

# **WFP NSART Programme Evaluation 2008:**

**A WFP HIV and AIDS targeted food support 'pilot' programme in Zimbabwe.**

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## LIST OF ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
AREX	Agricultural Research and Extension Services
ART	Antiretroviral Therapy
ASO	AIDS Service Organisation
BMI	Body Mass Index
CBO	Community Based Organization
CFSAM	Crop and Food Supply Assessment Mission
CP	Country Partner (to WFP)
CRS	Catholic Relief Services
CRS	Catholic Relief Services
C-SAFE	Consortium for Southern Africa Food Emergency
CSB	Corn Soya Blend
C&T	Counseling and Testing
DAAC	District AIDS Action Committee
DFID	Department for International Development (British Government)
ESP	Expanded Support Programme
FDP	Food Distribution Point
GFTAM	The Global Fund to Fight AIDS, Tuberculosis and Malaria
GMB	Grain Marketing Board
HBC	Home Based Care
HIV	Human Immunodeficiency Virus
IEC	Information, education and communication materials
IGA	Income Generating Programme
M & E	Monitoring and Evaluation
MAM	Moderately acute malnutrition
MoHCW	Ministry of Health and Child Welfare
MSF	Medecins Sans Frontieres
MUAC	Mid-Upper Arm Circumference
NGO	Non Governmental Organization
NSART	Nutrition Support to Antiretroviral Therapy
OI	Opportunistic Infection
ORAP	Organisation of Rural Associations for Progress
OVC	Orphaned and other Vulnerable Children
PRP	Protracted Relief Programme
PLHIV	People Living with HIV
PPTCT	Prevention of Parent to Child Transmission
SAM	Severe acute malnutrition
TB	Tuberculosis
WFP	World Food Programme
VGF	Vulnerable Group Feeding
VCT	Voluntary Counselling and Testing
WASH	Water, Sanitation, Health and Hygiene
WHO	World Health Organization
WVZ	World Vision Zimbabwe
ZIMVAC	Zimbabwe Vulnerability Assessment

# Report in summary

## Main component review outcomes

### *Overall performance*

The programme has successfully supported 3,300 participants and 16,500 beneficiaries with a supplementary food basket (equivalent to two meals a day for the participant and up to 5 household members) for between 3 and 15 months. The tri-partite relationship between WFP, MSF and CRS has had its successes and the group went beyond its own programme to link up with WV, C-SAFE and HELP Germany to better coordinate support efforts. Guidelines, which were not all in place at the start, were introduced and helped support decision making throughout the pilot. However, the following have posed challenges:

- Verification of beneficiaries has been very limited and inclusion errors have been noted;
- Integrating livelihood support initiatives has not been well coordinated or planned during the pilot, resulting in participants not being discharged from the programme;
- Limited and poor quality data gathering and sharing has resulted in an inability to clearly measure impact or progress and adequately inform a way forward at this time.

## Efficiency and effectiveness review outcomes

### *Has the programme made an impact?*

- Yes, on accessibility of food for selected ART clients. However, this food aid has resulted in exclusion from other food benefits (access to GMB grain) for some in Tsholotsho. As NSART food support is supplementary this may compromise the whole household's food security if the practice persists.
- On stabilisation of acute malnutrition amongst beneficiaries the food basket appears to have supported some transferring from therapeutic feeding. However, MSF note that the malnutrition they see is largely related to HIV and not food deficiency. Malnutrition is not necessarily an ideal indicator for food aid support to ART initiatives.
- Registrations began to increase dramatically as VGF feeding terminated in March/April 2007. Comparing NSART programme and VGF beneficiary lists to see the overlaps may be useful. Comparative data between food availability across Districts would also be useful to help attribute change to the food basket and NAC may be able to look at data from Tsholotsho and Lupane at the programmes request.

### *Has the programme demonstrated Value For Money (VFM)?*

- The perceived cost/benefit by participants given the limited accessibility, availability and unaffordability of food commodities is understandably high. Participants are prepared to collect the food at times regardless of the high financial costs/time spent doing so. This is especially so in Tsholotsho.
- Associated costs (cost to beneficiaries) may be an indicator of VFM to some degree. Participants are typically paying around 2USD each month in transport costs to and from the hospital to get their food. Those without this cash, trade their food. Sometimes food for transport is demanded even when cash is there. Associated costs appear to be high. In some ways the increasing associated costs of the food and ART package may indicate exclusion factors in the programme (most needy and most vulnerable will not attend clinics nor be able to cope with the increasing costs associated with ART).
- To better understand VFM in the programme, cost effectiveness would need to be tracked from WFP warehouses to arrival in the household, including all associated costs, some of which may change from month to month.

## Lessons on Nutrition and ART

### *Relevance and appropriateness of the food basket*

- Beneficiaries have come up with innovative ways of preparing meals using the rations-e.g. baking with CSB, which is a desirable and nutritious commodity appropriate from 6 months upwards.

- Some homes in Tsholotsho run out before month end due to a combination of using the food for their transport costs, repaying neighbours in food when they have had to borrow and where there are more than 5 dependants in the home.
- The basket meets national policy guidelines but varies in recommended calories by about 1 meal less a day due to its supplementary nature. In Bulawayo the majority of participants met were able to meet this extra meal from their own means; in Tsholotsho less so.
- Field work has noted that participants are generally happy with the ration quantity (more so in Bulawayo than in Tsholotsho). Whilst participants often noted this was due to household size investigations noted that in Bulawayo availability of food stuff was higher and opportunities for double dipping from other programmes were greater, than in Tsholotsho. Food aid items were regularly sold or traded across the programme (maize meal and cooking oil being the most tradable items).

#### *Adherence and Compliance to ART*

- The programme helps with adherence to ART in the first few months and when there are no complications or co- infections. A bigger factor in adherence and compliance for many programme participants, however, appears to be the use of cotrimoxazole whilst patients are on the waiting list to receive ART. This introduces the issues for the ART treatment regime.
- Defaulting on medicines was very limited.
- The robust psycho-social support offered by MSF is a key factor in adherence.
- A feeling of wellness and the experience of being sick (and the subsequent determination to live) ensures the majority comply with their medicines. Many beneficiaries feel that the food is a bonus and helps them with their medicine.
- No analysable data was available on households without food support to compare the role of food and ART. Ideally the MSF database in Tsholotsho could be interrogated. By comparing clients within the programme before they received a household ration [before January 2007] and then the same ART clients after the CRS/WFP component came on-stream, and before and after the food scenario could be established.

#### *Impact*

- Participants report eating more regularly and feeling strong enough to go for check ups and take their treatment. MSF note that very few default on their medicine once they start on ART. This could be a behaviour change partly as a result of food aid.
- There is marked weight gain reported by clinic and hospital staff for CRS participants (but this is not being compared to non-participants). Analysis of data on trends in weight gain is needed. As demand is high for the programme it will be possible to get information on participants of a similar socio economic status on ART who are not receiving food, especially in Bulawayo.

#### *How long should food be provided for?*

In an ideal situation where drugs are regularly available, the following table could apply. The table on the left is a preventive programme- clients on the waiting lists are at risk of malnourishment or getting sicker faster. This impacts the ART programming (the table on the right) as clients present in a more severe condition and with greater demand.

<b>Pre-ART Inclusive [HIV+ critical clients waiting for ART/PMTCT]</b>	<b>Proposed time*</b>	<b>Discharge to</b>	<b>ART Focused Intervention [those HIV+ currently on ART/PMTCT]</b>	<b>Proposed time</b>	<b>Discharge to</b>
Severe or Moderately malnourished	Up to 3 x 3 months cycles; after 3 months linked to medical review	Livelihood activities/ ART programme	TB co-infection	9-12 months	Livelihood activities/ ART programme based on medical issues
TB	9-12 months	Support groups & ART	Infants	2 x 3 months linked to medical review	Parents in support groups

Pre-ART Inclusive [HIV+ critical clients waiting for ART/PMTCT]	Proposed time*	Discharge to	ART Focused Intervention [those HIV+ currently on ART/PMTCT)	Proposed time	Discharge to
Infants	6 months	Parent in support groups & ART	Pregnant and/or lactating women	12 months	Livelihood activities and support groups
Children	6 months	OVC or child support programme & ART	Children	2x 3 months linked to medical review	OVC or child support programme and parents support groups
Adolescents	2 x 3 months based on medical review	OVC or child support programme and parents support groups	Adolescents	2 x 3 months based on medical review	OVC or child support programme and parent support groups
Pregnant and/or lactating women	12 months	Support groups & ART/PMTCT programme	Severe or Moderately malnourished	Up to 3 x 3 months linked to medical review	Livelihood activities
Other	2 x 3 months linked to medical review..	Support groups & ART	Other	2x 3 months linked to medical review	Support groups

\*( if individual moves to ART [i.e because of rapidly declining CD count] pre-ART food is terminated and the participant is transferred to the start of the ART food support in whichever category)

#### *Complimentary programmes*

These need to be set-up and available at the start of the food aid programmes. Complimentary programmes cover both the need for medical and clinical support as well as relief and development initiatives. This includes spiritual, psycho-social, positive living/life skills, pre-ART support and counselling, blood test capacities, trained clinicians, country partners with IGA projects, health and nutrition education programmes and linkages/referrals with other Aids Service Organizations (ASO's) for HIV health education programmes and support groups. A national entry point would be ideal. Round 1 and Round 5 Global Fund (GFATM) and Expanded Support Programme (ESP) sites in food insecure areas are ideal expansion points for NSART support nationwide. Findings have shown that:

- Support groups are key to go beyond the clinic and hospital and present a first point for the necessary involvement of community based structures;
- Mobile VCT is a key link to getting men involved and communities better tackling stigma ;
- A rigorous verification process is part and parcel of both better targeting of support and the starting point for developing safety nets at community level.

#### *Recommendations made in this report*

NSART Objective	Recommendation made
To improve the overall uptake of ART and support the roll-out plan for the [national] ART programme	<ul style="list-style-type: none"> <li>• <b>For WFP to best support nutrition with ART it needs to further comply with the WHO Three Ones Principles (one coordinating body, one implementing strategy and one monitoring and evaluating system) and go to scale [more food to more people through national entry points].</b> In addition this will help WFP access the non food resources/funds it needs for the supporting environment and encourage better linkages between donors for exit to local safety net systems and longer term social protection plans.</li> <li>• WFP and stakeholders to advocate for coordination of food through GFATM, ESP and other donor programmes. <b>Lobby for links between NSART and</b></li> </ul>

NSART Objective	Recommendation made
	<p><b>HBC.</b></p> <ul style="list-style-type: none"> <li>• <b>Develop an entry checklist</b> for WFP involvement in NSART support, including linkages with national programming and the supportive environment.</li> <li>• <b>Develop a partnership checklist</b> for engaging with NGO's/CP's including their involvement and linkages to the national programme and livelihoods support.</li> </ul>
To improve/ maintain health and nutritional status of ART patients	<ul style="list-style-type: none"> <li>• Collaboration beyond referrals is needed to ensure nutritional indicators are collected, and data is clean, useful and analysed. <b>Referral partners at hospital/clinic level need to be accountable for medical data and analysis of it.</b> A formal MOU with MSF is recommended for this programme and with the clinical structures involved in renewed, new or expanded programmes.</li> <li>• The Global Fund to Fight AIDS, Tuberculosis and Malaria has placed a nutritionist on its Technical Review Panel. WFP has a nutritionist post at HQ and this may need to be matched at CP level to support the collection and analysis of nutritional data.</li> </ul>
To improve adherence and compliance to drug therapy amongst ART patients	<ul style="list-style-type: none"> <li>• Minimum standards must be set for food provision at household and individual levels to avoid dependency. This should be done collaboratively and with an understanding of the interaction of food and ART at a general level. <b>Communication about the window of food support</b> should be supported through a number of media - via CP's, using IEC materials and local networks and media.</li> <li>• <b>WFP should consider revisiting its pipeline issues before engaging in long term food handouts to PLHIV homes.</b> Increasing locally procured/available food items within the WFP basket may help reduce pipeline breaks. WFP is in a position to lobby for support to local production and manufacture of food basket items through the wider UN family.</li> </ul>
To enhance food access and improve food security for ART patients and their households	<ul style="list-style-type: none"> <li>• <b>At the start of programming, once verification has been done, income generation, support group and livelihoods programmes should be set up with the households of participants.</b> Community structures should be involved. Support groups are able to self regulate and monitor for double dipping as these membership organisations have a vested interest in sharing the benefits of ART and food as widely as possible amongst their client members.</li> <li>• <b>Long term food insecurity should be dealt with through linkages with other relief programmes.</b> This needs to be negotiated before NSART support begins so that planning is continuous and transitions are possible following medical review processes.</li> </ul>

## Overview and Introduction

WFP Zimbabwe is currently involved in providing food support to vulnerable people primarily to mitigate the impact of HIV and AIDS and safeguard the nutritional well being of vulnerable populations. Current WFP Zimbabwe HIV and AIDS activities include food support to Orphans and Other Vulnerable Children (OVC), Home Based Care (HBC), and a pilot programme for people on Anti-Retroviral Therapy (ART).

The food component of the ART programme, which is the focus of this report, aimed to:

- Improve the overall uptake of ART and support the roll-out plan for the ART programme
- Improve/ maintain the health and nutritional status of ART patients
- Improve adherence and compliance to drug therapy
- Enhance food access and improve food security for ART patients and their households

WFP in direct partnership with Catholic Relief Services (CRS) and through a strategic partnership with Medecins Sans Frontiere-Spain (MSF) are since January 2007, providing food support on pilot basis to food insecure ART patients and their families in Bulawayo and Tsholotsho Districts. The food basket is comprised of a monthly ration of cereals (10Kg), pulses (1.8Kg), vegetable oil (0.5Kg) and Corn-Soya Blend (3Kg) per person. This evaluation will focus on the impact of food aid in complementing the ART programme in Zimbabwe. It is expected to assist participating agencies to learn and better understand the implementation of food assistance alongside anti-retroviral therapy.

The pilot programme was implemented from January to December 2007 and extended for a further three months to cover the peak hunger season. March 2008 was the last month for distribution of a food basket under the pilot programme. The main task of this review is to evaluate how food aid has complemented the ART programme in Bulawayo and Tsholotsho Districts since January 2007. Recommendations from the evaluation will provide learning and guidance for programming future interventions.

## Methodology & approach

Both quantitative and qualitative data have been used for this review. Some quantitative data has been provided via WFP by CRS and MSF in the form of participant databases and derived from monthly monitoring reports. Beneficiary profiles and some impact information have been generated from these databases. Some primary quantitative data has been generated both in previous studies and during field work conducted between 26<sup>th</sup> February and 1<sup>st</sup> March 2008 in Tsholotsho and Bulawayo. Qualitative data has been generated from semi structured interviews with programme partners, stakeholders and participants and community members (both beneficiaries and non beneficiaries at community level). The activity plan for this review was as follows:

Activities
Participation at the WFP NSART programme workshop in Bulawayo with key stakeholders to discuss pertinent issues related to the programme and set the scene for the consultancy.
Document review – monthly reports from MSF, CRS, WFP, analysis of patient June 2007 data, programme documents, etc. Interviews with Harare offices of CRS, MSF, WFP
Field work based at Bulawayo Mpilo and Tsholotsho hospitals. Interviews and focus group discussions with a broad range of stakeholders, strategic partners and key informants, participants, beneficiaries and community members not on the programme. Some visits to defaulters’ homes in Bulawayo and Tsholotsho were included. Interviews with Bulawayo offices of MoHCW, City Council, WFP, HELP, MSF-Spain, CRS, NAC, C-Safe, World Vision, MAC
Analysis of available patient data and comparison with June baseline. Production of preliminary report and presentation to WFP Harare and WFP Bulawayo. Production of final report

Annex 1 lists those talked to and gives the numbers involved in group discussions.

Prior to this review WFP commissioned a desk review<sup>1</sup> that looked at OVC, HBC and ART support in Zimbabwe and across the region. In addition a targeting and selection guide<sup>2</sup> was drawn up for use with ongoing and future OVC, HBC and ART support programme for WFP and their country partners. In addition two other studies/surveys were commissioned in June/July2007, a Nutrition and ART study was conducted across a number of WFP programmes and an assessment of the appropriateness of cash and voucher programmes in urban and peri urban areas of Zimbabwe. Information and field work findings from these exercises have been brought into this review.

## This Report

The report closely follows the guidance provided by the ten listed tasks in the assignments TOR's (see box).

The first section after this introduction comprises a main component and activities review section. This section looks at management and implementation of the programme with the aim of drawing lessons for future programming. The focus is on targeting, selection and discharge criteria.

An efficiency/effectiveness review follows. This examines the pilot in relation to its original logframe and asks the questions - how well has the programme been implemented? Has the programme made an impact? And has there been value for money?

Nutrition support is the next section. The food basket is looked at from the beneficiaries' perspective with feedback on some of the measurable impacts of the food basket. The broader operational content is also brought in with a look at the guidelines available for programming.

Before wrapping up the review we look at the findings on complimentary programmes. This section discusses livelihoods, the involvement of men, and, where available, brings in experiences from other nutrition support programmes.

Finally the report makes some conclusions against the pilots four stated objectives as a summary of the reports findings. Recommendations are also made for the way forward and for WFP involvement in nutrition support to ART in the future.

### Scope of work: Specific tasks

1. Design and develop a multi-method approach incorporating both qualitative and quantitative tools.
2. Review implementation of targeting, selection and discharge criteria for ART patients receiving food support.
3. Review programme adherence to implementation guidelines.
4. Assess relevance and appropriateness of the food basket and implementation process and appropriateness of the intervention – that is, whether it is in line with project purpose and with needs.
5. Review efficiency measures, that is, if inputs were effectively correlated to outputs.
6. Assess effectiveness of the programme, that is if actuals, outputs have achieved planned outcomes.
7. Assess timeliness and sustainability of the programme and review of minimum duration of food support using National ART guidelines in Zimbabwe as a basis for comparison.
8. Explore complimentary programmes, including livelihood activities, which are linked to food support programmes as exit strategies.
9. Review current mechanisms/modalities to enhance male involvement in the programme.
10. Review policy guidelines on food support to ART, programme ownership and accountability.

<sup>1</sup> 'WFPDeskreviewfinal1' sent to WFP HQ in Harare on 25thFebruary in both word and PDF format

<sup>2</sup> Appendix within WFPDeskreviewfinal1 document

# Main Components and Activities Review of the Pilot Programme

This section covers the management and implementation of the programme and looks at its success and its challenges in order to generate lessons for future programming.

## On paper/in practice

On paper	In practice
<p><i>Partnerships:</i> The program will be implemented in a tripartite arrangement with WFP providing the food commodities, MSF referring the patients and CRS doing the distribution as the WFP implementing partner. Ministry of health will provide the operating institutions.</p> <p><i>Registration and Verification of beneficiaries:</i> registration will be documentation of patients and their household demographics. Verification is a process that ensures food security is the key factor for nutrition support through household visits to patient's homes and to verify household demographics.</p> <p><i>Food distribution:</i> the process will involve the allocation of available food commodities to referred patients who meet the food criteria based on food insecurity.</p> <p><i>Post distribution monitoring:</i> CRS will carry out household visits to households that have received food rations with the purpose of assessing the usage of food the household level.</p> <p><i>End use monitoring:</i> the activity monitors the use of food at household level and the level of acceptance, dilution of ration, complimentary food etc.</p> <p><i>Identification of appropriate projects:</i> CRS livelihoods unit will coordinate this activity which is dependent on soil types and area; appropriate projects will be identified with the involvement of local officials and also the livelihoods department of CRS.</p> <p><i>Training in livelihoods project implementation:</i> the training will be carried out by CRS with participation of local officials and other stakeholders on implementation of the identified appropriate projects.</p> <p><i>Monitoring of livelihoods projects implementation:</i> monitoring will be a continuous process to ensure sustained standard of implementation of projects for maximum benefits to the patients. The CRS livelihoods unit will assist in the monitoring.</p> <p><i>Nutrition Assessment:</i> to assess if nutritional needs are being met. This assessment is carried out collaboratively with other stakeholders like the Ministry of health, MSF, UNICEF and others.</p>	<p>This has gone according to plan with regular coordination and clear separation of duties. However, capacity at MoH institutions remains an ongoing concern and the recent institution of clinic fees has been raised as an issue that may hold back benefits. One possible approach is for WFP to collaborate only with those institutions that do not charge clinic user fees.</p> <p>This has been a central challenge and the weakest point in meeting the food security mandate of the WFP food programme. Cluster sampling in urban high density areas has been helpful in highlighting inclusion errors. Placing participants on a household ration before household verification has resulted in inclusion across the programme.</p> <p>Food distribution is slow and could be improved by including approaches that involve the beneficiary directly. Distribution follows a calendar month and does not always tie in with monthly visits to doctors.</p> <p>Despite multiple requests, the review team were unable to access information held by the CRS M&amp;E unit which would have enabled us to remark on the efficacy of both post distribution and end use monitoring.</p> <p>CRS has drawn upon their experience with similar and same communities under other funding (Such as DFID PRP) and had identified business/IGA training for Bulawayo participants and small livestock for Tsholotsho participants.</p> <p>The budget for this activity was limited (USD7,000) and only a training strategy though support groups could be possible on this budget. Progress has not been made. Capacity to initiate funds was not there with CRS. CRS had asked ORAP to take this component forward but this has not yet been done.</p> <p>No programmes to monitor. Capacity to implement within CRS is limited.</p> <p>The extent of nutritional assessment remains unclear. Gaps in data and utility of data have been questioned. MoH have no qualified nutritionists at Tsholotsho. MSF nutritionists have had a high turnover. Information on nutrition indicators are held in hospital/MSF databases and do not inform programming.</p>

On paper	In practice
<p><b>Food Basket:</b> The Food basket will consist of the following monthly ration 10kg cereal, 1.8kg pulses, 450ml oil, 3kg CSB for the individual and 50kg cereal, 9kg pulse, 2.25l oil, and 15kg CSB for the household.</p> <p><b>Gender strategy:</b> CRS will ensure that the program is at minimum on line with the WFP Gender Policy # 8 on Enhanced Commitment to women which states as follows: "Make progress towards gender equality in staffing, opportunities and duties, and ensure that human resource policies are gender sensitive and provide possibilities for staff members to combine their personal and professional priorities."</p>	<p>There were pipeline breaks for CSB in at least 4 of the 15 months. Maize was affected by delays. Otherwise food was generally available and on time.</p> <p>CRS employ both women and men in a variety of positions within the organisation. CRS staff interviewed were not aware of any gender workplace policy. The programme ensured that staff working after 5pm were provided with transport home.</p>

## ***Implementation of Targeting, Selection and Discharge Criteria for ART Patients receiving Food Support***

### *Targeting ART support in Zimbabwe*

**The approach:** The overall framework for targeting in this programme has been largely top down and donor driven. While this is understood within the context of a time-bound and resource set pilot programme, these factors are important should the programme continue, expand, go to scale and/or be replicated elsewhere. The following observations were made in support of this:

<p>Top down because of:</p> <ul style="list-style-type: none"> <li>• Hospital rather than community based</li> <li>• Very specific focus on HIV+ on ART</li> <li>• Limited community/participant involvement in the project cycle</li> <li>• A food basket of set size</li> </ul>	<p>Donor driven because of:</p> <ul style="list-style-type: none"> <li>• The use of predetermined medical and socio-economic criteria of vulnerability and poverty as well as targeting processes and indicators;</li> <li>• The resource limitations set by WFP that have bounded the pilot rather than by actual need [numbers on the programme, size of food basket];</li> <li>• A bias towards locations where MSF-Spain are currently operating.</li> </ul>
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WFP do not have an overall framework for supporting ART in Zimbabwe at this time. Their approach to NSART has been a responsive one, assessing proposals for support that have come to them from practitioners and stakeholders in the field rather than being part of an overall strategy at national level. WFP's targeting approach is itself geographically biased for the following reasons:

- WFP operating areas are based on CFSAM, ZIMVAC and food security indicators rather than HIV and AIDS prevalence;
- WFP's current response is not linked to the National ART roll out plan, the Global Fund Round 1 or Round 5 sites or donor ESP funding;
- The lack of accurate [or regularly estimated] district level HIV prevalence rates and nutrition surveillance data make it hard to include HIV and AIDS within the WFP current targeting strategy.

However, WFP do outline the complimentary services that need to be made available for food support to be placed. Setting up a checklist for sites and CP's can help standardise the environment for WFP food support to ART.

On Paper	In Practice
<ul style="list-style-type: none"> <li>• Comprehensive supportive counselling, including referral to VC and Testing services</li> <li>• Counselling and psycho-spiritual support</li> <li>• Social support</li> <li>• Nutrition education and support</li> <li>• Palliative care (i.e. moderating pain or sorrow by making it easier to bear)</li> <li>• Information/skills sharing on reproductive health and hygiene, etc.</li> </ul>	<ul style="list-style-type: none"> <li>• There is a robust hospital based programme that covers C &amp; T through MSF in both Tsholotsho and Bulawayo. Over a 6 month period, this equips the participants with medical knowledge, information on nutrition and life skills.</li> <li>• Palliative care is provided via the hospital structures.</li> <li>• Hygiene is a topic covered in the daily dialogue session by CRS/WFP food distribution. Reproductive health is not a topic covered and capacity may not lie with CRS/WFP</li> <li>• No linkages made on livelihood support.</li> </ul>

On Paper	In Practice
<ul style="list-style-type: none"> <li>• Livelihood support (nutrition gardens, conservation farming, micro-finance, poultry keeping, natural harvesting technologies)</li> <li>• Water and sanitation, health and hygiene</li> <li>• Formation of ART social support groups</li> </ul>	<ul style="list-style-type: none"> <li>• No WASH issues in the programme.</li> <li>• MSF support groups are already in existence and some CRS participants are part of these groups. CRS participants are also members of DAAC/WAAC and ZNNP+ groups mostly through their own initiatives to be part of those groups.</li> </ul>

*Targeting participants in the programme for food support:*

The programme of WFP food support is based on clinical referrals from MSF to CRS. MSF use only medical criteria regardless of socio-economic status. CRS assess the referred patients for vulnerability eligibility based on participant interviews at the hospital site, and subsequently distribute a household food basket.

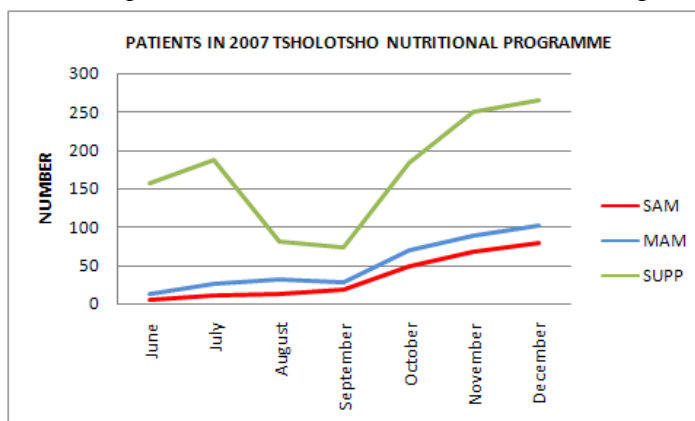
On paper	In practice
<p><b>Selection:</b></p> <p><i>Primary beneficiaries (participants)</i></p> <ol style="list-style-type: none"> <li>1. HIV/AIDS positive women, men and children indicating WHO clinical stages 3 and 4 and are enrolled for ART services</li> <li>2. ART patients with HIV infection who have a peripheral blood CD4+ lymphocyte count of less than 200.</li> <li>3. Nutritionally vulnerable ART patients</li> <li>4. HIV+ lactating mothers on ART ( nutritionally vulnerable)</li> <li>5. HIV positive infants and children on ART who are malnourished</li> </ol> <p><i>Secondary beneficiaries</i></p> <ol style="list-style-type: none"> <li>1. Nutritionally vulnerable household members (up to a maximum of 5) of every ART patient.</li> <li>2. Nutritionally vulnerable household members (up to a maximum of 5) of lactating mothers on ART.</li> <li>3. Nutritionally vulnerable household members (up to a maximum of 5) of malnourished children on ART.</li> </ol>	<p><i>Statistics from the CRS database:</i></p> <p><i>Of the 1,408 rural households and 2,203 urban households:</i></p> <ul style="list-style-type: none"> <li>• 63% females in rural programme, 62 % females in urban programmes</li> <li>• Marital status – coded information is in the database but details of codes are missing</li> <li>• No rural participants recorded as on medical aid, 1% of urban participants are on medical aid</li> <li>• 0.3% of rural participants have declared employment and 0.7% of urban participants have declared employment</li> <li>• 39% of rural participants declared they were living with 3 or more orphaned children with 37% in the urban programme</li> <li>• The average declared age of the rural participants is 35 years whilst for urban programme it is younger at 27 with an age range across both programmes from 1 to 75 years.</li> <li>• Average household size in the urban programme is a surprising 11, and 12.7 in the rural site (ZHDS figures show national average household size for 2005/6 as 4.6)</li> </ul> <p><i>The following detailed CRS information is needed to verify the selection criteria</i></p> <ul style="list-style-type: none"> <li>✓ % participants on the CRS registration list with a CD 4 count less than 200</li> <li>✓ % presenting with SAM/MAM who are on CRS list</li> <li>✓ % who were referred from the therapeutic feeding programme</li> <li>✓ % HIV+, pregnant and lactating mothers on the list</li> <li>✓ % infants on ART on the CRS list (under 5)</li> <li>✓ % children on ART on the CRS list (6-12)</li> <li>✓ % adolescents on ART (13 to 18)</li> </ul>
<p><b>Targeting:</b></p> <p><i>Medical criteria</i></p> <ul style="list-style-type: none"> <li>- Automatic entry for HIV and AIDS positive women, men and children indicating WHO clinical stages 3 and 4 and are enrolled for ART services</li> <li>- Automatic entry for ART patients with HIV infection who have a peripheral blood CD4+ lymphocyte count of less than 200.</li> </ul>	<p><i>The following information on pre-CRS selection, which has not been made available from the MSF or hospital database, is required to verify the targeting criteria being used:</i></p> <ul style="list-style-type: none"> <li>✓ Waiting list information - those HIV+, numbers waiting for ART, other treatment issues</li> <li>✓ % participants with a CD 4 count &lt;200 on MSF list and those on CRS list</li> <li>✓ % presenting with SAM/MAM who are not on CRS list</li> </ul>

On paper	In practice
<ul style="list-style-type: none"> <li>- Automatic entry for ART patients who are malnourished</li> <li>- Automatic entry for lactating mothers who are on ART (nutritionally vulnerable BMI <math>\leq</math> 18.5 or MUAC of <math>\leq</math> 21cm for adults and MUAC of <math>\leq</math> 12.5 cm for children).</li> <li>- Automatic entry for HIV positive children on ART (nutritionally vulnerable)</li> <li>- Anthropometrical screening for ART patients using Body Mass Index (BMI). BMI will be used to screen and monitor ART patients. BMI cut-off point is <math>\leq</math>18.5</li> </ul> <p><i>Socio-Economic Criteria</i></p> <ul style="list-style-type: none"> <li>- Decline in a household's ability to access food.</li> <li>- No trading</li> <li>- No assets that can be sold in order to buy food.</li> <li>- No gainful employment or income from labour or remittances from any member of the household.</li> <li>- Not receiving any food aid from any other source</li> </ul> <p><i>Anthropometric Indicators</i></p> <ul style="list-style-type: none"> <li>- BMI (Body Mass Index) will be used to screen and monitor ART patients. BMI cut-off point is <math>\leq</math>18.5</li> <li>- Weight for Height (WFH) percentage between 70-80% for malnourished HIV+ children on ART</li> <li>- MUAC can be used to screen ART patients at risk of malnutrition</li> </ul>	<ul style="list-style-type: none"> <li>✓ % HIV+, pregnant and lactating mothers on MSF list/CRS list</li> <li>✓ % infants/children/adolescents on ART</li> </ul> <p>The MSF database for Tsholotsho shows approximately 8% of (147) patients had BMI &gt; 18.5 on admission. Further analysis is not possible at this time due to large amounts of errors in the uncleaned data.</p> <p>The use of medical criteria for targeting participants appears to function efficiently and is mostly reliable as a project selection tool.</p> <p><i>The following information has been requested from CRS but to date has not been supplied</i></p> <ul style="list-style-type: none"> <li>✓ Number and % of household visits conducted</li> <li>✓ Findings from the household visits</li> </ul> <p>These indicators have challenged the programme and the utility of data collected in the CRS database is questionable. The current MSF data to hand is uncleaned. A MSF BMI indicator analysis should be required at 3-6-9 months</p> <p>CRS/MSF data provided does not show WFH changes or MUAC changes, although they have been requested.</p>

*Discussion:*

*Selection of participants:*

- There is no outreach or community based component in this programme so participants are drawn from those individuals who approach the hospitals for treatment and/or who are encouraged to attend by the availability of food. Exclusion errors may be high at this point without an outreach VCT programme directly linked to the ART roll-out initiative.
- Once the participant is within the hospital system, selection is based on eligibility criteria- the first and overarching one being that the participant must be HIV+ and on ART. Thus those on the waiting list for ART have not been part of the programme. The hospital/MSF agenda has been to ensure that all



people receive a well balanced and sufficient diet to support their treatment regime for at least 3 months and refer all medically eligible patients to the WFP programme. This second level has resulted in the exclusion of those waiting to receive ART, many of whom may be malnourished during this waiting period.

*Household size:*

- WFP Zimbabwe CHS round VIII noted that the average household size for Matabeleland rural homes was 6 and Bulawayo as 3, making the figures recorded here over double for rural participants and triple for urban participants. ZDHS figures for 2005/6 note household size as 4.1 and 4.6 for urban and rural homes respectively.
- Overstating household size could be attributed to the free food component of the programme.

*Medical criteria:*

- Counselling and testing are voluntary. CD4 counts and clinical assessments are done to determine readiness for ART. However, due to the problems faced with shortages of CD4 count machines, subsequent 6 monthly CD4 counts are deferred to 1 year. Symptomatic diagnosis predominates.
- MSF doctors report that the vast majority of cases of SAM and MAM in both Tsholotsho and Bulawayo appear HIV related. Response to therapeutic feeding has been good. It is reported that very few return to therapeutic feeding once they are successfully through food therapy but no data has been made available to confirm this.

*Socio-economic criteria:*

Participants interviewed at the hospital sites have been the main source of socio-economic verification for the programme. This is insufficient to determine socio-economic status at the household level and screen the clients effectively. Household verifications are critical. Client confidentiality has been cited as a constraint together with staff capacity to conduct household visits, especially in Tsholotsho. Cluster sampling has been started in Bulawayo and inclusion errors are evident. Double dipping has also been noted and mechanisms for tackling this instituted [card stamping at clinics]. However, unless all agencies giving food are coordinated and jointly set principles for food distribution, double dipping will still occur.

During FGD's with Bulawayo programme participants and other stakeholders a key informant noted that other agencies such as HELPAGE provide food in their community. This particular informant benefited from three food programmes and was selling her surplus on the open market

*Anthropometric indicators:*

Anthropometric screening has posed challenges to the referral system and revisions of the BMI cut-off have been made. Deviations from the recommended cut-off point have been reported. MoHCW staff morale has been low and recording of weight and heights have not always been consistent. Infants and adolescents appear to present with malnutrition more often than other groups.

*Participant profiles from the CRS database have been found as:*

Bulawayo	Tsholotsho
<i>Demographics &amp; characteristics</i>	<i>Demographics &amp; Characteristics</i>
More women than men	More women than men
Infants and adolescents present with SAM/MAM	Infants and adult male present with SAM/MAM
Younger	Older
Single and multiple orphans	Single and multiple orphans
Some access to medical aid	No access to medical aid
Some formal employment	No formal employment
Fewer active IGA's	Active gardens and IGA's
Support groups	Support groups

*Discharge/Exit from food support*

On paper	In practice
<p><b>Discharge</b> Patients will be discharged from the program for the following reasons:</p> <ul style="list-style-type: none"> <li>• Confirmation of restoration of productive capacity by ART patients</li> <li>• Improved CD4 counts between 800-1200 (MSF / MOH&amp;CW)</li> <li>• Indication of improved nutritional status and reduced HIV wasting (BMI between 20 to 24.9 for three consecutive months for adults)</li> <li>• ART children indicating WFH &gt; 85% for two consecutive months</li> <li>• ART children identified with a WFH of less than 70% should be referred to the therapeutic feeding programme.</li> <li>• Establishment of tangible livelihood support initiatives.</li> <li>• Defaulting for 2 consecutive months.</li> <li>• Death of ART patients (3 months transition period and orphans of the deceased transferred to safety net programmes)</li> </ul>	<p>No discharge based on impact or health changes have been made in the programme. The following data obtained from participants database:</p> <ul style="list-style-type: none"> <li>✓ CRS 'good news stories' and personal testimonies are available within the beneficiary group that demonstrate restoration of productive capacity</li> </ul> <p><i>Data requested but not supplied and still needed to complete this section includes</i></p> <ul style="list-style-type: none"> <li>✓ Participants on the CRS list who have CD4 counts of between 800-1200... CRS</li> <li>✓ Participants on the CRS list who have BMI's between 20 to 24.9 for 3 months in a row.</li> <li>✓ MSF data analysis on children with WFH of less than 70% (10% of 193 children in Tsholotsho, on admission)</li> <li>✓ Numbers of children on CRS list sent back for therapeutic feeding (not thriving and reasons)</li> <li>✓ Numbers of recorded defaulters from CRS and their reasons for defaulting</li> <li>✓ Statistics on participant deaths from CRS (WFO monthly reports have some information but it is not comprehensive)</li> </ul>

*Discussion:*

- Comparison to VGF and other relief support programme profiles can inform whether food aid support to ART should be tackled within the general food aid support programme with only seasonal support to ART when VGF is not operational..
- Concerns for the prevailing macro-economic environment are keeping participants indefinitely on food rations (sometimes justified sometimes not) which clouds the objective of 'adjustment' to treatment with ongoing food security issues.
- There is obvious concern about the impact/consequences on the ART participant of not having enough food. Household verification should lead over compassionate approaches. Regularity of a full food basket is also important.
- Linking discharge to improved nutrition is weakened without good quality nutritional monitoring.
- An eye to generating and recording the missing critical information in the table above, in future programmes could be a practical way forward.
- The 2007 baseline report commissioned by WFP and NAC noted that in Mpilo and Tsholotsho most clients did not understand BMI but were aware they were measured for weight and height. They also understood the importance of weight measurements in relation to nutrition and therapeutic intervention.
- Evidence from the formative assessment showed that no clients had ever been assessed using the MUAC measurement.

*Yes I understand the weight, when it goes up I will be doing well and when it comes down I will be deteriorating. When I'm doing well I know that I am responding well to the drugs and food.*  
**Client: Mpilo Hospital, 2007 baseline**

*Yes increasing figures for weight means I'm doing well and responding to food. I do not understand when weight and height are measured to calculate BMI and what that means.*  
**Client: Tsholotsho, 2007 baseline**

## Programme Adherence to Implementation Guidelines

An initial proposal document was set-up for the 6 month pilot. Within this document implementation procedures were laid out.

*On paper/in practice:*

On paper	In practice
<p><b>Implementation procedures</b></p> <ol style="list-style-type: none"> <li>The operation to provide nutrition support to ART patients will be implemented at hospital/clinic level. (FDP will be the hospitals)</li> <li>The targeting of beneficiaries for the nutrition support will be based on a referral mechanism and will involve a verification process to determine the vulnerability of the household.</li> <li>Distribution of food to beneficiary households will be done daily to coincide with each household's "check up" day. Each family will receive a ration to last the month. There will be 2 distribution assistants based at each health institution. The two will be responsible for the registration and verification of beneficiaries. They will distribute the food to deserving beneficiaries after a verification process.</li> <li>Monitoring will be a continuous process that will be carried out by the Monitoring and Evaluation Officer who will be assisted in the monitoring activities by data collection officers from the CRS main M &amp; E unit.</li> <li>Reports will be compiled as per format at district level and will be consolidated at provincial level by a Field Coordinator who will forward them to the CRS Assistant Food Aid Program Manager. The reports, after review, will be distributed appropriately to stakeholders and WFP from the Harare office.</li> <li>The CRS Field Coordinator will be based in Bulawayo and will maintain links with the Bulawayo WFP Bulawayo office and other stakeholders at local levels and also represent CRS in local meetings.</li> </ol>	<ol style="list-style-type: none"> <li>All food is distributed at hospital level.</li> <li>Verification is done 'on site' using a questionnaire approach. Capacity to do household visits has been held back by lack of transport (Tsholotsho) and staffing levels (Tsholotsho and Bulawayo). Monitors are responsible for daily food distribution and household visits. Less than 25% (from WFP monthly reports) of households have been verified. CRS have managed to secure motorbikes from another of their projects to support monitors in Tsholotsho.</li> <li>Daily food distributions have been the model in both Bulawayo and Tsholotsho. However, linking distribution to the medical review process has meant multiple visits to the hospital by participants. CRS strictly follows a monthly distribution cycle whereas medical appointments do not.</li> <li>Monthly collection of data is in place.</li> <li>Monthly reports from CRS have been generated and distributed to WFP. WFP generate monthly reports based on CP report.</li> <li>The CRS field coordinator is based in Bulawayo and visits the field for DRRC meetings and to meet district and hospital based staff. Regular meetings are held with WFP and other stakeholders.</li> </ol>

*Discussion:*

- The biggest constraint to CRS programming has been staffing and resourcing. Monitors and food distributors are on site daily but they are preoccupied with ration distribution. This means follow-up household visits are sidelined. The Bulawayo based M&E Officer has been assigned primary responsibility for home visits but transport and time constraints were sited as holding back regular household verification.
- The programme uses a single and direct distribution model which involves decanting of oil and beans by CRS staff. This is different from the VGF model of group beneficiary distribution. As the programme has rations for 5 people set already, self distribution can speed up the waiting time.
- A major challenge has been defining the limitation of food support. Community based processes may have helped in setting a minimum duration for the food basket and in communicating programme changes. Interviews at community level show local groups and traditional leadership are aware and willing to get involved. Many noted that the need for treatment and support far outweigh the issue of stigma. Stigma could be better measured during community outreach as feedback from the participant base is, in reality, feedback from the already 'converted'.

Concerns around participants and beneficiaries distributing their own rations were raised. Some raised concerns round those who were ill being involved in scooping foodstuffs. This can be easily tackled through awareness. The majority of symptomatic clients travel with family

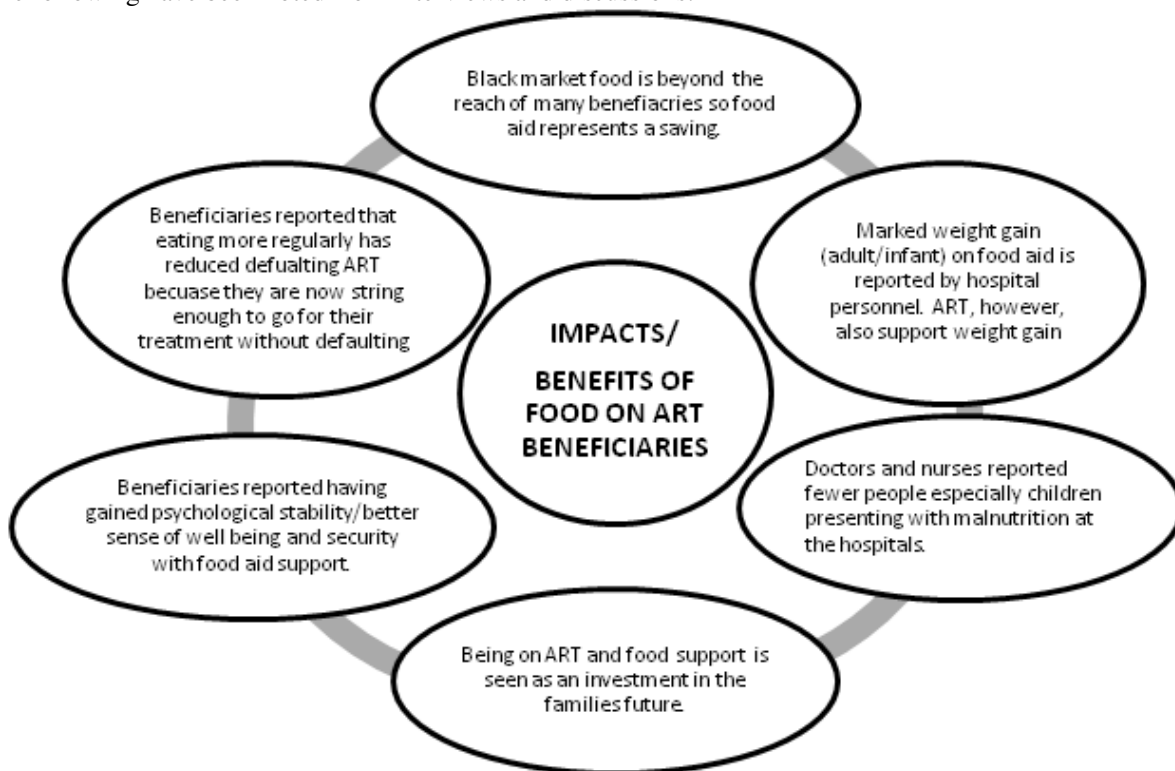
## Efficiency and Effectiveness Review:

It is understood that the logframe was set up for a 6 month pilot and that the extension to the programme may have overridden the initial framework. Reviewing the initially outline logframe can still inform the programme on efficiency and effectiveness (utility) issues.

### Has the programme made an impact?

Goal/impact statement	Performance indicator	Outcomes to impact issues	
Improved access to food commodities of ART patients.	Monthly rations allocation to vulnerable households	<ul style="list-style-type: none"> <li>✓ Key beneficiary feedback has been very positive on the combination of food and ART.</li> <li>✗ There have been pipeline breaks in a key commodity (CSB)</li> <li>✗ Food commodities are being sold, traded/bartered for transport costs and to replace 'borrowed' food items at community level when household availability is low.</li> <li>✗ Some households in Tsholotsho have not been able to access grain from elsewhere as a result of being on the programme.</li> </ul>	
Outcomes	Performance indicators	Progress	Comments
Reduced and/or stabilized prevalence of acute malnutrition among beneficiaries	Number of discharged patients Improved physical features (clinical features)	<p>There have been no discharges from the CRS programme based on improved health and well being or transfer to other safety net support.</p> <p><i>There may be further information in the MSF database but data cleaning has not yet been carried out.</i></p>	<ul style="list-style-type: none"> <li>✓ Professional or salaried participants were removed from the participants list by CRS.</li> <li>✓ Stabilisation of malnutrition is a joint task of MSF and CRS. MSF have jurisdiction over the therapeutic feeding. It is therapeutic feeding that has the most tangible effects on malnutrition.</li> </ul>

The following have been noted from interviews and discussions:



*Discussion:*

- The indicators set at outcome level have been only partially achieved. Numbers discharged are few. Livelihood support should have been mobilized within the first three months of the programme (this was an initial 6 month pilot). Capacity constraints have been cited by CRS as the main reason why they were not, and the situation remains the same 15 months on.
- Improved health and wellbeing is determined by MSF not CRS. Improved physical condition has in some way been achieved through the therapeutic feeding programme prior to the ART and food aid support.
- With no clear mechanism to improve the clients socio-economic status WFP may be engaging in a long term social protection programme which they are ill equipped to support.
- In Tsholotsho, participants were infuriated by the local policy that they cannot purchase mealie-meal from the Grain Marketing Board as long as they are on food aid, with or without a letter from the social welfare. WFP rations are only a supplementary basket for 5.

***Has there been value for money in the programme?***

Outputs	Performance indicators	Progress	Comments
Nourished beneficiaries	Reduced vulnerability and shocks causing poverty.	No quantitative evidence available	Utility of nutritional data and indicators is questionable.
Improved access to inputs and adoption of improved and affordable technologies	Increased sustainable productivity and resilience. Beneficiary households taking up new technologies.	No progress since livelihoods or community level safety nets support were not instituted.	Unless WFP goes to scale non-food related funding by WFP remains very limited. Even at scale WFP need capacitated partners with the ability to link other relief and recovery funds to the NSART beneficiary group.
Activities	Inputs	Progress	Comments
<ul style="list-style-type: none"> <li>• Registration of beneficiaries.</li> <li>• Verification of food insecurity status and size of household.</li> <li>• Food distribution to households.</li> <li>• Monitoring</li> <li>• Assessment of households for livelihoods activities.</li> <li>• Training in livelihoods activities identified.</li> <li>• Planning and monitoring livelihoods activities.</li> </ul>	<ul style="list-style-type: none"> <li>✓ Head office program manager</li> <li>✓ Bulawayo based field officer to oversee implementation</li> <li>✓ Field monitors for registrations and verification</li> <li>✗ Experienced livelihood programme personnel</li> <li>✓ Food distribution assistance based at health institutions</li> <li>✓ Stationary supplies</li> <li>✗ Transport for verifications and monitoring</li> <li>✗ Venues for training beneficiaries in livelihoods</li> <li>✓ Offices in Bulawayo</li> </ul>	<ul style="list-style-type: none"> <li>✓ In place</li> <li>✓ Field coordinator not able to speak Ndebele</li> <li>✓ Field monitors in place but focus on registration or distribution and not on verification.</li> <li>✓ CRS do not have the capacity for implementation of livelihoods in this programme so they needed to subcontract which would be slow and costly.</li> <li>✓ Distribution at Tsholotsho hospital and Mpilo clinic.</li> <li>✓ Transport not made available through the programme funds.</li> <li>✓ Venue not established.</li> <li>✓ NSART team within CRS Bulwayo office.</li> </ul>	<p>The perceived cost/benefit by participants given the limited accessibility/availability and unaffordability of food commodities is understandably high.</p> <p>Participants are prepared to collect the food at times regardless of the high financial costs/time spent doing so. This is especially so in Tsholotsho. Accessing basic commodities is the main issue being addressed.</p> <p>Associated costs to the participant and beneficiaries may be a better measure of VFM.</p> <p>Participants are typically paying around 2USD each month for a single visit in transport costs to and from the hospital to get their food. Those without this trade their food. Sometimes food for transport is demanded even when cash is there.</p>

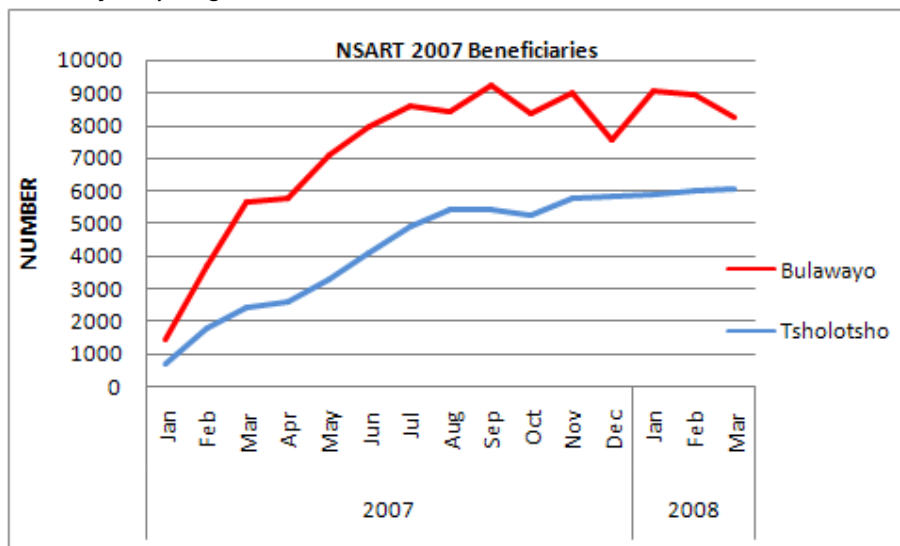
*Discussion:*

- The outputs can only be partly achieved. With increased poverty and unavailable or unaffordable basic commodities a supplementary food basket may fall short of need for some. Participants and beneficiaries interviewed noted that supplementation of food rations is minimal. Most households interviewed noted that they only required salt and vegetables to augment their meals.
- An issue highlighted by stakeholders in the review was that of both professionals and other salaried recipients of ART being discharged. One finding was that beneficiaries at Mpilo asked whether nurses at the OI clinic who are also on ART should be given food. Reasons were that the nurses can't provide them with an efficient and quality service if they (nurses) are hungry and that it is unfair and tempting for the nurses to see other people receiving food on a daily basis when they themselves have nothing to eat. It was also reported that many nurses were affected by their removal from food aid and have left the OI clinic when in fact they could be the ideal counsellors and care givers because they can relate to the patient's plight.
- A cost effectiveness analysis could be undertaken provided detailed costs, from WFP through to CRS and to household level, are made available.

## Timeliness and sustainability of the programme

The programme has been unable to stick to its initial 6 months. Participants were not registered as a 'body' at the start of the programme but were registered progressively over the first 6 months and beyond. New participants have been registered with MSF as late as February 2008 whilst dates for registration with CRS have not been made available. While selection criteria were generated later in the pilot phase, no time was set for food support to end at individual or household level. This has resulted in the programme reaching its maximum capacity with no discharges by October 2007. This was in the initial extension phase. CRS applied for and received a 10% increase in funding from WFP at this point and distributions have continued through March 2008.

*Participants and beneficiary targets:*



### *Food distribution targets*

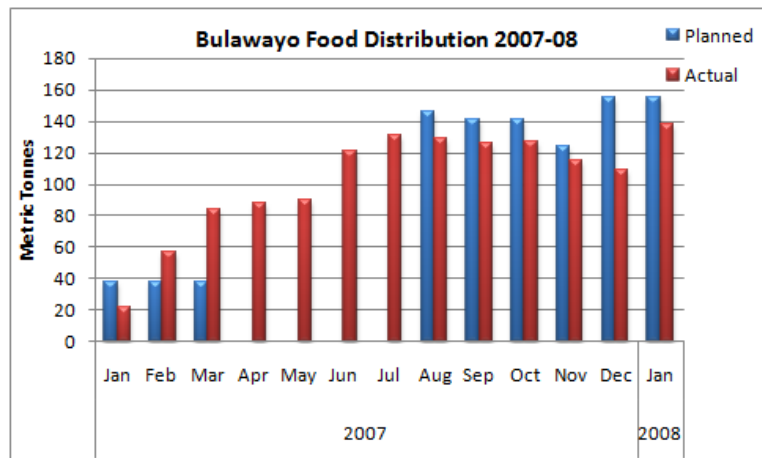
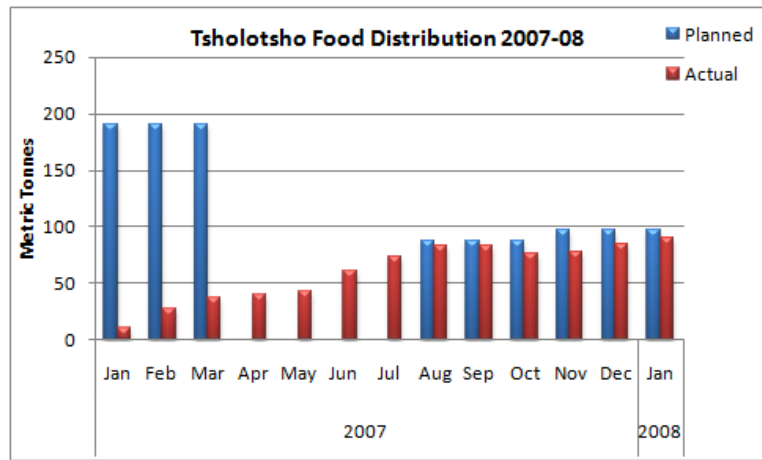
The charts overleaf provide some indication of planned and actual tonnages of food delivered between January 2007 and January 2008.

*Reasons for Actual not Meeting Planned:* Two principle factors were that planned commodities were overstated in all the months and the occurrence of pipeline breaks, especially in CSB, affected targets.

### *Other issues:*

- A big issue has been the pilot's inability to address the wider socio-economic status of the beneficiaries through the integration of livelihood support side by side with the food safety net.

- The failure to discharge participants undermines the sustainability of the programme and limits its benefits and impact. It has also reduced the pilot phases ability to generate lessons around treatment support and impact.
- The extension and expansion of the programme requested by CRS focused on getting more participants on board rather than looking at support issues for those already registered in the programme.
- Targets could also not be met because some beneficiaries defaulted in both districts due to floods in Tsholotsho and high transport costs to participants.
- There was an increase in the number of beneficiaries from December to January since in December some people were away for the festive season and the distribution period was shorter than usual.



## Lessons on Nutrition and ART

### ***Relevance and Appropriateness of the Food Basket: Is it in line with project purpose and participant need?***

#### *Role of a food basket*

Although nutrition and food security has a role to play in ART intake and uptake, evidence on its direct effects on ART efficacy has yet to be concluded. A recent DFID summary paper highlighted the following:

- Disease progression is not inhibited by provision of food rations neither do food rations increase the effectiveness of anti-retroviral treatment, except to stabilise excessive weight loss and provide energy through calorific supplementation.
- Improved food intake may improve adherence to anti-retroviral treatment among patients who are poorly nourished when they begin treatment (Etard 2006; Paton 2006), including by diminishing adverse side-effects (e.g. nausea) of ARV consumption.
- Evidence shows that malnourishment and low body weight at the time of initiating antiretroviral therapy are associated with poorer survival; a body mass index below 18 has been identified in several studies as a significant predictor of poor survival during the first 6-12 months of treatment (Etard 2006; Paton 2006).
- Fear of increased appetite after starting antiretroviral therapy was identified as a disincentive to good treatment adherence in a study in Rwanda, in which patients who had recently begun treatment were questioned about obstacles to adherence (Au 2006).
- A Zambian study found better treatment antiretroviral adherence (as measured by pharmacy visits) during twelve months of follow-up for food insecure patients who received supplementary food, but no difference in CD4 cell gain after twelve months (Megazzini 2006).
- Although malnutrition may also increase the risk of side effects like neuropathy (nerve damage), malnutrition on drug metabolism still needs to be studied.
- Initiation of antiretroviral therapy is associated with weight gain during the first year, although much of the weight gain occurs in the form of fat rather than lean muscle tissue.
- WHO's 2005 expert consultation concluded that the nutritional needs of HIV-positive women during pregnancy and breastfeeding have not been shown to differ from those of HIV-negative women. The consultation also noted that an HIV-positive mother who is well nourished is likely to have improved immune function, positively influencing maternal and infant survival.
- Several other studies and assertions on micronutrient supplementation and their effects on HIV and AIDS disease progression have been documented in different countries.

Field work in this programme has noted that participants are generally happy with the ration size, (more so in Bulawayo than in Tsholotsho). Whilst participants often noted this was due to household size, the reviews investigations noted that in Bulawayo the availability of food stuffs was higher and opportunities for double dipping from other programmes were greater, than in Tsholotsho.

An adequate and balanced, diversified diet, rich in whole grains, legumes and a variety of fruits and vegetables is important in maintaining a healthy nutrition status for PLHA. An HIV infected person requires high energy foods in order to cope with the HIV Infection and opportunistic infections which require extra energy levels of between 300-800 calories per day. The average energy needs of a non-active person are 2070 Kcal/day (FANTA, 2003). Extra energy requirement for an asymptomatic HIV infected adult and adolescent is 10 – 15%, and 20 – 30% if symptomatic (FANTA, 2001) Protein requirement for a non HIV infected person is about 45 grams per day (King and Burgess, 1992). No extra protein is required for an HIV infected person (WHO, 2003).

According to WHO, HIV-infected adults have 20–30% increased energy needs; children's energy needs increase by 50–100%. WHO recommends that these needs be met by food-based programming wherever possible.

#### *The WFP Food Basket*

The WFP food basket is not a complete one. The percentage deficit of the WFP ration in comparison with MoHCW guidelines is  $54,950/69,500 = 79.06\%$  and therefore the deficit in percentage Kcal is 20.94%. The total daily deficit per individual in actual Kcal is 483 Kcal- almost equivalent to 1 meal.

WFP describes an adequate ration as that which should be able to:

- Meet the population’s minimum nutritional requirements for light activity
- Be diversified including a range of commodities
- Acceptable and broadly familiar
- Fit for human consumption (free from contamination within shelf life)
- Easily digestible for children and vulnerable groups
- Maximise the use of available resources
- Be economic in terms of fuel requirements, preparation time and waste.

Field assessment findings on the food basket showed that beneficiaries were content with the quality and size of the food basket as well as with all the other above requirements. Food rations were reported to be barely sufficient for those house holds with more than five household members. The average family size in Tsholotsho was between 10-11 people per household due to the high prevalence of polygamy, compared to an average of 5 household members in Bulawayo.

Some recipients attempt to collect their food rations before their due date because the food aid is the only source of food and this is compounded by the CRS/WFP ceiling of 5 people per household.

Beneficiaries have come up with innovative ways of preparing meals using the rations in order to provide variety menus such as baking ‘Maqebelengwana’ (traditional muffins) from CSB and mealie -meal. At times, beneficiaries did not receive a full food basket due to pipeline breaks and late delivery of commodities at the warehouses in both Tsholotsho and Mpilo.

***Minimum duration of food support (using National ART guidelines in Zimbabwe as a basis for comparison)***

*Zimbabwe National Policy Guidelines on ART*

The guidelines on antiretroviral therapy in Zimbabwe promote a standardized approach to HIV treatment by private as well as public sector health practitioners with the aim to minimize drug resistance and ensure sustainability of the programme. Although food and nutrition is recognized as an integral aspect of ART, the guidelines do not present information and direction on the issue.

However the importance of nutritional support is only mentioned on the section detailing antiretroviral therapy and children in the following quote ‘Nutritional support is a crucial intervention in the managing of HIV infected children’. This is followed by stating that at each clinic visit, children should undergo a growth monitoring and development assessment and that dietary advice and counselling on breast feeding and weaning should be given to mothers to prevent HIV transmission and malnutrition. The guidelines also provide a medical and psychosocial criterion for initiating ART in adults which provides some useful guidance to this pilot programme:

<b>Medical Criteria</b>	<b>Psychosocial Criteria</b>
<ul style="list-style-type: none"> <li>• Patient with WHO clinical stages 3 and 4</li> <li>• Patient with HIV Infection who have a peripheral blood CD4 +lymphocyte count of 200</li> <li>• Patient with a total lymphocyte count of less than 1,200 on two separate occasions</li> </ul>	<ul style="list-style-type: none"> <li>• Demonstration of reliability e.g. compliance with cotrimoxazole prophylaxis, keeping appointments, as this is a measure of the future likelihood of adherence to ART.</li> <li>• Completion of adherence counselling sessions</li> <li>• Availability of treatment to partner and disclosure of treatment to partner, are strongly encouraged</li> <li>• Easy to follow up the patient</li> </ul>

MSF shows adherence to these guidelines and the same are reflected in the CRS ART policy guidelines (although CRS is not in a position to monitor this aspect of the programme directly). The use of cotrimoxazole treatment to help ensure compliance seems to be a bigger factor than food at policy level and its widespread use in Zimbabwe further complicates attribution of benefits to food support.

### *Adherence and Compliance*

Adherence to ART means taking the medication in the correct amount, at the correct time and in the way prescribed. Adherence is more than simply following instructions and involves self efficacy (valuing the medication), commitment, motivation and knowledge on the part of the PLHIV. It is a partnership between the family, friends and the medical practitioners. For this motivation to occur, PLHIV need knowledge in understanding their treatment regimens and assistance to overcome any challenges to taking ART accordingly. When non adherence to HIV treatment is high it is usually because ART involves a lengthy period of treatment and side effects are common.

Compliance to ART means success in following the doctor's orders appropriately and is based on the social, cultural and personal circumstances of the person on treatment. These factors have a bearing on the ability to comply. A person may be willing to comply but fail to do so due to reasons beyond their control ( such as poverty or stigma, among others) resulting in failure to, for example, attend repeat visits at a clinic or reach relevant support services.

Findings of the review reveal that adherence to ART is strong among programme participants whereas compliance is affected by many factors such as lack of disposable income and distance and the number of repeated visits to the FDP during pipeline breaks amongst other constraints.

#### *Feedback from participants on Defaulters of ART noted:*

- All participants of the pilot programme interviewed, denied ever defaulting treatment as a result of food shortages. Participants expressed that they appreciate the importance of adhering to treatment regimens as recommended by their doctors. *“ART is our lifeline, we cannot stop taking it - especially if one went through the serious illness some of us went through before ART treatment”*
- Communities have developed social support systems whereby food is shared between neighbors and relatives in times of need. Participants return borrowed rations when they get their monthly supplies from CRS. Even where this system is absent, participants do find the means of getting some form of food to consume before taking their medication. This occurs in both rural and urban settings.
- Tsholotsho hospital has introduced user fees of Z\$7 million since February 2008 for all patients. The municipality clinics in Bulawayo urban where many CRS beneficiaries have been referred to for regular ART supplies, so avoiding transport costs to Mpilo Hospital, charge Z\$8 million as user fees. This has increased the cost burden for the majority of beneficiaries and could lead to defaulting.

#### *Feedback from participants on Defaulters of Food noted:*

Participants who fail to collect their monthly food rations were those who reside very far from the food distribution point. Distances to the FDPs in Tsholotsho District range from as much as a 100-200km radius from Tsholotsho Hospital, the main food distribution point.

A sizable proportion of participants fail at times to collect their food rations at stipulated periods. Constraints encountered were reported as:

In Tsholotsho a young mother with her infant child was returning to collect her ART after a break of some 3 to 4 months. When asked why she had defaulted she explained that the father of her child had not wanted her to return to the clinic as he did not want anyone to know she of the child was sick. When she defaulted she fell sick. This drove her to leave the child father and stay with her family. Her family accepted her because she was sick. They encouraged her to return to the programme.

#### **Community Coping Mechanisms**

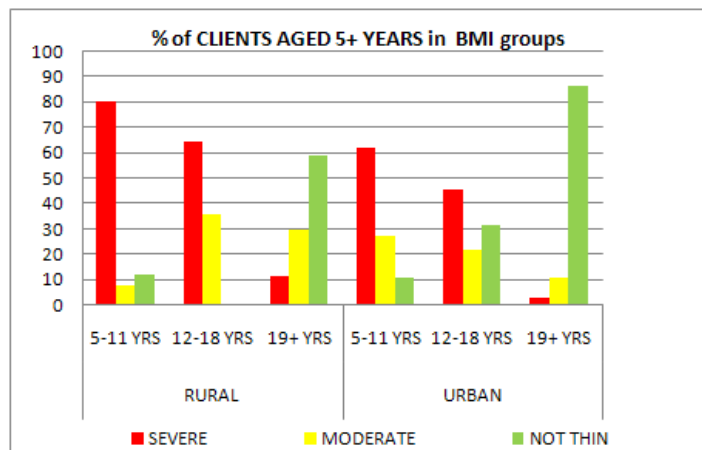
Participants have had to develop coping mechanisms in order to ensure that they comply with food supply and medication demands. Some of the mechanisms developed are counter productive to the objectives of the NSART programme and listed below.

- Participants who are sick can send a proxy to collect supplies. A priest (well known and respected person) from Dlamini area has at times collected food rations for his parishioners on food aid using his own vehicle.
- Food is sold or forcibly taken away from the beneficiaries by transport operators in payment of transportation costs from the hospital
- When food runs out for ART beneficiaries, they often borrow from neighbours and return the rations whenever they get their own supplies from CRS. This might mean that a household is perpetually owing food to someone if their rations are insufficient or are taken away by transport operators. In Bulawayo urban the support group reported that they encourage sharing of food by those on food rations to those who are HIV positive and not on food aid.
- As much as beneficiaries are willing to pay clinic/hospital user fees for other illnesses and would want exemption for ART they would also accept reduced ration sizes in order to allow for new entries into the programme provided they can access food from the shops at affordable prices.

- Flooding of rivers and failure to access the hospital in Tsholotsho. The incessant rains in Tsholotsho caused flooding which destroyed bridges in some areas.
- Failure to raise bus fare to the food distribution points in both rural and urban centres. The socio-economic criteria for food support streamlines those who are poor and needing assistance. These participants are likely to have difficulty in raising money for the bus fare to the FDP. The bus fare from Siphepha to Tsholotsho hospital is between Z\$10-30 million per trip. In Bulawayo, participants hire scotch cart to transport their food rations to the nearest bus station for Z\$ 7-8 million and pay more to transport the food to their homes in buses.
- Food distribution days are incongruent with doctor's consultation appointments resulting in participants having to source bus fare for more than one journey a month. A participant on CRS food ration can only be supplied once per calendar month whereas the doctor's visits are scheduled for 4 weeks or 12 weeks for adults and 2 weeks or 8 weeks for children. This suggests that a beneficiary may be required to visit the hospital a minimum of 3 times a month if together with a child they are on ART. Poor timing was reported to result in food rations not collected
- Households with orphans headed by old people usually have no means of accessing the food distribution points as a result of lack of manpower and bus fares.

#### *Impact/benefits of Food on ART Beneficiaries*

- How has food aid changed the health status of beneficiaries? Although food rations are not the most appropriate incentive to encourage to take up of ART, beneficiaries reported that eating regularly has reduced defaulting ART in that they are now strong enough to go for their treatment without defaulting.
- Marked weight gain in both adults and infants on food aid is reported by hospital personnel although this cannot be attributed to food alone as ART is also known to improve weight gain.
- It is difficult to attribute weight gains to food aid especially in situations where the food is shared and at times traded.
- A baseline review conducted in 2007 also highlights that clients from Mpilo and Tsholotsho who had their CD counts monitored showed a significant increases, attributable to 'the close relationship between food and ART'. In addition, improvements in weight were noted as significant for clients on food support. General health was also noted as having improved and the report attributed this to the NSART interventions.



#### *Issues around Children and Infants*

HIV positive infants and children are likely to have low birth weight and to experience growth failure and malnutrition. They are susceptible to diarrhoea which may further hinder food absorption and have retarded growth. Such children need diets that are high in protein, energy and micronutrients. Children's nutrition requirements differ from those of adults in terms of quantities, and more frequent feeding times.

The type of food rations provided for children through the NSART project does not differ from that provided to adults. Although additional protein supplements could be added onto the rations, current rations which include CSB, often reserved by households for children, are acceptable to the beneficiaries. Mothers are aware of how to prepare food, for example beans, in a manner that children can easily consume and digest them. Soured milk is a common supplement in Tsholotsho.

<b>MSF food rations for infants and children vary according to specific needs, weight and age of a child</b>	
Severely Malnourished	Plumpy nut
Moderately malnourished	CSB
0-6 months old orphan	NAN milk powder
Above 7 month old orphan	1 sachet plumpy nut per day
Over one year and depending on weigh for height or health status	CSB, oil, beans

Adolescents and infants are presenting with malnutrition that is HIV and AIDS related. WFP programming and food basket provision may need to take greater cognisance of children's specific needs.

*Beneficiary consultative model on duration of food support*

The following shows a prioritized list of beneficiaries who could be targeted by CRS in future targeting and give some suggested time and follow-on support:

<b>Pre-ART Inclusive [HIV+ critical clients waiting for ART/PMTCT]</b>	<b>Proposed time*</b>	<b>Discharge to</b>	<b>ART Focused Intervention [those HIV+ currently on ART/PMTCT]</b>	<b>Proposed time</b>	<b>Discharge to</b>
Severe or Moderately malnourished	Up to 3 x 3 months cycles; after 3 months linked to medical review	Livelihood activities/ ART programme	TB co-infection	9-12 months	Livelihood activities/ ART programme based on medical issues
TB	9-12 months	Support groups & ART	Infants	2 x 3 months linked to medical review	Parents in support groups
Infants	6 months	Parent in support groups & ART	Pregnant and/or lactating women	12 months	Livelihood activities and support groups
Children	6 months	OVC or child support programme & ART	Children	2x 3 months linked to medical review	OVC or child support programme and parents support groups
Adolescents	2 x 3 months based on medical review	OVC or child support programme and parents support groups	Adolescents	2 x 3 months based on medical review	OVC or child support programme and parent support groups
Pregnant and/or lactating women	12 months	Support groups & ART/PMTCT programme	Severe or Moderately malnourished	Up to 3 x 3 months linked to medical review	Livelihood activities
Other	2 x 3 months linked to medical review..	Support groups & ART	Other	2x 3 months linked to medical review	Support groups

\*( if an individual moves to ART [i.e. because of rapidly declining CD count] pre-ART food is terminated and the participant is transferred to the start of the ART food support in whichever category)

### How could nutrition support to ART be targeted?

WFP Zimbabwe's current activity levels are inadequate and should go to scale within the framework of the national programme. WFP need to ensure they have sufficient resources [through their Zimbabwe food pipeline] to bolster the inadequate national healthcare systems and roll out programmes in Zimbabwe today and in the long term. The consequences of defaulting on food could be detrimental to participants. The following table summarises current and planned coverage of ART for Round 5 of the Global Fund in Zimbabwe. (Annex 3 lists the districts already assessed)

The Global Task Team on Improving AIDS Coordination among Multilateral Institutions and International Donors (GTT) produced a set of recommendations for the multilateral system to simplify and harmonize procedures and practices and align its support more closely with national needs and priorities. As part of the GTT-agreed division of labour, WFP is the lead organization for dietary and nutrition support for national governments.  
WFP '5 years later report' 2006

District Programming for 5 <sup>th</sup> Round Global Funding	Criteria for selection of 9 "new" 5 <sup>th</sup> Round districts as follows:
<ul style="list-style-type: none"> <li>The Round 5 proposal will support comprehensive district ART provision in 22 districts - these districts will be a combination of First Round districts and new fifth round districts</li> <li>A total of 13 districts are currently benefiting from Round 1 Global Funds (initially 12 districts, but one district was split into two by GOZ in the middle of the 1<sup>st</sup> Round planning process)</li> <li>Individual sites in 5 of these districts will be offering ART with Round 1 funds (Chiredzi, Bulilima, Zvimba, Chimanimani, Mount Darwin)</li> <li>All 13 districts with Round 1 funds will be supported to provide ART through a district approach (i.e. additional capacity building in 5 districts already receiving Round 1 support for ART, and initiation of ART in remaining 8 districts from Round 1)</li> <li>An additional 9 new districts have been identified for Round 5, to initiate district ART provision</li> </ul>	<ul style="list-style-type: none"> <li>Not currently offering any ART services, or covered by any other major planned ART donors (GFATM 1, JP, MSF, EC); coverage by does not necessarily imply <i>comprehensive coverage</i> and access to ART in that geographical area, BUT at least some ART activity has already been initiated as a basis for further expansion as additional funds are sourced</li> <li>Districts had already been assessed for ART (this implies provincial ownership of district selection for round 5 districts, as PMDs had already prioritized their districts for national ART assessment)</li> <li>Provincial funding coverage (proportion of districts within the province already implementing some ART provision – provinces with lower percentage of existing coverage may have more "new" round 5 districts selected)</li> <li>Evidence of districts already offering other services to support district ART (e.g. testing and counseling, PMTCT, community based services), as identified during national assessment of sites.</li> </ul>

### What other reports say!

The WFP-ODJ report notes the following:

Intervention type	Proposed activities	Population prioritised	Intended outcomes
<b>Food support for universal access to care, treatment and support.</b>	<ol style="list-style-type: none"> <li>Home-Based Care Support</li> <li>ART Support</li> <li>PMTCT Support</li> <li>Paediatric Aids Support</li> <li>TB Support</li> </ol>	<ol style="list-style-type: none"> <li>Households with a chronically ill household member.</li> <li>Take-home rations provided to food insecure mothers at risk</li> <li>Pregnant and lactating mothers living with HIV.</li> <li>Children living with HIV and AIDS.</li> <li>Individuals with TB.</li> </ol>	<ol style="list-style-type: none"> <li>Alleviation of the impact of HIV and AIDS related illness on the household.</li> <li>Supporting adherence and uptake of ART.</li> <li>Prevention of parent to child transmission of HIV and AIDS.</li> <li>Supporting adherence and uptake of pediatric ART.</li> <li>Adherence to DOTS.</li> </ol>

### IASC guidelines note

Sectoral response	Emergency preparedness	Minimum response	Comprehensive response
Food security and nutrition	Contingency planning/preposition supplies <ul style="list-style-type: none"> <li>Train staff on special needs of HIV/AIDS affected populations</li> <li>Include information about nutritional care and support of PLWHA in community nutrition education programmes</li> <li>Support food security of HIV/AIDS-affected households</li> </ul>	Target food aid to affected and at-risk households and communities Plan nutrition and food needs for population with high HIV prevalence Promote appropriate care and feeding practices for PLWHA Support and protect food security of HIV/AIDS affected & at risk households and communities Distribute food aid to affected households and communities	<ul style="list-style-type: none"> <li>Develop strategy to protect long-term food security of HIV affected people</li> <li>Develop strategies and target vulnerable groups for agricultural extension programmes</li> <li>Collaborate with community and home based care programmes in providing nutritional support</li> <li>Assist the government in fulfilling its obligation to respect the human right to food</li> </ul>

## Findings on Complimentary Programming

### ***Livelihood activities, which are linked to food support programmes as exit strategies.***

Support groups initiated by MSF and ORAP are thriving in Tsholotsho despite the poor water sources and supply for garden projects. A variety of crops are grown such as sweet potatoes, beans, vegetables and tomatoes.

One of the Siphepha Support groups managed to plant Sorghum in the last rainy season. Such variety provides a wide range of nutrition for PLHIV. Beneficiary list for ongoing initiatives need to be compared with beneficiary list for the NSART programme as a starting point.

In Bulawayo, Support Group members engage in buying and selling goods and have contributed money towards paying for a stand to market and sell their wares during Trade Fair. They grow vegetables in individual home gardens. CRS organized a self reliance and livelihoods preparatory training for the group which was conducted in February 2008, by the Self Help Development Foundation. The

The Good Samaritan Support Group in Tshabalala suburb of Bulawayo was established by a person whose child died of AIDS and who subsequently mobilized the community and encouraged HIV testing. Supported by the Roman Catholic Church and with strong links with ZNPP+ organisation, the group comprises of people who are on ART through the MSF programme at Mpilo Hospital. The majority receive food aid from World Vision International.

following topics:

- Business planning and management
- Marketing Strategies and public relations
- How to choose business ventures that PLHIV can easily manage
- Book keeping, trade and banking
- Costing/pricing, saving and inflationary issues

Following training, the group has developed project proposals for grinding mill and candle-making projects.

### ***Self reliance and projects from the participants perspective***

There is a window of opportunity engaged. During focus group discussions with Support Group members in the urban areas, it was apparent that although they appreciate food support, the beneficiaries would rather embark on income generating projects for long term sustenance.

*'The food we get is a privilege and not a right....so we are thankful for it'*

The CRS participants in both Tsholotsho and Bulawayo were not aware of the period for food assistance. No indication or guidelines were provided to beneficiaries at the start of the programme on when and whether food aid ends and the role of food in the NSART programme (i.e. compliance and adherence rather than mitigating food insecurity). Longer term food security targets seem to have dominated the other programmes objectives.

*'Although we were not told when food aid will end, we use our brains to realize that food will end... especially when we see them starting to train us on income generating projects.....we just don't know when'*

### ***Male involvement in the programme***

Male involvement has not been a focus for the programme but is an area that has the potential for tremendous impact. In Tsholotsho many men present at hospitals only when they are very sick or helpless. But many do not. In Bulawayo incidences of husbands not revealing their status to families has been recorded. Stigma prevails across the programme (perhaps not at such high levels). Support Groups are dominated by women as are the food distribution queues. Reasons provided by beneficiaries on lack of male involvement included:

Women avoid entrusting men with collection of food rations as the men are likely to sell the food for alcohol or for other uses. In such cases there is the perception that food aid brings with it disharmony in the homes.

- Men are dying faster than women
- Men are still in denial of possible HIV infection amongst themselves and do not want to go for counseling and testing until they are sick.
- Men were reported to have the tendency of stigmatizing PLHIV and those on ART.
- Those who could go for treatment are often shy to do so for fear of being stigmatized.
- There are no programmes specifically designed to counsel and treat men such as the PMTCT programmes for women. Hence women are more involved than men. Although the PPTCT programmes are meant to include partners, the men do not usually present themselves.

The 2007 baseline report noted the limited involvement by men that support the above points. Spousal support was also noted as an important factor for many households involvement.

# Conclusions and Recommendations

## Conclusions

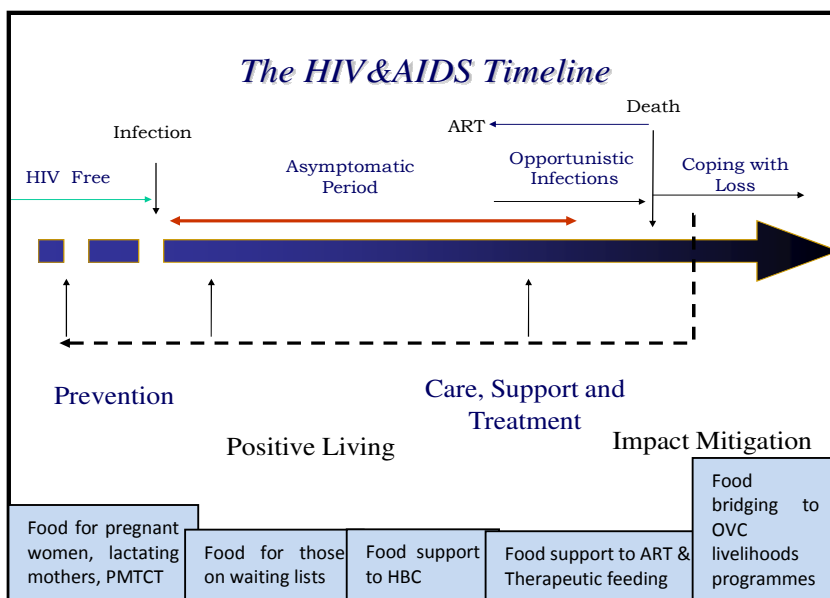
With the increase in poverty nationwide it is not clear that WFP are reaching the neediest with food support in this pilot. **Food handouts in Zimbabwe should be aimed at the chronically poor** in need of longer term social transfers and should not create dependency amongst the able poor who can be engaged in productive activity through opportunities and training. Poor communication and decision making around the duration of the food basket encourages inclusion.

Uptake of ART certainly increased at both project sites when food support was offered. However, **food as an incentive to test and receive ART raises ethical issues.** It does not address stigma and it does not engage whole communities in tackling the issue of HIV transmission, infection, treatment literacy and impact.

Improving the nutritional status of the sick is achieved through a combination of food and ART. Breaks in either ART or food can compromise wellness in clients. It is only through the appropriate and consistent supply of food and medicine that nutritional status can be supported. The **consequences of defaulting ART and food** have widespread implications beyond the mitigative capacity of WFP or NGO partners.

Improving nutritional status that slows down the progression from HIV to full blown AIDS and returns individuals, where possible, to a productive state is only possible when the **food is placed into a supportive environment.** The NSART programme has no mechanism to directly improve the socio-economic status of households and communities. This fundamentally flaws this particular ambition.

By managing the disease, NSART programmes can help to improve food security at household level by ensuring that partner's link their supportive environments to livelihood opportunities and options. Planning is very important. The use of the **HIV and AIDS timeline can help NSART CP programmes become more holistic** by ensuring that the supportive environment is able to manage its stages. It can thus help in the preparation of checklist to help WFP to decide to engage in NSART support beyond the pilot. At community level HBC programmes are an ideal entry point for NSART programme and have advantages over hospitals in their outreach capacity.



Sikhanyiso is 23, HIV+ and lives near Tsholotsho town. She had a baby boy in 2007 who is now 8 months old. When her partner discovered she was attending the clinic he told her to stop as he did not want people to know she was sick. This caused her to default. Stopping her medicines, she soon became very sick. Her parents took her in and encouraged her to return to the ART programme. Support at home/community is an important factor in ART uptake, adherence and compliance.

Mai Sibanda is a coordinator for ZNNP+ in Bulawayo and a trained councillor. She is HIV+ and on cotrimoxazole. There are 38 support groups across the town. Many are based at churches and community halls. Their membership is over 1,200. 600 are on the ART waiting list. CRS participants are amongst their members. They keep a register of their beneficiaries and the support they receive.

staff who are HIV +. Both participants and others are members of +ve networks such as ZNNP+. When PLHIV become partners in their own treatment and informed users of healthcare, they develop valuable expertise that can complement that of the professionals in their communities. WVI's NSART model in Bulawayo uses committees at community level and a 'help desk team' made up of beneficiaries and other community members, **linked to HBC interventions** that help communicate, advocate and monitor the programme. GIPA principles and MIPA posts within programmes and WFP could assist in creating the supportive environment that NSART needs.

## Recommendations

NSART Objective	Recommendation made
To improve the overall uptake of ART and support the roll-out plan for the [national] ART programme	<ul style="list-style-type: none"> <li>• <b>For WFP to best support nutrition with ART it needs to further comply with the WHO Three Ones Principles (one coordinating body, one implementing strategy and one monitoring and evaluating system) and go to scale [more food to more people through national entry points].</b> In addition this will help WFP access the non food resources/funds it needs for the supporting environment and encourage better linkages between donors for exit to local safety net systems and longer term social protection plans.</li> <li>• WFP and stakeholders to advocate for coordination of food through GFATM, ESP and other donor programmes. <b>Lobby for links between NSART and HBC.</b></li> <li>• <b>Develop an entry checklist</b> for WFP involvement in NSART support, including linkages with national programming and the supportive environment.</li> <li>• <b>Develop a partnership checklist</b> for engaging with NGO's/CP's including their involvement and linkages to the national programme and livelihoods support.</li> </ul>
To improve/ maintain health and nutritional status of ART patients	<ul style="list-style-type: none"> <li>• Collaboration beyond referrals is needed to ensure nutritional indicators are collected, and data is clean, useful and analysed. <b>Referral partners at hospital/clinic level need to be accountable for medical data and analysis of it.</b> A formal MOU with MSF is recommended for this programme and with the clinical structures involved in renewed, new or expanded programmes.</li> <li>• The Global Fund to Fight AIDS, Tuberculosis and Malaria has placed a nutritionist on its Technical Review Panel. WFP has a nutritionist post at HQ and this may need to be matched at CP level to support the collection and analysis of nutritional data.</li> </ul>
To improve adherence and compliance to drug therapy amongst ART patients	<ul style="list-style-type: none"> <li>• Minimum standards must be set for food provision at household and individual levels to avoid dependency. This should be done collaboratively and with an understanding of the interaction of food and ART at a general level. <b>Communication about the window of food support</b> should be supported through a number of media - via CP's, using IEC materials and local networks and media.</li> <li>• <b>WFP should consider revisiting its pipeline issues before engaging in long term food handouts to PLHIV homes.</b> Increasing locally procured/available food items within the WFP basket may help reduce pipeline breaks. WFP is in a position to lobby for support to local production and manufacture of food basket items through the wider UN family.</li> </ul>
To enhance food access and improve food security for ART patients and their households	<ul style="list-style-type: none"> <li>• <b>At the start of programming, once verification has been done, income generation, support group and livelihoods programmes should be set up with the households of participants.</b> Community structures should be involved. Support groups are able to self regulate and monitor for double dipping as these membership organisations have a vested interest in sharing the benefits of ART and food as widely as possible amongst their client members.</li> <li>• <b>Long term food insecurity should be dealt with through linkages with other relief programmes.</b> This needs to be negotiated before NSART support begins so that planning is continuous and transitions are possible following medical review processes.</li> </ul>

## Annex 1: People met during field visits

### Programme Staff met

Name	Title	
Elijah Ncube	Field Monitor CRS	
Dorothy Momdela	Nutrition Assistant MSF	
Nombeko Ndebele	Nutrition Assistant MSF	
Philemon Mguni	Counselor MSF	
Mcetshwa Sibanda	Councilor Siphepha- Ward 5	
Dr Verenga	DMO Tsholotsho District	
Nhlanhla Sibanda	Food Distributor CRS Tsholotsho	
Lumbidzai Maphosa	Food Distribution Assistant CRS Bulawayo	
Gugulethu Nsidane	Food Monitor CRS Bulawayo	
Jabulani Ndlovu	MSF Pediatric Counselor MSF Bulawayo	
Nurse Khumalo	Acting Matron OI Clinic Mpilo Hospital	
Khopano Mholpe	PA VGF & NSART WFP	
Preacherd Donga	VAM M & E officer WFP	
Sipiwe	Prog Assistant VGF WFP	
Tsogo	Prog Assistant VGF WFP	
Rui Pisolo	Head of Office	WFP

### Participants Met

SITE	Total Participants		ART+ Food	ART+ No Food	Not on ART+ No Food	On ART+ VGF
	Male	Female				
Siphepha Clinic- CRS Food Beneficiaries	9	13	18	2	8	4
Tshabalala Suburb- MSF Support group- WV food Beneficiaries	6	31	37	0	0	0
Tsholotsho –CRS Beneficiaries	17	57	67	-	7	-
Tsholotsho- CRS food beneficiaries- mothers with children		4	4	-	-	-
Home visits in Tsholotsho	-	2	1 MSF	1	-	-
Bulawayo OI clinic. CRS food beneficiaries- mothers with children	-	6	6	-	-	-
Home Visits in Bulawayo	1	4	5			

### Additional stakeholder met

Elizabeth Sibanda	ZNNP+ coordinator in Bulawayo
Mandla Moyo	M & E Officer CRS
Felix Dembetembe	CRS Field Coordinator;
Samuel Gili	MSF
Dr Paco & Dr Miguel	MSF Byo & Tsholotsho respectively
Sally Muropa	CRS HQ
Farai Mutibvu	CRS HQ
Elijah Ncube	CRS Tsholotsho
Prosper Mupa	NAC M& E Bulawayo
Mrs Shumba	NAC programme officer Mat North
Memory Moyo	Acting District Nutritionist Tsholotsho
Mrs E Katuruza	Provincial Nutritionist Mat North
Leona & Webster Mhondera	HELP Germany
Tessa Vorbohle	WV Bulawayo
Janelle Zwier-Marongedza	WVI Programmes Team leader
Daniel Wanganga	WV Food Resources Team Leader
Viola George	Acting Director, Matabeleland AIDS Council

## Annex 2: References

### References and further reading:

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[www.who.int/3by5/publications/document/en/ARTpaper\\_DFID\\_WHO.pdf](http://www.who.int/3by5/publications/document/en/ARTpaper_DFID_WHO.pdf) - provision of ART in resource limited settings

### Annex 3: Global Fund Round 5 Districts assessed for ART

Province	District	ART
Bulawayo City		MOHCW MSF, Private Providers
Chitungwiza City		MOHCW, ZAPP-MSF
Harare City		MOHCW, Private Providers
Manicaland	1. Makoni	GFATM 1 MOHCW
Manicaland	2. Mutasa	JP
Manicaland	3. Chipinge	JP and EC
Manicaland	4. Mutare	GFATM 5 MOHCW
Mash Central	5. Mount Darwin	GFATM 1
Mash Central	6. Guruve	JP
Mash Central	7. Bindura	EC
Mash Central	8. Centenary	EC, MOHCW
Mash Central	9. Mazowe	GFATM 5
Mash East	10. Mudzi	GFATM 1
Mash East	11. Murewa	EC, MOHCW
Mash East	12. Marondera	MOHCW
Mash East	13. Mutoko	GFATM 5
Mash West	14. Zvimba	GFATM 1
Mash West	15. Makonde	MOHCW
Mash West	16. Chegutu	
Mash West	17. Karoi	GFATM 5
Masvingo	18. Chiredzi	GFATM 1
Masvingo	19. Gutu	JP
Masvingo	20. Masvingo	JP MOHCW
Masvingo	21. Chivi	GFATM 5
Masvingo	22. Mwenezi	
Mat North	23. Hwange (North – Vic Falls)	JP
Mat North	24. Hwanage (South – Rural)	JP
Mat North	25. Lupane	GFATM 5
Mat North	26. Tsholotsho	
Mat South	27. Beitbridge	GFATM 1, JP
Mat South	28. Mangwe	GFATM 1
Mat South	29. Gwanda	GFATM 5 MOHCW
Mat South	30. Matobo	
Mat South	31. Bulilima	GFATM 1
Midlands	32. Zvishavane	GFATM 1, JP
Midlands	33. Gweru	GFATM 5 MOHCW
Midlands	34. Kwekwe	MOHCW
Midlands	35. Shurugwi	
Midlands	36. Mvuma	GFATM 5

## Annex 4: Outstanding Data and Information

### Requested from CRS

- ✓ Post distribution monitoring info/reports - needed to extract data on verification process as WFP reports reliant on CRS data and are not conclusive on this (Jan 07 to Jan 08).
- ✓ End use monitoring forms- needed to extract information on core beneficiary feedback on food use at household level (Jan 07 to Jan 08) .
- ✓ CRS stakeholder/monthly reports on the programme- these are distinct from WFP and reflect the CRS perspective in the evaluation (Jan 07 to Jan 08) .
- ✓ Database keys: needed for the number codes assigned for *livelihoods in rural/urban* areas and for *marital status*.
- ✓ A list/database of participants and their details for those who registered after June 07- this list would include food defaulters and the additional participants as a result of the WFP increase in funding (10% top up) .
- ✓ Numbers of participants removed from programme and when [the issue of discharging professionals was discussed but numbers were not provided].
- ✓ The numbers of households verified month by month on site and by household visit. The following table summarise the details we can find from that supplied to WFP reports on actual household visits.

Month	Households visited in Tsholotsho	Households visited in Bulawayo
January	0	0
February	0	16
March	9	0
April	?	0
May	10	21
June	0 [18 from study]	0
July	0	8
August	?	?
September	?	?
October	?	?
November	0	0
December	0	0
January	0	14

The database provided by CRS does not have the following information on indicators that a fuller and more statistical analysis would need:

- %age, urban/rural pregnant and lactating mothers
- %age who went back to MSF support [SAM/MAM/therapeutic feeding]
- %age of participants with a CD 4 count less than 200 on CRS registration list
- %age presenting with SAM/MAM who are on CRS list/%age who were referred from the therapeutic feeding programme
- %age HIV+, pregnant and lactating mothers on the list
- %age infants on ART on the CRS list (under 5)
- %age children on ART on the CRS list (6-12)
- %age adolescents on ART (13 to 18)
- Numbers of children on CRS list sent back for therapeutic feeding (not thriving and reasons)
- CRS 'good news stories' and personal testimonies are available within the beneficiary group (CRS monitors cited some).
- Stats on defaulters from CRS and reasons
- Stats on participant death from CRS. WFP monthly reports have some but not comprehensive recording of this info..

### Requested from MSF

For analysis on impact/change to be more robust a before and after scenario needs to be included. The review required a broader MSF/hospital list [pre-CRS selection] with the following information:

- Waiting list information- those presenting by self targeting with HIV+, those numbers waiting for ART, other treatment issues, estimated local prevalence rates of HIV
- %age of participants with a CD 4 count <200 on MSF list and those on CRS list
- %age presenting with SAM/MAM who are not on CRS list
- %age HIV+, pregnant and lactating mothers on MSF list/CRS list
- %age infants/children/adolescents on ART
- MSF database for Tsholotsho shows approximately 8% of (147) patients had BMI > 18.5 on admission – this needs confirmed due to data errors.
- Need MSF BMI indicator analysis changes after 3-6-9 months
- WFH changes
- MUAC changes
- Participants on the CRS list [taken from MSF referrals] who have CD4 counts of between 800-1200
- Participants on the CRS list who have BMI's between 20 to 24.9 for 3 months in a row (may be obtained from MSF data after cleaning)
- MSF data analysis on children with WFH of less than 70% (10% of 193 children in Tsholotsho, on admission)