U.S. President's Emergency Plan for AIDS Relief

Policy Guidance on the Use of Emergency Plan Funds to Address Food and Nutrition Needs

September 2006

1. Introduction

Systemic and chronic food insecurity have long plagued many parts of the world most severely affected by HIV/AIDS, and there is a complex relationship between the two issues. The Emergency Plan has a clear responsibility to support prevention, treatment and care for people living with HIV/AIDS (PLWHA), but comprehensively addressing issues of food insecurity is beyond the scope of the Emergency Plan. Even so, the Emergency Plan recognizes we can integrate specific and targeted nutrition interventions with HIV/AIDS treatment and care programs in an effort to improve clinical outcomes for PLWHA.

Key precepts of the Emergency Plan include remaining focused on HIV/AIDS, maximizing leverage with other partners that provide food resources and providing support for limited food assistance in defined circumstances. These partners include other U.S. Government (USG) agencies, host-nation Governments, non-governmental organizations (NGOs) and international partners. Some key partners are the U.S. Agency for International Development (USAID) with its Title II and agricultural development programs; the U.S. Department of Agriculture (USDA) with its Food for Progress (FFP), Food for Education (FFE) and market-development assistance programs; and the World Food Program (WFP), which receives U.S. Government Title II funding support. Such organizations have strong comparative advantages and non-HIV funding to address the underlying causes of food insecurity and to provide direct food assistance to HIV-affected populations.

Looking toward the future, it will be essential for severely HIV-affected nations to develop sustainable sources of food. The Emergency Plan will work with host nations to build linkages between HIV/AIDS programs and programs that foster sustainable agricultural development.

The purpose of this policy is to clarify the appropriate use of Emergency Plan funds for nutrition and food interventions. It is based on the *Report on Food and Nutrition for People Living with HIV/AIDS*[1], and tracks closely with the Emergency Plan's Preventive Care Package Guidance[2,3] as well as the program guidance for Orphans and Other Vulnerable Children (OVCs)[4]. As noted above, the U.S. Government approach to HIV/AIDS and nutrition, including food assistance,

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[1] Report on Food and Nutrition for People Living with HIV/AIDS, The President's Plan for AIDS Relief, May 2006, http://www.state.gov/s/gac/rl/more/2006/c18025.htm

[2] Guidance for United States Government In-Country Staff and Implementing Partners for a Preventive Care Package for Adults, The President's Plan for AIDS Relief, April 2006, https://www.pepfar.net/C19/Preventive%20Care%20Package%20Docume/Document%20Library/2006-04-28%20Adult%20preventive%20care%20package%20FINAL.doc

[3] Guidance for United States Government In-Country Staff and Implementing Partners for a Preventive Care Package for Children Aged 0-14 Years Old Born to HIV-Infected Mothers, April 2006, https://www.pepfar.net/C19/Preventive%20Care%20Package%20Docume/Document%20Library/2006-04-28%20Pediatric%20preventive%20care%20package%20FINALcr.doc

[4] Orphans and Other Vulnerable Children: Programming Guidance For United States Government In-Country Staff and Implementing Partners, The President's Emergency Plan for AIDS Relief, July 2006

draws on the comparative advantages of the respective U.S. Government partner agencies, such as USAID (Food for Peace, Health, Infectious Diseases and Nutrition, and Agriculture), the U.S. Department of Health and Human Services (HHS), and the USDA (Foreign Agricultural Service and Food and Nutrition Services), as well as non-U.S. Government partners, such WFP and the U.S. private voluntary organization (PVO) community.

Working closely with national Governments within the context of the "Three Ones" principles (one national HIV/AIDS action framework as the basis for coordinating the work of all partners, one national AIDS coordinating authority with a broad-based, multi-sectoral mandate, and one country-level monitoring and evaluation system), Emergency Plan funds should primarily provide nutritional assessment, counseling and support to PLWHA and OVCs in HIV/AIDS care and treatment programs. The U.S. Government requires the use of non-HIV funding mechanisms for wide-scale food support and associated efforts intended to relieve food insecurity and reduce poverty within HIV/AIDS-affected populations. The strategy depends upon interagency joint planning at headquarters and country levels to ensure we address the priority nutrition and food needs of the most affected and vulnerable populations.

Therefore, while the Emergency Plan strongly encourages comprehensive programming that addresses the wide range of needs of PLWHA in food insecure environments, Emergency Plan funds may purchase food only in limited circumstances and for specific populations, as outlined below. The needs, even within HIV- infected populations, are far greater than Emergency Plan funds can handle. Thus U.S. Government country teams will need to coordinate with national governments, United Nations (UN) organizations and other international partners, and the private sector for the planning and implementation of a comprehensive approach to this problem within their specific country context. Examples of success in this kind of leveraging also appear below, and the Food and Nutrition Technical Working Group is available to provide additional detail as needed.

2. Allowable Uses of Emergency Plan Funds

Activities for the clinical needs of PLWHA and for HIV-affected OVCs that Emergency Plan funds can support include the following:

- Development and/or adaptation of nutrition and food policies and guidelines for HIV-infected people and AIDS patients, including those on anti-retroviral treatment (ART);
- Nutritional assessment and counseling, including hygiene and sanitation, maternal nutrition, and safe infant and young-child feeding related to prevention of mother-to-child transmission (PMTCT);
- Micronutrient supplementation, where evidence suggests such supplementation will improve clinical outcomes;
- Replacement (weaning) feeding and support within the context of World Health Organization (WHO) and national PMTCT and infant-feeding guidelines;
- Linking Emergency Plan programs to food-assistance, food-security and safety-net programs.

The Emergency Plan allows for the provision of nutrition and food support to specifically identified target populations under these conditions:

- Nutrition and food support must directly contribute to meeting the prevention, treatment and care goals stated in the *U.S. Five-Year Global HIV/AIDS Strategy*;
- Nutrition interventions must be based on scientifically-established WHO assessment criteria and guidelines for nutritional care;

- Emergency Plan programs must first attempt to access food resources for therapeutic and supplementary feeding from other sources;
- Emergency Plan programs should provide food support to severely malnourished patients within the context of specific eligibility and exit anthropometric criteria consistent with WHO and/or national guidelines, with plans for patients to transition to more sustainable food access and security (there is evidence and beginning practice from some organizations that suggests that six months could be an appropriate limit);
- Resources should be leveraged to provide support to PLWHA and their families to address their broader health, food security and livelihood needs.

3. Target Groups and Allowable Uses of Emergency Plan Resources for Food and Nutritional Support

The highest priority groups for nutritional support are the following:

- OVCs, especially children under the age of two, born to HIV-positive mothers and identified through and linked to PMTCT/antenatal care (ANC)/maternal-and-child health (MCH) clinics, community-outreach or other OVC programs
    - Support can include, according to the criteria listed above, nutritional assessment and counseling, therapeutic and supplementary feeding, replacement feeding and support under acceptable, feasible, affordable, sustainable and safe (AFASS -- please see page 6) conditions, and, where indicated, micronutrient supplementation.
- HIV-positive pregnant and lactating women (identified through PMTCT or MCH programs)
    - Support can include, according to the criteria listed above, nutritional assessment and counseling, therapeutic and supplementary feeding, and micronutrient supplementation.
- Patients on ART or eligible for ART with evidence of severe malnutrition
    - Support can include, according to the criteria listed above, nutritional assessment and counseling, therapeutic and supplementary feeding with clear eligibility and exit anthropometric criteria and plans to transition recipients to more sustainable food security, and micronutrient supplementation. (There is evidence and beginning practice from some organizations that suggests six months could be an appropriate limit.)
- PLWHA who are in care programs and have evidence of severe malnutrition
    - Support can include, according to the criteria listed above, nutritional assessment and counseling, therapeutic and supplementary feeding with clear eligibility and exit anthropometric criteria and plans to transition recipients to more sustainable food security, and micronutrient supplementation. (There is evidence and beginning practice from some organizations that suggests six months could be an appropriate limit.)

In these cases, as described in the guidelines given in the *Report on Food and Nutrition for People Living with HIV/AIDS* mentioned earlier, Emergency Plan funds may pay for the procurement of food only as a last resort. All funding used for food procurement must be tracked by dollar amounts and reported in annual reports.

To date, there are few established program models for integrating nutrition and food interventions within HIV/AIDS care and treatment without overburdening already stretched clinic staff. Those programs have yet to be fully developed and implemented at scale. The strongest approaches will likely use multiple funding sources and build on the concept of networking and integration,

whereby a patient receives short-term therapeutic or supplementary feeding support based on clinical (anthropometric) assessment, while the patient and family receive referrals and access to an association of PLWHA, community group, home-based care network or a social worker to provide further nutritional counseling, food assistance where appropriate and feasible, and support for longer-term food security and livelihood assistance. Other U.S. Government, host-country or international partner agencies should take the lead in addressing the nutrition and food needs of malnourished affected family members and caregivers of PLWHA and food-insecure HIV-affected communities.

4. Types of Nutrition and Food Interventions

The U.S. Government supports activities at (i) the level of policy and planning and (ii) the level of patient care and programs.

i) Policies, Guidelines and Planning

A key objective and focus of national, district and community policies, guidelines and planning is the integration of nutrition and food interventions into HIV/AIDS care and support. The Emergency Plan supports the development of national policies and guidelines that provide a framework for linking nutrition and food activities within the care and support of people infected and affected by HIV/AIDS, including OVCs and their caretakers. In accordance with overall Emergency Plan guidelines, policy work must target clear outcomes achievable over a defined period of time. We expect such work will require relatively few financial resources. Examples of policy work include the following:

- National guidelines on HIV/AIDS and nutrition for policy makers, program managers, service providers and/or caregivers;
- Policy work to support linkages with other sources of food and sustainable approaches to improve food access and security in the targeted population;
- Training for health-care personnel, including community health workers and lay counselors, on the implementation of policy and technical guidelines;
- Development or adaptation of a common set of training curricula, nutrition and dietary-assessment tools, quality assurance, and other country-specific program materials;
- Policy and guidance on PMTCT and infant feeding.

U.S. Government country teams across the economic growth, agriculture, environment and other food security-related sectors, including the Emergency Plan, are encouraged to work with local Government counterparts, as well as other international partners and PVOs, to ensure that appropriate nutrition policies are in place and that planning is underway for the implementation of nutrition and food-related HIV/AIDS interventions. Planning should include different Ministries, such as the Ministries of Health (MOH), Agriculture and Education.

ii) Interventions for Patient Care

The Emergency Plan can fund the following nutritional interventions for patient care according to the guidelines outlined earlier. U.S. Government country teams should integrate the implementation of nutrition interventions into broader HIV/AIDS care and treatment programs, including PMTCT in the antenatal and postnatal periods.

<u>Nutritional Assessment</u>

Nutritional assessment, particularly anthropometric and dietary assessments, supports the clinical management of HIV-positive individuals before and during ART, and helps target nutrition and food support for malnourished adult and pediatric patients, as well as HIV/AIDS-affected OVCs to improve clinical outcomes. Nutritional assessment includes the following:

- Guidelines and tools for conducting assessments. These are often available through the WHO Secretariat or host-country Governments, and where they are not available, the Emergency Plan will support their creation for the specific country context;
- Nutritional assessment by service providers on the ground. Nutritional assessment primarily occurs at the *facility* level, integrated with the clinical management of PLWHA, but can also occur at the *community* level through home-based care programs; and
- Referral guidelines based on nutritional assessments. PLWHA should be referred to necessary clinical care, nutrition programs or other support.

The Emergency Plan will help ensure that focus countries have access to nutritional assessment tools and equipment (such as scales for weighing), and support appropriate training and quality assurance monitoring.

Counseling and Education

Emergency Plan country teams should support counseling to accomplish the following: (1) promote weight gain or maintenance; (2) prevent and manage food- and waterborne illnesses; (3) manage dietary complications related to HIV infection and ART; (4) promote safe infant and young-child feeding practices, including the promotion of exclusive breastfeeding for HIV-exposed infants in situations in which conditions are not conducive for safe replacement feeding to reduce MTCT, and (5) nutrition interventions to protect the health and survival of OVCs. This approach includes support for training health-care personnel to ensure incorporation of current technical best practices into counseling and service delivery. Nutrition-related health education should be part of the counseling curriculum for PLWHA and their caretakers, and with linkages to related care in MCH programs.

Therapeutic and Supplementary Feeding

In general, the Emergency Plan prioritizes nutritional rehabilitation with appropriate therapeutic foods for severely malnourished members of the four priority target groups to improve clinical outcomes. Therapeutic foods for the management of severe malnutrition include products such as ready-to-use therapeutic foods (RUTFs), e.g. *PlumpyNut*, an energy-dense, fortified peanut butter/milk powder-based paste, or other locally produced RUTFs equivalent to F100 therapeutic milk, and therapeutic fortified milks (e.g. F75 and F100), for HIV-positive women and OVCs. Supplementary foods for continued treatment of severe malnutrition after an initial stabilization and weight-recovery period are primarily fortified, blended flours (e.g. corn-soya blend (CSB)). For these patients, exit criteria based on WHO and/or nationally established anthropometric guidelines must apply. Clinicians need to inform patients of this exit plan at the start of their treatment and, ideally, engage them in a planning process.

The primary point of patient identification can be within hospitals, clinics and/or communities. The Emergency Plan's primary point of interface is at health facilities (clinics and hospitals), or through community-based organizations and outreach workers. Any individual in the priority groups for Emergency Plan-funded nutrition support identified through a community-based approach should receive a referral for further assessment at a health facility, where feasible. Indeed, the Emergency Plan Country Operational Plans should encourage and support strong referral networks between health facilities and the community to address these issues. U.S. Government country teams should implement community-based interventions for broader food security and livelihood assistance through WFP, Title II and other non-Emergency Plan program support.

In addition to nutrition counseling and the identification of clinical need for food support, there is an important commodity logistic support element to these programs. USAID/FFP and WFP have

comparative advantages in the logistics of targeting, procurement of food, and delivery of therapeutic and supplementary feeding. However, U.S. Government country teams should identify opportunities to link clinical care and community/ home-based care programs with the local food industry to provide nutrition support, as needed, as specified in the *Report on Food and Nutrition for People Living with HIV/AIDS*. Emergency Plan country teams should coordinate with other host country or international partners or feeding programs funded by the U.S. Government to ensure a smooth transition for nutritionally rehabilitated PLWHA, and to establish linkages with food-assistance programs for PLWHA who might be mildly or moderately malnourished, food-insecure families and caregivers of PLWHA, and communities affected by HIV/AIDS.

Addressing Micronutrient Requirements

Broadly speaking, the nutrient needs of PLWHA and OVCs are best met through consumption of a diverse diet, including fortified foods. However, targeted micronutrient supplementation may be necessary to improve clinical outcomes for high-risk individuals, such as malnourished PLWHA, pregnant and lactating HIV-positive women, and OVCs, for whom dietary assessment determines that intake of micronutrient-rich foods are inconsistent and likely inadequate. Furthermore, HIV-infected and-exposed infants and young children require routine vitamin A supplementation, as well as a course of zinc supplements for the treatment of diarrhea. Additional multi-micronutrient supplementation is recommended for those children who are unable to meet daily micronutrient requirements through local diets. When required, micronutrient supplements should be provided *at a single Recommended Daily Allowance (RDA) level*: there is currently no evidence to support micronutrient requirements for HIV-infected individuals different from recommendations for the general population, and this point should be emphasized in nutrition counseling and education. Therefore, the Emergency Plan will provide these only where there is evidence for an improved clinical outcome. Furthermore, U.S. Government country teams should make efforts to link micronutrient supplementation to food-related activities that can improve the quality of the individual's diet.

Prevention of Mother-to-Child Transmission (PMTCT)

In accordance with guidelines published by the WHO, United Nations Children's Fund (UNICEF) and the Joint UN Programme on HIV/AIDS (UNAIDS), Emergency Plan programs should support the principle that all mothers should make an individual, informed choice between breast feeding and replacement feeding. In addition, Emergency Plan programs must also be consistent with the guidelines and policies established by host country Governments. Mothers who are HIV-negative or do not know their HIV status should receive counseling to breastfeed exclusively for approximately six months, and thereafter introduce appropriate complementary foods and continue breastfeeding for two years or longer. HIV-positive mothers should be counseled, on an individual basis, to avoid all breastfeeding from birth if replacement feeding is acceptable, feasible, affordable, sustainable and safe (AFASS). Otherwise, exclusive breastfeeding is recommended during the first months of life, and then should be discontinued as soon as AFASS conditions can be met. When HIV-infected mothers choose not to breastfeed from birth or wean a child early, they should receive specific counseling and support for at least the first year of the child's life to ensure adequate replacement feeding.

In general, however, Emergency Plan support should focus on program activities (e.g. nutritional assessment, and especially nutrition counseling and support); while relying to the extent possible on other partners (e.g. Ministries and the Global Fund to Fight AIDS, Tuberculosis and Malaria) for the procurement of infant formula and other replacement foods. Emergency Plan procurement and provision of infant formula and other replacement foods is permissible, and could be warranted in some cases within the context of national guidelines, where established, or

according to WHO guidelines where not. Because of the increased vulnerability of exposed infants weaned early, PMTCT and OVC programs should link with MCH programs and clinics to protect these infants, according to Emergency Plan guidance (*Preventive Care Package for Children Aged 0-14 Years Old*).

Livelihood and Food Security Support

U.S. Government Emergency Plan country teams should link HIV/AIDS care and treatment programs with broader food-assistance programs that address food security, nutrition, health and development needs of the general population, including those affected by HIV/AIDS. Some of these include the USAID Title II, USDA FFP and FFE, WFP, and local or internationally supported agriculture and food assistance programs.

Cohesive, multi-sectoral programs help ensure PLWHA and HIV-affected communities receive appropriate support, including income-generation and food-security interventions. Limited Emergency Plan support is available to facilitate access to other food resources for food-assistance programs, such as therapeutic and supplementary feeding. Emergency Plan country teams should link HIV/AIDS programs to food-security and livelihood assistance projects, such as income-generating activities, labor-saving farming techniques, agricultural-development programs within USAID Food for Peace Multi-Year Assistance Programs (MYAPs), and USDA Food for Progress activities. Within comprehensive care strategies for OVCs, the Emergency Plan supports nutrition- and food-related interventions for affected OVCs and their caregivers, such as support for nutritional counseling to promote dietary diversity and small-scale agriculture activities, e.g. gardening and animal husbandry, which also have income-generation potential.

Support to Agriculture and Local Food Industries

HIV/AIDS has taken a large toll on the agriculture sector at the household, community and national levels. While USAID's FFP or Economic Growth, Agriculture and Trade (EGAT) Bureau will fund the majority of programs to mitigate these effects, there are some opportunities to ensure that agriculture is "HIV-responsive," particularly when integrating HIV-prevention messages. Furthermore, public-private partnerships provide an opportunity to leverage resources to support food-related interventions. By developing relationships with local food industries, Emergency Plan partners can provide technical assistance to producers of processed foods so they can supply safe, nutritious products appropriate for PLWHA.

5. Limitations and Restrictions

Food fortification for the general population will alleviate underlying micronutrient deficiencies and improve the nutritional status of vulnerable populations, including people living with and affected by HIV/AIDS. As noted above, however, Emergency Plan funds must be strictly targeted and cannot pay for broad-based food and food-security interventions. Thus, the Emergency Plan may not fund interventions such as the social marketing of food products to the general population and fortification of staple foods consumed by the general population.

Leveraging support from other donors will continue to be a key factor in each country's response to the nutrition and food needs of PLWHAs. Successful Emergency Plan programs in this regard have been able to leverage food from other donors while paying for logistics and other programmatic support to the groups outlined above, and in line with the overall strategy. Please be in touch with the Emergency Plan Food and Nutrition Technical Working Group for specific examples of how to do this.

6. Process

As described in the *Report on Food and Nutrition for People Living with HIV/AIDS*[5], this interagency process builds on the comparative advantages of the U.S. Government agencies working in HIV/AIDS, nutrition and food, agriculture, income-generation, and livelihood assistance to benefit HIV-infected individuals and communities affected by HIV/AIDS.

At the field level, where many of the key partners in this strategy, including USAID (FFP, EGAT and the Office of Health, Infectious Diseases and Nutrition) and USDA (Foreign Agriculture Service and Food and Nutrition Service) are already working in several focus countries, we expect key people from each of these agencies will come together to create a work plan in-country for addressing nutrition and food needs. This could entail the review of the different funding mechanisms of each agency and interagency planning for nutrition and food needs during the Emergency Plan Country Operational Plan (COP) or mini-COP process. U.S. Government field teams should strongly consider the establishment of a local Food and Nutrition Working Group that brings together the different U.S. Government entities that are working at the country level to ensure strong interagency collaboration to plan, implement and evaluate food and nutrition interventions on the ground. The Emergency Plan Food and Nutrition Technical Working Group is available to help guide the process.

[5] Report on Food and Nutrition for People Living with HIV/AIDS, The President's Emergency Plan for AIDS Relief, May 2006, http://www.state.gov/s/gac/rl/more/2006/c18025.htm

Annex 1. Glossary

Food aid refers to food resources—locally purchased food and/or imported food (direct distribution or *monetized* to support program costs)—provided by the U.S. Government or other donors. The Farm Bill (Public Law 480), which contains six titles, governs U.S. Government food aid with the goal of using agricultural commodities to combat world hunger, promote sustainable development, expand trade, develop markets, prevent conflict and increase democratic participation. Sources of food aid to be considered under the Emergency Plan are from Title II (Food for Peace), the USDA-run programs (Food for Progress, McGovern-Dole, PL480 Title 1, and Section 416 (b)), and the World Food Program (WFP) and local purchases.

Food security is achieved when all people at all time have both physical and economic access to sufficient food to meet their dietary needs for a productive life. Achieving food security requires that the aggregate availability of physical supplies of food is sufficient, that households have adequate access to those food supplies through their own production, through the market or through other sources, and that the utilization of those food supplies is appropriate to meet the specific dietary needs of individuals (*USAID Policy Determination #19*, 1992).

Macronutrients are nutrients required in relatively large amounts, including carbohydrates, proteins and fats.

Malnutrition, in clinical terms, is characterized by inadequate or excess intake of protein, energy, and micronutrients such as vitamins, and the frequent infections and disorders that result (WHO definition). It can result from consumption of not enough or too much food or of the wrong types of food, and/or from the body's response to a wide range of infections that result in malabsorption of nutrients or the inability to use nutrients properly to maintain health.

Micronutrients are nutrients required in minute amounts, including vitamins and minerals.

Monetization is the selling of U.S. agricultural commodities to obtain currency to support development and emergency-assistance programs. Sources of food aid for monetization to coordinate with the Emergency Plan include USAID Food for Peace, Title II food resources and USDA. Current WFP policy does not include monetization for anything other than the direct costs of administering food programs.

Nutrition counseling refers to an interactive process between a provider and a client with regard to dietary/nutrition recommendations, the client's (and family's) specific needs, and a feasible course of actions and behaviors to overcome constraints and achieve improved nutritional status.

Nutrition rehabilitation is the process of recuperating a severely and/or moderately malnourished individual through therapeutic and/or supplementary feeding, as well as basic health interventions that affect nutritional status.

Nutritional (or dietary) supplements include products (e.g. food, pills and "sprinkles") given to individuals to supplement the usual diet.

Orphans and Vulnerable Children (OVCs) for the purposes of the Emergency Plan are children, 0-17 years old, who are either orphaned or vulnerable because of HIV/AIDS. An orphan is a child who has lost one or both parents because of HIV/AIDS. A child is vulnerable due to HIV/AIDS because of one of the following factors: the child (1) is HIV-positive; (2) lives with missing or

inadequate adult support because of death, abandonment, economic distress or chronic illness; (3) lives outside family care.

Replacement feeding refers to the process of feeding infants who are receiving no breast milk with a diet that meets their nutrient requirements until the age at which they can be fully nourished on family foods. During the first six months, this should be with a suitable breast-milk substitute, preferably a commercial infant formula. After six months, infants may continue to consume formula or other breast-milk substitutes complemented with other foods. In the absence of breast milk, and, especially beyond six months of age, micronutrient supplementation is likely to be essential.

Supplementary feeding refers to the provision of additional food to selected individuals to prevent clinical malnutrition or treat mild-to-moderate malnutrition. The supplementary rations are additional to what the beneficiaries might be receiving as their share of a general household ration, and the food commodities selected reflect the particular physiological needs of the individual or group.

Therapeutic feeding refers to provision of specialized foods to treat persons with *severe malnutrition*. Therapeutic feeding generally involves two phases: a *stabilization phase* and a *rehabilitation phase*, which may require different therapeutic foods for treatment. The stabilization phase usually requires facility-based treatment, whereas the rehabilitation phase may be done all or in part on an outpatient basis at the community level.

Annex 2. Selected Resources

A Clinical Guide on Supportive and Palliative Care for People with HIV/AIDS. The HRSA HIV/AIDS Bureau, 2003. http://hab.hrsa.gov/tools/palliative/

Anthropometric Indicators Measurement Guide. Bruce Cogill. Nutrition and food Technical Assistance (FANTA), Academy for Educational Development (AED), 2003. www.fantaproject.org/publications/anthropom.shtml

Nutrition and food Implications of Antiretroviral Therapy in Resource Limited Settings (English, French). Tony Castleman, Eleonore Seumo-Fosso, and Bruce Cogill. FANTA/AED, 2004. www.fantaproject.org/publications/tn7.shtml

Handbook: Developing and Applying National Guidelines on Nutrition and HIV/AIDS. Regional Centre for Quality of Health Care (RCQHC) and FANTA/AED, 2003. www.fantaproject.org/downloads/pdfs/rcqhc03.pdf

HIV/AIDS: A Guide for Nutritional Care and Support. FANTA/AED, 2004. www.fantaproject.org/publications/HIVguide.shtml

HIV/AIDS and Nutrition and food Security: From Evidence to Action. Stuart Gillespie and Suneetha Kadiyala. International Food Policy Research Institute (IFPRI), 2005. www.ifpri.org/pubs/fpreview/pv07/pv07.pdf

HIV/AIDS and Nutrition: A Training Manual. RCQHC, FANTA/AED, and LINKAGES/AED, 2003. www.fantaproject.org/focus/preservice.shtml

HIV/AIDS Mitigation: Using What We Already Know. Patricia Bonnard. FANTA/AED, 2002. www.fantaproject.org/publications/tn5.shtml

Integrating Nutrition Therapy into Medical Management of Human Immunodeficiency Virus, Clinical Infectious Diseases, 1 April 2003, Vol 36, Suppl 2. http://www.journals.uchicago.edu/CID/journal/contents/v36nS2.html?erFrom=9762446207647697 29Guest

Living Well with HIV/AIDS: A Manual on Nutritional Care and Support for People Living with HIV/AIDS. Food and Agriculture Organization (FAO) and World Health Organization (WHO), 2002. www.fao.org/documents/show_cdr.asp?url_file=/DOCREP/005/Y4168E/Y4168E00.htm

Management of Severe Malnutrition: A Manual for Physicians and Other Senior Health Workers. WHO, 1999. whqlibdoc.who.int/hq/1999/a57361.pdf

Nutrient Requirements for People Living with HIV/AIDS: Report of a Technical Consultation. WHO, 2003. www.who.int/nut/documents/hivaids_nut_require.pdf

Nutrition and HIV/AIDS: *Evidence, Gaps, and Priority Actions*. SARA Project/AED, 2004. http://www.phishare.org/documents/SARA/2202/

Nutrition and HIV/AIDS: Report by the Secretariat. WHO, 2005.

Rethinking Food Aid to Fight AIDS. Stuart Gillespie and Suneetha Kadiyala. IFPRI, 2003. www.ifpri.org/divs/fcnd/dp/papers/fcndp159.pdf

The Sphere Humanitarian Charter and Minimum Standards in Disaster Response. The Sphere Project, 2004. www.sphereproject.org/handbook/index.htm

Annex 3. Other Food Resources

U.S. Government Food Aid

The Farm Bill governs U.S. Government Food aid with the goal of using agricultural commodities to combat world hunger, promote sustainable development, expand trade, develop markets, prevent conflict and increase participation. Food aid to developing countries is primarily channeled through the U.S. Agency for International Development (USAID) and the U.S. Department of Agriculture (USDA) to the World Food Program (WFP), foreign Governments and a myriad of PVO/NGO recipients.

USAID addresses food insecurity through development projects and emergency humanitarian assistance by using U.S. commodities (largely unprocessed grains, blended/ fortified processed commodities, oils and pulses) provided by Public Law 480 (PL 480), Title II[6]. Title II programs encompass both 1) the direct provision of food and 2) the use of limited cash resources (derived from the monetization[7] of U.S. commodities or as 202(e) grants[8]) for complementary relief and development activities. Legislation requires Title II programs to focus on food security, but many of these programs, by necessity, have integrated HIV/AIDS components.

USDA provides agricultural commodities through direct donations and concessional programs under four program authorities: PL 480 Title I, Food for Progress, Section 416(b), and the McGovern-Dole International Food for Education and Child Nutrition Program. *Title I* provides concessional financing to Governments and private entities to purchase U.S. commodities. The commodities are normally sold on the recipient country's market, and proceeds go to agricultural, economic or infrastructure development projects. *Food for Progress* provides for the donation of U.S. commodities to Governments and PVOS/NGOs for the support of democracy and the expansion of private enterprise, especially within the agricultural sector. The commodities may be distributed freely or sold to support agricultural, economic or infrastructure development programs. *Section 416(b)* provides for overseas donations of surplus commodities in U.S. Governments inventory to Governments and PVOs/NGOs for direct feeding or for local sale to support development projects. *The McGovern-Dole International Food for Education and Child Nutrition Program* supports education, child development and food security through donations of U.S. agricultural products, as well as financial and technical assistance, to Governments and PVOs/NGOs for school feeding and maternal and child nutrition projects. The commodities may be used for direct feeding or monetized to support project activities. The Foreign Agricultural Service (FAS) has lead responsibility for the four USDA-administered food aid programs.

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[6] Information on individual commodities available under U.S. PL480 can be found at: http://www.usaid.gov/our_work/humanitarian_assistance/ffp/crg/sec2.htm.

[7] The 1990 Farm Bill authorized monetization to enhance food security and generate foreign (largely local) currency to support development activities. "Monetization" is the selling of agricultural commodities to obtain foreign currency for use in US assistance programs. Recipient Governments and non-government organizations monetize commodities donated by the U.S. Government through PL480 Title II and USDA programs.

[8] 202(e) U.S.-dollar-denominated grants to fund in-country expenses for the management of Title II programs.

The United Nations World Food Program (WFP)

WFP is the food aid arm of the United Nations (U.N.), providing food to meet emergency needs and to support economic and social development. Last year, WFP provided food to more than 100 million people in 81 countries. Its total food and operating budget was $2.6 billion, the largest in the U.N. system. WFP receives food commodities and, to a lesser extent, cash contributions from numerous donor countries. The U.S. Government provides about one-half of the WFP's food-aid resources. WFP delivers its food aid primarily through more than 1000 NGOs, many of which are also recipients of USAID and USDA food assistance. WFP targets its food aid to food-insecure families, including those affected by HIV/AIDS, orphans and vulnerable children, food-for-work projects, school feeding programs, and mothers and young children in conjunction with antenatal and postnatal health care. There is limited provision for commodity monetization for food-aid program support.

Local Food Purchase

Local food purchases enhance or diversify the commodity mix of the food ration, reduce transportation and handling costs, and/or support local producers, processors and markets. The Title II program does not currently support local purchases with cash resources or with the proceeds of monetization. USDA allows organizations to purchase a limited amount of local commodities with monetization proceeds. WFP has very limited resources available for local food purchases, and, in general, these purchases are limited to traditional food-aid commodities (e.g. soy, cereals grains, and pulses). An extremely limited amount of ready-to-use therapeutic foods (RUTF), such as "Plumpy Nut," has occasionally been procured by UNICEF for use with severely malnourished children, but in general UNICEF does not procure food. Other funding sources that could be explored for local food purchase include the Global Fund, Global Development Alliance (GDA), World Bank, the private sector and local Government. U.S. Government country teams must exhaust all other potential sources of funding before seeking Emergency Plan funds for purchase of locally procured foods.