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Update on WFP's Response to HIV and AIDS

Executive Summary

At the request of the Board, WFP provides regular updates on the implementation of its HIV policy. The policy[1] is in line with the strategies for 2011–2015 and 2016–2021, the Division of Labour and the 90-90-90 treatment targets of the Joint United Nations Programme on HIV/AIDS (UNAIDS), and with the WFP Strategic Plan (2014–2017).

WFP is the convener agency under the UNAIDS Division of Labour for ensuring that food and nutrition support is integrated into national programmes for people living with HIV. WFP and the Office of the United Nations High Commissioner for Refugees are co-convenors for HIV in humanitarian emergencies, and ensure that the special needs of people living with HIV are considered in emergency response.

WFP's two-pronged approach involves working with governments to ensure that food and nutrition support is: i) included in national HIV and tuberculosis strategies and programmes; and ii) provided to people living with HIV and to tuberculosis patients and their households, when needed.

WFP's HIV and tuberculosis programmes reached approximately 540,000[2] beneficiaries in 27 countries in 2015. This figure includes people on antiretroviral therapy, tuberculosis patients and their household members, participants in prevention of mother-to-child transmission programmes, and orphans and other vulnerable children receiving support.

In the Central African Republic, the Democratic Republic of the Congo and South Sudan, and in refugee camps in Cameroon, Kenya, Nepal and Rwanda, people living with HIV were reached by general food distributions and HIV-specific interventions. Although HIV-specific funding continued to decline, WFP maintained its sustainable holistic approach to HIV programming: i) food assistance was connected to economic and income-generating activities to foster long-term sustainability; ii) nutrition support for participants in prevention of mother-to-child transmission services was further integrated with mother-and-child health and nutrition programmes; iii) support for HIV-sensitive social safety nets was increased; iv) development of national capacities for sustainable responses to food and nutrition needs in the context of HIV and tuberculosis was prioritized; and v) partnerships were established in

[1] http://documents.wfp.org/stellent/groups/public/documents/eb/wfp225092.pdf

[2] Preliminary data from 2015 Standard Project Reports.

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certain countries with the United Nations Population Fund and the United Nations Children's Fund to reach women and girls through various platforms such as the initiative Action for Adolescent Girls. WFP's logistics partnership with the Global Fund – established in 2014 – improves access for patients to HIV-related goods, especially during emergencies, through the use of WFP's supply chain networks.

HIV and Tuberculosis in 2015

1. HIV remains one of the world's most serious challenges: in 2014 there were 36.9 million people living with HIV (PLHIV), and 2 million became newly infected[3] – nearly half of these newly infected people lived in eastern and southern Africa. Adolescent girls and young women are at disproportionate risk, accounting for 62 percent of all HIV-infected adolescents at the global level, and 71 percent in sub-Saharan Africa.[4]

2. The rapid scale-up of life-saving treatment has helped to reduce AIDS-related deaths by 42 percent since 2004.[5] Worldwide, however, AIDS is still the leading cause of death among women of reproductive age and the second leading cause among adolescents aged 10–19 years.[5]

3. New HIV infections are declining, particularly among infants. Worldwide, 220,000 children were infected with HIV in 2014 – 58 percent fewer than in 2000. Increased access to antiretroviral medicines for pregnant women living with HIV – 73 percent of whom now have access – has prevented new HIV infections among children since 2009;[3] an estimated 85 countries are within reach of eliminating new infections among children, with fewer than 50 new cases each year. However, structural, legal, policy and socio-cultural factors continue to restrict access to HIV services, resulting in increased transmission among people in high-risk population groups,[5] who – together with their sexual partners – account for 40–50 percent of new HIV infections.[6]

4. HIV care and treatment begin on the day that an individual is diagnosed with HIV. In addition to medicines, effective treatment also requires access to complementary services that promote health and ensure that individuals are retained across the "treatment cascade"[7] to achieve durable viral suppression.[8] In the United States of America, for example, only one in four PLHIV has suppressed viral load because of gaps in the HIV treatment continuum.[9] Recent evidence suggests that in southern Africa 30 percent of patients who discontinued treatment have died.[6] Research and increased support for adherence would facilitate sustainable treatment for PLHIV.

5. Among prevention interventions evaluated in random controlled trials, HIV treatment has the most substantial effect on HIV incidence. Based on new evidence from clinical trials and observational studies, the consolidated guidelines of the World Health Organization (WHO) were revised in 2015. Core recommendations include treating all PLHIV and initiating antiretroviral therapy (ART) regardless of CD4 cell count.[10]

6. Worldwide, in 2014, an estimated 9.6 million people fell ill with tuberculosis (TB), of whom 12 percent were HIV-positive;[11] of the 1.5 million people dying from TB, 400,000 were HIV-positive. TB is a major cause of death among PLHIV and deaths from HIV-associated

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[3] UNAIDS. 2015. *AIDS by the numbers*. 2015. Geneva. Available at: http://www.unaids.org/en/resources/documents/2015/AIDS_by_the_numbers_2015

[4] UNAIDS. 2015. *UNAIDS 2016–2021 Strategy. On the Fast-Track to end AIDS*. Geneva.

[5] UNAIDS. 2015. *How AIDS changed everything – MDG 6: 15 years, 15 lessons of hope from the AIDS response*. Geneva.

[6] UNAIDS. 2014. *The Gap Report.* Geneva. Available at: http://www.unaids.org/sites/default/files/en/media/unaids/contentassets/documents/unaidspublication/2014/UNAIDS_Gap_report_en.pdf

[7] With the convergence of HIV treatment and prevention, attention has turned to how well people living with HIV are receiving attention in the continuum of services, including testing, care and ultimately, effective treatment. The concept of an HIV "treatment cascade" has emerged as a way to identify gaps in the continuum.

[8] Viral suppression occurs when there is a low level of HIV in the body; the person is not cured.

[9] UNAIDS. 2015. *Treatment 2015*. Geneva. Available at: http://www.unaids.org/sites/default/files/media_asset/JC2484_treatment-2015_en_1.pdf

[10] For more information on CD4 cell count see: Ford, N., et al. 2015. The future role of CD4 cell count for monitoring antiretroviral therapy. *The Lancet Infectious Diseases*, 15(2): 131–248. 2015. *Guideline on when to start antiretroviral therapy and on pre-exposure prophylaxis for HIV*. Geneva.

[11] WHO 2015. *Global Tuberculosis Report*. Geneva. Available at: http://apps.who.int/iris/bitstream/10665/191102/1/9789241565059_eng.pdf?ua=1

TB have decreased by only 18 percent since 2010.[5] Countries report improved integration of HIV and TB services, but only 392,000 HIV-positive TB patients were on ART in 2014 – one third of the estimated 1.2 million PLHIV who developed TB in that year.[11]

Funding Challenges

7. As the challenging global economic situation results in decreased funding of HIV programmes by traditional donors, ART treatment has been prioritized, making it difficult to secure funding for food and nutrition support for PLHIV and TB patients.

8. The Global Fund to Fight AIDS, Tuberculosis and Malaria and the United States President's Emergency Plan for AIDS Relief are the largest sources of HIV-specific funding. Since the pilot phase of the new Global Fund funding model in 2013, WFP has provided technical support for the integration of food and nutrition and/or logistics components into national strategic plans and programmes, and has supported several countries in applying for Global Fund grants.

9. For WFP, the decline in donor resources calls for combining HIV-specific with HIV-sensitive programmes.[12] WFP is focusing on linking health and food systems and integrating consideration of HIV issues into broad-based social safety nets, to promote long-term adherence to ART. As PLHIV are starting treatment earlier and living longer, new complications and co-morbidities are emerging and require sophisticated systems for disease management. Social protection schemes, including food and nutrition support, can increase people's access to health services, thus contributing to greater uptake of and adherence to treatment, and reduced mortality.

WFP and UNAIDS

10. Under the UNAIDS Division of Labour, WFP is the convener on food and nutrition issues, ensuring that food and nutrition interventions are integrated into comprehensive packages of treatment, care and support for PLHIV and TB patients at the country level, in line with WFP's 2010 HIV policy.

11. This policy emphasizes the need to embed WFP activities in country-led responses and to cooperate with UNAIDS partners on food and nutrition for HIV and TB response.

12. In October 2015, at its 37th meeting, the UNAIDS Programme Coordinating Board (PCB) adopted a new strategy for ending the AIDS epidemic as a public health threat by 2030. The UNAIDS 2016–2021 Strategy, "On the Fast-Track to end Aids", is one of the first in the United Nations system to be aligned with the Sustainable Development Goals (SDGs), and aims to advance progress towards the "three zeros": zero new HIV infections; zero discrimination; and zero AIDS-related deaths. The PCB also approved UNAIDS' operational framework and Unified Budget, Results and Accountability Framework (UBRAF) for 2016–2021. WFP contributed to development of the strategy.

13. The new UNAIDS Strategy is grounded in evidence and right-based approaches and is in line with the 90-90-90 treatment targets.[13] Its people-centred goals for 2020 are: i) fewer than 500,000 people newly infected with HIV; ii) fewer than 500,000 people dying from AIDS-related causes; and iii) elimination of HIV-related discrimination.

[12] WFP's HIV-specific interventions focus on people and households living with or affected by HIV or TB; they are delivered through two programme pillars: i) care and treatment; and ii) mitigation and safety nets. HIV-sensitive interventions do not focus primarily on HIV or TB response, but take into account the HIV/TB-related vulnerabilities of programme participants.

[13] The 90-90-90 treatment targets for 2020 are: i) 90 percent of all PLHIV will know their HIV status; ii) 90 percent of all people with diagnosed HIV infection will receive sustained ART; and iii) 90 percent of all people receiving ART will have viral suppression.

WFP'S Contribution to the Goals of UNAIDS Strategy 2011–2015

Universal Access to ART for PLHIV who are Eligible for Treatment

14. HIV treatment is only part of the HIV care and treatment continuum, which aims to achieve durable viral suppression. In 2015, WFP continued to work with governments and partners to ensure that HIV treatment is accompanied by nutrition assessments and counselling to maintain bodyweight and health; treatment of malnutrition with specialized nutritious food when required; and household rations when necessary to defray the costs of care and promote adherence to treatment and retention in care.

15. The 2012–2015 UBRAF asks UNAIDS Cosponsors to prioritize their interventions and focus on 38 countries – defined as high-impact countries – that account for 70 percent of the global HIV/AIDS burden. In 2015, WFP implemented HIV-specific interventions in 17 of these countries[14] and supported governments in sustainably addressing the food and nutrition needs of PLHIV and TB patients in 21.[15] In Swaziland, for example, WFP supported the Government in gradually integrating financial contributions for nutrition assessment, counselling and support services into the Ministry of Health's budget.

16. Building on WFP's expertise in logistics and extensive field presence, the logistics partnership between WFP and the Global Fund, established in 2014, increases patient access to HIV-related commodities, especially during emergencies.

Tuberculosis Deaths among PLHIV Reduced by Half

17. HIV infection leads to increased numbers of HIV-related TB cases. WHO's End TB Strategy is aligned with the SDGs and recommends that integrated TB and HIV activities become the global norm across countries. In Myanmar, for example, WFP provided technical support to generate information to guide the design of integrated HIV/TB national programmes.

18. In 2015, WFP: i) provided food and nutrition assistance for TB patients in 16 countries[16] to increase adherence to treatment; ii) continued to promote integrated programming with United Nations and government counterparts to ensure that TB patients are tested for HIV, and vice versa, especially where HIV prevalence is high; and iii) helped countries to integrate food and nutrition support into national TB strategies and guidelines and Global Fund proposals.

Vertical Transmission of HIV Eliminated and AIDS-Related Maternal Mortality Reduced by Half

19. Among the demand-side barriers to prevention of mother-to-child transmission (PMTCT) services,[17] food insecurity was found to compromise access and adherence. Comprehensive services that include food assistance enable more women to start and adhere to PMTCT programmes.

20. In line with global trends, WFP continued to integrate its PMTCT and mother-and-child health and nutrition (MCHN) programmes to prevent HIV transmission and ensure that mothers and infants, regardless of their serological status, have access to growth monitoring, vaccinations, micronutrient supplements, nutrition assessments, education, counselling and complementary foods. In Malawi, WFP continued to treat moderate acute malnutrition in all children and pregnant and lactating women, including those living with HIV and those in displacement camps. In Lesotho, in collaboration with the United Nations Population Fund (UNFPA), WFP continued

[14] Burundi, Cameroon, Central African Republic, Côte d'Ivoire, the Democratic Republic of the Congo (DRC), Djibouti, Ethiopia, Ghana, Kenya, Lesotho, Malawi, Mozambique, Myanmar, Rwanda, Swaziland, South Sudan and Zimbabwe.

[15] Chad, Guatemala, Haiti and Zambia are the additional four countries.

[16] Based on 2015 Standard Project Reports (SPRs) for the Congo, Djibouti, DRC, Guinea, Guinea-Bissau, Kenya, Lesotho, Madagascar, Malawi, Myanmar, Nepal, Somalia, South Sudan, Swaziland, Tajikistan and Zimbabwe.

[17] HIarlaithe, M.O., Grede, N., de Pee, S., and Bloem, M. Economic and social factors are some of the most common barriers preventing women from accessing maternal and newborn child health and PMTCT services: A literature review. *AIDS and Behavior*, 18 (Suppl. 5): S516–30.

to support pregnant women in "waiting homes" to encourage them to deliver their babies in health centres, thereby helping to reduce mother-to-child HIV transmission.

21. In 2015, WFP continued to help develop guidelines and educational materials to improve the nutrition knowledge of health care providers, especially those working with pregnant and lactating women and children who are exposed to HIV or HIV-positive. In Kenya, WFP supported the National AIDS and Sexually Transmitted Infections Control Programme to develop a Nutrition and HIV Orientation Package for health workers that includes nutrition modules. In Cambodia, WFP in coordination with the National Maternal and Child Health Centre provided a master training, a Training of the Trainers and three practitioner training sessions on the "Good Food Toolkit" for 130 government and non-governmental organization (NGO) staff.

PLHIV and Households Affected by HIV are Addressed in all National Social Protection Strategies and Have Access to Essential Care and Support

22. WFP continued to explore linkages between HIV/TB responses and livelihood promotion activities. In Lesotho, vulnerable ART and TB patients were involved in community-level livelihood activities, such as vegetable production, food preservation and saving schemes. In Djibouti, PLHIV were involved in micro-credit programmes.

23. WFP continued to support governments in strengthening their social protection mechanisms and making them more HIV-sensitive. In Swaziland, for example, as a member of the United Nations Working Group on Social Protection. WFP supported the Deputy Prime Minister's Office in advocating for child- and HIV-sensitive social protection programmes to ensure greater coverage of vulnerable children.

24. Given the challenging funding situation for HIV programmes, WFP is seeking opportunities to co-finance coordinated efforts that have been shown to produce HIV-related benefits, rather than focusing on funding for HIV-specific interventions. WFP is commissioning an analysis to assess the investment case for including food and nutrition components in HIV responses and to define the impact of HIV-sensitive interventions on HIV outcomes.

Reduce Sexual Transmission of HIV

25. Through its partnership with the North Star Alliance, WFP provides services along transport corridors at 30 road wellness centres in 12 countries[18] that account for many new HIV infections. The partnership aims to ensure access to HIV prevention, treatment, care and support for mobile workers, sex workers and other affected populations.

WFP's Work in HIV in Emergencies

26. The links between HIV and humanitarian emergencies are complex because responses must take into account the needs of both PLHIV and other people. Vulnerabilities are amplified in an emergency, including the risk of sexual and gender-based violence (SGBV). Access to health services and HIV programmes may become difficult or non-existent.

27. At the 36th meeting of the UNAIDS PCB, WFP – as co-leader of the Inter-Agency Task Team (IATT) on HIV in Emergencies – organized a thematic segment on HIV in emergency contexts, which increased attention to HIV issues in emergencies and to the barriers faced by key populations when seeking access to support. WFP played a pivotal role in supporting IATT and NGO partners to draft decision points that emphasized the importance of strategic information, logistic and supply chain management, funding, access to services including food and nutrition support, SGBV prevention and other issues. The decision points were adopted at the 37th PCB meeting. WFP and other United Nations agencies developed an advocacy and guidance brief on the need to maintain a minimum HIV programme during Ebola outbreaks.

[18] Botswana, DRC, Islamic Republic of the Gambia, Kenya, Malawi, Mozambique, South Africa, Swaziland, Uganda, the United Republic of Tanzania, Zambia and Zimbabwe.

28. WFP provided food assistance in humanitarian settings, including refugee camps, through HIV-specific interventions such as in Cameroon, the Central African Republic and South Sudan, and through general food distribution to food-insecure households. WFP support contributed to United Nations efforts to maintain access to treatment and prevent default.

2015 in Numbers

29. WFP assisted almost 537,000 PLHIV, TB patients and their households in 27 countries through HIV-specific programmes (Table 1).

TABLE 1: HIV AND TB PROGRAMME BENEFICIARY NUMBERS (HIV-SPECIFIC), 2015*	
Objective 1: Ensure nutrition recovery and treatment success through nutrition rehabilitation – Care and treatment	➢ 227,428 ART and PMTCT participants and their households ➢ 78,138 TB patients on directly observed treatment, shortcourse and their households **305,566 total**
Objective 2: Mitigate the effects of HIV through sustainable safety nets – Mitigation and safety nets	➢ 56,865 ART and PMTCT participants and their households ➢ 112,872 orphans and other vulnerable children ➢ 61,216 TB patients and their households **230,953 total**
TOTAL	**536,519**

* Based on preliminary results of 2015 SPRs.

30. In addition, through its HIV-sensitive interventions – such as general food distributions, school feeding, food assistance-for-assets activities and MCHN services – WFP also reached PLHIV and TB patients not directly counted in the SPRs. WFP is shifting from implementation of programmes towards development of national capacities. These factors, combined with the decrease of HIV-specific funding, explain the falling number of beneficiaries in recent years.

Partnerships

31. In 2015, WFP and UNAIDS co-convened a global consultation on HIV and nutrition, which provided substantial inputs to the UNAIDS Strategy 2016–2021. WFP also provided additional inputs to the strategy to ensure adequate incorporation of food and nutrition considerations and to reaffirm WFP's role in the HIV response.

32. In 2015, WFP and the South African NGO *Kheth'Impilo* formalized a partnership on enhancing the knowledge base for community-based approaches to improving HIV treatment and health outcomes. WFP and *Kheth'Impilo* organized country missions in Lesotho and Zimbabwe to strengthen the sustainability of in-country HIV and nutrition programmes.

33. As lead of the IATT on Food and Nutrition, WFP organized meetings throughout 2015 to define goals for 2016 in three areas: El Niño response; the linkages between non-communicable diseases and food and nutrition; and MCHN and HIV.

34. The WFP/United Nations Children's Fund/UNFPA partnership based on UNFPA's Action for Adolescent Girls is seeking to address the health and nutrition needs of vulnerable adolescent girls by integrating nutrition and sexual and reproductive health services. Based on time trend analysis across five wealth quintiles and a literature review evaluating delivery platforms for reaching adolescent girls, recommendations for effective and sustainable programmes that target adolescents were drawn up for all six countries participating in the initiative.

35. Complementing its logistics partnership with the Global Fund, WFP established a global framework agreement with the Partnership for Supply Chain Management (PFSCM) – the Global Fund's supply chain partner – for the provision of services. WFP provided an urgent airlift of HIV medicines on behalf of the Global Fund to prevent depletion of critical stocks. WFP continues to provide "last-mile" delivery services to UNFPA, and established a framework agreement with UNFPA for the provision of logistics services.

36. WFP and New York University initiated a course on the system approach to health, food security and nutrition for heads of programme to build the capacity of WFP's staff and share the latest developments in nutrition and HIV. During the course, participants explore models and theories for investigating outcomes and identifying social, behavioural, economic and environmental variables that affect population health and health disparities in different settings.

37. WFP is collaborating with the science-based company Royal DSM, Wageningen University and the University of Pretoria on the development of a drinkable, fermented maize-based product for treatment of malnutrition among adults, particularly PLHIV and TB patients. Following pre-sensory and sensory testing in 2014–2015, future phases include research on sensory-specific satiety and prolonged acceptability.

Outlook in 2016

38. In 2016, WFP chairs the UNAIDS Committee of Cosponsoring Organizations, providing it with opportunities to enhance its partnership with the UNAIDS Joint Programme and raise the profile of food and nutrition in HIV response.

39. WFP will support governments in integrating food and nutrition programmes into the health sector and linking them with community-based initiatives and social protection strategies, providing cash-based transfers when feasible to prevent the overburdening of health systems.

40. In collaboration with the IATT Child Survival Working Group, WFP will strengthen its role in addressing paediatric HIV by using existing nutrition services as an entry point for HIV testing of children in epidemic settings.

41. Through its partnership with the Global Fund and its global framework agreement with the Partnership for Supply Chain Management (PFSCM), WFP will build the capacity of Global Fund implementers to develop and strengthen distribution systems and prevent supply gaps in antiretroviral drugs and other HIV-related commodities.

42. WFP will work with academic partners to assess the impact of HIV-sensitive interventions on HIV outcomes. Findings will inform the adaptation of existing HIV-sensitive actions, increase WFP's visibility as a trusted and capable partner in HIV response, and be used in advocacy with other UNAIDS Cosponsors for the scale-up of HIV-sensitive social protection interventions.

43. Increasing interest in HIV-sensitive social protection provides opportunities for WFP to build its staff's commitment to and capacities in HIV and social protection across areas such as asset creation, livelihoods, safety nets and social protection, including school feeding and vulnerability analysis and mapping, and levels – Headquarters, regional bureaux and country offices.

44. WFP will continue to advocate for addressing the needs of PLHIV affected by the El Niño phenomenon through the creation of a sub-working group on El Niño within the IATT on HIV in Emergencies, with links to the IATT on Food, Nutrition and HIV and other regional and global initiatives.

Acronyms Used in the Document

ART	antiretroviral therapy
DRC	Democratic Republic of the Congo
IATT	Inter-Agency Task Team
MCHN	mother-and-child health and nutrition
NGO	non-governmental organization
PCB	Programme Coordinating Board
PLHIV	people living with HIV
PMTCT	prevention of mother-to-child transmission
SDG	Sustainable Development Goal
SGBV	sexual and gender-based violence
SPR	Standard Project Report
TB	tuberculosis
UBRAF	Unified Budget, Results and Accountability Framework
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
WHO	World Health Organization