

PART 3: TRAINER'S GUIDE

The trainer's guide is the third of four parts contained in this module. It is NOT a training course. This guide provides guidance on how to design a training course by giving tips and examples of tools that the trainer can use and adapt to meet training needs. The trainer's guide should only be used by experienced trainers to help develop a training course that meets the needs of a specific audience. The trainer's guide is linked to the technical information found in Part 2 of the module.

Module 18 is about HIV/AIDS and nutrition in emergencies. There are a number of key areas in emergencies where considerations of HIV/AIDS and nutrition are critical. The trainer's guide provides exercises to test the knowledge of participants around the subject matter and poses some likely situations that humanitarian workers will face. Not all answers are perfectly standardized, and trainers should take into account the differences in their own settings. The examples given are taken or adapted from real situations.

Navigating your way round the guide

The trainer's guide is divided into six sections.

1. **Tips for trainer** provide pointers on how to prepare for and organise a training course.
2. **Learning objectives** set out examples of learning objectives for this module that can be adapted for a particular participant group.
3. **Testing knowledge** contains an example of a questionnaire that can be used to test participants' knowledge of HIV/AIDS and nutrition either at the start or at the end of a training course.
4. **Classroom exercises** provide examples of practical exercises that can be done in a classroom context by participants individually or in groups.
5. **Case studies** contain examples of case that can be used to get participants to think by using real-life scenarios.
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1. Tips for trainers

Step 1: Do the reading!

- Read Part 2 of this module.
- Familiarise yourself with the technical terms from the glossary.

Step 2: Know your audience!

- Find out about your participants in advance of the training:
 - How many participants will there be?
 - Do any of the participants already have experience of HIV/AIDS and nutrition programming?
 - Could participants with HIV/AIDS experience be involved in the sessions by preparing a case study or contribute through describing their practical experience?

Step 3: Design the training!

- Decide how long the training will be and therefore what activities you can cover within the time available. In general the following guide can be used:
 - A **two-hour** classroom-based training can provide a basic overview of HIV/AIDS and nutrition in emergencies.
 - A **one-day** classroom-based training can provide an overview of HIV/AIDS and nutrition and include a practical exercise.
 - A **two-day** classroom-based training can provide a more in-depth understanding of HIV/AIDS and nutrition in emergencies and include a number of practical exercises and/or one case study.
 - A **three- to eight-day** classroom plus field-based training can provide a full training in order to carry out an actual assessment suitable for a particular context. This would include case studies and field practical exercises.
- Identify appropriate learning objectives. This will depend on your participants, their level of understanding and experience, and the aim and length of the training.
- Decide exactly which technical points to cover based on the learning objectives that you have identified.
- Divide the training into manageable sections. One session should generally not last longer than an hour.
- Ensure the training is a good combination of activities, e.g., mix PowerPoint presentations in plenary with more active participation through classroom-based exercises; mix individual work with group work.

Step 4: Get prepared!

- Prepare PowerPoint presentations with notes (if they are going to be used) in advance. Recommended PowerPoint presentations can be prepared from Part 2 of this module and many of the guides in Part 4 have downloadable PowerPoint slides. If you are making your own slides: don't put too much text on any one slide, and use diagrams and images as much as possible. Do a trial run and time yourself!
- Prepare exercises and case studies. These can be based on the examples given in this trainer's guide but should be adapted to be suitable for the particular training context.
- Make sure your information is up to date. HIV/AIDS and nutrition is a rapidly changing field. In the last few years, a number of new guidelines have come out. Individual country guidelines may also be in flux.
- Plan sessions that can benefit from an interactive approach, especially if they can be mixed with a more 'top-down' teaching/training.
- Prepare a 'kit' of materials for each participant. These should be given out at the start of the training and should include:
 - Timetable showing break times (coffee and lunch) and individual sessions
 - Parts 1, 2 and 4 of this module
 - Pens and paper

REMEMBER

People remember 20% of what they are told, 40% of what they are told and read, and 80% of what they find out for themselves.

People learn differently. They learn from what they read, what they hear, what they see, what they discuss with others and what they explain to others. A good training is therefore one that offers a variety of learning methods which suit the variety of individuals in any group. Such variety will also help reinforce messages and ideas so that they are more likely to be learned.

2. Learning objectives

Below are examples of learning objectives for a session on HIV/AIDS and Nutrition. Trainers may wish to develop alternative learning objectives that are appropriate to their particular participant group. The number of learning objectives should be limited; up to five per day of training is appropriate. Each exercise should be related to at least one of the learning objectives.

Examples of learning objectives

At the end of the training, participants will:

- Be aware of the importance of nutrition for people living with HIV.
- Be able to identify the changing nutritional requirements of people living with HIV and how these could be managed in emergencies.
- Be aware of the complex issues surrounding targeting of people living with HIV in emergencies.
- Understand the issues linked to breastfeeding for HIV-positive mothers in emergencies.
- Have enough knowledge to plan and manage therapeutic feeding facilities or community therapeutic feeding programmes for children with HIV.
- Be aware of the gaps in guidelines for nutrition and HIV in emergencies and the practical implications for managing a nutrition programme in emergencies.
- Have enough knowledge to understand the importance of key services for the treatment and care of people living with HIV in emergencies to maintain nutritional status.
- Understand the importance of good hygiene, water and sanitation for people living with HIV.
- Be aware of the importance of pro-active measures to protect men, women and children from sexual abuse during emergencies, especially in areas of high HIV prevalence.

3. Testing knowledge

This section contains one exercise: a series of questions that can be used to ensure that all participants in the training session have basic knowledge of the issues linked to HIV/AIDS and nutrition in emergencies. The question list can be adapted to include questions relevant to the specific situation. The questions below should serve as a guide for a trainer for the preparation of the classroom based training course.

In a short course, PowerPoints/flip chart/handouts should be prepared summarising key points from Part 2 of this module in the following areas that will enable participants to answer the questions in Handout 1a or to provide emphasis after the discussion:

- Linkages between HIV/AIDS and nutrition
- Additional nutritional requirements of people living with HIV, including targeting issues
- Breastfeeding/infant feeding considerations for HIV-positive mothers in emergency situations
- Therapeutic and supplementary feeding options for HIV-positive people in emergencies
- Key programmes that should be established to maintain the health of people living with HIV in emergency situations
- Hygiene, water and sanitation considerations for people living with HIV in emergencies

Exercise 1: What do you know about HIV/AIDS and nutrition in emergencies?**What is the learning objective?**

- To ensure that basic knowledge of the main issues around HIV/AIDS is understood by practitioners who will be working on nutrition in an emergency

When should this exercise be done?

Testing knowledge can come at several points in a training course. The trainer should choose one point for this type of exercise.

- At the beginning to bring up issues in the group and start discussions
- After an introductory power point session or summary
- At the end of the course to gauge knowledge gained
- Before the course to gain insight into the participants to give you time to tailor the training to their particular needs

How long should the exercise take?

- 60 minutes

What materials are needed?

- **Handout 1a:** What do you know about HIV/AIDS and nutrition in emergencies?: Questionnaire
- **Handout 1b:** What do you know about HIV/AIDS and nutrition in emergencies?: Questionnaire answers

What does the trainer need to prepare?

- Familiarise yourself with the questions and answers.
- Adapt questions to training to be carried out, depending on the material taught during the course.
- Prepare summary points (PowerPoint, flip chart, or verbal presentation list)

Instructions

Step 1: Give each participant a copy of Handout 1a.

Step 2: Give participants 30 minutes to complete the questionnaire working alone

Step 3: Give each participant a copy of Handout 1b.

Step 4: Give participants five minutes to mark their neighbours' questionnaires. You may need to clarify answers where necessary.

Step 5: Give participants 20 minutes to discuss problem areas (for a pre-test this should guide the training, and for a post-training test, it should be used for an additional session for clarification).

Handout 1a: What do you know about HIV/AIDS and nutrition in emergencies?: Questionnaire

Time for completion: 30 minutes

1. Describe the different stages of HIV and AIDS.
 - Stage I -
 - Stage II -
 - Stage III -
 - Stage IV -

2. a) What is the effect of poor nutrition on the immune system?
 - b) Can good nutrition slow the progression of HIV to AIDS?

3. What are the additional energy needs of people living with HIV in the asymptomatic phase of the illness?
 - A) No additional energy
 - B) 10% more energy
 - C) 30% more energy
 - D) 50% more energy

4. List the main criteria that should be used to decide whether a household should receive benefits (food or cash) during an emergency?
 - 1)
 - 2)
 - 3)

5. a) What are the criteria for safe formula feeding?
 - b) When the criteria for safe formula feeding are not met, how should an infant of an HIV-positive mother be fed?

Below the age of 6 months	
6 months to 12 months	
Over the age of 12 months	
If the infant is HIV positive	

6. Regarding HIV-positive children, Mark **T** for True or **F** for False:
- 1) HIV-positive children should have a nutritional review every 2-3 months.
 - 2) Asymptomatic HIV-positive children have a 20-30% additional energy requirement.
 - 3) Children with HIV should stop breastfeeding at 12 months.
 - 4) An HIV-positive child with poor weight gain should be given an additional 20-30% of energy.
 - 5) Standards for severe acute malnutrition are different for HIV-positive children.
 - 6) Severely malnourished children should be provided with 50-100% extra energy (this is 150-220 Kcal/Kg/day) and a balanced supply of micronutrients.
 - 7) A child on ART will always need an additional 30% energy requirement.
 - 8) Vomiting in a child on ART may or may not be a medication side effect.
7. Regarding HIV-positive adults, mark **T** for True or **F** for False:
- 1) The most commonly used measure of malnutrition in adults is BMI, body mass index.
 - 2) Unexplained loss of greater than 10% of body weight in adults is a criteria for WHO AIDS clinical stage 2.
 - 3) Home based care programmes should not focus solely on people living with HIV/AIDS.
 - 4) Only short-term nutritional interventions are needed for families affected by HIV/AIDS.
8. List at least 4 key services that a person living with HIV/AIDS requires to stay healthy in emergency situations?
- 1)
 - 2)
 - 3)
 - 4)
9. How does the provision of health care to people living with HIV/AIDS help maintain nutritional status?

Handout 1b: What do you know about HIV/AIDS and nutrition in emergencies?: Questionnaire answers

1. Describe the different stages of HIV and AIDS.

The WHO classification of AIDS is as follows:

Stage I: HIV disease is asymptomatic and not categorised as AIDS

Stage II: Weight loss less than 10 per cent of body weight, minor mucocutaneous manifestations (for example, mouth ulcers, candida), herpes zoster and recurrent upper respiratory tract infection

Stage III: Weight loss of greater than 10 per cent of body weight, unexplained chronic diarrhoea for longer than a month, unexplained prolonged fever, oral candidiasis, oral hairy leukoplacia, severe bacterial infections and/or pulmonary tuberculosis within the past year

Stage IV: From HIV to AIDS. Variously classified by CD 4 cell count or a series of opportunistic infections linked to HIV, for example, severe wasting, persistent diarrhoea Kaposi sarcoma (skin lesions), pneumocystis pneumonia, extra pulmonary tuberculosis

The participant does not necessarily have to know all of the possible opportunistic infections, as the list is long and differs from country to country. However, the participant should understand that there is an asymptomatic phase where there are no visible symptoms, and then a progression of weight loss, recurrent infections and persistent diarrhoea through to serious life threatening tuberculosis, cancers and pneumonia.

2. a) What is the effect of poor nutrition on the immune system?

The effect of poor nutrition on the immune system is to further weaken the system, putting the person at a higher risk of opportunistic infections. Poor nutrition can also lead to lack of appetite, reducing nutrient intake, leading to weight loss and weakening of the immune system even further.

- b) Can good nutrition slow the progression of HIV to AIDS?

Yes. Most of the evidence points to good nutrition helping to strengthen a weakened immune system. However, in the case of HIV, nutrition cannot stop the progression of the virus.

3. What are the additional energy needs of people living with HIV in the asymptomatic phase of the illness? **Answer B**

Asymptomatic HIV-positive adults	Increase energy by ~10%
Pregnant or lactating women with asymptomatic HIV	Increase energy by ~20% + ~10% = ~30%
Adults with symptomatic HIV-related infection or AIDS (including pregnant or lactating women)	Increase energy by ~20-30%
Asymptomatic HIV-positive children	Increase energy by ~10%
HIV-positive children experiencing weight loss or HIV-related illness	Increase energy by ~50-100%
Children with severe acute malnutrition	According to WHO guidelines for all children with severe acute malnutrition

4. What are the main criteria that should be used to decide whether a household should receive benefits (food or cash) during an emergency?

Criteria for targeting:

- 1) Household food insecurity
- 2) Nutrition status of household members
- 3) If there are sufficient resources for categories of vulnerable households typically found in areas of high HIV prevalence, namely: child-headed households, elderly-headed households, food-insecure households hosting orphans

Other key criteria:

- Where resources allow to meet the needs of all food insecure households, and there are additional resources for households affected by HIV
- Where there are existing HIV/AIDS programmes and people are living openly with HIV (treatment, care and support programmes)
- Where adults or children living with HIV are severely malnourished and require therapeutic/supplementary feeding
- Where programmes are developed, with community support and agreement, to target households affected by HIV

5. a) What are the criteria for safe formula feeding?

Conditions needed to safely formula feed:

- Safe water and sanitation are assured at the household level and in the community
- The mother, or other caregiver, can reliably, continuously, provide sufficient infant formula milk to support normal growth and development of the infant
- The mother or caregiver can prepare formula cleanly and frequently enough so that it is safe and carries a low risk of diarrhoea and acute malnutrition
- The mother or caregiver can, in the first six months, exclusively give the infant formula milk and continue to provide appropriate formula or powder milk during the next 6 months and beyond as the child weans to other foods.
- The family is supportive of the practice
- The mother or caregiver can access health care that offers comprehensive child health services

or AFASS = Acceptable, Feasible, Affordable, Safe and Sustainable

- b) When the criteria for safe formula feeding are not met, how should an infant of an HIV-positive mother be fed?

Below the age of 6 months	Exclusively breastfed – no foods of any other kind AND the mother or infant should be on ART treatment
6 months to 12 months	Breastfed with the addition of complementary foods, AND the mother or infant should be on ART treatment
Over the age of 12 months	When a nutritionally adequate diet can be achieved without breast milk – (adequate caloric intake in appropriate energy dense food, safely prepared, with complete micronutrient balance) breastfeeding may be stopped for an HIV-negative infant.
If the infant is HIV positive	Breastfed exclusively for the first 6 months, then continued breastfeeding with complementary foods up to 2 years and beyond.

6. Regarding HIV-positive children: **1T, 2F, 3F, 4T, 5F, 6T, 7F, 8T****Nutritional recommendations for HIV-positive children include:**

- Children should be reviewed every 2-3 months, with a focus on dietary diversity, safe food preparation, and continued breastfeeding. They should receive an additional energy intake of 10% with a full RNI (Recommended Nutritional Intake) of micronutrients. Often this is not available in a regular diet of unfortified plant source foods.
- Children with HIV should continue breastfeeding up to two years of age or longer. Breastfeeding confers no additional risk and considerable nutritional benefit.
- An HIV-positive child with poor weight gain should be given an additional 20-30% of energy.
- Standards for severe acute malnutrition are the same in HIV-positive children: the presence of oedema in both feet, weight for height less than 3 Z-scores below median WHO reference values, or MUAC below 115mm in children aged 6-60 months.
- Severely malnourished children with no medical complications should be provided with 50-100% extra energy (150-220 Kcal/Kg/day based on the child's weight) and a balanced supply of micronutrients. This is true of all severely malnourished children regardless of HIV status.
- Children with HIV and severe malnutrition should follow the same protocol as HIV-negative patients initially, but will require additional attention for medical problems and will probably take longer to recover.
- Growth on ART is a good indicator of treatment response. When stabilised, a child will only need an increased energy intake of 10% for asymptomatic HIV infection. Medical review should take place every 3 months.
- Vomiting in a child on ART should be considered with respect both to medication side effects and to general causes of vomiting. It should be managed according to IMCI guidelines.

7. Regarding HIV-positive adolescents and adults: **1T, 2F, 3T, 4F**

- International guidelines have not been set for the determination of severe acute adult malnutrition in emergencies. Often BMI (Body Mass Index) is used as a criteria for Food by Prescription programmes, while MUAC may also be used in emergencies to determine acute malnutrition in adults.
- Unexplained loss of greater than 10% of body weight in adults is a criteria for WHO AIDS clinical stage 3
- Home based care programmes should never focus solely on people living with HIV and AIDS, but provide support for all chronically ill, bed-ridden patients, and home-bound people living with severe disability. In this way, there is no additional stigma attached to participation in a Home Based Care programme.
- A key action for nutritional support for families affected by HIV should be long term strategies to protect and adapt their livelihoods: agricultural assistance, labour-saving tools, income-generating activities, and skill-building programmes for youth are all appropriate interventions.

8. What are the key services that a person living with HIV/AIDS requires to stay healthy in emergency situations?

Some key services are:

- Access to adequate nutrition
- Treatment (ARV and opportunistic infections)
- Home based care including psycho-social support
- Good sanitation and food hygiene
- Potable water sufficient to consume 8 glasses of water daily
- Secure shelter that does not expose them to exploitation or danger
- Protection of basic human rights

9. How does the provision of health care to people living with HIV/AIDS help maintain nutritional status?

People who remain healthy will maintain nutrition status, have a good appetite and not lose weight; which in turn will help to maintain the immune system.

4. Classroom exercises

This section contains five exercises to be carried out in the classroom to deepen the understanding of the participants of the key intervention areas in HIV/AIDS and nutrition in emergencies. The exercises cover questions linked to: breastfeeding counselling for HIV-positive mothers in emergencies; targeting dilemmas linked to ART; hygiene, water and sanitation; HIV/AIDS and coping strategies, and protection issues.

Exercise 2: Breastfeeding counselling for HIV-positive mothers in emergencies

What is the learning objective?

- To understand the issues linked to breastfeeding for HIV-positive mothers in emergencies

When should this exercise be done?

- After the teaching sessions on the subject

How long should the exercise take?

- 70 minutes

What materials are needed?

- **Handout 2a:** Guidelines for breastfeeding and HIV
- **Handout 2b:** Brief for breastfeeding counsellors group B (Brazil)
- **Handout 2c:** Brief for breastfeeding counsellors group D (DRC)
- **Handout 2d:** Questions for breastfeeding mothers
- Flip charts for plenary discussion

What does the trainer need to prepare?

- Review the aspects that need to be taken into consideration for each group in order to facilitate the group work.
- During the role play take notes to feedback in the plenary.

Exercise 2: Breastfeeding counselling for HIV-positive mothers in emergencies (continued)**Instructions**

Step 1: Divide the group into four sub-groups.

Step 2: Two groups will prepare as breastfeeding counsellors and the remaining people will prepare as breastfeeding mothers with questions. They will each study Handout 2a: Guidelines for breastfeeding and HIV as a group.
Ten minutes

Step 3: Distribute Handout 2b to one group who will act as counsellors in Brazil. Distribute Handout 2c to another group who will act as counsellors in the DRC. These two groups should position themselves as far away from each other as is reasonably convenient, and discuss what their country policies for HIV and breastfeeding should be.

Step 4: At the same time, distribute Handout 2d to the remaining groups. They will be groups of HIV-positive women. They should spend 10 minutes dividing the questions among themselves and designing any new questions they would wish to ask. *10 minutes for Steps 3 and 4*

Step 5: The two groups of HIV-positive women should each go to a counselling group. The counsellors should explain the setting and the national situation, and then answer questions from the HIV-positive women.
15 minutes

Step 6: After a question and answer session between mothers and counsellors of 15 minutes, the HIV-positive women groups should change places and visit the other counselling group. Again, the counsellors should explain the setting and the national situation, and then answer questions from the HIV-positive women.
15 minutes

Step 7: The trainer will facilitate the plenary to discuss the outcome of the role play. The whole training group should discuss which answers were the same for all counsellors and why some answers were different from different counsellors in different settings. The group should discuss the situation for breastfeeding HIV-positive mothers in their current setting. *20 minutes*

Handout 2a: Guidelines for breastfeeding and HIV

Good breastfeeding practice for all:

Age of infant	Guidelines
0-6 months	Exclusive breastfeeding
6-9 months	Gradual introduction of complementary food with continued breastfeeding
9-24 months	Introduction of family food with continued breastfeeding

The World Health Organization released revised Guidelines on HIV and infant feeding in 2010. Each country should make an independent decision and express a consistent message to their population. They should choose between avoiding all breast milk exposure to an infant of an HIV-positive mother OR adopting safe breastfeeding practices.

- All mothers should receive the care that they need to prevent the progression of their HIV infection and to protect their infants from contracting HIV.
- When an HIV-positive mother is breastfeeding, either she or the infant should receive ART. While neither method is prioritised in the guidelines, it is more common for the mother to have begun ART while pregnant and continue this treatment for the entire duration of breastfeeding than for the infant to begin ART without treating the mother.
- HIV-positive mothers should exclusively breastfeed for the first 6 months and then continue to breastfeed while introducing healthy complementary foods for at least the next 6 months of life.
- Breastfeeding should only stop when a nutritionally adequate diet can be achieved without breast milk.
- When a mother decides to stop breastfeeding, the child should be weaned gradually over 1 month rather than abruptly. ART should continue for a week after all exposure to breast milk has ceased.
- Complementary foods should be provided to children over 6 months of age. Children should be fed at least 4 or 5 times a day.
- When a child is known to be HIV-infected, the mother should be encouraged to continue to breastfeed up to 2 years or beyond as is recommended for the general population.

Despite the strong recommendation to advise breastfeeding up to 12 months of age, a mother may choose to stop breastfeeding at another point. The decision to replace breastfeeding with formula feeding should be carefully made so that infants have sufficient nutrition for normal growth and development.

Following are the conditions needed to safely formula feed:

- a) Safe water and sanitation are assured at the household level and in the community
- b) The mother, or other caregiver, can reliably, continuously, provide sufficient infant formula milk to support normal growth and development of the infant
- c) The mother or caregiver can prepare formula cleanly and frequently enough so that it is safe and carries a low risk of diarrhoea and malnutrition
- d) The mother or caregiver can, in the first six months, exclusively give the infant formula milk and continue to provide appropriate formula or powdered milk during the next 6 months and beyond as the child weans to other foods.
- e) The family is supportive of the practice
- f) The mother or caregiver can access health care that offers comprehensive child health services

Source: World Health Organization 2010, *Guidelines on HIV and Infant Feeding: Principles and recommendations for infant feeding in the context of HIV and a summary of evidence*. WHO, Geneva.

Alternatives to recommended breast milk substitutes include:

- Wet nurse breastfeeding (when a woman other than the mother breastfeeds the child)
 - Breast milk banks (when lactating women donate expressed milk for feeding to children with a cup)
 - Home-treated expressed milk
- Artificial feeding with home-altered animal milk is no longer recommended except for very brief periods.

For non-breastfeeding children above the age of 6 months, the following alternative feeding guidelines should be followed:

- Ensure that energy needs are met: approximately 600 kcal per day at 6-8 months of age, 700 kcal per day at 9-11 months of age, and 900 kcal per day at 12-23 months of age.
- Gradually increase food consistency and variety as the infant gets older, adapting to the infant's requirements and abilities. Mashed food at 6 months, finger foods at 8 months, a variety of family foods at 12 months. Avoid foods in a form that may cause choking.
- For the average healthy infant, meals should be provided 4-5 times per day, with additional nutritious snacks (such as pieces of fruit or bread or chapatti with nut paste) offered 1-2 times per day, as desired. The appropriate number of feedings depends on the energy density of the local foods and the usual amounts consumed at each feeding. If energy density or amount of food per meal is low, more frequent meals may be required.
- Feed a variety of foods to ensure that nutrient needs are met. This should include animal-source foods in addition to or including milk if possible or if not both grains and legumes for protein quality. Foods should contain adequate calcium, vitamin A, and adequate fat content. Do not give drinks with low nutrient value, such as tea, or sugared drinks, and limit juice to avoid displacing higher nutrient content foods.
- As needed, use fortified foods or vitamin-mineral supplements that contain iron (8-10 mg/d at 6-12 months, 5-7 mg/d at 12-24 months). If adequate amounts of animal-source foods are not consumed, these fortified foods or supplements should also contain other micronutrients, particularly zinc, calcium and vitamin B12.
- Non-breastfed infants and young children need at least 400-600 mL/d of extra fluids (in addition to the 200-700 mL/d of water that is estimated to come from milk and other foods) in a temperate climate, and 800-1200 mL/d in a hot climate. Plain, clean (boiled, if necessary) water should be offered several times per day to ensure that the infant's thirst is satisfied.
- Practise good hygiene and proper food handling
- Practise responsive feeding, applying the principles of psycho-social care. Remember that feeding times are periods of learning and love – talk to children during feeding, with eye to eye contact.
- Increase fluid intake during illness and encourage the child to eat soft, varied, appetising, favourite foods. After illness, give food more often than usual and encourage the child to eat more.

Adapted from *World Health Organization 2009: Guiding principles for feeding non-breastfed children 6-24 months of age*, WHO, Geneva.

Handout 2b: Brief for breastfeeding counsellors group B (Brazil)

You are working as breastfeeding counsellors in a centre for people displaced due to a mudslide in the northeast of Brazil. It is an urban setting. You have available donated formula. There is high HIV prevalence, and there is high ART adherence.

Directions:

Discuss what your national policy will likely be towards infant feeding by HIV-positive women. Think about how the emergency has affected these women, and how you will counsel them in this setting.

In 5 minutes, you will be visited by two groups of HIV-positive women. Explain the situation (A mudslide in Brazil), and then answer their questions for this emergency setting.

Handout 2c: Brief for breastfeeding counsellors group D (DRC)

You are working as breastfeeding counsellors in a refugee camp in the Democratic Republic of the Congo (DRC). It is a highly under-developed rural area of the country. There is high HIV prevalence. There is no commercial network, very poor sanitation, and low availability of potable water.

Directions:

Discuss what your national policy will likely be towards infant feeding by HIV-positive women. Think about how the emergency has affected these women, and how you will counsel them in this setting.

In 5 minutes, you will be visited by a group of HIV-positive women. Explain the situation (a refugee camp in the DRC), and then answer their questions for this emergency setting.

Handout 2d: Questions for HIV-positive women

Directions: You are HIV-positive women, pregnant or with infants. When an emergency occurs, you have questions about how to feed your children. Think of some questions you may have in an emergency setting. Below are a few to get you started. Take 5 minutes to add questions of your own, and then visit one of the emergency counselling sessions.

Questions:

- I have HIV and I'm breastfeeding. My infant is 6 months old. What should I do now?
- How fast should I wean my infant?
- I don't know if I'm HIV-positive. Should I breastfeed?
- My child is HIV-positive too. Should I stop breastfeeding?
- What should I feed my 9 month old child?
- When can I stop taking these ART medicines?
- Should I give my 4 month old baby porridge? Is it okay to give him tea?
- I'm taking care of the 8 month old child of my deceased sister. What should I feed him?

Exercise 3: Maintaining nutrition status of people living with HIV/AIDS**What is the learning objective?**

- To be aware of the complex issues surrounding targeting of people living with HIV/AIDS in emergencies

When should this exercise be done?

- After the formal training has taken place
- Or as preparation of people to manage a food distribution programme

How long should the exercise take?

- 90 minutes

What materials are needed?

- **Handout 3a:** Instructions sheet
- **Handout 3b:** Issues for discussion

What does the trainer need to prepare?

- Review the module and, if possible, understand the emergency setting that the trainees are facing.

Instructions

Step 1: Read the description of the situation with the whole group.

Step 2: Divide the participants into four categories for the role play.

Step 3: Each group should take 15 minutes to prepare their arguments.

Step 4: The facilitator should convene the 'meeting' – each group presents for five minutes and the facilitator should chair the meeting and try and reach a consensus decision.

Step 5: Facilitate a 15-minute wrap-up session discussing the outcomes of the role play.

Handout 3a: Instructions sheet

Background

The hospital in the area where severe flooding took place has a functioning ART programme with 150 patients. These patients do not normally receive any food support linked to their ART. Of these patients, 50 are in the flood-affected area and have been displaced to an accommodation camp together with 500 other households. All the 550 households in the accommodation camp have lost all of their assets, and their food stocks and crops have been damaged. There are adequate food rations for the 550 households in the accommodation camp and there are possibilities of requesting more food for special needs groups.

The World Health Organization recommendations for caloric intake for HIV-positive individuals is as follows: in addition to increased energy, all HIV-positive individuals should receive one RNI of all micronutrients. This is often difficult to achieve with an unfortified plant-based diet.

Asymptomatic HIV-positive adults	Increase energy by ~10%
Pregnant or lactating women with asymptomatic HIV	Increase energy by ~20% + ~10% = ~30%
Adults with symptomatic HIV-related infection or AIDS (including pregnant or lactating women)	Increase energy by ~20-30%
Asymptomatic HIV-positive children	Increase energy by ~10%
HIV-positive children experiencing weight loss or HIV-related illness	Increase energy by ~50-100%
Children with severe acute malnutrition	According to WHO guidelines for all children with severe acute malnutrition

Create a role play of a meeting between these groups, to discuss whether to establish an additional ration for the patients on ART:

- Camp leaders
- Representatives from the group of patients on ART
- Food aid monitors
- Health staff

Step 1: The facilitator's role should be the chairperson. He or she should introduce the background and the question at hand.

Step 2: Divide the group into 4 parts and assign roles. Each group should take 15 minutes to organise their arguments.

Step 3: The chairperson (facilitator) should convene the meeting and give each group 5 minutes to put their case, noting key points on a flip chart (20 minutes).

Step 4: Key points of divergence should then be discussed in the 'meeting' (10 minutes). The meeting should last for 30 minutes, with the aim of reaching consensus on whether to establish an additional ration for people on ART.

Step 5: The facilitator should then facilitate a plenary session to discuss the results of the meeting and the implications of the 'decision' taken.

Handout 3b: Issues for discussion

Camp leaders

- concerns around discrimination and stigma if one group receives more food rations
- issues around discontent in the camp if some households receive more than others

Patients on ART

- concerns about taking antiretrovirals (ARVs) without adequate nutrition; concerns about weight loss and impact on health status
- type of food available (palatability and processing)
- worry about discriminating within the group of patients in treatment (between those who were affected by the floods and those who were not)

Food aid monitors

- need to calculate the implications in terms of extra food
- concerns about setting up parallel systems (resources, management, control)
- concerned about any suggestion that all patients (affected and non-affected by floods) should receive rations

Health staff

- concerns about health status of the patients on ART,
- worries about becoming involved in food distribution when they are already over-stretched
- worries about discrimination of patients on ART

There is no ideal outcome of this exercise. If possible the facilitator should make the situation as relevant as possible to the participants. The idea of the exercise is to raise the difficult issues of targeting in resource limited settings.

Exercise 4: Hygiene rules**What is the learning objective?**

- To understand the importance of good hygiene, water and sanitation for people living with HIV/AIDS

When should this exercise be done?

- As part of the training sessions or as a post-training exercise

How long should the exercise take?

- 30 minutes

What materials are needed?

- Cards and pens
- **Handout 4a:** Facilitator's guide

What does the trainer need to prepare?

- Review Sphere on hygiene and sanitation standards.
- Review Part 2 of this module: hygiene, water and sanitation section.

Instructions

Step 1: Divide the group into two teams.

Step 2: Team A will write a hygiene/water/sanitation message on a piece of card. Team B will have to say why that message is important for people living with HIV/AIDS and how in the emergency setting the aim of the message could be achieved.

Step 3: Reverse the order, with Team B writing the message and Team A responding.

Step 4: Carry on the exercise until the teams have no more messages.

Handout 4a: Facilitator's guide

Divide the group into two teams.

Team A: Write a water/food hygiene/sanitation message.

Team B: Indicate why this is particularly important for people living with HIV and how to find a solution in times of emergency.

Reverse the order.

Team B: Write the message.

Team A: Provide the link and solution.

Examples

Message: Store potable water in closed receptacles.

Response: Important to reduce possibility of water borne diseases

Solutions: Provide covered receptacles to store clean water; provide water filters for households with chronically sick members; provide sanitation education for all households.

Message: Guarantee the availability of potable water.

Response: Important for people living with HIV/AIDS to maintain their water consumption (eight glasses per day)

Solutions: See above. Plus – additional water rations for households with chronically sick members

Message: Wash hands before handling food.

Response: Important to reduce contamination of food for people with compromised immune systems

Solutions: Ensure adequate supplies of water for hand washing; provide sanitation education to all households.

Message: Wash food before preparation and consumption.

Response: Important to reduce contamination of food for people with compromised immune systems

Solutions: Ensure adequate supplies of water for washing of food; provide sanitation education to all households.

Message: Do not keep cooked food for a long period of time (such as overnight or from morning cooking to consumption in the late afternoon of the same day) without refrigeration.

Response: Important to reduce contamination of food for people with compromised immune systems

Solutions: Communal kitchens: education on food contamination and spoilage; training to improve measurement of food quantities

Households: education on food contamination and spoilage; discuss possibilities for safe storage of cooked food in the context (cool rooms/ water/clay coolers)

Message: Store food stocks in ventilated and clean installations.

Response: Important to reduce infestation of food by insects or contamination by rats or fungus as people living with HIV/AIDS are susceptible to intestinal infections and food poisoning

Solutions: Warehousing with ventilation; food sacks stored on pallets; regular inspection of food stocks: regular fumigation of warehouses; regular checks on the 'use by date' of the food stocks

Message: Keep the latrine clean at all times.

Response: Extremely important that Sphere standards are observed for latrine construction in areas where there is high prevalence of HIV due to the susceptibility of people living with HIV to diarrhoea

Solution: Ensure that Sphere standards are observed.

Exercise 5: Critical protection**What is the learning objective?**

- To be aware of the importance of proactive measures to protect men, women and children from sexual abuse during emergencies, especially in areas of high HIV prevalence

When should this exercise be done?

- At any point during the training period

How long should the exercise take?

- 60 to 90 minutes. The length of time needed will depend on the gravity of the situation the practitioners are facing, and the experience of the practitioners.

What materials are needed?

- Flip chart papers and pens
- **Handout 5a:** Instructions for the exercise on critical protection
- **Handout 5b:** Facilitator's guide

What does the trainer need to prepare?

- Be prepared to discuss the complex issue of sexual abuse; understand the Code of Conduct; be aware of the situation facing the practitioners on the ground.

Instructions

Step 1: Brainstorm with the group as many risky situations as they can imagine.

Step 2: Write these on the flip charts.

Step 3: Divide the situations between the working groups and ask them to provide suggestions for protection measures to avoid sexual exploitation.

Handout 5a: Instructions for the exercise on critical protection

- *Brainstorm with group as many risky situations in terms of exposure of (mainly) young girls and women to sexual exploitation. This may be sexual exploitation for food or for other resources.*
- *Make a list of all the situations suggested.*
- *Divide the situations between working groups and ask them to provide suggestions for protection measures to avoid sexual exploitation.*
- *Discuss in plenary.*

Handout 5b: Facilitator's guide

The examples below are not exhaustive but indicate the types of situation/measures that may occur.

Possible examples and answers:

1. Communal kitchens where food access is controlled by a small group of people

Monitoring groups are established to ensure access of all members of the centre to food, transparent processes for accessing meals, control over foodstuffs to prevent use of food away from the kitchens in exchange for sex, and move as quickly as possible away from communal kitchens to household access and control of rations.

2. Situations of food ration shortage

This is an extremely complex situation as desperate people will try anything in order to feed themselves and their children. Humanitarian workers must be trained in protection issues; there should be clear and enforceable course of action for violations of the code by humanitarian workers; all efforts must be made to discuss a similar code of conduct with all intervening parties. When there is violence or corruption in the process, the source of the violence may be traced back to community members or to those assisting in food distribution. Transparent selection processes agreed upon by the households should be used wherever possible, and those who abuse the systems need to be identified to prevent covert exchanges. In this situation it is extremely difficult to control the food for sex exchange.

3. Traditional leaders decide on which households will receive food rations or cash transfers

Wherever possible mixed groups of all interested parties should be involved in beneficiary selection; selection processes must be transparent; a code of conduct should be explicitly discussed with all parties involved, including a discussion of sanctions for people violating the code of conduct. Safe and anonymous ways of denouncing sexual abuse should be instituted.

4. Political party officials have control over the distribution lists

There should be public verification of lists.

5. Accommodation centres where there are high numbers of female headed households or women living by themselves

All efforts should be made to include women in the distribution/selection committees; open and frank dialogue should be encouraged; a code of conduct should be explicitly discussed with all parties involved, including a discussion of sanctions for people violating the code of conduct.

Safe and anonymous ways of denouncing sexual abuse should be instituted; if appropriate security measures to protect women and children should be established

6. Distribution points for rations are distant from homesteads requiring people to overnight at the distribution points.

Change the distribution points; provide safe accommodation for women and young girls at the distribution point; provide escorts for the women and girls back to their homesteads.

Exercise 6: HIV/AIDS and coping strategies**What are the learning objectives?**

- To be aware of the importance of nutrition for people living with HIV/AIDS.
- To be aware of the changing nutritional requirements of people living with HIV/AIDS and how these could be managed in emergencies

When should this exercise be done?

- Can be used during the training to highlight specific issues that need to be addressed programmatically in humanitarian response

How long should the exercise take?

- 60 minutes

What materials are needed?

- Pens and paper
- **Handout 6a:** HIV/AIDS and coping strategies
- **Handout 6b:** HIV/AIDS and coping strategies: Model answer

What does the trainer need to prepare?

- Review literature on coping strategies.
- Understand the context of the training (training for action in a particular disaster or generic training for humanitarian workers).

Instructions

Step 1: Give the participants time to read the table presented.

Step 2: Discuss in plenary (or groups) the table using the guiding questions.

Step 3: Finish the session with a list of possible programmatic responses to the coping strategies/role of HIV issues identified by participants.

Handout 6a: HIV/AIDS and coping strategies

Adults go hungry, reducing food intake to the minimum.	Adults with HIV/AIDS cannot go hungry without running high health risks. Their food needs are increased.
Collection and consumption of wild foods (highly labour-intensive and wholly female activity)	Many coping strategies require specialist skills (wild food collection requires knowledge about the properties of roots, berries and grains). Typically, this knowledge is passed from mother to daughter, but AIDS may interrupt this.
Asset sales to cover immediate food needs or taking out loans	Many households have already depleted their assets (including land and rights to land) to try to provide for the sick or orphans.
Short-term wage labour or labour migration, usually for very long hours for very low pay, often payment in kind	Most coping strategies are highly labour dependent. Households that have lost one or more adults, or that are caring for AIDS patients, may lack labour to collect wild foods or work for money.
Asking better-off relatives and friends for assistance, including placing children in their care for the duration of the famine (burden shifting to the better off)	Family and kin assistance networks are already overburdened by caring for orphans and the sick. Effective coping strategies require strategic planning. Many are seasonal. This requires expertise born of experience. Without the requisite adults this expertise may be absent.
Reliance on the lowest end of the informal sector (firewood sales, commercial sexwork)	Reliance on transactional sex and crime may increase.

Source: Harvey, Paul, 2004, *HIV and AIDS and Humanitarian Action*, HPG Research Briefing, Number 14, April, ODI.

Refer to the above table adapted from Alex De Waal, Alan Whiteside (2003), New Variant Famine: AIDS and food crisis in southern Africa, The Lancet, vol 362, October 11.

1. Discuss the type of emergencies where the coping strategies and role of HIV illustrated in the table would be most likely.
2. Add any additional coping strategies and the role of HIV (from their experience).
3. Identify the coping strategies/role of HIV most likely in the emergency situation they are currently facing.
4. After identification of these coping strategies discuss how to ameliorate the role of HIV – humanitarian actions that could be taken.

Handout 6b: HIV/AIDS and coping strategies: Model answer

(Note: For use by facilitator and distributed after the session to participants)

1. **Discuss the type of emergencies where the coping strategies and role of HIV illustrated in the table would be most likely.**

Acute food shortages and famines

2. **Add any additional coping strategies and the role of HIV (from their experience).**

This will depend on the specific experience of each participant. Ensure that any newly identified coping strategies are fully discussed in the group.

3. **Identify the coping strategies/role of HIV most likely in the emergency situation they are currently facing.**

This will depend on the emergency situation faced by the participants, for example, in conflict areas coping strategies linked to sexual exploitation may be more common than in settled communities facing a drought; in some areas there may not be an option of seeking wild fruits (a typical African response) but there may be looting/stealing from shops if the disasters has happened in an urban setting (New Orleans flooding).

4. **After identification of these coping strategies discuss how to ameliorate the role of HIV -humanitarian actions that could be taken.**

Once again this will depend on the answers to the above. Examples of actions that could be taken include targeting of additional rations to households with chronically sick members (see previous exercises for more discussion around this issue); supplementary/therapeutic feeding programmes for people living with HIV/AIDS; targeted income generation that is not labour intensive; HIV/AIDS prevention information dissemination; condom distribution.

5. Case studies

The case study below illustrates some real problems faced by humanitarian workers in areas with high HIV prevalence and limited resources. There are no correct answers to the questions in these exercises. The idea of using case studies is to stimulate participants to discuss real and complex situations.

Exercise 7: Sexual harassment in Burundi

What is the learning objective?

- To be aware of the importance of pro-active measures to protect men, women and children from sexual abuse during emergencies, especially in areas of high HIV prevalence

When should this exercise be done?

- During the training to highlight specific issues that need to be addressed programmatically in humanitarian response

How long should the exercise take?

- 45 minutes

What materials are needed?

- Pens and paper
- **Handout 7a:** Sexual harassment in Burundi
- **Handout 7b:** Sexual harassment in Burundi: Model answers

What does the trainer need to prepare?

- Understand the context of the training (training for action in a particular disaster or generic training for humanitarian workers).

Instructions

Step 1: Give participants time to read the short case study.

Step 2: Discuss in plenary (or groups) the case study using the guiding questions.

Step 3: Finish the session with a list of possible programmatic responses.

Handout 7a: Sexual harassment in Burundi

Background

CARE International worked with WFP in Burundi to provide food to displaced people due to the civil conflict. As the security situation in the country improved, CARE moved from generalised regular food ration distribution to less regular targeted distributions. Implementing partners and government were tasked with selecting the beneficiaries based on mutually negotiated criteria.

A study was conducted from October 2004 to June 2005 to ascertain whether sexual relations were being used as a means to access food. The findings of the study showed that both sexual harassment and exploitation were present. The sexual harassment was carried out secretly and people did not feel in a position to challenge this openly in the community meetings. Sexual harassment was linked to people wanting to go on the lists for receiving food; perpetrators were generally those who established the beneficiary lists. Widows and women with no male members in the household were most at risk.

Discuss in plenary the following questions:

1. What may have caused the flare up of sexual harassment in the situation described above?
2. Identify the risk factors mentioned in the case study.
3. How could CARE/WFP have reduced the risk of sexual harassment?
4. What additional implications could arise from the situation described above if the programme was operating in an area of high HIV prevalence?

Given the situation described in the case study, design a targeted distribution system that would reduce the risk of sexual exploitation.

Handout 7b: Sexual harassment in Burundi: Model answers

1. What may have caused the flare up of sexual harassment in the situation described above?

The change from general to targeted distribution was probably the ignition point. Households that previously received food may no longer have been eligible based on the new criteria. This created a situation in which those who established the lists had power over other community members who wanted to confirm a place on the new distribution lists. The targeting officials could then demand sexual favours from those dependent upon their influence to receive rations.

2. Identify the risk factors illustrated in the case study.

Some of the risk factors include: using local leaders as the main people to identify beneficiaries with no checks and balances; lack of transparency in the selection criteria; lack of trust in the community that led to people feeling they could not denounce the practices; significant number of widows and unprotected women in a cultural setting where male protection is important.

3. How could CARE/WFP have reduced the risk of sexual harassment?

Reduce risk: establish selection committees with female representation; negotiate and publish selection criteria; carry out protection training for all partners including government, local partners and international staff; disseminate a zero tolerance policy for sexual abuse and enforce the policy in institutions where CARE and WFP have legitimate influence and control.

4. What additional implications could arise from the situation described above if the programme was operating in an area of high HIV prevalence?

Increased transmission rates; potential for increased social disruption if more people found themselves positive; potential for violence and unrest.

Long-term impact: higher levels of HIV prevalence; increased burden on health services; increased acute malnutrition, increased morbidity and mortality.

6. Field-based exercises

This section contains guidelines for carrying out quick assessments of critical areas of programming linked to HIV/AIDS, nutrition and humanitarian disasters.

Exercise 8: Checklists for HIV/AIDS and nutrition programming in emergencies

What is the learning objective?

- To develop a series of relevant assessment tools for key areas of HIV/AIDS and nutrition interventions in emergencies

When should this exercise be done?

- Should be conducted in real situations as part of a longer training of several days.

How long should the exercise take?

- The development of each checklist will involve:
Initial preparation 1 hour
Field work 0.5 to 1 day
Feedback 1 to 2 hours

What materials are needed?

- Transport/logistics
- Pens and paper
- **Handout 8a:** Checklists for HIV/AIDS and nutrition programming in emergencies

What does the trainer need to prepare?

- Logistical arrangements.
- Agreement/Authorization from the community or the appropriate authorities for the exercise.

Instructions

Step 1: Before going to the field, collect as much information as possible about the situation on the ground, e.g., number of people affected, location, severity of the impact of the disaster, security issues, cultural issues that may impact on work, and humanitarian response to date.

Step 2: Spend an hour preparing key questions around the subject area that will be assessed.

Step 3: Carry out the field assessment.

Step 4: Provide feedback with the whole group using the responses to the assessment.

Step 5: Prepare an action plan based on results of the assessment.

Handout 8a: Checklists for HIV/AIDS and nutrition programming in emergencies

Before going to the field

Prepare a culturally sensitive check list and methodology for carrying out the assessments.

Take into consideration (using local knowledge/experience of the practitioners):

- HIV prevalence in the area affected by the emergency
- Openness to discuss sexual matters (by gender and age group)
- Whether it is possible to discuss sex (by gender and age group). For example, in some cultures it is possible to discuss sex openly as long as it is in same-sex group; in other cultures (e.g. strict Islamic cultures) it may not be possible to discuss sex with women even when they are alone. In many cultures there are sensitivities to discussing sex with adolescent children (seen as encouraging sexual activity).
- If it is not possible to carry out discussions with the affected population it may be necessary to discuss with people working with communities or people who are knowledgeable about the situation.
- There may be sexual exploitation and this may be raised in the discussion group. Practitioners need to be prepared to face complex issues linked to sexual abuse and be aware of the codes of conduct/international laws, etc.
- Ascertain known sensitivities to HIV/AIDS (stigma and discrimination).
- If anything illegal or disturbing is discovered during this field exercise, how can this be reported and ameliorated?

Examples of a checklist of questions

Use the suggestions below as a guide; add additional questions/remove questions according to the local situation/nature of the emergency/HIV prevalence in the area.

1. Assessment of situation for HIV specific targeting

- a) What is the extent of food insecurity among the affected population?
- b) Is there an estimate of HIV prevalence in the area affected by the emergency?
- c) Will existing programmes adequately cover the needs of households affected by HIV and AIDS, including orphan headed households, elderly headed households, and households hosting orphans?
- d) Are distribution strategies sensitive to the needs of households affected by HIV/AIDS, e.g., distance to distribution points, type of rations (if food is distributed)?
- e) Are there existing programmes that specifically target people living with HIV/AIDS, for example, home based care, nutrition supplementation for people on ART or PMTCT (prevention of mother to child transmission programmes)?
 - a. Can the programmes be sustained given the type of emergency?
 - b. If yes, try to obtain an idea of the number of people that are involved in each of the programmes and the resources necessary to maintain the programmes.
 - c. If no, pass to the next set of questions.
- f) Are there ways in which people living with HIV can be identified in a non-discriminatory way, for example, voluntary counselling and testing (VCT), voluntary self-identification, and registration of all chronically sick people in the affected population?
 - If yes, identify the ways in which non-discriminatory targeting could be carried out, for example, through health centres, home based care groups, child care institutions, schools, etc.

After carrying out focus group or key informant issues on the above topics, the group of participants should compile the answers and design the best approach to targeting given the information collected (See Part 2 of this module for guidelines).

Example of possible response

Group findings: The HIV prevalence rate was an estimated 15 per cent (but there were extremely low levels of testing). There is generalised food insecurity in the area due to the emergency. There are high levels of distrust of people living with HIV/AIDS. Vulnerable groups identified by the focus groups were children and the elderly. There are no home-based care programmes caring for the chronically sick in the affected area. There are no accessible VCT facilities in the vicinity of the affected populations.

The group decided that the targeting strategy should be:

- Blanket general food rations for all households in the affected area for three months (and then review the situation).
 - Carry out an additional assessment of the households vulnerable to food insecurity based on alternate criteria (not specifically HIV affected): elderly headed households, child headed households, and households with chronically sick members.
 - Evaluate the need for additional resources to ensure that these households are able to access and utilise the blanket food rations.
 - Individually assess the chronically sick for supplementary or therapeutic feeding programmes.
 - Ensure that distribution points for food are as close as possible to the affected populations.
 - Establish a VCT facility in the area.
 - Carry out extensive sensitisation campaigns on HIV and HIV testing.
2. **Assessment of situation for infant feeding of HIV-positive mothers**
- a) Is there a PMTCT programme in place/is there a mechanism for identifying HIV-positive mothers and ascertaining the HIV status of potential wet nurses?
 - b) What are the usual breastfeeding practices in the community affected by the disaster?
 - c) Is ART available to HIV-positive pregnant and lactating women?
 - d) Questions to assess the feasibility of expressing milk/ wet nursing/artificial feeding:

Is there guaranteed and sustainable availability of:

 - Safe breast-milk substitutes
 - Potable water for reconstituting formulas
 - Fuel for sterilisation or for boiling expressed milk
 - Cups, or cups and spoons (bottles and teats are NOT recommended unless there are very good sanitation facilities)
 - Nutrition education support for women taking any of these options

Is it culturally acceptable to not breastfeed (no stigma attached to not breastfeeding)?
- d) Exclusive breastfeeding to six months, and continued breastfeeding for up to 2 years
 - Is exclusive breastfeeding practiced and understood by the community?
 - Do mothers have access to suitable complementary foods for six-month-old infants through targeted feeding programmes or are there suitable products available in the market (when there are cash transfer programmes)? This would include animal source proteins such as milk or eggs, legumes, fortified cereals, and fresh vegetables.
 - Do mothers have adequate knowledge to make weaning porridges that satisfy all nutritional requirements of the young infant up to one year of life?
 - e) Are there trained breastfeeding counsellors in the humanitarian response staff?

Provide feedback of the assessment information to the group and develop an action plan for implementation.

After carrying out focus group or key informant issues on the above topics, the group of participants should compile the answers and design the best approach to breastfeeding and infant feeding counselling in the affected area (See Module 2 for guidelines.).

Example of possible action plan for breastfeeding counselling:

The group found: Based on the findings that there is a functioning PMTCT programme in the area (therefore able to identify HIV-positive mothers). The sanitary situation is poor. There is a critical shortage of drinking water. There is considerable stigma attached to HIV. Normally breastfeeding is practised by women in the affected community. The supply of replacement food (infant formula) is unreliable (by the humanitarian agencies) and absent in the commercial network. Humanitarian agencies can guarantee supplementary feeding products.

The team decided to:

- Emphasise and support six month exclusive breastfeeding and continued breastfeeding to age 12 months and beyond for all HIV-positive mothers in PMTCT programmes, with ART supplied to the mothers.
- Establish breastfeeding corners to support (all) mothers.
- Establish complementary feeding programmes for six-month-old to two-year-old infants of all mothers.
- Within PMTCT programmes: for the HIV-positive mothers of HIV-negative infants, give special guidance on weaning and ensure access to sufficient supplementary feeding products for weaning at about 1 year.

3. Assessment of therapeutic and supplementary feeding needs of HIV-positive individuals

- Are there functioning HIV/AIDS care and treatment programmes in the area affected by the emergency (ART; control of opportunistic infections; home based care; PMTCT)?
- Are there therapeutic and supplementary feeding programmes established in the area?
- If yes, is it possible to establish voluntary testing and counselling and/or registering HIV positive patients?
- Does the staff of therapeutic and supplementary feeding programmes have sufficient experience of working with HIV-positive patients?
- Are there additional supplies of medication/therapeutic and supplementary foods to cater for longer stay patients in the programmes?

Provide the assessment information to the group and develop an action plan for implementation.

After carrying out focus group or key informant issues on the above topics, the group of participants should compile the answers and design the best approach to therapeutic and supplementary feeding programmes in the area (See Module 2 for guidelines.).

Example of an action plan for therapeutic and supplementary feeding:

Group findings: There are HIV/AIDS treatment programmes in the area with registered patients – home-based care, ART and PMTCT. A humanitarian organisation has established a therapeutic feeding centre in the area and will establish a community-based therapeutic/supplementary programme within the next seven days. Only one member of staff in the team has experience of working in HIV/AIDS. There are (at present) no shortages of therapeutic or supplementary foods.

Team recommendations: The teams of staff from the HIV/AIDS programmes and the therapeutic/supplementary feeding (TFP/SFP) programmes should collaborate in order to:

- Ensure coverage (and not duplicate coverage) of all patients in need of additional nutritional support. This should be done for all community members, regardless of known HIV status.
- Prioritise HIV-positive pregnant and lactating women to receive ART.
- Rapidly train all staff in the TFP/SFP to perform regular assessment, categorisation, and nutritional care plan implementation for HIV-positive children and for dietetic management of adolescent and adult AIDS patients.
- The home-based care programme could be considered as a way of implementing the community-based therapeutic/supplementary programmes.
- Regular meetings should be held between all support staff to monitor the supplies and implementation of the programmes.

