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# WFP Operational Guidance on HIV/TB and Social Protection

INTERIM

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# About this guidance

## Purpose of the Operational Guidance

This document is intended to provide practical guidance for the planning, implementation and monitoring of social protection programmes that address the needs of people living with, at high risk of and affected by Human Immunodeficiency Virus (HIV) and Tuberculosis (TB).

More specifically, the purpose of this guidance is to:

- Increase understanding among WFP staff on the importance of including people living with, at high risk of and affected by HIV and TB in social protection interventions.
- Help build the skills of programme staff to appropriately and adequately address the needs of people living with, at high risk of and affected by HIV and TB when designing social protection instruments.

The broad definition of social protection suggests that most of WFP programmes can fall under this category. This guidance provides an overview on how the considered main WFP social protection instruments can be adopted and/or adjusted in the context of HIV/TB, as well as key partnerships and funding opportunities that would need to be explored to maximize the efforts.

## Audience

- The primary audience of this guidance is **WFP staff**, including but not limited to HIV/TB, Nutrition as well as Social Protection personnel, who seek to design social protection instruments that meet the needs of people living with, at risk of and affected by HIV and TB.

- In addition, this guidance may serve as a reference document for **WFP partners and other stakeholders** working in the area of HIV and TB as well as social protection including government agencies, other UN agencies, international and national non-governmental organizations (NGOs), community and faith-based organizations, people living with HIV (PLHIV) or TB networks, amongst others.

## Structure

The guidance is divided into 3 main parts:

**Part A** introduces HIV/TB as well as social protection concepts and covers the main global and corporate frameworks around these topics. This part is meant for WFP staff who want to familiarise themselves with these topics. It also provides content that can be used for developing advocacy messages and tools (Section 1, 2 and 3).

**Part B** covers the main steps required to design an in-country programme ( Section 4) and provides an overview of the different roles that WFP can cover at country office and field level, by referring to the most used social protection instruments within WFP programming (Section 5).

**Part C** introduces some key partnerships and funding opportunities that can be explored at regional and country offices for strengthening WFP role within social protection (Section 6 and 7).

Basic technical information and reference resources for more in-dept considerations and information are included throughout the document. The terminology chapter, at the top of the document, explains the most common terms related to HIV and TB context.


## Acknowledgements

This document reflects information drawn from reviews of literature and broad consultations with key WFP Nutrition Division colleagues.

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The guidance was informed by an extensive desk review and developed through consultations with a Task Force composed of WFP staff from Headquarter and Regional Bureau staff[1]: Hugo Farias, Giovanni Giordana, Lisemarie Lequere, Manaan Mumma, Deborah Wilson and Nonhlanhla Xaba.

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1 Names inserted in alphabetical order.

# Contents

# Terminology

## HIV and AIDS

**Acquired Immune Deficiency Syndrome (AIDS)** is an epidemiological definition based on clinical signs and symptoms. It is a term applied to the most advanced stages of HIV infection. There are four WHO clinical stages of HIV-related diseases; each stage is defined using clinical parameters, HIV-related opportunistic infections and associated conditions.

**Antiretroviral Therapy (ART)** uses a combination of at least three antiretroviral (ARV) drugs to maximally supress the HIV virus and slow progression of the HIV infection. Three drugs are used in order to reduce the likelihood of the virus developing resistance. ART has the potential to both reduce mortality and morbidity rates among HIV-infected people, and to improve their quality of life. Due to the availability of ART, HIV-infection has become a chronic disease rather than a "killer".

**Human Immunodeficiency Virus (HIV)** is the virus that infects CD4 lymphocyte cells of the immune system, destroying or impairing their function. As the virus destroys and impairs the function of immune cells, infected individuals gradually become immune deficient. Immunodeficiency results in increased susceptibility to a wide range of infections and diseases that people with healthy immune systems can fight off.

**Prevention of Mother-to-Child Transmission of HIV (PMTCT)**, also known as prevention of vertical transmission, refers to interventions to prevent transmission of HIV from a mother living with HIV to her infant during pregnancy, labour and delivery, or during breastfeeding.

## Tuberculosis (TB)

**Directly Observed Treatment Short-course (DOTS)** is the internationally recommended approach to TB control, which forms the core of the Stop TB Strategy. The five components of DOTS are (i) political commitment with increased and sustained financing, (ii) early case detection through quality-assured bacteriology, (iii) standardized treatment with direct supervision and patient support, often by a family member (iv) an effective drug supply and management system and (v) monitoring and evaluation system, and impact measurement. DOTS lasts 6-9 months.

**Extensive Drug-Resistant Tuberculosis (XDR-TB)** is a rare type of multidrug-resistant tuberculosis (MDR TB) that is resistant to isoniazid and rifampin, plus any fluoroquinolone and at least one of three injectable second-line drugs (i.e., amikacin, kanamycin, or capreomycin).

**Multidrug-Resistant Tuberculosis (MDR-TB)** is caused by an organism that is resistant to at least isoniazid and rifampin, the two most potent TB drugs. These drugs are used to treat all persons with TB disease.

**Tuberculosis (TB)** is caused by bacteria (Mycobacterium Tuberculosis) that most commonly affect the lungs. TB is a treatable and curable disease. The bcetaria is transmitted through the air from person to person by people with active respiratory disease. About one-third of the world's population has latent TB, which means people have been infected by TB bacteria but are not (yet) ill with disease and cannot transmit the disease. The lifetime risk of reactivation for a person with documented latent TB infection (LTBI) is estimated to be 5-10 percent. However, persons with compromised immune systems, such as people living with HIV, malnutrition or diabetes, or people who use tobacco, have a much higher risk of falling ill. TB is the leading HIV-associated opportunist infection in low- and middle- income countries and is a leading cause of death among people living with HIV globally.

**TB-cured** refers to a patient who was initially smear-positive and who was smear-negative in the last month of treatment and on at least one previous occasion.

**TB-completed treatment** refers to a patient who has completed treatment but has not been confirmed to meet the criteria for either cure or failure. This definition applies to patients that at the start of treatment were pulmonary positive and smear-negative patients and to patients with extrapulmonary disease.

**TB-failed** refers to a patient who was initially smear-positive and who remained smear-positive at month 5 or later during treatment.

## Treatment

**Adherence** is the "extent to which a client's behaviour coincides with the prescribed health care regimen as agreed through a shared decision-making process between the client and the health care provider" (KITSO Manual, 2004; Carter, 2004). The ability to keep to this pattern of utilization is defined as 100 percent adherence, while adherence of >95 percent is accepted as optimal adherence.

**Treatment default** is an interruption of treatment for 2 or more consecutive months during the intended treatment period. The precise number of 'missed medical visits' used to define default varies across countries. For WFP programming, default usually occurs when the clients have missed the second consecutive scheduled medical visit (usually monthly).

## Food & Nutrition

**Acute malnutrition**, also known as wasting, develops as a result of recent rapid weight loss or failure to gain weight. The degree of acute malnutrition of an individual is classified as either moderate acute malnutrition (MAM) or severe acute malnutrition (SAM) according to specific cut-offs and reference standard.

**Food basket** refers to the selection of food commodities provided by an aid agency and included in the rations distributed to the target beneficiaries

**Food security**, as defined by the World Food Summit of 1996, exists "when all people at all times have access to sufficient, safe, nutritious food to maintain a healthy and active life". Food security analysts look at the combination of the following three main dimensions:

1. **Food access**: access by individuals to adequate resources (entitlements) for acquiring appropriate foods for a nutritious diet. Entitlements are defined as the set of all commodity bundles over which a person can establish command given the legal, political, economic and social arrangements of the community in which they live (including traditional rights such as access to common resources).
2. **Food availability**: the availability of sufficient quantities of food of appropriate quality, supplied through domestic production or imports (including food aid).
3. **Food utilization**: utilization of food through adequate diet, clean water, sanitation and health care to reach a state of nutritional well-being where all physiological needs are met. This brings out the importance of non-food inputs in food security.
4. **Food stability:** to be food secure, a population, household or individual must have access to adequate food at all times. They should not risk losing access to food as a consequence of sudden shocks (e.g., an economic or climatic crisis) or cyclical events (e.g. seasonal food insecurity).

**Malnutrition** refers to deficiencies, excesses, or imbalances in a person's intake of energy and/or nutrients to maintain growth, immunity and organ function. Malnutrition is a general term and covers both undernutrition and overnutrition (overweight/obesity). In this document, the term "malnutrition" is normally used to refer to undernutrition.

**Specialized Nutritious Food (SNF)** refers to the range of specialized food products and supplements that provide varying levels of energy, micronutrients, and macronutrients necessary for growth and health, specifically formulated for the prevention or treatment of undernutrition. Specialized nutritious foods are often defined or categorized as follows: Lipid-based Nutrient Supplements (LNS) and Fortified Blended Foods (FBF). LNS includes Ready to Use Therapeutic or Ready to use Supplementary Foods (RUTF and RUSF).

**Undernutrition** denotes insufficient intake of energy and nutrients to meet an individual's needs to maintain good health. It is the consequence of an insufficient intake of energy, protein and/or micronutrients, poor absorption or rapid loss of nutrients due to illness or increased energy expenditure. Undernutrition encompasses low birth weight, stunting, wasting, underweight and micronutrient deficiencies.

## Others

**Inclusive** refers to a consistent and systematic approach to the equitable access, inclusion and integration of people with diverse and often intersecting economic, social and geographical vulnerabilities and inequalities. Inclusiveness is imperative in order to achieve the SDGs -leaving no-one behind.

**Fill the Nutrient Gap** is a nutrition situation analysis to identify vulnerable populations' barriers to adequate nutrient intake[2].

**Orphans and Vulnerable Children (OVC)**, there is no universal definition but varies across countries. In the international community, the term OVC sometimes refers only to children with increased vulnerabilities because of HIV/AIDS. At other times, OVC refers to all vulnerable children, regardless of the cause – incorporating children who are the victims of chronic poverty, armed conflict, or famine. Since this guide focuses on vulnerabilities due to HIV/AIDS, the definition of orphans and vulnerable are as follows:

- **Orphan** is a child aged 0-17 years whose mother or father or both are dead due to HIV/AIDS.
- **Vulnerable child** refers to a person under the age of 18 years who is made vulnerable by HIV. For example, is HIV-positive; lives without adequate adult support (e.g., in a household with chronically ill parents, a household that has experienced a recent death from chronic illness, single-headed or child headed household); lives outside of family care (e.g., in residential care or on the streets); it can also refer to a child who is marginalized, stigmatized, or discriminated against.

**Social determinants** are the economic and social inequalities that influence the health of individuals and communities

**Social protection** is a set of policies and programmes aimed at preventing, and protecting people against, poverty, vulnerability and social exclusion throughout their life with a particular emphasis on vulnerable groups. These typically cover a range of cash and/or in-kind transfers; they may also include some fee waivers, active labour market schemes, targeted subsidies and/or social care services.

2 https://www.wfp.org/publications/2020-fill-nutrient-gap

# Part A

Familiarize yourself
with the main topics

# 1 Introduction

Advances in HIV/TB treatment and pioneering public health strategies have yielded remarkable successes in the global fight against HIV and TB. However, to ensure that individuals will be able to reap the benefits of today's potent biomedical tools, it is paramount to address social and economic challenges that persist for those living with, affected by and at high risk of HIV/TB.

**AIDS** was first recognized as a new disease in 1981 when increasing numbers of young homosexual men succumbed to unusual opportunistic infections and rare malignancies[3]. A retrovirus, now termed human immunodeficiency virus type 1 (HIV-1), was subsequently identified as the causative agent of what has since become one of the most devastating infectious diseases to have emerged in recent history. HIV continues to be a global public health issue.

Key population groups[4] and their sexual partners amongst the age group 15-49 years account for most of all new infections globally. In addition, given their life circumstances, a range of other populations may be particularly vulnerable, and at increased risk of HIV infection, such as adolescent girls and young women in Sub-Saharan Africa and indigenous people in some communities. In some countries in the Southern Africa region up to one third of pregnant women living with HIV are in the age group 15 to 24 years[5]. The transmission of HIV from a HIV-positive mother to her child during pregnancy, labour, delivery or breastfeeding is called mother-to-child transmission. In the absence of any intervention, transmission rates range from 15 percent to 45 percent[6]. Progress in reducing mother-to-child transmission of HIV has been significant largely because of increased access to Prevention Mother to Child Transmission (PMTCT)-related services and the increased number of pregnant women living with HIV accessing lifelong antiretroviral medicines. PMTCT interventions can reduce this risk to below 5 percent. However, gaps along the continuum of services for the PMTCT in Western and Central Africa are leaving still a lot of children exposed to HIV, mainly due to low coverage of ARV among pregnant women.

There is no cure for HIV yet, however, thanks to the advent of HIV treatment, HIV/AIDS has shifted to a chronic, largely manageable condition. Whereas someone who acquired HIV in the pre-treatment era could expect to live only 12.5 years, a young person in industrialized countries who becomes infected today can expect to live a near normal lifespan with the use of lifelong HIV treatment[7]. Consequently individuals are experiencing being HIV positive across a large spectrum of the life cycle; people are facing different challenges, including age-related ones (e.g., more likely to have comorbidities and they also develop geriatric symptoms and frailty earlier) which are reported to be more frequent in people living with PLHIV than in general population.

Late diagnosis of HIV remains the most substantial barrier to scaling up HIV treatment and it contributes to HIV transmission. Many people delay testing because they fear the discrimination that may follow. Despite progress in promoting knowledge of HIV status, almost 20 percent of people living with HIV are unaware of their status[8].

**Tuberculosis (TB)** is caused by bacteria (Mycobacterium tuberculosis) that typically affects the lungs. TB is spread from person to person through the air. It is a curable and preventable disease. TB is a top infectious disease and one of the top ten causes of death and is the leading cause of death among people living with HIV. TB infection does not always result in active TB disease. Many people who have latent TB infection never develop TB disease. In these people, the TB bacteria remain inactive for a lifetime without causing disease. But in other people, especially people who have a weak immune system, the bacteria become active, multiply, and cause TB disease. With a timely diagnosis and treatment with first-line antibiotics for a period of 6 months, most people who develop TB can be cured and onward transmission of infection curtailed. Drug-resistant TB (including rifampicin-resistant TB, multidrug-resistant TB and Extensively drug resistant tuberculosis), continues to be a public health threat. Two reasons why multidrug resistance continues to emerge, and spread are mismanagement of TB treatment and person-to-person transmission. Most people with TB are cured by a strictly followed, 6-month drug regimen that is provided to patients with support and supervision. Inappropriate or incorrect use of antimicrobial drugs, or use of ineffective formulations of drugs (such as use of single drugs, poor quality

3 Greene WC 2007. A history of AIDS: Looking back to see ahead. Eur J Immunol 37 Suppl. 1: S94–S102
4 WHO defines key populations as people in populations who are at increased HIV risk in all countries and regions. Key populations include: men who have sex with men; people who inject drugs; people in prisons and other closed settings; sex workers and their clients; and transgender people.
5 UNAIDS 2020 data
6 WHO Mother to child transmission
7 UNAIDS. Ambitious treatment targets: writing the final chapter of the AIDS pandemic https://www.who.int/teams/global-hiv-hepatitis-and-stis-programmes/hiv/prevention/mother-to-child-transmission-of-hiv
8 UNAIDS 2020 data

medicines or bad storage conditions), and premature treatment interruption can cause drug resistance, which can then be transmitted, especially in crowded settings such as prisons and hospitals[9]. Historically, TB has been considered the archetypal disease of poverty[10].

## HIV within the WFP agenda

The World Food Programme (WFP), as a UNAIDS co-sponsor, shares the vision of zero new infections, zero AIDS-related discrimination and zero AIDS-related deaths by 2030 and it aligned with the 95-95-95 testing, treatment and viral suppression targets[11]. Attaining these targets would put the world on course to ending the AIDS epidemic as a public health threat by 2030.

WFP, under the UNAIDS Division of Labour, co-leads with the International Labour Organization (ILO) on HIV sensitive social protection and works with partners and national government on strengthening national social and child protection systems to ensure that people living with, at risk of or affected by HIV benefit from social protection schemes. WFP and the ILO collaboratively lead this work through the Inter-Agency Task Team (IATT) on Social Protection, through continuous engagements and advocacy at global level, to ensure that HIV/TB are discussed and integrated in all relevant platforms. WFP also convenes the IATT on HIV in Emergencies, together with UNHCR, to ensure that the needs of PLHIV and their families are addressed in humanitarian crisis.

9 Kwonjune J Seung et al. Multidrug-Resistant Tuberculosis and Extensively Drug-Resistant Tuberculosis
10 WHO, Equity, social determinants and public health programmes
11 There is a global consensus that by ensuring that 95 percent of people living with HIV know their HIV status and by offering HIV treatment to 95 percent of people who know their HIV status, 90 percent of people on HIV treatment can achieve undetectable levels of HIV in their body (known as viral suppression) by 2030. https://www.unaids.org/sites/default/files/media_asset/fast-track-commitments_en.pdf

# 2 Understanding social protection in the context of HIV and TB

## 2.1. Social determinants in the context of HIV/TB

People have different needs, preferences and capacities, and face different risks, opportunities and disadvantages deriving from their unique social, economic and geographical circumstances. It is at intersections of multiple inequalities that the most vulnerable individuals lie, as unique vulnerabilities arise and compound - the most marginalised, continued to be the most left behind (**BOX 1**).

Many factors in our society, including poverty, physical and sexual abuse, lack of education, homelessness, stigma, discrimination, addiction, violence, untreated mental health problems, lack of employment opportunities, gender and age inequalities, lack of empowerment, lack of choice, lack of legal resident status and lack of social support, are known to be a driving force of health inequalities. These constraints, often referred to as social determinants of health (SDH), are economic and social inequalities that influence the health of individuals and communities. They can determine the extent to which a person possesses the physical, social, and personal resources to identify and achieve their goals, satisfy needs, cope with the environment, and achieve optimal health[12]. They shape the environments that facilitate or impede person's ability to protect themselves from illness, and if sick, their access to quality healthcare.

Even in high income countries, social determinants, are known to be a driving force of health inequalities and therefore can limit the access to testing, treatment, and retention in care and, consequently, reduce survival of people living with HIV (PLHIV) and/or with TB.

Social determinants influence the four stages of HIV and TB pathogenesis:

- **Exposure to infection** — for example, poor ventilation and overcrowding in homes, workplaces, and communities increase the likelihood of uninfected individuals being exposed to TB infection. Poverty is associated with poor access to general health knowledge and a lack of resource to act on health knowledge, which leads to increased exposure to HIV/TB.
- **Progression to disease** — for example, poverty, malnutrition, and hunger may increase susceptibility to HIV and TB infection, disease, and severity of the clinical outcome.
- **Late or inappropriate diagnosis and treatment** — for example, individuals with HIV and TB symptoms often face significant social and economic barriers that delay their contact with health systems in which an appropriate and timely diagnosis might be made. Barriers may include difficulties in transport to health facilities, fear of stigmatization if they seek HIV or TB diagnosis, and lack of social support to seek care when they fall sick[13].
- **Poor treatment adherence and success** — for example, lack of financial resources and food insecurity, HIV/TB can push people and households into poverty, by reducing household labour capacity and by increasing medical expenses. It is important to highlight that HIV and/or TB epidemics are a threat to the economic situation of not only the individual but also to the whole households, immediate and extended.

12 Hazel D, et al. Integrating a Social determinants of Health approach into Public health practice: a Five-year perspective of Actions implemented by CDC's National Center for HIV/AIDS, Viral hepatitis, STD and TB prevention.
13 James R. Hargreaves, et al. The Social Determinants of Tuberculosis: From Evidence to Action.

**BOX 1**

### Need, risk, inequality and vulnerability profile of people living with and affected by HIV/TB

- Essential needs that must be met so that people living with and affected by HIV/TB to have a basic social and economic security. These include health, food, nutrition, literacy, shelter, clothing, employment and security.
- Risks, which include shocks and stressors, such as market failures and many natural disasters such as drought, floods as well as armed conflict or other emergency situation. In the absence of appropriate measures, the HIV/TB epidemic may result in chronic or persistent poverty: people affected by HIV/TB may suffer from several overlapping and mutually reinforcing shocks that prevent them from building resilience to be able to better manage future risks with fewer negative impacts.
- Intersectional inequalities that interact and often compound one another at different lifetime stages of people living with and affected by HIV/TB which include economic status, ethnicity, citizenship, refuges or migration status, language, disabilities, health status, gender, age, locations (urban/rural), amongst others.
- Vulnerabilities, social and economic inequalities, including poverty, food insecurity, and malnutrition as well as stigma and discrimination drive the HIV/TB epidemic. They can both increase vulnerability to HIV/TB exposure and infection and undermine treatment for those infected. In turn HIV/TB themselves can have a negative socioeconomic impact, reducing work capacity and productive, and endangering household livelihood .

More information can be found in the WFP Social Protection Strategy (page 39)

## 2.2. Nutrition and food considerations

The linkages between HIV, TB and malnutrition are numerous and form a vicious cycle.

Undernutrition can both contribute to and result from the progression of HIV. Adequate nutritional status supports immunity and physical performance. A person who is undernourished and then acquires HIV is more likely to progress faster to AIDS than a person who has good nutritional status, because their body is already weak and cannot fight the infection: they are particularly vulnerable if not on ART. At the same time, PLHIV are more at risk of undernutrition as result of reduced food intake (due to loss of appetite, mouth ulcers, food insecurity), malabsorption, altered metabolism, as well as their increased susceptibility to chronic infections and illnesses. The relationship between TB and nutrition is also bidirectional: having active TB leads to loss of weight and being underweight is a known risk factor for developing tuberculosis or the development of progressive primary disease upon infection[14].

Since the introduction of ART and more effective treatment for HIV and AIDS, PLHIV are living longer and healthier lives. Among individuals on suppressive ART, wasting (low weight for height) has become less common, however metabolic complications related to the complex effects of viral and immune-mediated mechanisms are now a concern for PLHIV[15].Trends in overweight and obesity (overnutrition) in PLHIV are beginning to mirror those observed in the general population, particularly in contexts where ART coverage is high. Overweight and obesity further exacerbates the risk of Non-Communicable Diseases (NCDs), including cardiometabolic conditions such as type 2 diabetes (T2DM) and cardiovascular disease (CVD), in addition to premature mortality.

14 Yung-Feng Yen, at al. Underweight increases the risk of early death in tuberculosis patients.
15 Mechanisms relating to adipose dysfunction and fibrosis, immune function, inflammation, and gastrointestinal integrity

**Energy intake:**

- an 10 percent increase in energy intake is recommended during asymptomatic HIV infection. An increase in energy intake by 20–30 percent is recommended during symptomatic infection and shortly after it (during the recovery period);
- in children living with HIV, recommendations are for an increase of 10 percent more energy if asymptomatic, 20–30 percent more energy if they have opportunistic infections and 50–100 percent more energy during and after episodes of severe acute malnutrition to recover lost weight.

Energy requirements of PLHIV on antiretroviral therapy are not well known and are likely to vary according to the clinical condition. However, they are very unlikely to be lower than that for people without HIV infection or to be higher than during symptomatic infection. Monitoring weight is the best way to determine whether an individual is meeting their energy needs. It is important to note that certain life stages have increased recommended energy intakes that need to be added to the increased requirement due to HIV infection. Active TB, like other infectious diseases, is likely to increase energy requirement. Data on the actual level of increase in energy requirements caused by HIV infection may be used as a guide for those with active TB.

**Protein intake:** The recommended percentage of energy intake from protein is the same for PLHIV and people with active TB as for general population (10–12 percent of total energy intake). However, when energy intake is increased, the total amount of protein should also be higher for PLHIV and people with active TB.

**Fat intake:** Recommendations for fat intake are the same as for the general population, with: 15-30 percent of energy intake provided from fat.

**Micronutrient intake:** there is currently no definitive evidence on whether PLHIV and people with TB should increase (or reduce) their micronutrient intake. WHO recommends ensuring intake of 1 recommended nutrient intake (RNI) of each required micronutrient, per day[16].

**Infant Young Child Feeding:** For mothers living with HIV, combining anti-retroviral (ARV) interventions with breastfeeding can significantly reduce postnatal HIV transmission. Therefore, mothers living with HIV should be prioritized for access to ARV treatment and informed of the risks of not breastfeeding and the benefits of breastfeeding, within the context of HIV[17]. This means that the recommended breastfeeding practices for mothers living with HIV are linked to her access to ARV treatment as well as the risks of not breastfeeding. Staff will therefore have to assess what treatment and care for pregnant women is available, whether adequate prophylaxis for the child are available at birth, what post-delivery treatment is available for the mother (for life) and therefore what support will be needed to accompany her choices in terms of feeding her child. Regarding TB, breastfeeding is recommended, irrespective of the TB status of the mother; the risk of TB transmission through breast milk is negligible and, although the most commonly used anti-TB drugs are excreted into breast milk in small amounts, there is no evidence that this induces drug resistance or in any other way harms the child. Separation from a TB positive mother is not advised, especially in resource-limited settings where establishing breastfeeding and the mother-child bond can be critical for child survival[18].

16 Saskia de Pee, Richard D Semba. Role of nutrition in HIV infection: review of evidence for more effective programming in resource- limited settings
17 WHO | Infant feeding for the prevention of mother-to-child transmission of HIV
18 Guidance for national tuberculosis programmes on the management of tuberculosis in children (Second edition)

**BOX 2**

## Special eating needs for people living with HIV and TB

**A person who is living with HIV and/or TB and is not showing signs of illness** does not need a specific diet. However, they should make every effort to adopt good dietary practices, which include the consumption of diversified foods from across the food groups, such as:

- stable foods, such as cereals, starchy roots and starchy fruit with every meal to supply energy and protein;
- legumes, animal and milk products, if possible, regularly to supply good quality of proteins, vitamins, minerals;
- vegetable and fruit, in particular yellow, orange and dark green vegetable and fruit which are good source of vitamins; and
- drink plenty of clean and safe water. Avoid drinking tea or coffee when also eating food, as they reduce the absorption of iron contained in the foods.

**When people living with HV and/or with TB become ill** they may face challenges to maintaining an adequate nutritional status, such as:

**Reduced food intake**, because of:

- the illness and the medicines taken may reduce the appetite, modify the taste of the foods;
- symptoms such as mouth-sores, nausea and vomiting may make it difficult to eat;
- tiredness, isolation and depression may reduce their appetite and wiliness to make an effort to prepare food and eat regularly, and
- lack of money may reduce their ability to buy enough or nutrient-rich food.

**Reduced absorption of food** - one of the consequences of HIV and other infections is that the gut wall is damaged, therefore, food does not pass through properly and is consequently not absorbed. Diarrhoea is a common occurrence in people living with HIV and/or with TB. When a person has diarrhoea the food passes through the gut so quickly that it is not properly digested, and nutrients absorption is reduced.

**General recommendations to cope with these complications:**

- drink plenty of fluids, particularly potable water and soups;
- eat soft, mashed and moist food such as porridge from cereals, potato, vegetables, banana etc to help rehydrate the body and provide salts, energy and vitamins. These can be particularly important to support food intake when suffering from diarrhoea or vomiting;
- east small and frequent meals;
- avoid foods high in fat/oil and sugar in case of diarrhoea and vomiting: and
- avoid spicy, salty food or sweets foods (such as honey, sugar etc) when suffering from oral thrush.

For more information, refer to:

- Guidance note, nutrition assessment, counselling and support for adolescents and adults living with HIV, 2014
- Nutrient requirements for people living with HIV/AIDS. Geneva: World Health Organization; 2003
- World Health Organization, Food and Agriculture Organization of the United Nations. Living well with HIV/AIDS. Rome: Food and Agriculture Organization of the United Nations; 2002
- SPHERE Handbook, 2018 edition

## 2.3. What is Social Protection?

Social protection is defined as "a set of policies and programmes aimed at preventing, and protecting people against, poverty, vulnerability and social exclusion throughout their life with a particular emphasis on vulnerable groups". This is interagency definition adopted by WFP and linked to the Social protection Inter-agency Cooperating Board (SPIAC-B) is unpacked in the WFP social protection strategy.

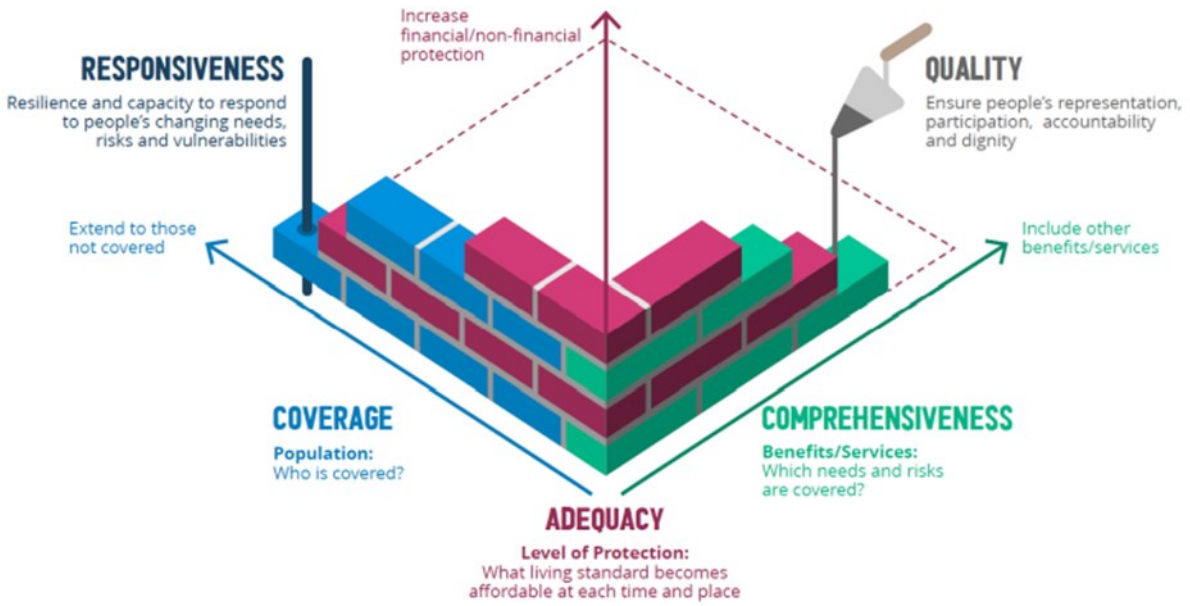
The progressive realization of universal social protection at the country level means building national social protection systems in a way that enhances their:

- **Coverage,** so everyone can access social protection when they need it
- **Adequacy,** ensuring the rights type and level of support to achieve aims
- **Comprehensiveness,** providing protection for a wide range of risks
- **Quality,** such as transparency and inclusiveness in programme targeting; timeliness, reliability and accessibility of benefits; the respect of dignity, privacy and accountability; sustainable long-term funding; and flexibility in the overall system
- **Responsiveness**, agile social protection design and implementation in the face of changing needs.

Improvements in these five dimensions will allow to better meet people's essential needs and address the risks and shocks they face throughout their lives.

Social protection continues to be conceptualised by many development agencies more as "economic protection" (for example social transfer). In reality, strategies to deal with problems of social vulnerability and intersecting inequalities require a transformative element, where 'transformative' refers to the need to pursue policies that integrate individuals equally into society as well as intra-household division of resource ownership, access and use.

***Figure 1:*** *The five dimensions for the realization of the universal social protection*



Social protection can:

- **Prevent** shocks from pulling people into levels of deprivation deemed socially unacceptable. These social protection schemes can include social insurance such as pensions, health insurance, maternity benefits and unemployment benefits, for 'economically vulnerable groups' – people who have fallen, or might fall, into poverty, and may need support to help them manage their livelihood shocks. They also include WFP microinsurance scheme for example to manage climate risks, such as those in the context of agriculture production.
- **Protect** those who cannot provide for themselves. They help meet the needs of those who are poor, disadvantaged or in a vulnerable situation, or who have no other means of support. They are narrowly targeted safety net measures and include social assistance for the chronic poor, especially those who are unable to work and earn their livelihood. These include WFP conditional or unconditional resource transfers (GFA).
- **Promote** wellbeing, livelihood opportunities and/or human capital development and help people move out of poverty. Examples include micro-credit invested in small enterprises, or public works projects that transfer food rations or cash wages while simultaneously building economic infrastructure such as roads or irrigation. Elements of WFP Food for Assets (FFA) as well as income generating activities can be classified as such.
- **Transform** the socio-normative power structures that create and perpetuate vulnerabilities, limiting people's ability to escape from the various form of poverty. Transformative interventions include collective action for workers' rights, changes to the regulatory framework to protect 'socially vulnerable groups' (for example, people with disabilities, or victims of domestic violence) against abuse, as well as sensitization campaigns and advocacy to promote social equity.

It is important to highlight that certain social protection measures have the potential to contribute to different objectives simultaneously and/or indirectly, supporting more than one of the categories described above. A school feeding programme, for example, might tackle immediate consumption needs (protection) while encouraging school attendance which may promote children's human capital development (promotion).

Naturally, one programme cannot fully achieve all these objectives for everyone. For example, activities may enhance some people's resilience to adverse circumstances by enabling them to be self-reliant; yet for other people in situations of the greatest vulnerability self-reliance may still not be achieved, and resilience may be enhanced by being in receipt of protective, long-term social assistance, even throughout their lives. It is therefore important that social protection systems incorporate a comprehensive range of programmes.

**BOX 3**

## What counts as Social Protection Programme for WFP

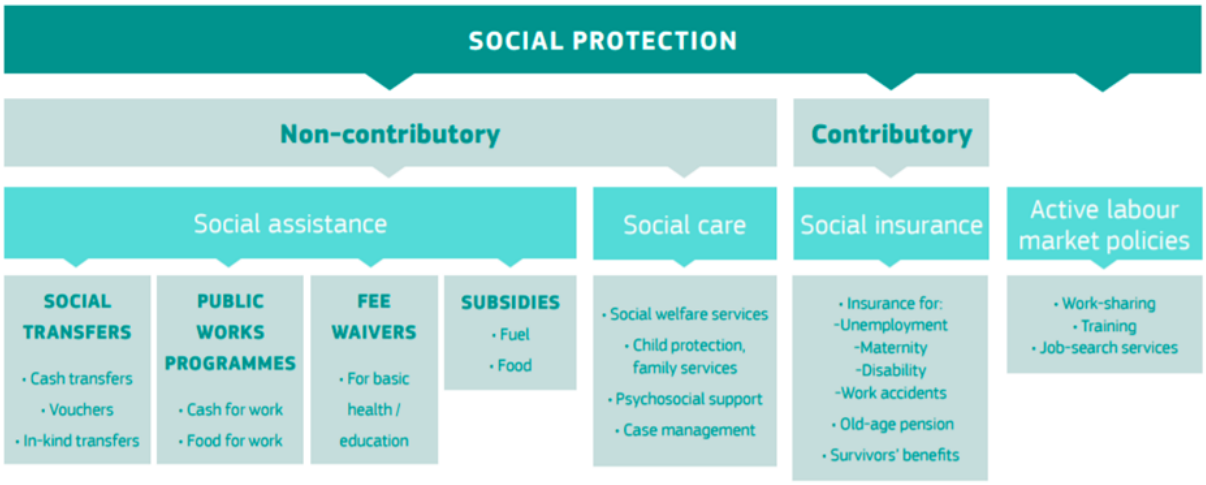
WFP values, and will work to support, all four functions mentioned above: each offers a different route to enable people to meet their needs and manage risks, and to address inequalities.

For WFP, the type of programme that count as social protection are government-owned.

WFP particular expertise is in supporting the strengthening of cash assistance (including vouchers) and food transfers, including general food distribution, school feeding programmes, asset creation programmes and programmes with a nutritional component. We also support livelihoods programmes and work with some kinds of social insurance, notably weather-indexed crop and livestock social insurance. WFP also sometimes supports other types of social protection programme when required and appropriate for meeting food security and nutrition needs, or in contexts exposed to risks and shocks and stressors.

A sustainable social protection system should combine contributory and non-contributory schemes. With contributory instruments, people or households pay into the scheme. With non-contributory instruments, people or households do not pay into the scheme and they are offered with a minimum income.

***Figure 2:*** *Non– contributory and contributory social protection*




Social protection activity can be classified as follows:

- **Social assistance**: non-contributory resource transfers to households or individuals. These might take the form of social transfers, public works and asset creation programmes, fee waivers, typically for essential services like health or education; targeted subsidies, such as for the purchase of food items.
- **Social care**: interventions to support people facing vulnerability or deprivation, that aren't resource transfers. Examples include child protection services, family support services, and domiciliary care.
- **Social insurance**: contributory social security, i.e. you pay in to be eligible to get something back. Examples include contributory pensions, formal unemployment benefits, disability allowance, and crop or livestock insurance.

Some organisations also count **active labour market** policies (such as work-sharing, training and job-search services) that promote job opportunities for the poorest or most vulnerable

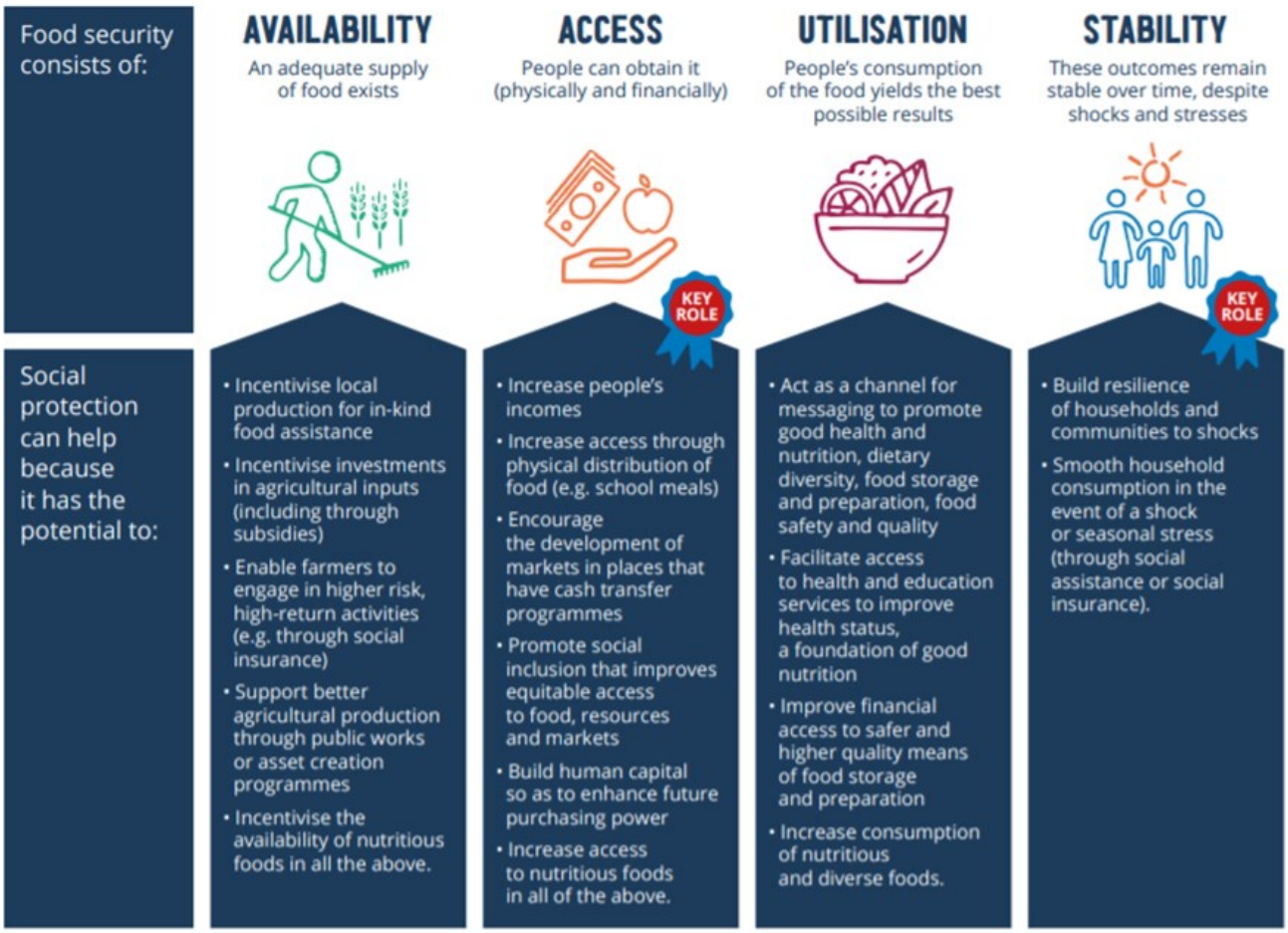
### 2.3.1. The relevance of social protection for food security and nutrition

Social protection is a key policy instruments for governments to make a positive impact on food security and nutrition through a range of entry points.

Improving the 'access' and 'stability' elements of food security is intrinsic to social protection, given its purpose of enhancing households' economic capacities (one way of improving access) and smoothing consumption during times of disruption (providing stability). Food availability may be improved through closer linkages with activities that strengthen food systems. Improving food utilisation, such as through better access to health services and nutritious food, has positive repercussions for nutrition, in particular.

When social protection programmes achieve their core aims of addressing poverty, vulnerability and social exclusion, they may also help food security and nutrition outcomes. However, such success is not guaranteed. Especially with respect to nutrition, social protection tends to be more effective when nutrition goals are pursued deliberately in programme design and implementation, in all aspects ranging from the choice of recipient to the value, modality and duration of a transfer, to ensuring that social protection does not inadvertently contribute to malnutrition by increasing access to unhealthy food.

***Figure 3:*** *How social protection can enhance food security and nutrition*




### 2.3.2. The relevance of social protection in the context of HIV and TB

Poverty and vulnerability compounded by chronic diseases like HIV or TB are impacted by multi-generational deprivation. It is important that social protection in the context of HIV/TB is informed by an understanding of the multiple and often intersecting vulnerabilities and risks faced along the life-cycle.

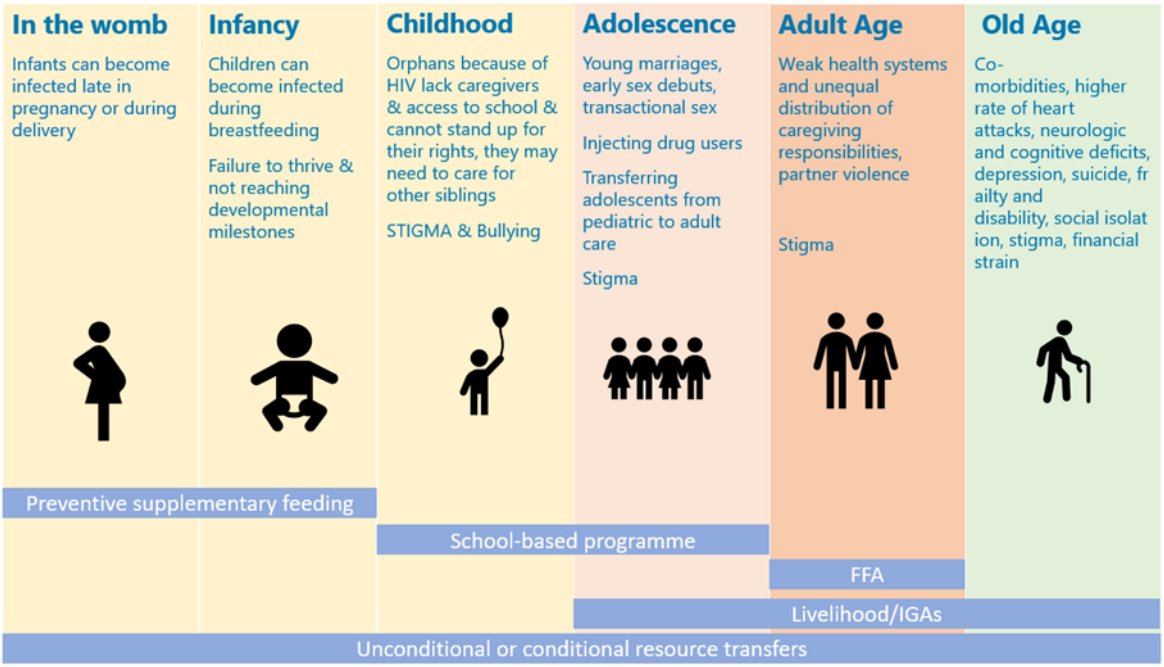
**The global AIDS response** has increasingly recognized the importance to move beyond a traditional "bio-medical" approach (with treatment as the main response) to embrace a broader "social" model (efforts to understand and address what social and cultural factors produce HIV vulnerability and risk and, hence, what constitutes effective prevention and treatment programmes).

Social protection is recognized as a critical and essential element of the AIDS response. It has the power to address the social economic drivers of the AIDS epidemic and to break down barriers people face to accessing HIV services. Social protection can reduce age, gender and income inequalities and social exclusion, all of which increase the risk of contracting HIV. Moreover, HIV programmes and social protection schemes interact positively around several targets of Sustainable Development Goals (SDGs)[19]. These links highlight the many opportunities that exist for combining interventions aimed at improving HIV, social protection and broader development outcomes[20].

19 SDG 1, 2, 3, 4, 5, 6, 8, 10, 11, 16 and 17
20 Social Protection: A fast track commitment to end AIDS- UNAIDS 2018

The figure below shows some of the age and gender specific vulnerabilities related to HIV. It also summarizes when WFP's social protection instruments can provide coverage at specific stages across the life cycle.

***Figure 4:*** *WFP Social protection instruments across the lifecycle to address age related vulnerabilities related to HIV*




WHO's End TB Strategy has identified social protection as a critical element of the global response to TB 21. Social protection interventions can contribute to TB prevention, care and support response either indirectly by influencing the social determinants of the epidemic (such as household / individual living conditions or food security), or directly through cost mitigation and promoting health-seeking behaviours relevant for TB (i.e. TB testing and preventive therapy among household TB contacts, TB treatment access, successful treatment outcomes with prolonged cure, BCG vaccination in children).

### 2.3.3. HIV/TB– sensitive and HIV/TB specific social protection

Supporting scaled-up action on HIV/TB and social protection is both the right thing to do to improve global health and development, and a smart investment to generate efficiency and effectiveness of the HIV response.[21]

To contribute to the HIV/TB response, social protection schemes should account for the needs of (for example cater for the "extra needs" of an individual and household) and be accessible by people living with, at risk of or affected by HIV and/or TB. There are two main approaches to effective HIV/TB and social protection programming (refer also to **Annex 2** for more information):

- **HIV/TB-sensitive social protection** (sometimes also defined as "inclusive") includes, but not exclusively focuses on, people who are living with, at risk of or are susceptible to the consequences of HIV/TB infection. The term "HIV/TB-sensitive" also refers to the degree to which people living with, at risk of or affected by HIV/TB are considered and included in the design and implementation of social protection schemes and systems. The degree of sensitivity in social protection programming can vary from no sensitivity to full sensitivity. Promoting HIV/TB-sensitive social protection entails using programmes designed for broad population groups (such as employees, the military, orphans and other vulnerable children, households with an income below the national poverty threshold, youth, girls and women, pregnant and lactating women, people with disabilities and elderly people) to overcome the legal, policy and social barriers and knowledge gaps that would otherwise leave behind people living with, at risk of or affected by HIV/TB.

21 HIV and spcial protection assessment tool UNAIDS 2017

Social Protection policy needs to explicitly recognise the very poor at risk or suffering from chronic disease and actively encourage measures to be inclusive of this group. HIV-sensitive social protection is the preferred approach, as this avoids stigmatization that exclusively focusing on HIV/TB may promote.

- **HIV/TB-sensitive social protection** are those programmes that focus exclusively on people living with, at risk of and affected by HIV/TB. They may risk stigmatizing individuals and if not adequately designed, they can create inequalities for individuals who are vulnerable due to other causes. However, they may be necessary in contexts where reforming social protection programmes is too slow, inefficient or politically difficult to meet the needs of people living with, at risk of or affected by HIV/TB. They can also be used to address pockets of vulnerability and neglect[22]. Examples include the targeted provision of free HIV/TB services and financial incentives to encourage individuals to access HIV services, or cash refunds to address the opportunity costs of accessing services, or food provision for people living with HIV or TB on ART or DOTS to encourage adherence.

22 HIV spcial protection assessment tool

# 3 Main framework around HIV/TB social protection

## 3.1. UNAIDS strategy framework

### 3.1.1. Global AIDS Strategy 2021-2026

The new Global AIDS Strategy, "End Inequalities. End AIDS", was adopted by the UNAIDS PCB in March 2021. The global strategy uses an inequality lens to end AIDS and sets out new targets and polices to be reached by 2025 to propel new energy and commitment to ending AIDS. The strategy places significant emphasis on integrating food and nutrition programming and social protection interventions to tackle structural deprivations, inequalities and vulnerabilities within communities and at scale.

Under a newly developed set of priority areas[23], Result Area 9 (*Integrated systems for health and social protection schemes that support wellness, livelihood and enabling environments for people living with, at risk of and affected by HIV to reduce inequalities and allow them to live and thrive*) provides an opportunity for WFP to directly contribute to the global AIDS strategy with an explicit focus WFP's unique value proposition as a humanitarian agency, and with a breadth and depth of social protection programming.

### 3.1.2. UNAIDS Division of Labour

In May 2018, the UNAIDS Division of Labour guidance note was updated reflect the roles and responsibilities of 11 Cosponsors[24] and the UNAIDS Secretariat. The document outlines the roles and responsibilities of Cosponsors and the UNAIDS Secretariat and serves to guide the Joint Programme organizations' capacities and resources for achieving the goals and commitments of the 2030 Agenda for Sustainable Development and the 2016 Political Declaration on Ending AIDS[25].

Under the Joint Programme's Division of Labour, WFP and the International Labour Organization (ILO) co-convene the United Nations Inter-Agency Task Team (IATT) on HIV Social Protection, and WFP and the Office of the United Nations High Commissioner for Refugees (UNHCR) co-convene the IATT of HIV in emergencies.

## 3.2. WFP Policy and Programme Framework

### 3.2.1. WFP Strategic Plan 2022-2026

Fully committed to supporting countries in their efforts to achieve the Sustainable Development Goals (SDGs), WFP's vision focuses on eradicating hunger and malnutrition (SDG 2); and strengthening and revitalizing partnerships (SDG 17). The strategic plan for 2022–2025 includes five strategic outcomes (SO) that WFP will work towards in collaboration with others. Three are relevant to SDG 2 and two to SDG 17.

23 In particular, under strategic priority area 3 - STRATEGIC PRIORITY 3: FULLY RESOURCE AND SUSTAIN EFFICIENT HIV RESPONSES AND INTEGRATE THEM INTO SYSTEMS FOR HEALTH, SOCIAL PROTECTION, HUMANITARIAN SETTINGS AND PANDEMIC RESPONSES
24 UNHCR, UNICEF, WFP, UNDP, UNFPA, UNODC, UN Women, ILO, UNESCO, WHO and the World Bank.
25 UNAIDS Joint Programme Division of Labour, Guidance note 2018.

Social protection is recognised as important pillar across the SO 1, 2, 3 and 4. Under SO1, by channelling emergency assistance through national social protection systems, WFP can also strengthen institutions and link beneficiaries to durable safety nets. Under SO2, WFP will contribute to addressing vulnerability, poverty, food insecurity, malnutrition and inequality by supporting social protection programmes in rural and urban settings and the redistribution of resources that help people meet their essential needs. Under SO3, supporting governments in strengthening national social protection programmes is another key approach by which WFP can contribute to building the resilience of individuals and households. Under So4, to help ensure that no one is left behind, WFP will leverage its operational presence, partnerships and technical skills to strengthen social protection systems.

### 3.2.2. WFP Strategy for Support to Social Protection

WFP has contributed to social protection for decades. The new strategy provides a strategic direction and a coordinating framework for ongoing activities. Building on the 'Update of WFP's Safety Nets Policy' (2012), and following an evaluation in 2018–19, it contains a detailed articulation as to how social protection can contribute to food security and nutrition; and enhanced focus on strengthening the effectiveness of social protection in fragile and conflict-affected contexts, to build resilience and as a channel for shock-response.

The strategy outlines how social protection can address the threefold challenge of 'poverty, vulnerability and social exclusion', which are parts of three broader domains of concern, relating to needs, risks and inequalities respectively.

# Part B

Designing social protection interventions

# 4 Know your epidemics, know your response

All WFP interventions need to be articulated in Country Strategic Plans (CSP), which are structured around strategic outcomes and activities and define WFP's entire portfolio of assistance within a country.

The design and implementation of each CSP must reflect the risks, vulnerabilities and needs of the population in the specific country, the added value that WFP can bring in a particular time and place, and the presence and capabilities of other actors across the humanitarian-development-peace-building nexus (**BOX 4**).

The Programme design is guided by the WFP Strategic Plan (see 3.2.1) and the intended results are summarised in the logical framework (logframe), in line with the Corporate Results framework (CRF)[26].

**BOX 4**

### Social protection across the Humanitarian, Development and Peace Nexus

There is increasing recognition that social protection can help bridge the humanitarian development divide in several ways. Social protection instruments can support the most vulnerable people living in fragile and conflict settings to build their resilience before shocks occur, to stabilise their livelihoods, and to support recovery after a shock. Social protection has the potential to transform short-term humanitarian interventions into development processes to achieve resilience, peace, stabilization and economic growth.

It follows that the design of social protection programmes and systems should be adjusted in a way that takes into consideration the crises that each particular country is most at risk of facing.

WFP can play a crucial role in laying the foundation for resilience and longer-term development. WFP's mandate and its strategic alignment with the 2030 Agenda positions the organisation well to contribute to humanitarian, development, and peace outcomes, including by facilitating the development of long-term, multi-stakeholder strategies that can be handed over to governments. Similarly, WFP's capacity strengthening work with national counter parts intersects with initiatives and goals within the development and peace spheres.

The decision of when, why, how, where and with whom WFP should support national efforts to address the needs of people living with, at high risk of and affected by HIV/TB should be driven by a deep context analysis and mapping of key actors.

26 The Corporate Results Framework details outcomes and outputs relating to the Strategic Plan (2017-2021) and includes indicative measures to capture management performance in terms of efficiency, effectiveness and economy.

When exploring opportunities for introducing or enhancing the HIV/TB social protection agenda nationally, WFP, with the support from the main national stakeholders, including PLHIV and TB networks, need to follow a step-by-step approach, that align with the building blocks approach, as outlined in the WFP Social protection Strategy .

## STEP 1: Assess the context

Individuals face various types of vulnerabilities and inequalities. These vulnerabilities and inequalities do not exist in silos but intersect with each other[27]. It is important to understand the context and assess the problem as well as understand enablers and promoters, at country and/or sub-national levels.

**Know your epidemic:** *This phase is pivotal to get a clear picture of HIV/TB epidemics, including understanding of the most affected population and of trends of the medical response in a given country.*

- Collect information around HIV and TB epidemiology, including prevalence and incidence of HIV (concentrated and generalised epidemics[28]) and TB as well as of HIV/TB co-infection. Analyse HIV and TB trends at the subnational geographical level. Check if the country is one of the 35 fast-track countries that account for most of the world's people newly infected with HIV[29].
- Identify the specific population groups who are significant to the epidemic and response. These may include key populations (such as gay men and other men who have sex with men, sex workers, transgender people, people who inject drugs and prisoners and other incarcerated people) or other high risk populations (for example adolescents, young people, refugees and internally displaced people). It may include also the most affected ones, such as orphans and vulnerable children (OVC).
- Gather information on ART and TB treatment outcome and coverage, including for PMTCT services, disaggregated by age and gender. For example, consult data on adherence, default rate, TB treatment success rate, mortality rate, rate of vertical transmission, etc. In addition, refer to data on coverage and effectiveness of national prevention strategies for the most at-risk population.

Source: The information can be collected from the UNAIDS country progress report and other national reports or surveillance data.

**Know the main social and structural determinants impacting on the HIV and TB response:** *This phase is to identify the main drivers of the epidemics, with a specific focus to food and nutrition vulnerabilities.*

- Whenever available, analyse primary and secondary data related to the main factors (such as vulnerabilities, inequalities as well as enablers and promoters) that drive the HIV and TB epidemics and hinder or facilitate ART and TB treatment access and outcomes. For example, poverty, food insecurity, malnutrition as well as stigma, recurrent humanitarian crisis. In particular, understand to what extent food and nutrition vulnerabilities are driving the epidemics. Whenever this information is not available, advocate for incorporating key indicators into any assessment conducted at country level – (See **Annex 1** - need assessments).
- Whenever possible, identify these factors disaggregated by for each specific sub-group, to highlight the different vulnerability.

**Know your national priorities and response:** *This phase is to have a clear understanding of the system architecture as well as programme features around social protection for people living with, at risk of and affected by HIV/TB:*

27 Addressing Intersecting Inequalities through Social Protection Programming for Greater Inclusion, April 2020. WFP and LSE.
28 Epidemics are said to be "concentrated" if transmission occurs largely in clearly defined vulnerable groups such as sex workers, men who have sex with men, and people who inject drugs. Conversely, epidemics are termed "generalized" if transmission is sustained by sexual behaviour in the general population (typically defined on the basis of population prevalence of >1 percent)
29 https://www.unaids.org/sites/default/files/media_asset/201506_JC2743_Understanding_FastTrack_en.pdf

**1** **SYSTEM ARCHITECTURE:**
It is imperative to be informed on and be aligned with the national social protection policies and frameworks to identify and guide priority areas and strategic opportunities to address the needs of people living with, affected by and at high risk of HIV and TB.

- **Policy and regulations:**
  - Identify if social protection is recognised as a key component for the HIV and TB response (e.g., it is included in the HIV National Strategic Plan), and to which extent HIV/TB-related issues are represented in national social protection policies. Assess if the county conducted any HIV/TB sensitive social protection assessments and how have that assessment influenced the social protection policy environment .
  - Consider where countries stand on developing legislative frameworks in the response to HIV and TB. Insufficient attention is often paid to the reform of discriminatory law or to working with parliaments, judges and police to ensure appropriate enforcement of law. The result is that human rights abuses in the form of discrimination, gender inequality and violence against women, and violations of confidentiality and privacy continue to increase vulnerability to HIV infection and represent a barrier to effective responses to HIV.
- **Governance, capacity and coordination:** identify the institutional effectiveness and capacity to address the needs of people living with, affected by and at high risk of HIV/TB, through social protection schemes. Have a good understanding of the main national and international stakeholders and partners working on HIV/TB and on social protection and their capacities and coverage area, and potential for partnerships (refer also to **Section 6**).
- **Platforms and infrastructures:** consider if management information systems and database, including integrated beneficiary registries, social registries and any other platforms in place for programme delivery and monitoring ensure data protection, privacy and data-sharing protocol, being these elements extremely important for people living with and affected by HIV/TB.
- **Planning and financing :** determine the level of integration of HIV/TB-sensitive social protection into national plans for emergency preparedness and for the transition from internationally led interventions to sustainable nationally led social protection systems. Describe the financial landscape, including evaluation of the domestic (i.e., national government funds) and donor funds allocated to social protection measures directed at addressing the needs of people living with, at high risk of and affected by HIV and TB. Identify financing sources, such as co-financing or innovative funding models as well as mobilise resource strategies (see **Section 7**).

**2** **PROGRAMME FEATURES:**
Gather and analyse information on existing social protection schemes, following a 5W's approach (WHO, WHAT, WHEN , WHERE and WHY). Therefore, gather information of:

- **WHO:** identify the main governments partners and stakeholders involved and therefore define the role of Government in the design and implementation of the programmes.
- **WHAT:** identify the purpose, eligibility criteria and HIV sensitivity of existing programmes. Barriers that people living with HIV face in accessing social protection services should also be identified, which may include stigma and discrimination, lack of knowledge about the existing programmes, and the complicated procedures for accessing the existing schemes. Assess also if indicators to measure the efforts around social protection in the context of HIV and TB are integrated into the national monitoring system.
- **WHEN- DURATION:** identify the timeframe and duration of programmes.
- **WHERE:** identify the geographical coverage of the programmes within a country, including urban or rural, refugees camps, sub-national locations, etc) and identify potential overlaps with other HIV/TB services.
- **WHY:** identify the rationale behind the implementation of the programmes and specific activities

UNAIDS, in close collaboration with its cosponsors, has developed an HIV and social protection assessment tool for a rapidly scanning existing social protection programmes and their sensitivity (or lack of) to the HIV response in a given country and location[30] (**BOX 5** – Assessment tool).

**BOX 5**

## HIV and Social Protection Assessment Tool

There is increasing recognition of the role of HIV-sensitive social protection in advancing the AIDS response to increase uptake and use of HIV prevention, treatment and care services. Many barriers exist, however, to people living with, at risk of or affected by HIV accessing HIV-sensitive social protection services. These barriers can be removed, though, and opportunities for HIV and social protection co-programming exist that could be exploited. In 2017, the inter-Agency Task team (IATT) on social protection care and support developed a HIV and social protection assessment tool which is used for a quick scan of existing social protection programme and their sensitivity (or lack of) to the HIV response in a given country and location.

The tool illustrates a three -stage process that actors should follow:

- **Stage 1** - Preparing to conduct the assessment, including securing high-level commitment, establish an HIV and social protection assessment team as well as collect, collate and store relevant documents
- **Stage 2** - Conducting the assessment which include the organization of workshop with the main actors, such as national AIDS and social protection authorities as well as UNAIDS and its cosponsors. The workshops consist of a training and completion of the assessment.
- **Stage 3** - Data analysis, reporting and validation of findings

For more information: HIV and social protection tool

30 UNAIDS 2017. HIV and Social Protection assessment tool.

## STEP 2: Identification of gaps and restrictions in the response

To ensure no-one is left behind, and therefore that the needs of people living with and affected by HIV/TB are addressed, it is pivotal to Identify gaps and restrictions in the existing social protection system which may be related to main 5 dimensions:

- **Coverage,** in particular:

  Geographical coverage: gaps in regional or any other geographical location (e.g. urban/rural setting) coverage

  Life-cycle coverage: gaps of programmes across the life cycle, for example older people, pregnant and lactating women, adolescents, may not be reached by any social protection scheme.

  Population coverage: unintentionally or explicitly programmes may exclude people living with, at risk of or affected by HIV/TB or specific subgroups, such as key populations.[31] In addition, the lack of data related to their vulnerabilities may affect the programme design and increase their risk of exclusion.

- **Adequacy** people living with, at high risk of and affected by HIV and TB may be included but their specific needs not adequately addressed. For example, the food ration is not meeting the nutrition or dietary requirement or the process of obtaining services imposes economic costs which are unaffordable to recipients, such as transportation costs.

- **Comprehensiveness:** frequently social protection programmes are not integrated one to another and are not adequately link to other services and sectors. This prevent people living and affected by HIV/TB to be protected for a wide range of risks.

- **Quality**: people living with, at high risk of and affected by HIV may not be well informed on available and existing HIV social protection programmes as well as on their eligibility criteria. Stigma and discrimination may prevent people living or affected by HIV from seeking support and registering existing programmes.

- **Responsiveness:** social protection programmes frequently are framed as short-term initiatives and not always available when people are in need. Funding gaps impact on the effectiveness of the social protection measures as they and not linked to long-term development efforts.

31 In the context of HIV, WHO defines key populations as people in populations who are at increased HIV risk in all countries and regions.

## STEP 3: Describe your strategy: identify opportunities

Based on the context analysis described above and considering WFP's comparative advantages, it is possible to explore opportunities and ways to overcome the gaps and restrictions, and define:

- the role that WFP covers, in line with national request and identified needs: supporting nationally led social protection systems and programmes and complementary actions (**See Section 5**);
- the main objective (s), that programmes are aiming to contribute to;
- the types of programmes based on the target population groups and the defined objectives (**Section 5 and Annex 3**);
- the best approach (HIV/TB specific or HIV-TB sensitive) to adopt considering existing opportunities as well as limitations or barriers (**see Section 2.3.3**);
- the geographical coverage, target criteria and caseload of programmes based on the assessed needs and available funding (**See Section 5**);
- key partnerships for ensuring a coordinated and complementary response (**Section 6**); and
- funding opportunities to guarantee operational continuity (**see Section 7**).

# 5 The role of WFP at country office level in the context of HIV and TB

In the context of HIV and TB, WFP's role in social protection is to support national systems designed to reduce poverty, to address the social economic drivers of the AIDS or TB epidemic, reduce HIV/TB risk behaviour, break down barriers to the access of HIV/TB services and make HIV/TB programmes more effective.

WFP's role in HIV/TB Social Protection at country level can be three-fold:

1

**Supporting nationally led social protection system and programme**, by providing advice and guidance to national actors and/or delivery on behalf of national actors. WFP can help national government and other actors understand the needs of people living with, at high risk of and affected by HIV/TB. It can support the government to determine policy options, and design social protection responses which the national actors themselves deliver (**Section 5.1**).

For example, by supporting countries to conduct an HIV social protection assessment, to integrate HIV/TB indicators/proxy into vulnerability assessments (such as Fill the Nutrient Gaps as well as food security assessment), to make social protection policy and systems more inclusive, to designing programmes as well as define transfers. Help government develop a training curriculum for extension workers to build their knowledge and skills to undertake communication, referral and sensitive counselling for PLHIV/TB.

### Rwanda: advocacy and financial support

During the COVID-19 pandemic, the Rwanda Country Office advocated and provided financial support to the Ministry of Agriculture and Animal Resources (MINAGRI) and Rwanda Biomedical Centre (RBC-agency under the Ministry of health) to address the food insecurity needs amongst people living with and affected by HIV. The targeting and the distribution of food was undertaken by the Network of PLHIV under RBC's coordination while the food procurement was done by MINAGRI. Although it was a one-time assistance (so not classified as social protection measure) the programme contributed to increase awareness around main national stakeholders and donors on the importance of assisting the vulnerable households affected by HIV. As result, the programme was incorporated into the national Global Fund proposal for ensure continuity.

2

**Complementary actions:** WFP runs its own programmes in a way that is complementary to national social protection. The form depends on what is already in place.

For example, when a nationally led social protection system is limited or disrupted, WFP might set up systems for its own programmes that have the prospect of underpinning a future national system; whereas when the national system is already established, WFP might, for example, design its assistance so as to support people not currently covered by a national programme. See **Section 5.2**.

3

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## Djibouti: Complementing national efforts

Djibouti is characterized by a generalized HIV epidemic. The national HIV prevalence is estimated at 1.51 percent, or about 6,900 people. Consistent with observable global trends, there appears to be a feminization of the HIV epidemic, with women being disproportionately affected compared to men.

In Djibouti, social protection is guided by the National Strategy for Social Protection 2018-2022 and underpinned by the law on the social and solidarity economy. There are two main social protection programmes in the country: *Programme National de Solidarité Famille* (PNSF), an unconditional cash transfer programme for the most vulnerable people, and the *Programme d'Assistance Sociale de Santé* (PASS), a subsidized health insurance scheme. Both use the social registry to ensure efficiency and reduction of duplications in benefit delivery. PSNF beneficiaries are automatically eligible for health insurance under PASS.

PNSF has been implemented in Djibouti Ville since 2016 to support households living in extreme poverty or with members who have a disability or are elderly (> 70 years old), children under 5 years old, orphan and vulnerable children. Cash transfer is distributed to each eligible household, on quarterly basis.

To respond to the COVID-19 crisis and mitigate the socio-economic impact of the epidemic on the most vulnerable and marginalised population, WFP complements PNSF with a cash-based transfer programme for the most vulnerable households affected by HIV. Simultaneously, WFP strongly advocates and advises national counterparts for the inclusion of these households into the PNSF. This has helped to give visibility to this target group so that their food needs are addressed.

WFP, with the support of two local NGOs, namely Le Reseau and Solidarite' Feminine, and in close collaboration with the Ministry of Health (MoH) and Ministry of Social Affair and Solidarity (MASS), is responsible for the implementation of the programme: cash transfers are delivered to households affected by HIV for 9 months. To reduce barriers related to stigma and discrimination, beneficiaries are enrolled in the national social registry managed by MASS, like the other PSNF beneficiaries. Once enrolled in PSNF, beneficiaries are automatically eligible for health insurance under Programme d'Assistance Sociale de Santé (PASS).

The involvement of NGOs trusted by the HIV community contributed to incentive people living with HIV and their families to register to the national social registry. In addition, the efforts to align and harmonize this programme (with the national social protection programme for example by adopting the same eligibility criteria and transfer value) has reduced the issue of stigma in the country.

Key features of the programme:

- **A committee** was established to strengthen coordination between the MoH and MASS and the agencies involved. Monthly meetings are scheduled to support better monitoring of the programme implementation.
- **Training packages** developed and delivered to physicians, community workers and members of the national network of PLHIV to sensitize them on the importance of nutritional support, on the social protection service package and on the ways and means for PLHIV to benefit from it
- **Advocating efforts** for putting in place and strengthening social protection policies and initiatives that integrate the most vulnerable PLHIV and key populations.

The two roles are not mutually exclusive: much of WFP's assistance are hybrids. Roles may also evolve over time for example a technical solution begun by WFP in its own programming may later be adopted by government, with WFP providing advisory support.

WFP's engagement and support in social protection can be **at policy, programme and partnership levels:**

- Policy level: WFP can strengthen national capacity, including systems, to refine and formulate inclusive policy/legal framework as well as support knowledge and evidence generation.
- Programme level: WFP can strengthen institutions and provide technical capacity for programme design and implementation of inclusive social protection measures.
- Partnership level: WFP can strengthen in-country partnership, by bringing the relevant partners together and establishing critical platform for multilateral engagement. This includes also building strong partnerships for resource mobilization efforts.

More information is available at: Policy brief on HIV Social protection

*Please note, that for the purpose of this guidance, the following section will be focusing mainly on the technical and complementary role.*

## 5.1. WFP advice and guidance role

Drawing on decades of experience in safety net programming in crisis contexts and technical expertise in analysis, assessment, programme design, delivery systems and accountability to affected populations, WFP offers its support to governments to design and deliver large-scale responses.

In the context of HIV/TB, WFP plays a key role to national institutional capacity building. WFP can work with governments and interested partners to:

- Build the national capacity across the different steps of the programme design, including monitoring and evaluation;
- Increase understanding of needs and changing vulnerabilities arising from a potential crisis. This may include support in the development and conduction of assessment, analyse available data, etc.;
- Design appropriate responses at individual, household and community levels taking into account needs and challenges faced by PLHIV and people with TB and their families;
- Leverage existing safety nets to increase the value or coverage of social assistance. For example, by supporting the government to revise the targeting and eligibility criteria, so that PLHIV and people with TB and their families can be enrolled;
- Establish new schemes to reach populations who are not able to be covered by current safety nets. For example, by supporting government to explore additional platforms to use for reaching this target group; and
- Strengthen the coordination between the national social protection and national HIV/TB response.

### 5.1.1. General considerations for HIV/TB Social protection programming

When designing social protection programme in the context of HIV and TB it is important to take into account some general considerations:


**1 Sensitive or specific:** a specific approach should only be considered when the integration in existing social protection programmes is impossible, if reforming social protection programmes is too slow, programmatic and politically complicated to meet the needs of this target groups or when the programme implementation relies on specific HIV/TB platforms (for example, provision of in-kind or cash-based transfers (CBT) at health facility level, as part of the ART/TB continuum of care approach). Sensitive approaches should be explored and prioritised, especially in context with high stigma and discrimination, and when national social protection systems are already in place to address the needs of the more vulnerable population. Please refer to **Section 2.3.3** and the **Annex 2**.

**2 Conditionality/unconditionality:** Social protection has been intended as demand side intervention that can in one hand facilitate and support the update of essential social services, such as health and education to promote human capital development. On the other hand, being a springboard to see economic and productive opportunity with labour and productive sectors. Evidence shows that a conditionality does not matter as much as the quality of services provided. Conditionality needs to consider the " do no harm", and therefore it requires a careful analysis of what are the benefits and what are the risks that the given populations may incurred into (**BOX 6**).

**3 Social and behaviour change (SBC) strategy:** ensure to incorporate a strong SBC component and therefore use a variety of communication channels to drive and sustain positive behaviour around HIV/TB treatment adherence, HIV/TB transmission, food and nutrition as well as any other relevant topics (e.g., COVID-19). More information available at: WFP SBCC Guidance Manual

**4 Food and nutrition needs:** ensure that food and nutrition needs of people living with and affected by HIV/TB are considered and analysed in the development of the strategy. If information is missing, actions need to be taken to ensure data is collected to adequately inform the programme design. For example, explore the opportunity to include HIV/TB consideration in the Fill the Nutrition Gaps analysis[32].

**5 Trusted community-based platforms and HIV/TB networks:** in most contexts, people living with and affected by HIV/TB are very marginalised which prevents them from seeking and accessing health, social and economic services. Therefore, consider partnering with any formal and informal community-led network trusted by HIV/TB beneficiaries as well as networks of PLHIV and TB , HIV expert clients, to inform PLHIV and people with TB how to access to social protection measures and to support the implementation of any SBCC strategy. Education and sensitization campaigns at all levels are critical to increase awareness and trust amongst the population and to reduce the likelihood of HIV-associated stigma. Consider conducting stigma reduction trainings for services providers, in collaboration with community-based platforms. Finally, consider partnering or co-locating with I/NGOs that have complementary programmes e.g., WASH, livelihoods.

**6 Stigma and discrimination:** in the targeting as well as in the selection of the transfer, distribution platforms and implementation modalities, it is important to consider stigma and discrimination issues. Stigma is still very high in communities and people may prefer accessing services, such as medical or social protection support, which are located far from their community. For example, home visits might discourage people to be enrolled into the programmes due to fear associated with disclosing their HIV/TB status to their household's members and neighbours. For example, when people living with or affected by HIV/TB are integrated into broader social protection schemes or when there is more than one programme implemented at country office level, it is important to avoid adopting different approaches for registering beneficiaries in order to reduce the risk of generating stigma and discrimination. For example, do not use of names and ID numbers for general population and identifier code for people living with HIV/TB.

**7 Targeting:** targeting based on HIV/TB status can lead to increased stigma and social disharmony. In addition, being affected by HIV/TB does not automatically denote being food insecure or with acute malnutrition. Effective targeting should be tailored and respond to the HIV/TB epidemic and the food and nutrition vulnerabilities of individuals living with or at high risk of HIV and TB, as well as that of households affected by the disease. (For more information on targeting, refer to the different programmes under **Section 5.2**).

**8 Referral system:** ensure that social protection programmes are linked to HIV/TB services, including HIV/TB testing as well as ART/TB treatment programmes, and to nutrition programme, if established, to promote a comprehensive and holistic approach.

**9 Flexibility:** social protection mechanisms must be flexible to respond to the fluid and dynamic realities and needs of this target group. Common shocks to general population may render people living with, affected by and at risk of HIV and TB further vulnerable include changes to living environments through political and natural events, displacement, losing caregivers, grief, as well as other situational factors. (See **BOX 7**)

**10 Sustainability:** ensure that policies and legal frameworks integrate HIV and TB considerations, that resource mobilization strategy are in place to secure funding and that main stakeholders are consulted and actively engaged throughout the programme cycle.

32 WFP Fill the Nutrient Gap

**BOX 6**

## Conditional or unconditional

One important policy choice is whether access to benefits should be made conditional on recipients complying with specific behaviours. Conditions are often linked to school attendance or health check-ups (for example to check treatment adherence for PLHIV). Non-compliance results in a sanction, such as the withdrawal of a benefit. On the contrary, unconditional transfers do not place any obligations on recipients.

The value of conditions is contested and there is little evidence that conditions have an impact on the behaviour of the beneficiaries. The use of conditions and sanctions also makes social protection programmes significantly more complex.

Increasingly, countries are use a short of hybrid, which can be referred to "soft conditionality" (Davis et al, 2021) that impose no penalties for noncompliance but rather just reenforces the positive behaviours that the programme aims to achieve. The idea is that (regularly) reminding people why they are receiving the transfer increases the likelihood of achieving the programme's goals, without the monitoring and evaluation. For example, Malawi's Social Cash Transfer Programme includes what they call a 'school incentive', whereby beneficiary households with children of a school-going age receive an additional transfer. There is no strict monitoring of school attendance, however anecdotal evidence suggests communities find it important that these children actually go to school.

## Sierra Leone

WFP CO Sierra Leone played a key role to advocate and engage with the National Commission for Social Action (NaCSA), to ensure the integration of food and nutrition security for PLHIV in the National Social Protection Policy.

A series of meetings with NaCSA, including a field visit to the site of WFP CBT programmes for people living with and affected by HIV, were organized with the aim of increasing awareness around HIV-related vulnerabilities and as well as to strengthen partnerships. This helped convince NaCSA colleagues of the need for vulnerable PLHIV to be integrated into the social protection schemes with the objective to sustainably improve their livelihoods and strengthen their resilience to food and nutrition insecurity. This process additionally served as an opportunity to position NaCSA to engage with donors for extending the current social protection programmes to other vulnerable groups such as PLHIV. To complement these efforts, WFP and the UN Joint Team on AIDS are supporting NaCSA by conducting a nationwide profiling assessment to determine the vulnerability of PLHIV, using a set of commonly agreed criteria and to establish a database to inform the inclusion of the most vulnerable PLHIVs and other affected populations into NaCSA's response schemes.

## Regional Bureau of Panama

Social protection plays a critical role in helping people to overcome the structural inequalities that impact on the HIV epidemic and that serve as barriers to treatment, access to testing, schooling and other essential services. Along with the centrality given to this issue, it is also recognised that there is lack of information about the social protection needs of people with HIV in Latin America and the Caribbean. Therefore, the Regional Bureau of Panama proposed to carry out qualitative studies in three countries of the region (Peru, Ecuador, and Chile).

The information collected through the studies contributed to:

- increase understanding around the problems that people face in accessing social protection services; and
- stimulate in-country discussion and influence national policies to ensure a comprehensive response for this group of the population.

The studies referred to and mainly used the HIV and social protection assessment tool developed by the IATT-Social Protection to quickly scan existing social protection programmes and determine their sensitivity (or lack of) to the HIV response in each country and location. However, the data collection tools proposed focused exclusively on the health sector, assuming the existence of social programmes specifically for people living with HIV. Therefore, adaptations were necessary to align with the country context.

**BOX 7**

## Considerations in emergency contexts

In the last decade, the magnitude and frequency of humanitarian emergencies (e.g., complex crises, food insecurity, climate change events, protracted conflicts) are increasing. They are likely to have a negative impact on household income, access to nutritious diets, access to health care services and supplies, and on people's mental health and well-being. In this scenario, the existing vulnerabilities experienced by PLHIV, people with TB and their families may be further aggravated. Health care services may be disrupted, movements restricted or PLHIV and people with TB may be afraid to access to health care facilities, and therefore from accessing medical services. Disruption of existing social protection services as a result is also likely.

Some actions that may need to be considered include:

- ensure intersectoral coordination with Food security and nutrition clusters as well as social protection platforms to ensure that HIV/TB considerations are incorporated into contingency as well as humanitarian response plans;
- strongly advocate for the inclusion of this vulnerable population, taking into account their special needs into any existing safety nets programme or in any other social protection measures, that the government/ partner may plan to implement. Revise the targeting criteria to ensure that vulnerable people living with and affected by HIV/TB are benefiting from the food assistance and livelihood support;
- design of agile programmes that can scale up or down and adapt according to need, the transition from crisis to post-crisis contexts
- consider the special nutritional and dietary needs of people living with and affected by HIV/TB in planning rations or transfer size of any food or cash-based intervention;
- when in kind assistance is provided, distribution sites should be chosen carefully, considering walking distance, terrain and the practicalities of transport (availability and costs) for vulnerable population, including PLHIV and people with TB;
- consider to channel food assistance (as appropriate to the local context) through programmes such as, home-based services, antiretroviral treatment, or programmes that provide care and support to OVC;
- consult with and actively involve networks of PLHIV, people with TB and other community members in establishing and maintaining a referral system between the health facility and the community food and nutrition services, by taking into account any potential stigma and discrimination issues. Involve community networks, support group, existing partners' platforms, such as out-reach clinics and home visit systems, psychosocial support groups, networks of PLHIV/TB , or other channels, such as radio messaging, WhatsApp/phone SMS, among others to establish and maintain an effective referral system; and
- use appropriate social behaviour change communication strategy to sensitise the population around HIV/ TB protection measures and share messages against stigma and discrimination. Leverage existing platforms (such as nutrition assessment and counselling sessions and food distributions) or explore additional ones, such as media channels (e.g., radio, sms/whatsapp) to deliver simple feasible practical concise and harmonised messages and.

For more information, refer to:

- WFP's guidance for adaptations of food and nutrition assistance to PLHIV and TB and their families in the context of COVID-19 pandemic
- Integrating HIV in the Cluster response

## 5.2. WFP complementary role

The activities categorised as social protection includes many interventions that look familiar to WFP, for instance, school health and nutrition programmes, asset creation programmes or general food assistance to households.

This does not mean that everything WFP does can be called "social protection". It depends on the context. In general, to be counted as "social assistance", the programme should have some elements of predictability, reliability and sustainability.

A WFP-supported transfer is considered to count as "social protection" only if[33]:

- The government is involved in the design or implementation of the activity (government-owned).
- It is implemented a reliable way, and everyone can access social protection when they need and that that regular transfers are provided.

This chapter is meant to complement the existing guidance of each of the programme category listed below with general (see **Section 5.1.1**) and specific considerations in the context of HIV and TB.

The programmes described below can be designed and implemented in a specific or sensitive way, depending on the context. The suggested considerations are valid in both scenarios. Also refer to **Section 5.**1, **Annex 2** (checklist) and **Annex 3** (decision tree) for further guidance.

33 WFP Quick Guide: Social protection, 2018

**BOX 8**

## WFP HIV and TB programming

In the context of HIV and TB, WFP programming can be grouped into two main categories:

1) **Nutrition programme,** which include both nutrition prevention and treatment strategies, that are implemented with the aim of improving the nutrition status of people living with HIV and TB. In COMET[34], these programmes are classified as Care and Treatment, and tagged as HIV/TB_C&T. Most of nutrition programmes for PLHIV/TB are for moderate acute malnutrition treatment. Sometimes, also a household ration is provided to compensate for sharing practices within the household.
2) **Safety nets and livelihood programme** to mitigate the impact of HIV and TB on individuals living with and affected by HIV and TB. This includes conditional and unconditional food or CBT, specific asset creation programme (such as public works and productive safety nets) and School Based Programmes. In COMET, these programmes are classified as Mitigation and Safety Nets programme and tagged as HIV/TB_M&SN.

Both programme categories can be designed in a specific or sensitive way and therefore targeting specifically or inclusively people living with and affected by HIV and TB, respectively.

### 5.2.1. General food assistance: Unconditional and/or conditional resource transfers (in-kind/CBT)

**General Food Assistance** (GFA)- which can be classified as a social assistance programme- provide transfers (in-kind, cash and/r voucher) to households to make up for shortfalls in household food access, i.e. the difference between their food consumption requirements and what they are able to provide for themselves without adopting distress negative coping strategies. GFA typically takes place during lean, harsh and/or extended lean seasons, after a natural disaster or in conflict/displacement situations. GFA can be provided to everyone in a geographic area or a camp (known as blanket distribution) usually in the direct aftermath of a shock when the urgency of a response outweighs the accuracy, or targeted to specific households, individuals or groups considered particularly vulnerable (according to evidence-based defined eligibility criteria).

WFP now has three distinct transfer modalities for distributing resources to target beneficiaries:

- Food in kind
- Vouchers
- Cash

Even in low HIV/TB prevalence and incidence contexts, GFA should be considered when poverty and food security drive the epidemics and hinder or facilitate ART and TB treatment in the country. The programme should be aligned, though, with national priorities and strategies.

34 WFP Country Office Tool for Managing Effectively is the WFP's online tool to design, implement and monitor programmes.

## Rationale

The relationship between HIV, TB and food insecurity is complex and bi-directional. The impact of HIV and TB on food insecurity has been well-documented and manifests through the debilitation of the most productive household members, decreased household economic capacity, decreased household agricultural output, and increased caregiver burden. Conversely, food insecurity has been associated with increased behavioural risk of HIV/TB transmission, reduced access to HIV and TB treatment and care, decreased ART adherence, and worse clinical outcomes among PLHIV and people with TB[35,,36].

## Objectives

The main objectives of the General Food Assistance in the context of HIV/TB are:

- mitigate the impact of HIV/TB on household and therefore compensate for lost income and increased illness-related expenses;
- act as enabler to support people living with HIV/TB to access services and adhere to treatment;
- improve food security; and
- prevent households from adopting potentially harmful coping mechanisms that can increase the risk of HIV/TB transmission.

## Targeting and eligibility criteria

GFA should be targeted to a specific household profile. This profile needs to be informed by the needs assessment and programme objectives. A solid understanding of the given context as it related to HIV/TB epidemic ( for example developed through community consultations, focus group discussion and key informant interviews) can inform the development of eligibility criteria that are HIV/TB sensitive. Generally, in the context of HIV/TB, GFA is meant to support food insecure and vulnerable households affected by HIV/TB, which may include households with high dependency rates, dependent on income from the informal sector, or which are hosting persons with disabilities.

In the absence of knowledge of an individual's HIV/TB status, especially when programmes are designed in a sensitive way, proxies are often used, for example[37]:

- households with one or more chronically ill person
- household hosting or headed by OVC
- household hosting adolescents (for example in contexts with high rate of new HIV infections amongst adolescents)

When identified needs cannot be met with available resources, the most vulnerable people within the targeted population need to be prioritized.

In the context of HIV/TB, community-based targeting and prioritization is highly recommended, and PLHIV as well as TB networks or other organizations should be consulted and should contribute to determining the eligibility criteria and identification of beneficiaries. However, community-based targeting is not recommended when there is tension or conflict between ethnic, religious or social groups within the community, as this can further exacerbate tensions.

For more information on targeting please refer to **WFP Targeting and Prioritization Operational Guidance note**.

## Duration

Support to each household should be provided for a limited period of time, (usually not more than 12 months) and frequently provided on a regular basis (normally monthly). This household support should represent an opportunity for referral to other programmes providing psychological support, training to acquire new skills, microfinance or other forms of livelihood support.

35 Anema A, et al. Food insecurity and HIV/AIDS: Current knowledge, Gaps and Research Priorities
36 The converging impact of tuberculosis, HIV/AIDS and food insecurity in Zambia and South Africa. IFPRI.
37 Josh Colston. Review of targeting methods in HIV programmes

### Service delivery points

The transfer should be distributed by WFP Cooperating Partners (CPs) using community platforms or through leveraging public government systems. The programme design needs to consider what is the most convenient distribution point(s) with the lowest risk of stigma and discrimination as well as the least logistical implications, considering that this population regularly attend medical services. This support should be delivered based on an established functional referral system between health and community platforms. This implies that the health and community health workers should inform and sensitize individuals about the programme, including how to access to it. Normally, these programmes are conditional on a minimum of treatment attendance rate of PLHIV and people with TB not missing more than two consecutive visits[38].

It is preferable to limit the use of the health sector for food distribution, as it may overburden the health workers and may force beneficiaries to carry heavy bags of food over long distance. However, in some circumstances (for example for HIV/TB specific approach), distribution at health center may need to be considered to reduce risk of stigma and discrimination.

### Transfers

Choosing the right transfer modality (in-kind/cash/voucher) or a combination of modalities should be driven by an evidence-based decision-making process, informed by regular needs, markets and sectorial assessments.

The decision on how much to provide, to whom, where and for how long is rarely a clear cut one. The transfer should make a concrete contribution to household members' diet without aiming at providing the full requirement. It may also include the provision of specialised nutritious foods, to address the nutrition needs of this target group. To define the transfer value, consider healthcare-related expenditures (e.g., medications, clinic fees, transportation cost, overnight accommodation near the clinic, expenditure on alternative source of care including private doctor or childcare/caregiver) and potential earning losses which could further threaten the ability of people living with HIV/TB and their families to meet basic needs such as food, education and access to health care. There are several processes and tools available that can inform this process, including the Fill the Nutrient Gap (please refer to **BOX 9**)

38 Patients are considered defaulted when they missed 2 consecutive visits.

### Additional considerations in the context of HIV/TB

To complement the general considerations listed in **Section 5.1.1**, consider the following aspects when you design a GFA:

- Cash and vouchers are generally preferred over in-kind, in the context of HIV/TB-specific approach, as they reduced the risk of stigma and discrimination and restore dignity to beneficiaries by normalizing the market experience[39]. However, the right transfer modality needs to be defined based on a market assessment.
- Consider the inclusion of fortified foods, for example fortified oil, rice or Super Cereal[40], to address the nutrition requirements of people living with HIV and/or TB, acknowledging that a deterioration of their nutrition status may have direct impact on their health and HIV/TB treatment outcomes. In addition, consider the digestibility and sensory aspects of the rations (see **Section 2.2** and **BOX 9** for more information).
- Whenever in-kind food distribution is preferred over CBT, consider the size, weight and shape of the food package provided to beneficiaries and potential transportation difficulties and associated costs.
- Avoid labelling voucher/card/food packages as being specific for HIV/TB programmes, in order to minimize the risk of beneficiaries of HIV/TB support being identified.
- According to the level of stigma and discrimination, sharing personal identity data, such as name and address, with service providers (e.g., mobile companies) may be a problem in the context of HIV and TB. Measures for confidentiality and security protection should be explored, such as limiting the actors involved in the implementation of the programme (e.g., WFP owing the Bank Account), sharing only essential beneficiary information to financial partner avoiding any reference to HIV/TB status, or exploring alternative ways for identifying beneficiaries (e.g., identification code). These measures should go hand in hand with community and advocacy efforts to reduce HIV-related stigma. Also refer to WFP Guide to Personal Data Protection and Privacy .
- Try to reduce the logistic burden on people living with HIV/TB associated with their participation in food distribution and attendance at medical services. In HIV/TB context, it may be necessary to have flexible schedules for programme delivery activities and to accommodate medical appointments.

**BOX 9**

## Setting a transfer value

The first step in designing a transfer value is to understand what the needs of the beneficiaries are, which of these are covered through the local market and at what cost. Meeting beneficiaries' food and nutrition needs requires a deep understanding of beneficiaries' access to food, preferences, consumption patterns and the trade-offs they face between meeting their household's food and other essential needs. There are different methods to estimate the proportion of households needs that can meet through the items available in the local markets and related costs. Some common examples are listed below.

The most common way to determine the cost of meeting food and non-food needs is to establish a **Minimum Expenditure Basket (MEB)**. The MEB defines what an average household requires to meet their essential needs, on a regular or seasonal basis, and its cost. It is a monetary amount describing the cost of average, recurrent household essential needs (food and non-food) for a household, typically for a period of one month. As such, it puts a price on the minimum cost of living and thereby provide a basis to determine transfer values. The MEB should reflect actual consumption patterns of people who can adequately cover their needs and is often built using expenditure data.

**Essential needs Assessment** is well-suited to gather and analyse relevant essential needs information in an emergency context. It identifies and analyses essential needs and gaps for food and non-food items as well as the number and profile of people in need.

39 According to Focus group Discussions conducted by the WFP HQ HIV Team in Ethiopia, Zimbabwe and Mozambique amongst beneficiaries of in-kind and voucher programmes, in 2015.
40 Refer to the WFP SNF sheet available at https://docs.wfp.org/api/documents/WFP-0000001477/download/ and the SNF substitution guidelines available at: https://docs.wfp.org/api/documents/WFP-0000099472/download/

**Fill the Nutrient gap (FNG):** is a nutrition situation analysis used to identify barriers to adequate nutrient intake in a specific context for specific target groups. The availability, physical access, affordability and choice of nutritious foods and how systems can improve these aspects is central to the analysis.

Several tools are available or being developed that can be used to support the above analysis and assessments. These include:

**The Cost of the Diet (CotD)** is software tool that use linear programming to identify the minimum cost of a nutritious diet. It estimates how much it would cost households to purchase a nutritious diet from locally available foods and whether a diet based on locally available foods can provide the required nutrition for individuals. It establishes the lowest cost diet that can meet requirements for energy, protein, fat and 13 micronutrients, for particular individuals in a population. The software can be accessed through the link http://software.costofthediet.org/CostOfDiet.zip.[41]

**Optimus** is an optimization tool developed by WFP Supply Chain to determine the optimal design for WFP operations, focusing on the design of the food basket (which commodities to provide, what ration sizes, etc.), the transfer modality selection (should we provide assistance through in-kind, cash, vouchers, or maybe a hybrid solution?) as well as the sourcing and delivery plan (where and when to buy, where to ship and pre-position, etc.). By optimizing these decisions, WFP can identify operational plans that achieve programmatic goals (calories, dietary diversity, etc.) at the lowest cost while respecting operational constraints such as funding levels and supply chain lead times.

**Optimus Lite** is a self-service tool designed to calculate and compare cost and nutrient contribution of WFP transfers. It functions as a ration calculator that enables users to select commodities from different procurement and programme options. Based on the users selection Optimus Lite provides information on the cost and nutrient breakdown of the individual commodity as well as the overall basket. It can be used to estimate both the programme and the logistics cost of in-kind, CBT and hybrid modality food baskets. Accessible through optimus.wfp.org

**Nut Val** design food assistance rations that meet nutritional requirements. Link: https://www.nutval.net/2007/05/downloads-page.html

For more information please refer to:

- WFP MEB guidance
- Setting the transfer value for CBT interventions
- Fill the Nutrient Gap and Minimum Expenditure Baskets- Technical Note
- Demonstration of Optimus Lite for Nutrition (video)
- Fill the Nutrient Gap and Cash Based Transfer

41 The software is currently revised so a new version may coming soon.

## Mozambique

In 2011, the Mozambique Ministry of Health (MISAU) launched an initiative (*Cesta Basica*) to assist PLHIV on ART and TB clients with a household food basket via a food-voucher system. This initiative was incorporated into the national Direct Social Action Programme (PASD) which aimed at protecting households against the shocks that exacerbate the degree of vulnerability of individuals and families through different types of social transfers. The MoH requested WFP's support in the design and implementation of the programme.

**Main steps for PADS enrolment:**

- Selection of beneficiaries: health staff referred PLHIV and TB clients with acute malnutrition to INAS (National institute for Social Action) by completing and signing "Ficha de Certicação Clinica" which contained personal information and details on the medical and the nutrition and food insecurity conditions. On top of a preliminary question-based evaluation, INAS staff were responsible for conducting home visits within a period of 15 days, to define the socio-economic condition of any potential beneficiaries.
- Registration of beneficiaries: registration was done at INAS office. Personal data were inserted in the electronic system and a unique identification number was automatically generated for each beneficiary. Details of an alternative contact were also entered in the system, in case the clients were not able to collect and redeem their vouchers.
- Monthly visit: each month beneficiaries were supposed to go to the health facility for nutritional and medical assessment and then to INAS delegation to collect the voucher, according to a predefined schedule. In order to get the voucher, beneficiaries had to present their personal identity card (ID) and the patient card containing their medical and nutritional information.
- Voucher redemption: each month beneficiaries went to the shops to redeem the voucher. The voucher and the beneficiary numbers were introduced in the system using a mobile telephone.

**Overview of the voucher-based programme:**

Beneficiary target: the programme targeted four beneficiary categories namely households with PLHIV on ART and/or TB treatment, people and lactating women and girls (PLWG) and children aged 6 months to 14 years with acute malnutrition.

Voucher-value: 985 meticais/month (USD 33) for 6 kg of rice, 6 Kg of maize meal, oil 1L, 2 Kg of sugar, 3 Kg of groundnuts, 2 Kg of beans, 1 Kg of salt and 1 dozen of eggs

Duration: 6 months

Country examples

## Bolivia

At the end of March 2020, the Government issued a rigid quarantine in attempt to contain the spread of COVID-19.

PLHIV in two main cities (La Paz y El Alto) were supported by WFP to mitigate the effects of the COVID-19 restrictions, through the delivery of value vouchers that could be exchanged for food and biosecurity items. Additionally, nutrition trainings to PLHIV were carried out to reinforce their knowledge around good nutrition and adherence to their treatment, including issues due to the context of COVID-19.

As a result of positive feedback reported by beneficiaries and health staff, the National Network of PLHIV (REDBOL) recognized the importance of nutrition trainings to support HIV treatment and officially requested WFP Bolivia to systematically integrate the training package into the HIV services in other cities. REDBOL assisted WFP with involving PLHIV in the dissemination of the training materials.

**Key features of the intervention:**

1) The use of different training modalities (virtual, face-face or hybrid) to mobilise people to attend, based on the learner preferences and physical/economic access. For example, older people preferred to attend face-to-face session mainly due to their technological limitations.
2) Mechanisms for follow-up established to provide tailored nutrition counselling to participants of the trainings.
3) Focus Group Discussions with women living with HIV were conducted to inform the programme design. The participants helped to identify their main regular health and nutrition needs and to define their training priorities.
4) The use of virtual platforms for holding pair support groups, to share messages and experiences.

### 5.2.2. School health and nutrition programmes (formal and informal settings)

School feeding is defined as the provision of food to children, prepared at school, in the community or delivered through central kitchens. Some programmes might provide complete meals, while others might offer nutritious snacks. Where possible the food is procured locally and includes fortified foods. School feeding programmes may also include take-home rations, provided to families as an incentive to send children to school, conditional on their attendance. These help to lower drop-out rates and bring more out of school children into the classrooms.

WFP is the largest supporter of school feeding programming globally, a key tool for providing a safety net for children and their families and in building longer-term human capital through education and nutrition. School Meals, using schools as a delivery platform, are a key element of an essential package of integrated health and nutrition services.

School feeding's primary objective is to contribute to child development through increased years of schooling, better learning and improved nutrition. It also contributes to reducing the gender gap in education. Furthermore, school feeding programmes have a wide range of potential benefits that are mutually reinforcing. Not all potential benefits will materialise in all situations, and there will be trade-offs between different objectives and outcomes. The programmes can be implemented in formal and/or informal schools or any other education centres, as long as these are recognised and/or endorsed by national authorities.

## Rationale

Families struggling to cope with HIV and TB may decide to withdraw children from school to save and earn money, help in food production, or assist in caretaking. Children and adolescents living with HIV and/r with TB may miss school days due to illness and medical appointments[42].

## Objective

The main objective of school feeding in the context of HIV/TB is to increase school attendance amongst children and adolescents living with or affected by HIV/TB. School feeding can contribute to delaying child marriage and other risky behaviours which could further expose children and adolescents to HIV/TB. Attending school is associated with lower-risk sexual behaviours and also with lower HIV prevalence among young men[43].

Under the school health and nutrition approach, schools may facilitate the referral or the access to sexual and reproductive health services, as well as to HIV education. Indeed, research shows that the most trusted source for young people to learn about HIV/AIDS is through schools and teachers (Boler 2003).[44]

## Targeting and eligibility criteria

As all targeting involves trade-offs, it is important to have a clear set of objective criteria that are agreed upon with national authorities , and that are well documented and clearly communicated to communities. Targeting criteria are based on the priorities of each particular school feeding programme. Agreeing with stakeholders on these priorities is a process that can contribute towards local ownership and sustainability of the programme.

A school feeding programme should be considered when the situation analysis suggests that school attendance may have been adversely affected by food insecurity and the effects of HIV/TB, a school feeding programme should be considered. It can also be considered when there is high risk of HIV infections among out of school children/adolescents.

Targeting should be as detailed as possible to reach children with the greatest needs according to the objectives of the programme and the available resources.

- If food is provided at the school, it should be given to all children to avoid stigmatization of those living with HIV and/ or with TB or from affected households.
- When there is high HIV/TB prevalence- reflected in a high proportion of children living with HIV and/or with TB, made orphans by AIDS, or whose families are affected by HIV/TB- combined with high levels of poverty and food insecurity, low school attendance and weakened social safety nets, then a take-home ration (THR) in the form of in-kind or cash incentives may be considered as an alternative or complementary support. This measure is to help specific groups of vulnerable children/adolescents stay longer in schools - which may include OVC or children/adolescents living in female-headed households, or households hosting chronically-ill individuals or persons with disabilities[45].
- The targeting should not be based solely on HIV/TB status but rather on specific vulnerabilities faced by the target group, which can overlap with other children or adolescents not affected by the disease. These transfers are meant both to incentivize households to send their children to school and transfer additional value to the most vulnerable households. The transfer should be provided to each child/adolescent meeting the criteria (rather than to each household), therefore a household may benefit from more than one ration.

## Service delivery points

**On-site meals** should be provided to all children attending school on that day. **Take-home rations (THR) or cash-** incentives would normally be directed to the parent or guardian, who would collect the ration from the school. When relevant, distributions through school-organized volunteer outreach, roadside pick up or other alternative distribution schemes outside the school can also be considered for the most vulnerable households. Distributions should be frequent, even fortnightly or weekly. THR/cash incentive are normally conditional on a minimum of monthly attendance, which is usually 80 percent. However, in the calculation of this conditionality, we should consider the likelihood of school

42 Hargreaves JR, Morison LA, Kim JC, et a. The association between school attendance, HIV infection and sexual behaviour among young people in rural South Africa Journal of Epidemiology & Community Health 2008;62:113-119.
43 ibid
44 DCP3, Re-Imagining School Feeding: A High-Return Investment in Human Capital and Local Economies, Chapter 20, p.210
45 Current experience with cash-based school feeding is limited and lesson learned have yet to be distilled from pilot countries. Example of cash-based transfer in school-based programme are collected in this document: https://docs.wfp.org/api/documents/WFP-0000040005/download/

absenteeism for children/adolescents living with and affected by HIV/TB due to illness, medical appointment and other family restrictions, and adjust the threshold accordingly.

Sexual and reproductive health messages, including HIV/AIDS education, sensitization and prevention activities should be integrated into the school feeding programme. To ensure an effective school-based education on HIV/AIDS, it is pivotal to develop an appropriate curriculum and then train the teachers to use the knowledge and skills attained during the training to improve students' knowledge about HIV prevention and transmission, attitudes toward HIV prevention, and behaviours relating to HIV/AIDS. WFP should collaborate with the governments, UN agencies and NGOs to ensure that HIV/AIDS awareness and prevention education activities are incorporated into School Feeding programmes in accordance with each country's specific context and national HIV/AIDS strategies.

For more information, please refer to HIV/AIDS section in the School feeding manual

**Transfers**

The choice of food commodities for **on-site meals** should be guided by the nutrition needs, acceptability of the food to beneficiaries, logistic constraints, and associated costs. In the absence of specific guidance from national policies, the nutritional composition of school meals should at the minimum, meet 30 percent of daily requirements for energy and macronutrients (carbohydrates, protein and fats) and 50-70 percent micronutrients. It is important that the Government and partners are consulted in the planning stage for additional information that may help in the decision-making. (More information in the School feeding Programme Guidance Manual and Quick guide on health meals and snacks). In the context of high HIV/TB prevalence, it is important to consider the following:

- The inclusion of food commodities that are fortified as per WFP specifications, including specialised nutritious foods to ensure that the energy and micronutrients needs are appropriately met. Normally, in asymptomatic children living with HIV, it is recommended an increase of 10 percent of energy and 20-30 percent in case of opportunistic infections. For adolescents, more attention should be given to specific nutrients (e.g., calcium, vitamin D, vitamin A, Iron) (see **Section 2.2.**).
- The selection of food commodities and feeding practices that are appropriate to cope with common complications (e.g., diarrhoea, sore mouth, lack of appetite, etc) observed in children and adolescents living with HIV.
- Ensure food safety and hygiene practices are followed and guaranteed, in line with the Guidance "From the School Gate to Children's Plate: Golden Rules for Safer School Meals".
- Train teachers and other relevant staff on how to support children and adolescents with feeding difficulties.

The **take-home ration assistance can be provided through** a combination of different transfer modalities (in-kind, cash or voucher). The transfer modality and value should be calculated based on the relevant essential needs and be in alignment with the programme objective (s), for example it should consider:

- the direct and indirect household expenses caregivers face, related to schooling, in order to overcome primary caregivers' resistance to enrolling children in schools and medical expenses;
- rate of school absenteeism amongst children living with or assisting primary caregivers with HIV/TB due to illness and medical appointments;
- estimated food consumption requirements and the additional nutrition needs of children or adolescents living with HIV and/or with TB; and
- additional transfer(s) provided by other intervention(s) in the same areas.

Country examples

## NCP in Eswatini

Since 2009, in Eswatini, WFP has provided social safety nets for Orphans and Vulnerable Children, with 59 percent of them due to AIDS, in pre-primary school age across the country. WFP provides school meals five day a week and together with other partners promote access to education, health care and other basic social services.

**In Lesotho,** in 2019, WFP, in partnership with MoH, conducted HIV and AIDS awareness sessions for primary school learners and caregivers, including teachers. Topics discussed included modes of transmission, prevention of HIV, care and treatment.

### 5.2.3. Asset creation and livelihood support activities

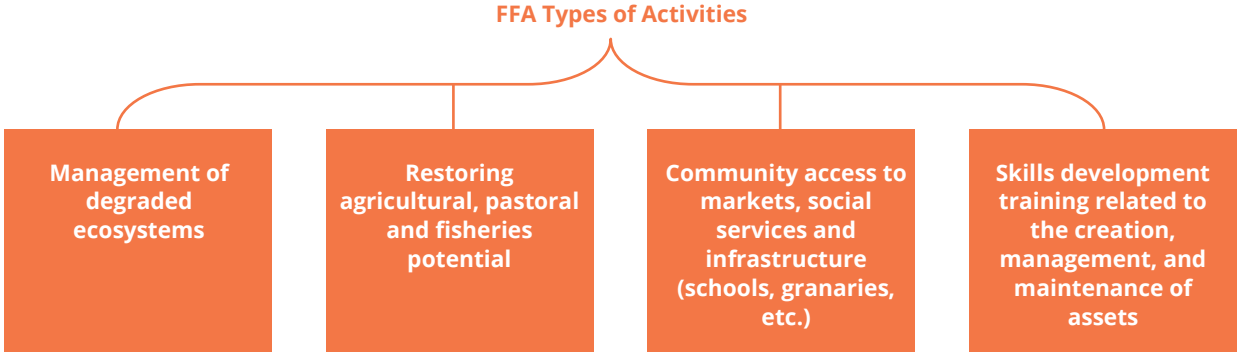
Public Work Programmes (PWPs) are the most widespread social protection instrument combining transfers, labour schemes, and asset creation. The World Bank defines PWPs as social protection instruments with the dual objectives of providing temporary employment as well as generating and/or maintaining some labour-intensive infrastructural projects and social services (Subbarao et al, 2013). PWPs have a range of objectives, as summarised in **Table 1**. To achieve these, PWPs may be short-term (e.g., to mitigate shocks) or longer term (e.g., for poverty relief or food security).

***Table 1:*** *Examples of PWPs by their objective. (Summarised from Subbarao et al, 2013)*

| PWP objective | Examples of PWPs |
|---|---|
| Mitigation of covariate shocks (both unexpected and seasonal) | Morocco's Promotion Nationale<br>Bangladesh's Food for Work<br>Bolivia's National Plan for Emergency Employment |
| Mitigation of idiosyncratic shocks in response to a temporary or structural job crisis | India's Mahatma Gandhi National Rural Employment Guarantee Scheme (MGNREGS)<br>Red Cross's Home-Based Care Programmes in Malawi and Zimbabwe |
| Poverty relief and food security | Ethiopia's Productive Safety Net Programme (PSNP)<br>Bangladesh's Rural Maintenance Programme<br>South Africa's Expanded Public Works Programme (EPWP) |
| As a bridge to more permanent employment | Bangladesh's Rural Maintenance Programme<br>Argentina's Jefes de Hogar (Head of Household) programme<br>El Salvador's Temporary Income Assistance Programme (PATI)<br>South Africa's EPWP |

**Food Assistance for Assets (FFA) programmes**

The concept is simple: people receive cash or food-based transfers to address their immediate food needs, while they build or boost assets (such as constructing a road or rehabilitating degraded land) that will contribute to improving their livelihoods such as by creating healthier natural environments, reducing risks and impact of shocks, increasing food productivity, and strengthening resilience to natural disasters.



In each community, WFP aims to integrate multiple types of FFA activities with government strategies and other WFP and partners' interventions, including UN partners such as Food and Agriculture Organization (FAO) and International Fund for Agricultural Development (IFAD) to reinforce each other's impact.

**FFA cannot be classified as a social protection programme at all times**

In fact, a majority of current FFA programme do not meet the criteria defined above:

- It is implemented in a predictable and reliable way.
- The government is involved in the design or implementation of the activity.

On top of this, there are substantial differences between the PWP and the FFA approaches. Critics of PWPs argue that PWPs' primarily focus is on the transfer – rather than the nature or quality of the assets created or maintained – and that this results in poor long-term outcomes.

Early iterations of WFP's Food for Recovery (FFR) and Food for Work (FFW) bear strong similarities to the present-day PWPs. The focus was on the transfer rather than the assets created. Over 50 years of implementation, WFP evolved FFR/ FFW into its current day FFA. The emphasis is on a) planning: putting communities and their needs at the centre of planning processes; b) applying crosscutting lenses: such as gender equality and women empowerment, protection, nutrition; and c) design: ensuring quality standards are applied to asset building (WFP, 2016).

In an increasing number of countries of operations, WFP is contributing to enhancing PWPs by providing technical advice to governments in their design and planning (and potentially, implementation), and building upon FFA approach, principles and experiences. (**BOX 10**)

**BOX 10**

## FFA and PWP scheme

Situations when FFA may be considered within PWP schemes should include:

- When PWPs are designed to achieve food security and development objectives for food insecure populations reached through seasonal/temporary work. For example, FFA can be used to support PWPs component for meeting the food needs of food insecure populations – but not as a provision of a salary and formal employment in large scale schemes.
- When PWPs are categorised as community-based asset creation schemes - some governments may use PWPs to create community assets, although this is generally the exception rather than the rule. To qualify as community-based asset creation schemes, the PWPs needs to have the communities as an integral part of the identification, selection, planning, construction, use, management, maintenance, and ownership of the assets created.

When framed in this way, FFA can be a type of social protection programme that by providing food or cash transfers and promoting the construction or rehabilitation of productive assets and resilience-building as a primary or explicit goal.

**Livelihood support activities**

include training for value chain development and financial capital (including marketing, income generation, handcraft making, saving, etc) or any other training/income generation activity (including Food for Assistance Training) not related to asset created through FFA. This type of programmes may also include the provision of food or cash-based transfer.

### Rationale

Households are often inadequately equipped to cope with the shocks and stresses of a family member living with HIV and/or TB. HIV is a life-long chronic disease which require a sustainable care model. AIDS-related death also represents a massive shock to household livelihoods. When someone living with HIV and/or with TB is facing significant illness, caregiving responsibilities can hinder the household's productive capacity and reduce income. Moreover, pervading discrimination and stigmatisation can lead to avoidance of the individual's business, refusal to buy, sell or trade with, and even lead to attacks on businesses owned by people living with HIV/TB. Small businesses suffer and can become unable to continue in the face of inaccessible markets. Workplace discrimination can make working unbearable and can lead to unlawful dismissal from employment. Travel to and from care and treatment centres and time given to caregiving responsibilities reduces the available time for productive labour within the household. The majority of people providing care for PLHIV are unpaid, often family members of sick relatives or volunteers working with local organisations. Livelihoods are inevitably undermined due to competing priorities. Finally, economic insecurity heightens vulnerability and decreases adherence to HIV/TB treatment[46], through increased mobility and unsafe migration in search of job, and the risk of HIV transmission through transactional sex to secure income or access to commodities[47].

### Objective

Livelihood and asset creation programmes can support people living with and affected by HIV/TB by:

- providing direct food or cash-based transfers to meet the consumption gaps of the most vulnerable people;
- building household/community assets and capacities that reduce the risk of disaster, strengthen livelihood and build resilience over time; and
- maintaining the dignity of people living with and affected by HIV/TB, by increasing their independence and confidence through productive work as well as their community integration.

### Targeting and eligibility criteria

Targeting should be based on a good understanding of the context and therefore the distribution of vulnerable groups, exposure to shocks, aggravating factors, among others. Participatory planning, including of targeting, is highly recommended for livelihood and asset creation programmes to empower the most vulnerable and to promote social inclusion.

In the context of HIV/TB, groups generally requiring special attention include; people living with HIV/AIDS and people cured from TB; people caring for people living with HIV/AIDS or TB and/or orphans and households fostering orphans (in particular, orphan-headed households and single-parent households, especially those headed by women). However, targeting programmes on the basis of HIV status is frequently not recommended, due to the risk of increasing stigma and discrimination. A solid understanding of the given context as it relates to HIV/TB epidemic, developed for example through community consultations, focus group discussions and key informant interviews, can inform the development of eligibility criteria that are sensitive.

Generally, in the context of HIV/TB, the following proxy can be used:

- households with high dependency rates
- households with one or more chronically ill person

  households hosting or headed by OVC

### Service delivery points

FFA and livelihood interventions are generally implemented by CPs at community level, by leveraging the involvement of

46 Beth S. Rachlis et al. Livelihood Security and Adherence to Antiretroviral Therapy in Low and Middle Income Settings: A Systematic Review
47 Masanjala W. The poverty-HIV/AIDS nexus in Africa: a livelihood approach. Soc Sci Med. 2007;64:1032–1041

### Transfers

The transfer (food or cash-based) value is calculated based on the food gaps and with consideration of the working days, regardless of the number of participants by household. However, in the context of HIV and TB consider:

- The calculation of the transfer should consider healthcare-related expenditures as well as factor the earning loss faced by individuals and households affected by HIV/TB.
- The composition (food, cash or a mix of both) or value of the transfers should enable recipients to access nutritious food and address the food needs of individuals and households (see **Section 5.2.1** and **BOX 9** for more information on the design of a ration). To the extent possible, fortified foods should be considered.

### Additional considerations in the context of HIV/TB

Specific considerations are needed regarding the implementation of asset creation and livelihood programmes in the context of HIV and TB (or those that can generate potential negative effects). To complement the general considerations listed in **Section 5.1.1**, consider the following aspects when you design asset creation and livelihood programmes:

- Created and rehabilitated assets can contribute to mitigate the impact of HIV and TB, directly and indirectly, and help tackling some of the drivers of HIV and TB epidemics. Examples include the construction of latrines, handwashing facilities, water points suitable for domestic, livestock and irrigation use, to reduce exposure and extent of vulnerability to opportunist infections, such as diarrheal illness. The construction of roads and other small infrastructure can improve access to basic social and health services, including access to HIV/TB treatment centres.
- In most FFA and livelihood projects, works are organized and supervised in a way such that participants are often required to adhere to specific working days during the week, and specific hours or period during the day. In the context of HIV/TB there is the need to give flexibility to participants to decide on the best time during the day or week to work and to designate one or more participants from the household to engage in the activities, when the ability of the PLHIV to work is reduced. For example, working hours may be adjusted to reflect the period of the day or week that is preferred by PLHIV/TB, given that they often also need to accommodate regular medical appointments.
- The project may account for less working hours for specific vulnerable groups and include low labour-intensive activities. People who are physically unable to participate, can be engaged in less physically demanding activities such as community administrative responsibilities, nursery (weeding, watering, shade making, pots filling, fencing, etc.) or Community-based Participatory Planning (CBPP) training, etc. This type of arrangement should be organized with them by the community itself and CPs without causing any stigma.
- Vulnerabilities and needs of people living with and affected by HIV and TB may not receive adequate attention by the community and not be addressed in the planning phase. In countries or areas with known higher prevalence, the communities would need to be sensitized to promote activities that reduce hardships, promote social inclusion (e.g., awareness creation and anti-stigma efforts) and enable inclusion in income generation activities (e.g. partnerships for vocational training delivered by partners, etc.).
- Train community members including members from the networks of PLHIV and TB networks to be social workers. The training should include anti-stigma, voluntary testing, avoidance of malpractices, solidarity mechanisms and awareness raising.
- Consider involving PLHIV and TB networks in the community-based participatory planning process to reduce the risk of stigma and to ensure the assets are relevant for people living with and affected by HIV, and that targeting is sensitive to the needs of these vulnerable groups.

For more information on FFA and livelihood programmes :

- FFA Manual
- FFA Infobits collection
- FFA regional Factsheets
- Guidance: Reporting school feeding during school closures amid COVID-19

Country examples

## Zimbabwe

The FFA programme acts as a platform to raise awareness in relation to sexual reproductive health and rights (SRHR), among which family planning, birth spacing, and HIV considerations.[48]

**In Somalia,** as part of a multi-year Rome-Based Agencies (RBA) Resilience Strengthening Initiative, referral pathways were established between nutrition, TB/HIV and livelihood activities, with the aim of eventually leading to improved food security, nutrition and increased resilience for populations. The referral system creates synergies among the different activities of the RBA programme thereby strengthening their effectiveness. For example, nutrition beneficiaries, including those living with HIV, not only benefit from the Specialized Nutritious Foods (SNFs), but they are also referred to livelihood activities (implemented by both WFP and FAO) to strengthen their resilience to shocks[49].

## Guatemala

In 2020, WFP supported HIV positive women of the local association Mujeres Amigas. Each woman received technical assistance and seed capital to roll-out income-generating activities such as hydroponic gardens, catering and food preparation. Training included the topics of labelling techniques and product commercialization. Throughout the trainings, women were educated on the importance of adhering to antiretroviral ARV treatment, healthy eating habits and protective health practices.

## Cameroon

In Cameroon, the East and Adamawa regions are among those most affected by poverty and HIV and have recently been facing a massive influx of refugees fleeing violence in the Central African Republic. One in 6 people living with HIV and taking ART is estimated to have acute malnutrition, and half of the households affected by HIV are considered food insecure or vulnerable to food insecurity.

In 2014, WFP initiated a nutrition rehabilitation programme to support retention of ART clients in care and adherence to treatment. As at 2021, approximately 2000 ART clients (two third women) benefit from the programme annually.

After a study revealed that 33 percent of ART clients having graduated from the nutrition rehabilitation programme had relapsed into acute malnutrition, in 2017, WFP implemented an additional intervention in 2017 to help the most vulnerable build their livelihoods (with a focus on

48 The potential of Food Assistance for Assets (FFA) to empower women and improve women's nutrition, p. 62 https://reliefweb.int/sites/reliefweb.int/files/resources/1520243328.WFP-0000023821.pdf

49 Rome-based Agencies Resilience Initiative, 2018 Annual Report https://docs.wfp.org/api/documents/WFP-0000110496/download/?_ga=2.221977434.313546159.1609837883-773744317.1586959948, p.86

single female-headed households). Since then, 850 persons have joined 37 Village Savings and Loan Associations. All received training on agriculture, small livestock rearing or petty trading and start-up kits. They managed to produce 11.7 tons of food (maize, peanut, and soybeans), raise 1,600 broilers and sell them for a total of USD 12,000 while small businesses made a profit of USD 6000. Beneficiaries collectively saved USD 4,500, granted USD 3,200 as interest credit, and mobilized USD 1,800 for solidarity funds with their associations. This economic empowerment programme has contributed to improving the nutrition, food and financial security of these vulnerable HIV-affected households and allowed them to lead healthier and more dignified lives. This also led to further social inclusion as people living with HIV have increased their participation in their communities' economy and are in a better position to support their families.

### 5.2.4. Preventive Nutrition Programme

Through **Preventive Nutrition Programme**, WFP provides supplementary rations in the form of in-kind, cash or voucher to the most nutritionally vulnerable groups, primarily young children, PLWG and adolescents for a defined period of time particularly in areas where high food insecurity (availability and/ or access) or high prevalence of acute and chronic malnutrition or risk thereof due to aggravating factors (i.e., morbidity, population displacement and population density). This programme typically forms part of a multi-sectoral package of assistance (i.e., GFA, health, WASH, nutrition SBCC) provided by WFP and other stakeholders to prevent context-specific drivers of malnutrition.

#### Objective

The main objective of preventive nutrition programme in the context of HIV/TB is to prevent malnutrition and related mortality in vulnerable populations and high-risk groups. In addition, it can contribute to HIV/TB treatment uptake and outcome and thereby reduce HIV vertical transmission.

#### Rationale

HIV and malnutrition are closely interlinked. HIV affects the immune system increasing the risk of opportunistic infections and diseases. In turn, infection increases nutritional needs while increasing nutrient losses and reducing intake and absorption of nutrients. The ensuing deterioration of nutritional status affects the immune system and the cycle continues with disease progression and further worsening of nutritional status. Mortality risk is 2-6 times higher amongst PLHIV on ART with a low Body Mass Index (BMI). This vicious cycle also applies to TB infection.

#### Targeting and eligibility criteria

Geographical locations targeted are those which have high levels of malnutrition or risk of deterioration due to aggravating factors such as food insecurity, morbidity, population displacement.

The targeting of individuals within the areas assessed as meeting the defined programme criteria should not extend to everyone living with HIV/TB but should focus on the most nutritionally vulnerable individuals within this target group; these are normally children aged 6-23 or aged 6-59 months and also pregnant and PLWG. The target group can extend in specific contexts (for example those with high as food and nutrition insecurity, as part of the immediate emergency response) to complement general food assistance.

*Note: With the introduction of 2010 HIV and AIDS Policy, WFP has moved away from a preventive approach for everyone living or affected by HIV and/or TB, which were defined unstainable and inopportune, to instead prioritise targeted programmes.*

#### Service delivery points

Preventive nutrition programmes typically provide rations consumed at home, once per month, however the frequency should be modified as appropriate to the context.

The programme should be implemented through community-based services or by leveraging health system platforms. This support should be linked to ART/TB treatment, in particular to PMTCT, therefore it is imperative that there is functional referral system between health and community platforms. In the context of HIV/TB, it may be necessary to have multiple days a week for programme delivery to accommodate attendance to medical check-ups.

Preventive nutrition programmes are established for a pre-defined period. The duration should be guided by the objectives of the programme, and the scale and severity of the crisis. The need for the programme should be re-assessed as the context evolves.

### Transfers

Provision of food transfers, frequently Specialised Nutritious Foods (SNF)[50], is the primary modality used for prevention programming. Use of specialized products should be discontinued as soon as the situation allows, in order to encourage a shift to sustainable and age-appropriate healthy diets prepared using locally available foods. Cash or voucher transfers an also be considered to enable access to nutritious foods available on the markets. However, the success of these programmes depends on a variety of age-appropriate healthy foods being available in the marketplace and on the implementation of complementary activities necessary to improve knowledge and support behaviour change for improved nutrition and hygiene practices.

Information collected during the nutrition situation analysis should inform decision-making on which transfer to select for a given context. Ultimately, the transfer needs to appropriately fill the potential energy and nutrient gap of the target population. See also **Section 2.2.** and **BOX 9**.

### Additional considerations in the context of HIV/TB

To complement the general considerations listed in **Section 5.1.1**, the following aspects should also be taken into account when designing a Preventive Nutrition Programme:

- To define the target group, consider the overall nutrition-related vulnerabilities, as well as barriers, such as health-care expenditures and potential earning losses that make individuals living with HIV and TB more prone to become malnourished. For example, consider extending preventive nutrition programme to PLWG, when high food insecurity and malnutrition are associated with poor uptake of PMTCT services.
- Reduce the time and the logistics related to food distribution, so they do not interfere with the routine medical appointment. In the context of HIV and TB, it may be necessary to have flexible schedule for food distribution to accommodate medical appointment and potential illness condition.
- To define the transfer value, consider the additional nutrition requirements of the specific target group and the cost of a healthy diet (refer to **Section 2.2.** and **BOX9**)
- Stigma and discrimination can discourage PLWG with HIV/TB from seeking food and nutrition assistance. Involve HIV/TB support groups or any trusted organization with informing PLHIV/TB about the programme. Consider sensitising healthcare and community workers in both clinical and non-clinical settings.
- Create awareness among people living with, at risk of and affected by HIV and TB about the programmes, including eligibility, entitlement and duration.

### M&E framework

Preventive nutrition programme in the context of HIV/TB can be classified as Care and Treatment programmes (activity tag: HIV/TB C&T) because they address individual nutrition needs.

**Table 10 and 11 summarise** the most relevant outcome and output indicators in the CRF that can be used for monitoring preventive nutrition programme programmes in the context of HIV/TB. It should be acknowledged that monitoring HIV/TB sensitive preventive nutrition programme is normally not feasible, mainly due to fears of breaches in confidentiality and risk of increasing risk of stigma and discrimination. However, whenever the Country Office is able to disaggregate data on children, adolescents and women targeted because of HIV/TB criteria, the current WFP CRF and COMET systems allow the Country Office to report the information, as follows.

50 SNF fact sheet

***Table 10:*** *Outcome indicators relevant Preventive Nutrition Programme in the context of HIV/TB*

| Outcome indicators | Activity category and tag |
|---|---|
| Adherence to nutrition programme | NPA_HIV/TB_C&T |
| Proportion of eligible population that participates in programme (Coverage) | NPA_HIV/TB_C&T |
| Proportion of target population that participates in adequate number of distributions (adherence) | NPA_HIV/TB_C&T |
| Minimum diet diversity for women (MDD-W) | NPA_HIV/TB_C&T |

***Table 11:*** *Output indicators relevant for preventive nutrition programme in the context of HIV/TB*

| Output indicators | Example | Activity tag |
|---|---|---|
| Number of individuals receiving food/ cash-based transfers/commodity vouchers transfers | e.g., Number of PLHIV/TB receiving food transfer | NPA_HIV/TB_C&T |
| Number of individuals reached through interpersonal SBCC approaches | e.g., People benefiting from PREVENTIVE SUPPLEMENTARY FEEDING PROGRAMME who receive messaging around nutrition/HIV/TB | NPA_HIV/TB_C&T |

For more information:

- WFP ACR Guidance for HIV and TB Programming
- WFP Indicator Compendium
- WFP Corporate result Framework

# Part C

Leverage partnerships and explore funding opportunity

# 6 Key partnerships

To better achieve its goals, WFP should partner with key actors in the area of social protection at global level, as well as regional and country levels.

Under the UNAIDS Division of Labour, WFP and ILO are co-conveners of the IATT on Social Protection, established to enhance global coordination and advocacy around social protection and HIV/TB. Other partners include UNICEF, Word Bank, UNESCO, UNHCR, UNODC, UNDP , WHO, UN women, amongst others. WFP also partners with research institutions, including the London School of Hygiene and tropical Medicine (LSHTM) and the University of Oxford.

At the regional level, WFP should engage with key regional bodies, including key UN agencies, regional bodies ( such as SADC, AU, ECOWAS ) donors and research institutions, to raise the visibility of the important role social protection can play in addressing the specific vulnerabilities and inequalities faced by this PLHIV, people with TB and their families.

At country level, a strong partnership with the Government is essential. WFP should work closely with the Ministries of Agriculture, Social Development and Finance and other relevant ministries according to the country context. WFP should also work with rural organizations, research institutions and civil society organizations, including community-based, community led-organization and PLHIV networks. The objective is to enhance the national social protection agendas, and to strengthen policy dialogue and synergies between social protection and HIV/TB.

*Note: Promote and support the meaningful and active participation of PLHIV, people with TB in all processes, to fully take part in the decision-making process towards inclusive social protection strategies and systems.*

### Leveraging partnerships to advocate for social protection in the context of HIV

In the Southern Africa region, WFP signed an Memorandum of Understanding (MoU) with the Southern African Development Community (SADC) for the period 2020 -2022 with the aim of making significant contributions to improved food and nutrition security. Supported by an implementation plan, the two institutions agree to collaborate on sectoral themes such as social protection, health, climate change, food and nutrition security and disaster risk reduction. This partnership provides an opportunity for advocacy work on HIV sensitive social protection at the regional level.

# 7 Funding opportunities

Developing a financing or resource mobilization strategy is an important step in the implementation of programmes that integrate and enhance sustainability. Social protection cannot be seen as a “matter of charity or morality”, but as a legal obligation, that every individual is entitled to. In the face of an unlimited number of possible demands it is important to consider the scarcity of financial resources, globally. However, governments and other relevant stakeholders should aim at a progressive realisation of rights and therefore concentrated efforts over time to allocate resources that address the needs of all people every-where, inclusive of PLHIV and people with TB.

## 7.1. Traditional HIV/TB donors

**The UNAIDS Joint programme** supports each cosponsors' work with the annual UBRAF allocation. Recently[51], UNAIDS introduced the Country Envelope (CE) and the Business Unusual Fund (BUF) with the aim at reducing gaps in "Fast Countries" and populations in greatest needs in other countries. While UBRAF allocations are managed at global level, Country Offices are encouraged to coordinate with the UNAIDS country teams for CE and BUF allocation. CE envelopes are available in all priority countries including but not limited to "Fast-Track" countries. BUF is a different mechanism based on countries proposals on basis of persisting gaps.

Ahead of each UNAIDS biennium, the Country UN Joint Teams on AIDS develop Joint plans focussed on a limited number of high priority areas under which clear deliverables and specific activities are listed. These plans reflect the UN's Joint Teams contributions to the national HIV priorities and are meant to provide a comprehensive picture of what UNAIDS cosponsors do individually and jointly to advance the HIV response in each country. Each year around October, after regional level consultations, Country Joint Teams are informed of the funding they will be available for country envelope allocations. The regional Joint Team is then in charge of conducting a quality assurance review exercise, to decide on BUF allocations per country.

The CE funds are meant to be catalytic funds that can initiate short-term work for co-sponsors on an annual basis. If the situation dictates, as in the context of urgent re-programming due to COVID-19, the Joint Team can re-prioritise action and resources or develop a new plan.

When it comes to allocating funding, the particular emphasis is to be placed on closing the persisting response gaps. For the persisting gaps that run across countries of the region, collaboration of the country-level, regional and HQ teams will be required to effectively move the agenda, under the leadership of the cosponsors leads as per the division of labour.

### RBN experience in the CE and BUF funding allocation

Based on previous experience in RBD regions, presented below is some guidance for WFP RBs and COs on how to engage in the Joint Plan and CE/BUF allocation processes:

**What can you do at regional level?**

Advocate for additional countries to receive CE and BUF funding if needed. Members of the regional joint teams on AIDS (JURTA) can influence decisions about CE recipient countries and allocated amounts by country. Such requests need to be backed up by evidence (epidemiological data, HIV response gaps, capacity of the Joint Team on AIDS). For example, in 2017, JURTA in West and Central Africa (WCA) advocated for Guinea Bissau to be added to the list of countries to receive CE allocations. This request was based on epidemiology: despite a very small population, Guinea Bissau has the highest HIV prevalence rate in West Africa. Since then, Guinea Bissau has been kept on the list of recipient countries. In 2019, the JURTA also encouraged Mauritania and the Gambia (two countries that do not receive CE) to submit for BUF allocations, and they both accessed such funding in 2020.

**Seize the quality assurance process as an opportunity to advocate for key thematic issues to be considered by Country Joint Teams on AIDS.**

In both 2019 and 2020, discussions were organized between the regional and country joint teams to discuss the country Joint Plans and proposed CE allocations. This was an occasion to discuss the strengths and weaknesses of proposed plans including gaps in addressing some key thematic issues. In 2018, JURTA advocacy efforts led the Joint Team in Nigeria to add an activity dedicated to HIV in emergencies in their plan which was later integrated as deliverable in the 2020-2021 plan. In 2020, during the quality assurance process, WFP RBD asked questions to the country joint teams in WCA about their plans regarding social protection and HIV. For many, this initiated a reflexion about this area of work. This was part of JURTA-led advocacy efforts to initiative work on HIV-inclusive social protection throughout the region – Several countries are committed to conduct assessments on social protection and HIV in 2021, some with CE funding while other will prepare to do so in 2022.

51 Country Envelope was introduced for 2018-2019 funding allocation process, while Business Unusual Fund was introduced for the 2020-2021 funding allocation process.

**What should you do at country level?**

**Have meaningful engagement with your country-level Joint Team on AIDS (JUTA) all year long.** Do not wait for discussions on CE and BUF to take place before to attending JUTA meetings. The more engaged you are with the team, the more likely your contributions and proposals will be considered and valued.

**Make sure that you are fully aware of the timeline and attend all key meetings.** The process will differ from one country to the other in terms of timeline and working arrangements between UNAIDS and cosponsors. If you cannot attend, make sure that you discuss with your UNAIDS counterpart and/or send an email with your requests to the Joint Team ahead of the meeting.

**Try to think "out of the box" to propose WFP activities that fit with the Joint Team priorities and contribute to joint initiatives whenever feasible.** Whatever the main priorities set by the Joint Team, there might be an opportunity for WFP to further contribute. Think of the many entry points that WFP could leverage to identify opportunities for involvement and positioning. Discuss with other cosponsors and find out where WFP could make a difference based on WFP mandate and capacities in country. Keep in mind that developing synergies and joint actions with other cosponsors is a key element of successful joint plans and HIV responses and will assist with securing CE funding.

**Prepare in advance to seize opportunities for BUF funding.** BUF allocation is a very competitive process, as each region only has limited amount of money to be allocated to joint, innovative, accelerator type of initiatives to address persisting gaps in countries. If you come prepared, having discussed ideas for joint interventions with other cosponsors, this will increase your ability to submit a strong proposal and thereby be selected for funding. Once the process has started there will been insufficient time to develop a new proposal.

**Global Fund** allocates multilateral funding to countries to support HIV, TB and malaria programs and to build resilient and sustainable systems for health. These allocations are made every three years at the beginning of a new funding period. To access the funding, countries should meet the defined eligibility. Each country that receives support from the Global Fund holds ongoing "country dialogues" where people affected by the diseases can share their experiences and help define the programmes and services that could better meet their needs and the needs of their community. It is also where the choices are made about which services the Global Fund should be requested to fund[52].

Key actions to consider:

- WFP Country Office must connect with the Country Coordinating Mechanism or equivalent steering committee in given country. This is the body responsible for coordinating an inclusive country dialogue process for the development of the funding request.
- When WFP Country Office contacts the Country Coordinating Mechanism, it is essential to find out if a national organization, including PLHIV networks, is already representing similar interests. If so, it is highly recommended to connect and strongly collaborate with it.
- WFP Country Office should actively participate in country dialogue, using data to support the funding requests.

52 More information on the Global Fund funding model is available at: https://www.theglobalfund.org/en/funding-model/

Country examples

## Eswatini Global Fund support to the CoVID-19 Response

To mitigate the impact of the COVID-19 pandemic on the HIV, TB and malaria and support health and community systems in Eswatini, the Global Fund awarded the country a total of USD 2,158,144 for the COVID-19 response, under the Global Fund COVID-19 Response Mechanism. Of this amount, **a total of about USD 100,000 was awarded to WFP Country Office** for the provision of nutritional support for PLHIV and people with TB with acute malnutrition.

In 2020, WFP reached 1,837 households of PLHIV with acute malnutrition with cash-based transfers to meet immediate food needs. This cash provided was based on a nationally designed emergency social protection package considering the costed Minimum Expenditure Basket and the food transfer value used by National Disaster Management agency. The rural beneficiaries (9,185) received a monthly cash transfer for a total of three months covering 60-70 percent of the Minimum Expenditure Basket.

The Client Management Information System was used to identify PLHIV and people with TB with acute malnutrition for support. Health facilities in Lugongolweni, Lomahasha, Mtsambama and Mkhiweni rural constituencies (Lubombo, Lubombo, Shiseweni and Manzini regions respectively) were targeted. Data on body mass index and/or mid upper arm circumference and/or nutritional oedema and/or weight loss were considered for diagnosis of malnutrition. Upon identification, targeted PLHIV and TB beneficiaries with acute malnutrition were registered and household information (including number of household members) verified. The number of beneficiaries per household was used to determine the total household cash support to provide.

**PEPFAR** Since 2003, PEPFAR had continued to support countries to tackle the global HIV and TB epidemics, through bilateral funding. PEPFAR funds and operates programmes in more than 50 countries. However, between 2017 and 2020, PEPFAR has prioritized funding to 13 high burden countries[53].

## RBJ experience with PEPFAR funding

In December 2016, WFP RBJ region received USD 5,641,490 from the United States President's Emergency Plan for AIDS Relief (PEPFAR), through the United States Agency for International Development (USAID), to mitigate the effects of a historic drought on people living with and affected by HIV in Lesotho, Eswatini and Zimbabwe. The funding was used to a) procure and provide SNF to children and people living with HIV with acute malnutrition; b) procure and provide nutritious food to prevent acute malnutrition among OVC; and c) provide food rations to food insecure families hosting people living with HIV and children with malnutrition.

What made this funding a reality for the RBJ region, was that, in the 2016 food and nutrition security vulnerability assessments, efforts had been made to integrate HIV/TB in the routine Vulnerability Assessment Committees (VACs) in select countries. When the drought hit, RBJ was then able to show the effects of the drought on already vulnerable populations which included PLHIV, households affected by HIV and OVC.

53 Botswana, Côte d'Ivoire, Haiti, Kenya, Lesotho, Malawi, Namibia, Rwanda, Swaziland, Tanzania, Uganda, Zambia, and Zimbabwe.

**Bill and Melinda Gates Foundation** is the leading philanthropic funder of international HIV efforts. It is one of the largest private foundations in the world, and its primarily aim is to enhance healthcare and reduce extreme poverty. The foundation has committed HIV grants to organisations around the world and has also contributed to the Global Fund grant.

## 7.2. Non-traditional donors

In the face of competing priorities and limited resources, the HIV and TB responses must exploit synergies for identifying fiscal space, cross-sectoral financing and co-programming of HIV/TB and social protection programmes. Combining HIV/TB and social protection programmes offers opportunities to tap into new funding streams and to increase the potential for the HIV/TB response to reach more people, especially those left behind. With relatively small technical and financial inputs, social protection instruments could have the capacity to address the needs of people living with, at risk of and affected by HIV and TB.

Non-traditional HIV/TB donors, could include social protection donors such as:

- World Bank
- Asian Development Bank
- European Commission

# Annex

## Annex 1: HIV/TB relevant questions/indicators/proxy to include in the vulnerability assessment

WFP needs assessments include food security focused assessments such as Emergency Food Security Assessments (EFSA) or the Comprehensive Food Security and Vulnerability Analysis (CFSVA) which take people's capacity to meeting their food security and nutrition needs as an entry point. They also include Essential Needs Assessments which take a more holistic approach and examines the full range of household essential needs and how they interplay, how households meet them and where they face gaps. These assessments typically include indicators that assess the general households' economic capacity to meet their needs in the market, without a specific focus on HIV and TB.

Some of the questions listed below can be integrated into needs assessment to gather data around vulnerabilities, in the context of HIV and TB. They are presented in the categories:

1. **To identify potential risk factors for HIV/TB transmission on a given location:**

   Examples of information to find out:

   - Number of adolescents (10-19 years old) married?
   - Number of school children by sex who dropped out of school in the last 6 months. And the three main reason(s), such as family can't afford fees, work outside home for good or cash, care for sick family members.
   - Can you access to the following services;
     - information on HIV/TB and sexually transmitted diseases (STIs)?
     - condoms and costs?
     - voluntary counselling testing centre?
     - treatment for HIV/TB as well as STIs?
   - What are the living conditions of the community members? For example, crowded houses?
   - Are you living in the house with people who are not part of your family?
   - Have you heard about a case of sexual violence against a woman or girls in your community?
   - Are women engage in water collection? Are water collection points safely and easily accessible to women?

2. **To assess the impact of HIV/TB on a given location:**

   Examples of information to find out:

   - Household size- How many people by age group eat and stay in the household permanently? How many of these persons living in the house are chronically unable to work for health or disability reason?
   - Is there any member living with HIV (or TB) in this household?
   - How many adults (18+ years) in the household have been ill for more than 3 months during the last 6 months? (Interested in establishing HIV related chronic medication/illness so please refer to members that keep getting sick over and over)
   - Is the head of household among the household members who have been ill for a period of more than 3 months during the last 6 months?
   - Has someone in the household died in the past 12 months?
     - Was this person a male/female?
     - If someone in the household died, was the person a breadwinner?

- Was this person HIV positive before dying?
- Was this person on TB treatment before dying?

- If an adult member of a household is ill for a long time or dies, how do households raise cash, if required?
- Number of orphaned children (defined as one or both parents lost and less than 17 years of age)?

**3. To draw out the implications for project design and implementation**

Example of questions:

- Where do you go for formal health care? (formal/informal health care setting). Distance to the closer health facility? Distance from closer health facility providing HIV/TB treatment?
- If someone was sick and did not seek formal health care, what was the main reason? (no money to pay the treatment or transport, distance of health care post, poor quality of services, prefer not to go for religious or cultural reasons, fear of stigma)
- Are there any activities taking place in the community to help households with chronically ill persons or lost the bread winner to cope with the impacts of illness? If so, what activities, who is undertaking them and who is supporting them?
- The average percentage of total household expenditures that are spent on food in HIV-affected households?
- Are there any food/supplements requested by health counsellor to consume/take? If so, are these given for free?
- Indicate monthly/weekly costs associated with the HIV/TB conditions, related to:
  - transport costs for collecting ART/TB
  - ART/TB DOTS or other drugs expenditure
  - hospital fees
  - others
- Adherence to HIV treatment (and/or TB treatment):
  - Is ART (TB-DOTS) provided for free?
  - During the last month how many doses of medicines (ART and/or TB) did you miss?
  - What are the reasons for missing the doses?
    - No money for buying the drugs
    - No money for transport costs
    - Failed to follow the instructions for taking the medicines
    - Was not at home
    - Was too busy and forgot
    - To avoid side effects
    - Lack of transport to go and collect the drugs
    - My medication was finished
    - Did not have food to eat
    - Internal migration (within the country)
    - External Migration (out of the country)

## Annex 2: Checklist for HIV/TB-sensitive Social Protection

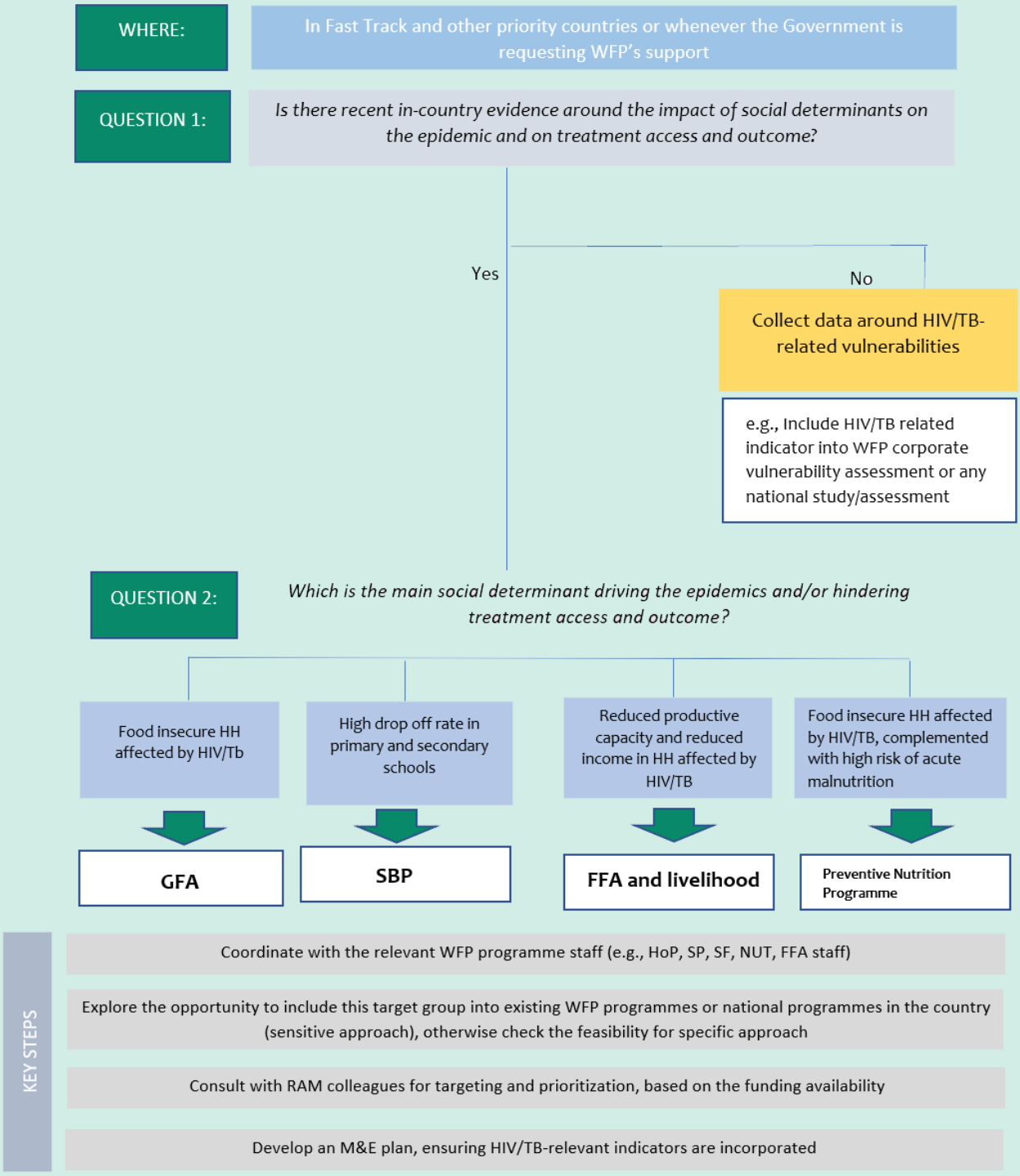
This checklist serves to guide WFP staff as well as partners' staff, to identify what key elements should be considered to ensure that social protection programmes are HIV/TB-sensitive. Ideally all the below elements should be part of the programme, however some of them may require additional time for their integration. For example, monitoring may not be always feasible, due to fears of breach of confidentiality. The SBCC strategy may require efforts from other partners. The integration of HIV/TB indicators into corporate and/or national vulnerability assessments should require sometimes as result of active advocacy efforts.

The elements marked with an asterisk are ESSENTIAL, therefore they need to be always considered when WFP designed a HIV/TB-sensitive programme. The others are NECESSARY which means that needs to be discussed and explored to ensure an adequate sensitivity of the programme.

| ESSENTIAL AND NECESSARY ELEMENTS FOR HIV/TB SENSITIVE PROGRAMME | |
|---|---|
| 1 | **Assessment**: the programme is informed by a detailed analysed of the needs of this target group. HIV/TB relevant indicators must be included into national or WFP assessments. |
| 2* | **Targeting**: targeting processes considers HIV/TB specific vulnerabilities.<br>Targeting criteria must minimizes harmful unintended consequences, such as exclusion or stigmatization of beneficiaries |
| 3* | **Transfer design**: the transfer modality (in-kind, cash or voucher) and transfer value decision-making process considers HIV/TB-related vulnerabilities, including nutrition needs, stigma and discrimination aspects, attendance to medical treatment, and financial inequalities amongst others. |
| 4* | **Distribution modality**: the location, the frequency and the modality of the transfer distribution consider HIV/TB-related aspects, including financial barriers, attendance at medical appointments, sickness and caring of sick people, amongst others |
| 5 | **Communication/sensitization**: the social behavioural change communication strategy includes considerations around HIV/TB transmission and treatment as well as information related to adequate nutrition and hygiene practices. In addition, sensitization campaigns to reduce stigma at community level, and amongst health staff, is included into the planning. |
| 6 | **Monitoring**: HIV/TB-relevant indicators are integrated into the M&E plan to ensure adequate monitoring of the interventions. |
| 7* | **Budgeting**: adequate funding for ensuring that the above elements can be guaranteed |

## Annex 3: Decision tree

This tool can guide WFP staff on *"when"*, "why", "what" and *"how"* is pertinent to incorporate HIV and TB considerations into some of some of the most used WFP social protection instruments, namely General Food Assistance, School Based programmes, FFA, and Preventive Supplementary Feeding Programmes.



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