RTE:

1. Key questions at strategic level:

- **Should DG ECHO at all be involved in food assistance for HIV/AIDS affected households?** If so, what are **appropriate (generic) entry and exit criteria at programme level?**
- **What would be the best design for food support to Home Based Care clients and their household members?**
- **How best to measure performance of Food Support to Home Based Care programmes?**
- **What are the cost implications if DG ECHO would decide to take up a more structural involvement in food support to Home Based Care programmes in Southern Africa?**

2. Key questions at operational level:

- **Which adaptations are necessary in the CARE Home Based Care food support programme to ensure that the programme is relevant, effective, cost-efficient and sustainable?**
- **What coordination and complementarity is required in the area of Home Based Care food support in Zimbabwe and in broader terms in all sectors that affect the health and nutrition status of chronically ill?**
- **What could be the future role for DG ECHO with regard to food and nutrition within HIV responses in Zimbabwe?**

1.2 Epidemiological update on the HIV/AIDS pandemic

6. The new AIDS Epidemic Update published by UNAIDS and WHO in December 2007 states that *“the HIV pandemic remains the most serious of infectious disease challenges to public health”*. *“Every day, over 6800 persons become infected with HIV and over 5700 persons die from AIDS, mostly because of inadequate access to HIV prevention and treatment services”* (p. 4). Global incidence peaked in the late 1990s at over 3 million new infections per year, and was estimated to be 2.5 million in 2007 of which two-thirds occurred in Sub-Saharan Africa, by far the most affected geographical area.

7. **This latest epidemiologic assessment is encouraging, as there are records of localized reductions in prevalence in specific countries, a reduction in HIV-associated deaths, partly attributable to the recent scaling up of anti-retroviral treatment (ART) access, and reduction in the number of annual new HIV infections globally.**

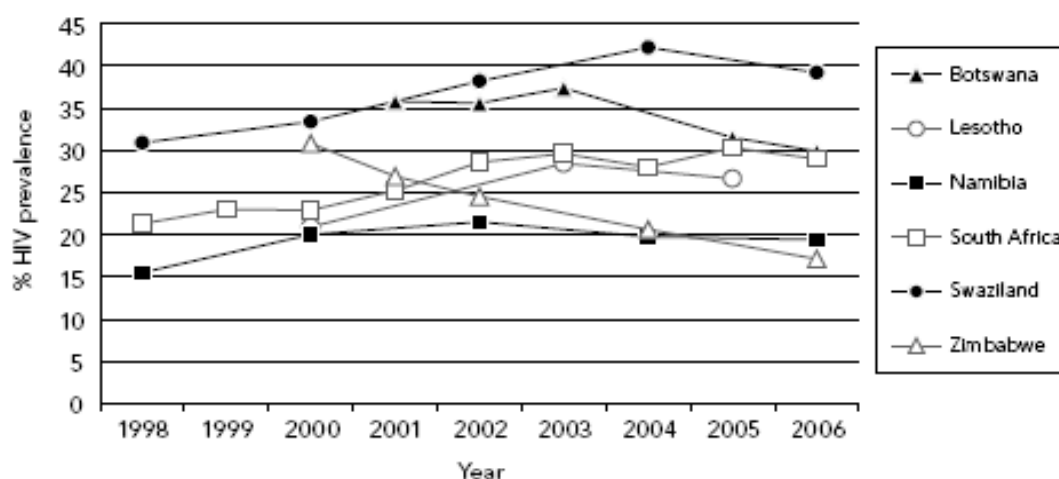
Table 1: Global HIV prevalence and AIDS deaths in 2007

Global rates		
PLHIV in 2007		
Adults		30.8 million
Women		15.4 million
Children < 15 year		2.5 million
Total		33.2 million
AIDS deaths in 2007		
Adults		1.7 million
Children		0.33 million
Total		2.1 million

(Source: UNAIDS / WHO, 2007)

8. **Generalized HIV / AIDS epidemics are sustained among the populations of many sub-Saharan African countries, especially in the southern part of the continent** where AIDS remains the leading cause of death although there are a number of countries with downward trends in HIV prevalence. The Southern Africa subregion accounts for 35% of all people living with HIV and 32% of all new HIV infections and AIDS deaths globally. National adult HIV prevalence is reaching a peak in most of the Southern African countries (apart from Mozambique where HIV is still increasing), exceeding 15% in eight Southern African countries³. In other parts of Sub-Saharan Africa, HIV prevalence is still worrying although rates are generally at much lower levels than in Southern Africa. **In most countries in East Africa adult HIV prevalence is either stable or has started to decline. In most of the comparatively smaller epidemics in West and Central Africa, adult national HIV prevalence over the past year has remained stable.**

Figure 1: Median HIV prevalence among women (15-49 years) attending antenatal clinics in consistent sites in Southern African countries, 1998-2006



(Source: UNAIDS / WHO, 2007)

9. The 2007 UNAIDS Update concludes that **increased investments in interventions for HIV prevention, treatment and care are clearly showing results**. It is stated that the impact of specific interventions cannot be defined through national statistics, as it would require special studies in local areas including direct assessment of HIV incidence, mortality, programme effectiveness and the burden of HIV infection, disease and death in children. “As the resources committed to AIDS and other major health problems continue to increase, more emphasis is required to strengthen systems to collect and analyse data and to improve the quality of such data to strategically guide programming” (UNAIDS/WHO, 2007, p. 6).

1.3 International responses to the HIV/AIDS pandemic

10. In 2001, the first **Special Session of the United Nations General Assembly on HIV/AIDS (UNGASS)** was held where the Declaration of Commitment⁴ on HIV/AIDS was unanimously adopted, acknowledging that the AIDS epidemic constitutes a “*global emergency and one of the most formidable challenges to human life and dignity.*” The Declaration of Commitment covers ten

³ The highest rates are found in Swaziland, Lesotho, South Africa and Botswana. In Zimbabwe there is evidence of a significant decline (from 33.7% in 2001 to 20.1% in 2005³).

⁴ UNGASS (2001), Declaration of Commitment on HIV/AIDS, New York, June 2001; see http://data.unaids.org/publications/irc-pub03/aidsdeclaration_en.pdf

priorities, from prevention to treatment to funding. It was designed as a blueprint to meet the Millennium Development Goal of halting and beginning to reverse the spread of HIV/AIDS by 2015.

¹¹ A further step forwards was the **UNGASS 2006 “Declaration of Commitment on HIV/AIDS: five years later”**⁵ which highlights that a strong foundation exists now in most countries to build an effective AIDS response including national AIDS strategies and national coordination bodies. Financial resources for AIDS have significantly increased; approximately US\$ 8.3 billion was spent in 2005 on AIDS programmes in low- and middle-income countries⁶. Treatment access has greatly expanded, although the global goal of having 3 million people on antiretroviral treatment (ART) by the end of 2005 (the UNAIDS/WHO “3 by 5” initiative launched December 2003) was not reached⁷. The 2006 UNGASS report provides a high-profile **international endorsement to scale up HIV response interventions for prevention, treatment, care and support**. A multi-sectoral approach involving governments, donors including the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), regional and sub-regional organizations, organizations of the UN system, civil society, the private sector, communities, people living with HIV and vulnerable groups in general was advocated.

¹² As with regard to the international policy framework on HIV/AIDS responses in emergency settings, the key reference is the **IASC Framework for Multi-Sector Activities** that was published in 2003 by the UN Inter-Agency Standing Committee (IASC, 2003⁸). The framework includes a listing of emergency preparedness, minimum response and comprehensive response options for each of the main humanitarian sectors.

¹³ The **main international donors for HIV responses** are: (a) The **World Bank** which funds a multi-country AIDS programme and which ran an additional US\$ 60 million AIDS treatment acceleration project in 2004/05; (b) the **Global Fund (GFATM)** which by the end of 2005 was supporting delivery of ART to 384,000 people worldwide^{9,10}; (c) The US President’s Emergency Plan for AIDS Relief (**PEPFAR**), a US\$ 15 billion 5-year programme of funding (in which it is planned to incorporate food support to HIV+ people¹¹) to speed up prevention, care and treatment in 15 focus countries¹² (US\$ 9 billion), to bilateral programmes in more than 100 non-focus countries¹³ (US\$ 5 billion) and an increased pledge to the Global Fund (US\$ 1 billion). End 2005, PEPFAR was providing ART to more than 400,000 people worldwide; and (d) the **European Commission** through

⁵ UNGASS (2006), [Declaration of Commitment on HIV/AIDS: five years later](http://data.unaids.org/pub/Report/2006/20060324_SGReport_GA_A60737_en.pdf), New York, March 2006; see http://data.unaids.org/pub/Report/2006/20060324_SGReport_GA_A60737_en.pdf

⁶ The financial target in the 2001 UNGASS Declaration of Commitment was between US\$ 7 and US\$ 10 billion.

⁷ By the end of 2005, 1.3 million people in low- and middle-income countries were benefiting from access to ART.

⁸ The IASC Guidelines on HIV responses in emergency settings are currently being updated to incorporate latest developments, new Guidelines are expected to be released in the second half of 2008.

⁹ It is to be noted that the EC has been a founding member of the Global Fund and is a member of the Board. The EC is the second largest individual donor to the GFATM while the EC together with the EU Member States is the biggest donor to the Global Fund.

¹⁰ At a recent WHO/UNICEF meeting on Nutrition and HIV/AIDS it was discussed how to mobilize resources for nutrition programmes in HIV context through inclusion in national Global Fund submission proposals (WHO/UNICEF, 2007).

¹¹ Food support to HIV+ people and for orphans and vulnerable children (OVCs) is a new component within the PEPFAR programme that will be implemented in FY 2008, which includes therapeutic and supplementary feeding of malnourished adults with special foods including Ready-to-Use Therapeutic Food (USAID, 2007a).

¹² PEPFAR focus countries are: Botswana, Cote d’Ivoire, Ethiopia, Guyana, Haiti, Kenya, Mozambique, Namibia, Nigeria, Rwanda, South Africa, Tanzania, Uganda, Vietnam and Zambia. The goals for these countries are known as the “2/7/10 goals” meaning prevention of 7 million new infections, treatment of 2 million HIV-infected people, and care for 10 million people infected and affected by HIV/AIDS including orphans and vulnerable children.

¹³ Zimbabwe is a non-focus country. However, in FY 2005, Zimbabwe was receiving the second-largest share among the non-focus countries, and over the 4-year period 2004 – 2007 a total of US\$ 82.9 of PEPFAR funds was allocated to Zimbabwe.

a range of budget lines¹⁴ including direct contributions to the Global Fund, country-level allocations through the European Development Fund (EDF), the Thematic Budget line on Good Health For All and, for humanitarian responses, through DG ECHO. In some countries there are also substantial contributions from the **private sector**, e.g. in South Africa with 60,000 people being provided with ART.

1.4 DG ECHO responses to HIV/AIDS

¹⁴ In 2004, PROLOG Consult was contracted by DG ECHO to undertake a first review of potential approaches for DG ECHO with regard to HIV/AIDS. A concept paper and ‘**DG ECHO Model Guidelines**’ that both were published on the DG ECHO evaluation webpage resulted from the review (PROLOG Consult, 2004 and 2004b). However, the 2004 guidelines were never endorsed by the EC. In the Model Guidelines it is explicitly stated that they are valid for the year 2005 only. Regular updates were expected to be necessary in response to changes in HIV/AIDS related situations.

Key characteristics of the DG ECHO approach to HIV/AIDS as recommended by PROLOG Consult were:

- Because of the particularities of its core mandate as a humanitarian organization, DG ECHO cannot position itself as a front line vertical HIV/AIDS actor. Therefore, **HIV/AIDS *per se* will not function an entry criterion for DG ECHO interventions**. The disease should be addressed through mitigation of HIV/AIDS impacts in natural or man-made disasters as secondary objective within DG ECHO programme portfolios.
- HIV/AIDS should be addressed through a **multi-sectoral approach**, not just through the health sector, and should be considered in **all regions of the world**.
- **Depending on local context conditions and the type of activity, various levels of preconditions exist**.
- There is a clear prioritization of interventions: (a) **compulsory essential activities** geared to mainstreaming of HIV prevention; (b) strongly recommended ‘**core**’ **HIV mitigation activities** where appropriate and feasible **as component of existing multi-sector humanitarian programmes** (e.g. food aid, health, nutrition, water and sanitation interventions, etc.); and (c) ‘**non core**’ **HIV mitigation activities** to be considered **subject to strong preconditions only** including **clear timeframes in case of gap filling within regular HIV programmes and existence of options for hand-over to the government or other donors** (e.g. gap filling for ART, PMTCT and livelihood support for HIV/AIDS orphans and their caretakers).
- The model guidelines are **based on the 2003 IASC framework for multi-sector activities**.

¹⁵ **In 2007, DG ECHO started to update the DG ECHO HIV/AIDS guidelines** through a more formal policy development process involving a wide range of stakeholders with DG ECHO and DG DEV, both at headquarters and from the field. The need for the revision became very apparent because of new approaches in the HIV/AIDS field that have emerged related to the scaling up of ART coverage and because of the shift of responsibility for management of the EC emergency food aid budget from AIDCO to DG ECHO from 2007 onwards. ‘Draft DG ECHO HIV/AIDS funding guidelines’ (an EC non-paper) were discussed at a round table in Brussels which was held 21st February 2008¹⁵. These guidelines among others have much more detailed sections on the role of food, nutrition and livelihood support responses in high prevalence contexts. The evaluators have contributed to these new guidelines through production of a short report reflecting on version 3 of the

¹⁴ See: European Commission (2005), Communication from the Commission to the Council and the European Parliament, A European Programme for Action to Confront HIV/AIDS, Malaria and Tuberculosis through External Action (2007-2011), COM(2005) 179 final, Brussels, April 2005; and the “EC/EU Policies and Strategies on HIV/AIDS at Country Level” document issued in January 2006, available at: http://ec.europa.eu/development/icenter/repository/06-04_Programming_HIV-long_en.pdf

¹⁵ This round table was attended by a wide range of international stakeholders on HIV/AIDS responses, including from the DG ECHO partners framework, GFATM, UNAIDS, OCHA, UNICEF, UNHCR, WHO, UNFPA and WFP.

new draft funding guidelines (attached as Annex B) and provision of feedback to later versions of the new draft guidelines including attendance at the round table conference.

¹⁶ The Real Time Evaluation of the DG ECHO pilot financing for the CARE food support to Home Based Care patients in Zimbabwe is meant to feed into this **currently ongoing process of redefining and elaboration of DG ECHO’s role and potential approaches to HIV/AIDS**. It is hoped by DG ECHO that critical reflection on this important pilot project financed from the Food Aid Decision¹⁶ will offer an analytical framework resulting in clear lessons that can guide future decision-making on DG ECHO financing for food rations and nutritional programmes in contexts with high HIV prevalence.

1.5 Conceptual framework Integrated Home Based Care

¹⁷ The Home Based Care (HBC) approach stands at the core of this Real Time Evaluation of the DG ECHO financed food support to Zimbabwean rural households affected by HIV and AIDS and other chronic diseases. **HBC is seen as including all forms of non-hospitalized care and support for chronically ill people where the primary care is provided by household members, while the community plays a role to support that household in their care giving role.**

¹⁸ The evaluators have approached this RTE through the ‘lens’ of a need for integrated approaches towards assessing and analyzing the needs of households affected by HIV / AIDS. As part of the assignment, **a visualized conceptual framework on Integrated Home Based Care** was developed. **This “HBC triangle” is an adaptation of the UNICEF Malnutrition Conceptual Framework, the very same key factors (insufficient household food security; inadequate care; insufficient health services and unhealthy environment) are taken as corners of the HBC triangle¹⁷.**

¹⁶ Please note that this Food Support to Home Based Care projects actually forms only one type of HIV response that can be financed by DG ECHO based on the Food Aid Decision budget. Other options for food-based support programmes will be discussed later on in this report.

¹⁷ After the HBC was developed, the evaluators discovered that a somewhat similar diagram called the household nutrition security triangle was presented in an article by S Lemke in Public Health Nutrition on the results of a field study on nutrition security, livelihoods and HIV/AIDS among farmer worker households in South Africa (Lemke, 2005).

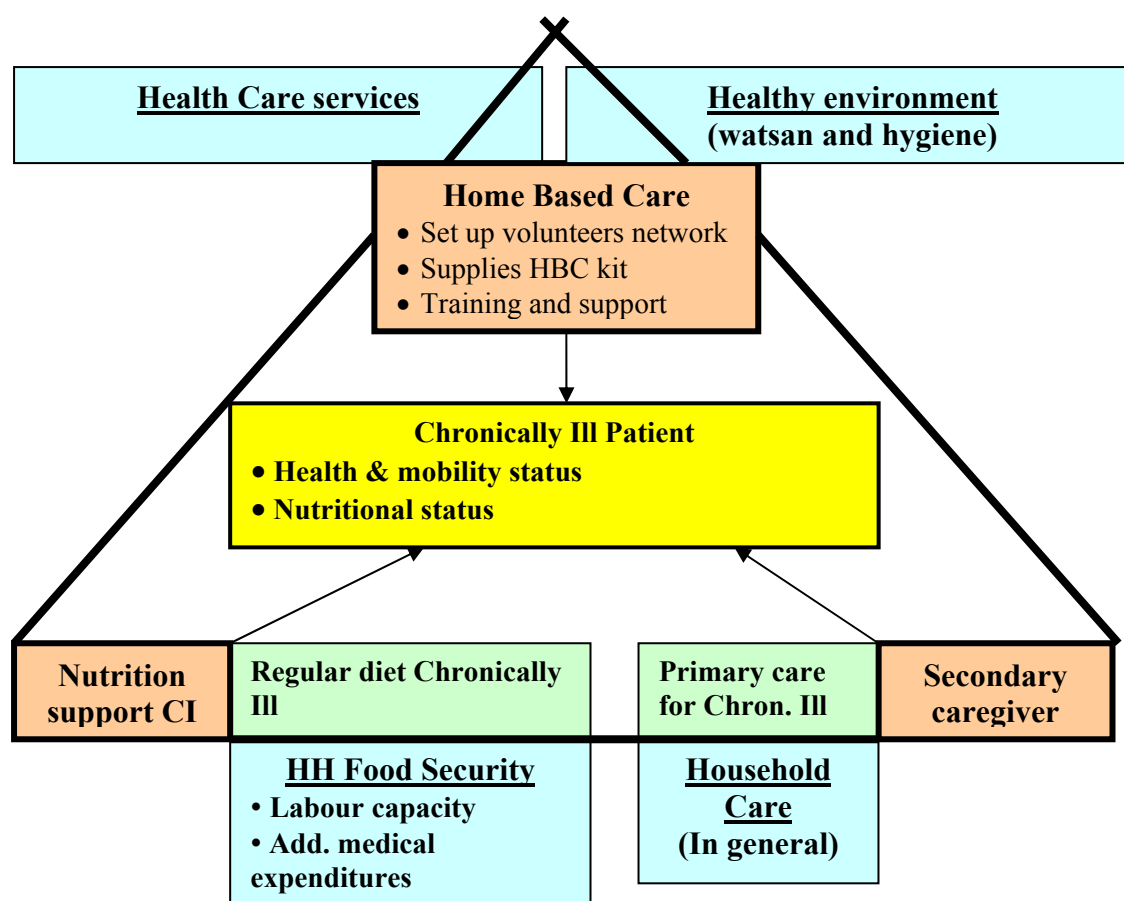


Figure 2: Home Based Care Conceptual Framework

1.6 Key conclusions and recommendations of the Zimbabwe case study

¹⁹ The main findings of the case study of the CARE International Food Support to Home Based Care programme in Zimbabwe financed by DG ECHO (the basis for this Real Time Evaluation) are summarized here, while a more detailed overview of the results of this study is presented in Annex C.

Key findings CARE Food Support to Home Based Care programme Zimbabwe

²⁰ Assessment of this programme incorporated the revision and no-cost extension that was proposed by CARE Deutschland as part of the first narrative report to DG ECHO. Some key findings of this evaluation are that the food support to Home Based Care clients programme:

- Is very relevant in the current Zimbabwean context and in line with the national HIV/AIDS policy;
- Is in line with the DG ECHO 2004 Model Guidelines and falls in the Priority 2 ‘Strongly recommended where appropriate and feasible’ category;
- Is exploiting synergies with longer term development activities also implemented by CARE International with funding from DFID;
- Is suffering from several design flaws as the overall design was more based on the model for general food support to Home Based Care clients and their household members than specifically geared to therapeutic / supplementary feeding of HIV+ individuals. Particularly, the following elements were found to have been missing: a rigorous assessment of nutrition

needs and availability and access to antiretroviral therapy for Home Based Care clients in the three districts, acknowledgement of the important context condition that basic health care services in the three programme districts are very limited, a choice for the most effective and cost-efficient food rations (selection of types or products and adopted ration scales), the definition of appropriate beneficiary entry and exit criteria, good coordination with the much larger vulnerable group feeding (general food distribution) programme, and the definition of a clear exit strategy.

21. The implementation of the programme during the first four months of operation from July 2007 onwards has been negatively affected by a range of internal and external factors. Key factors that have led to compromised programme results so far are (a) lack of permission by the Government of Zimbabwe to import Ready-to-Use Therapeutic Food; (b) limited medical support to fight opportunistic infections because of occurrence of some gaps in the supply line for medical materials for the Home Based Care programme; (c) delayed imports of weighing scales and height measuring equipment; (d) delayed implementation of the nutrition knowledge and practices survey; and (e) insufficient allocation of human resources to the project compromising technical backstopping on nutrition and smooth programme coordination including monitoring and evaluation functions.

22. Based on the request for a no-cost extension to a total of ten monthly food distribution rounds instead of eight, the programme costs have been calculated to amount to € 2.82 per targeted beneficiary per month (including both Home Based Care clients and the household members), but € 4.39 per beneficiary per month if the calculation is based on the actual programme coverage of 30,000 people. In terms of total cost per chronically ill patient reached, the cost figure is € 19.08 per beneficiary per month¹⁸. The evaluation concludes that for fortified blended foods the first choice commodity should be Corn Soy Blend. The actual cost of Ready-to-Use-Supplementary Food imported from France is about 15.9 times higher than for the same amount of dietary energy transferred through Corn Soy Blend produced in the Southern African region¹⁹.

Main findings on the role of DG ECHO in Zimbabwe

23. Since 2002, DG ECHO has spent a total humanitarian aid budget of € 88.9 million in Zimbabwe (see Annex J for a detailed overview²⁰) plus € 15 million from the 2007 Food Aid Decision, including earlier involvement in financing from 2002 to 2005 for food support to Home Based Care programmes implemented by the Zimbabwean Red Cross Society.

24. For the DG ECHO financing in 2007 for food assistance within HIV responses in Zimbabwe it is concluded that it is coherent with the assistance packages provided by other main donors to Zimbabwe and also with the national HIV/AIDS policy framework, but that CARE urgently needs to start up coordination and harmonization with similar nutrition support for people living with HIV operations run by WFP and MSF-Holland and MSF-Spain. In future, it is suggested to continue with piloting of food/nutrition support within HIV responses, but to aim at more geographical convergence with other intervention lines in the DG ECHO Global Plans and Food Aid Decision for Zimbabwe and to better exploit the potential for linking with recovery types of financing by the EC,

¹⁸ The monthly cost per chronically ill patient reaches amount to € 5.75 for patients who only receive Corn Soy Blend (CSB) rations but to € 21.56 per month for the malnourished patients who receive Supplementary Plumpy and Corn Soy Blend rations.

¹⁹ This costs analysis is based on comparison of food purchase costs only.

²⁰ From the start in 2002 onwards, DG ECHO financing has been focused on four key areas of work: (a) funding for general food aid and provision of agricultural inputs; (b) water and sanitation projects, plus some support for medical and nutrition interventions and psychosocial support to OVCs; (c) integrated assistance to IDPs (mainly ex-commercial farm workers and the population affected by Operation ‘*Murambatsvina*’); and (d) budget for presence of DG ECHO technical assistance capacity in-country.

DFID, USAID and other donors to Zimbabwe in the medical and food security sector, and with e.g. the big DFID Poverty Relief Programme.

1.7 Methodological considerations for the RTE

²⁵ The overall guiding framework for the evaluation has been the global and specific objectives as stated in the Terms of Reference, which the evaluators found to be clear and complete. The evaluation has been based on the **OECD-DAC²¹ definitions for commonly used evaluation criteria²²** and the guidelines annexed to the ToR. The RTE has also been based on commonly used guidelines for humanitarian practice, like the **Sphere standards** and the **Principles of Good Practice of Humanitarian Donorship (Stockholm Conference)**. Finally, the evaluation has been grounded in the legal framework for DG ECHO (Council Regulation (EC) 1257/96).

²⁶ The work plan and methodology for this RTE are attached as Annex D. The **evaluation framework** that was elaborated during the first days of the assignment (included as Annex F) consists of three sets of evaluation questions (together with a set of judgment criteria, indicators and sources of information) for each of the three different strategy levels for this RTE. This included programme quality criteria (relevance, effectiveness, efficiency, impact and sustainability) and assessment of the implementation of the LRRD objective and attention for cross-cutting issues like the elderly, gender, community networks and participation.

²⁷ In this report, the two-pronged purpose of the Real Time Evaluation is reflected in the way how the chapters have been organized. In Chapter 1, an overall introduction is given and the objectives and methodology for the real time evaluation including the key conclusions and recommendations of the Zimbabwe case study on targeted nutrition support for Home Based Care clients. Chapter 2 then focuses on analysis of key strategic issues for DG ECHO in decision-making on food and nutrition support programmes alongside Home Based Care (and to some extent for people living with HIV in general).. In Chapter 3, key conclusions and recommendations are given (a) at strategic level how DG ECHO could use food assistance within HIV response programmes and (b) at the operational level how the CARE International programme in could be improved and on the future role for DG ECHO in food and nutrition assistance within HIV responses in Zimbabwe.

²¹ OECD – DAC stands for the Development Assistance Committee of the Organization for Economic Cooperation and Development. The OECD is an international organization with about 30 member countries including the main international players. The OECD is committed to democracy and the further development of the global market economy.

²² Beck T (2006), [Evaluating humanitarian action using the OECD-DAC criteria; an ALNAP guide for humanitarian agencies](http://www.odi.org.uk/ALNAP/publications/eha_dac/index.htm), ALNAP, Overseas Development Institute, London, March 2006, see http://www.odi.org.uk/ALNAP/publications/eha_dac/index.htm

2. KEY STRATEGIC ISSUES FOR DG ECHO FOOD AND NUTRITION SUPPORT PROGRAMMES ALONG HOME BASED CARE

2.1 Potential for use of DG ECHO food aid within HIV responses

²⁸ From the start of the assignment, it has been realized by the evaluators that the central underlying strategic issue for this RTE is the current internal policy discussions as to whether DG ECHO should get involved in scaling up of food and nutrition assistance as part of HIV responses in Southern Africa or not. **The RTE is expected to feed into the process of defining medium term strategies for DG ECHO with respect to food and nutrition support programmes for HIV/AIDS infected and affected people, building on the Model Guidelines drafted in 2004 which are currently being updated.** The *caveat* here is that the context conditions in Zimbabwe are very specific and do not represent overall regional conditions in Southern Africa. Also, it is to be realized that extrapolations just based on one single case study will have to be treated with extreme caution, although some triangulation has taken place with experiences and lessons from other countries through literature search and meetings with stakeholders at regional level.

²⁹ At the conceptual level, **any discussion on potential roles for DG ECHO should be based in the internationally accepted foundations for humanitarian action (the “Principles and Good Practice of Humanitarian Donorship” endorsed by the Stockholm Conference in June 2003) and the new European Consensus on Humanitarian Aid endorsed in December 2007²³.** Humanitarian aid is an expression of solidarity between people and as such a moral imperative to assist people in need affected by man-made and natural disasters, based on respect for the principle of neutrality, impartiality, humanity and independence of humanitarian action while national authorities will retain primary responsibility for protecting populations confronting disaster. **Within the EU vision, the objective of humanitarian aid is to provide a needs-based emergency response aimed at preserving life, preventing and alleviating human suffering and maintaining human dignity in respect of the “do no harm” principle.** The European Consensus aims at boosting EU coordination and emphasizes good donor practice including allocation of humanitarian funding in proportion to the needs and underpinned by effective partnerships and good understanding of the different roles of those involved in providing relief and the necessity to achieve linkage between relief, rehabilitation and development (LRRD) from the earliest phases of a crisis response.

³⁰ As stated in the EU Consensus document, the **comparative advantage and added value of DG ECHO²⁴** is based on: (a) its global presence through a **network of field experts and a very wide partner network including all main UN agencies and international relief organizations**; (b) **coherence of the provided humanitarian aid with EC / EU assistance for development, food security, public health etc.**; (c) the DG ECHO track record of promotion of good humanitarian practice; (d) **the ability to flexibly intervene in politically sensitive situations**; and (e) an emphasis on close coordination with Member States, other donors and the UN system. DG ECHO avails of efficient, flexible, transparent and where necessary rapid decision-making procedures. **Next to provision of financing for implementation of humanitarian operations, within its mandate DG**

²³ This Consensus on Humanitarian Aid follows the signing of the European Consensus on Development Aid in December 2005, which is the common legal framework for development policies of the European Union and its member countries. The chief objective is to reduce poverty worldwide in the context of sustainable development, and to contribute to meeting the Millennium Development Goals.

²⁴ The Humanitarian Service of the EC based on EC Council Regulation No. 1257/96 of 20 June 1996.

ECHO also can decide to finance preparatory and feasibility studies and general studies in the field of humanitarian operations, including for monitoring of humanitarian projects.

³¹ Referring to the study of donor behaviour in humanitarian financing by Smillie and Minear (2003) which was one of the background documents for the Stockholm Conference on Good Humanitarian Donorship, **humanitarian policy can be disaggregated into the following headings: (a) humanitarian principles** as e.g. laid down in the European Consensus document; **(b) sectoral policies** which can emphasize some sectors over others; **(c) policies on preferred delivery channels; (d) geographic policies;** and **(e) cross-cutting policy themes** like gender, children, risk reduction, LRRD etc.

³² The question now is what does this all mean in practical terms for the **potential for DG ECHO to allocate food aid budgets for incorporation within HIV responses?** This question has been addressed in this RTE through a combination of humanitarian policy and technical perspectives. The Real Time Evaluation based on the Zimbabwe case study and some further literature study has resulted in the following observations on **what food and nutrition interventions within HIV responses would be pertinent to the humanitarian mandate** of the organization:

- a) **A humanitarian organization like DG ECHO that intends to provide a needs-based emergency response aimed at preserving life, preventing and alleviating human suffering and maintaining human dignity one way or another will have to address the particular needs of HIV+ individuals, particularly in Sub-Saharan Africa.**
- b) As was clearly spelled out in the 2004 Concept Paper on DG ECHO’s approach to HIV/AIDS (PROLOG Consult, 2004a), **DG ECHO’s core mandate is bound to the framework of natural or man-made disaster situations which involve multi-sector assistance with short timeframes and results-oriented approaches.** It is through this approach that DG ECHO has an optimum added value to the humanitarian space. Thus, **the mandate of DG ECHO precludes taking up longer-term responsibility for “vertical” programmes targeted at particular diseases including HIV/AIDS. Therefore, HIV/AIDS clearly can never be an entry criterion *per se* for DG ECHO.** However, in order to respond to prioritized needs and to ensure the effectiveness of other DG ECHO funded programmes, **DG ECHO will need to incorporate a strong focus on HIV/AIDS interventions in settings where other emergency relief programmes are already being implemented.**
- c) **In acute and protracted emergencies DG ECHO should make sure that HIV/AIDS is mainstreamed in all of the financed activities. Programming decisions should be in line with various levels of preconditions, according to the type of activities and the local situation.** The current DG ECHO policy discussion focuses on where to draw the line as per the various options for expansion of DG ECHO involvement in HIV/AIDS. It is unambiguous that **long-term commitments can never be eligible for funding from a humanitarian donor source like DG ECHO. However, to some extent the door will need to be open for funding of gap filling measures during times of emergency to make sure that existing programmes (like ART, PMTCT, livelihood support to vulnerable orphans and their caretakers) will continue.**
- d) **In the realm of food aid within DG ECHO humanitarian responses, the prime focus should be to address the food crisis while ensuring that the general (targeted) food distribution programmes are also reaching food insecure vulnerable households affected by HIV/AIDS including Home Based Care clients and orphans and their caretakers if they qualify for general food assistance based on the level of household**

food insecurity²⁵. In the 2004 Model Guidelines and also in the new draft guidelines (the non paper), this objective is included under the Priority 2 (strongly recommended Core HIV mitigation activities).

- e) **Secondly, as part of DG ECHO humanitarian responses to a food crisis and depending on HIV prevalence figures and malnutrition levels among HIV+ individuals, there might be a need to establish targeted nutrition interventions geared to the need for nutritional rehabilitation among people living with HIV/AIDS (interventions that are complementary to general food distributions).** Such an objective also falls within the **Priority 2 category of the 2004 and new draft Guidelines (now called ‘Activities that DG ECHO will normally consider funding’)**. In line with the humanitarian mandate, DG ECHO food support piggybacked onto existing HIV response programmes should prioritize addressing the needs of moderately and severely malnourished HIV affected individuals²⁶ including HIV patients at advanced stages of the disease irrespective of whether they are on ART or not. Another cost-efficient approach could be to look for options for inclusion of malnourished HIV+ adults in regular therapeutic and supplementary feeding programmes that are normally targeted at young children. Upfront it should be clear that DG ECHO’s role as per the provision of food support to the selected delivery channels to reach nutritionally vulnerable people living with HIV/AIDS can only be confined to the duration of the acute or protracted food crisis and should stop as soon as the food crisis situation is resolved²⁷.
- f) **Other options for incorporation of food-based complementary programmes within humanitarian crisis response packages (in more general terms, not only in situations of food crisis) fall in the Priority 3 category of the 2004 and new draft Guidelines (‘non core’ HIV mitigation activities) which implies that DG ECHO will consider funding under exceptional circumstances only. E.g., it can be explored by DG ECHO to provide **food assistance to specific programmes for vulnerable people affected by HIV, like food support to needy clients of Prevention of Mother to Child Transmission (PMTCT) programmes**²⁸, **food support to socio-economically vulnerable or food insecure patients alongside Home Based Care or while starting up ART treatment schedules**²⁹. The objectives of such programmes are to provide a nutrition supplement to HIV+ individuals, to increase treatment uptake and to encourage adherence to treatment particularly in the first months of administration (both through the incentive effect and through the transfer of basic food items to food-insecure people so that time is freed to seek treatment). Another type of food-based intervention in the Priority 3 category is **food support to vulnerable orphans****

²⁵ In the case of Zimbabwe this role is already taken up by the WFP Vulnerable Group Feeding (being co-funded by DG ECHO, in 2007 € 12.5 million was allocated to WFP for their programmes in Zimbabwe) and the USAID C-Safe food safety net programmes, but the situation might be different in case of emergencies in any of the other Southern / Eastern African countries with high HIV prevalence.

²⁶ In line with targeting practices of other main actors in this field, it is suggested to use a BMI < 18.5 as entry criterion for such programmes for adults, and the regular cut-off points for nutritional rehabilitation of children. There are modified criteria for use with pregnant and lactating women which are based on Mid Upper Arm Circumference.

²⁷ In line with the typology of the roles for DG ECHO in different kinds of crises as presented in the EC document on LRRD (European Commission, 2001).

²⁸ This could be alongside DG ECHO support to PMTCT programmes including funding of ARVs as short term intervention also impacting on child malnutrition and mortality, or in the form of support to PMTCT+ (continued therapy for infected mothers after birth) when there are sufficient back-up services and a fair possibility of handing the programme over to longer-term funding providers.

²⁹ There is gradual convergence of the international opinion on the effectiveness of targeted nutrition support to reduce mortality after putting advanced HIV patients on ART. Temporary food support by DG ECHO prior and during the initial stages of ART has also been shown to greatly improve the uptake of ARVs (The International Bank for Reconstruction and Development / The World Bank, 2007). The effect of food support on adherence to treatment regimes is less clear and sometimes debated from the point of view that eligible HIV+ individuals should be motivated to follow the treatment regime irrespective of receiving “fringe benefits”.

and their caretakers which usually serves as a year-round social safety net and therefore requires very careful definition of eligibility criteria. However, food support to orphans and their caretakers preferably should be mainstreamed in general food distribution programmes (and in emergency livelihood programmes) if these exist. For all of these Priority 3 types of food-based support programmes, vulnerability should be defined in line with the thinking behind the Integrated Phase Classification (FAO/FSAU, 2006). This classification is based on a livelihoods approach where it is emphasized that food security should be analyzed within a framework of medium and longer-term time trends and with recognition of the dynamic interlinkages with sectoral crises in the fields of health, and water and sanitation. A similar stress on the need for integrated approaches is reflected in the conceptual framework for Home Based Care that was developed for this evaluation. **Detailed decision-making on the use of the range of eligible options and on operational aspects for each of the interventions within the Priority 3 category will have to be adapted to specific country contexts.** For all of these types of food support, it should be clear from the start onwards that DG ECHO financing is **mainly suitable for gap filling purposes**, which points to the essential **precondition of sustainability after DG ECHO’s phase out**, e.g. through handing over to other food pipelines or through handing over to public safety nets, or for **a clear exit strategy (scaling down / phasing out altogether)** as soon as the immediate food crisis has been resolved. **In general DG ECHO does not qualify as an appropriate instrument for comprehensive HIV responses in the stabilized phases of a humanitarian crisis.**

2.2 Technical design considerations with regard to food / nutrition support alongside Home Based Care Programmes

³³ Once the programming decision has been made to start up specific food / nutrition support for chronically ill through linking up with a Home Based Care programme, immediately **the subject of how to best approach design issues** presents itself. While guidelines for supplementary and therapeutic feeding of malnourished under fives were already developed in the 80ies and 90ies of the past century (e.g. the ones published by MSF International), technical resources for nutrition support for malnourished adults are much more recent phenomenon (World Bank, 2007; UNHCR/WFP, 2004; FANTA, 2004). Some key programming recipes in three main international guidelines on food and nutrition and HIV/AIDS are summarized here:

- **One of the first practical guidelines on nutritional care and support within HIV responses was published by FANTA (2001). The revised edition of 2004³⁰ is one of the most detailed practical resource books.** The guide is pursuing the idea that sound nutrition practices will benefit both infected and affected populations. Especially for PLHIV it is seen as necessary to consume adequate amounts of macronutrients (providing sufficient energy to meet increased needs, and regularly recommended amounts of protein) and micronutrients (vitamins and minerals according to the regular Recommended Daily Allowances – RDAs -). The FANTA guide is primarily focusing on **correction of dietary imbalances**, but also has sections on **possible outlines of specific supplementary feeding programmes to meet the nutritional care and support needs of adult individuals infected with HIV³¹.**

³⁰ FANTA (2004), HIV/AIDS: A Guide For Nutritional Care and Support, 2nd edition, Food and Nutrition Technical Assistance Project, Academy for Educational Development, Washington DC, October 2004.

³¹ There are chapters with specific guidelines for nutrition care and support of malnourished children, pregnant and lactating women and adolescent girls but not for chronically ill as such.

- In 2004 UNHCR and WFP published a joint practical guidelines booklet³² that presents a wide range of **programme strategies for integration of HIV/AIDS activities with food and nutrition support in refugee settings**, many of which are also applicable in resource poor non-refugee settings where high levels of food insecurity and HIV prevalence go hand in hand. Another good publication on programme strategies for integration of HIV, food and nutrition activities in refugee settings was published by UNAIDS in 2006³³ which builds on the 2004 UNHCR/WFP publication. The book discerns a range of programme categories (but without any prioritization): (a) use of food and nutrition programmes as instrument for behaviour change communication programmes; (b) modified general food distribution programmes that better meet nutritional needs of PLHIV and address specific access issues; (c) nutrition support as integral components of health care and treatment services including Home Based Care and Antiretroviral Therapy programmes; and (d) use of food resources as incentives for training and capacity building and for community-level HIV-related activities.
- It was underlined in a published state-of-the-art World Bank document (2007) synthesizing international guidance on nutrition and HIV/AIDS³⁴ that there is **wide agreement on the integral role that nutrition plays in HIV prevention, treatment and mitigation and on the importance of nutrition in caring for HIV+ individuals, affected households and communities, and that there is great potential for nutrition to contribute to a decline in HIV- and AIDS-related morbidity and mortality**. This is for instance evidenced in the **WHO Resolution on Nutrition and HIV/AIDS** adopted at the 2006 World Health Assembly³⁵, which however also identified some **gaps in the technical guidelines**, including in the area of nutrition support for high HIV-prevalence populations affected by emergencies. The document acknowledges that there are still **unanswered questions as to how to put some of the technical recommendations and protocols into practice** including a need to compare costs and effectiveness of various programme options. Although it is recognized that there are still some technical issues that require further study (which possibly could lead to revised insights and a concomitant need for adaptations in programming), the key messages on nutritional requirements for various categories of people living with HIV are clearly stated in the World Bank document. For HIV+ adults it is recommended to increase the energy intake (10% more in the asymptomatic stage 1 and 20% to 30% more in stages 2 and above) but to follow the regular recommended daily allowances (RDAs) for protein, fat and micronutrients. Especially with regard to operational issues, **DG ECHO could play an influential role through financing of pilots to test new approaches and document lessons learned within food / nutrition support to vulnerable people affected by HIV/AIDS**. This for instance could be geared to (a) development of efficient beneficiary targeting methods; (b) development of efficient integrated intervention models that require good coordination and cooperation between stakeholders from various sectors; (c) development of effective and cost-efficient local production of fortified blended foods, etc.

³² UNHCR/WFP (2004), Integration of HIV/AIDS activities with food and nutrition support in refugee settings: specific programme strategies, First Version, Geneva, December 2004.

³³ UNAIDS (2006), The development of programme strategies for integration of HIV, food and nutrition activities in refugee settings, UNAIDS Best Practice Collection, Geneva, May 2006.

³⁴ The International Bank for Reconstruction and Development / The World Bank (2007), HIV/AIDS, Nutrition and Food Security: What We Can Do: a Synthesis of International Guidance, Washington, November 2007. This document was written by World Bank staff with inputs from a wide range of key international nutrition and HIV/AIDS experts. The document has been co-sponsored by WFP, WHO, UNAIDS, UNHCR, PEPFAR, USAID, AED/FANTA, PARTH/IYCN and IFPRI/RENEWAL.

³⁵ WHO (2006), Nutrition and HIV/AIDS, Fifty-ninth World Health Assembly, Agenda item 11.3, Geneva, May 2006; see http://www.who.int/gb/ebwha/pdf_files/WHA59/A59_7-en.pdf

³⁴ Based on the Zimbabwe case study plus some further literature study, and drawing from the programming approach for food-based interventions that is pursued by WFP³⁶, this Real Time Evaluation comes up with the following recommended **technical design considerations (key programming principles) for food / nutrition support to Home Based Care programmes that will fall in the ‘Priority 2 Core HIV mitigation activity’ category in the DG ECHO 2004 and new draft Guidelines:**

A. **Clear situational analysis and targeting of individuals and households with insufficient access to foods leading to malnutrition:**

- The nutrition support programme alongside Home Based Care needs to be based on a **rigorous analysis of the prevalence and causes of malnutrition among chronically ill**. This logically should contain analysis of HIV prevalence rates, overall food security trends and water and sanitation conditions.
- As nutrition support alone will not do the trick, there is a need to ensure that **minimum levels of medical support to chronically ill** are available. The analysis therefore should include an assessment of available treatment options (ART, TB treatment and availability of cotrimoxazole for treatment of opportunistic infections) and general medical care services, and an assessment of bottlenecks to access the services available.
- Based on the situational analysis, a choice will need to be made for therapeutic and/or supplementary feeding programmes. Both types of programmes require **unambiguous entry and exit criteria at individual patient level which should be based on nutritional status only (not on socio-economic vulnerability!)**.
- Also based on the situational analysis, a decision will need to be made whether a **complementary household food ration should be provided**, and **whether the targeting of these household rations should be made dependent on further assessment of the socio-economic vulnerability at individual household level**. A critical factor in this respect will be whether alarming food security trends are observed and whether the target population is covered by a general food distribution programme.

B. **Community involvement and community-based approaches:**

- The major comparative advantage of linking the nutrition support programme with a Home Based Care programme is that it is a **community-based intervention** with involvement of volunteer care facilitators. This design facilitates **sustainable outreach to peripheral rural areas against reasonable cost levels**. However, Home Based Care cannot function in isolation. It always will have to be supported by medical care that has to remain service-based (with the option to use a system of mobile clinics to reach out to remoter and less densely populated areas).
- There are many options with regard to the **choice for an incentive for community volunteers**, food-based or non food-based. There is wide variation in the regularity of the incentive provision. Interestingly enough some Home Based Care programmes appear to do very well with just a one-off incentive (e.g. a bicycle), while others are based on monthly allowances in cash or kind (often food-based) which make the programme more demanding in terms of sustainability.

³⁶ E.g., refer to WFP (2006), Summary Report of the Thematic Review of WFP-supported Mother-and-Child Nutrition Interventions, WFP/EB.1/2006/7-C, Rome, January 2006.

C. **Strategic Partnerships and integration with other social care programmes:**

- For any nutrition support to Home Based Care programme, from the design stage onwards there is a **need for effective coordination with relevant stakeholders on food and nutrition in HIV policy and programming**, including the Government and WFP³⁷.
- By its very nature, this nutrition support programme for chronically ill builds on the foundations of an existing Home Based Care programme. This set-up facilitates **good integration with a community-based social care programme**, whether it is implemented by the same agency as the nutrition support programme or not.
- For Home Based Care programmes, there is an obvious **need to link up with medical sector activities**, which can be a weaker part of the programme in situations where provision of health services to Home Based Care clients is not fully ensured. The effectiveness and sustainability of achieved impacts of any nutrition support programme for chronically ill in principle will primarily depend on continued access to medical services.
- In situations where general food distribution programmes exist to address acute or protracted food insecurity conditions, there is a **need to link up with the dominant food aid agency** in order to make sure that households with a chronically ill patient are not *a priori* excluded from regular beneficiary selection exercises just because they are also being assisted with nutrition support for the patient. As long as double dipping is being avoided, it will depend on the situational context (including expectations about donor support levels) whether food needs for vulnerable households with a chronically ill patient are best being served by the general food distribution or by the food support to Home Based Care programme.
- To promote sustainability of achieved nutrition improvements, there is a **need to link up with agencies involved in local development activities**. After discharge from the nutrition support programme, households could graduate to livelihood support interventions in the farming sector and non-farming sector as appropriate to improve household food security and as pertinent in local context settings.

D. **Provision of a quality food ration including micronutrient fortification:**

- Depending on the objectives of the nutrition support programme, a choice can be made for either **therapeutic feeding** of severely malnourished chronically ill (BMI < 16) or for **supplementary feeding** of moderately/mildly malnourished chronically ill (BMI < 18.5). Both types of programmes require **specific feeding protocols** that clearly spell out which types and amounts of food support will be provided and how much supplementary energy and protein these rations will provide per beneficiary per day. This should be in line with the **Sphere standards for correction of malnutrition**.
- The choice for a particular (package of) food items will need to be based an **ex-ante assessment of their suitability and acceptability among the chronically ill, time requirements for its preparation and a comparison of cost levels for procurement of various products options (including locally produced fortified foods)**³⁸.

³⁷ In line with the recommendations of the Global Task Team on Improving AIDS coordination among Multilateral Institutions and International Donors (GTT), a series of measures have been taken to simplify and harmonize procedures and practices and align its support more closely with national needs and priorities. Within the agreed division of labour, WFP is the lead organization for dietary and nutrition support for care, support and treatment programmes (See: WFP (2007c), *Time to Deliver – An Update on WFP’s Response to HIV and AIDS*, WFP/EB.a/2007/5-B, Rome, May 2007).

³⁸ E.g. for the purpose of this RTE of the CARE International Food Support to Home Based Care programme in Zimbabwe, a comparison was made of the nutritional values and costs of Corn Soy Blend (CSB) and Supplementary Plumpy produced by Nutriset, France. This analysis revealed that Supplementary Plumpy is about 1.5 times more energy dense than CSB, but that the two products otherwise are rather comparable in terms of the contribution per 100 g of product towards the Recommended Daily Allowances (RDAs) for protein and most of the micronutrients. On the costs side, Supplementary Plumpy appeared to be about 16 times as expensive as CSB for the same amount of transferred dietary energy. For more details see Section 3.1.4 of this report.

- To avoid unnecessary delays and disruptions, already at the stage of programme planning it **should be ascertained that the provision of nutrition support is in line with national HIV/AIDS policies and that national authorities will allow the import or local production of specific nutrition products** (fortified blended foods). For coordination and harmonization reasons, the planned nutrition support programme will need to be presented and discussed at the level of **national nutrition cluster meetings or working groups** and any other national coordination bodies in the area of HIV/AIDS.
- **Nutrition education is seen as an essential element in such food-based support programmes** as it strengthens the continuum of care through promoting more balanced and nutrient-rich diets, thus contributing to sustainability of nutrition impacts of the project. General nutrition education messages will at the same time serve as a secondary preventive measure for those who are still in WHO stages 1&2 of the HIV infection, as healthy diets and correction of any nutritional deficiencies form effective practical measures to avoid accelerated progression to the symptomatic stages. Preferably, this should be accompanied by **hygiene and health education messages** and e.g. provision of agricultural inputs, nutrition gardens, income generating projects and water and sanitation projects.

The FANTA guide (2004) defines ‘**nutritional supplement**’ as any food or nutritional product that is provided to supplement or add to the daily diet. There are three types of food and nutrition supplements:

- a) **Foods like CSB, vegetable oil and lentils** which can assist to manage HIV-related symptoms and secondary infections, to maintain weight and treat mild weight loss, manage the nutrition-related side effects of ART, and to address nutritional needs in food insecure areas;
- b) **Multi-vitamin supplements** for specific HIV+ groups at risk of malnutrition like HIV+ children and pregnant and lactating women;
- c) **Therapeutic foods** like F100 therapeutic milk, Plumpynut³⁹ and locally produced nutrient-dense foods for rehabilitation of moderate and severe malnutrition in HIV+ adults and children that can be used for clinic-based stabilizations and in community-based care programmes.

2.3 Performance measurement for food/nutrition support alongside Home Based Care Programmes

2.3.1 Theoretical framework

2.3.1.1 Overview of performance measurement

³⁵ Performance measurement is at the core of any organisational learning⁴⁰, decision-making and accountability. It is about systematic collection of evaluative evidence that demonstrates “real-time” impact and the factors explaining the results. Indicators are essential for measurement of results but the process must extend to rating the performance, attributing impact and explaining factors that influenced these positively or negatively.

2.3.1.2 Results to be measured in nutrition support to CHBC?

³⁶ More broadly, the results to be measured can be deduced from the prioritised options for food support within Home Based Care that have already been discussed in Section 2.1 of this report. Supplementary / therapeutic feeding programmes in support of CHBC would in general be expected to bring about, among others, the following key results:

³⁹ Brand name for a Ready-to-Use Therapeutic Food (RUTF) manufactured by Nutraset in France.

⁴⁰ UNDP Evaluation Office (2002), Handbook on Monitoring and Evaluating for Results; page 75

- nutrition recovery of HIV+ individuals⁴¹ and prolonging of their lives;
- strengthened immunity system better able to fight opportunistic infections;
- regaining of strength (calories) to participate in normal livelihood activities;
- improved adherence to recommended drug regimes (especially those on ART and DOTS); and
- greater access to and utilisation of health services.

The CARE CHBC pilot project identifies three results which are consistent with the above. They are:

- *Properly managed nutrition among the severely malnourished chronically ill patients.*
- *Enhanced intake of kcal for chronically ill and family members.*
- *Enhanced knowledge and practices for effective diets, food handling and utilisation by primary and secondary caregivers.*

2.3.2 Recommended indicators for performance measurement in nutrition support to CHBC

³⁷ Like in any other intervention, performance measurement in food and nutrition support to CHBC should involve looking at results at three generic levels: *impact*; *outcome*; and *output*. Table 2 below shows the type of indicators required for each level of results, what will be measured and who the primary user of the information might be.

Table 2: Indicators and the monitoring of results

Type of Result	What is measured	Indicators	Primary level of use
Output	Effort, or goods and services generated by the nutrition support to CHBC project	Number and quality of goods and services produced or delivered	Project management, local government including the medical services involved, and national aids commission, NGOs, donor agencies
Outcome	Effectiveness, or results in terms of access, usage and stakeholder satisfaction from goods and services generated by the CHBC project, programmes, partners and soft assistance	Use of outputs and sustained production of benefits	Programme management National government agencies, aids commission and other NGO partners
Impact	Effectiveness, or results in terms of the sum effect of a combination of outcome activities that improve development conditions/living standards at an individual, household, community, regional or national level	Use of outcomes and sustained positive development change	Senior Country Office management National government agencies, aids commission and other NGO partners Funding agency

Source: Adapted from UNDP (2002), Handbook on Monitoring and Evaluating for Results

³⁸ Since the focus of CHBC programmes is to improve the quality of life of the patient, it is essential that the indicators for the results focus on the quality of life for the client (impact) as opposed to outputs and outcomes. The discussion below on core indicators is therefore devoted to impact indicators and to some extent outcome indicators. The indicators mainly relate to nutritional support but since CHBC is broader than food and nutrition, a more comprehensive list of output, outcome and impact indicators for an integrated CHBC programme approach are also presented in Annex K.

⁴¹ See Annex J for a summary of results expected from the CARE Pilot Project Zimbabwe.

2.3.2.1 Core indicators for assessing impacts and outcomes of the nutrition support to CHBC

39. **Core Indicator No. 1: Mortality among CHBC clients**

Trials evaluating the effect of food supplementation or nutritional support to people on home-based care are few but it is plausible that food supplementation or therapy to such patients and their families might help to **prolong survival**, help reduce wasting and alleviate symptoms⁴². **Mortality among the CHBC clients** is therefore a critical indicator to monitor when providing food/nutrition support to CHBC. A recent study of risk factors for high early mortality in patients on antiretroviral treatment in a rural district of Malawi defined this indicator as the “*cumulative proportion of deaths that occur after initiation of therapy*” and uses three cut-off points: *first 3 months* (very early mortality); *first 6 months* (early mortality); and *first 12 months*⁴³. These cut-off points are equally applicable to both food supplementation and nutrition support for home-based care. Mortality would be monitored every month using the beneficiary card, and every quarter by cohort analysis which can be carried out retrospectively every 3 months using the CHBC client master-card or ART register (in cases where client is also on ART). Observed client status can be standardised and coded as: *alive and receiving food*; *alive and receiving both food and ART*; *died*; *lost to follow-up*, and *stopped and transferred out*. Deaths can be stratified by nutritional status of the deceased persons at the time of death or at time of initiation of food/nutrition support. Another dimension of mortality that could be analysed is *median time to death* (days). There is also the scope to introduce the concept of QALYS as an indicator which should monitor the quality of adjusted life years. The indicator would monitor the quality of life of person whose life has been extended due to the intervention.

40. **Core Indicator No. 2: Nutritional status of CHBC clients as measured by Body Mass Index (BMI) for adults and MUAC for pregnant women and weight for age or weight for height for children**

Food supplementation and nutrition therapy seek to address two interconnected objectives, namely: (a) *proper management of nutrition among the severely malnourished chronically ill patients*; and (b) *enhanced intake of kcal for chronically ill and family members*. The most immediate result expected at the level of the beneficiary is weight gain. The **Body Mass Index (BMI)** is the standard, generally accepted way of expressing weight in adults as it takes into account the height⁴⁴ of the person, thus enabling judgment to be made on whether the weight of the person is normal, insufficient or excessive. A normal BMI is defined as 18.5–24.9 kg/m². Malnutrition is defined as a BMI < 18.5 kg/m²; mild malnutrition, BMI = 17.0 to 18.4 kg/m²; moderate malnutrition, BMI = 16.0 to 16.9 kg/m²; and severe malnutrition, BMI < 16.0 kg/m²⁴⁵. BMI is the most commonly used entry and exit criterion for food and nutrition support interventions at individual/household level and is often used to determine food types and ration sizes per client group (children, adult men and pregnant and lactating women). Weight gain can be tracked by analyzing *changes in BMI* after 3 months, 6 months and 12 months of introduction of food support. Some studies including by Valid International recommend the use of *change in BMI per 100 days* or *weight gain per 1000 k-calories provided* as indicators⁴⁶.

⁴² Mahlangu SN, Makola D, Volmink J: Nutritional interventions for reducing morbidity and mortality in HIV infected individuals (Protocol for a Cochrane Review). In *The Cochrane Library Issue 3* Chichester, UK: John Wiley & Sons, Ltd; 2004.

⁴³ Sources: (a) <http://www.core.monash.org/bmi.html>; (b) “*Risk factors for high early mortality in patients on antiretroviral treatment in a rural district of Malawi*” by Rony Zachariah, Margaret Fitzgerald, Moses Massaquoi, Olesu Pasulani, Line Arnould, Simon Makombe and Anthony D. Harries, 2006; *AIDS* 2006, 20:2355–2360.

⁴⁴ The BMI is calculated by dividing the weight of a person (in kg) by the square of the height (in metres).

⁴⁵ Sources: (a) <http://www.core.monash.org/bmi.html>; (b) “*Risk factors for high early mortality in patients on antiretroviral treatment in a rural district of Malawi*” by Rony Zachariah, Margaret Fitzgerald, Moses Massaquoi, Olesu Pasulani, Line Arnould, Simon Makombe and Anthony D. Harries, 2006; *AIDS* 2006, 20:2355–2360.

⁴⁶ Valid International, 2007, Acceptability and effectiveness of chickpea sesame based Ready To Use Therapeutic Food in malnourished HIV positive adults. A study by Paluku Bahwere, Kate Sadler and Steve Collins.

41. For under-five children, weight for age and weight for height are recommended since the use of the mid-upper-arm circumference (MUAC) for this group in emergencies is still controversial, and disagreement over the preferential selection of younger children, the levels of cut-off points used, the efficiency of a two-phase screening process and poor reproducibility in the measurement continues⁴⁷. However, for pregnant women, MUAC is more appropriate since other weight-related indicators such as BMI or weight for height are not suitable given the weight gain associated with the pregnancy itself which would bias the assessment of programme outcomes.

42. **Core Indicator No. 3: Incidence of opportunistic infections among CHBC clients**

Antiretroviral therapy if combined with better nutrition is known to dramatically improve the recovery and survival of patients living with HIV/AIDS who are in WHO stages III and IV. Patients on good diet and receiving ART are better able to fight opportunistic infections (OIs), than otherwise. Good nutrition may boost the immunity system and contribute not only to the alleviation of symptoms but also the effective fight against OIs thus improving the quality of life of the clients. Hence the incidence of OI symptoms on CHBC clients receiving food and nutrition support can be considered as a core proxy indicator for assessing impact of nutritional support. Common OIs would include diarrhoea, oral recurrent Candida, oesophageal candidiasis, Kaposi's sarcoma, bacterial pneumonia, active TB, cryptococcal meningitis, chronic fever, pneumocystis jirovecii pneumonia, superficial skin infection, headache, and malaria. The incidence of OIs can be monitored monthly. The definition of this indicator will have to be specific and relate to a smaller list (2-3) most common OIs.

43. **Core Indicator No. 4: Physical activity change (Karnofsky score) among CHBC clients**

The **Karnofsky Performance Scale Index** allows the CI clients to be classified as to their functional impairment. Each client is periodically rated in accordance with the level of physical activity they exhibit. The KP score has three categories:

- Able to carry on normal activity and to work; no special care needed (score of 80-100%).
- Unable to work; able to live at home and care for most personal needs; varying amount of assistance needed (50-70%).
- Unable to care for self; requires equivalent of institutional or hospital care; disease may be progressing rapidly (0-40%) (see Annex L for details on the scoring).

44. This indicator is widely used in the medical field in programs to rehabilitate cancer patients and those that suffered from a stroke as well as by medical NGOs such as the MSF family who are promoting the scaling up of ART using nutritional support as a complement. The KP score is useful for comparing effectiveness of different therapies and to assess the prognosis in individual patients. The lower the Karnofsky score, the worse the survival for most serious illnesses. The client KP score can be monitored monthly even by community volunteers. An improvement in the score over time would depict effectiveness of the therapy (food or medicines).

45. **Core Indicator No. 5: Adherence to ART and DOT treatment regimes among CHBC clients**

Due to the higher energy demands of ARVs in a patient, and the side effects of these drugs, food supplementation can have positive results in enabling patients to better adhere to the recommended treatment protocols. The indicator can easily be monitored using periodic pill counts as is already being practiced by medical NGOs such as MSF Spain in their ART roll-out programmes in Kenya.

⁴⁷ The World Health Organisation recommendation remains the use of Weight for Height. A meta-evaluation of the experience of humanitarian agencies in the use of MUAC-based admission criteria is currently underway to conclude on the targeting effectiveness of the indicator and its usefulness in future humanitarian operations.

46. **Core Indicator No. 6: Participation of CHBC patients in livelihood interventions**

Nutritional recovery through a balanced diet is expected to enable patients to regain their physical strength and capacity to re-engage in livelihood activities such as gainful employment. This participation in ability would signal their readiness to graduate out of the food programme and point to the sustainability of the impact of the food support.

47. **Other indicators for assessing results of nutrition support to CHBC**

Other complementary indicators commonly used and are recommended also here to measure effectiveness of the nutrition support to CHBC are: (1) *acceptability of the energy-dense, micronutrient enriched nutritional supplements by clients (grams consumed per person per day)*; (2) *daily kcal intake by clients*; and (3) *dietary diversity and frequency*. The first indicator uses daily intake (grams per person) as a proxy for beneficiary acceptability of the nutritional products, whilst the second quantifies the calories (energy value) consumed per day. The third measures the number of individual foods or food groups consumed over a given time period. This indicator is usually used in conjunction with a weighted food consumption score (FCS) that allows for comparison of dietary quality and diversity between beneficiary and non-beneficiary populations.

2.4 Cost implications for scaling up food / nutrition support alongside Home Based Care programmes in Southern Africa

2.4.1 Underlying assumptions

In determining the cost implications of scaling up food and nutrition support to the regional level in Southern Africa, several assumptions have been made and these are detailed in Annex M. The assumptions are based on lessons learned from the design and implementation of the DG ECHO-funded CARE CHBC pilot model in Zimbabwe as well as recommendations by the World Food Programme on best practices in food and nutrition support to CHBC⁴⁸. The cost estimates are based on a general assumption that DG ECHO will only intervene in country situations justified by its mandate and in activities where it has a clear comparative advantage. DG ECHO will not implement vertical interventions for HIV and AIDS but these activities will be mainstreamed into DG ECHO funded Humanitarian multi-sectoral programmes where this is possible and appropriate. HIV/AIDS itself will not be considered an entry point for food and nutritional support alongside HBC, Hence, while the scale up operation will target high HIV and AIDS prevalence countries in Southern Africa, high HIV/AIDS prevalence alone will not be a sufficient condition for DG ECHO to intervene, other criteria will have to be met such as the occurrence of other forms of rapid onset national disasters linked say to drought or other natural or man-made phenomena. The scale up operation will target those PLHIV among the most vulnerable in communities affected by humanitarian crises. These are assumed to be those PLHIV who are malnourished and are in stages 3 and 4 according to the World Health Organisation Staging System.

2.4.2 Costing the different options of the CHBC scaled-up operation

2.4.2.1 Option I: CSB and nutrition, health and hygiene education only

⁴⁸ Option 1 relates to a basic package that combines nutrition support with IEC targeting CHBC clients and their household members. The objective of this option would be nutritional rehabilitation of PLHIV (children and adults), where entry and exit criteria at programme level would be based on food insecurity and other indicators⁴⁹, whilst at the individual level would be based on a combination

⁴⁸ WFP, 2006, Cost of Nutritional Support for HIV/AIDS Projects.

⁴⁹ In accordance with the DG ECHO mandate, this intervention would be expected to be short-term and should therefore meet the following criteria: (i) do no harm; (ii) have demonstrable and durable impact; (iii) avert an imminent

of nutritional status and disease staging. The nutrition support can be considered under “Priority 2 Activities” of the proposed DG ECHO Guidelines for Funding Interventions Related to HIV and AIDS⁵⁰ whereby food resources can either be used to “mitigate food insecurity and malnutrition in high prevalence contexts” or “support HIV-AIDS treatment and care” or better still “support the integration of children and adults living with HIV in emergency nutritional programmes”.

⁴⁹. IEC would fit within “Priority 1 Activities”. Under this category, DG ECHO seeks to encourage partners to “take every opportunity to include IEC” activities targeting both staff and programme beneficiaries primarily to promote prevention of HIV transmission. This IEC would be broadened to include nutrition education and hygiene and sanitation promotion within a home based care setting. The incorporation of IEC into such a nutrition support package is highly recommended. On the one hand, nutrition education helps to sustain impacts of the short-term DG ECHO nutrition supplementation intervention, whilst hygiene and sanitation promotion would reduce the spread of HIV/AIDS and opportunistic infections from HBC patients to care givers.

⁵⁰. Costing of this package is based on assumptions alluded to under section 2.4.1 above and builds upon unit costs of the CARE-Zimbabwe pilot project. It is assumed that the package is provided to HBC clients in the six low-income Southern African countries that have high HIV and AIDS prevalence rates and suffer from occasional humanitarian emergencies triggered by shocks such as drought, flooding and disease outbreaks. Under this option, it is assumed that CSB is provided to all those in Stages 3 and 4 who are malnourished, irrespective of whether or not they are on treatment: ART, DOTS or Cotrimoxazole (column A). Although it is now universally accepted that there are strong synergetic effects between nutrition supplementation and treatment, ethically inability to access treatment should not be used to disqualify potential HBC patients from accessing nutritional support.

⁵¹. Under this option, it is assumed that a ration package of 25kg of CSB will be distributed per malnourished CI per month and will be shared as follows: 5 kg for the patient and an additional 5 kg per each of the other four household members. This means the programme provides 5 kg per month for the malnourished client and an additional 20 kg per month as protective ration. This would in turn imply providing 25 kg of CSB to 379,830 chronically ill patients for a period of 10 months or one year⁵¹. It is further considered that IEC on nutrition, health and hygiene will be an integral part of the programme and will be part of the overhead costs (management, training, transport, insurance, storage, etc), which according to the revised budget for the CARE-Zimbabwe pilot project, can amount to €1.25 per every €1.00 invested in food.

⁵². Assuming an average of 5 patients per care facilitator as per the CARE pilot project in Zimbabwe, a total of 75,966 care facilitators would benefit specifically from IEC and these would cascade the knowledge to primary care givers and families of the HBC patients.

⁵³. The budget for such a regional operation targeting food insecure low income countries affected by a region-wide drought or other such disaster would be €12.94 per client. At programme level this translates to €49.1 million over a 10 month programme covering all malnourished PLHIV, or €58.9 million over one year (or €155.25 per CI/year) (Table 3: Estimated cost for scaling up CSB plus IEC on nutrition, health and hygiene). These costs would exclude incentives for community

deterioration of humanitarian risk into large scale emergency; and (iv) if necessary provide a temporary stop-gap assistance but with clear prospects for handover or for a cessation of need, at the end of the emergency.

⁵⁰ This category refers to “Strongly recommended activities that DG ECHO will consider funding”.

⁵¹ A 10 month programme is assumed for DG ECHO but a cost estimate for 12 months is also provided so as to inform other donors that may have an interest in taking over from ECHO the various programme options. The annual cost is obtained by using a scale up factor of 20% on the cost for the 10-month programme.

volunteers. If including a CSB ration for care facilitators or its equivalent value in other forms (uniforms, T-shirt, tennis shoes, oil, etc), the budget would rise by a further €873,609.00 or €1,048,330.80 to reach €50.0 million and €60.0 million for 10 and 12 rounds of distribution, respectively. Assuming that not all beneficiaries that are eligible have access to home based care, but only 75% have coverage of CHBC services, then the annual programme costs would be €44.2 million.

Table 3: Estimated cost for scaling up CSB plus IEC on nutrition, health and hygiene

a) Unit costs

Item	Direct cost per client per month (Euros)	Overhead per Euro spent (Euros)	Total cost per client per month (Euros)	Total cost per client per year (Euros)
CSB	5.75	1.25	12.94	155.25
Total	5.75		12.94	155.25

b) Country level costs

Country	Estimated case load /1	Cost per month (Euros)	Cost per year (Euros)
Lesotho	18,810	243,354	2,920,253
Malawi	62,700	811,181	9,734,175
Mozambique	92,400	1,195,425	14,345,100
Swaziland	14,520	187,853	2,254,230
Zambia	75,900	981,956	11,783,475
Zimbabwe	115,500	1,494,281	17,931,375
Total	379,830	4,914,051	58,968,608

Notes: /1=Malnourished WHO stage 3&4 clients.

Source: RTE Mission estimates based on unit costs from the revised CARE project proposal.

2.4.2.2 Option 2: CSB, IEC on nutrition, health and hygiene; ART and Cotrimoxazole as antibiotic/prophylaxis for Opportunistic Infections

⁵⁴ The second option assumes that in addition to the basic food plus IEC package (Option 1), anti-retroviral treatment and a prophylaxis for OIs are added. Once initiated, ART and OI prophylaxis treatment are supposed to continue for the full life of the individual. Hence, they are best provided under long-term social protection mechanisms funded through the government budget or longer term pool funding arrangements by donors. The activities entailed in such support are long term in character and should be supported with predictable resource commitments which may be outside DG ECHO’s mandate and working parameters. However, the package costed under Option 2 refers to exceptional circumstances whereby DG ECHO funding may be needed to play a crucial short-term gap-filling role and a guarantee exists of handover to alternative funding mechanisms. This may entail short term provision of ART to new patients where such services will have substantial benefits of alleviating human suffering above non-treatment or continuation of therapy in patients experiencing a temporary supply break in ARVs or prophylaxis during an emergency.

⁵⁵ The cost of ARVs (first and second line drugs) and that of Cotrimoxazole (as a prophylaxis) are both on the decline. At the time of the RTE, it was established from one of the regional pharmaceutical organisations (*Centrale Humanaire Medico-Pharmaceutique*) supplying the MSF Spain chain in the Eastern and Southern Africa region that the cost for a month’s dose (excluding in-country distribution costs⁵²) was approximately USD14 for a first line ARV drug (*Zidovudine*) and

⁵² Estimation of distribution costs would require a thorough study of the distribution chain through government and non-government health service delivery systems and this was beyond the scope of the RTE.

USD1.00 for Cotrimoxazole in December 2007. This converts to approximately €9.52 per patient per month for ARVs and €0.68 for Cotrimoxazole⁵³. Hence, for a patient on both ARVs and Cotrimoxazole, the cost per month for both drugs excluding overhead/distribution costs would amount to approximately €10.20 or about twice the direct cost of the food commodity (CSB) itself.

Table 4: Estimated cost for scaling up CSB; IEC on nutrition, health and hygiene; ART and Cotrimoxazole (at 70% coverage of ART and Cotrimoxazole)

(a) Unit costs

Item	Direct cost per client per month (Euros)	Overhead per Euro spent (Euros)	Total cost per client per month (Euros)	Total cost per client per year (Euros)
CSB (25kg)	5.75	1.25	12.94	155.25
ART	9.52	unavailable	9.52	114.24
Prophylaxis	0.68	unavailable	0.68	8.16
Total	15.95		23.14	277.65

(b) Country level costs excluding overheads for public services

Country	Estimated case load /1	Cost per month (Euros)	Cost per year (Euros)
Lesotho	18,810	377,658	4,531,893
Malawi	62,700	1,258,859	15,106,311
Mozambique	92,400	1,855,161	22,261,932
Swaziland	14,520	291,525	3,498,304
Zambia	75,900	1,523,882	18,286,587
Zimbabwe	115,500	2,318,951	27,827,415
Total	379,830	7,626,037	91,512,442

Notes: /1=Malnourished WHO stage 3&4 clients; /2=Assume 70% coverage of ART and prophylaxis.

Source: RTE Mission estimates partly based on the revised CARE project proposal.

⁵⁶ With the addition of ART, and assuming 100% coverage of malnourished PLHIV in stages 3&4 by home based care and by both ART and Cotrimoxazole, the cost for a 10 month distribution programme increases by about 55% to €87.9 million (Table 4). However, assuming that about 30% of the malnourished HBC clients will already be receiving some ART through existing programmes, the overall cost of a 10-month programme will reduce slightly to €76.3 million⁵⁴, or €91.5 million if implemented over 12 months. This translates to €241/CI per year. This figure is very high thus underscoring the need for DG ECHO to first ensure that: (a) sustainability of funding from other sources (e.g., government and other donors) is guaranteed; (b) there is a clear consensus on the benefits of the short-term ART intervention; and (c) a clear exit strategy exists, prior to intervening in the area of long term therapies such as ART.

2.4.2.3 Option 3: CSB, Maize, Oil, IEC on nutrition

⁵⁷ The third option assumes a different package for the food component from that in Option 1. The food package would be modeled following the composition recommended by the World Food Programme in their recent costing exercise to determine the budgetary implications of scaling up globally food and nutrition support to PLHIV⁵⁵. The food package includes 10 kg of CSB, 1 litre of vegetable oil, and 25 kg of maize. The objective remains one of nutritional rehabilitation of malnourished PLHIV in emergency settings but the option extends food support to household members as a protective general household food ration. A distinction is made between the more

⁵³ November Euro to USD exchange rate was Euro0.68, see <http://www.x-rates.com/d/EUR/USD/hist2007.html>

⁵⁴ The regional average for ART coverage stands at approximately 39%. However in food insecure areas, the proportion already covered is likely to be less hence the use of a conservative figure of 30% instead of the 39% estimated.

⁵⁵ WFP, 2006, Cost of Nutritional Support for HIV/AIDS Projects.

specialized nutritional needs of malnourished PLHIV and food supplementation needs of household members in order to “protect” the ration for the HBC patient. Oil is added to the ration as an energy dense commodity.

Table 5: Price ranges for maize in maize exporting countries in the SADC region, 2007/8 marketing season

Country	USD/tonne			Euros/tonne		
	Low	High	Costing price	Low	High	Costing price
South Africa	214.29	242.86	242.86	145.71	165.14	165.14
Zambia	190.00	230.00	230.00	129.20	156.40	156.40
Malawi	211.27	281.69	281.69	143.66	191.55	191.55
Mozambique	180.00	240.00	240.00	122.40	163.20	163.20

Sources: (i) Noble Investments, South Africa, Regional maize trading database; (2) SAFEX Trading Statistics.

⁵⁸ The cost of maize is based on most recent maize trading price data from four countries where domestic purchases or exports have been possible for humanitarian programmes. The data shows relatively low prices of about €122-145/tonne soon after the harvest but much higher prices at the close of the marketing season during the traditional hunger period (October – February) (Table 5). By March or April farmers will be expecting another harvest and the prices come down, and the cycle continues. For purposes of costing maize, the high end prices which obtain during the period when most humanitarian activities are intensified have been used here. More specifically, maize for the humanitarian action (food and nutrition support to CHBC) that is being costing here has been assumed to cost €191.55, the price prevailing in Malawi at the end of the 2007/8 marketing season. This translates to €0.19 per kg and €4.79 per client per month excluding the overhead costs (transport and distribution). The overhead costs are assumed to be the same as for CSB.

⁵⁹ The direct procurement cost of oil is estimated at €1.00 per litre according to prices prevailing in the region, but this excludes overhead costs, which are also assumed to be similar to those of CSB, although they may be expected to be slightly higher due to higher costs involved in handling pre-packed cooking oil in general.

Table 6: Estimated cost for scaling up CSB; Maize; Oil; IEC on nutrition, health and hygiene; ART; Cotrimoxazole; hygiene kits and other medical supplies

(a) Unit costs

Item	Direct cost per client per month (Euros)	Overhead per Euro spent (Euros)	Total cost per client per month (Euros)	Total cost per client per year (Euros)
CSB (10kg)	2.30	1.25	2.88	34.50
Oil (1 litre)	1.00	1.25	1.25	15.00
Maize (25kg)	4.79	1.25	5.99	71.83
ART	9.52	unavailable	9.52	114.24
Prophylaxis	0.68	unavailable	0.68	8.16
Total			20.31	243.73

Item	Direct cost per client per month (Euros)	Overhead per Euro spent (Euros)	Total cost per client per month (Euros)	Total cost per client per year (Euros)
CSB (10kg)	2.30	1.25	2.88	34.50
Oil (1 litre)	1.00	1.25	1.25	15.00
Maize (25kg)	4.79	1.25	5.99	71.83
ART	9.52	unavailable	9.52	114.24
Prophylaxis	0.68	unavailable	0.68	8.16
Total			20.31	243.73

(b) Country level costs excluding overheads of the public services

Country	Estimated case load /1	Cost per month (Euros) /2	Cost per year (Euros) /2
Lesotho	18,810	328,327	3,939,928
Malawi	62,700	1,094,425	13,133,095
Mozambique	92,400	1,612,836	19,354,035
Swaziland	14,520	253,446	3,041,348
Zambia	75,900	1,324,830	15,897,957
Zimbabwe	115,500	2,016,045	24,192,543
Total	379,830	6,629,909	79,558,907

Notes: /1=Malnourished WHO stage 3&4 clients; /2=Assume 70% coverage of ART and prophylaxis.

Source: (1) CSB and training cost figures based on revised CARE project proposal; (2) Cost of ART based on figures from *Centrale Humanitaire Medico-Pharmaceutique*; (3) Cost estimates for hygiene kits and medical supplies based on CARE-Zimbabwe estimates from actual on-going programme.

⁶⁰ The results show that the cost of food only nearly doubles when changing the ration from 25 kg CSB to 10 kg CSB, 1 litre of oil, and 25 kg of maize. There may be scope to reduce the cost of maize by buying earlier in the season or by using the futures market to secure lower prices in advance if funding for such a humanitarian activity can be predictable. The cost of food and IEC and associated overheads (for food and IEC only) would be €10.11 per client per month or €121 per client per year **which compares favorably to the US\$ 236 (or €159) per client per year estimated by WFP**. For the package which also integrates ART and Cotrimoxazole, the cost comes to €20.31 per client per month (Table 6). At programme and regional level, the cost translates into €66.2 million for 10 months or €79.6 million for one-year (i.e., €209 per client per year), assuming 70% coverage of ART.

⁶¹ The conclusion here is that the cost per client for a more diversified food and nutrition package may be more expensive per beneficiary than providing one commodity. However, a more diversified package may be more effective in meeting the objectives of the food and nutrition support as it provides a more nutritionally adequate diet. There is also the scope for cost-savings when maize purchases are better planned for and if funds can become more predictable so as to allow advance procurement. The cost of the food package is volume-driven and the size of the package is a key contributor to costs (both direct costs and overheads, especially transport). In a diversified package, maize would account for more than half the cost of the food package, whilst CSB would account for about 28% and oil 12%. If costs are to be reduced significantly, the intervention would have to scale down the protective household ration portion of the package.

⁶² Overall, with the cost per client per year reaching €209, it is clear that cost-effectiveness and financial sustainability are two key factors to consider in decisions on DG ECHO intervention in nutrition and medical (ARV) support to malnourished PLHIV in emergency settings. Given the

short-term nature of DG ECHO funding in general, and the high cost nature of nutritional and medical support to PLHIV, DG ECHO funding should be considered only when there is a guarantee that the short term assistance will have demonstrable and sustainable impacts and there is a clear exit strategy linked to follow-on funding either by other donors, global funds or by government’s own resources (through the national budget instruments). For ART and OI treatment, these are clearly long-term under-takings where DG ECHO may not have a comparative advantage, vis-à-vis other EC instruments or bilateral and multilateral donors (DFID, World Bank, USAID, etc) hence DG ECHO should first seek to activate more appropriate longer-term sources and pipelines before mobilizing emergency humanitarian partners. Of priority would be European Commission instruments or other donors funding social protection programmes on a longer term basis in the same country affected by a humanitarian emergency.

2.4.2.4 Other Options

⁶³. Some HBC programmes (such as the CARE pilot project in Zimbabwe) add to the food and IEC package hygiene kits and medical supplies. These are considered essential complements of food but may be beyond the mandate of DG ECHO. The cost calculations are presented in Annex N which shows that adding hygiene materials (including gloves) over and above the package in Option 2, the cost increases by €6.14 per client per month, whilst addition of other medical supplies would increase further the cost by an estimated €9.16 excluding the overheads of the public health service delivery system. It should be noted that the cost estimates for hygiene and medical supplies are based on partner budgets and not on actual rates of utilization of the hygiene items and medical supplies. They are therefore only indicative as there is no study as yet that has been undertaken to establish the rate of utilization of the items by HBC patients. If DG ECHO is to incorporate these into an integrated HBC package, a more **robust study would be needed to establish the cost-effectiveness of different items commonly included in the hygiene/medical first aid kits and come up with a prioritized list of essential materials that are properly costed which DG ECHO could consider but only in exceptional circumstances and only in a temporary gap-filling role targeting the malnourished and bed-ridden PLHIV.**

3. CONCLUSIONS AND RECOMMENDATIONS

Conclusions and recommendations at strategic level on the potential for DG ECHO involvement in food aid as part of HIV responses

HIV/AIDS in emergency settings

⁶⁴. The IASC Framework for Multi-Sector Activities published in 2003 remains the international reference guiding HIV/AIDS response options in emergency settings for each of the humanitarian sectors. This has also been the basis for the DG ECHO Model Guidelines on HIV/AIDS responses published by PROLOG Consult in 2004 (currently being updated) that provide a clear overall framework for decision-making. For DG ECHO, HIV/AIDS *per se* will not function as entry criteria and in the hierarchy of priorities for DG ECHO financing of HIV responses, HIV prevention is seen as most important (mainstreaming compulsory for all DG ECHO funded activities). Furthermore, the guidelines differentiate between ‘core’ and ‘non core’ HIV mitigation activities eligible for DG ECHO funding, with the latter being subject to strong preconditions only while the former are strongly recommended where appropriate and feasible as component of existing multi-sector humanitarian programmes. The new draft funding guidelines (the non paper) are based on the same division in three priority categories, but they are much more explicit on particular health and food and nutrition interventions that potentially could be funded by DG ECHO under priority 2 and 3.

Recommendation 1:

It is recommended to continue with the elaboration of DG ECHO’s role and potential approaches as to HIV/AIDS and to aim at formalisation in an official EC policy statement. The new Guidelines should be based on endorsement of the overall outlines of the 2003 IASC framework including updates as they become available, should maintain the position that HIV/AIDS per se will not serve as an entry point, and should elaborate on the interventions eligible for DG ECHO funding incorporating the feedback that was given at the round table conference .

DG ECHO food aid in relation to HIV responses

⁶⁵. DG ECHO has several comparative advantages that add value to international humanitarian assistance efforts, particularly because of the wide partner network including all main UN agencies and international relief organizations, the flexibility to intervene in politically sensitive environments and the options for linking humanitarian aid with EC / EU development assistance. The overall vision is that any humanitarian action should be needs-based aimed at preserving life, preventing and alleviating human suffering and maintaining human dignity in respect of the “do no harm” principle.

⁶⁶. Nowadays there is firm international agreement on the integral role that nutrition can play in HIV responses, nevertheless a need exist for operational research to answer programming questions on how to put available evidence-based technical recommendations and protocols into practice in the most effective and cost-efficient way, and some technical questions with regard to specific relations between nutrition and HIV/AIDS. DG ECHO could play an influential and important role in the area of food assistance in relation to HIV responses through financing of pilots to test new programming approaches. These pilots for instance could be geared to development of efficient beneficiary targeting methods, efficient integrated intervention models, and for development of effective and cost-efficient local production methods for fortified blended foods.

Recommendation 2:

It is recommended that DG ECHO continues to respond to the food and nutrition needs of HIV infected and affected people in emergency situations, with a secondary objective to contribute to the piloting of new approaches and documentation of lessons learned. The following prioritized options are suggested to be considered by DG ECHO to address the particular food and nutrition needs of HIV+ individuals in any emergency context where the organization is already present with other humanitarian interventions and where HIV is a public health problem⁵⁶:

- ***Within the overall focus in the food aid sector to respond to food crises as a result of natural or man-made emergencies, it should be ensured that food insecure households affected by HIV/AIDS are also being reached in the general (targeted) food distribution programmes (Priority 2 ‘Core’ HIV mitigation activities in the DG ECHO Guidelines that will normally be considered for funding).***
- ***Depending on HIV prevalence figures and malnutrition levels among HIV+ individuals, there might be a need for targeted interventions for nutrition rehabilitation of people living with HIV which is complementary to general food distributions (also Priority 2 in the 2004 and new draft DG ECHO Guidelines). These programmes could either be piggybacked onto existing HIV response programmes or existing (therapeutic and supplementary) feeding programmes. The selection of beneficiaries should be based on the nutritional status of HIV+ individuals and should be irrespective of whether patients are on ART or not. DG ECHO support for these programmes should be confined to the duration of the (acute or protracted) food crisis only.***
- ***Other options of lower priority (‘non core’ HIV mitigation activities, Priority 3 in the 2004 and new draft Guidelines) only can be eligible for DG ECHO funding in the context of a non-stabilized humanitarian crisis while it is ensured that preconditions of sustainability and existence of exit strategies can be sufficiently met (DG ECHO support for gap filling purposes only). This pertains to food support alongside PMTCT programmes, food support to food insecure / socio-economically vulnerable Home Based Care clients and their households (to be differentiated from the nutrition rehabilitation included under Priority 2), food support to HIV+ patients while starting up ART treatment schedules, and possibly for year-round food support to vulnerable orphans and their caretakers (but support to this category of beneficiaries preferably should be mainstreamed in general food distribution programmes and emergency livelihood interventions). In these cases, the food assistance plays a role as incentive and/or as nutrition supplement***

Design of food / nutrition support alongside Home Based Care programmes that would fall in the Priority 2 category in the DG ECHO funding guidelines

⁶⁷. While there is a range of publications on general nutrition care and support within HIV responses, there is a paucity of specific practical guidance how to best design food / nutrition support alongside Home Based Care programme. Through collation of available guidelines on food and nutrition and HIV/AIDS, some general design outlines have been drawn for nutrition rehabilitation programmes (for which existing Home Based Care programmes could form a good delivery channel) that fall within the DG ECHO humanitarian mandate (see above, targeted support for nutrition rehabilitation of malnourished chronically ill is included under priority 2 in the DG ECHO Guidelines). This is based on the following general programming principles for food-based interventions (a) need for clear situational analysis as basis for targeting, (b) need for community involvement in the

⁵⁶ Although no clear cut international thresholds so far have been defined, a HIV/AIDS public health problem is usually declared when HIV prevalence in a country amounts to 5% or higher.

programme, (c) necessity to seek strategic partnerships and integration with other social care programmes, and (d) need to design of a quality food ration including micronutrient fortification.

Recommendation 3:

It is recommended to DG ECHO to support the development of practical guidelines and to more capacity building among DG ECHO partners for programming of food/nutrition support alongside Home Based Care from a humanitarian assistance perspective. These activities will support DG ECHO partners for elaboration of funding proposals which are cognizant of the minimum requirements for appropriate programme designs including:

- ***Need to be coherent with national policy frameworks***
- ***Need for coordination and partnerships with actors in other sectors that directly or indirectly are linked to the system of Home Based Care. This specifically applies to the need for linking with the medical sector, water and sanitation sector, food aid sector and food security / livelihoods sector.***
- ***Design of appropriate feeding protocols that are effective and cost-efficient.***
- ***Need for definition of unambiguous entry and exit criteria differentiating therapeutic and supplementary feeding objectives***
- ***Need for inclusion of a component of nutrition and health and hygiene education***
- ***Basis for decision-making on the need for inclusion of a complementary household food ration in the programme***
- ***Defining the type of incentive package for community volunteers providing secondary care.***

How best to measure performance of Food Support to Home Based Care programmes?

⁶⁸. Although it is now widely accepted that comprehensive care for PLHIV must include nutritional support, there is in general, a dearth of evaluative evidence on the effectiveness of food and nutritional support to adult HBC patients which at present is being scaled up. Many of the agencies involved continue to grapple with the challenge of quantifying results. Most studies conducted so far have been small and relatively of a short-term nature. Key limitations have been the lack of measurement of viral loads to assess the response to therapy, lack of solid baseline information especially on mortality rates prior to the intervention as well as the lack of suitable control groups to monitor the counterfactual, due to ethical concerns over the issue. Interest in the subject is however growing globally and the evaluation of the CARE pilot project by this RTE demonstrates the urgency of the need to develop explicit guidance particularly on how best to integrate operational research into on-going pilot HBC-oriented nutrition interventions.

Recommendation 4:

It is recommended to DG ECHO to mainstream operational research as a core activity within future nutrition interventions in support of CHBC as a means for ensuring accountability for resource use by measuring results as well as generating the evidence that informs programme improvement. The process should start by carefully reviewing and reaching a consensus on a short list of core impact and outcome indicators sufficient to inform the collection and analysis of data on the effectiveness of these interventions, then incorporating them into the guidelines for preparation and assessment of partner proposals. Based on a review of most recent studies on the topic, some of the core indicators the RTE recommends for closer consideration are: (a) mortality of CHBC patients 3 months, 6 months and 12 months after initiation of nutritional support; (b) Nutritional status of CHBC clients as measured by Body Mass Index (BMI) for adults and MUAC for pregnant women, and by weight for age and weight for height for children and adolescents; (c) Incidence of opportunistic infections among CHBC clients; (d) physical activity change

(Karnofsky score) for CHBC clients, (e) drug adherence (ART and DOTS), and participation in livelihood interventions. These could be monitored together with complementary indicators such as: (1) acceptability of the energy-dense, micronutrient enriched nutritional supplements by clients (grams consumed per person per day); (2) daily kcal intake by clients; and (3) dietary diversity and frequency.

What are the cost implications if DG ECHO would decide to take up a more structural involvement in food support to Home Based Care programmes in Southern Africa?

^{69.} A basic package of 25 kg of CSB and IEC on nutrition, health and hygiene would cost DG ECHO €12.94 per client per month or €155.25 per client per year. Assuming that DG ECHO will provide support only to malnourished PLHIV who are in WHO Stages 3 and 4, and only in those countries in Southern Africa that have frequent occurrence of drought and that these countries meet the necessary entry criteria for DG ECHO, it is estimated that in the worst case scenario six countries may be affected (Lesotho, Malawi, Mozambique, Swaziland, Zambia and Zimbabwe) and DG ECHO may anticipate the cost of scaling up this type of programme to cover these six countries to amount to € 60 million per year.

^{70.} ART and Cotrimoxazole can be added to this package at an additional cost of €114 and €8.16 per client per year, respectively, resulting in an annual programme budget of €91.5 million or (€241 per CHBC client). If DG ECHO decides also to add hygiene materials such as gloves and other supplies for bed-ridden clients, this is highly recommended as this is in conformity with Priority 1 activities of the DG ECHO HIV/AIDS Guidelines which seek to reduce the spread of HIV/AIDS and related OIs. However, antiretroviral therapy, Cotrimoxazole as treatment/prophylaxis against opportunistic infections and hygiene materials would be long-term undertakings and alternative funding sources in the context of longer term social protection programmes should be mobilised for this cause first and DG ECHO only intervene with a clear exit strategy linked to well articulated strategy for handover to more sustainable funding instruments. As a general principle, inclusion of hygiene/other medical supplies should be conditional upon results of a proper study to evaluate the cost-effectiveness of these supplies which should be commissioned first. The study should culminate into the identification of a prioritised and properly costed set of essential items that should be included in the hygiene/first aid medical supplies kit.

^{71.} Finally assuming the composition of the food package is diversified to 10 kg CSB, 1 litre cooking oil and 25 kg maize as recommended by WFP, the direct cost of food and IEC only almost doubles to €10.11 per client per month or €121 per client per annum. If ART and OI treatment/prophylaxis are included the cost increases to €20.31 per client per month or €243.73 per client per year, giving rise to a total regional programme cost of €79 million.

^{72.} The cost per client for a more diversified food and nutrition package may be more expensive per beneficiary than providing one commodity. However, a more diversified package may be more effective in meeting the development objectives of the food and nutrition support as it provides a more nutritionally adequate diet. There is also the scope for cost-savings when maize purchases are better planned for and if funds can become more predictable so as to allow advance procurement, say using futures markets or if DG ECHO partners better manage transportation costs. The cost of the food package is volume-driven and the size of the package is a key contributor to costs (both direct costs and overheads, especially transport). In the diversified package recommended for CHBC by WFP, maize would account for (60%) the cost of the food package, whilst CSB would account for about 28% and oil 12%. If costs are to be reduced significantly, the intervention would have to scale down the protective household ration portion of the package, which is principally maize. Otherwise

for development effectiveness, it is better to maintain the recommended more diversified package which clearly distinguishes the special nutritional needs of the malnourished HBC patients and the food supplementation needs of other household members and share costs thereof with other development partners supporting the same sector.

Recommendation 5:

On the basis of cost effectiveness, DG ECHO should consider using CSB ahead of RUTF, savings from RUTF could be invested in other complementary support (Hygiene and medical supplies including ARVs and Cotrimoxazole) that increase development outcomes of the package.

IEC and provision of hygiene materials can both be achieved at little additional cost and should always be components of DG ECHO funded food and nutrition programs in support of CHBC. IEC on nutrition, health and hygiene can be an effective LRRD tool but its timing should be carefully considered in order to be beneficial to the current programme as well as sustain its gains in the future. Hygiene materials (especially gloves and detergents) will also prevent the spread of diseases to caregivers (this fits within Priority level 1 of the DG ECHO HIV and AIDS Guidelines).

The high cost of a comprehensive CHBC package including food, IEC, ART, prophylaxis, hygiene materials and medical first aid supplies, and long term nature of the engagement in some elements of the package (e.g., ART) - which package is likely to achieve the intended outcomes and impacts - suggests the need for DG ECHO to pursue viable cost-sharing arrangements. These should be worked out together with other interested funding sources (donors and governments). As a general principle, DG ECHO funding should be considered only when there is a guarantee that its short-term response will have demonstrable and sustainable results and, where activities need to continue beyond the horizon of the DG ECHO funding, there is a clear exit strategy linked to continued and predictable funding (including Global Funds) by other donors or by local government. Partners should also demonstrate innovative strategies for cutting costs, for example in procurement, without the necessity of compromising the quality of assistance provided to the beneficiaries.

The main drivers of costs for the intervention are commodity costs and transport, both of which are closely related to the size of the food basket. Cost-cutting measures need to be identified and pursued such as promoting the local manufacture of CSB or maximizing on local procurement of complementary non-processed foods (such as maize, pulses, etc), or the use of futures markets to fix prices at competitive levels, or negotiating a delivered price per tonne instead of purchasing ex-silo, wherever feasible, as this might reduce the cost of transportation and handling from source. Such cost-cutting measures should not compromise the quality of the package as this will in turn compromise impact.