

# FANTA · 2

FOOD AND NUTRITION  
TECHNICAL ASSISTANCE



**USAID**  
FROM THE AMERICAN PEOPLE



UGANDANS AND AMERICANS  
IN PARTNERSHIP TO FIGHT HIV/AIDS

## NuLife

FOOD AND NUTRITION  
INTERVENTIONS FOR UGANDA

**Meeting on Nutrition Assessment,  
Counseling, and Support in HIV  
Services: Strategies, Tools, and  
Progress, September 14–17, 2010,  
Jinja, Uganda**

**Meeting Report**

**January 2011**



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## Abbreviations and Acronyms

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ANC	antenatal care
ART	antiretroviral therapy
BMI	body mass index
CDC	United States Centers for Disease Control and Prevention
CMAM	Community-Based Management of Acute Malnutrition
FANTA-2	Food and Nutrition Technical Assistance II Project
FBF	fortified-blended food
FTF	Feed the Future - USG Global Food Security and Hunger Initiative
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
HBC	home-based care
HCIP	Health Care Improvement Project
IMAM	Integrated Management of Acute Malnutrition
M&E	monitoring and evaluation
MUAC	mid-upper arm circumference
NACS	nutrition assessment, counseling, and support
NGO	nongovernmental organization
NHP	Nutrition and HIV Program (Kenya)
OVC	orphans and vulnerable children
PEPFAR	United States President's Emergency Plan for AIDS Relief
PLHIV	people living with HIV
PMTCT	prevention of mother-to-child transmission of HIV
PRN	Programa de Reabilitação da Nutrição (Nutrition Rehabilitation Program) (Mozambique)
QI	quality improvement
RCQHC	Regional Centre for Quality of Health Care (Uganda)
RUTF	ready-to-use therapeutic food
SBCC	social and behavior change communication
U.N.	United Nations
URC	University Research Corporation, LLC
USAID	United States Agency for International Development
USG	United States Government
WFP	World Food Programme
WHO	World Health Organization

## 1. Background

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Governments, donors, international organizations, and nongovernmental organizations (NGOs) have increasingly recognized the importance and benefits of nutrition care for people living with HIV (PLHIV). As a result, several countries have made substantial progress in integrating nutrition components into HIV care and treatment services. The primary model supported by the United States President's Emergency Fund for AIDS Relief (PEPFAR) for integrating these nutrition services into clinical services is nutrition assessment, counseling, and support (NACS).

Different countries are at different stages of NACS programming. Kenya, Malawi, and Uganda have operated NACS programs for several years. Ethiopia and Tanzania began programs during 2010. Côte d'Ivoire, Ghana, Mozambique, Namibia, and Vietnam are starting programs soon, and Haiti is considering initiating programs. While the core set of NACS services are similar across countries, different countries have taken different approaches to their programs, with variations in government ownership, community linkages, and implementing partner configurations. Given the different stages and different approaches, there is ample opportunity for countries to learn from each other's experiences and from the emerging lessons and challenges.

To enable countries to share tools and experiences and to disseminate promising approaches, the Food and Nutrition Technical Assistance II Project (FANTA-2) at AED collaborated with the United States Agency for International Development (USAID); the University Research Corporation, LLC (URC)/NuLife; the Uganda Regional Centre for Quality of Health Care (RCQHC); and the Uganda Ministry of Health to hold a 4-day meeting on NACS programs. The meeting was funded by USAID and was held September 14–17, 2010, in Jinja, Uganda.

## 2. Objectives

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The overall goal of the meeting was to share experiences that can be used to improve the design and implementation of NACS programs.

The specific objectives were to:

- Share country experiences and lessons learned in the process of implementing NACS interventions, including food by prescription; developing and operationalizing guidelines; strengthening capacity, monitoring and evaluation (M&E) and reporting; and linking to community services and wrap-around programs.
- Disseminate innovative approaches and effective practices in implementing NACS at different levels, especially at scale (e.g., approaches for commodity production and flow, M&E and training issues, and quality improvement [QI] approaches for NACS).
- Share tools and materials, such as guidelines; job aids; information, education, counseling/social and behavior change communication (SBCC) materials; training manuals; M&E tools; and commodity management tools.
- Develop country-level action plans for initiating or improving NACS interventions based on a country's status.
- Support PEPFAR country teams in incorporating NACS into programs, including staff requirements, cost planning, and reporting.

## 3. Participants

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Ninety-eight participants from 18 countries attended the meeting. Attendees included representatives from government ministries and agencies, USAID and the United States Centers for Disease Control and Prevention (CDC), implementing partners, United Nations (U.N.) agencies, and technical assistance partners. The countries represented were Côte d'Ivoire, Ethiopia, Ghana, Haiti, Italy, Kenya, Malawi, Mozambique, Namibia, Rwanda, South Africa, Switzerland, Tanzania, Uganda, the United Kingdom, the United States, Vietnam, and Zambia.

## 4. Meeting Process

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The meeting used a range of formats, including presentations, plenary discussions, panel discussions, break-out sessions, field visits, country planning sessions, and poster and materials exhibits. Participants delivered 10 presentations on a range of topics related to NACS programming, including the program model, the evidence base supporting the NACS approach, costing of NACS programs, and QI. Panel discussions were held on food production and procurement, links between NACS and Feed the Future - United States Government Global Food Security and Hunger Initiative (FTF), and outstanding issues and questions remaining at the end of the meeting. During four break-out sessions of three groups each, participants worked in small groups to learn and discuss 12 topics in greater depth. For field visits, participants divided into four groups that each visited a clinical facility implementing NACS as well as community services linked to the facilities. On the final day of the meeting, country teams met to develop action plans for priority activities over the short and medium term for initiating or strengthening their NACS services. Tools and materials from country NACS programs were displayed outside the meeting room, and an opportunity was provided to share and discuss these materials. The detailed agenda for the meeting can be found in Annex 1.

## 5. Key Issues Identified

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The following key issues and conclusions emerged from the meeting.

- **Sharing experiences, challenges, and lessons across countries** enhances stakeholder understanding, broadens perspectives, and enables implementers to build on each other's experience to enhance their programs. In particular, countries that were at an early stage in the NACS process benefited from the experiences of countries with longer histories of implementing NACS services. Participants agreed that they would like to stay in touch with each other, both informally and, if possible, formally.
- **The degree of program ownership and control by government stakeholders** is an important factor affecting implementation of NACS. Depending on the context, different countries have different degrees of country ownership and shift responsibility from external partners to the government at different paces. Participants pointed out that strong government ownership of the NACS program assists in integrating nutrition into government services (as opposed to developing parallel services) and can offer valuable benefits for long-term sustainability of services, though participants also pointed out that in many cases external resources continue to be needed for the foreseeable future to operate NACS programs at scale.
- **Human resource capacity** in nutrition at the service delivery level is a critical factor in successful NACS programs and in many countries remains a significant challenge. Inadequate numbers of service providers and lack of time among existing service providers continue to constrain the quality and scale of NACS programs. Countries are continuing to roll out training and support materials, which partially address the human resource capacity needs, but additional inputs are needed, including expanding the number of available service providers and establishing supervision and other systems to strengthen the quality of NACS services.
- Related to this, solid consensus emerged from participants about the value of **QI systems**. The Uganda NACS program has collaborated with the Health Care Improvement Project (HCIP) to incorporate QI methods to maintain high levels of nutrition assessment coverage. Discussion of this approach helped other countries consider how QI could be incorporated into their services, and many of the country action plans highlighted QI as a priority area for emphasis in the medium term.
- **Food production, procurement, and supply chain management** are a central—and often challenging—component of NACS programs. Different systems are in place in different countries. Some use locally produced food while others imported food; some use the government drug supply chain system while others use private sector companies or external partners for food supply chain management. Food costs comprise a large share of overall program costs, and the proportion of costs going to food increases as programs scale up. Efforts to reduce import and other taxes on food products can assist in reducing these costs. Adequate and safe storage for

food remains a challenge in many settings as programs scale up, especially for fortified-blended food (FBF) products.

- Participants recognized the need for **linkages between NACS services in facilities and various types of community services**. Where possible, these linkages should involve bidirectional referral systems, with community groups and health workers referring clients to clinical facilities for assessment and treatment as needed and facility-based NACS services referring clients for community-based follow-up for nutrition counseling, food security services, and tracing of clients lost to follow-up. As part of the field visits, participants had an opportunity to visit both facility services and community follow-up services.

## 6. Meeting Proceedings

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### 6.1 OPENING REMARKS

Representatives of the conveners of the meeting made the opening remarks. Janex Kabarangira, Deputy Health Team Leader, USAID Uganda, welcomed participants to the meeting and encouraged them to focus on concrete steps to improve the impacts of their programs. Dr. Harriet Kivumbi, Director of RCQHC, urged participants to strengthen existing partnerships and exploit opportunities to create new partnerships to build synergies on issues of common interest. Paul Lwamafa, representative of Uganda Ministry of Health, noted that HIV/AIDS has been further aggravated by poor access to food and nutrition, which led to inclusion of a significant nutrition component in the recently launched National Development Plan. Dr. Robert Mwadime, Senior Regional Nutrition Advisor, AED/FANTA-2, gave an overview of the meeting agenda, the topics of focus, and the objectives and expectations.

### 6.2 PLENARY SESSION: INTRODUCTION TO NACS

The first plenary session commenced with a definition of NACS and its components and an overview of PEPFAR guidance on food and nutrition programming. Food, nutrition, and HIV activities were categorized into three program areas: nutrition care, prevention of mother-to-child transmission of HIV (PMTCT) and infant feeding, and food security. The primary target groups identified for NACS services were orphans and vulnerable children (OVC) under 2 years of age, HIV-positive pregnant and lactating women in PMTCT programs, OVC over 2 years of age with evidence of malnutrition or faltering growth, and adult PLHIV in care and treatment programs. NACS services consist of nutrition assessment (anthropometric, biochemical, clinical, dietary, and, in some cases, water and sanitation and food security); nutrition counseling and nutrition support, which may include provision of specialized food products to malnourished clients; provision of micronutrient supplements; provision of safe water devices; and referral for food security support and other community services. Entry points for NACS services include antenatal care (ANC)/PMTCT, HIV counseling and testing, clinical referral, and community nutrition surveillance and referral. Challenges noted included integration of NACS as the standard of care, limited human resource capacity, linkages among programs, household food insecurity, the need to focus on HIV-free survival outcomes among HIV-exposed infants, and production and distribution of specialized food products. Responses to these challenges included QI, training, task shifting, tracking and follow-up, home-based care (HBC), local food production, PMTCT continuum of care, national standards for specialized food products, and public-private partnerships.

The next presentation was on the evidence base for the NACS approach. Results were summarized from studies carried out in Kenya and Malawi, which have the longest-running NACS programs, as well as from studies in the Gambia, Singapore, Tanzania, Uganda, Zambia, and a few developed countries. There is strong evidence of the association between poor nutritional status and mortality among adult PLHIV, including both those on antiretroviral therapy (ART) and those not on ART. Evidence of the impacts of specific nutrition interventions is more limited, but there is some evidence that food supplementation improves ART adherence and weight and lean body mass gain. A study in Kenya indicated that food supplementation may also improve the immune response of pre-ART clients. This study also suggested that nutrition counseling, even absent food supplementation, may improve

nutritional status. The benefits of food supplementation appear to be greater for pre-ART clients than for ART clients.

In response to a question about the evidence base among children, it was pointed out that there is solid evidence of the benefits of therapeutic feeding for children with severe acute malnutrition and some evidence regarding supplementary feeding for children with moderate acute malnutrition. More evidence is needed on HIV-infected children, and continuing research and evaluation of program approaches will be beneficial, but programs targeting malnourished HIV-positive children should not wait for complete evidence to implement interventions.

The third presentation gave an overview of the status of NACS in different countries. The data were drawn from stakeholder interviews, country policy documents, country reports, and feedback from partners. The data covered the status of integration of nutrition in national HIV responses via national policy and coordination, capacity strengthening, service delivery, information systems, and the evidence base. The presentation was supported by a matrix depicting the situation and progress in different countries. Participants suggested a need to clarify the source of information: government or other partners. Following the presentation, the matrix was circulated among participants for feedback, and a revised version reflecting updates and input from participants was circulated on the last day of the meeting.

### **6.3 PLENARY SESSION: EXPERIENCE OF LONG-RUNNING PROGRAMS IN UGANDA AND KENYA**

The first presentation of this plenary session described how NACS operates at the clinic and community levels in the Uganda program. The Ministry of Health carries out supervision of the districts and health facilities and is responsible for the policies and guidelines under which the services operate. All malnourished beneficiaries receive ready-to-use therapeutic food (RUTF), which is procured from a local food manufacturing company. The health facilities provide services to clients and link to existing community-based services for follow-up. The USAID-funded NuLife program provides support to the ministry and health facilities. The broad objectives of NuLife are to provide technical support to integrate food and nutrition intervention into HIV/AIDS care, treatment, and support programs; develop high-quality, low-cost, nationally acceptable RUTF; and establish a supply chain system for delivery of RUTF.

Participants raised questions about training, follow-up of clients who do not return to the clinic, M&E, and maintenance of health workers' and community volunteers' motivation. The presenter responded that training in nutrition was carried out as part of regular professional development for health care providers. Follow-up has been greatly aided by PLHIV groups themselves formed around the concept of "living positively with HIV/AIDS," and a number of members volunteer their time to do follow-up in the communities. The project has a built-in M&E mechanism and encourages health workers to collect data. Motivation for volunteers includes a modest payment (US\$10) to facilitate transport and items like T-shirts and bags.

The next presentation focused on the approaches and lessons from rapidly scaling up NACS in Kenya. The program scaled up from fewer than 50 sites to more than 350 sites. This expansion aimed to reach underserved parts of the country and to share lessons and information from initial sites with new ones. The main issues in expansion of service delivery included making sure that the government and partners are both involved in planning; leadership and management; resource needs; design of the service package; identification of novel approaches, such as private sector delivery channels; and synergies and partnerships. The main lessons involved human resources at facility and district levels, coordination, packaging of food products, accountability, and harmonization of data capture systems. A number of pending matters need to be completed in Kenya: scaling up linkages with other programs, social marketing of FBF for greater access and sustainability, support for standards that facilitated the entry of investors, and policy reviews.

Kenya also served as a case study of a private-public partnership (Government of Kenya, USAID/Kenya, Insta Products, AED) to illustrate how effective such partnerships can be if responsibilities are clear cut and shared between the parties.

## **6.4 BREAK-OUT SESSION 1**

Participants divided into three groups to discuss the following three subjects:

- Experience applying national guidelines to NACS programming and experience applying prior field experience
- Issues to consider when designing a NACS program
- The experience of the World Food Programme (WFP) with PEPFAR-supported programs on nutrition and HIV

## **6.5 TOOLS AND MATERIALS DISPLAY**

Countries displayed their tools and materials at tables outside the meeting room, and participants viewed and sampled each other's materials. Country representatives explained and demonstrated how tools were used. The displays remained throughout the course of the meeting so participants could look at them later at their leisure.

## **6.6 BREAK-OUT SESSION 2**

Participants divided into three groups to discuss the following three subjects:

- Lessons from starting and managing NACS within government institutions
- Integration of NACS and Community-Based Management of Acute Malnutrition (CMAM) services and national initiatives
- Use of community-based approaches to reduce loss to follow-up

## **6.7 FIELD VISITS**

The second day of the meeting started with field visits to NuLife program sites in Kayunga, Iganga, and Jinja Hospital, where participants visited HIV treatment facilities with NACS services and community-based sites. Upon returning to the meeting venue, participants shared their observations from the field visits. Participants expressed appreciation for the level of commitment of staff at the sites, the demonstration that NACS services were well integrated into services, the display of SBCC materials, and the use of volunteers at community level. A number of concerns were also raised. The provision of therapeutic doses of RUTF to moderately malnourished clients was a concern in terms of both patient safety and resource implications. Participants also pointed out that the use of 10 percent weight gain as a discharge criterion for adults may not be adequate, as some patients may still be malnourished even after a 10 percent weight gain. The message given to adults to consume only RUTF was also raised as a concern. The choice of using mid-upper arm circumference (MUAC) as an entry criterion for all adults instead of body mass index (BMI) was also discussed. NuLife informed the group that some of these issues have recently changed in the guidelines, but practice had not yet been modified at sites. Challenges discussed based on the field visits included maintenance of patient records and data and limited linkages between agriculture/food security services and health/nutrition services.

## **6.8 PANEL: FOOD PRODUCTION, PROCUREMENT, AND LOGISTICS**

The next session focused on production, procurement, and supply chain management of food commodities. Reco Industries, the Ugandan company that produces RUTF for the NuLife program, made a presentation on its production. An interesting feature of Reco's local production is that the company has contracted approximately 4,000 farmers to grow the crops used in the company's products. The farmers, some of whom are HIV positive, are provided with inputs and assured of a market. The challenge is to ensure that the initiative and the assured market are sustainable.

Following Reco's presentation, a panel discussion was held with participants who are involved in various approaches to food commodity production, procurement, and logistics in their respective countries. Representatives from Ethiopia shared that the country was importing food products for its NACS program and that the supply chain was being managed by the government agency that manages other health

facility supplies. Partners are strengthening the capacity of the agency to handle food commodities. For non-HIV programs, other distribution systems are in place, such as a system in which UNICEF procures products and supplies them to the regional governments. In Malawi, a government system of distribution works with partners. Kenya uses a system outside of the government in which the local food manufacturer also takes responsibility for distribution and logistics. In Uganda, the NuLife program oversees procurement and distribution, with Reco manufacturing and dispatching the commodities. Tanzania uses the government system to distribute the food commodities to sites, with FBF imported from Kenya and RUTF imported from France, while capacities are built for local production.

One point that emerged from the discussion was that the slow speed of government distribution systems can cause problems with products such as FBF, which has a shelf life of 6–9 months. Another point was the need for a planning system that accounts for problems of delays and stock outages. There was considerable discussion about ways to reduce the costs of the products, for instance, through tax waivers on imported raw materials.

## **6.9 PLENARY SESSION: NACS COSTING AND FINANCING**

A presentation on costing the scale-up of NACS programs examined the main cost drivers and determinants of scale-up. Cost areas identified included coordination and planning, materials, training, equipment, transport and storage, community linkages, and food commodities. Data from selected sites in Uganda and Kenya illustrated the relative contribution of the different areas to the total cost. Food wastage contributes between 26 percent and 33 percent of costs and is primarily caused by products' limited shelf life, the length of time it takes for products to reach sites, and limited storage space. Taxation was cited as a significant cost factor, especially in the inputs used to produce FBF and RUTF. Challenges to consider with scale-up include higher costs per beneficiary because larger sites are often already covered during programs' early stages and scale-up leads to fewer clients per site, limited supervision and poorer quality of services as scale increases, limited availability of equipment and data collection tools, and increased wastage and stock outages.

The next presentation explored sources of funding for NACS programs other than PEPFAR. The greatest opportunity may be the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM). It was suggested that countries consider leveraging funding for food and nutrition activities from GFATM to complement PEPFAR resources. The somewhat different mandates and funding processes of PEPFAR and GFATM can offer opportunities to integrate resource streams for more effective programming. An example was given of WFP's urban HIV program in Ethiopia, which combines resources from multiple sources. Coordination among stakeholders in country is critical for such resource integration to be successful.

## **6.10 PANEL: LINKS TO FEED THE FUTURE**

A panel of United States Government (USG) participants discussed coordination between NACS and the FTF initiative. An overview of FTF was presented, and country representatives shared initial experiences with FTF and its relation to PEPFAR activities. While a significant proportion of FTF funds are used in the agriculture sector, the initiative also aims to strengthen integration of nutrition into broad health systems, a process that can build on and link to the NACS process in HIV health systems.

USAID/Ghana stated that nutrition components of FTF in Ghana aim to reduce stunting and wasting and to address anemia, which remains a severe problem in Ghana. Implementation of NACS will strengthen the existing CMAM program, and, under FTF, increased emphasis is needed for prevention of malnutrition. In addition, SBCC strategies would be an important approach in the initiative's activities in Ghana.

In Malawi, facility-based nutrition programs are well developed, but community approaches and preventive components need strengthening. The plan is to emphasize prevention under FTF and to work with community partners. Linkages to community partners and a greater emphasis on prevention, e.g., through nutrition counseling, are approaches that can be applied to Malawi's advanced but largely facility- and treatment-based nutrition and HIV services.

In Ethiopia, planned approaches under FTF include increasing market linkages between producers and consumers, maximizing impact on nutrition, and increased focus on prevention. In Kenya, a framework has been developed to incorporate nutrition into agricultural programs so that the concepts and principles are in place. The question is how to implement. Members of the panel pointed out that improvement in agricultural productivity or economic growth does not necessarily translate into improved nutrition status. Therefore, actively linking to nutrition interventions is essential. It was felt that experience from PEPFAR programs could be valuable in this regard.

## **6.11 PLENARY SESSION: QUALITY IMPROVEMENT AND M&E**

NuLife and HCIP delivered a joint presentation on the QI approach applied to the NACS program in Uganda. To facilitate QI, NACS services were broken down into seven steps, listed below.

1. Assessment of all PLHIV clients at each visit
2. Categorization and recording of clients' nutritional status
3. Counseling of all malnourished patients
4. Food by prescription, in which all moderate and severely malnourished patients who pass the appetite test receive RUTF
5. Follow-up for all patients who receive RUTF
6. Links to community services
7. Education of all PLHIV clients, irrespective of nutritional status, on healthy nutrition and hygiene

The model was used to enhance supervision and monitoring and to identify and address gaps in service delivery. As a result, a number of promising practices have emerged. These include the use of expert clients to bridge staffing gaps; assessment at registration; use of a single register; group counseling; decongestion of the clinic to reduce workload; and incorporation of different parties, such as community coordinators, on QI teams. A number of lessons have emerged from the QI work. The QI collaborative approach of bringing service providers together across sites sped the uptake of successful approaches through sharing of tried best practices and lessons learned across clinics, enhanced ownership, and emphasized systematic evaluation of progress. Staff often find clever solutions to challenges, which should be shared, and collaboration offers a forum for such sharing. Also, implementation was affected by staff attrition and availability of equipment.

Following the discussion of QI, there was a presentation on M&E of NACS. The measureable inputs, program activities, outputs, outcomes, and impacts of NACS were identified. The PEPFAR Next Generation Indicators related to food and nutrition were described, as were proposed global harmonized indicators on nutrition care, PMTCT, and infant feeding and food security. A number of challenges to M&E and options for addressing them were identified. One challenge is that integration of nutrition is often seen as a "special interest" or as parallel to treatment, care, and support. To address this, it was suggested to facilitate understanding of the value of nutrition information in clinical care. Another issue countries face is whether data collection uses separate reporting forms or is integrated into existing reporting forms and systems. In most settings, it was recommended to incorporate nutrition data into existing forms where possible. Related to these issues was the fact that the nutrition focal point is often the only person who sees or uses nutrition information. It was recommended that clinical care providers and others also use nutrition data.

## **6.12 BREAK-OUT SESSION 3**

Participants divided into three groups to discuss the following three subjects:

- Integrating M&E into national HIV frameworks
- Food insecurity, malnutrition, and HIV: Targeting individuals versus households
- Measuring HIV-free survival among HIV-exposed infants and nutrition implications of HIV among older adults

## 6.13 BREAK-OUT SESSION 4

Participants divided into three groups to discuss the following three subjects:

- Alternative approaches to integrating NACS and PMTCT services
- Approaches for bringing training to scale
- Innovations in linking NACS with livelihood programs

## 6.14 PANEL: PENDING ISSUES AND QUESTIONS

Throughout the meeting, pending issues and questions that were not addressed in individual plenary or break-out sessions were collected in a “parking lot” on the wall of the meeting room. On the last day of the meeting, a panel of various participants responded to the collected issues. The topics covered were related to protocols, integration, QI guidelines, and FTF.

Protocol issues focused on managing malnourished OVC under 6 months of age, the RUTF-only message for adults, a therapeutic dose of RUTF for adults/children with moderate acute malnutrition, the basis of the food regimen for pregnant and lactating women, and the use of MUAC versus BMI as an entry criterion for adults. A representative from NuLife responded to these questions, identifying areas where modifications might be needed.

Questions related to integration focused on whether NACS should be entirely managed by the government and, if so, at what stage of the program this should happen. Panelists indicated that different country contexts might require different arrangements and paces of integration.

A question was raised whether QI systems look at the quality of implementation of services, such as counseling, in addition to coverage. A panelist responded that coverage and implementation are both part of quality, and that issues of quality implementation also need to be addressed through QI systems. A participant asked whether there was a need for generic global guidelines on NACS programming, and it was agreed that such guidelines would be beneficial.

Questions on FTF focused on the role of agricultural research, coordination of the program, guidance for countries, and indicators. This multiyear initiative by the USG has committed US\$3.5 billion to fight hunger, poverty, and food insecurity through the promotion of agricultural-led growth. Agricultural research is definitely a part of the initiative. Because focus countries have been selected in Africa, Asia, and the Latin America/Caribbean region, there is some complementarity with PEPFAR. Coordination mechanisms are still being worked out, but it does appear that there will be central coordination of some kind as there is for PEPFAR. Initial guidance to countries has been issued, and the USG is working on a results framework that will include reporting indicators.

## 6.15 COUNTRY ACTION PLANNING

The final major session focused on country action plans. Participants were guided to focus on priority areas in the medium term and specific steps they would take to make progress in these areas. They were asked to frame their plans in terms of what the country wants to do, who will be involved, and the resources that will be needed. Each country team deliberated, outlined its plans, and presented them briefly in the final plenary session. Summaries of the action plans presented are below.

**Ethiopia.** Priority areas were identified to initiate and scale up QI systems and coordinate joint supervision with government, donors (USG), U.N. agencies (WFP, UNICEF, Joint United Nations Special Programme on HIV/AIDS [UNAIDS], the World Health Organization [WHO]), and appropriate civil service organizations and NGOs. For supply chain and logistics, emphasis was placed on coordination to ensure delivery of nutrition products and timely systems, appropriate cost and storage options, quantification, and strengthened reporting. Resources needed included funding from PEPFAR and hopefully from GFATM; human resource training, both in-service and pre-service; and possibly local production of FBF in the future.

**Haiti.** The team identified its highest priority as training of health workers on nutrition assessment and counseling at both clinic and community levels in 10 health departments (public and private sectors).

**Malawi.** Development of an M&E framework and tools and training/orientation of relevant parties was the first priority area. The second priority was to revive the thematic working group meetings. Government ministries, donors, and NGOs would be involved in this. Resources needed included technical assistance from USAID and FANTA-2.

**Mozambique.** Priorities and action steps included development of a manual for the Programa de Reabilitação da Nutrição (PRN) (Nutrition Rehabilitation Program), training for PRN, strengthening the central supply system for commodities for PRN, initiating QI, and strengthening coordination.

**Namibia.** The first priority in Namibia was training in NACS. Activities would include harmonizing manuals, training of trainers, and training at both facility and community levels. The second priority was coordination. Activities included convening regular meetings to discuss linkages between facility and community nutrition services. These activities would involve government ministries, donors, U.N. agencies, and NGOs.

**Rwanda.** The priority area was coordination, and actions included integration of the HIV-nutrition technical working group with the overall ministry nutrition desk, initiating QI methods, and improving the quality of nutrition counseling by training health workers and updating counseling tools and job aids.

**South Africa.** Two key priorities identified were coordination to provide guidance to PEPFAR partners on program development and strategic use of resources for NACS. Stakeholders included implementers of PMTCT/infant and young child feeding, tuberculosis, ART, OVC, and palliative care and support programs; provincial governments; and facilities and community groups. The first step to move this forward was to establish a technical working group on nutrition and HIV and related interventions. The other priority area was to integrate NACS as standard of care in all facility and community-based HIV programs. This would involve the National Department of Health; provincial departments of health; and other relevant departments, such as Social Development. To achieve this, NACS would be integrated into subdistrict plans and partners' budgets would be reprioritized to include NACS components

**Tanzania.** Priorities in the next 12 months included costing a national scale-up and implementation plan, including production of specialized food products. The target is to set up 50 additional care and treatment centers, with NACS drawing on the lessons from past implementation and from this meeting. An important step in the process would be to obtain government approval for NACS materials, including training materials, guidelines incorporated into acute malnutrition materials, job aids, and monitoring tools.

**Uganda.** Priority areas were building sustainability by including RUTF in the list of essential drugs, sustaining interventions in place at clinic and community levels, and achieving a 20 percent to 30 percent cost reduction in RUTF through a tax waiver. Specific steps to achieve these goals included advocacy to quicken certification by lobbying key individuals and organizations, increasing RUTF production to obtain certification by USG and UNICEF to enable purchase in other countries, and scaling up NACS by integrating it into other departments and HCIP sites in addition to continuing ongoing interventions. The other area identified as a priority was to strengthen coordination with partners. The Ministry of Health will take the lead in this through a stakeholders meeting.

**Vietnam.** The first action area was to strengthen advocacy and coordination for nutrition and HIV. Steps to achieve this included establishing a core working group and a Nutrition and HIV Partnership Group, drafting national nutrition and HIV guidelines, and including HIV in the National Nutrition Strategy. The second action area was to standardize and implement training. Steps to achieve this included harmonizing training manuals for clinic-based health providers and community HBC providers, strengthening the nutrition network for supportive supervision and quality assurance, developing job aids and counseling materials, training national and provincial trainers, and implementing training through PEPFAR partners.

**Zambia.** The priority area was capacity building in NACS. To achieve this, priority steps included mapping existing staff and activities to identify challenges and gaps and carrying out mentorship/coaching activities.

Many issues were common to action plans across countries. These included coordination, QI, M&E, training, linkages, costing, scale-up, and sustainability. Country teams were advised to follow up upon return and engage with partners to maintain the momentum generated at the meeting.

## **7. Conclusion**

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The meeting organizers summarized what was discussed during the meeting, what was learned, and what was planned for the future. Countries were encouraged to keep in touch with each other to continue to learn and build on each other's experiences. Concluding remarks were made by FANTA-2, USAID/Uganda, USAID/Washington, RCQHC, and NuLife. Thanks were given to the organizers, the funders, the hosts, and the participants.

## Annex 1: Meeting Agenda

Regional Meeting on Nutrition Assessment, Counseling, and Support in HIV Services:  
Strategies, Tools, and Progress  
September 14–17, 2010  
Jinja, Uganda

### TUESDAY, SEPTEMBER 14, 2010

TIME	SESSION	FACILITATOR/PRESENTER
8:30-8:45	Opening	USAID/Uganda representative Harriet Kivumbi, RCQHC Director Dennis Lwamafa, Uganda Ministry of Health
8:45-9:15	Introductions and expectations	Robert Mwadime, FANTA-2, Uganda
<b>Plenary Session: Introduction to NACS Chairperson: Dr. Elizabeth Madraa, Uganda Ministry of Health</b>		
9:15-9:50 (20 min pres. + 15 min Q/A)	What is NACS? What are the components? PEPFAR guidance on nutrition and HIV?	Tim Quick, USAID/Washington
9:50-10:25 (20 min pres. + 15 min Q/A)	What is the basis of NACS? What is the evidence base?	Tony Castleman, FANTA-2, U.S.
10:25-10:50 (10 min pres. + 15 min Q/A)	What is the current status of NACS in countries?	Serigne M. Diene, FANTA-2, U.S. Amie Heap, USAID/Washington
10:50-11:20	BREAK	
<b>Plenary Session: Experience of Long-Running Programs in Uganda and Kenya Chairperson: Justine Mirembe, USAID/Uganda</b>		
11:20-12:10 (20 min. pres. + 30 min. discussion)	How does NACS work at clinic and community level?	Margaret Kyenkya, NuLife/URC, Uganda
12:10-13:00 (20 min. pres. + 30 min. discussion)	Approaches and lessons from rapidly scaling up NACS	David Mwaniki, Nutrition and HIV Program (NHP)/AED, Kenya
13:00-14:00	LUNCH	

TIME	SESSION	FACILITATOR/PRESENTER
<b>14:00-15:20</b>	<b>Break-out session 1</b>	
	1. Using national guidelines for NACS program design, and using prior field experience	Kenya Team
	2. Issues to consider when designing a NACS program	Earnest Muyunda, FANTA-2, Zambia Pierre Adou, FANTA-2, Côte d'Ivoire
	3. WFP HIV-nutrition programs supported by PEPFAR: Opportunities and Challenges	Willy Mpoyi, WFP/West Africa Gertrude Kara, WFP/Southern Africa
15:20-16:10	TOOLS & MATERIALS DISPLAY (with BREAK)	
<b>16:10-17:30</b>	<b>Break-out session 2</b>	
	1. Lessons from starting and managing NACS within government institutions	Francis Modaha, Tanzania Food and Nutrition Centre, Tanzania Wilhemina Okwabi, Ghana Health Services, Ghana
	2. Integration of NACS and CMAM services and national initiatives	Alison Tumilowicz-Torres, FANTA-2, Mozambique Alice Nkoroi, FANTA-2, Ghana
	3. Use of community-based approaches to reduce loss to follow-up	Margaret Kyenkya, NuLife/URC, Uganda

**WEDNESDAY, SEPTEMBER 15, 2010**

TIME	SESSION	FACILITATOR/PRESENTER
8:30-13:00	FIELD VISIT 1. Visit an HIV treatment facility OR 2. Visit a community-based site	NuLife/URC, Uganda
13:00-14:00	LUNCH	
<b>Plenary Session Chairperson: Pamela Fergusson, FANTA-2, D.C.</b>		
14:00-14:30	Discuss lessons from the field visit	NuLife/URC, Uganda
14:30-15:15 (30 min present. + 15 min Q&A)	Lessons from local production of RUTF	Reco Industries, Uganda Margaret Kyenkya, NuLife/URC, Uganda
15:15-15:35	BREAK	

TIME	SESSION	FACILITATOR/PRESENTER
15:35-17:30 (5 min. each presentation + 90 min discussion)	Panel discussion on food commodity procurement options and experiences	Janet Chikonda, MOH Malawi, Margaret Kyenkya, Nulife/URC Uganda, Habtamu Fekadu, Save the Children Ethiopia, NHP/AED, Kenya SCMS, Tanzania

**THURSDAY, SEPTEMBER 16, 2010**

TIME	SESSION	FACILITATOR/PRESENTER
<b>Plenary Session: NACS Costing and Financing Chairperson: Cassim Massi, National Food and Nutrition Centre, Zambia</b>		
8:30-9:30 (20 min pres.+ 40 min discussion)	Costing the scale-up of NACS programs	Robert Mwadime, FANTA-2, Uganda
9:30-10:00	Linking to GFATM and other non-PEPFAR resources for bringing NACS to scale	Nils Grede, WFP/Rome Saskia de Pee, WFP/Rome Janet Chikonda, Malawi Ministry of Health
10:00-10:45 15 min pres. + 30 min discussion)	Panel discussion on coordination between NACS and FTF	<i>Panel:</i> Tim Quick, USAID/Washington Amie Heap, USAID/Washington Pam Ching, CDC/Atlanta Janex Kabarangira, USAID/Uganda Juliana Pwamang, USAID/Ghana
10:45-11:00	BREAK	
<b>Plenary Session: Quality Improvement and M&amp;E Chairperson: Nils Grede, WFP/Rome</b>		
11:00-12:00 (30 min pres. + 30 min discussion)	Experiences with QI approaches to improve NACS program performance	Nigel Livesley, URC/HCIP, Uganda Tamara Nyombi, URC/NuLife, Uganda
12:00-13:00 (30 min pres. 30 min discussion)	Multicountry M&E of NACS: Expectations and lessons	Amie Heap, USAID/Washington
13:00-14:00	LUNCH	

TIME	SESSION	FACILITATOR/PRESENTER
14:00-15:30	<b>Break-out session 3</b>	
	1. Integrating M&E into national HIV frameworks	Mary Njoki, NASCOP, Kenya David Mwaniki, NHP/AED, Kenya
	2. Food insecurity, malnutrition, and HIV: Targeting individuals vs. households	Saskia de Pee, WFP/Rome Nils Grede, WFP/Rome Mutinta Hambayi, WFP/Rome
	3. Combined session: <ul style="list-style-type: none"> <li>Measuring HIV-free survival among HIV-exposed infants AND</li> <li>HIV among older adults: nutrition implications</li> </ul>	Pamela Fergusson, FANTA-2, U.S.
15:30-15:45	BREAK	
15:45-17:15	<b>Break-out session 4</b>	
	1. Alternative approaches for integrating NACS and PMTCT services	Deborah Ash, FANTA-2, Tanzania
	2. Approaches for bringing training to scale	Peter Gichangi, USAID/Ethiopia Mary Njoki, NASCOP, Kenya
	3. Innovations of linking NACS with livelihood programs	Margie Brand, LIFT/AED, Washington Fanice Komen, AMPATH, Kenya

**FRIDAY, SEPTEMBER 17, 2010**

TIME	SESSION	FACILITATOR/PRESENTER
<b>Plenary Chairperson: Dr. Pamela Ching, CDC/Atlanta</b>		
8:30-9:15	Panel to respond to key issues raised in the week	Tony Castleman, FANTA-2, U.S. Panel: Janet Chikonda MOH Malawi, Habtamu Fekedu Save the Children/Ethiopia, Peter Gichangi USAID/Ethiopia, Nigel Livesley URC/HICIP, Tim Quick USAID/Washington,
9:15-9:25	Introduction of country Action Plans	Amie Heap, USAID/Washington Pamela Fergusson, FANTA-2, U.S.
9:25-11:30 (including break)	Country teams meet to develop Action Plans	

<b>TIME</b>	<b>SESSION</b>	<b>FACILITATOR/PRESENTER</b>
<b>Plenary Chairperson: Dr. Serigne Diene, FANTA-2, U.S.</b>		
11:30-12:30	Country teams present Action Plans	Wendy Hammond, FANTA-2, U.S.
12:30-13:00	Wrap-up, next steps, and closing	Robert Mwadime, FANTA-2, Uganda
13:00-14:00	LUNCH	
14:00	Sightseeing, departure, etc.	

## Annex 2: Participants List

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Regional Meeting on Nutrition Assessment, Counseling, and Support in HIV Services: Strategies, Tools, and Progress, Jinja, Uganda, September 14–17, 2010

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