The relationship between HIV, nutrition and food security is well known. Once HIV and AIDS enter a home, a family who may already be struggling to meet basic needs can be pulled into a downward spiral of poverty and illness.

Personal illness, caring for sick family members or death of a family member can disrupt household livelihood patterns, reducing food and income flows, and increasing health and other HIV-related costs. The most vulnerable people living with HIV and their families typically cope with these economic shocks by cutting overall expenditure, even for essential items such as medication, transport to clinics and school fees, and reducing the frequency, quality and quantity of food they consume. Other common coping strategies include selling assets and curtailing productive activities. Healthy family members, usually women, often stop working to care for sick relatives. This further reduces household income for food, health care and other basic needs. Children are often taken out of school to help care for the sick or generate cash, negatively impacting education outcomes and future opportunities for food and livelihood security.

The Livelihoods and Food Security Technical Assistance (LIFT) project was launched in 2009 by USAID to end this downward spiral by strengthening the capacity of USAID missions, implementing organizations and host governments to design and implement livelihood and food security interventions that sustainably improve the economic resiliency and health of vulnerable households. LIFT’s primary goal is to build the continuum of care for people living with HIV and other vulnerable households by increasing their access to high quality, context appropriate, market-led economic strengthening, livelihood and food security (ES/L/FS) opportunities to improve their economic resilience and lead to better health.

To improve nutritional status among patients, the Nutrition Assessment Counseling and Support (NACS) approach integrates supplemental feeding and nutritional counseling into clinical HIV care regimens. An essential component of LIFT’s approach is establishing links to integrate economic strengthening and food security activities within NACS programs. Strong linkages between clinical facilities and community-based services are needed to ensure that patients have access to support mechanisms which will help them maintain adequate access to food, which is an important strategy to prevent relapse after the course of nutritional therapy and counseling is completed.

Three broad categories of ES/L/FS services have been identified in an effort to understand which types of programs would best suited for different types of households. These categories include:

PROVISIONING activities, best suited for destitute households, provide temporary support to help households recover assets, put food on the table and meet basic needs. Temporary provisioning of livelihood support can assist PLHIV and affected household members to avoid harmful coping strategies, such as withdrawing children from school to help care for the sick or to generate cash, thus negatively impacting educational outcomes and future opportunities.

PROTECTION activities target vulnerable households struggling to make ends meet and help them to strengthen household money management and retain key assets. A common protection intervention is household gardening, which is intended to improve access to food and offset the high cost of nutritious produce.

PROMOTION activities are best suited for households that are ready to grow by assuming risk and investing capital and other resources for future gains. These activities include a variety of programs such as enterprise development, market linkages, and vocational and skills training.

Given the successive nature of provisioning, protection and promotion activities, service providers within a referral system or network should be trained to identify a client’s specific needs and to provide referrals for clients moving between these categories.
Working with government counterparts, LIFT supports communities to establish referral systems and networks to link graduating NACS patients or their caregivers with ES/L/FS programs and services that will help sustain the positive impacts of therapeutic feeding and counseling. Formal referral networks and systems within NACS are just beginning to emerge, and additional research is needed to develop and test adaptable models. The following key components of a referral system have been identified:

- **Community ownership**: It is important to ensure community involvement and ownership in the initial stages of establishing the referral network and process so that the program becomes self-sustaining.

- **Identification and evaluation of available services**: Communities must identify appropriate organizations to be involved in the referral network and ensure they have the requisite financial, technical and administrative capacities to absorb new clients. Available services should be mapped, assessed and then documented in a referral guide specific to the referral catchment area.

- **Referral points of contact**: Each organization in the referral network including the clinical sites, community-based intermediaries, and service providers should have a dedicated person responsible for tracking individual referrals and supporting the referral system.

- **Establishment of a referral committee**: A referral network should include a referral committee comprised of clinic-based NACS providers as well as community based services. The committee should meet regularly to monitor and evaluate how the referral system is working to address challenges identified.

- **Community referral coordinating mechanism**: Clinical sites are usually the entry point to NACS, but because clinical facilities are not equipped or staffed to identify appropriate livelihood services or track referral outcomes, it is important to identify a community intermediary agency, organization or individual to coordinate the referral process. The referral coordinator should be knowledgeable about ES/L/FS services and will conduct the client assessments, make the referrals to appropriate services and manage the feedback process. Government social workers, home-based care providers, NGOs and CBOs, or PLHIV support groups are all potential resources to serve as the referring agency/organization. Such entities generally provide some formal or informal referrals, and maintain contact with beneficiaries.

- **Assessing individual patient needs and capacity**: Prior to referring a patient to services, an assessment of the client’s needs and abilities should be conducted by the referral coordinating mechanism. Specific ES/L/FS programs may also have their own assessment/intake procedures to determine whether potential clients are eligible. Within a referral system or network, the purpose of such an assessment is to determine which of the available programs and services are best suited to an individual client’s needs at that time.

LIFT can provide technical assistance to develop the tools and processes required to establish the referral system including community mapping, evaluation of available services, patient assessment, referral tracking, monitoring and feedback processes, and evaluation of patients’ experience and outcomes, as well as provide training to staff involved in the referral network. LIFT works with referral networks to improve the quality of existing ES/L/FS services as well as identify gaps in available services and support advocacy to local NGOs, donors and government institutions to build capacity in these areas.

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