Executive Board
Annual Session

Rome, 3–6 June 2014

POLICY ISSUES

Agenda item 5

UPDATE ON WFP'S RESPONSE TO HIV AND AIDS

For information*

Distribution: GENERAL
WFP/EB.A/2014/5-D
17 April 2014
ORIGINAL: ENGLISH

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NOTE TO THE EXECUTIVE BOARD

This document is submitted to the Executive Board for information.

The Secretariat invites members of the Board who may have questions of a technical nature with regard to this document to contact the WFP staff focal points indicated below, preferably well in advance of the Board's meeting.

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EXECUTIVE SUMMARY

At the request of the Board, WFP provides regular updates on implementation of its HIV policy. Approved in November 2010, the policy[1] is in line with the Joint United Nations Programme on HIV/AIDS (UNAIDS) strategy for 2011–2015 "Getting to Zero",[2] the UNAIDS Division of Labour and the WFP Strategic Plan (2014–2017).

WFP is the lead agency within UNAIDS for ensuring that food and nutrition support are integrated into national plans and 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, ensuring that the special needs of people living with HIV are taken into account.

In line with its 2010 HIV policy, WFP has shifted the focus of its HIV programmes from mitigation of the consequences of HIV infection to enabling access to treatment and improving treatment outcomes through food and nutrition support. Three years into implementation of the new policy and in response to the UNAIDS strategy, WFP has adopted a two-pronged approach. It is collaborating with countries to ensure that food and nutrition support is included in all national HIV and tuberculosis strategies and programmes; and it is working with governments to implement such food and nutrition support for people living with HIV.

WFP also supports people living with HIV and tuberculosis clients in other ways: its broader programmes in high HIV- and tuberculosis-prevalence areas are sensitive to, and mitigate the consequences of, the two diseases on individuals, households and communities. Examples include WFP's school meals programmes, which reach many orphans and other vulnerable children and often include life skills training, and WFP's productive safety nets and general food distributions.

In 2013, WFP reached 1.3 million beneficiaries with its HIV/tuberculosis-specific programming in 31 countries: 680,000 anti-retroviral treatment and prevention of mother-to-child transmission clients and their households, and 421,000 tuberculosis clients and their households. In addition, WFP supported 206,000 orphans and other vulnerable children, and provided food and nutrition support in refugee camps and other humanitarian settings. In Côte d'Ivoire, the Democratic Republic of the Congo and South Sudan, and in refugee camps in Kenya, Nepal, Rwanda, the United Republic of Tanzania, Zambia and Zimbabwe, people living with HIV were reached by both general food distribution and specific interventions. People living with HIV in Mali were reached by general food distribution alone.

In 2013, WFP practised a more integrated, sustainable and holistic approach to HIV-specific and HIV-sensitive programming. Food assistance was further connected to economic strengthening activities to foster long-term sustainability; HIV- and tuberculosis-related work was further converged with nutrition programmes; support was increased for HIV-sensitive social safety net strategies; use of cash and vouchers in HIV programming was increased; and

[1] http://one.wfp.org/eb/docs/2010/wfp225092~1.pdf

[2] UNAIDS. 2011. *Getting to Zero 2011–2015 Strategy*. Geneva.

a new partnership was established with the United Nations Population Fund and the United Nations Children's Fund to reach women and girls through Health 4+, which works with countries to strengthen their health systems, and the Adolescent Girls Initiative.

HIV AND TUBERCULOSIS IN 2013

1. HIV remains one of the great challenges of our time. More people than ever – an estimated 35.3 million – are living with HIV.[3] Sub-Saharan Africa is the most affected region: with only 12 percent of the world's population, 69 percent of all people living with HIV (PLHIV) and 70 percent of people newly infected in 2012 live there.[4] HIV often compounds pre-existing food insecurity and malnutrition in a well-documented vicious cycle. People who are food- insecure often engage in risky coping behaviours which may put them at risk of HIV infection. If left untreated, HIV gradually destroys the immune system and results in weight loss, often exacerbating malnutrition. HIV-infected children are at high risk of stunting.

2. A continued increase in the number of PLHIV reflects improved access to treatment, which enables many to live for longer. By the end of 2012, 10.6 million PLHIV had access to anti-retroviral therapy (ART). However, under the 2013 World Health Organization (WHO) guidelines, the 9.7 million people receiving ART in low- and middle-income countries represents only 34 percent of the 28.6 million people eligible for the treatment. WHO guidelines released in 2013 further raised the CD4 (white blood cell) threshold at which treatment should be initiated,[5] guaranteeing a further increase in that gap.

3. In 2012, there were an estimated 8.6 million new cases of tuberculosis (TB), of which 13 percent were cases of co-infection with HIV. A total of 1.3 million people died from TB, including 320,000 PLHIV. TB is one of the major causes of death among PLHIV and one of the top killers of women. The integration of HIV and TB services has improved: in 2012, 46 percent of TB clients had a documented HIV test result and the number of people in HIV care who were screened for TB increased by 17 percent (3.5 million to 4.1 million) between 2011 and 2012.[6]

4. HIV is a leading cause of death among women of reproductive age and contributes significantly to maternal mortality. Despite the gains made with the scale-up of effective prevention of mother-to-child transmission (PMTCT) regimens – to 58 percent coverage among known HIV-positive pregnant women[7] – and the phase-out of single-dose nevirapine, treatment coverage for eligible pregnant women in 2012 still remained less than 50 percent, while for the general population it was 64 percent.[7]

5. New HIV infections are on the decline, including among infants and women. According to the 2013 UNAIDS Global Report, the number of new paediatric infections declined by 22 percent from 2011, from 330,000 to 260,000. New HIV treatment guidelines recommend

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[3] UNAIDS. 2013. *Report on the Global AIDS Epidemic 2013*. Available at: http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2013/gr2013/UNAIDS_Global_Report_2013_en.pdf

[4] UNAIDS. 2013. *Report on the Global AIDS Epidemic*. *AIDS by the numbers*. Available at: http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2013/JC2571_AIDS_by_the_numbers_en.pdf

[5] WHO. 2013. *Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection*. Available at: http://www.who.int/hiv/pub/guidelines/arv2013/download/en/

[6] WHO. *Global Tuberculosis Report 2013*. Available at: http://apps.who.int/iris/bitstream/10665/91355/1/9789241564656_eng.pdf?ua=1

[7] *Global HIV/AIDS response: Epidemic update and health sector progress towards Universal Access* (WHO, the United Nations Children's Fund (UNICEF), UNAIDS).

offering treatment to certain populations such as pregnant and lactating women (PLW) and children under 5, irrespective of CD4 count.

6. Research has found that ART can prevent transmission of infection among sexual partners because it lowers the viral load to undetectable levels. In addition to saving the lives of those infected, treatment is clearly important for preventing new infections.

Impacts of Changes in the Global Funding Context on Food and Nutrition within the HIV Response

7. Increasingly, donors are urging integration of HIV work into broader health interventions, which can make it more challenging to track HIV funding. In the post-2015 agenda, HIV will likely be integrated within a broader health-related goal that emphasizes universal access to health and the reduction of child and maternal mortality. The High-Level Panel on the Post-2015 Development Agenda report mentions HIV as a target under the "Ensure healthy lives" goal.

8. In 2012, the Global Fund to Fight AIDS, Tuberculosis and Malaria (hereafter "The Global Fund") adopted a new funding model, aiming to invest more strategically and enhance accountability. The model changed how countries apply for funding, obtain approval of their proposals and manage their grants, encouraging the implementation of National Strategic Plans and inclusive country dialogue. Several countries piloted the model in 2013 and others will begin implementation in 2014.

9. For WFP, the change in the donor landscape for HIV programming highlights the need to converge HIV-specific and HIV-sensitive programmes. Food and nutrition support can enable access to health services. WFP has focused increasingly on improving adherence to treatment and retention in care through food and nutrition support and linkages to social protection programmes. By keeping clients in care, mortality risks are reduced and investments made in a client's recovery are not lost.

WFP AND UNAIDS

10. In June 2011, the UNAIDS Programme Coordinating Board endorsed a 2012–2015 Unified Budget, Results and Accountability Framework (UBRAF) of USD 485 million.

11. As one of the 11 Cosponsors of UNAIDS, WFP shares the UNAIDS vision of achieving zero new infections, zero AIDS-related deaths and zero discrimination by 2015. Under the UNAIDS Division of Labour, WFP's mandate is to convene with other Cosponsors on food and nutrition issues. WFP's main roles are to ensure that food and nutrition are integrated appropriately into comprehensive packages of care, treatment and support for PLHIV and TB clients at the country level in line with WFP's approved policy.

12. WFP's 2010 HIV policy emphasized the need to embed WFP activities in broader country-led responses while cooperating with its main UNAIDS partners on food and nutrition in relation to HIV and TB. This fits well with the 2012–2015 UBRAF increased emphasis on enabling country-level HIV responses.

13. The UNAIDS 2011–2015 strategy seeks to: i) revolutionize HIV prevention; ii) catalyse the next phase of treatment; and iii) advance human rights and gender equality. These areas are subdivided into the ten UNAIDS strategic goals. WFP contributes to some of these, as described below.

UNAIDS Strategy Goal: Universal access to ART for PLHIV who are Eligible for Treatment

14. Improving the efficiency and effectiveness of treatment services is central to the long-term success of the HIV response. WFP works with governments and partners to ensure that treatment is accompanied by assessment of nutritional status, counselling on nutrition to maintain body weight and health and to mitigate side-effects, and nutritious food to treat malnutrition. A household ration complements this support, helping households cope with the often high costs of care in the initial phase and increasing the likelihood of adherence to treatment and retention in care.

15. To maximize synergies and partnerships, the UBRAF asks Cosponsors to prioritize their interventions and to focus their investments in 38 high-priority countries, which together account for 70 percent of the disease burden. WFP is supporting governments to implement HIV and TB programmes in 26 of these countries,[8] with HIV-specific interventions in 20 of them.[9]

UNAIDS Strategy Goal: TB Deaths among PLHIV Reduced by Half

16. Rapid rises in HIV infection could also lead to increased numbers of HIV-related TB. The Stop TB strategy aims to integrate TB and HIV/AIDS programmes to benefit both TB clients and PLHIV. In Swaziland, WFP helped the Government to increase access to food by prescription for co-infected clients, integrate nutrition indicators for HIV and TB, and improve referral and follow-up for HIV and TB care programmes.

17. In 2013, WFP provided food and nutrition assistance to TB clients in 20 countries[10] to increase adherence to treatment. WFP continued to promote integrated programming with the United Nations and governmental counterparts to ensure TB clients are tested for HIV and vice versa, especially in high HIV-prevalence settings. It helped countries integrate food and nutrition into national strategies, TB protocols and guidelines, and Global Fund proposals on TB.

UNAIDS Strategy Goal: Vertical Transmission of HIV Eliminated and AIDS-Related Maternal Mortality Reduced by Half

18. WFP focusses on women because of the roles they often play in guaranteeing food security for the household, acting as primary caregivers, and purchasing and preparing food for the household.

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[8] Burkina Faso, Burundi, Cambodia, Cameroon, Central African Republic, Chad, Côte d'Ivoire, Democratic Republic of the Congo, (DRC), Djibouti, Ethiopia, Ghana, Guatemala, Haiti, India, Indonesia, Kenya, Lesotho, Malawi, Mozambique, Myanmar, Rwanda, South Sudan, Swaziland, the United Republic of Tanzania, Zambia and Zimbabwe.

[9] Burundi, Cameroon, Central African Republic, Côte d'Ivoire, Djibouti, DRC, Ethiopia, Ghana, Haiti, Kenya, Lesotho, Malawi, Mozambique, Myanmar, Rwanda, South Sudan, Swaziland, United Republic of Tanzania, Zambia and Zimbabwe.

[10] Based on preliminary 2013 Standardized Project Reports for Afghanistan, the Congo, Djibouti, DRC, Guinea, Guinea-Bissau, Haiti, Lesotho, Madagascar, Malawi, Mozambique, Myanmar, Nepal, Sierra Leone, Somalia, South Sudan, Swaziland, Tajikistan, Zambia and Zimbabwe.

19. WFP staff were guest editors of a paper examining the role of food insecurity in relation to adherence to care and treatment.[11] Qualitative and quantitative studies found that food insecurity is associated with non-adherence to treatment and care among HIV-infected pregnant women and their infants, and in child and adolescent populations of PLHIV. Women with HIV who are pregnant are more likely to be food-insecure than non-pregnant, non-infected women because of increased nutrient demands. Non-adherence to treatment has implications not only for a woman's health, but also for the health of her children: there is risk of vertical transmission of HIV and babies born with low birthweight. This evidence supports addressing food insecurity in pregnant women and their children to improve adherence to care and treatment for PLHIV.

20. WFP continued to integrate its PMTCT activities with comprehensive mother-and-child health and nutrition (MCHN) services to prevent HIV transmission and ensure that mothers and infants have access to growth monitoring, vaccinations, micronutrient supplementation, nutrition assessment, education and counselling, and complementary foods.

21. The provision of more comprehensive services, including food assistance, enables more women to take up and adhere to PMTCT programmes. In line with global trends, WFP has integrated many of its PMTCT programmes into nutrition programmes such as the prevention and treatment of moderate acute malnutrition; this makes it more difficult for WFP to distinguish PMTCT beneficiaries.

22. WFP also helped 13 countries elaborate their national PMTCT programmes to ensure that food and nutrition support is provided for pregnant malnourished women who use MCHN services. WFP has also encouraged inclusion of PMTCT aspects in other programmes: in Cambodia, a Good Food Toolkit was revised to include PLW and HIV-exposed children. In Ethiopia, 2,230 PLHIV received food in exchange for attending PMTCT services. WFP converted in-kind food support to voucher support to allow households to purchase fresh vegetables, eggs and milk. In 2012, 97 percent of the babies of the mothers receiving food assistance tested negative for HIV.

UNAIDS Strategy Goal: PLHIV and Households Affected by HIV are Addressed in all National Social Protection Strategies and have Access to Essential Care and Support

23. In line with its policy and with the UNAIDS Division of Labour, WFP works with UNICEF, the World Bank and the International Labour Organization to enhance social protection for PLHIV. The broad definition of social protection adopted by UNAIDS suggests that all WFP HIV-specific and HIV-sensitive beneficiaries could be counted under this category.

24. WFP is exploring ways of integrating cash or voucher schemes into health sector care-and-treatment programmes, where the health sector determines eligibility for food support and WFP provides cash or food vouchers, thus limiting the burden on the health care system and simplifying the logistics normally associated with in-kind food distribution. In 2013, vouchers were used in innovative ways for HIV programming. In DRC, vouchers provided via mobile phones were conditional on beneficiaries sending their children to school and going to a health facility on a regular basis for nutritional and medical assessments, ART, TB directly observed treatment, short course (TB-DOTS) or PMTCT

[11] Young, S., Wheeler, A.C., McCoy, S.I. & Weiser, S.D. 2013. A Review of the Role of Food Insecurity in Adherence to Care and Treatment Among Adult and Pediatric Populations Living with HIV and AIDS. *AIDS and Behavior,* available at http://link.springer.com/article/10.1007%2Fs10461-013-0547-4#page-1

support. In Mozambique, vouchers provided via mobile phones allowed beneficiaries to acquire food products in local shops. WFP is contributing research to the evidence base for HIV-sensitive social transfers.

25. WFP continued to expand its economic strengthening projects. In Ethiopia, PLHIV receive vouchers for food products during six-month training courses in small-business skills. They also receive assistance in setting up village savings and loan associations that encourage them to save and allow them to take out small loans to start income-generating activities. After the six months, they get help preparing business plans and receive matching funds to start their own businesses.

26. With nutrition set to take a prominent position in the post-2015 development agenda, and with the momentum galvanized by the Scaling Up Nutrition movement, many countries are expected to mainstream food and nutrition components in their social protection programmes. MCHN schemes could provide opportunities to incorporate HIV-sensitive programming, particularly for scaling up PMTCT. WFP will continue to identify opportunities to link PLHIV who are completing nutrition programmes to safety nets or livelihood activities. It will also continue to gather evidence on how food and nutrition interventions can improve the cost effectiveness of the HIV response; an analysis of lessons learned in South Africa is planned for 2014.

27. In DRC, Ethiopia, Mozambique, Swaziland and elsewhere, WFP worked with governments to ensure that nutritional support was integrated in national social protection programmes, not necessarily targeting PLHIV and TB clients. Significant national ownership and involvement has guaranteed coordination and continuity of service delivery, along with better referral systems.

UNAIDS Strategy Goal: Reduce Sexual Transmission of HIV

28. Transport workers and other mobile populations are particularly susceptible to HIV and other sexually transmitted infections because they often have multiple sex partners and limited access to health services. WFP continued to provide financial support to North Star Alliance in 2013. Founded jointly by WFP, TNT and other organizations in 2006, this longstanding partnership expands access to HIV prevention, treatment, care and support for transport workers, sex workers and other affected populations through 30 Road Wellness Centres along transport corridors in Botswana, DRC, the Gambia, Kenya, Malawi, Mozambique, South Africa, Swaziland, Uganda, the United Republic of Tanzania, Zambia and Zimbabwe. By the end of 2013 it had reached 750,000 people.

29. New evidence shows that being born small – a result of undernutrition during pregnancy – contributes to at least 20 percent of the stunting prevalence rate. This inspired WFP to form a new partnership with the United Nations Population Fund (UNFPA) and UNICEF with a view to improving nutrition among adolescent girls and PLW. While the main goal of the partnerships is to prevent stunting, providing nutrition support for adolescent girls may enable them to stay in school, which may delay sexual activity. Poor and vulnerable girls will be reached through WFP's school feeding programmes and UNFPA's Adolescent Girls Initiative. WFP Headquarters staff participated in missions to Burkina Faso, the Niger, Sierra Leone and Zambia to support the initiative.

WFP'S HIV AND TB WORK IN 2013 IN NUMBERS

30. In 2013, WFP assisted 1.3 million PLHIV and TB clients, along with people affected by either disease, in 31 countries through nutrition rehabilitation, mitigation and safety net activities, or both. Table 1 shows the breakdown of beneficiaries by disease and by main programme objective.

TABLE 1: HIV AND TB PROGRAMME BENEFICIARY NUMBERS, 2013*	
Objective 1: Ensure nutrition recovery and treatment success through nutrition rehabilitation – Care and treatment	**897 061 total** − 637,696 ART and PMTCT clients and their households − 259,365 TB-DOTS clients and their households
Objective 2: Mitigate the effects of HIV through sustainable safety nets – Mitigation and safety nets	**427 036 total** − 35,507 ART clients and their households − 205,936 orphans and other vulnerable children − 185,593 TB clients and their households
TOTAL	**1 324 097**

*Based on 2013 preliminary Standardized Project Reports.

31. WFP also reached PLHIV through HIV-sensitive interventions that did not focus on HIV, but took vulnerability related to HIV into account; in humanitarian settings, including through general food distribution; and in school feeding and food-for-assets programmes. PLW were reached through broader, integrated MCHN services.

PARTNERSHIPS AND RESEARCH

32. WFP organized an Inter-Agency Task Team (IATT) on Food and Nutrition meeting in December 2013 to update members on research regarding linkages between food and nutrition and HIV care. Future research and communication activities were planned, such as a series of advocacy papers that will appear in the journal Sight and Life in 2014. Plans were also made to set up an IATT Sub-Working Group based in South Africa, with focal points in the South Africa Medical Research Council and UNICEF, to document lessons learned on linking HIV treatment services with nutrition, social protection and education in the South Africa context. WFP also co-chairs the IATT on HIV in humanitarian contexts and participated in social protection-related IATTs.

33. At the 17th International Conference on AIDS and Sexually Transmitted Infections in Africa held in Cape Town in December 2013, WFP contributed to sessions on HIV in emergencies and social protection interventions, and presented on country-level experience in DRC.

34. A research project begun in 2012 is underway to better understand food preferences of malnourished adult PLHIV in early stages of treatment in different cultural settings in Asia and Africa. The research, which will inform product development, is carried out with Wageningen University, the Thai Red Cross and Malawi's Project Peanut Butter, with some private sector support.

OUTLOOK FOR 2014

35. WFP's HIV and TB work supports food assistance as a means to enable broader health outcomes such as nutritional recovery, retention in care and treatment success, designing and implementing programmes through existing government processes. WFP's work will increasingly support governments to integrate food and nutrition programmes in the health sector and link them to community-based initiatives and social protection strategies, providing cash and/or vouchers to help governments avoid overburdening health systems. Some WFP country offices are linking formerly malnourished PLHIV to livelihood activities, with a view to consolidating health gains and allowing PLHIV to engage in productive activities. Such activities help PLHIV ensure food and nutrition security for themselves and their households and also contribute to retention in care and treatment success, which in turn helps reduce transmission.

36. WFP will foster dialogue at global and country levels. It will continue to engage with the Global Fund with a view to ensuring that food and nutrition are included in its policies and guidelines, and with country offices and regional bureaux to facilitate access to Global Fund resources and support for countries already receiving them. WFP will continue to expand its work in HIV-sensitive partnerships, programmes and policies, including through the WFP/UNFPA/UNICEF partnership for nutrition among adolescent girls and PLW, which plans to pilot programmes in four countries starting in 2014.

37. One third of PLHIV beginning treatment are not retained in care within three years, but access and adherence to treatment have not been a main focus of global attention. Better understanding of PLHIV needs and preferences and enabling environments will be essential for addressing the problem. Social protection needs to be leveraged better and linked to food and nutrition assistance. In 2014, WFP will provide training in advocacy on HIV/AIDS and nutrition, in partnership with the Institute of Development Studies.

ACRONYMS USED IN THE DOCUMENT

ART	anti-retroviral treatment
CD4	white blood cell
DOTS	directly observed treatment, shortcourse
DRC	Democratic Republic of the Congo
IATT	Inter-Agency Task Team
MCHN	mother-and-child health and nutrition
PLHIV	people living with HIV
PLW	pregnant and lactating women
PMTCT	prevention of mother-to-child transmission
TB	tuberculosis
UBRAF	Unified Budget, Results and Accountability Framework
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organization