RESPONDING TO GENDER ISSUES TO IMPROVE OUTCOMES IN NUTRITION ASSESSMENT, COUNSELING, AND SUPPORT SERVICES

Background

Nutrition and food security are important factors influencing the wellbeing of families affected by HIV. Adherence to a nutritious diet maintains the immune level, decreases susceptibility to opportunistic infections, improves the effectiveness of antiretroviral drugs (ARVs), and sustains healthy physical activity and productivity, which facilitates improved health outcomes and quality of life. Yet food access, availability, and utilization remain a challenge for many people living with HIV (PLHIV), which can increase vulnerability to the virus and its progression into AIDS.

Nutrition assessment, counseling, and support (NACS) is an approach to integrate evidence-based nutrition interventions into health services including the prevention, categorization, and treatment of malnutrition and sustained improved nutritional status. Nutrition assessment helps determine the nutritional status of women, men, girls, and boys using information about the patient’s medical history, eating habits, current health, and social and economic status. Nutrition counseling involves a discussion about the results of the nutrition assessment, identification of barriers and issues leading to poor nutrition outcomes, and key activities that could improve the nutritional status of those affected by HIV. Nutrition support aims to provide support through the provision of therapeutic and supplementary food, water purification products, and referrals to nutrition-sensitive interventions to improve food security and health outcomes (FANTA, 2012). The NACS approach aims to improve the nutritional status of patients by integrating nutrition into policies, programs, and health service delivery infrastructure. The NACS platform is also being used to improve engagement, adherence, and retention of PLHIV in care by incorporating a self-management approach to counseling and strengthening the linkages between communities and points of care for nutrition services.

Gender issues in NACS services

- Harmful social, cultural, and economic norms and practices related to nutrition and food security
- Unequal access to and utilization of nutrition assessment services
- Inappropriate or discriminatory nutrition counseling
- Issues impacting adherence to and retention in nutrition support services
- Unequal knowledge and skills to participate in food security or income-generating activities

Gender Issues in NACS Services

Vulnerabilities and challenges related to nutrition and food security

Gender inequality is a major driver of vulnerability to malnutrition and food security, especially for PLHIV. The nutrition and food security needs of women and children are often neglected at the household level due to social, cultural, and economic inequalities between males and females (BRIDGE, 2014). Food access, availability, and utilization can be different for men, women, boys, and girls. In many countries, women comprise a large percentage of the agricultural labor force but have limited access to information, resources (e.g., income, land, equipment, training, seeds, fertilizer), and credit; little say in how to use the land; and limited access to markets. In communities where gender inequality is pervasive, women and girls tend to eat lower quantities and varieties of food that are generally less nutritious than the food eaten by their male counterparts (IFPRI, 2005). As a result, twice as many women suffer from malnutrition as men (FAO, 2015). In some settings, girls are more likely to suffer from malnutrition, yet in others, boys have higher rates (FAO, 2015; World Bank, 2012). Whether resulting from cultural beliefs (e.g., pregnant women should not eat eggs) or power relations (e.g., males eat first), discriminatory practices and attitudes that favor one sex over the other contribute to

MAY 2016

This technical brief was written by Megan Ivanovich, Rony Jose, Elizabeth Romanoff Silva, and Taroub Harb Faramand of WI-HER, LLC for the USAID Applying Science to Strengthen and Improve Systems (ASSIST) Project, which is funded by the American people through the United States Agency for International Development (USAID) Bureau for Global Health, Office of Health Systems. The USAID ASSIST Project is managed by University Research Co., LLC (URC) under the terms of Cooperative Agreement Number AID-OAA-A-12-00101. URC’s global partners for USAID ASSIST include: EnCompass LLC; FHI 360; Harvard T. H. Chan School of Public Health; HEALTHQUAL International; Institute for Healthcare Improvement; Initiatives Inc.; Johns Hopkins Center for Communication Programs; and WI-HER, LLC. For more information on the work of the USAID ASSIST Project, please visit www.usaidassist.org or write assist-info@urc-chs.com. For more information on gender considerations in nutrition and HIV programming, please contact tfaramand@wi-her.org.
harmful outcomes for the individual and the community.

Gender-based violence (GBV) can affect HIV vulnerability and impact food security and nutrition of affected persons and their families. GBV increases the risk of contracting HIV, is sometimes a consequence of disclosing HIV status, and affects ability to cope with the infection (WFP, 2006; FAO and Dimitra Project, 2010). In addition, as rates of HIV in a community rise, GBV increases as well, as seen in Sub-Saharan Africa (FAO and Dimitra Project, 2010). GBV can also affect people’s ability to produce and sell food or access inputs essential for food productivity (BRIDGE, 2014). This can fuel a vicious cycle since food scarcity itself can lead to GBV: insufficient food in the home can create tension and lead to physical or psychological violence and discrimination by men towards women or by older women towards their daughters-in-law (Hossain and Green, 2011). Food scarcity can also lead to forced and early marriage of girls (Girls Not Brides).

HIV can also decrease a person’s ability to harvest quality food or engage in waged labor to purchase food, dramatically affecting household food security. Moreover, women and girls are often responsible for taking care of sick family members, so they might not have time to focus on food production, which can affect the nutritional status of the whole family. Livelihood insecurity can put people—especially women and girls—at risk of contracting HIV and violence as they are forced to migrate for waged labor or engage in transactional sex work for income or goods to support their families (ICAD, 2006).

PLHIV require 20% to 30% more calories during the symptomatic phase of HIV and 10% during the asymptomatic phase (FAO, 2010), and pregnant and lactating women living with HIV require extra care. Factors such as lack of information and knowledge about dietary practices and nutrition for PLHIV can further exacerbate health outcomes and food security (Bukusuba and Whitehead, 2010).

**Gender norms and issues affecting nutrition assessment**

Males and females often have different levels of access to and utilization of nutrition management services that are age- and sex-dependent. For example, women and girls tend to be less economically independent and have less decision-making power, which can prevent them from accessing health services (WFP, 2006). Male partners and mothers-in-law can play an important role not only in a woman’s nutrition status, but also in the decision for her to access or be retained in nutrition services. In many communities, male partners hold decision-making power about how money is spent and can be unwilling or unable to provide money for transportation or services.

Harmful gender norms can lead communities to stigmatize males and females for accessing services, but in different ways. For example, in many countries in Sub-Saharan Africa, men and boys are less likely to seek care, including preventive health services and knowing their HIV status. As a result, the virus is more likely to be further developed in males when they access services, and males are less likely to be aware of their increased nutrition requirements (FANTA, 2009). Women face stigmatization as well; HIV-positive women are often stigmatized for being pregnant (UNAIDS, 2014), and HIV-positive lactating women who are not enrolled in care can face stigmatization for not breastfeeding in some settings, even though they are following appropriate infant feeding practices for HIV-positive women not taking ARVs (WHO, 2010). In both cases, these women are less likely to access nutrition management services, thus affecting their own nutrition as well as that of their infants.

Women can be less able to travel long distances to facilities due to cultural norms that dictate that it is not acceptable for a woman to travel without being accompanied by a man. Women are also more likely to have responsibilities in the home that prevent them from traveling long distances to receive health and nutrition services, including caring for family members and housework. Men are more likely to be employed in the formal labor market and may lose a day’s salary if they take time to access services.

**Gender norms and issues affecting nutrition counseling**

It is vital that a nutrition counselor is trained to identify how malnutrition affects men, women, girls, and boys differently, and how to respond to their different needs, including identifying high-risk patients who have a higher nutrient requirement. While women tend to be in charge of food preparation, male partners and mothers-in-law are more likely to be in charge of food allocation. Therefore, counseling women who are malnourished can be less effective if other family members who hold decision-making power are not also sensitized.

Another important gender issue related to NACS service quality is counselor attitudes and beliefs about clients. These can lead to biased care and treatment that perpetuate stigma and can result in low quality counseling services. Many women with HIV report feeling stigmatized by health care providers when considering becoming pregnant, while pregnant, or after delivery. In addition, in some cultures it is not appropriate for patients to be counseled by counselors of the opposite sex.

**Gender issues affecting nutrition support services**

A review of Kenya’s Food by Prescription Program (predecessor to NACS) found that rates of malnutrition were similar for males and females living with HIV entering treatment services, but males improved their nutrition status substantially quicker than women on average (2.3 months for females vs. 1.2 for males) due to differences in adherence. Women were more likely to share prescribed food with family members (Zambia MOH, 2011). Yet males can also face gender-related challenges that prevent them from improving their nutrition outcomes: stigma can make men less willing to be...
seen carrying supplements (FANTA, 2009). Sharing supplemental food, non-availability of home support, and access to other foods are also important factors in treatment of malnutrition (Zambia MOH, 2011).

It is critical to analyze whether women and men have equal education and knowledge to succeed when designing food security referral or income-generating services. If men in a community are more likely to have basic skills relevant to the activity, extra support should be provided to women so existing gender inequalities are not exacerbated. Nutrition support services that do not take into account varying literacy levels can leave females disadvantaged as they can be less able to utilize written services and guidance.

Home-based peer counseling must take culturally appropriate gender dynamics into account; it may not be acceptable or safe for male peer counselors to provide home visits, or for a female peer counselor to visit a male patient at home.

Considerations for Responding to Gender Issues in NACS Services

Different gender-related issues need to be taken into account when designing and implementing NACS services to improve the quality of services and patient outcomes and to ensure existing inequalities are not exacerbated. The following actions will help improve program quality and health outcomes.

1. Assess the unique needs of men, women, boys, and girls in nutrition programs
   - Conduct a gender analysis, preferably before the start of a NACS activity, to identify gender-related issues relevant to the nutrition and food security of HIV-infected and affected women, men, girls, and boys and how they could affect the NACS service or program. For example, determine who makes decisions in a family about how food is distributed.
   - Work with facility staff to ensure that sex- and age-disaggregated NACS data are collected and analyzed, where feasible.
   - Using the results of the gender analysis and program data, identify specific challenges that influence the ability of males and females of different ages to access and utilize NACS services and develop strategies that engage both males and females to overcome identified challenges.

2. Design and implement gender-responsive nutrition assessment services
   - Design tailored outreach strategies that work to increase the proportion of HIV-positive males and females in the community who have their nutrition status assessed and categorized.
   - Identify opportunities to promote male and female patients to invite their spouse/partner to the facility to have their nutrition level assessed and be tested for HIV.
   - Since male partners, mothers-in-law, and other community members can play an important role in familial nutrition status due to their influence related to access, payment, and support for health and nutrition services and improved nutritional behavior, all NACS services must respond to their unique positions and influences to optimize the impact of nutrition management interventions. For example, consider targeting nutrition messages to mothers-in-law and male partners.

3. Account for and respond to gender issues in nutrition counseling
   - Consider a range of counseling venues. Hold separate, targeted counseling for men, women, boys, and girls. In addition, health-seeking behaviors of males made them less likely to access services and that both health facility and community nutrition volunteers noted that women were more likely to share food supplements with family members. In response to these issues, ASSIST has provided support to facilities to collect and analyze sex-disaggregated data. ASSIST data collection tools and processes were modified and all sites started collecting sex-disaggregated data in January 2016. These data will be used to identify quantifiable gaps in how males and females access and benefit from nutrition services, to identify differences in the rates of malnutrition among males and females, and to respond appropriately to improve nutrition and health outcomes.

For example, identify whether females or males are more likely to be severely or moderately malnourished and design mechanisms within counseling and support services to respond to their heightened vulnerability.

In Zambia, the USAID ASSIST Project supports the continued adoption, adaptation, and scale-up of nutrition assessment, counseling, and support as a standard of care within the national HIV/AIDS program, in line with USAID and PEPFAR goals. ASSIST’s work in Zambia is being conducted at 13 facilities in Kitwe and Mkushi districts, in collaboration with the Ministry of Health, Food and Nutrition Technical Assistance (FANTA) III Project, and Livelihoods and Food Security Technical Assistance (LIFT) II Project.

In March 2015, ASSIST provided gender sensitization and training to one of the eight facilities in Kitwe and began identifying gender issues affecting the program in Zambia. Such issues included that

Addressing gender issues in NACS services in Zambia

- For example, identify whether females or males are more likely to be severely or moderately malnourished and design mechanisms within counseling and support services to respond to their heightened vulnerability.
- Consider a range of counseling venues. Hold separate, targeted counseling for men, women, boys, and girls. In addition, health-seeking behaviors of males made them less likely to access services and that both health facility and community nutrition volunteers noted that women were more likely to share food supplements with family members. In response to these issues, ASSIST has provided support to facilities to collect and analyze sex-disaggregated data. ASSIST data collection tools and processes were modified and all sites started collecting sex-disaggregated data in January 2016. These data will be used to identify quantifiable gaps in how males and females access and benefit from nutrition services, to identify differences in the rates of malnutrition among males and females, and to respond appropriately to improve nutrition and health outcomes.

- Identify whether lack of male involvement in counseling of females is preventing improvement in nutrition status and design strategies to engage male partners and also test them for HIV and link them to care if they test positive.
- Evaluate whether it is culturally appropriate for a patient to be counseled by the opposite sex. Offer counseling by an expert patient or volunteer of the same sex if it is an issue.

4. Provide equitable nutrition support services for males and females
   - Identify whether female or male patients are sharing food supplements with family members and identify culturally sensitive strategies to ensure patients take the prescribed supplements, while being sensitive to the fact that family members may also need additional food.
   - Develop strategies to combat stigmatization of males or females as the result of being seen with food supplements. For example, use individualized supplement foods rather than bulk supplements or modify packaging so the supplement is less recognizable.
   - Analyze whether males and females have equal education and knowledge to succeed with income-generating activities.
when designing food security or economic strengthening services and respond to inequalities identified.

5. Strengthen the capacity of health care workers and facilities regarding gender

- Sensitize staff to gender issues, gender bias, and the importance of integrating gender in the provision of NACS services by holding special training and education sessions.
- Develop gender-sensitive communication materials for staff to reference while counseling clients regarding nutrition.
- Ensure facility processes and guidelines mandate services that are uniform and gender-sensitive to ensure a safe, culturally appropriate, and positive environment and to optimize patient outcomes.
- Develop simple protocols for the collection, analysis, and dissemination of sex- and age-disaggregated data on services.

References


FAO. 2015. Gender and nutrition. Rome, Italy: FAO.

FAO and Dimitra Project. 2010. Guidance Note: Gender-based Violence and Livelihood Interventions: Focus on populations of humanitarian concern in the context of HIV. FAO.


IFPRI. 2005. Women: Still the key to food and nutrition security. Washington, DC: IFPRI.


Resources to learn more


This training manual instructs users on the role of nutrition in response to HIV/AIDS. It presents different strategies that could be used to understand and impact the role of households and the community in improving the nutritional needs of PLHIV.

Inter-agency Standing Committee (IASC). Nutrition: Gender Marker Tip Sheet. 2011


This tool helps implementers ensure that all segments of the affected populations have equal access to nutrition activities and that targeted support to advance gender equality is based on a gender analysis. This makes nutrition projects more effective.


This technical brief captures the connection between gender, nutrition and food security for PLHIV and provides steps to action and best have been proven as successful approaches and helpful starting points to increase the food and nutrition security of households.


This series of modules provides program managers and implementers with a package of essential information and resources. Additional modules are slated to be released on such topics as nutrition support, monitoring and reporting, tools, and service implementation.