

# Integration of Food and Nutrition Support in Treatment Programmes

Many countries in sub-Saharan Africa, are experiencing three concurrent, mutually-reinforcing epidemics: malnutrition, HIV and active TB. In recent years, adult malnutrition has become evident due to HIV and related opportunistic infections. The proportion of HIV clients with clinical malnutrition varies widely from country to country, some reporting less than 10 percent while others as much as 30 percent. HIV-infected individuals have higher nutritional requirements, particularly energy (10-30 percent increase), with commensurate increases in protein and fat.

Today, the UN World Food Programme (WFP) is the world's largest provider of food support through care and treatment programmes. In 2009, WFP provided food assistance through programmes linked to home-based care, tuberculosis treatment and antiretroviral drug treatment (ART) to more than 1.8 million beneficiaries in 47 countries. There is a growing body of evidence demonstrating that food availability and good nutrition are essential for preventing HIV infection, for keeping people living with HIV (PLHIV) healthy for longer [1] and for improving responses to treatment.[2]

Most countries in Southern Africa are providing nutrition support using the **Food by Prescription (FBP)** approach. Food is given as a basic package of support to ART/TB/PMTCT clients. Nutrition supplements are provided to meet a clinical requirement and may take the form of either food or micronutrients that can be added to food. They can be prescribed for therapeutic or supplementary feeding purposes. Selection and discharge criteria is based on nutrition indicators such as Body Mass Index (BMI), Weight for Height, and/or Mid Upper Arm Circumference (MUAC) measurements. Two additional inter-connected components are put in place to ensure the success of a comprehensive FBP programme:

a) **Social Safety Nets** (which may include a household food ration, cash transfers or vouchers) to support clients in their efforts to adhere to treatment and protect their households from further vulnerability and possible dissolution;

b) **Livelihood Promotion**, to encourage a prompt recovery to productivity and sustain long-term adherence. FBP sites coordinate with organizations that provide income-generation or other livelihood services to ensure that clients who exit the FBP programme continue to receive needed services.

Between November 2009 and March 2010, WFP conducted a review of FBP programmes in Kenya, Malawi, Mozambique and Rwanda. Results of the review indicated that in WFP-supported areas, there is strong anecdotal evidence of

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positive impact of a *comprehensive approach*[3] on clients' nutritional status, treatment adherence, mental health and rapid return to productivity; however, empirical evidence has not yet been produced.

Rwanda's free, integrated ART is poised to achieve 2010 Universal Access, with every district offering a complete package of HIV services in at least one site.

The strong commitment of government, funders, NGOs and technical experts have combined to make this programme a success.

The nascent FBP programme operates in 77 locations. WFP provides nutrition support rations (corn-soya blend, oil and sugar) to malnourished clients on ART to improve nutritional status, and enhance treatment acceptability, adherence and effectiveness. Clients are reassessed on a monthly basis.

A standard six-month period leads to discharge unless the client's nutritional status is not yet stable.

Malawi's HIV Care and Treatment programme has benefited from tangible support at the highest levels of government and extends to the integration of nutrition and food security.

Locally-produced Ready-to-Use Therapeutic Food (RUTF) is now available at approximately 150 of the 202 government facilities offering ART. Non-profit organizations provide technical assistance, while most procurement and delivery is carried out by UNICEF.

National guidelines governing admission and discharge follow anthropometric indicators: clients with BMI <17 are enrolled, with a target BMI of 18.5 for graduation. WFP supports PMTCT and TB programmes with blanket feeding (corn-soya blend, cereals, pulses and oil) in several districts.

Health Surveillance Assistants (HSAs) record weight and height, while clinical staff (clinical officers, medical technicians or nurses) generate the actual FBP referral. HSAs also provide nutrition education and counselling, and carry out monitoring and recording.

It was also noted that there is no established system for monitoring and a lack of information about outcomes for clients on therapeutic rations, supplementation or household food assistance.

Currently, there is no consensus on a gold standard for FBP programming. Empirical evidence of the outcomes of FBP programming will only emerge as programme delivery systems strengthen, methodologies mature and data quality improves. It is important to remember that FBP is a nascent programming area with no historical context even in developed countries. *It legitimately needs time to consolidate and learn.*

1. Friis H (2006). Micronutrient intervention and HIV infection: a review of current evidence. *Tropical Medicine & International Health*, 11(12):1–9; www.who.int/nutrition/topics/Paper%20Number%202%20-%20Micronutrients.pdf
2. Paton, N., et al., The impact of malnutrition on survival and the CD4 count response in HIV-infected patients starting antiretroviral therapy. HIV Medicine, 2006(7): p. 323-330.
3. A 'comprehensive' approach is comprised of three components: Nutrition Support (Assessment, Education, Counseling and (as needed) Supplementation); Social Safety Nets (in this case, with a food basket); and Livelihood Promotion (in this case, linkages to livelihoods with concurrent food support to the household, as the family regains self-sufficiency).