Eastern and Southern Africa Regional Meeting on Nutrition and HIV/AIDS

2-4 May 2007
Nairobi, Kenya

Meeting Report
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ACKNOWLEDGEMENTS

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ACRONYMS

AED Academy for Educational Development
AFASS Acceptable, Feasible, Affordable, Sustainable and Safe
AIDS Acquired Immuno-Deficiency Syndrome
AMPATH The Academic Model for the Prevention and Treatment of HIV
ANC Antenatal Care
ART Antiretroviral Therapy
ARV Antiretroviral
BFHI Baby Friendly Hospital Initiative
CCC Comprehensive care clinic
CTC Community-based therapeutic care
DHS Demographic and Health Survey
ECHO European Community Humanitarian Aid Department
ESAR East and Southern Africa Region
ESARO East and Southern Africa Regional Office
FANTA Food and Nutrition Technical Assistance
FAO Food and Agriculture Organization
GoK Government of Kenya
HBC Home-based Care
HIV Human Immuno-Deficiency Virus
HKI Helen Keller International
HMIS Health Management Information System
HQ Head Quarter
HTC HIV Testing and Counseling
IEC Information, Education and Communication
IF Infant Feeding
IMMAI Integrated Management of Adolescent and Adult Illness
IMCI Integrated Management of Childhood Illness
IYCF Infant and Young Child Feeding
IATT Inter-Agency Task Team
M&E Monitoring and Evaluation
MICS Multiple Indicator Cluster Survey
MOH Ministry of Health
MRC Medical Research Institute
MTCT Mother-to-Child Transmission
NAF National HIV/AIDS Action Framework
NASCOP National AIDS/STIs Control Programme
NGO Non-Governmental Organization
NPA National Plan of Action
OVC Orphans and Other Vulnerable Children
PLWHA People Living with HIV/AIDS
PMTCT Prevention of Mother-to-Child Transmission
PCR Polymerase Chain Reaction
RIACSO UN Inter-Agency Coordination Support Office
RO Regional Office
RUTF Ready-To-Use Therapeutic Food
SAM Severe Acute Malnutrition
SFP Supplementary Feeding Programme
STI Sexually Transmitted Infection
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<td>TA</td>
<td>Technical Assistance</td>
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<td>TB</td>
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<td>TFP</td>
<td>Therapeutic Feeding Programme</td>
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<td>TOT</td>
<td>Training of Trainers</td>
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<td>Terms of Reference</td>
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<td>TWG</td>
<td>Technical Working Group</td>
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EXECUTIVE SUMMARY

The main purpose of the workshop was to review the progress of the participants’ recommendations of the 2005 Durban consultation on Nutrition, Human Immuno Deficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) as well as to determine best practices, identify lessons learned and gaps, and give recommendations on the way forward towards scaling up nutrition interventions in the context of HIV.

The Participants were a core group of approximately 100 national experts in the Nutrition and HIV/AIDS field from 11 countries including Kenya, Lesotho, Malawi, Mozambique, Namibia, Rwanda, Swaziland, Tanzania, Uganda, Zambia and Zimbabwe and key representatives from regional and global UN agencies, partners and Non-Governmental Organizations.

The three day Nutrition and HIV/AIDS meeting was divided into seven sessions:

• In the introductory session, the participants were provided with technical updates on Nutrition and HIV/AIDS, and progress since the Durban consultation on Nutrition and HIV/AIDS held in April 2005. The presentations highlighted the latest evidence on Nutrition and HIV/AIDS including infant feeding (IF) and the management of malnutrition in the context of HIV, plus the synergistic relations between nutrition and infectious diseases.

• The first and second sessions covered programmatic updates, guidelines, materials and tools available to improve integration of Nutrition and HIV/AIDS programming such as: framework for integrating food security and nutrition into HIV/AIDS programming; guidelines and tools on nutrition, care and support for people living with HIV/AIDS; the revised Baby Friendly Hospital Initiative (BFHI) material; new guidelines on management of moderate and severe malnutrition of HIV positive children. In addition, available HIV and nutrition courses were discussed including the integrated infant and young child feeding (IYCF) course, the BFHI training materials and tools, and the Nutrition and HIV/AIDS training course. Also covered in these sessions were findings from the IF component of the joint Prevention of Mother to Child Transmission (PMTCT) missions in the region and inclusion of Nutrition and HIV/AIDS curriculum in pre-service and in-service training.
Sessions three to five were devoted to three multi-country studies commissioned by UNICEF and WHO on (1) implementation of guidelines, training materials and tools on nutrition care and support for People Living with HIV/AIDS (PLWHA); (2) HIV and IF counseling and support; and (3) management of moderate and severe malnutrition and HIV. Each multi-country review was followed by countries sharing successful experience in the respective areas.

The sixth session focused on a global and a regional review on Orphans and Other Vulnerable Children (OVC), food security and nutrition. Session seven covered resource mobilization for Nutrition and HIV/AIDS programmes through the Global Fund submissions and Mozambique’s successful inclusion of nutrition in the HIV Global Fund submission.

Finally, participants worked together in groups to identify key achievements, major constraints and key priority action for six thematic areas:

1) integration of nutrition into national AIDS policies and programs with national budget allocation;
2) nutrition care and support for PLWHA;
3) HIV and IYCF;
4) management of moderate and severe malnutrition and HIV;
5) OVC, food security and nutrition; and
6) resource mobilization.

This was followed by each country team preparing and presenting a plan of action highlighting the main constraints and challenges, way forward and technical assistance required.

The meeting concluded with final remarks from both UNICEF ESARO and WHO AFRO summarizing the main findings of the meeting, recommendations and follow-up actions.

A summary of the main outcomes, derived from presentations and discussions, is presented below:

**Research and Framework for Nutrition and HIV/AIDS**

- It is evident that effectively integrated Nutrition and HIV/AIDS interventions result in improved immunity, decreased morbidity and prolonged lives for infants, children and PLWHA.
- It is paramount that the latest science and evidence on Nutrition and HIV/AIDS be translated into policy and program implementation.
- To improve the nutrition and HIV/AIDS response, UNICEF/WHO are working on a global Nutrition and HIV/AIDS framework for priority actions and programming. This framework is built on countries’ experiences and good practices.

**Infant Feeding and HIV**

- The WHO October 2006 Consensus Statement on Infant Feeding in the context of HIV re-emphasizes the importance of exclusive breastfeeding for HIV positive mothers up to 6 months unless replacement feeding is acceptable, feasible, affordable, sustainable and safe (AFASS). It also emphasizes the necessity of continued IF counselling and support for HIV positive mothers.
- Research in IYCF has shown that mixed infant feeding (that is, both breastfeeding and other fluids and/or foods) carries a higher risk of HIV transmission than exclusive
breastfeeding. Though replacement feeding eliminates the risk of HIV transmission through breastfeeding, early mortality risk is higher than for breastfed children due to other illnesses such as diarrhoea and pneumonia, such that by 18 months there is little difference in HIV-free survival between replacement fed and breastfed children. Research has also shown that prolonged exclusive breastfeeding is possible with good and continuous counseling.

- It was pointed out that currently HIV and IF counseling is mainly done pre-natally. Follow-up counseling is necessary.

- As a whole, counseling skills on IF remain weak. The IF component of PMTCT training is very limited. As such, it is critical to scale-up IYCF training to overcome this capacity gap. For this, it is necessary to develop a plan and to allocate sufficient funding.

- The meeting agreed that IF related indicators on coverage and outcome should be included in the general Monitoring and Evaluation (M&E) indicators. Global partners are in the process of including IF indicators in the general HIV indicators.

- It was noted that Joint PMTCT missions are a useful approach to address IF in the context of HIV, but this needs to be matched with adequate resources to implement joint mission recommendations on HIV and IF.

- It is necessary to demonstrate empirically the effectiveness of a comprehensive intervention on pre-natal and post-natal counseling and support to HIV-positive mothers on child nutrition, morbidity and HIV-free survival. This will be useful for future advocacy and resource mobilization in support of strengthening of the IF component in an HIV and PMTCT context.

**OVC, HIV, food security and nutrition**

- The findings from a joint UNICEF/WFP global review carried out in 2007 have shown that the Food Security and Nutritional Status of OVC are largely unknown because the information, even if collected, is rarely disaggregated according to OVC status. Following a review of the limited data available, it was unable to be determined if there are disparities between OVC and non-OVC.

- Despite this lack of data, all of the 13 countries with approved National Plans of Action (NPA) in East and Southern Africa are employing a wide mix of food security and nutrition strategies (long and short term outcomes).

- When the impact of OVC programs on food security and nutrition cannot be shown, it is difficult to ensure funding and commitment to sustain OVC programs.

- To improve the nutrition and food security for HIV affected OVC, the meeting highlighted the following areas of importance: improved analysis of OVC by age, gender and location is likely to reveal disparities; better defined vulnerability including nutritional needs; balance and focus on both short and long term interventions; and more evidence and lessons learned to be feed back into scaling up effective evidence-informed programs.

**Management of Malnutrition and HIV**

- A global guideline on an integrated approach to the nutritional care of HIV-infected children aged 6 months to 14 years is being finalized by WHO. It is expected to be released soon for country implementation.
Global guidelines and standards on admission and discharge criteria for moderately and severely undernourished children and adults living with HIV/AIDS are urgently needed. As such, WHO will need to accelerate progress on finalizing the above mentioned.

To improve management of moderate and severe malnutrition in the context of HIV, the meeting highlighted the following important areas: earlier identification of HIV status in malnutrition to be incorporated and implemented through Integrated Management of Childhood Illness (IMCI), Community-based therapeutic care (CTC), Supplementary Feeding Programmes (SFP), Child Health Days; evaluation of the use of therapeutic foods like Ready To Use Therapeutic Foods (RUTF) among others in HIV context; improved access to paediatric HIV care and treatment services with clear links to paediatric units providing services on management of acute malnutrition; capacity building in the nutrition field and retention of staff; and consistent definitions and uniform entry and exit criteria in managing malnutrition in HIV context.

Funding and Policy

Resources from the Global Fund have been made available for Nutrition and HIV/AIDS programming and WHO has created a framework to improve nutrition and HIV submissions. Mozambique has been successful in being granted Global Fund money for HIV and nutrition programmes.

Three priority areas were identified by the meeting to improve resource mobilization:

1. capacity building for advocacy and good proposal development;
2. champion identification; and
3. identification of local resources.

To improve integration of Nutrition and HIV/AIDS into policy and budgeting, the meeting identified some crucial areas: increase the number of nutritionists at strategic/policy levels; facilitate support to coordination boards to make appropriate policy decisions and directions; improve referral networks and M&E tools; drive the agenda of mainstreaming and decentralization to all stakeholder departments; and mainstream and decentralize all stakeholder departments.

The Way Forward

To further intensify and accelerate efforts at the country level, national level consultations are needed to improve coordination and integration between Nutrition and HIV/AIDS by sharing the meeting report and main outcomes with key stakeholders, and then reaching a consensus on the way ahead to strengthen links with HIV control and improve multi-sectoral collaboration.

Several countries in ESAR have made significant efforts to address different areas of Nutrition and HIV/AIDS integration challenges and it is important to document these positive achievements and lessons learnt. Inter-country experience exchanges and visits could also be a valuable way for countries to learn from each other.

UNICEF, WHO, FANTA/AED and partners are committed to work together to assist countries with accelerating the implementation progress on Nutrition and HIV/AIDS, and enhance regional coordination of their support to countries in ESAR.
INTRODUCTION

Opening Remarks

The opening remarks were made by Dr David Okello, WHO Kenya, Per Engebak, UNICEF ESARO and Dr Emily Koech, NASCOP from the opening session of the Nutrition and HIV/AIDS meeting.

Dr Okello welcomed all the participants to Kenya, on behalf of the WHO. He stated that this meeting will undertake a comprehensive review of progress made to implement key recommendations made during the April 2005 technical consultation in Durban on Nutrition and HIV/AIDS, and also on the progress made in the implementation of the 59th WHA resolution on the same subject matter. Given the urgency we face in dealing with matters of Nutrition and HIV, it is now time to take stock of what countries have done on the Durban recommendations. This meeting should be able to draw key lessons learned, gaps and map the way forward. If we must make gains, we must recognize the critical value of working together. Partnership is important in the response of Nutrition and HIV/AIDS. People die every day and they need our help. We know the practical way forward but we do not move forward. We need to accelerate the implementation of nutritional strategies and unite to improve the lives for people living or affected by HIV. He wished all a fruitful deliberation, and thanked them for their attention.

Mr Engebak extended his welcome to the participants of regional workshop. He indicated that this impressive gathering has brought together delegations from 11 countries, including Kenya, Lesotho, Malawi, Mozambique, Namibia, Rwanda, Swaziland, Tanzania, Uganda, Zambia and Zimbabwe. He stated that we are also pleased to see a number of solid allies participating this week. WHO and UNICEF has a strong relationship and we also have representatives from sister organisation FAO, WFP, UNAIDS, USAID, FANTA/AED, ECHO and a number of NGOs. He thanked them for taking time and participating at this meeting.

He reminded the participants that ESARO is the epic centre of the HIV epidemic, with 17.4 million people and 1.4 million children under 15 that are directly affected by HIV/AIDS. We have a total of 15 million children that are orphans in ESAR due to HIV/AIDS. In Southern Africa, 30-60% of children
under-five deaths are directly related to HIV/AIDS. It is also clear that malnutrition continue to be a major problem with over 1/3 of all under 5 year old in ESAR being under-nourished.

HIV positive mothers are more likely to give birth to children that are underweight. These mothers are less able to care for the children. If the parents die, the responsibility often lies with the relatives, the grandparents. They may not have the strength or the resources to care for the children. This is putting children further at risk. Children and AIDS is one of UNICEF’s main priorities and we are committed to work with key partners to address this area. He hoped that all of the participants will go back with a renewed sense of purposes and new energy level to accelerate implementation progress in Nutrition and HIV/AIDS programmes.

Dr Koech noted that nutrition is a critical part of the comprehensive care that should be given to the HIV/AIDS patients and yet, we all know that for many years, it has not been accorded the seriousness it deserves. Kenya is one of the few countries in Africa that has witnessed a remarkable decline in prevalence of HIV. The prevalence here has come down from a high of 14% in 1998, to 6.7% in 2003 and an estimated 6.1% in 2005.

Kenya is a country that has trained more than 600 nutritionists and focused evidence based nutrition interventions are being implemented by the partners and Ministry of Health through the National AIDS and STI Control Program (NASCOP). We have highly qualified nutritionists working at NASCOP and about 50 more were employed and deployed to various comprehensive care clinics in the country. We are in the process of trying to integrate nutrition in on-going programmes, such as Antiretroviral Therapy, prevention of mother to child transmission of HIV/AIDS (PMTCT), home based care, TB, voluntary counseling and testing. Meanwhile, the presence of a nutritionist at NASCOP has seen the development of materials on Nutrition in HIV including, national nutritional guidelines a training curriculum for health care workers, job aids and wall charts. Currently, Nutrition and HIV/AIDS programme in Kenya has received a lot of technical support but resources to support this program are still minimal.

The Ministry of Health will remain committed to educate Kenyans on the value of good nutrition to ensure that the food that can be easily accessed by the majority of the poor is nutritious and people are informed of the health benefits of certain products.

The private sector must play its role through increased research and introduction of more fortified foods. Through Government regulations, those in the food industry can add specified amounts of vitamins and minerals to maize meal, wheat flour and other varieties of affordable foods that are most frequently consumed. This can create an impact by improving the nutritional status of our population.

This conference, she believed, will empower the participants with knowledge and skills required to manage people living with HIV/AIDS effectively and efficiently. This meeting brings together an assorted group of professionals and experts in this field to think and share experiences on evidence. She commended the organizers for the efforts and work they have put into the preparations towards this conference.

Finally she wished all very fruitful discussions that will clearly delineate the way forward on this important aspect as we seek to give the infected person the best that we can.

Dr Koech then declared the Eastern and Southern Africa Regional Meeting on Nutrition and HIV/AIDS officially open.
Meeting Objectives

The overall objectives of the joint UNICEF and WHO Nutrition and HIV/AIDS meeting, held from 2 to 4 May 2007 in Nairobi, Kenya, was to review the progress made on the implementation of the 2005 Durban consultation on the Nutrition and HIV/AIDS participants’ recommendations and to identify lessons learned and gaps, give recommendations for the way forward towards scaling up nutrition interventions in the context of HIV.

The specific objectives of the meeting were:

- To provide technical updates on Nutrition and HIV/AIDS related to macronutrients; micronutrients; pregnancy and lactation; growth; infant and young child feeding (IYCF); anti-retroviral treatment; infectious diseases; management of severe malnutrition and Orphans and Other Vulnerable Children (OVC).

- To orient countries with new programmatic guidelines on Nutrition and HIV/AIDS.

- To share country experiences on best practices, lessons learned and gaps on the key nutrition components of HIV/AIDS prevention, control and mitigation in Eastern and Southern Africa.

- To develop a framework for accelerated implementation and monitoring of the Nutrition and HIV/AIDS recommendations made in Durban taking into considerations countries experiences since then, with regards to the best practices, lessons learned and gaps.

- To agree on the roles and responsibilities of key stakeholders in the implementation of the Nutrition and HIV/AIDS recommendations.

Participants

A total of 96 participants attended, including 11 country teams from Kenya, Rwanda, Namibia, Tanzania, Malawi, Lesotho, Swaziland, Zambia, Uganda, Zimbabwe and Mozambique composed of national Nutrition and HIV/AIDS expert. In addition, key representatives from regional and global UN agencies and NGOs attended. The full agenda is in Annex 2 and the list of participants in Annex 3.

Themes Explored at the Workshop

- New evidence and technical and update on Nutrition and HIV/AIDS

- Updates on Nutrition and HIV/AIDS guidelines, training materials and tools

- Review of implementation of national guidelines, training materials and tools concerning nutrition, care and support for people living with HIV/AIDS

- Review of HIV and infant feeding counseling and support

- Review of management of moderate and severe malnutrition and HIV

- Review of OVC, food security and nutrition

- Resource mobilization for Nutrition and HIV/AIDS programmes
Presenters and Resource Persons

The main presenters and resource persons of the workshop included the followings:

- Charles Sagoe-Moses, WHO AFRO
- Saba Mebrahtu, UNICEF ESARO
- Gary Gleason, Tufts University
- Randa Saadeh, WHO HQ
- Anirban Chatterjee, UNICEF HQ
- Peggy Henderson, WHO HQ
- Mercy Chikoko, FAO RIACSO
- Nigel Rollins, Uni. of KwaZulu-Natal
- Steve Collins, Valid International
- Paluku Bahwere, Valid International
- Robert Mwadime, FANTA/AED
- Bosielo Majara, Ministry of Health, Lesotho
- Mickey Chopra, South African MRC
- Bertha Mlay, UNICEF Tanzania
- Pamela Ferguson, University of Chester
- Ruth Akelola, NASCOP Kenya
- Penelope Campbell, UNICEF ESARO
- Sonia Khan, UNICEF Maputo

The rest of the report details key issues raised during both the main presentations, plenary and group discussions.
**Nutrition and HIV - What do we know?**

- Energy requirement among HIV positive individuals is higher than negative population.
- Pregnancy and lactation do not hasten the progression of HIV infection to AIDS.
- Optimal nutrition for HIV positive women during pregnancy and lactation increases weight gain, improves pregnancy and birth outcomes.
- Postnatal HIV transmission from mother to child can be reduced through good and repeated counseling on optimal infant feeding.
- The benefits of Antiretroviral Therapy (ART) are fully recognised but to achieve the complete benefits, adequate dietary intake is needed.

**BACKGROUND**

Presenters: Dr Charles Sagoe-Moses WHO AFRO, Randa Saadeh WHO HQ, Ass. Prof. Gary Gleason Tufts University, Prof. Nigel Rollins University of KwaZulu-Natal, and Peggy Henderson WHO HQ.

### 1.1 2005 Durban Consultation and WHA Resolutions

The motivation to hold the 2005 Durban consultation on Nutrition and HIV/AIDS was to review scientific evidence on Nutrition and HIV/AIDS and to ensure that nutrition is part of comprehensive HIV/AIDS response. Six scientific papers were presented covering micronutrients; macronutrients; infant feeding (IF) and HIV transmission; growth faltering and wasting in children; maternal nutrition for pregnant and lactating women; and nutrition and antiretrovirals (ARVs).

The scientific evidence shows that nutrition interventions in HIV programming result in improved immunity, morbidity and mortality for people living with HIV/AIDS (PLWHA), even in those not yet eligible for ARVs. In addition, pregnancy outcome and management of severe malnutrition and body weight and work capacity is enhanced with inclusion of nutrition in HIV programming. Furthermore, the benefits of adequate nutrition for PLWHA is know to help reduce vulnerability to weight loss and wasting and may help delay the progression of HIV disease as it enhances the body's ability to fight opportunistic infections. Nutrition also improves the effectiveness of medications, prolongs independence and enriches quality of life.

Nutrition and HIV - What do we know?

- Energy requirement among HIV positive individuals is higher than negative population.
- Pregnancy and lactation do not hasten the progression of HIV infection to AIDS.
- Optimal nutrition for HIV positive women during pregnancy and lactation increases weight gain, improves pregnancy and birth outcomes.
- Postnatal HIV transmission from mother to child can be reduced through good and repeated counseling on optimal infant feeding.
- The benefits of Antiretroviral Therapy (ART) are fully recognised but to achieve the complete benefits, adequate dietary intake is needed.

**Durban Consultation Recommendations**

Recognizing the scientific-based evidence on Nutrition and HIV/AIDS, the 2005 Durban consultation made the following recommendations:

1) Strengthen political commitment and improve the positioning of
nutrition in national policies and programmes;
2) Develop practical tools and guidelines for nutritional assessment for home, community, health facility-based and emergency programmes;
3) Expand existing interventions for improving nutrition in the context of HIV;
4) Conduct systematic operational and clinical research to support evidence-based programming;
5) Strengthen, develop and protect human capacity skills; and
6) Improve nutrition indicators into HIV/AIDS monitoring and evaluation plans

1.2 Nutrition and HIV/AIDS Evidence and Guidelines

Scientific Evidence on HIV and Nutrition

The relationship between HIV and nutrition has been known right from the start, with the first reports on HIV/AIDS in Africa labeling the infection “the slim disease”. Yet it is taken a long time to show the importance and impact of nutrition in HIV programming. Now there is research that shows this link. For example, in Sub-Saharan Africa, growth faltering is common and occurs early in life in HIV positive infants. Studies show that poor growth is strongly and independently associated with reduced survival in HIV positive populations. In Uganda, a study in 1997 demonstrated that HIV positive infants with low weight had a 5-fold increase in risk of death by 25 months (Berhane, 1997).

Increased Energy Needs and Losses

For PLWHA, the energy needs increase by 10% even when the infection is asymptomatic. The increase is even greater when another opportunistic infection is present. This increase can be as much as 25-30% with tuberculosis (TB), chronic lung disease and persistent diarrhoea to as high as 50 to 100% with AIDS progression in children.

Another possible explanation for increased energy losses can be malabsorption and diarrhoea. PLWHA may also have a decrease intake of food as appetite loss, depression and a feeling of stress leading to a lack of care for one’s person are very common. In the African setting, the potential for limited access to food is high, a factor which may also decrease intake.

It should also be noted that weight loss, especially muscle mass loss, usually is a precedent to death. A body mass index (BMI) <18 is a significant independent predictor of mortality in adults.
**Micronutrient Status**

Increased micronutrient status/intake may affect the transmission of HIV infection through mother-to-child transmissions, sexual transmission and infectiousness and susceptibility. It may also affect the progression of HIV infection through HIV load, CD4 counts, AIDS, death, morbidity from other infections and drug acceptability.

The WHO technical review micronutrients requirements states that:

- HIV positive adults and children frequently have low levels of micronutrients.
- Micronutrient intakes at recommended dietary allowance need to be assured in HIV-infected adults and children through consumption of diversified diets, fortified foods and micronutrient supplements as needed.
- The WHO recommendations on vitamin A, zinc, iron, folate and multiple micronutrients remain the same. No additional micronutrients are needed for PLWHA.
- Vitamin A supplements reduce diarrhoeal morbidity and mortality especially in young children.
- Micronutrients are not an alternative to comprehensive HIV treatment including ARV therapy.
- Studies have shown that some micronutrient supplements may prevent HIV disease progression and adverse pregnancy outcomes.

Micronutrient supplements are not an alternative to comprehensive HIV treatment but micronutrient supplements may prevent HIV disease progression and adverse pregnancy outcomes.

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**Nutrition and ARVs**

ARVs need to be combined with good nutrition as it affects absorption, reduces nausea and vomiting, enables weight and muscle mass recovery and improves adherence. The WHO technical review focusing on nutrition and ARVs states:

- The benefits of Antiretroviral Therapy (ART) are fully recognised but in order to realise these, adequate dietary intake is needed.
- Dietary and nutritional assessment is an essential part of comprehensive HIV care both before and during ART.
- Long term complications can occur with ART but the benefits outweigh the potential harm.

**1.3 Synergism of Nutrition and Infection**

**Nutrition and Infections**

The positive links between nutrition and infections are well recognized. Through improved nutrition, morbidity and mortality from HIV/AIDS, malaria and TB lessens. By decreasing the burden of these infections, peoples’ nutritional status improves.

The relationship between nutrition and infection can also have negative impact. Infections such as HIV/AIDS, malaria and TB, increase energy requirements and affect nutritional status by reduced food intake, internal diversion for immune reactions and metabolic losses in urine and faeces. It is also know that the metabolism increases with fever and that malnutrition affects the clinical progression of TB, malaria and HIV/AIDS. In addition, malnutrition influences the response to treatment in infectious diseases.

**Nutrition and Malaria**

The close correlation between nutrition and infections is evident in the case of malaria. Nearly 550,000 annual malaria deaths are attributable to underweight in children less than 5 years of age:
In addition, malaria is an important cause of anemia, especially with compromised or underdeveloped immunity.

1.4 Update on HIV and Infant Feeding

New Evidence and Experience

New studies and experience constantly improve the knowledge and understanding of IF in the context of HIV. Some of the latest evidence in this area was presented at the 2006 October WHO Consensus Statement meeting. A summary of the presentations is outlined below:

- A recently published study in the *Lancet* demonstrates that mixed feeding (breastfeeding while also giving other fluids and/or foods) carries a higher risk of HIV transmission than exclusive breastfeeding. The study also showed that the risk of HIV transmission was double when mixing breastfeeding and formula feeding and 11 times higher when mixing breastfeeding and solids.

- In a study from Botswana, where children who were exclusively formula fed or breastfed and given AZT were compared, it was not possible to see any difference in 18-month HIV-free survival (infants alive and without HIV infection) between the two groups.

- Research from a diarrhoeal disease outbreak in Botswana has also shown increased severe diarrhea and increased mortality among formula fed children, not associated with HIV status.

- In Kenya, Malawi, Uganda and Zambia it has been found that early cessation of breastfeeding is associated with diarrhoea and mortality in HIV-exposed children.

Research from programs confirms that high exclusive breastfeeding is possible with good counseling. In addition, programmatic experience on maternal ART use shows a likely lower risk of transmission through breastfeeding, however this is still to be confirmed.

October 2006 WHO Consensus Statement

As a result of the new scientific evidence, WHO held a consultation in October 2006 to slightly modify the existing advice on HIV on IYCF and infant feeding.

The new Consensus Statement reads:

**HIV-negative women or HIV status unknown**

- Exclusive breastfeeding for 6 months and continued breastfeeding for 2 years and beyond

**HIV-positive women**

- Exclusive breastfeeding is recommended for HIV-infected women for the first 6 months of life unless replacement feeding is acceptable, feasible, affordable, sustainable and safe (AFASS) for them and their infants before that time.

- When replacement feeding is AFASS, avoidance of all...
breastfeeding by HIV-infected women is recommended.

To help HIV-positive mothers make the best choice, they should receive counselling that includes information about the risks and benefits of various IF options, and guidance in selecting the most suitable option for their situations.

Other Modifications and New Emphasis

The 2006 Consensus Statements also stresses:

- Exclusive breastfeeding does carry a lower risk of HIV transmission than mixed feeding.
- HIV-infected infants should continue to be breastfed. Breastfeeding beyond 6 months may be the best option for some HIV-exposed infants.
- Assessments of feeding choice and counselling with the mother should focus on two main options; exclusive breastfeeding or exclusive replacement feeding for the first 6 months. Other local options should only be discussed if the mother is interested.
- Home-modified animal milk is no longer recommended for infants during the entire first 6 months. This milk is only to be used as a short-term measure for replacement-fed infants when formula is not available.

Continued Support for IF Choices

It is important that the mother gets support to choose and implement a feeding option that is best for her and her baby. Before delivery and in the first months, the counseling is based on a broad definition of AFASS for her and her baby. During the first months, the breastfeeding mother will need additional support at the following key events:

- Early testing (PCR). If the baby is HIV negative then the mother may choose to exclusively replacement feed if it is AFASS. If the baby is HIV positive, then the mother should be recommended to continue to breastfeed.
- Financial/social change. A re-assessment of AFASS should be considered if the mother’s financial/social/support situation is changed.
- Mother on ART. The risk of transmission through breastfeeding is low, and, the mother should only exclusively replacement feed if it is AFASS.

The mother also needs additional support when feeding practices change at 6 months. If she is still breastfeeding at 6 months and if other milk and animal source-foods are available, then she should cease all breastfeeding and give other milk and foods. If no such foods are available, then the risk of mixed feeding for a few months is probably less than the risk of severe malnutrition. However, if breastfeeding has already stopped then she should continue to use milk of some kind and add complementary foods.

Successful IF and HIV Interventions

For improved HIV and IF programming, countries are advised to follow the “HIV and IF Framework for Priority Actions”. This framework highlights the importance of developing an IYCF policy and it ratifies the Code of Marketing of Breast-milk Substitutes which promotes breastfeeding for the general population. The code also seeks to improve IF counselling and support for HIV positive mothers by having good quality counselling by adequately trained and supervised counsellors and continuously monitoring and evaluating the progress.
1.5 Discussion

- Solid research is now available to show the relationship between HIV and nutrition however there are still many areas where additional research is needed.

- There is a need to translate existing scientific evidence into policy and program implementation.

- Nutrition and micronutrients are important in HIV programmes, however, WHO does not recommend nutritional interventions or micronutrients instead of ARVs.

- Recent studies do not show increased maternal mortality among HIV positive women during breastfeeding, but attention must be given to maintaining mothers' nutritional status.

- Home modified cow’s milk has been removed from the recommended IF options following the 2006 technical consultation, as cow’s milk is nutritionally inadequate for long term use during the first six months of life. Commercial infant formulae should be used if women decide to replacement feed, rather than modified cow’s milk.

- It was recommended that WHO provide more specific evidence on the actual risk of transmission of HIV from mother to child through breastfeeding in all guidelines, training materials and consensus statements. The risk (in terms of increased morbidity and mortality) related to avoidance of breastfeeding and mixed feeding should also be included and specified in the documents.
2.1 Framework for Priority Action on Nutrition and HIV/AIDS

WHO Global Priority Action Framework

WHO is currently developing a global framework for priority actions on nutrition and HIV/AIDS. The objective of the framework is primarily to outline key actions which comprise Member States’ and partners’ response to HIV/AIDS. Secondly, the framework will provide guidance on the components of such a response and seeks to create an environment that encourages improved food, nutrition and feeding practices for those infected and affected by HIV. The framework highlights five priority action areas for governments and partners:

1. To integrate Nutrition and HIV/AIDS into currently existing policies and guidelines
2. To improve and maintain the nutrition of people infected and affected by HIV/AIDS
3. To integrate nutrition care and support into prevention of Mother-to-Child Transmission programmes
4. To improve food security
5. To support M&E and research for Nutrition and HIV/AIDS

Table 1: WHO Global Priority Action Framework

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<thead>
<tr>
<th>PMTCT</th>
<th>Pediatric HIV Care and Support</th>
<th>Care and Support for OVC affected by HIV</th>
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<tbody>
<tr>
<td>PMTCT protocols with nutrition/growth monitoring</td>
<td>Pediatric HIV protocols include nutrition monitoring and dietary guidance</td>
<td>OVC access to growth monitoring and promotion</td>
</tr>
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<td>Implementation of framework for priority action on HIV and IF</td>
<td>Identification of HIV infected children during growth monitoring and referral</td>
<td>Nutrition guidance of OVC under 5 years old</td>
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<tr>
<td>Dietary guidance and support for non breastfed children</td>
<td>Referral between ART centers and nutrition rehabilitation units</td>
<td>Micronutrient supplementation</td>
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<tr>
<td>Micronutrient supplementation</td>
<td>National guidelines on nutrition for HIV+ children</td>
<td>Nutrition guidance for non-breastfed OVC &lt;24 months</td>
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<tr>
<td>Nutrition surveys/routine nutrition data collection includes data on HIV affected children</td>
<td>Pilot nutrition care for HIV+ children through home based care and CTC of HIV+</td>
<td>School health/nutrition/feeding to increase OVC’s access to education,</td>
</tr>
<tr>
<td>Community/ Home based nutrition care and support, for non-breastfed children</td>
<td></td>
<td>Food for training and take home rations</td>
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UPDATES ON GUIDELINES, TRAINING MATERIALS AND TOOLS
Ensure Collaboration among Partners

With this framework, WHO hopes to ensure stronger and closer collaboration between partners as the framework clarifies the obligation of each partner. The framework is under construction and WHO will work with partners and countries to finalize it.

“Every minute of every day, a child dies of AIDS and four young people are infected with HIV. In addition, a staggering 15 million children have been orphaned by AIDS-related causes.”

UNICEF

2.2 Integrated Programming for Children

UNICEF National Programming Framework

UNICEF is currently developing a Nutrition and HIV/AIDS programming framework. It is a work in progress to improve programme integration for children. The idea is to integrate nutrition programmes such as IYCF; BFHI; management of moderate and severe malnutrition; and other nutrition/food activities with HIV programmes such as PMTCT+; pediatric HIV care and support; and care and support for HIV affected OVC.

The framework list suggested priority actions that should be undertaken in all countries with PMTCT, pediatric HIV and OVC programmes to facilitate integration of nutrition in these programmes.

According to the Nutrition and HIV/AIDS programming framework the list of suggested priority actions should be implemented through situation assessment and analysis; development of national policies/strategies/guidelines and advocacy; and through M&E, documentation of experience and operational research studies.

2.3 Nutritional Care for People Living with HIV/AIDS (PLWHAs): A Short Training Course

WHO and FAO have jointly designed a two day short course on nutritional care for PLWHAs to provide caregivers with practical knowledge about nutritional care and support for people living with HIV/AIDS.

The course covers the following:

- HIV and nutrition; food safety and access for PLWHAs; and nutrition and ART;
- Nutrition for pregnant and lactating women with HIV; and feeding options for infants of HIV positive mothers and feeding a child with HIV;
- Communication skills;
- Prevention of weight loss and promotion of physical activity; and use of nutritional supplements and herbal remedies.

Course Updates

Currently the course is being reviewed and field tested to include the new scientific evidence. In addition the content on food safety needs to be further strengthened and modules on counselling skills need to be developed. After the second field test the revised course will be available on the WHO website.

Regional Capacity Building

FAO gave examples on how the progress of implementing the nutritional care for PLWHAs short course has been undertaken. A regional project implementation plan was designed which included the development of Training of Trainers (TOT) and field workers materials, an inter-country training workshop and the roll out of training courses in 7 southern African countries -
Angola, Lesotho, Malawi, Mozambique, Swaziland, Zambia and Zimbabwe.

Progress to Date

The inter-country training workshop has been held and next step - the stakeholder consultations and needs assessment to identify existing activities, possible lead institutions and resource materials around nutrition care and support for PLWHA has been completed in three countries.

After finalizing the needs assessment, countries are encouraged to develop a work plan to roll out training at national, district and provincial level. This plan should also include M&E aspects; advocacy and resource mobilization; the exchange of lessons learned; and good practices.

FAO highlighted the importance of integrated and coordinated programming within countries and in the region to avoid duplication; reinforce and support existing programs; and strengthen outcomes.

2.4 Discussion

- It is good that frameworks are being developed on Nutrition and HIV/AIDS, but all the key stakeholders need to be part of the process.
- Many of the participating countries have already implemented parts of the draft WHO framework, and they asked WHO to ensure that they capture lessons learned from the region and that human resources and pre-service training be included in the guidelines.
- It was emphasized that WHO is only producing overall generic guidelines as the evidence obtained from country to country is not expected to change. WHO does, however, include an adaptation guide for countries to translate these guidelines at the national level. The process of developing guidelines is lengthy as a wide range of people are involved in the production and the material is thoroughly tested.
- It was stressed that a lot of work has already been done at national level and in view of this, there is no need for UNICEF/WHO to duplicate this effort. Instead, countries’ experiences and good practices are to be included in the guidelines.
- Participating countries raised the need for specific guidelines and training on nutrition and care for people on ART. WHO acknowledge this need. They have already started to develop material on this topic. FANTA informed the participants that materials are developed on nutrition and ART.
- The meeting agreed that there was need for better sharing of materials across countries, the region and organizations. Regional level organizations should get together and collect all material available to share with countries and to avoid overlapping.
- Zimbabwe shared their experience of successful integration of growth monitoring, IF, ARV, cotrimoxazole and immunization which are all included on their child health card. A manual for implementing these procedures has been developed to assist health care providers with the use of the card.
- Some participants discussed that the focus of the frameworks and the short nutrition course for PLWHA have to have a more long term outlook. Improved access to food at household levels is vital for sustainable development.
2.5 Revised Baby Friendly Hospital Initiative Materials and Tools

History and Aims of BFHI

The Baby Friendly Hospital Initiatives (BFHI) was introduced in 1991 to transform hospitals and maternity wards through improving the role of maternity services in enabling mothers to breastfeed babies for the best start in life. It aims to improve the care of pregnant women, mothers and newborns at health facilities that provide maternity services by protecting, promoting and supporting breastfeeding. Although the spread of the concept has been successful, with over 20,000 baby-friendly hospitals globally – lately the initiatives have seen some weakened commitment, especially in the face of the HIV/AIDS pandemic. Some baby-friendly hospitals are falling back to old patterns - there is a lack of good counselling skills, supervision, monitoring and in many developing countries the influence of the infant food industry is very strong.

Revision of the BFHI material and tools

The BFHI material and assessment tools were revised based on the lessons learned since 1991, and new policies, guidelines and emerging research. The updated material now includes support to mothers who are not breastfeeding; provides modules on HIV and infant feeding and mother-friendly care; and gives more guidance for monitoring and reassessment including hospital self-appraisal and monitoring. The new material also includes a course for Hospital Decision-makers, the 10 Steps have been more implementation focused and information on the Code of Marketing of Breastmilk Substitutes has been reinforced. For more info on the BFHI see:

http://www.who.int/nutrition/topics/bfhi/en/index.html

Revitalizing the BFHI Material in ESAR

In Eastern and Southern Africa Region (ESAR), the first multi-country workshop to introduce BFHI in the context of HIV and PMTCT was held in Harare in 2005, followed by a regional TOT and multi-country workshop in South Africa in 2006.

In these meetings/training courses, the participating countries and partners highlighted some lessons learned in revitalizing and scaling up BFHI:

- A number of countries, e.g., Malawi, Madagascar and Zambia, have demonstrated that IF practices can be improved through comprehensive and well integrated, harmonized IYCF policy, planning and effective implementation at all levels – national, district, community and family.
- Inter-country experience exchange is a valuable learning opportunity that can serve as a basis for future advocacy and sharing.
• Decentralization of reassessment can enhance cost-effectiveness.
• Involving the community in BFHI is essential for continued support of breastfeeding mothers.
• Health workers’ counseling skills are weak; effective use of job aids in counseling can reduce training duration and BFHI training needs should be included in pre-service training to reduce costs and ensure sustainability.
• A Global Strategy on Infant and Young Child Feeding should be adopted and implemented at the national level.
• The link between BFHI and HIV and PMTCT programs need to strengthened.

Next Steps for the BFHI in ESAR

The way forward to scale up BFHI in ESAR is the dissemination of best practices and lessons learned, the translation of the materials into French and Portuguese, the provision of support workshops and training courses for the remaining ESA countries and the strengthening of links between IYCF/BFHI and PMTCT by following-up support and monitoring the implementation of joint PMTCT and Paediatric AIDS mission recommendations.

Revision of Global HIV and IF Tools and Guidelines

Due to the updated recommendations through the 2006 WHO Consensus Statement (for more information see section 1.4 Update on HIV and Infant Feeding of this report) and new evidence and experience on IF and HIV, some of the global WHO HIV and IF tools and materials will undergo minimal revision. A complete review of the tools and materials will be undertaken when more evidence on ARVs and breastfeeding is available in 2008 or 2009.

Countries are advised to review their current guidelines/training materials in light of the 2006 Who Consensus Statement and update and disseminate widely to key stakeholders within countries.

2.6 Infant and Young Child Feeding Counselling: An Integrated Course

Integrated Course on IYCF Counselling

To improve IYCF counseling, there is an urgent need to train a large number of people on these counseling skills. The Infant and Young Child Feeding Counselling: An Integrated Course has been developed for counsellors and health workers to enable counseling and support of mothers to carry out the WHO recommended feeding practices for their infants and young children from birth up to 24 months of age. In addition, this course also aims to counsel and support HIV-infected mothers to choose and carry out an appropriate feeding method for the first two years of life.

The course takes approximately 35 hours, with a mixture of theoretical and practical sessions. The main focus is on developing knowledge and counseling skills on IYCF.
Course Progression in Sub-Saharan Africa

The implementation of the course started in 2006 and so far 7 countries (Burundi, Ivory Coast, Kenya, Nigeria, Tanzania, Uganda, Zimbabwe and Zambia), have held training courses at the national level. Over 10 regional training courses have been held and a national training course is planned for 8 countries in 2007.

Challenges and Recommendations

The scaling up of training has been slow as it has been difficult to get adequate resources to the courses as most donor support goes to national level training. In addition, there is often inadequate budget allocation for training at district and national level. There has also been a lack of comprehensive national training strategies. To overcome these challenges it is important to improve local resource mobilization, find innovative ways to reduce training costs, include the course in pre-service training and encourage advocacy among key stakeholders at all levels, especially at district level.

2.7 Discussion

- It was recognized that currently IF counseling is mainly done pre-natally and that follow-up counseling after ANC counseling is necessary. In addition, step 10 has been revised to incorporate community BFHI activities. A good example of this is the Malawi experience in which BFHI activities have been extended to the community.
- Participating countries mentioned that selecting good IYCF counselors seems to produce better counseling results. It is therefore vital to identify the right people to undertake the IYCF short course.
- It is possible to evaluate the quality of counseling by measuring changes in knowledge, attitudes and practices immediately after counseling.
- To scale up IYCF training, it is necessary to develop a plan and a budget and to allocate funding.
- Strengthening of breastfeeding protection is especially critical in the HIV context, through enactment and enforcement of national laws. It is possible to penalize organizations for violating the Code of Marketing of Breastmilk Substitutes if the Code has been legislated and if the government demands that companies follow the legislation.

2.8 Guidelines for an Integrated Approach to the Nutritional care of HIV-infected Children

New Guidelines on Nutritional Care of HIV-infected Children

The new draft guidelines for an integrated approach to the nutritional care of HIV-infected children aged 6 months to 14 years are based on available evidence and are easy to implement. These guidelines can be linked to other standard guidelines including "The management of children with severe malnutrition", IMCI and Integrated Management of Adolescent and Adult Illness (IMAAI). The integrated approach to nutritional care of HIV-infected children guidelines have been developed to follow the same pattern as the IMCI guidelines - with a 10 step approach - and they should be used alongside with the IMCI guidelines, as a complement.

How to Use the Guidelines

The integrated approach guidelines are organised in a way that will make it easy for the health care provider to assess the
child and to give clear and concise advice to the mother/caregiver. In the guidelines, the assessment of any HIV-infected child is accomplished through three steps:

- Assess;
- Classify; and
- Manage.

The questions to the child’s caregiver include current health or illness of the child, feeding patterns, access to food and patterns of caregiving, as well as the health of the caregiver and changes in caregiving circumstances. Secondly, the health worker would assess the growth pattern of the child and other clinical signs. Based on these two steps, the health worker will classify the child as severely malnourished, poor weight gain or growing appropriately and then finally, manage the child through one of three nutritional care plans.

*Note that the guidelines do not address infants less than 6 months or prevention issues.*

**Next Steps**

WHO is currently finalising the guidelines. This will be followed by the preparation of a country specific adaptation guide and a training course to complement the guidelines. It is also important to harmonise the guidelines with the Severe Malnutrition and IMAAI documents.

### 2.9 Guidelines on Community-Based Management of Severe Malnutrition

**The Integrated Approach**

Recent publications have demonstrated that approx 50% of under-5 deaths are associated with malnutrition and that acute malnourished children would benefit from treatment. An approach that has been shown to be highly effective - with high cure rates, high coverage and valuable cost savings - is the integrated approach. This approach combines outpatient treatment for majority of cases of acute malnutrition with inpatient treatment for minority of cases that need medical treatment.

In 2006, the Community-based Therapeutic Care (CTC) manual, based on the integrated approach, was published and training materials will soon be available to complement the manual. Many countries – Burundi, Chad, Ethiopia, Mauritania, Mozambique, Niger, Uganda and others - have now developed their own guidelines on management of acute malnutrition and have started to harmonize the inpatient and outpatient approach.

**Balancing Creation of Demand and Scale Up**

The harmonized inpatient and outpatient approach has been proven to be successful as it is demand driven. As health workers and the community see its efficacy in curing malnourished children, they want to implement it. There is a need to scale up the use of this model, however, Valid International emphasized the importance of balancing the push of scale up with creation of demand and sufficient support for the services at all levels, decentralization, and thorough training. Due to the high staff turnovers and the cost of continuously training new staff, it is also important to include the training in the pre-service training curriculum to reduce the costs and make the training sustainable.
CTC as a Point of Entry for HIV Positive Children

The first study showed that CTC is a good entry point for ARV treatment. The study also showed that combining voluntary counseling and testing (VCT) with CTC dramatically increases VCT uptake since over 90% of the children participating in the study were HIV tested. The study also demonstrated that the CTC approach is a successful method for the majority of HIV positive children to regain their weight. Around 60% of the HIV positive children responded to basic CTC protocols without ARV therapy, however their recovery was slower and an increase relapse rate could be seen. In spite of this, many HIV positive children remain well in the community 15 months post discharge.

RUTF in HBC Programmes

The other operational study reviewed the distribution of RUTF in existing HBC programmes for HIV positive adults. The study showed that RUTF (2600 kcal per day) was associated with several positive health and well being responses including decreased mortality rates, improved nutritional status, increased physical activity and access to clinics/ART. Many of the bedridden PLWHA could walk and seek treatment by themselves after being enrolled in the RUTF programme for a short time.

A small cost analysis was conducted which concluded that the RUTF programme appeared to be cost effective as it had a precise target and a short duration of response. It showed that RUTF can be effectively delivered through existing HBC interventions.

CTC as Entry Point for HIV in Malawi

In Malawi, Valid International examined CTC as an entry point for HIV positive children and looked at adding Ready-To-Use Therapeutic Food (RUTF) into existing home based care (HBC) programmes for adults through operational research. The results from the study are presented below:

Challenges

Although the two programmes were successful, some challenges needed to be addressed. The long term nutrition/food security and cotrimoxazole prophylaxis follow up, support and monitoring was unsatisfactory. The research also showed that there was need to create uniform entry and exit criteria and that the programmes had issues around human resources and logistics.

2.10 Discussion

- WHO could not assure a timeline for completion of the guidelines for an integrated approach to the nutritional care of HIV-infected children. When the final testing and approval is complete, the document will be available on the WHO website for countries to use as a draft for one year and give feedback. After the comments have been incorporated, the document will be printed.

- Countries raised concerns about high mortality rates among HIV positive children who are severely malnourished and are commencing ART

- The meeting discussed the need to agree on the entry and exit criteria from nutrition supplements and therapeutic feeding programmes as there is currently an inconsistent approach to management of severely malnourished children.
3.1 Multi-country Review on Implementation of National Guidelines, Training Materials and Tools on Nutrition, Care and Support for PLWHA

Robert Mwadime presented the results of a rapid review of implementation of national guidelines, materials and tools on nutrition care and support for PLWHA in Kenya, Lesotho, Malawi, Rwanda, South Africa, Uganda and Zambia. This was done through surveys, country visits and conference calls with key stakeholders. The six areas of interest which were included in the review are presented below:

1) Advocacy and resource mobilization

It was found in the review that leadership is essential to move nutritional care and support for PLWHA. This can be seen in Malawi, where currently the Ministry of Nutrition and HIV/AIDS is located in the Office of the President. Although, nutrition is increasingly appreciated as an essential component of care and treatment of PLWHA, with the exception of Malawi, most countries have not had systematic advocacy for funds.

2) Policies, guidelines, plans and coordination

Most countries in the region with the exception of a few, have nutrition guidelines. However, research in Uganda has shown that just distributing guidelines alone is not adequate to improve nutrition care and support for PLWHA. The distribution should be accompanied by a strategic plan, course materials and training.

3) Training and capacity development

Training materials, although rarely evaluated, are available in most countries.

4) Human resources

For most ESA countries, human resources continue to be a major challenge. As a result, countries are coming up with innovative solutions. In Malawi non-nutrition cadres are used to support nutrition interventions and in Kenya, South Africa and Uganda, nutrition care and
support training is included in pre-service training. In addition, in Kenya and South Africa, and to some extent Zimbabwe, a nutrition/dietetics section is found in government structures.

5) Implementation of the package
Most countries in the review have defined a nutritional care and support package for PLWHA which includes:

- nutritional assessment and monitoring;
- nutrition counseling and education;
- targeted food supplements and therapeutic foods for (severely) malnourished patients; and
- in a few countries, activities to improve livelihood/household food access.

Although these packages are provided, many countries lack of quality in data and counseling and food supplements delivery is mainly handled by nutritionists who rarely take the opportunity to link/integrate with HIV care and treatment.

6) Monitoring and evaluation
In general, most countries have indicators on nutrition education/counselling, BMI and food supplementation for PLWHA. Very few countries, however, have integrated their indicators into the national HIV/AIDS M&E framework.

Moving to the Next Level

To move nutritional care and support for PLWHA at country level forward, Robert Mwadime recommended the establishment of a multi-sectoral working group with defined roles; advocacy for integration of Nutrition and HIV/AIDS; the development of a strategic plan; the identification of resources; and documentation of promising practices. It is also important to estimate the level of malnutrition among PLWHA.

3.1.1 Introduction of Nutrition and HIV Curriculum to Pre-service and In-service Training

A curriculum for pre- and in-service training for Nutrition and HIV/AIDS was developed in consultation with several universities and key partners. The curriculum was finalized through needs assessments among possible users, followed by a TOT, pre-testing and dissemination in 2003. The package includes a trainer's manual, a CD with power-point presentations, handouts, further reading materials, case-studies, protocols and examples of exam questions. In 2005/6 an evaluation of the material showed that the training was too focused on academic performance and theory rather than practical application.

As a case study in Kenya illustrated, by involving different partners (NGOs, private sector, hospitals, NASCOP and Universities/Colleges) and offering internship for students, the students get more hands on experience which improves their nutrition care and support for PLWHA.

For more information and training materials, guidelines and tools on nutrition care and support for PLWHA please visit: www.fantaproject.org

3.1.2 The Lesotho Country Experience

Nutrition Care and Support for PLWHA

Lesotho is a country with 2.2 million inhabitants and an adult HIV prevalence of 23%, one of the highest HIV rates in the world. To ensure good nutrition for their HIV affected and infected population, the government of Lesotho is giving out targeted food assistance and gardening tools so that PLWHA can grow their own produce. In addition, the country has finalized, translated and
conducted training on IYCF and dietary guidelines at district level.

Lesotho is faced with many challenges which impact on the HIV and nutrition health service delivery. These include difficulty in sustaining the required financial support, lack of coordination, high staff turnover within the health sector and a weak tracking system for infected and affected PLWHA at the community level. The difficult geographic terrain in Lesotho makes it tricky to ensure service provision for everyone. Furthermore, the ever increasing prevalence of OVC puts high pressure on the health system.

### Lessons Learnt

Essential areas to improve nutrition care and support for PLWHA identified by Lesotho:

- Good nutrition prolongs lives and results in reduction in the number of OVC
- Training and guidelines are more effective if translated into the local language
- Effective coordination systems and a sound Health Management Information System (HMIS) and M&E systems are important
- Strong advocacy is needed to mobilize resources for the health sector both within and without government infrastructure

### 3.1.3 Discussion

- Countries urged the FANTA and partners to consider integration of Nutrition and HIV/AIDS in pre-services curriculum into non-university health education programmes as well as universities.
- Evidence from *The Lancet* showed how important care, responsive feeding and stimulation are for a child.

- The distribution of free infant formula in Lesotho within PMTCT programme raised concern at the meeting in terms of benefit and risk. Lesotho highlighted that they were trying to follow AFASS guidelines as closely as possible.

- The effects of zinc have been found to be no different among HIV positive and HIV negative severely malnourished children. Possible increased mortality was shown when more than 6mg/kg/day of zinc were given for prolonged periods of time. Although it was advised that countries should follow the current recommended 2mg/kg/day; the chance of toxicity from zinc is very low as it is not stored in the body unlike Vitamin A.

### 3.2 Multi-country Review on HIV and Infant Feeding Counselling and Support

Mickey Chopra presented the results of a rapid review of HIV and IF counselling in Kenya, Malawi and Zambia. The purpose of this review was to document country experiences and to support HIV+ mothers with IF counselling and nutritional support, identifying the critical success factors and lessons learned. To accomplish this, the team carried out a desk-review, stakeholder interviews and an in-depth field assessment, visiting a total of 36 facilities in 21 sites across the 3 countries. Through this process, the team identified key factors for successful integration at two different levels.

#### Level 1: Health Sector Policy and Strategic Management

- Integrated systems for planning and management
- Integrated HIV and IF policies
- Inter-sectoral action and partnership for health between government and civil society
3.2.1 Findings from Joint PMTCT and Paediatric Care Joint Mission: Focus on HIV and IF

The main findings from the HIV and IF part of the Joint Inter-Agency Task Team (IATT) Country Missions in Botswana, Lesotho and Tanzania were presented by Saba Mebrahtu. The goal of the missions was to provide technical assistance to support the acceleration of PMTCT scale up and to ensure the integration of paediatric care into national ART programmes, including HIV and IF aspects. The status of the HIV and IF implementation was reviewed in the context of the PMTCT and paediatrics care support and treatment programmes on the basis of the findings concerning the respective strengths and weaknesses, the team made recommendations for improved coverage and effective and increased access of services to children. The main findings on the strengths, weaknesses or lessons learnt, recommendations and conclusions were as follows:

Strengths

- Infant and young child feeding policy is in place or under development in the three countries.
- Code for marketing of breast milk substitutes is in place in two countries (Tanzania and Botswana) and is under endorsement in one (Lesotho).
- Infant Feeding and Nutrition is increasingly being recognized as an important component of PMTCT and Paed Aids.
- Support for Breastfeeding and BFHI is being revitalized in three countries.

Lessons Learnt

- Capacity of health workers on HIV and IF counseling remains weak or is not uniform among key partners – in some cases, non-existent.
- IF components of PMTCT plans and resources allocated for this are very

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**Level 2: Health Service Delivery**

Integration of supplies and information systems
Management and technical guidance
Human resource management and quality

**Recommendations**

For each of these factors findings from the three countries were presented. Dr Chopra then made the following recommendations, aimed at countries and other stakeholders, based on the findings:

- Advocate for improved HIV and IF counseling, focused on mapping of key decision makers and development of advocacy materials, i.e. Powerpoints.
- Strengthen capacity of nutrition policy makers.
- Focus on orientation of doctors, mid-level managers at district level.
- Update country guidelines in light of recent revised global guidance.
- Allocate more time for IF counselling in PMTCT courses.
- Simplify/reduce IF options discussed with mothers.
- Mobilize resources for integrated IYCF courses for nutritionists, supervisors and senior health workers.
- Build up supervisor skills and knowledge.
- Provide technical assistance for developing a country-level monitoring and evaluation framework for HIV and IF.
- Develop capacity building materials and strategies that encourage a culture of using information for decision-making.
- Develop a systematic and coordinated communication approach for promotion of optimal IYCF.
• There is limited capacity for nutrition within the Ministry of Health – consistently under funded
• Exclusive breastfeeding rates are low and infant and neonatal mortality rates are on the increase due to HIV and less than optimal feeding practices

Recommendations

• Greater involvement of nutrition departments in national PMTCT working or coordinating groups, development of national PMTCT scale-up plans to ensure that the HIV and IF component is adequately addressed, and in resource mobilization allocation of adequate funding to support HIV and IF component
• Strengthen current IF training using 40 hour integrated IYCF course and ensure that it is linked and coordinated with PMTCT training
• Strengthen IYCF counseling services for mothers through reactivation of BFHI, supervision and mentoring of counselors, and through mother and community groups involving NGOs, FBOs etc.

Conclusions

Saba Mebrahtu noted progress made in the three countries to implement key recommendations of the mission. She concluded by saying that the joint missions have been very useful in:

• Advocating for renewed commitment by the government to PMTCT, including HIV and IF.
• Building capacities of managers and implementers.
• Strengthening partnerships.
• Harmonizing strategies and approaches to scale up between partners and between different parts of government.
• Coordinating technical assistance to countries.

3.2.2 The Tanzania Country Experience

National Progress of IYCF Activities

Tanzania's country team described how they developed a national training team and materials on IYCF. The work started in 2000, with initial training for counsellors. An evaluation in 2002 of the national PMTCT programme showed the need to scale-up HIV and IF training and develop job aids. In 2004, Tanzania developed its national strategy on IYCF, including HIV, and counsellors have been trained using the new WHO/UNICEF integrated IYCF course. Job aids were developed based on formative research findings and the generic WHO/UNICEF counseling tools. An evaluation took place of the resulting training package, and incorporation of suggestions is ongoing.

Lessons Learnt

The Tanzanian team identified factors contributing to the success of the work as: dedicated technical team; evidence-based local adaptation; a participatory process involving major stakeholders; integration within the PMTCT programme; commitment of resources; and a dissemination plan. Challenges remaining include the fact that there are multiple training packages on the ground and the package in use needs to be updated to reflect new evidence/guidance; scale-up and sustainability; and staff shortages.

Future plans on IYCF activities in Tanzania include:
• National adoption of the training package and counseling job aids.
• Harmonization of the training packages, job aids and IEC materials.
• National scale-up of whole facility training package to include all facilities implementing PMTCT.
• Greater emphasis on training to re-establish the BFHI.

3.2.3 Discussion

• Participating countries seem to have in common challenges in terms of lack of human resources in the health sector. In Tanzania, the government has developed a plan which indicates how many health staff are working in each district and how many additional staff are needed. In addition, lower grade cadres are being trained and upgraded and there is a strategy to give incentives to staff in hardship areas including upgrading the living environment in these duty stations.
• WHO/UNICEF highlighted that even though updating guidelines and developing policies can be a lengthy process, they are crucial in order to have one harmonized national message. However, the dissemination of the guidelines from central to community level needs to be improved. Currently there is a lot of confusion on the transmission risk of HIV from mother to the child. This shows that a clear consensus message should be given to the mother.
• Effectiveness in programmes depends on coverage and intensity. Countries like Tanzania, which have hosted a joint PMTCT mission have seen some great progress in the government commitment and inclusion of IF in PMTCT activities after the mission. Although Tanzania is still faced with challenges on quality assurance and budget allocation, there is now a national plan in place to cover all health facilities with IF counseling by 2010.
• WHO advised the group that at global level work is in progress to have an IF process indicator included in the general global HIV and PMTCT M&E HIV indicators.
• Dr Chopra highlighted that more IF related indicators among the standard M&E HIV ones are needed to outline coverage (for example, number of counseling sessions happening) and outcome, (for example % of mothers exclusively breastfeeding at first immunization visit).
• Countries should address the need for more than one entry point for IF in the context of HIV counseling and support for PMTCT e.g. Antenatal Care (ANC) and maternity.

3.3 Multi-country Review on Management of Moderate and Severe Malnutrition

Pamela Fergusson presented the results of a multi-country progress review on malnutrition and HIV in three countries: Kenya, Malawi and Zambia. The analysis was done through a desk review, stakeholders’ interviews and field visits to the three countries. A summary of the review is presented below in six theme areas:

1) Advocacy and Policy

Although all countries have to some extent have a national policy, strategic plan and guideline on malnutrition and HIV, often the linkage is poor between these documents and budges/ funding proposals and programming/M&E. Kenya has made some great achievements with national policy, strategic plan and guidelines on malnutrition and HIV.

2) Programmes

The three countries have some form of therapeutic and/or supplementary...
feeding at ART clinics however; the national coverage is low and there is a need to scale up and have services at all levels, national, district and community.

3) Commodities for service delivery
All three countries have commodities for package care of HIV and malnutrition. In Malawi, they are achieving high coverage through the human rights based approach to therapeutic-and supplementary feeding commodity provision and they have also started a local production of RUTF.

4) Capacity development
As most countries in ESA, the three countries are faced with lack of human resources. To solve this issue, Kenya has hired 600 nutritionists and 50 HIV/nutritionists within the national health system and in Malawi, 8000 community health workers are trained in nutrition. The three countries all have malnutrition included in medical and nursing curriculum and there is a vibrant local and international research community.

5) M&E
In all three countries there needs to be improve national reporting systems in Severe Acute Malnutrition (SAM). What has been proven successful in Malawi is the national monthly reporting of Therapeutic Feeding Programme (TFP) and Supplementary Feeding Programme (SFP) as well as single report form for both inpatient and outpatient malnutrition patients. This report also includes HIV status.

6) Operational research
Continuous operational research that can be fed back into the programmes is needed, especially in the areas of affect of therapeutic and supplementary feeding for malnourished in ARV programmes; and effect supplementary feeding of moderately malnourished to prevent severe malnutrition.

Recommendations
Pamela Fergusson concluded that with the following achievements realized, a more successful programme would be in place:

- Improved programme quality and scaled up coverage
- Improved government leadership with support from international organizations.
- Better M&E which is linked to policy, collected in programmes analyzed and used
- Closer collaboration between HIV and nutrition groups

3.3.1 The Kenya Country experience

National Approach to Management of Moderate and Severe Malnutrition

Kenya has made progress at the national level to improve management of moderate and severe malnutrition and HIV by developing guidelines/strategies, training curriculum, counseling materials and training manuals. In addition, to improve the integration between nutrition and HIV, a national technical working group (TWG) on Nutrition and HIV/AIDS has been established which includes experts on health, nutrition, agriculture, the United Nations, donors, and regional and national NGO partners. The country has trained over 1000 nutritionists, agricultural extension workers and other service providers on nutritional care and support for PLWHA; a training course that includes supportive supervision. In addition, the country has a total of 650 nutritionists and HIV posts nationally. The GoK/UNICEF, GoK/USAID, AMPATH and WFP form the backbone of national large scale service delivery
programmes in Kenya providing food aid for PLWHA:

**Challenges and the Way Forward**

Although Kenya has strengthened management of malnutrition and HIV, the country is still challenged by weak multi-sectoral partnerships; lack of focus on nutrition, especially within national HIV/AIDS training efforts; and insufficient service delivery scale up. To address these issues, Kenya plans:

- To better target and greater involve PLWHA in planning of interventions.
- To advocate for government to allocate funds for implementing activities.
- To include nutrition in the Global Fund HIV submission for Round 7.

**3.3.2 Discussion**

- Dr. Nigel Rollins highlighted that there is a need to advocate for the use of MUAC for screening of SAM. It is a fairly good and simple indicator with high predictive value of the likelihood of death. However, it is not a good tool for monitoring recovery from SAM as truncal weight is restored before limb tissue; instead weight or weight-for height should be used. In addition, the use of MUAC for adults still requires more research.
- Weight is a good indicator of HIV disease progression but should not be used alone as moderate or severe malnutrition can be present even before HIV is acquired.
- Many participants mentioned that admission and discharge criteria for PLWHA have to be standardized and that access to economic empowerment aspects should be included in programme for PLWHA. In the AMPATH programme in Kenya, the entry criteria to get food supplements are very broad and AMPATH has some issues in discharging PLWHA from the programme after the 6 month time period that people are entitled to participate. Up to 70% of the enrolled are not discharged due to difficulties in ensuring adequate access to means of survival after discharge. They are currently reviewing their entry and exit criteria.
- Discussions arose on how to balance stigmatization of HIV positive in malnutrition programmes and at the same time ensure that HIV infected children are not missed. Should there be different entry criteria for HIV positive children when they come to the feeding centers? In Malawi, the Blantyre clinic is using the indicator of <80% weight for height as admission criteria for HIV positive children, which is higher than the normal admission standard for HIV negative children (<70% weight for height).
- The workshop agreed that there is a need to make sure that the surveillance systems are matched with the feeding services provided and that the data collected is fed back to the service.

**3.4 Global Review on OVC, Food Security and Nutrition**

UNICEF and WFP have just completed a global review on OVC, Food Security and Nutrition (2007). In the review, it was found that although there are numerous OVC programmes, they rarely focus on nutrition issues. Moreover, there is severe lack of data (disaggregated by OVC status), analysis and documentation of evidence-informed lessons learnt and best practices. The review also found that specific targeting of OVC is costly, labor intensive and ethically problematic. Thus, household wealth/assets may be a better indicator than just orphan-hood. Other potential alternative entry points for targeting may be discovered by the community themselves identifying OVC, or through
PMTCT programmes or home based care networks.

Innovations to Improve OVC Nutrition Programmes

Although food and nutrition have to be part of a comprehensive package for OVC, access to food is not enough. Other central components for programming are: better hygiene, de-worming, sharing information on IYCF and better nutrition practices. These interventions should be combined with coordinated and collaborative programming across several sectors and should focus on long term, dynamic assistance. The review suggested that nutrition training courses should be made available for teachers and school feeding programmes as well as programmes which target youth not currently in school or school leavers.

The Way Forward

The way forward for OVC, food security and nutrition programmes is to invest in M&E and programmes that can be scaled up and replicated across the region.

3.4.1 Food Security and Nutritional Status of OVC in ESAR

A preliminary analysis of the integration of OVC in National Plans of Actions (NPA) and current implementation status was done in ESA countries. This review showed that 13 out of 20 countries have approved national plans of action for OVC and all countries in ESA have integrated food security and nutrition for OVC. Presently, at country level, various approaches are being applied to support the nutritional status, food security and livelihoods of OVC, indicating some promising practices. There is little evidence informing these efforts however, since the food security and nutritional status of OVC is largely unknown. This is because only a few countries disaggregate the data on OVC. Another problematic issue that arose was the ambiguous definitions of OVC. This has resulted in the lack of a clear target group, denominator and baseline data. For example, if little is known about the scope of coverage of existing services, it is difficult to strategically determine targets and plan.

Estimation of OVC in ESA

To estimate the numbers reached, orphan data was used (AOVG report, UNICEF and UNAIDS 2006) as the denominator and numbers of ‘vulnerable’ children reportedly reached as the numerator. This analysis showed that the proportions reached in Eastern Africa appear less (no more than 4%) than the proportions reached in Southern Africa (up to 40%).

Inclusion of OVC in Nutrition Programmes

In the review, there seemed to be a directly proportional relationship between vulnerability and poverty. Evidence demonstrating the effectiveness of interventions on nutritional status or food security amongst OVC is limited. Only Swaziland (children attending neighborhood care points) and Ethiopia (cash transfer scheme) could show better access to and variety of food and increased number of meals. However, a number of countries have initiated operational research in pilot districts (Ethiopia, Kenya, Malawi, Namibia, Rwanda and Zambia) which will be able to provide a clearer theoretical framework of what works and what does not.

The Way Forward

- Make full use of existing data
• Ensure OVC module included in next DHS or MICS
• Ensure OVC indicators are incorporated in WFP Community and Household Surveillance
• Collect data from organizations covering or providing nutritional support to OVC
• Conduct rigorous baseline and impact evaluations in at least one identified nutritional area in those countries implementing national policy/plan responses – in order to build on evidence-informed approaches
• Facilitate scale up by optimizing and establish linkages across key sectors (health, education)
• Ensure that nutritionists sit on national OVC steering or coordination committees
• Strengthen dissemination of data – so service providers can tailor their approaches according to data
• Ensure swift incorporation of OVC policies into nutrition interventions where they exist.

3.4.2 Discussion

• UNICEF highlighted that it is important to review social protection, cash transfer, nutrition education and access to basic services for OVC affected by HIV in addition to providing direct nutrition and feeding support.
• One way to prevent children from being orphaned or vulnerable is to ensure that the mother has access to nutritional support and ARVs.
• Countries raised the issues of lack of adequate data and validation and evaluation of existing data. When the impact on OVC programmes can not be shown, it is hard to ensure funding and therefore sustain OVC programmes.
• UNICEF emphasized that countries can learn from each other and that best practices should be documented and shared with among countries and partners.
4.1 Resource Mobilization for Nutrition and HIV/AIDS Programmes through the Global Fund Submissions

Nutrition programmes implemented in an HIV context are often under-financed. One way to improve resources mobilization is to include nutrition in the HIV/AIDS part of the Global Fund (GF) submission. When WHO reviewed the incorporation of food and nutrition in countries’ HIV/AIDS submissions to the GF, however, they found that nutrition rarely was included in the proposals. If nutrition was mentioned in the application, it almost always only focused on the provision of IF formula without mentioning the need for IF counseling and support.

To advance the nutrition component of the GF submissions, a meeting was held in Harare in 2007 to discuss this topic. At the meeting, it became evident that the HIV colleagues are eager to integrate nutrition into GF proposals and some countries (Kenya and Botswana) committed to include nutrition in the round 7 GF proposal. Other countries expressed their interest in including nutrition but they highlighted that more advocacy is needed to ensure that national decision-makers understand the important correlation between Nutrition and HIV/AIDS.

Six Steps to a Successful GF Submission

To improve the chances of a successful inclusion of food and nutrition into the HIV/AIDS GF proposal, WHO has created a framework with 6 steps that should be addressed in the proposal.
**Figure 2: Six Steps to a Successful GF Submission**

**Step 1**  
Base decisions regarding food and nutrition support on a sound situation assessment on primary nutritional problems. Questions addressing why nutrition problems occur, how widespread they are and who is affected should be answered. It is also important to assess which policies, programmes and resources exist already available/implemented to address these problems.

**Step 2**  
Define the objectives for food and nutrition support based on recent scientific evidence with respect to macro and micronutrients, nutritional issues related to ARV use, and special nutritional concerns throughout the lifecycle.

**Step 3**  
Decide on specific interventions that should meet the following objectives:
- a) Nutritional status and dietary assessment
- b) Counselling and behaviour change communication
- c) Supplementary/replacement and therapeutic feeding
- d) Targeted micronutrient supplements
- e) Household food and livelihood support.

**Step 4**  
Identify activities that will support implementation and be supported by partners including: policy and guidelines; training and capacity development; development of tools and materials; communication and advocacy; M&E; and research and dissemination.

**Step 5**  
Estimate resource requirements for each intervention needed and the contribution of other partners.

**Step 6**  
Include monitoring and evaluation indicators for nutrition activities/interventions and HIV. These indicators should be linked with the assessment and cover outcome, output and impact in the different programme areas.

### 4.1.1 The Mozambique Country Experience

**Successful Inclusion of Nutrition in GF proposal**

Mozambique achieved approved HIV/AIDS GF submission in 2002 (round 2) and 2006 (round 6). In the 2006 HIV/AIDS submission, coordinated by the Ministry of Health, there was a strong commitment to incorporate nutrition which was exemplified in the narrative, where nutrition was significantly highlighted. WHO, through two external consultants and the regional office and partners (UNICEF, HKI and WFP), supported the submission with technical assistance. The GF approved the round 6 HIV/AIDS submission for the first two years including the nutrition component. The Mozambique team found that discussions prior to the GF submission on the nutrition component further strengthened the momentum for Nutrition and HIV/AIDS in the country. For round 7, nutrition will play a more prominent role in the GF proposal. The plan is to include nutrition as one of the three main components in the HIV/AIDS section.

### 4.2 Discussion

- Potential resources have been made available for Nutrition and HIV/AIDS programming.
- WHO informed the meeting that the GF does not fund buildings, but staff can be funded as long as the proposed intervention can make an impact.
• WHO informed the meeting that two nutritionists have now been recruited as members of the panel that approves the GF proposals.

• WHO advised countries to broaden the scope and not only focus on food delivery and infant formula when including nutrition in the GF proposal.

• WHO informed the meeting that to ensure commitment to nutrition and inclusion of nutrition in the GF submission, strong advocacy at the highest level possible is needed.

• Some participating countries raised the issue of clinicians refusing to buy in on Nutrition and HIV/AIDS integration. Mozambique shared their positive experience. Clinicians have realized the importance of nutrition at all level of health care and support, not only within HIV/AIDS programmes but overall.

• Rwanda shared how the civil society has been strengthened through training and assisting in proposal writing. This has been achieved by creating an “easy to fill out proposal sheet”, which has greatly assisted preparation of the GF proposals.

• WHO emphasized that the indicators used in the GF HIV submission should always relate to the proposed interventions.
Participants at the workshop joined one of six thematic areas to look at how to improve Nutrition and HIV/AIDS integration. Each group reviewed key achievements, major constraints and key priority actions.

Group 1: Integration of Nutrition into National HIV/AIDS Policies and Programs with National Budget Allocation

Progress

In many countries in Eastern and Southern Africa, the integration of nutrition into national HIV/AIDS policies has been sound. There are now HIV/AIDS policies with nutrition focus and nutrition policies with an HIV/AIDS agenda. Many governments have nominated a national focal point for Nutrition and HIV and the national TWG exists to provide policy direction and to drive a multi-sectoral approach. In addition, in some countries, nutrition guidelines and protocols have been developed and in high prevalence HIV countries, HIV and Nutrition is incorporated in the Food Security Policy and the national plan of action. The reason for this successful integration of Nutrition and HIV/AIDS is often due to strong governmental commitment, decentralization, development of M&E tools and the establishment of coordination bodies with a Nutrition and HIV/AIDS focal point. Some countries have found specific solutions that have proven constructive. In Uganda, mainstreaming of nutrition as a comprehensive package of care to all line ministries has been successful and in Malawi, 2% of the Ministry budget is allocated for HIV/AIDS related activities in the work place.

Bottlenecks

Although there has been positive policy development, the group identified some challenges:

- Lack of high level structure for strategic leadership to drive the process.
- M&E systems that use indicators that are not useful or achievable.
- Lack of channels to link TWG ideas to the national decision makers.
- Complex arrangement for resource allocation.

To address the challenges, the group identified some priority areas to be discussed:

- Make mainstreaming and decentralization critical to all stakeholders.
• Strengthen capacity for the coordination boards to make policy decisions and directions.
• Develop and improve referral networks.
• Develop M&E tools that produce results making it easier for stakeholders to implement programmes.
• Review the placement of nutritionists at strategic/policy levels and mobilize support for this position.

Group 2: Nutrition Care and Support for PLWHA

Progress
In the past year, networking and capacity building have improved in nutrition and PLWHA programmes and needs assessments have been undertaken prior to project start to identify requirements and to ensure that sufficient food is provided. There are also efforts within these programmes to prevent developing dependency by linking programmes to income generating projects, and/or by relying on local foods and seeds. Successful programmes have been created holding the community directly repositionable for vulnerable children and people, thereby reducing stigmatization. The group also highlighted that many countries have developed innovative communication based strategies such as guidelines translated into local languages and tools to make IEC materials clear and easy to understand, further reducing counselling time. Finally, the group addressed the need for preventing rather than treating within nutrition, for example, more focus on counselling instead of provision of therapeutic feeding.

Bottlenecks
• Inadequate resources - both financial and human.
• Poor understanding of the meaning of nutrition, care and support.

Group 3: HIV and Infant and Young Child Feeding

Progress
In the last couple of years, ICYF in the context of HIV has seen some best practices in countries in Eastern and Southern Africa. In Kenya, Tanzania, and Uganda, there are now policies and guidelines on HIV and IYCF in place and many countries have integrated IYCF policy into more general food and nutrition policies and also into PMTCT polices. Malawi is using HIV resources for scaling up of key nutrition actions and Uganda is employing 200 psycho-social groups as community support groups for IYCF across PMTCT sites. They have reached 50% of the sites so far. To revitalize and scale up BFHI, Namibia is using Global Fund resources, Uganda is supporting BFHI through the HIV directorate and Tanzania has seen increased commitment from government and partners.
Bottlenecks

The challenges that need to be addressed are similar in many countries in the region. They include:

- High staff turnover and migration, especially at senior levels.
- Insufficient time to re-build skills base to re-launch BFHI.
- Lack of good indicators for M&E for IYCF.
- Nutrition is competing with many other training courses offered – struggle to make it a priority area.
- Poor nutrition management capacity especially at the district level.
- Mixed messages in terms of risk on breastfeeding and HIV.

To address the challenges, the group identified five areas that where they would like to see prioritised:

1. Integration of IYCF in the pre and in-service curriculum.
2. Harmonization and updating training packages, IEC materials, job aids to reflect same messages, strengthen advocacy and communication.
3. System strengthening to address IYCF issues, budget for IYCF and including M&E indicators.
4. Advocate for nutrition plans to include service delivery e. g. food supplements, micronutrients.

Group 4: Management of Moderate and Severe Malnutrition and HIV

Progress

In Eastern and Southern Africa, achievements of integration of moderate and severe malnutrition and HIV have been seen in the expansion of access to nutrition support for HIV beneficiaries and decentralization of CTC/ outpatient therapeutic programs. For example, in Malawi, nutrition is included in the district funding. It is also positive that updates of HIV counselling and testing in inpatients and clinics have increased due to the acceptability of testing without HIV illnesses as an indicator. The group pointed out that referral pathways for malnutrition beneficiaries into HIV services have improved access to Cotrimoxazole, ARVs and nutrition at ART sites. It is also positive that HIV counselling and testing is included in the CTC guidelines. Moreover, referral pathways for malnutrition beneficiaries into HIV services and RUTF into ARV sites have been improved. At global and national level, an increased linkage of policy and guidelines has been seen for both HIV and nutrition documents.

Bottlenecks

In Africa, the burden of food insecurity, HIV and limited resource availability are three challenges in the Nutrition and HIV/AIDS programming. The group also identified other areas of constrains for severe and moderate malnutrition programming:

- Weak links of CTC/ nutrition into IMCI.
- Limited access to HIV testing and counseling within CTC/ Supplementary feeding programmes.
- Differences in regional and local in SAM/MAM prevalence.
- Occurrence of TB co-infection.
- Lack of inclusion of children 6-9 years old in IMCI, SAM, SFP programme guidelines. This group is increasing due to HIV.
- Insufficient transfer of national policy into practice including district management plans, availability of staff resources to deliver and handover of sites/ activities from NGOs.
- Unsatisfactory linkage into HIV services for staff and capacity and CD4, infant diagnosis, nutrition in ARV sites, Cotrimoxazole access.
Priority Actions

The group noted five issues they would like to see prioritised:

1. Earlier identification of HIV status in malnutrition to be incorporated in IMCI, CTC, SFP, and Child Health Days etc.
2. Improved access to care in HIV services.
3. Health systems development including capacity building in the nutrition field and retention of staff.
4. Consistent definitions and uniform entry and exit criteria for nutrition interventions in HIV and what to use corn soy blend (CSB) vs. RUF in moderate malnutrition.
5. Informative research interventional research to guide policy/practice.

Group 5: OVC, Food Security and Nutrition

Progress

One of the key achievements seen in the area of nutrition and OVC is that all National Plans of Action now incorporate Food Security and Nutritional Support interventions in support of OVC. In addition, a number of pilot projects are ongoing to improve the nutritional situation for OVC.

Bottlenecks

However, nutrition and OVC still have great challenges to face:

- Lack of coordination between social welfare, nutrition and other key sectors (e.g. agriculture).
- Government and NGO require capacity building and greater resource allocations in order to be effective.
- Most interventions are short term.
- Lack of objective information e.g. product research often funded by producers.
- Data is available but rarely disaggregated.
- Infants 0-6 months require greater balance between commodities and counseling services to match their particular needs.
- There is a lack of focus on infant 6-24 months, which is a critical period of child development.

According to the group, the following must happen in order to foster secure links between Nutrition and HIV/AIDS and OVC programmes:

- More specific age, gender and location (urban and rural) breakdown to better tailor interventions to groups with specific needs.
- Better analysis on how to balance and focus both short and long term interventions by age, gender and location and ensure links to other programmes.
- Better defined vulnerability criteria that take into account age group for nutritional needs and support.
- More evidence and lessons learned to guide policies, interventions and program design.
- Better adapted and more integrated, multi-sectoral approach across several domains including food production and accessibility to consumption, utilization and provisions of special products and care.
- Ensure OVC indicators are included in nutrition surveillance and household surveys.
- Improved incorporation of safety nets, cash transfers etc. in emerging social protection programs to reduce malnutrition and protect OVC.
Group 6: Resource Mobilization

Progress

Funding is necessary for programming. Since the Durban consultation in 2005, resources have been allocated through better articulation and advocacy which has led to repositioning of nutrition into national priority and reprogramming of available funds including national budgetary allocations. In addition, community- and human resources have been made available.

Bottlenecks

The main constraints for resource mobilization, as identified by the group are:

- Contractual agreements
- Minimal nutritional packages
- National policies/strategies
- M&E variations
- Changes in national priorities.

The group identified three areas that should be priorities to improve resource mobilization:

1. Capacity building for advocacy and good proposal development.
2. Champion identification.
3. Identification of local resources.

Discussion

- The OVC group clarified that they would like all OVC, not just HIV positive, to have improved access to IF counselling and support.
- Some participants stated that as nutrition is a cross cutting and dynamic area, there is a need to both prevent and treat sick and malnourished children to save lives.
- Participating countries asked WHO for more assistance on how to assist the HIV positive mother with appropriate IYCF practices in the context of early (PCR) testing.
- Some participants highlighted that there was very little focus on nutrition for adolescents and that they are an important group that often gets neglected.
- The workshop participants agreed that it is time to reposition nutrition through policy development, advocacy, communications (harmonization of training materials and messages) and mainstreaming nutrition into all areas. In addition, improved planning, decentralisation and resources mobilization are other ways forward for countries.
- There is an urgent need at country level to strengthen existing health systems by improving the referral systems and human resources.
- WHO, UNICEF and partners highlighted that many countries in ESAR have successfully addressed different areas of Nutrition and HIV/AIDS integration challenges and they request countries to document their positive achievements.
Each of the eleven countries at the meeting presented a plan of action with constraints and challenges, way forward and technical assistance required. The future key priority actions for each participating country are described below. The full plans of action can be found in Annex 4.

6.1 Kenya

- Establish national model and standard of care for nutritional care and support for PLWHA through counseling/education and nutritional care package (multiple micronutrient, SFP, TFP, food based support).
- Increase capacity of service providers through continued training with a focus on skills in counselling.
- Enhance service provision through collaboration with communities and networks of PLWHA.
- Strengthen supervision and mentoring to empower nutritionists at a provincial and district level.
- Establish and standardize algorithms and standards of care for integration of nutritionists and nutritional care in service provision.
- Establish national advocacy and communication strategies to promote optimal nutrition for PLWHA.
- Strengthen national M&E structure for Nutrition and HIV/AIDS interventions, use M&E manager/office (NASCOP) to expand data collection on Nutrition and HIV/AIDS activities and operational analysis of nutritional programme efforts.

6.2 Lesotho

- Expedite the decentralization process with emphasis on recruitment and placement of nutrition personnel and responsibilities at district and community level.
- Coordinate and nationally scale up the PMTCT and Paediatric AIDS Programmes (IYCF within PMTCT and management of moderate-severe malnutrition within paediatric AIDS). Family health division to be the lead agency.
- Establish coordination and integration between Family Health Division and Social Welfare Division for fast tracking implementation of the OVC National Plans.

6.3 Malawi

- Strengthen co-ordination and integration of Nutrition and HIV/AIDS at operational and central levels and in the national response plans,
• Harmonise the Nutrition and HIV/AIDS tools (M&E, training, National HIV/AIDS Action. Framework - NAF, joint planning) and strengthen monthly or quarterly directorate meetings within the MOH and coordination meetings with stakeholders.

• Review and harmonise documentation of referral services and networks for nutrition, HIV and AIDS and produce district specific referral mechanisms.

• Create a comprehensive M&E framework for NCST and IYCF in PMTCT programs for tracking impact and improve evidence based programming.
  ➢ Integrate M&E indicators in the NAF, HIV/AIDS.
  ➢ Have contact person for M&E for HIV/AIDS including nutrition components.

• Strengthen interventional and operational research for evidence based programming.
  ➢ Solicit national consensus for national research agenda in Nutrition and HIV/AIDS.

• Integrate Nutrition and HIV/AIDS in the pre-service curricular.
  ➢ Conduct review of current pre-service curricular and facilitate integration of Nutrition and HIV/AIDS.

• Continue with advocacy for resource mobilisation, both human and financial
  ➢ Conduct evidenced based advocacy; documentation of best practices, cost-benefit analysis for nutrition interventions.

  ➢ GF funds starting in 2008, then Ministry of Health (MOH) funds from human resources training plan.

• Ensure that nutrition interventions are systematically integrated in government annual plans (MOH, CNCS, INAS etc) and that resources, both government and common funds, are allocated.
  ➢ Financial and technical support already in place mainly from UNICEF and WHO.

• Conduct advocacy and communication activities.
  ➢ Advocacy at all levels for integration of nutrition interventions in the government annual plans. Plan meetings with decision makers.

• Undertake inter-sectoral co-ordination.

6.5 Namibia

• Strengthen capacity building at all levels including facility, district and region by:
  ➢ Filling of vacant posts
  ➢ Training in nutrition management with HIV, IF counselling, job aides and counselling cards.
  ➢ Follow up after training.

• Strengthen monitoring and evaluation by:
  ➢ Reviewing nutrition indicators in health information systems, analyse and report.

• Strengthen research by:
  ➢ Undertaking prospective surveys on IF practices related to HIV.
  ➢ Undertaking food and nutrition security assessment for PLWHA.

6.4 Mozambique

• Develop overall training plan on Nutrition and HIV/AIDS training for at senior and medium levels; at health facilities, at community level and with civil society partners.

6.6 Rwanda

• Update the existing nutrition strategic plan based on current information – July 2007.

• Work with WHO/UNICEF to develop the IYCF strategy – August 2007.
• Scale up resource mobilization for implementation of the strategy.
• Harmonize training and reinforcing counselling in Nutrition and HIV/AIDS.
• Strengthen management SAM.
• Strengthen coordination.
• Strengthen M&E, including nutrition surveillance.
• Undertake a situation analysis and data compilation for evidence based advocacy-(simple advocacy).

6.7 Swaziland

• Strengthen the collaboration between the nutrition department and the HIV/AIDS department.
• Improve IYCF counselling.
  ➢ Use joint review of results from 2007 national IYCF situational analysis.
  ➢ Revise PMTCT training curriculum to include more content on IYCF counseling.
  ➢ Adapt WHO/UNICEF integrated IYCF counseling course and scale up training on the new adapted course.

• Improve the management of severe malnutrition in hospitals.
  ➢ Adapt WHO guidelines for management of severe malnutrition.
  ➢ Assess of management of severe malnutrition current practice in health facilities.
  ➢ Plan and implement interventions in hospitals.
• Pilot of community based management of severe malnutrition.

6.8 Tanzania

• Strengthen coordination among various stakeholders dealing with Nutrition and HIV/AIDS.
  ➢ Strengthen national nutrition working group.

6.9 Uganda

• Debrief the Director General of H/S on the outcome of the Nairobi meeting.
• Call a meeting of stake holders involved in nutrition, HIV/AIDS, TB and Malaria.
• Set up the coordination structure at all levels and especially at district and community levels.
• Constitute a national multi-disciplinary coordination team/advisory committee.
• Finalize the integration of the community-based and facility-based approach for management SAM and MAM.
• Strengthen the capacity of districts and communities to implement nutrition interventions.
• Revise and finalize the M&E plan for nutrition in the context HIV
  ➢ Review and finalize the National key nutrition indicators (in IF, PMTCT, ART, Paediatric AIDS etc.).
• Identify the budget line to support nutrition activities to scale up resource mobilization.
• Source for TA from development partners e.g. WHO etc.

6.10 Zambia

• Establish functional TWG at all levels and get government input into the cooperative agreement through TWG.
• Ensure inclusion of proposed Nutrition and HIV/AIDS indicators into the national HIMS.
• Build capacity at all levels and lobby for high level positions.
• Develop national nutrition/ HIV strategies with sustainability options.

6.11 Zimbabwe

• Develop capacity of NGOs, government and staff retention through:
  ➢ Integration of nutrition in pre-service training.
  ➢ Harmonization of training curricula and services.
• Make the money work; channelling it to community and implementers through:
  ➢ Open partnerships.
  ➢ Accountability with tangible outcomes for the beneficiaries.
  ➢ Building ownership of communities, revolving funds.
  ➢ Identifying champions.
• Mainstreaming Nutrition and HIV/AIDS in government policies, sectoral strategies and outreach programmes.
  ➢ Nutrition Council empowered and reinstated under the President's office.
  ➢ Improving the livelihood with food security in linkage with agricultural ministry.
  ➢ Ongoing counselling at community level (support networks and women’s groups).
  ➢ Networking with PMTCT, ANC and postnatal care and EPI, BFHI, community based nutrition care programme.
  ➢ Organizing key stakeholders into a common national network.

6.12 Conclusions

• Both UNICEF and WHO in conclusion thanked all the participants for their active and valuable contributions. Participating countries were encouraged to be proactive in improving coordination and integration between Nutrition and HIV/AIDS by sharing the report and outcomes of this meeting with key partners and by better linking up with HIV colleagues and improve multi-sectoral collaboration.
• They were also encouraged to learn from each other, work together and visit each other. This country level interaction will be supported by regional level partners.
• UNICEF, WHO and partners are committed to work together to assist countries with accelerating Nutrition and HIV/AIDS, and to enhance regional coordination of their support to countries in ESAR.

Workshop Evaluation

Of the 80 participants (non-facilitators) at the joint Nutrition and HIV/AIDS meeting, 66% completed the meeting evaluation form. The vast majority of the participants felt that all meeting objectives had been achieved, that they had been updated on new technical areas in Nutrition and HIV/AIDS and that the time allocation for each area was appropriate. Almost all participants believed that the facilitators were knowledgeable and based on the lessons learnt at the meeting, every country team had new Nutrition and HIV/AIDS activities to be included in their national plans of action. All country teams that had not yet been part of the joint PMTCT and Pediatric AIDS Joint Mission expressed an interest in hosting such a mission.
Although the overall meeting objectives were fulfilled, the participants highlighted some areas that needed to be further addressed. They would have liked a more comprehensive overview on Nutrition and HIV/AIDS policies in the region and a clearer definition of roles and responsibilities among partners in the context of Nutrition and HIV/AIDS. Several participants also emphasized that more time could have been spent on M&E; community-based interventions; TB/malaria and nutrition; and issues around sustainability. For the next meeting, a number of participants would like to see a focus on nutrition for adolescents, HIV positive pregnant women and elderly people.

Below are some of the comments made by the participants on the meeting:

“Very enlightening especially for me - a clinician who has never really dealt with nutrition issues”.

“I have learnt a lot and enjoyed being part of the nutritional team in the region”.

“The meeting could have been more systematic and a consensus reached”.

“I’m glad that I was one of the participants in this meeting. I have learned a lot and I plan to implement practices that I learnt”.

“More time should have been given to technical updates as they are vital for relevant programming”.

“All facilitators did a wonderful job, however, time for presentations and discussions was limited”.

“The technical sessions were very useful!”

“The presentations were sometimes long and not to the point”.

“This has been a well organized and important forum and we should continue to organize follow up meetings to stimulate countries to work harder to achieve the goals and be able to share the best practices”.

“National Key Strategy, Priority Actions and Conclusions”
# Annexes

## 7 The Meeting Agenda

### Wednesday, 2 May 2007

**Main Rapporteur:** Ida Neuman

### Plenary

**Introductory and Opening Session**

**Rapporteur:** Ida Neuman  
**Moderator:** UNICEF (Saba Mebrahtu)

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
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<tbody>
<tr>
<td>08.30–09.00</td>
<td>Participants’ introductions</td>
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<tr>
<td>09.00–09.10</td>
<td>Overview of workshop goals and expected outcomes</td>
</tr>
<tr>
<td></td>
<td>• Charles Sagoe-Moses and Saba Mebrahtu</td>
</tr>
<tr>
<td>09.10–09.30</td>
<td>Key activities and progress update since Durban</td>
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<tr>
<td></td>
<td>• Randa Saadeh</td>
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<tr>
<td>09.30–09.45</td>
<td>Security briefings and administrative announcements</td>
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<tr>
<td></td>
<td>• UNON/Ida Neuman</td>
</tr>
<tr>
<td>09.45–10.15</td>
<td>Break</td>
</tr>
<tr>
<td>10.15–11.00</td>
<td>Meeting Opening and Welcome</td>
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<tr>
<td></td>
<td>• UNICEF Regional Director – ESAR</td>
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<td>• WHO Country Representative</td>
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<td></td>
<td>• Ministry of Health Kenya – Official Opening</td>
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</tbody>
</table>

### Session 1: Accelerating Integration of Nutrition into HIV/AIDS Programs: Programmatic Updates, Experiences and Lessons Learned

**Rapporteur:** Kenya/UNICEF (Linda Beyer  
**Moderator:** UNAIDS (Erasmus Morah)

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
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<tbody>
<tr>
<td>11.00–11.20</td>
<td>Nutrition and infections: the importance of science and lessons learned on nutrition integration into HIV/AIDS, malaria and tuberculosis programs</td>
</tr>
<tr>
<td></td>
<td>• Gary Gleason</td>
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<tr>
<td>11.20–11.40</td>
<td>Framework for priority action on nutrition and HIV/AIDS</td>
</tr>
<tr>
<td></td>
<td>• Randa Saadeh</td>
</tr>
<tr>
<td>11.40–12.00</td>
<td>Programming for integration of nutrition into HIV/AIDS Programs</td>
</tr>
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<td></td>
<td>• Anirban Chatterjee</td>
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<tr>
<td>12.00–12.30</td>
<td>Discussion</td>
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<td>Time</td>
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<tr>
<td>12.30–13.30</td>
<td><strong>Lunch Break</strong></td>
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<td></td>
<td><strong>Plenary</strong></td>
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<td></td>
<td><strong>Session 2: Updates on Nutrition and HIV/AIDS Guidelines, Training Materials and Tools</strong></td>
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<tr>
<td></td>
<td><strong>Rapporteur:</strong> Uganda/AED (Earnest Muyunda)</td>
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<td><strong>Moderator:</strong> Tanzania</td>
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<tr>
<td>13.30–13.50</td>
<td><strong>Nutrition and HIV/AIDS Training Course</strong></td>
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<tr>
<td></td>
<td><strong>Overview of updated nutrition and HIV/AIDS training course</strong></td>
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<tr>
<td></td>
<td>• Randa Saadeh</td>
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<tr>
<td>13.50–14.10</td>
<td><strong>HIV and Infant Feeding</strong></td>
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<tr>
<td></td>
<td><strong>HIV and IF technical consultation consensus statement: Steps to update existing guidelines, materials and tools</strong></td>
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<td></td>
<td>• Peggy Henderson</td>
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<tr>
<td>14.10–14.30</td>
<td><strong>What is new in the revised BFHI materials</strong></td>
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<tr>
<td></td>
<td>• Randa Saadeh</td>
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<tr>
<td>14.30–14.45</td>
<td><strong>Revised BFHI materials and tools</strong></td>
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<td><strong>Progress to date and way forward</strong></td>
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<td></td>
<td>• Saba Mebrahtu</td>
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<tr>
<td>14.45–15.05</td>
<td><strong>IYCF integrated course</strong></td>
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<td><strong>Progress and challenges to roll-out IYCF in HIV and PMTCT context</strong></td>
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<td></td>
<td>• Charles Sagoe-Moses</td>
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<tr>
<td>15.05–15.35</td>
<td><strong>Discussion</strong></td>
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<tr>
<td>15.35–16.00</td>
<td><strong>Break</strong></td>
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<tr>
<td>16.00–16.40</td>
<td><strong>New Guidelines on Facility- and Community-based Management of Malnutrition of HIV Infected Children</strong></td>
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<tr>
<td></td>
<td><strong>Overview of the new WHO guidelines on integrated approach to the nutritional care of HIV-infected children (6 months – 14 years)</strong></td>
</tr>
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<td></td>
<td>• Randa Saadeh and Nigel Rollins</td>
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<tr>
<td>16.40–16.55</td>
<td><strong>Guidelines on community-based management of severe malnutrition and HIV</strong></td>
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<td></td>
<td><strong>Progress to date, challenges and way forward</strong></td>
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<tr>
<td></td>
<td>• Steve Collins and Paluku Bahwere</td>
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<tr>
<td>16.55–17.20</td>
<td><strong>Discussion</strong></td>
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<tr>
<td>17.20–18.00</td>
<td><strong>Review/display materials of existing guidelines and tools</strong></td>
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</tbody>
</table>
### Thursday, 3 May 2007
Main Rapporteurs: Mickey Chopra, Pamela Ferguson, Robert Mwadime, Ida Neuman

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
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<tbody>
<tr>
<td>08.30–08.50</td>
<td>Technical Update on Nutrition and HIV/AIDS</td>
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<td>Summary of latest scientific evidence on the relations between Nutrition and HIV/AIDS</td>
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<tr>
<td></td>
<td>• Nigel Rollins</td>
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<tr>
<td></td>
<td><strong>Plenary</strong></td>
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<tr>
<td></td>
<td><strong>Session 3: Critical Review on Implementation of National Guidelines, Training Materials and Tools on Nutrition Care and Support for People Living with HIV/AIDS</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Rapporteur:</strong> Zimbabwe/FAO (Georges Codjia)</td>
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<td></td>
<td><strong>Moderator:</strong> Namibia</td>
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<tr>
<td>08.50–09.10</td>
<td>Summary of the main findings of a multi-country review</td>
</tr>
<tr>
<td></td>
<td>• Robert Mwadime</td>
</tr>
<tr>
<td>09.10–09.25</td>
<td>Experiences and lessons learnt to introduce nutrition and HIV curriculum to pre-service and in-service training</td>
</tr>
<tr>
<td></td>
<td>• Robert Mwadime</td>
</tr>
<tr>
<td>09.25–09.35</td>
<td>Country experience on challenges and lessons learned</td>
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<tr>
<td></td>
<td>• Lesotho</td>
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<tr>
<td>09.35–10.00</td>
<td>Discussion</td>
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<td><strong>Plenary</strong></td>
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<td></td>
<td><strong>Session 4: Review on HIV and Infant Feeding Counseling and Support</strong></td>
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<tr>
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<td><strong>Rapporteur:</strong> Zambia/WHO (Peggy Hendersen)</td>
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<td><strong>Moderator:</strong> Malawi</td>
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<tr>
<td>10.00–10.20</td>
<td>Summary of the main findings of a multi-country review</td>
</tr>
<tr>
<td></td>
<td>• Mickey Chopra</td>
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<tr>
<td>10.20–10.30</td>
<td>Findings from PMTCT and pediatric care joint missions: An opportunity to review and strengthen IF/Nutrition component of PMTCT scale-up plans</td>
</tr>
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<td></td>
<td>• Saba Mebrahtu</td>
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<tr>
<td>10.30–10.45</td>
<td><strong>Break</strong></td>
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<tr>
<td>10.45–10.55</td>
<td>Country experience on challenges and lessons learned</td>
</tr>
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<td></td>
<td>• Tanzania</td>
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<tr>
<td>10.55–11.30</td>
<td>Discussion</td>
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<td></td>
<td><strong>Plenary</strong></td>
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<td></td>
<td><strong>Session 5: Review of Management of Moderate and Severe Malnutrition and HIV</strong></td>
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<tr>
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<td><strong>Rapporteur:</strong> Mozambique/UNICEF (Anirban Chatterjee)</td>
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<td><strong>Moderator:</strong> Rwanda</td>
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<tr>
<td>11.30–11.50</td>
<td>Summary of the main findings of a multi-country review</td>
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<tr>
<td></td>
<td>• Pamela Ferguson</td>
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<tr>
<td>11.50–12.00</td>
<td>Country experience on challenges and lessons learned</td>
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<td></td>
<td>• Kenya</td>
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<tr>
<td>12.00–12.30</td>
<td>Discussion</td>
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<tr>
<td>12.30–13.30</td>
<td><strong>Lunch Break</strong></td>
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### Plenary

**Session 6: OVC, Food Security and Nutrition**

**Rapporteur:** Swaziland/WFP (Sana Cessay)  
**Moderator:** Lesotho

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
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</table>
| 13.30–13.45| Summary of the main findings of global review of OVC, food security and nutrition:  
  *Where we stand*  
  - Anirban Chatterjee |
| 13.45–14.00| Country experience on challenges and lessons learned  
  - Penelope Campbell |
| 14.00–14.30| Discussion                                                             |

### Plenary

**Session 7: Resource Mobilization for Nutrition and HIV/AIDS**

**Rapporteur:** Kenya/WHO (Charles Sagoe-Moses  
**Moderator:** Anirban Chatterjee

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
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</table>
| 14.30–14.50| Summary of the main findings and follow-up actions to the Harare meeting  
  - Randa Saadeh |
| 14.50–15.00| Country experience on challenges and lessons learned  
  - Mozambique |
| 15.00–15.30| Discussion                                                             |
| 15.30–16.00| Break                                                                 |
| 16.00–16.05| Introduction to Group Work # 1  
  *Key Implementation Challenges, Bottlenecks and Key Priority Actions*  
  Group Work and Main Rapporteur (Ida Neuman)  
  Moderator: Charles Sagoe-Moses |
| 16.05–18.00| **Group 1:** Integrating nutrition into national AIDS policies and programs with national budget allocation  
  **Group 2:** Nutrition care and support for PLWHA  
  **Group 3:** HIV and infant feeding  
  **Group 4:** Management of moderate and severe malnutrition and HIV  
  **Group 5:** OVC, food security and nutrition  
  **Group 6:** Resource mobilization |
**Friday, 4 May 2007**
*Group Work and Main Rapporteur: Ida Neuman*

### Plenary

<table>
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<tr>
<th>Time</th>
<th>Session</th>
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<tbody>
<tr>
<td>08.30-09.30</td>
<td>10 minute presentation per group</td>
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<tr>
<td>09.30–10.30</td>
<td>Discussion</td>
</tr>
<tr>
<td>10.30–10.45</td>
<td><strong>Break</strong></td>
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<tr>
<td>10.45–10.50</td>
<td>Introduction to Group Work # 2</td>
</tr>
<tr>
<td></td>
<td><em>Key Strategies and Priority Actions</em></td>
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<tr>
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<td>Moderator: Saba Mebrahtu</td>
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<tr>
<td>10.50–12.30</td>
<td>Country team group work discussions</td>
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<tr>
<td>12.30–13.30</td>
<td><strong>Lunch Break</strong></td>
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### Plenary

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<th>Time</th>
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<tbody>
<tr>
<td>13.30-14.30</td>
<td>5 minute presentation per group (11 countries)</td>
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<tr>
<td>14.30–15.00</td>
<td>Discussion</td>
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<tr>
<td>15.00–15.15</td>
<td><strong>Break</strong></td>
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<tr>
<td>15.15–16.00</td>
<td>Global and Regional TA requirements</td>
</tr>
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<td></td>
<td>Moderators: Charles Sagoe-Moses and Saba Mebrahtu</td>
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<tr>
<td>16.00–16.30</td>
<td>Closing and conclusion</td>
</tr>
</tbody>
</table>
7.2 List of Participants

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### 7.3 National Plans of Action for Nutrition and HIV

#### Kenya

<table>
<thead>
<tr>
<th>Challenges</th>
<th>Way Forward</th>
<th>Technical Assistance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Focus on nutrition limited/ gaps in national HIV/AIDS training efforts and service delivery scale</td>
<td>Strengthen national M&amp;E structure for Nutrition and HIV/AIDS interventions (universal access targets, form 726/727), use of M&amp;E manager/officer (NASCOP) to expand data collection on Nutrition and HIV/AIDS activities and operational analysis of nutritional programme efforts (paediatric supplementary and therapeutic support)</td>
<td>4 m USD per year to address universal access targets with aim at enhancing broader sectoral support (e.g. food based and social safety nets for OVCs) with a target of 10 m USD/year as per draft Kenyan Nutrition and HIV/AIDS Strategy</td>
</tr>
<tr>
<td>Limited capacity and scale up of nutrition interventions</td>
<td>Increased capacity development of service providers through continued training (CCC, PMTCT, Paediatric HIV/AIDS providers) with a focus on skills in counselling and strengthen supervision and mentoring to empower nutritionists at a provincial and district level to strengthen nutrition interventions</td>
<td>Technical assistance to develop service pathways placing nutrition strategically with in key service delivery points of HIV/AIDS care</td>
</tr>
<tr>
<td>Need to strengthen research component (operational research) in Nutrition and HIV/AIDS programmes with adaptation to service provision and scale up</td>
<td>Establishing national advocacy and communication strategies to promote optimal nutrition for PWHA (radio spots, hotline, bi-weekly programmes on nutrition and HIV/AIDS) and Continue to advocate the role of nutrition within key policy and strategy forums (e.g. National Food and Nutritional Policy/Strategy, KNASP II, Legislating Code for Marketing of Breast Milk Substitutes)</td>
<td>Resources for national training utilizing national standards of training for improving the capacity of service provision</td>
</tr>
<tr>
<td>Need to strengthen integration efforts in interventions (relief, rehabilitation and development)</td>
<td>Establishing national model and standards of care for nutritional care and support for PWHA in counselling/education and nutritional care package (multiple micronutrient, SFP, TFP, food based support) – 4 m USD / year estimated</td>
<td>Resources and technical assistance for documentation and dissemination of programme delivery and best practices</td>
</tr>
<tr>
<td>Weak cross – sectoral/intrasectoral partnerships/linkages all levels (particularly at provincial and district levels)</td>
<td>Establish and standardize algorithms and standards of care for integration of nutritionist and nutritional care in service provision (i.e. non clinical referral form, CDC care) – MCH/PMTCT, Paediatric CCC and enhancing service provision through collaboration with communities and networks of PLWHA. Better targeting and greater involvement of PLWHA in planning of interventions</td>
<td>Government to allocate funds for implementing activities as planned – Essential Drug List, MTEF, Priority Area for Global Fund Round 7</td>
</tr>
</tbody>
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### Lesotho

<table>
<thead>
<tr>
<th>Challenges</th>
<th>Lessons Learned</th>
<th>Way Forward</th>
<th>How?</th>
</tr>
</thead>
<tbody>
<tr>
<td>High staff turnover within Health Sector and Difficult geographic terrains for service provision</td>
<td>Good nutrition prolongs lives &amp; results in reduction of # of OVCs and their care</td>
<td>GOL to expedite the decentralization process with emphasis and urgency on recruitment and placement of nutrition personnel and responsibilities at district and community level</td>
<td>Advocacy – Government of Lesotho is finalizing the HR strategy</td>
</tr>
<tr>
<td>Weak coordination mechanisms and weak tracking systems for infected &amp; affected adults &amp; children at community level</td>
<td>Effective coordination system is critical and training &amp; use of GLs in local language more effective</td>
<td>Family Health Division to be the lead agency for coordination and national scale up of the PMTCT and Paediatric AIDS Programmes (IYCF within PMTCT &amp; mgt of moderate-severe malnutrition within Paeds AIDS)</td>
<td>Capacity building - Scale-up plan is being implemented – lead by FHD. TFP operational in all hospitals will move to the community. 17 hospitals to be certified as BFHI by end of 2010</td>
</tr>
<tr>
<td>Rightful placement of PMTCT &amp; Paediatric AIDS services- AIDS Directorate vs FHD and Infant formula in ART sites providing Paeds AIDS services</td>
<td>Strong advocacy to mobilize resources for the health sector within and outside Gov. system - target 15% of Gov. budget.</td>
<td>Establish coordination &amp; integration between FHD &amp; SWD for fast tracking implementation of the OVC NP</td>
<td>Coordination - PMTCT programme is placed in FHD and the OVC nutrition programme is under implementation. Programmes to be scaled up in 2008</td>
</tr>
<tr>
<td>Service delivery improvement</td>
<td>Strengthened HMIS- M&amp;E</td>
<td>Securing/ sustaining the required financial support and ever increasing prevalence of OVCs</td>
<td>Nutrition surveillance system in place. Nutrition survey carried out and sentinel sites development is undertaken.</td>
</tr>
</tbody>
</table>
### Malawi

<table>
<thead>
<tr>
<th>Constraints and Challenges</th>
<th>Way Forward</th>
<th>Technical Assistance</th>
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</table>
| Limited co-ordination and integration at operational and national level and in the National HIV/AIDS response framework | Strengthen co-ordination and integration of nut and HIV AIDS at operational and central level and in the national response plans, implementation structure and M&E and training tools, NAF indicators  
☑️ Harmonise the Nut and HIV/AIDS tools- M&E, training, NAF, joint planning, strengthen monthly or quarterly directorate meetings within the MoH and coordination meetings with stakeholders.  
☑️ Have contact person for M&E for HIV/AIDS including Nutrition components, Nutrition and HIV  
☑️ Review and harmonise documentation of referral services and networks for NU, HIV and AIDS and produce district specific referral mechanisms.  
☑️ Strengthen co-ordination and integration of nut and HIV AIDS at operational and central level and in the national response plans, implementation structure and M&E and training tools  
☑️ TA for M&E, evaluation of the NCST and IYCF in PMTCT programmes, development of the advocacy package. |                                                                                                 |
| Weak and unclear integration and referral/linkage networks between nutrition and HIV/AIDS e.g HTC, HBC, CTC, linking BFHI and PMTCT | Have a comprehensive M and E for NCST and IYCF in PMTCT programs for tracking impact and evidence based programming  
☑️ Integrate M&E indicators in the NAF, HIV/AIDS |                                                                                                 |
| Comprehensive M&E for tracking impact and evidence based programming and advocacy            | Interventional and operational research for evidence based programming  
☑️ Solicit national consensus for national research agenda in Nut and HIV/AIDS |                                                                                                 |
| Inadequate Institutional and human capacity to effectively scale up the Nut and HIV programmes e.g counsellors for IYCF, District Nutritionists, high staff attrition rates | Integration of Nutrition and HIV in the pre-service curricular  
☑️ Conduct review of current pre-service curricular and facilitate integration of nutrition and HIV |                                                                                                 |
|                                                                                           | Continue with advocacy for resource mobilisation (human and financial)  
Conduct evidenced based advocacy; documentation of best practices, cost-benefit analysis for nutrition interventions, |                                                                                                 |
### Mozambique

<table>
<thead>
<tr>
<th>Constraints and Challenges</th>
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<tbody>
<tr>
<td>Limited resources – low coverage (e.g. only 10% of PLWHA on ART receiving food &amp; nutrition support) and limited capacities for nutrition (The amount requested from the GF is USD 2.3 mil.on mostly for 2 yrs out of a total requested budget of USD 76 million for 3 years)</td>
<td>Develop overall training plan on nutrition and HIV training at senior and medium level; at health facilities, at community level and for civil society partner. GF funds starting in 2008, then MOH funds from HR Training Plan, and other; Financial and technical support already in place mainly from UNICEF &amp; WHO</td>
<td>Mainly UNICEF &amp; WHO for technical updates &amp; planning;</td>
</tr>
<tr>
<td>Government policy in different sectors still in process of being finalized e.g. types of intervention, criteria, approach to operationalization and no systematic M&amp;E</td>
<td>Ensure nutrition interventions are systematically integrated in Government annual plans (MOH, CNCS, INAS etc) &amp; resources (Govt. &amp; common funds) are allocated; Intersectorial co-ordination</td>
<td>Other Agencies interested.</td>
</tr>
<tr>
<td>Fragmented implementation with no standard guidance on operational issues: currently in process of development with WB support and Limited inter-sectoral coordination at operational level (e.g. linking nutrition interventions in health sector with social safety nets, livelihood support, food security etc)</td>
<td>Conduct advocacy and communication activities Advocacy at all levels for integration of nutrition interventions in Government annual plans (meetings with decision makers);</td>
<td></td>
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<table>
<thead>
<tr>
<th>Achievements</th>
<th>Challenges and Constraints</th>
<th>Way Forward</th>
<th>Technical Assistance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nutrition Management with HIV/AIDS Guidelines and Nutrition Management with HIV/AIDS Training Manual and Nutrition and Food Security Assessment Tool developed.</td>
<td>Lack of capacity both in number of staff and technical expertise of staff</td>
<td>Capacity building at all levels (facility, district and region).</td>
<td>BFHI Training of Trainers</td>
</tr>
<tr>
<td>37 Trainers and 158 health workers trained in Nutrition Management with HIV/AIDS, in-service, pre-service, counselors and University of Namibia lecturers.</td>
<td>Position for National Programme Officer is vacant, creating difficulties in establishing programme.</td>
<td>Monitoring and Evaluation. Review nutr indicators in HIS &amp; analyse &amp; report</td>
<td>Review of job aides and counseling cards</td>
</tr>
<tr>
<td>Nutrition and IF considerations integrated into roll-out and training for Early Infant HIV diagnosis (DNA PCT testing) and draft counseling cards for IYCF and IYCF Policy 2004, and draft Guidelines available.</td>
<td>Poor understanding of importance of nutritional assessment as part of basic HIV care and treatment.</td>
<td>Research Prospective survey on IF practices related to HIV (feeding options, morbidity, HIV status) Food and Nutrition Security Assessment for HIV+ pts</td>
<td>Food and Nutrition Security Assessment (FANTA)</td>
</tr>
<tr>
<td>Nutrition considerations integrated into HIV/AIDS Policy and nutrition issues integrated into ART/PMTCT guidelines and training manual and Nutrition considerations integrated into Paediatric HIV training manual.</td>
<td>Difficulty with monitoring and evaluation of nutritional services as appropriate indicators are not being collected</td>
<td>Follow up after training</td>
<td></td>
</tr>
<tr>
<td>Regular Integrated review and planning meetings with Subnational Health staff and with other sectors, as well and regular Integrated supportive supervisory visits conducted, including nutrition and Each ART clinic has at least one registered nurse trained in Nutrition Management with HIV/AIDS.</td>
<td>Poverty, food insecurity and emergencies provides a vicious cycle that undermines quality of nutrition and health services.</td>
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</tbody>
</table>
## Rwanda

<table>
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<tr>
<th>Constraints and Challenges</th>
<th>Way Forward</th>
<th>Technical Assistance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of a champion for nutrition in country</td>
<td>Update the existing nutrition strategic plan based on current information – July  Work with WHO/UNICEF to develop the IYCF strategy – August 2007  Harmonization of IEC materials – July</td>
<td>M&amp;E Technical assistance</td>
</tr>
<tr>
<td>Weak coordination mechanism</td>
<td>Strengthening the management SAM and Strengthening coordination and Resource mobilization</td>
<td>Development of strategy</td>
</tr>
<tr>
<td>Weak M&amp;E system and inadequate analysis of available data</td>
<td>Situation analysis and data compilation for evidence based advocacy-(simple advocacy)</td>
<td>Strengthen management of SAM</td>
</tr>
<tr>
<td>Human resource constraints</td>
<td>Strengthening M&amp;E (HMIS &amp; TRACnet) including nutrition surveillance and Harmonization of training &amp; reinforcing counseling in nutrition and HIV.</td>
<td>To develop job aids</td>
</tr>
<tr>
<td>Challenges and Constraints</td>
<td>Key Priorities</td>
<td>Strategies for implementation</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------------------------</td>
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<td>-----------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Poor collaboration between Nutrition Council and SNAP (HTC, PMTCT, ART)</td>
<td>Strengthen the collaboration between the nutrition department and the HIV/AIDS department</td>
<td>Strengthen the collaboration between the nutrition department and the HIV/AIDS department and plan and implement interventions in hospitals</td>
</tr>
<tr>
<td>Poor quality IYCF counseling</td>
<td>Improvement of IYCF counselling</td>
<td>Improvement of IYCF counselling</td>
</tr>
<tr>
<td>Poor management of severe malnutrition in hospitals</td>
<td>Improvement of the management of severe malnutrition in hospitals</td>
<td>Improvement of the management of severe malnutrition in hospitals and piloting of community based management of severe malnutrition</td>
</tr>
<tr>
<td>Officials of nutrition service (SNAP) and nutrition department of the Ministry of Health</td>
<td>Piloting of community based management of severe malnutrition</td>
<td>Assessment of management of severe malnutrition and pilot the community based management of severe malnutrition</td>
</tr>
<tr>
<td>Officials of nutrition service (SNAP) and nutrition department of the Ministry of Health</td>
<td>Assessment of management of severe malnutrition current practice in health facilities</td>
<td>Adapt WHO guidelines for management of severe malnutrition and pilot the community based management of severe malnutrition</td>
</tr>
</tbody>
</table>
### Tanzania

<table>
<thead>
<tr>
<th>Challenges</th>
<th>Key Priority Areas and Strategies</th>
<th>Technical Assistance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inadequate coordination of various stakeholders dealing with nutrition &amp; HIV and inadequate nutritional actions/ capacity in most of the HIV/AIDS interventions</td>
<td>Strengthen coordination among various stakeholders dealing with nutrition and HIV ➢ Strengthen national nutrition working group ➢ Review TOR of the group ➢ Incorporate more key stakeholders and relevant program managers</td>
<td>Technical assistance to standardise the training materials, tools and guidelines and to incorporate nutrition and HIV into pre-service and in-service training</td>
</tr>
<tr>
<td>Presence of several guidelines with different nutrition messages and misinterpretation of nutrition care and support as only provision of food</td>
<td>Scale-up and strengthen advocacy and sensitisation of nutrition and HIV issues at all levels ➢ Develop advocacy package on nutrition and HIV ➢ Develop advocacy and dissemination plan ➢ Mobilize resources</td>
<td>Technical assistance to develop advocacy package and dissemination plan</td>
</tr>
<tr>
<td>Lack of standardized M&amp;E nutrition indicators and Limited dissemination of research findings in the area of nutrition &amp; HIV to policy makers and program managers and Inadequate resources for nutrition interventions especially at district level</td>
<td>Capacity building to be able to address nutrition issues at all levels ➢ Standardization of the existing training materials through workshop which involve all key stakeholders ➢ Develop national training plan ➢ Develop planning guide for nutrition and HIV ➢ Facilitate employment of nutritionist at all key areas</td>
<td>Support key sensitisation and advocacy meeting and Government commitment</td>
</tr>
</tbody>
</table>
### Uganda

<table>
<thead>
<tr>
<th>Challenges</th>
<th>Priority Areas for Action</th>
<th>Key Priorities to Accelerate progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coordinating the different partners involved in Nutrition and HIV/AIDS activities</td>
<td>Constitute a National Multi-disciplinary Coordination Team (Advisory Committee) and Strengthen the capacity of districts and communities to implement nutrition interventions</td>
<td>Debrief the Director General of H/S on the outcome of the Nairobi meeting. And Call a meeting of <strong>stake holders</strong> involved in nutrition, HIV/AIDS, TB and Malaria (Gov't line ministries; NGO, Dev’p partners. Researchers, academic institutions, PHA’s networks etc.)</td>
</tr>
<tr>
<td>Inadequate Human resource at all levels and especially at district and community levels</td>
<td>Finalizing the Integration of the community based and facility based approach for Management SAM &amp; MAM</td>
<td>Setting the coordination structure at all levels and especially at district and community levels</td>
</tr>
<tr>
<td>Integration of the various activities</td>
<td>Revise and finalize the M&amp;E plan for nutrition in the context HIV</td>
<td>Review and finalize the National key nutrition indicators (in IF, PMTCT, ART, Paediatric Aids etc.)</td>
</tr>
<tr>
<td>Inadequate funding</td>
<td>Resource Mobilization - Identify the budget line to support Nutrition Activities.</td>
<td>Sourcing For TA from development partners e.g. WHO etc.</td>
</tr>
</tbody>
</table>
Zambia

<table>
<thead>
<tr>
<th>Constraints and Challenges</th>
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</thead>
<tbody>
<tr>
<td>Lack of high level Position related to Nutrition and HIV</td>
<td>Establishing Functional TWG at all levels.</td>
<td>Consultancy to harmonize Indicators.</td>
</tr>
<tr>
<td>Lack of Multi-sectoral and Coordination Team and Inadequate funding</td>
<td>Ensure inclusion of proposed Nutrition and HIV indicators into the National HIMS</td>
<td>Consultancy to lobby for resources.</td>
</tr>
<tr>
<td>Poor M&amp;E system and Poor understanding and appreciation as it relate to Nutrition</td>
<td>Capacity building at all levels</td>
<td>Consultancy for Capacity building.</td>
</tr>
<tr>
<td>Sustainability strategies and Transfer of Policy into practice</td>
<td>Lobby for High level Position</td>
<td>Consultancy in Developing Sustainability strategies</td>
</tr>
<tr>
<td>Incomplete Minimum Nutrition package and Contractual agreements</td>
<td>Develop National Nutrition/ HIV Strategies with Sustainability options</td>
<td>Financial Assistance</td>
</tr>
<tr>
<td>Changing National priorities</td>
<td>Government input into The Cooperative Agreement through TWG</td>
<td></td>
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</tbody>
</table>
### Constraints and Challenges

<table>
<thead>
<tr>
<th>Resources</th>
<th>Way Forward</th>
<th>Technical Assistance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Funds are not channelled to operational level</td>
<td>Mainstreaming nutrition and HIV in government policies, sectoral strategies and outreach programmes</td>
<td>Funds</td>
</tr>
<tr>
<td>Inflation and insufficient resources management from the government</td>
<td>How: Nutrition Council empowered and reinstated under the President's office</td>
<td></td>
</tr>
<tr>
<td>HIV integrated into nutrition policies there is a lack of access to HIV funding for nutrition programmes</td>
<td>Improving the livelihood with food security in linkage with agricultural ministry</td>
<td></td>
</tr>
<tr>
<td>Funding proposals mostly looking for food aid and social welfare, not nutrition</td>
<td>Ongoing counselling at community level (support networks, women groups,)</td>
<td></td>
</tr>
<tr>
<td>Nutrition is not seen as a priority in technical and funding agendas, even for major partners</td>
<td>Networking with PMTCT, ANC and postnatal care and EPI, BFHI, community based nutrition care programme. Organizing key stakeholders in a common national network</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Coordination and leadership</th>
<th>Make the money work- channelling it to community and implementers.</th>
<th>Technical support from the food and nutrition council</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nutrition on the agenda of the health and child welfare but not on the social welfare: some more coordination needed even if there are some good initiatives.</td>
<td>How: Open partnership</td>
<td></td>
</tr>
<tr>
<td>Lack of adequate recognition of nutrition in HIV work</td>
<td>Accountability with tangible outcomes for the beneficiaries</td>
<td></td>
</tr>
<tr>
<td>Missing linkages with other programme (verticalization)</td>
<td>Building ownership of communities, revolving funds</td>
<td></td>
</tr>
</tbody>
</table>

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<thead>
<tr>
<th>Capacity to implement is insufficient in CBOs and partners, (Human resources constraints and need for training and awareness)</th>
<th>Capacity development of NGOs government and staff retention</th>
<th>Technical support from experienced countries (Kenya) and NGOs UN agencies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Distribution and management of food supply is a challenge (Shelf life and timely decentralisation up to community level).</td>
<td>How: Integrating nutrition in pre-service training</td>
<td></td>
</tr>
<tr>
<td>One agreed country level M&amp;E planned, not yet implemented need to include nutrition-</td>
<td>Harmonizing of training curricula and services</td>
<td></td>
</tr>
</tbody>
</table>