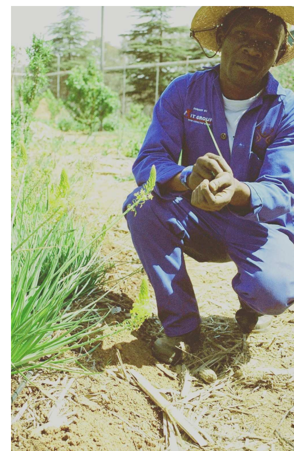
HIV-Nutrition Programming

Nutritional Clinic Gardens Protocol

Overview to project

This outline is based on a concept, designed by GardenAfrica, and implemented in partnership with HIVSA, Ukuvuna and Hope Nutrition. The project & subsequent research was undertaken at the Chris Hani Baragwanath Hospital, and seven further outreach clinics across Soweto between 2005-7.

The following protocol is not intended to be in any way prescriptive. Accepting that each and every operating environment looks entirely different, it is intended to *guide* GardenAfrica's partners, and other interested NGO/CBOs to develop interdisciplinary relationships towards the formulation of sustainable healthcare strategies. These strategies are aimed at utilising available land around clinics and other health facilities for the achievement of positive health outcomes (nutrition & palliative care).



Isaac showing how he uses *Bulbine frutuscens* to manage thrush & other skin complaints

The basis of this approach recognises that, while ARVs control HIV, they do not directly affect the immune system, by building immune responses. Good nutrition is needed *alongside* ARVs to facilitate immune reconstitution for those with diminishing CD4 counts. Vitamins and minerals found in fruits and vegetables are vital for a strong immune system to ward off secondary (opportunistic) infections which speed up viral decline. Increasing access to nutritious foods is the first step to boosting natural immunity against these infections, and for improving the absorption of, and adherence to, life saving ARVs. Using the same plant-based approach, it is possible to demonstrate how compounds produced by medicinal plants can be useful in the management of opportunistic infections.

Furthermore, this approach aims to promote the capacities of those living with HIV who are trained as 'expert patients', and who establish clinic gardens as localised resource centres, from which skills, information and materials can be shared with others. This interaction serves as an important tool for overcoming stigma and discrimination in the community, as well as promoting sustainable resource-use and plant-based livelihoods.

Outputs:

1. To establish direct linkages between nutritional demands of HIV+ patients attending clinics for feeding, anti-retroviral treatment and monitoring.
2. To increase access to nutritious food for those in an urban and peri-urban environment who are affected by HIV.
3. To promote inter-disciplinary understanding of the role played by nutrition for those affected by HIV/AIDS and other increasingly prevalent conditions such as diabetes and hypertension, amongst care givers and service providers.
4. To develop a training resource for practioners which bring together sustainable urban agriculture principles, health and nutrition.

Key Actors:

- Department of Health – providing permissions for garden establishment and training activities within clinics.
- Clinics – Integration of garden & clinic activities through active engagement. Nutritional data to be captured in accordance with regular CD4 counts, with selected participants agreeing to take part.
- HIVSA – Provision of clinical links to promote improved awareness of nutrition as a compliment to ART amongst clinic staff – and to stimulate referrals for those who are under nourished.
- Ukuvuna – (Permaculture) training which is relevant to the needs to HIV+ participants, allowing them to develop cost effective low-input/energy techniques for natural resource management.
- Hope Nutrition – development and delivery of training to provide a basic understanding of nutrition, as well as cooking and value-addition.

Process

Orientation at selected clinics – involving Dept/Ministry officials, clinic staff, support groups and other interested parties. Explanation of intended activities, roles and responsibilities.

Call for training participants (within each clinic) - Candidates express an interest in training – usually these are derived from the various support groups in each clinic.

The selection of 'active poor' over 'passive poor' remains a central pillar to our strategy – thereby ensuring that those who are selected are innovative and willing to put in the time to learn, and transfer skills to others. This also effectively ensures that participation in training is not adversely affected as the course progresses. If a primary person cannot make a training block, then the garden team elects a replacement representative.

1. **Selection Training** – Candidates are called to a central location at a pre-defined date (in our case Baragwanath Hsp) to take part in a 1 day workshop – developed around their application to a task. In our case this was fence-building (using only natural and/or recycled/reclaimed materials).

2. **Selection Task** – each participant is given 6 weeks to complete their task at home or, if they don't have access to a plot (those living in informal settlements) they can do this at the clinic. We would advocate ensuring that buy-in from clinics and DoE enables the selection task to be demonstrated at clinics.

   This is undertaken with the knowledge that the person who is selected transfers the skills to others intending to work from the same clinic, who may not be selected for training per se. This therefore provides a ready-made peer group for ongoing garden development.

3. **Participant Selection** – partner NGO specialising in sustainable agriculture assesses work at all candidate sites – scored on a specific worksheet. (this can be provided separately by GA). Consultation takes place with partners and stakeholders before announcement is made (baring in mind that optimal workshop size is between 15-30 depending on your facilities and resources). Ideally you would want 2 candidates from each clinic – one who is able to articulate learning, and the other to have propagation and plant skills.

4. **Monthly Training** – takes place at the primary site, with participants developing the site in line with their training modules (a week per topic: soil, water, companion planting, medicinal plants & pest management, propagation, small livestock, value addition, nutrition). Exchanges to various clinic gardens are also recommended.

5. **Monthly Monitoring** – each participant is visited at their clinic, where they are tasked with carrying out their homework. This also provides an opportunity for the training team to monitor the level/success of peer transfer to the rest of the clinic gardeners.

6. **Launch** – community demonstration day, where all members of each garden team invite and welcome the public (including leaders and stakeholders/social partners) and provide a lunch with produce/products from the garden. Is also an opportunity to present the participant/trainers with their graduation certificates, and formally launch the garden as a resource at the heart of the community.

Physical development

Over the training phase (8 months) the intension is to see all sites develop as sustainable resources – with tools stores and 'zones' - propagation/nursery areas, herb gardens, vegetable production and fruit trees. Each should be able to demonstrate simple technologies and appropriate use of resources so that others can see how they can establish similar gardens of their own – without waiting for funding from external sources.

Retention and Transfer

Over the life of the project, there were a number of different views on retaining garden teams at each clinic. The nature and quality of the training meant that some of our participants went on to get paid work with local CBOs/NGOs – extending the approach and skills further afield. This is unavoidable, but can be viewed as a *positive* gain. However, it does mean that skills transfer to peers is important – to ensure other garden team members were able to take on the mantle.

Linkages

- An MoU should be signed between all project partners, with clear role and responsibilities related to capacity and skills.
- An MoU should be signed between the project and the Dept/Min of Health agreeing to the use of land.
- An MoU should be signed between the clinic its the garden team – with a clear commitment stated that the garden team will provide a complementary service, and the clinic will refer its 'clients' where beneficial or practicable.
- Each garden team should also sign an MoU between its' own members – defining roles and responsibilities.

While all relationships are important, the relationship between the garden teams and clinic staff is central to the utility and legacy of the garden - not simply as a resource often hidden to the rear – but as an integrated resource which adds value to those working in the clinic. This relationship will effectively increase the confidence of the garden team, who will in turn serve the needs of both the clinic and the wider community.

Clinic staff can be encouraged to interact with each garden team – buying fresh produce for home use - increases their buy-in and promotion of the resource on a personal level – and is more likely to remain with them when they consult with patients.

Livelihoods

We chose not to pay participants for their time. Skills training was offered for free, as was access to a previously untouched land (clinics) which was protected with high fencing and security guards. This meant that we had to put our minds to promoting market research for products which were to be cultivated. The deal was that they could continue to use this land if they, in return, supported others when referred to the garden for advice on cultivation and nutrition.

In addition, the sale of produce is encouraged outside the clinic gates – increasing the visibility of the project. This could be in the form of a weekly organic market – which has a directly beneficial impact on the local community – increasing access to naturally grown nutritious foods and (non-contentious) medicinal plants, while promoting the approach to sustainable healthcare & livelihoods.

Starter packs – in line with the 'companion planting' model behind our Permaculture approach & training – we are able to promote the links between biological and nutritional diversity. With this in mind, each clinic garden can produce starter companion packs for people to buy. This could be clients from feeding programmes or other support programmes, or the general public who become interested.

Extending from this – herbs, trees and other plants could form part of supply and demand.

Ongoing Benefits

There are a number of benefits, realised through potential of ongoing activities.

Referrals and advice to clinic patients, who regularly engage with the garden. Ideally garden elements would be created around the entrance or outdoor waiting areas (where these exist).

Markets - produce sold provide livelihood/remuneration for garden team, while providing a 'window' on the project.

Feeding – clinics (and other related NGOs) are encouraged to pursue 'feeding' activities – linked with, or held in the garden – providing information on how garden produce can supplement staples (distributed under feeding schemes). Clinic feeding schemes can themselves be supplemented with training in cultivation and cooking. Women can come to eat in the garden, but only after harvesting, cooking, eating (and talking) together. Skills are transferred by the garden team – but importantly, so knowledge and information is shared at many levels – generating confidence to address stigma & discrimination.

General – a resource which projects confidence and positive attitudes from within the heart of each community is important. So too are skills and knowledge about how to deal with persistent problems which may relate to each bio-physical environment (soil type, rain fall, pest & diseases etc). A local 'expert' team providing advice within each locale is an important legacy.

Materials

A reference manual will of course be important to assisting the ongoing work of the garden team to assist them in dealing with perennial challenges.

Information which 'clients' can pick up and read when they are sitting for long hours waiting to be seen, should also be considered. Double-sided A4 leaflets can be created to illustrate lessons in areas which are useful to home-based gardens – each stating that there is a garden outside which can be visited for more information.

Our open source training manual – incorporating health, nutrition, cultivation and resource management, as well as our growing series of leaflets can be found (and downloaded for free) on our website (http://www.gardenafrica.org.uk/our_resources.htm)

Data Collection & Analysis

Progress and impact can be measured in a number of ways, depending upon your project and donor requirements, and should of course be integrated in to your planning (time and tools) – captured variously by your garden team or the clinic records, and analysed by the project partners at regular intervals (evaluations).

For instance:

An assumption that any increase in nutritional access can only be a good thing, leads to a simple measurement of produce harvested & consumed *(how much and by whom/under what programme or intervention).*

If your interest is in whether your means of production (low-input) has been successful, then you would need to analyse planting and harvest data *(simple record keeping practices by garden team).*

If the *quality* of skills and information transfer is important, then setting up a mechanism for the garden team to follow up at people's homes to capture the diversity of cultivation and consumption will be necessary. If quantity, rather than quality is required then a visitors book will suffice *(how many visitors / how many gardens resulting).* If possible, both would be advantageous.

Utility of the garden resource in adding value to work of clinical staff measured in terms of the number of referrals – this could either reveal lack of buy-in from the staff – or, when analysed and aligned with garden visitor records could also show repeat visits – without further referrals necessary. Understanding, and responding to these dynamics is important in order to be able respond quickly and appropriately.

Additional livelihood impact measurements can be simply designed and collected on the basis of produce and materials sold *(record keeping by garden teams – capturing volumes and pricing).*

If however there is a requirement to measure on the basis of health impacts, then there would need to be a pre-existing agreement (and permissions) to undertake regular CD4 counts. This should take place with specific reference to formal policies & procedures – sought by clinics from the M/DoH. While there may ordinarily be a 'control', under the given circumstances, the ethics of such a methodology should be scrutinised. In the presentation of empirical evidence, it is equally admissible to a undertake comparative analyses (both in terms of that individual, and clinical averages – annual data on surrounding 'clients').