

**ASSURING FOOD AND NUTRITION SECURITY IN AFRICA BY 2020:
Prioritizing Action, Strengthening Actors, and Facilitating Partnerships**
April 1–3, 2004, Kampala, Uganda

SUMMARY NOTE

- Parallel Session:** **Implementing Action in Key Areas: Improving Nutrition and Health**
- Panelist:** *Robert Mwadime*, Child Survival and Nutrition Advisor, Regional Center for Quality of Health Care, Uganda
- Title:** **How to Successfully Implement Health Interventions That Improve the Food and Nutrition Security of HIV/AIDS-Afflicted People and Communities in Africa**
- Date:** April 2, 2004

Introduction

Nutrition security refers to the ability of the individual (including unborn babies) to access to the right mix of quality health and care, and adequate food (in terms of quantity, mix of energy and nutrients, and timeliness) in order to live a healthy life to the full potential of development and with dignity. Loss of weight (failure to thrive) is an indication of nutrition insecurity. In the context of HIV/AIDS in Africa, food security is of paramount importance, but access to food alone is not adequate to ensure nutritional security.

In developing world, loss of weight is almost universal among people with HIV/AIDS: It is a strong predictor of survival (independent of CD₄⁺ lymphocyte counts). Nutritional insecurity among PHA is due to many reasons:

- HIV infection itself, which may alter metabolism. The virus has direct effect on key hormones needed for metabolism of nutrients (e.g., growth hormone, glucagons, insulin, epinephrine). Higher levels of viral loads are associated with higher risk of decreased lean body mass (especially among children).
- Other underlying disease, such as TB.
- Inadequate macro/micro nutrient intake, due to:
 - Decreased intake due to reduced food availability or due to oral disease (thrush),
 - Anorexia associated with illness but also due to psychosocial effects,
 - Increased loss of nutrients due to diarrhoea, malabsorption,
 - The effect of the drugs commonly taken in HIV (for OIs, symptoms, ARV).
- Or a combination of any, or all of the above.

Pregnant/lactating women and HIV-infected children who are orphans are most affected by nutritional insecurity—they have higher rates of stunting. This is as a result of HIV on immunity but also on poverty, depression and psychological effects, in addition to sub-optimal care practices. **Which health interventions?**

Decide which interventions are priority given the context, the stage of the disease, food availability, knowledge and attitude towards food. For instance, in communities where most of the clients have low food intake (below 80% of the daily allowance) one may want to have a food supplementation program targeted at risk groups (like children born to infected women and with

faltering weights) together with nutritional counseling and education. In any case, the interventions can be grouped to food security, care and support, and health care.

Improved food accessibility

- Ensure adequate energy and nutrient intake
 - Supplement high energy food (or a ready to use therapeutic food) if necessary
 - Meal planning and diet counseling
- Ensure adequate intake of micronutrients, especially vitamin A, antioxidants, selenium, zinc
 - through micronutrient supplementation and/or food fortification (industrial or home)
- Monitoring possibilities of interaction between food and drugs (TB drugs), and efficacy of the drugs

Improved care and support

- Periodic nutritional assessment (diet intake and any side-effects) and growth monitoring (weight, height, developmental assessment), education, counseling and promotion should be done regularly
- Psychosocial support and counseling

Quality and timely health care

- ART (to improve food intake and use of nutrients)
- Prompt treatment of OIs (e.g., candida) for improved utilization of nutrients
- Public health interventions (deworming, immunization, sanitation/hygiene, exercises)

How to implement the interventions

Understand the underlying context, for example:

- Nutritional status.
- Dietary intake levels (proportion of RDA available in the homes). This could be disintegrated by households under the home-based care (those with someone who is chronically ill) and their neighbor.
- Demographic (distribution), children/adolescents and infection rates in each group.
- Who is involved in addressing the HIV/AIDS scourge in the localities (NGOs, ASOs, donors, government, the government set-up in providing leadership).
- Existing nutritional programs and their capacity to provide quality services, access by general population (especially those with HIV infection).
- Effectiveness of existing systems (health, agricultural, education).
- Use of ART (who, where, criteria).
- Priority areas of key stakeholders—what are they willing to invest in (depends on what is politically, culturally, technically appropriate).

Create and maintain partnerships at all levels

- Advocate to create buy-in and support of the process
 - Use PROFILES advocacy tool (? HIV/AIDS modules), use credible data and channels/people to advocate
- Agree on the importance of and need to improve nutrition security as part of the comprehensive package for care for PHA
- Define clear roles among the partners, especially on leadership at the various levels (national, sub-national, community, facility), and on resources.

Clearly define what we need to do for programs to be successful

Agree on what exactly needs to be done to improve nutrition security for PHA.

- Conducting formative research to identify what has been found to work in the context, the foods they eat and feeding patterns.

- Having clear policies and guidelines/standards. Sometimes this is given as an excuse of not initiating programs on nutrition and HIV/AIDS.
 - Issues of targeting services (including food, counseling): e.g. chronically ill?
 - Ensuring the guidelines and protocols are harmonized with other policies, and activities of the different sectors are coordinated.
 - Indicating clearly the package of nutritional services to be provided and when. The question is not whether food/nutrition is needed but of dynamics:
 - o Criteria for food distribution (not every one who is HIV infected needs food).
 - o Which food supplementation (food baskets, is it e-pap, HEPS, CSB, RUTF) and for what purpose?
 - o Counseling on food and nutritional care for PHA and children born by women infected with HIV. Demonstration for skill building.
 - o Breastfeeding (a major source of “food” for young children) in relation to the child’s nutrition and MTCT.
 - o Growth monitoring (use weight for length/height if possible) and nutritional assessments (dietary history, eating problems like chewing, swallowing, appetite, intolerances/aversions, supplementation).
- Integrate nutritional services integrated with other services such as community based growth promotion (as in CTC), home-based care, and facility-based care or combined with VCT or ART services.
 - Access to quality health services is particularly important to ensure PHA and infants born to women infected with HIV are attended on timely manner (e.g., with ORS in case of diarrhea, supplements, treatment of OIs and other infections like malaria/fever and ARI, diet advice/counseling, other primary health care like immunization and presumptive deworming 4–6 monthly, vitamin A supplementation, hygiene and sanitation).
 - Integrate ARV and nutrients/foods issues in ART for its effectiveness and adherence.
 - Support families (or family members) with decisions on feeding (e.g., adhering with decisions on feeding infants less than six months, or diet modification for each individual e.g. if oral thrush or nauseated).
 - Integrate nutrition in training guides and plans, supervision checklists (update the supervisors on key issues in nutritional security for PHA) and HMIS. Most HMIS do not cover nutrition and HIV/AIDS. Train those to administer ARVs, to carryout home-based care and palliative care, on nutritional implications.
- Build the necessary capacities through both in-service and pre-service (reviewing the curriculums). Make it practical by providing the necessary tools to facilitate learning and application.
 - Train the critical mass of staff at national level (TOT)
 - Institutionalize a system of finding root cause to performance problems
 - Ensure that external support strengthens and does not undermine community initiatives and motivation.
 - Develop and use model sites for handling problems and lessons learned (and for training).
 - Provide the tools and materials needed to improve or assure the performance of service providers

Contact	Action	Nutrition Tools
Home-based care	Psychosocial support Referral Nutritional counselling Distribution of “specific foods” Deworming	Counselling cards Posters Brochures Food baskets FAQ on nutrition

Contact	Action	Nutrition Tools
	ITN distribution	
Community schools	Deworming Supplementation School/community meals	Posters Food
Communication media	Nutrition/food education Referral Counselling	Radio/TV messages Posters/brochures Labelling Drama/music
Health facility	Counselling, education Deworming Growth monitoring ART, OIs management	Job-aids Flow/wall-charts FACs Scales and height meters

- Evaluate the effectiveness of the strategies being suggested.
 - Documenting and dissemination of lessons learned.

Challenges

- Service providers being able to make their messages clear and simple for the mother and relevant to their context of limited financial and knowledge resources.
- Documentation/recording of the interventions provided to PHA (because of many actors and many actions)
- Documentation of promising practices in nutrition and HIV/AIDS at programmatic level

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