

**Guidance for Operationalizing the US President's
Emergency Plan for AIDS Relief Policy**

Using Funds to Address Food and Nutrition Needs

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Acronyms

AFASS	Acceptable, feasible, affordable, sustainable, and safe
AIDS	Acquired immune deficiency syndrome
ANC	Antenatal care
ART	Antiretroviral therapy
BMI	Body mass index
FAO	Food and Agriculture Organization of the United Nations
FHI	Family Health International
HIV	Human immunodeficiency virus
MCH	Maternal and child health
OVC	Orphans and other vulnerable children
PEPFAR	US President’s Emergency Plan for AIDS Relief
PLHIV	People living with human immunodeficiency virus
PMTCT	Prevention of mother-to-child-transmission
RDA	Recommended daily allowance
SD	Standard deviation
US	United States
USG	United States government
WFP	World Food Programme
WHO	World Health Organization

Summary of US President’s Emergency Plan for AIDS Relief Policy Guidance on Food and Nutrition Activities ^[1]

Table 1, below, provides a summary of the US President’s Emergency Plan for AIDS Relief (PEPFAR) Policy Guidance – what is allowable, not allowable, and unclear use of PEPFAR funds for food and nutrition activities [1].

Table 1. Summary of PEPFAR allowable, unclear, and not allowable food and nutrition activities

<p>Allowable (if not able to be sourced elsewhere and according to specific rules outlined subsequently)</p>	<ul style="list-style-type: none"> • Development or adaptation of nutrition and food policies and guidelines. • Nutrition assessment for PLHIV (all ages) and OVC. • Nutrition counseling and education for PLHIV (all ages) and OVC. • Micronutrient supplements where clinically indicated for malnourished PLHIV and in specific circumstances. • Therapeutic and supplementary feeding for severely malnourished adult PLHIV (BMI <18.5). • Therapeutic and supplementary feeding for affected infants, HIV-positive children, and HIV-positive pregnant and lactating women, and OVC up to 17 years old when clinically indicated. • Replacement feeding for infants if safe (AFASS). • Referral and advocacy with partners.
<p>Unclear (please consult with country-based USG for further guidance).</p>	<ul style="list-style-type: none"> • Clinical indications for therapeutic and supplementary feeding of affected infants, HIV-positive children, pregnant and lactating women, and OVC up to 17 years old.
<p>Not Allowable</p>	<ul style="list-style-type: none"> • Broad-based food and food-security interventions. • Therapeutic or supplementary feeding for moderate and mild malnutrition in PLHIV (and others). • Micronutrient supplementation where it is not clinically indicated – never exceed RDA. • Programs supplying therapeutic or supplementary feeding that do not have in place exit strategies and anthropometric entry and exit criteria.

Background

In September 2006 the US President's Emergency Plan for AIDS Relief (PEPFAR) released a document providing policy guidance on the use of emergency plan funds to address food and nutrition needs [1]. This was informed by the PEPFAR Report on Food and Nutrition for People Living with HIV/AIDS (PLHA) provided in May 2006 [2]. USAID in collaboration with PEPFAR subsequently released a revised policy for adult patients who are enrolled in antiretroviral therapy (ART) and care programs [3].

Family Health International (FHI) complies with these policy guidelines in its PEPFAR-funded and United States government-funded projects. This document is a tool for FHI country office staff who implement HIV projects, to clarify policy and ensure compliance with the policy guidance.

FHI recognizes the importance of working in partnership with appropriate agencies that specialize in providing food resources and support, to avoid replicating services and to optimize the most sustainable increase in the health and well-being of people living with HIV (PLHIV).

FHI provides a diverse range of services to PLHIV on behalf of PEPFAR. Food and nutrition are relevant to treatment, palliative care (basic healthcare and support), orphans and other vulnerable children (OVC), policy analysis and system strengthening, counseling and testing, and even prevention activities. FHI provides services globally, but each country has a unique mix of service delivery elements.

Food and Nutrition and the Role of PEPFAR-Funded Programs

The worldwide spread of HIV has highlighted the complex relationship between food, nutrition, and HIV infection. Many parts of the world severely affected by HIV have long been plagued by systemic and chronic food insecurity [1, 2].

PEPFAR's Responsibility [1]

Following is an overview of PEPFAR's areas of responsibility with regard to food and nutrition support in HIV prevention and care programs:

1. To coordinate and communicate its roles and responsibilities in relation to food and nutrition to national governments (under the “three ones” principle) and all other country-level partners.
2. To support prevention activities for those at most risk of HIV, and treatment and care for PLHIV.
3. To provide nutritional assessment, counseling, and support (nutrition interventions) for PLHIV and OVC as part of comprehensive HIV care and treatment programs. This includes support for some food assistance **in defined circumstances and for specific populations**.
4. To maximize leverage with other partners providing food resources and addressing underlying causes of food insecurity, particularly partners with non-HIV funding mechanisms.

Not PEPFAR's Responsibility [1] – to comprehensively address issues of food insecurity with broad-based food and food-security interventions, e.g., social marketing of fortified foods and agricultural programs that improve food security.

Who Are the Partners?

Partners who address underlying causes of food insecurity and direct food assistance to HIV-affected populations include [1]:

- *United States government (USG) agencies* – US Agency for International Development (Title II and agricultural development programs, Food for Peace, health, infectious diseases, and nutrition), US Department of Agriculture (Foreign Agriculture Service and Food and Nutrition Service), US Department of Health and Human Services.
- *Host national and subnational governments in country.*
- *National and international nongovernmental organizations.*
- *United Nations agencies* such as the World Food Programme (WFP), World Health Organization (WHO), and Food and Agriculture Organization (FAO).
- *United States private voluntary organizations.*

It is suggested that partners come together and develop a joint work plan, and/or if feasible that local Food and Nutrition Working Groups be established and interagency collaboration be planned, implemented, and evaluated. This should involve as many partners as possible, especially US government agencies.

Allowable Uses of PEPFAR Funds [1]

Generally the focus is on meeting the clinical needs of PLHIV and HIV-affected OVC. The following table provides specific examples of the types of food and nutrition activities supported by PEPFAR funding:

Table 2. Types of PEPFAR Allowable Activities

Activity	Guidance on Elements of Allowable Activity	Population Group Coverage
Nutrition and food policies and guidelines	<ul style="list-style-type: none"> • National, district, and community level. • Development and/or adaptation. • Clear outcomes and timeframes. • Focus on integration of organizations providing food aid and food-security programs. • Training for health and community workers on program implementation and nutrition interventions. • Common set of training curricula. • Focus on PMTCT and infant feeding. • Work with all levels of government and other organizations to develop. 	PLHIV, including those on ART; people affected by HIV/AIDS, including HIV/AIDS-affected OVC and their caregivers.
Nutritional assessment	<ul style="list-style-type: none"> • Target nutrition and food support and improve clinical outcomes. • Use country-specific assessment guidelines and tools, if available. • Conduct at facility level (clinical) and community level (home-based care programs). • Establish referral guidelines to clinical care, nutrition programs, or other support, based on nutritional assessment. • Ensure focus countries have access to tools and equipment, training, and quality assurance monitoring. 	PLHIV before and during ART; children and HIV/AIDS-affected OVC. An important group is HIV-affected infants (especially those born to HIV-positive women).
Nutrition counseling and education	<ul style="list-style-type: none"> • Promote weight gain or maintenance of healthy weight. • Prevent and manage food-borne and waterborne illnesses (including hygiene and sanitation). • Manage dietary complications, symptoms, and side effects of HIV infection and ART. • Promote safe infant and young-child feeding related to PMTCT (i.e., promote exclusive breastfeeding when safe replacement feeding cannot be achieved). All mothers should make an informed choice between breastfeeding and replacement feeding and gain ongoing support. Follow national guidelines or, if none exist, use WHO guidelines. 	PLHIV (before and during ART), pediatric patients, and HIV/AIDS-affected OVC. Special focus on HIV-positive pregnant women and mothers of infants and young children.

Table 2. (cont.)

Activity	Guidance on Elements of Allowable Activity	Population Group Coverage
Nutrition counseling and education (cont.)	<ul style="list-style-type: none"> • Promote good maternal nutrition. • Promote appropriate nutrition interventions for OVC, dietary counseling and nutrition education for OVC and their caregivers. • Train healthcare personnel in best-practice dietary counseling. • Include nutrition education in programs for PLHIV and their caregivers. • Link to maternal and child health (MCH) programs 	
Nutrition and food support	See information below.	See information below.
Micronutrient supplementation	<ul style="list-style-type: none"> • Nutrient needs of PLHIV and OVC are best met through a diverse diet, including fruit, vegetables, and fortified foods. • Supplementation should be provided only when evidence suggests it will improve clinical outcomes. • HIV-infected and HIV-exposed infants and young children require routine vitamin A supplementation and a course of zinc supplements to treat diarrhea. • Micronutrient supplements, when required, should be provided at a single Recommended Daily Allowance (RDA) level. • Dietary counseling and nutrition education should stress that supplementation of micronutrients above the RDA is not indicated. • Refer to another food-based program that ensures RDAs are met. 	Malnourished PLHIV (including children), pregnant and lactating HIV-positive women, OVC where dietary assessment determines that intake of micronutrient-rich foods is inconsistent and likely inadequate.
Linkages, referrals, and partnerships	<ul style="list-style-type: none"> • Link beneficiaries to partners' programs that support livelihood and food security. Examples include food-assistance, food-security, and safety-net programs, and OVC-focused projects. • Partners or programs may be able to leverage food from other donors while paying for logistics and other programmatic support. 	PLHIV (including those on ART); people affected by HIV/AIDS, including HIV/AIDS-affected OVC and their caregivers.

Allowable Food and Nutrition and Food Support [1, 3]

This support is only allowable in defined circumstances and for specific populations. Food is to be procured only as a last resort. Food purchases must be tracked by dollar amounts and reported in annual reports.

Defined circumstances

- Nutrition and food support must directly contribute to meeting the prevention, treatment, and care goals stated in the *US Five-Year Global HIV/AIDS Strategy* [4].
- Nutrition interventions must be based on scientifically established WHO assessment criteria and guidelines for nutritional care.
- No other food resources for therapeutic and supplementary feeding must be available to the PLHIV.
- Eligibility and exit anthropometric criteria consistent with WHO, PEPFAR, and/or national guidelines must be in place.
- Planning must occur for clients to transition to more sustainable food access and security programs/environments (exit strategies).

Specific Populations [1, 3]

Special note on therapeutic and supplementary feeding: Each population group listed below in Table 3 has different clinical indicators for allowable therapeutic and supplementary feeding. These indicators are limited only to weight and height. Adults should have a body mass index (BMI) of less than 18.5; there are no clear cutoffs for children 0-17 years, OVC, and pregnant and lactating women. Severely malnourished children and pregnant and lactating women qualify, but the policy seems to indicate that because these groups are at greater risk they may qualify for feeding above the severely malnourished cutoff. In addition, the policy does not state specific clinical indicators for therapeutic versus supplementary feeding. Please consult with country-based USG for further guidance.

The following table outlines interventions permitted under PEPFAR funding, classified by recipient group.

Table 3. PEPFAR Allowable Food and Nutrition Activities by Recipient Group

Target Group	Selection criteria – clinical indicators	Suggested method of targeting	Suggested support in defined circumstances as detailed above
OVC, especially children under the age of 2, born to HIV-positive mothers	<ol style="list-style-type: none"> 1. Children under 2 years old born to HIV-positive mothers. 2. Infants (up to 12 months) and young children (1-5 years). 3. Other OVC (5-17 years) – defined as children of primary or secondary school age who are either orphaned or vulnerable because of HIV/AIDS. 	<p>Identified through and linked to hospitals, PMTCT/antenatal care (ANC)/MCH clinics, community outreach, or other OVC programs. Conduct nutrition screening or individual assessment to determine need for intervention and/or a household survey.</p>	<ul style="list-style-type: none"> • Nutritional assessment. • Nutrition counseling. • Therapeutic feeding – ready-to-use foods equivalent to F100 therapeutic milk and fortified milks (e.g., F75 and F100). • Supplementary feeding after initial stabilization and weight-recovery period – use fortified, blended flours (e.g., corn-soy blend). • Replacement feeding and support under AFASS conditions. The provision of infant formula and other replacement foods is permissible; infant formula should be supplied by other partners (e.g., global fund) where possible. • Micronutrient supplementation.
HIV-positive pregnant and lactating women	<p>HIV-positive test via appropriate country testing processes. Pregnant and lactating.</p>	<p>Identified through hospitals, PMTCT or ANC/MCH programs/clinics, and communities. If possible, conduct nutrition screening or individual assessment and/or a household survey to determine need for intervention.</p>	<ul style="list-style-type: none"> • Nutritional assessment. • Nutrition counseling. • Therapeutic and supplementary feeding (outlined above). • Micronutrient supplementation.
Clients on ART or eligible for ART with severe malnutrition	<p>WHO International Classification of adult severe malnutrition – BMI <18.5. For children, a z-score below -3 standard deviation (SD) for weight and height, based on WHO growth standards [5-8].</p>	<p>Identified via hospitals, ART clinics, or other clinics accessed by PLHIV. Conduct nutrition screening or individual assessment and/or a household survey to determine need for intervention.</p>	<ul style="list-style-type: none"> • Nutritional assessment. • Nutrition counseling. • Therapeutic and supplementary feeding (outlined above). • Micronutrient supplementation.

Table 3. (cont.)

Target Group	Selection criteria – clinical indicators	Suggested method of targeting	Suggested support in defined circumstances as detailed above
Severely malnourished PLHIV who are registered in care programs	WHO International Classification of adult severe malnutrition – BMI <18.5. For children, a z-score below -3 SD for weight and height, based on WHO growth standards [5-8].	Identified via hospitals, ART clinics, or other clinics and service providers accessed by PLHIV. Conduct nutrition screening or individual assessment and/or a household survey to determine need for intervention.	<ul style="list-style-type: none"> • Nutritional assessment. • Nutrition counseling. • Therapeutic and supplementary feeding (outlined above). • Micronutrient supplementation.

Issues to consider and further guidance [1, 3]

- Develop strategies that can be integrated into current practice so that care and treatment staff is not overburdened.
- Develop partnerships and integrate food and nutrition support with other agencies. Refer patients obtaining food and nutrition support to other services that address food insecurity as soon as possible. Develop referral pathways for PLHIV who are mildly or moderately malnourished, food-insecure families, caregivers, and communities affected by HIV/AIDS.
- Inform the patient about the anthropometric exit criteria at the commencement of treatment and engage them in a planning process.
- For PLHIV referred from a community-based organization, where feasible provide further nutrition assessment at a health facility (to establish eligibility for support).
- Logistics of targeting, procurement, and delivery of feeding support should be coordinated with assistance from USG country teams. Use of the local food industry, national, and international partners should be considered.

Uncertain areas [1, 3]

The criteria are unclear for entry into nutrition and food support for OVC, especially children under the age of 2 born to HIV-positive mothers, and HIV-positive pregnant and lactating women. It is suggested that FHI country offices seek clarification from country-based USG agencies.

Glossary

Body mass index: Measurement of height and weight allows calculation of the body mass index (BMI) as follows: Weight (kg)/Height (m)²

Example: for a man with a weight of 55 kg and a height of 1.65 m, BMI is calculated as

$$\frac{55 \text{ kg}}{1.65 \text{ m}^2} = 20.2 \text{ kg/m}^2 \text{ (normal weight range)}$$

WHO International Classification of adult underweight, overweight, and obesity using BMI	
	Cutoff points using BMI
Normal weight range	18.5–24.99
Overweight	≥ 25.00
Pre-obese	25.00–29.99
Obese	≥ 30
Malnutrition classification	
Mild	17 ≤ BMI <18.5
Moderate	16 ≤ BMI <17
Severe	BMI < 16

Exclusive breastfeeding: an infant receives only breast milk and no other liquids or solids, not even water, with the exception of drops or syrups consisting of vitamins, mineral supplements, or medicines [9].

Food aid: food resources – locally purchased food and/or imported food (direct distribution or *monetized* to support program costs) – provided by the USG or other donors. The Farm Bill (Public Law 480), which contains six titles, governs USG 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 Programme (WFP) and local purchases.

Food security: achieved when all people at all times 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.

Macronutrients: nutrients required in relatively large amounts, including carbohydrates, protein, fat, and water.

Malnutrition: in clinical terms, characterized by inadequate or excess intake of protein, energy, and micronutrients such as vitamins, and the frequent infections and disorders that result (WHO definition). Malnutrition 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: nutrients, including vitamins and minerals, that cannot be synthesized by the body but are required in minute amounts. Lack of these in the diet will result in a deficiency disease.

Mixed feeding: feeding both breast milk and other foods or liquids [8].

Nutrition counseling: 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: 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: products (e.g., food, pills, and "sprinkles") given to individuals to supplement the usual diet.

Orphans and other vulnerable children (OVC): for the purposes of the Emergency Plan, OVC 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; or (3) lives outside family care.

Replacement feeding: 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 by other foods. In the absence of breast milk, and especially beyond six months of age, micronutrient supplementation is likely to be essential.

Supplementary feeding: provision of additional food to selected individuals to prevent clinical malnutrition or treat mild-to-moderate malnutrition. The supplementary rations are in addition 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: 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.

Three ones principle: one national HIV/AIDS action framework as the basis for coordinating the work of all partners, one national HIV/AIDS coordinating authority with a broad-based, multisectoral mandate, and one country-level monitoring and evaluation system.

References

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