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UPDATE ON WFP'S RESPONSE TO HIV AND AIDS

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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 Executive 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 (2008–2013). WFP is the lead agency within UNAIDS for ensuring that food and nutrition support is integrated into national strategic plans and programmes for people living with HIV. With the United Nations Office of the High Commissioner for Refugees, WFP is also co-convenor for HIV in humanitarian emergencies, responsible for ensuring that the special needs of people living with HIV are taken into account during major humanitarian responses.

In line with its 2010 HIV policy, WFP is shifting the focus of its HIV programmes from mitigation of the consequences of HIV infection to enabling access to treatment and positive treatment outcomes through food and nutrition support. Two years into implementing the new policy, and in response to the UNAIDS strategy, WFP is realigning its focus, using a two-pronged approach of collaborating with country stakeholders, country coordinating mechanisms and national disease programmes to ensure that food and nutrition support is included in all national HIV and tuberculosis strategies and programmes; and working with governments to implement food and nutrition assistance programmes for people living with HIV.

WFP's support to people living with HIV and tuberculosis patients is not limited to its HIV- and tuberculosis-specific programmes. Broader WFP programmes in areas of high HIV and tuberculosis prevalence are also HIV- and tuberculosis-sensitive, seeking to mitigate the consequences of both diseases on individuals, households and communities. These efforts include WFP school feeding programmes – which reach many orphans and vulnerable children and often include life-skills training – productive safety nets and general food distributions.

A 2011 gap analysis found that country offices were making good progress in implementing the new policy;[3] just over a year after its adoption, most WFP HIV and tuberculosis programmes were well aligned to the policy. The report highlighted that WFP's HIV work is effective because it works with governments to integrate food and nutrition into national HIV policies and programmes, while also assisting the implementation of these programmes.

[1] http://onewfo.org/ed/docs/2010wfp225092~1.pdf

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

[3] The gap analysis focused on 15 countries, covering 85 percent of WFP-assisted HIV/AIDS and/or tuberculosis beneficiaries in 2011.

WFP reached a total of 2.8 million HIV-positive or tuberculosis-infected people, providing assistance to beneficiaries in 33 countries.[4] HIV-specific programmes reached 1.6 million of these beneficiaries – clients and household members – while approximately 1.2 million were reached through HIV-sensitive programmes, including curative nutrition programmes and school feeding programmes. WFP reached 1.4 million orphans and other vulnerable children through school feeding and HIV-specific programmes; 926,000 anti-retroviral therapy clients; 96,000 women through prevention of mother-to-child transmission clients and curative nutrition programmes;[5] and 360,000 tuberculosis clients and their households. Emergency food assistance was provided to people living with HIV or tuberculosis in high-prevalence populations affected by emergencies in Afghanistan, the Democratic Republic of the Congo, Somalia and South Sudan; transition and post-crisis situations in Côte d'Ivoire and Haiti; refugee emergencies in Rwanda; natural disasters in Kenya and Malawi; and economic collapse in Zimbabwe.

DRAFT DECISION*

The Board takes note of "Update on WFP's Response to HIV and AIDS" (WFP/EB.A/2013/5-D).

[4] Based on Standard Project Report data from WFP in 2012 SPR Analysis: HIV and TB Programmes. April 2013; WFP's Nutrition and HIV/AIDS Unit; and data from the project beneficiary data-set 2002–2012 available at: http://wiki.wfp.org/operationalreporting/index.php/SPRdata#Project_beneficiary_data Please note, numbers are rounded.

[5] Pregnant and lactating women and HIV-exposed infants were reached through specific prevention of mother-to-child transmission programmes or broader curative nutrition programmes.

* This is a draft decision. For the final decision adopted by the Board, please refer to the Decisions and Recommendations document issued at the end of the session.

HIV AND TUBERCULOSIS IN 2012

1. HIV remains one of the great challenges of the times. More people than ever – an estimated 34 million – are living with HIV.[6] Sub-Saharan Africa is the most affected region, with only 12 percent of the world's total population, but 69 percent of all people living with HIV (PLHIV) and 72 percent of those newly infected in 2011.[6] In sub-Saharan Africa, HIV often compounds pre-existing food insecurity and malnutrition. The vicious cycle created by HIV, food insecurity and malnutrition is well documented: food-insecure people often engage in risky coping behaviours that put them at risk of HIV infection, while HIV – when untreated – gradually destroys the infected person's immune system, resulting in weight loss and often exacerbating malnutrition. HIV-infected children often struggle to grow and are at high risk of stunting.

2. Recent increases in the number of PLHIV reflect generally improved access to treatment, which enables many PLHIV to live longer. Anti-retroviral therapy (ART) has averted an estimated 2.5 million deaths since 1995.[7] By the end of 2011, 8 million PLHIV had access to ART and, for the first time, most of the people (54 percent) eligible for ART in low- and middle-income countries were receiving it. However, an estimated 7 million additional PLHIV need ART but do not yet have access to it. If the World Health Organization (WHO) guidelines raise the CD4 (white blood cell) threshold at which treatment should be initiated, this gap will increase significantly. Access to HIV treatment has been significantly expanded and the pace at which new HIV infections occur is now 20 percent lower than it was in 2001.[6]

3. In 2011, there were an estimated 8.7 million new cases of tuberculosis (TB), 13 percent of which were co-infections with HIV, and 1.4 million people died of TB, including 430,000 PLHIV. TB is one of the main causes of death among PLHIV, and one of the top killers of women. The integration of HIV and TB services has improved: in 2011, 40 percent of TB patients had a documented HIV test result, and the number of people in HIV care screened for TB increased by 39 percent, from 2.3 million in 2010 to 3.2 million in 2011.[8]

4. Globally, HIV is a leading cause of death among women of reproductive age, and contributes significantly to maternal mortality. Despite the scale-up of prevention of mother-to-child transmission (PMTCT) regimens, which now cover up to 57 percent of known HIV-positive pregnant women,[9] and the phase-out of single-dose nevirapine, in 2011, overall treatment coverage was lower for eligible pregnant women, at 48 percent, than for the general population, at 54 percent.[9]

5. New HIV infections, including those among infants and women, are declining. According to the 2012 UNAIDS Global Report, there were 333,000 new paediatric infections in 2012, 24 percent fewer than in 2009, with 430,000. Implementation of the 2010 WHO guidelines for PMTCT has been shown to reduce the risk of transmission from 35 to less than 5 percent among breastfed infants, and from 25 to less than 2 percent in

[6] UNAIDS. 2012. *Report on the Global AIDS Epidemic*. Geneva. Available at: http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2012/gr2012/20121120_UNAIDS_Global_Report_2012_with_annexes_en.pdf

[7] UNAIDS. 2010. *Report on the Global AIDS Epidemic.* Geneva.

[8] WHO. Global Tuberculosis Report 2012. Available at: http://www.who.int/tb/publications/global_report/en/

[9] WHO/UNICEF/UNAIDS. 2011. Progress Report 2011: Global HIV/AIDS Response. Available at http://www.who.int/hiv/pub/progress_report2011/en/

non-breastfeeding infants[10]. In April 2012, WHO released a programmatic update with a third PMTCT option, Option B+, of initiating ART treatment for all pregnant women regardless of their CD4 count. Many countries are striving to implement this option, despite its cost implications.

6. Efforts to eliminate mother-to-child transmission (MTCT) have sometimes had the undesired effect of reducing emphasis on the need to roll out paediatric ART under the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), and there is insufficient recognition of the barriers to paediatric ART; the elimination of MTCT and greater access to paediatric ART should be tackled together. Greater linkages should be made with programmes treating acute malnutrition in areas of high HIV prevalence. In 2010, 3.4 million children less than 15 years of age were living with HIV. Currently, only 456,000 (23 percent) of the 2 million HIV-positive children in need of treatment receive it.[9]

7. Recent research found that ART can prevent the transmission of infection between sexual partners because it lowers the viral load to undetectable levels. This makes ART an important strategy for preventing new infections, as well as saving the lives of those already infected.

IMPACTS OF THE CHANGED FUNDING CONTEXT ON FOOD AND NUTRITION IN HIV RESPONSES

8. The difficult global economic situation of recent years has put HIV programming under increasing financial strain. Global financial assistance for HIV declined for the first time in 2011, which was also the first year in which a larger share of resources came from domestic than from international sources. Increasingly, donors are pushing to integrate HIV work into broader health interventions, which takes HIV out of isolation, but also makes it difficult to track HIV funding. The debate over the post-2015 period intensified in 2012; HIV will likely be integrated into broader health goals and placed under universal health coverage in the post-Millennium Development Goals agenda.

9. The biggest funder of the HIV response, the United States President's Emergency Plan for AIDS Relief (PEPFAR), has scaled back its support in some countries. PEPFAR's total spending for global HIV programmes – bilateral and multilateral – decreased by US$138.6 million in 2011 and US$102.3 million in 2012, dropping to an annual expenditure of about US$6.4 billion.[11] Nevertheless, among donor countries, the United States of America still provided roughly 60 percent of all funds for HIV in 2012.

10. Accountability issues in several recipient countries, coupled with the financial crisis, led the Board of GFATM to request time to consider reforms. In 2011, GFATM cancelled Round 11,[12] leading to a severe slowdown in disbursements and new grants. In late 2012, GFATM unveiled a new funding model that is no longer based on rounds; for the first time, countries will be given an indication of funding envelopes and allocation levels. The process for developing proposals will be more interactive: long delays in grant signature are to be eliminated and accountability mechanisms strengthened. However, the reform of

[10] WHO. PMTCT Strategic Vision 2010–2015: Preventing mother-to-child transmission of HIV to reach the UNGASS and Millennium Development Goals. Available at: www.who.int/hiv/pub/mtct/strategic_vision.pdf [UNGASS was the 2001 special session of the United Nations General Assembly on HIV/AIDS.]

[11] Salaam-Blyther, T. 2012. *The President's Emergency Plan for AIDS Relief (PEPFAR): Funding Issues After a Decade of Implementation, FY2004–FY2013*. Congressional Research Service, October.

[12] Each disbursement of grant money from GFATM is called a Round.

GFATM severely affected its ability to fund new programmes in 2012. In February 2013, it officially launched the new funding model and selected countries for piloting it in 2013.

11. Although the future outlook is uncertain, funding levels from traditional donors are expected to stagnate or decline, while many low- and middle-income country governments continue to pick up larger shares of the total costs of response. Countries such as Brazil, the Russian Federation, India, China and South Africa (BRICS) are likely to play a greater role in international HIV/AIDS assistance as they transition from recipient to donor status.[9]

12. The change in the donor landscape for HIV means that WFP needs to focus even more on demonstrating how its interventions create value from relatively limited investments. In low-resource settings, food and nutrition support can be a cost-effective way of enhancing treatment success and mitigating the consequences of HIV and TB on livelihoods; food and nutrition support helps to reduce early mortality during treatment, sustain nutrition recovery, facilitate treatment adherence and improve retention in care. These benefits apply to ART, TB treatment and the prevention of new infections through PMTCT programming and ART. The importance of retention in care is still often underappreciated; adherence to treatment keeps viral loads in check, improves quality of life, keeps people alive for longer and reduces the risk of ART clients developing drug resistance, which would require a switch to much more expensive second- and third-line regimens. It also keeps infectiousness low, thereby reducing the risk of transmission.

13. The 2001 and 2006 Declarations of Commitment on HIV/AIDS adopted at United Nations General Assembly Special Sessions acknowledged the important role of food and nutrition services. In June 2011, the General Assembly adopted resolution 65/277, making a strong commitment to integrating food and nutrition support into programmes for people affected by HIV.[13] While calling for specific, time-bound, measurable results, the 2011 Political Declaration emphasizes that results will be achieved only through strong partnerships, including with civil society and national governments.

WFP AND UNAIDS

14. In June 2011, the 27th UNAIDS Programme Coordinating Board endorsed the 2012–2015 Unified Budget, Results and Accountability Framework (UBRAF), setting total funding of US$485 million. WFP's good results in implementing activities in the previous biennium made it one of the few co-sponsors to receive a 15 percent increase[14] in its allocations from the UBRAF for the 2012–2013 biennium.

15. As one of the 11 official co-sponsors of the Joint United Nations Programme on HIV/AIDS (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 is mandated to convene other co-sponsors on food and nutrition issues. WFP's main role is to ensure that food and nutrition are integrated into packages of care, treatment and support for PLHIV and TB patients at the country level, in line with WFP's approved policy.

[13] "Poor nutrition exacerbates the impact of HIV on the immune system and compromises its ability to respond to opportunistic infections and diseases, and HIV treatment, including anti-retroviral treatment, should be complemented with adequate food and nutrition." United Nations resolution 65/277: Political Declaration on HIV/AIDS: Intensifying Our Efforts to Eliminate HIV/AIDS (8 July 2011).

[14] From US$8.5 million for the 2010–2011 Unified Budget and Workplan to US$9.8 million for 2012–2013.

16. The 2012–2015 UBRAF places greater emphasis on country-level impacts, aiming to enhance country-level HIV responses. The 2010 HIV policy prepared WFP for this focus as it stresses the need for WFP to embed its activities in broader country-led responses while cooperating with its main UNAIDS partners in food and nutrition related to HIV and TB response.

17. The UBRAF allocates contributions from co-sponsors and the UNAIDS Secretariat to achieve the goals set out in the UNAIDS 2011–2015 strategy. It covers four areas: i) revolutionizing HIV prevention; ii) catalysing the next phase of treatment; iii) advancing human rights and gender equality; and iv) supporting delivery of the strategic direction. These areas are subdivided into the ten UNAIDS strategic goals. WFP contributes to many of the goals, in line with its comparative advantages, and has both joint and individual deliverables under some of them. The following section summarizes some of WFP's work in relation to UNAIDS Strategic Goals and the UBRAF.

UNAIDS STRATEGY GOAL: UNIVERSAL ACCESS TO ART FOR PLHIV WHO ARE ELIGIBLE FOR TREATMENT

18. In the UNAIDS Division of Labour, WHO is the convening agency for ART and TB treatment. WFP works with WHO and other partners to ensure that food and nutrition support is integrated into HIV treatment and TB programmes.

19. Improving the efficiency and effectiveness of treatment is central to the long-term success of the HIV response. The Treatment 2.0 Framework[15] aims to accelerate the scale-up of treatment and to improve health outcomes by optimizing drug regimens, providing point-of-care and other simplified diagnostic and monitoring tools, reducing treatment costs, adapting service delivery models through decentralization and integration, and mobilizing communities to support the accessibility, uptake and success of treatment. WFP works with governments and other partners to ensure that treatment is accompanied by assessments of nutritional status; education and counselling on nutrition, for maintaining body weight and overall health while mitigating side-effects; and, where necessary, the provision of nutritious food to treat malnutrition. A household ration can complement this support from time to time, helping the household to cope with the often high costs of care in the initial phase of treatment and making adherence to treatment, and retention in care more likely.

20. To maximize synergies and partnerships, the UBRAF asks co-sponsors to prioritize their interventions and concentrate their investments in 38 high-priority countries, which together account for 70 percent of the overall disease burden. WFP is currently providing governments with support for the implementation of HIV and TB programmes in 20 of these countries.[16]

[15] UNAIDS/WHO. 2011. *The Treatment 2.0 Framework for Action: Catalysing the Next Phase of Treatment, Care and Support*. Geneva.

[16] Burundi, Cambodia, Central African Republic, Côte d'Ivoire, Democratic Republic of the Congo (DRC), Djibouti, Ethiopia, Ghana, Haiti, Kenya, Lesotho, Malawi, Mozambique, Myanmar, Rwanda, South Sudan, Swaziland, United Republic of Tanzania, Zambia and Zimbabwe. WFP also implements HIV and TB programmes in Afghanistan, Bolivia (Plurinational State of), Burkina Faso, Congo, Guinea, Guinea-Bissau, Honduras, Liberia, Madagascar, Nepal, Sierra Leone, Somalia and Tajikistan.

UNAIDS STRATEGY GOAL: TB DEATHS AMONG PLHIV REDUCED BY HALF

21. TB is a chronic and debilitating disease requiring at least six months of treatment, and much longer for multi- or extensively drug-resistant TB. It is often accompanied by weight loss, so the food and nutrition services provided to PLHIV are also beneficial in supporting the adherence to treatment, and recovery of TB patients.

22. WFP ensured that food and nutrition support in conjunction with TB directly observed treatment, short-course (DOTS) was included in the GFATM Round 10 TB proposals of Djibouti, Lao People's Democratic Republic, Swaziland and Tajikistan; the Djibouti and Swaziland proposals have been approved, and WFP is a GFATM sub-recipient for implementation of food and nutrition activities in the health sectors of both countries.

23. Another important aspect of WFP's new policy and the UNAIDS strategy is addressing TB where HIV and TB epidemics converge. Providing food and nutrition services to PLHIV on ART and TB patients can help integrate both programmes. Services are being integrated in Ghana, Guinea, Malawi and Sierra Leone, where food assistance for TB patients is aligned with the national food-by-prescription approach applied at most ART sites.

UNAIDS STRATEGY GOAL: VERTICAL TRANSMISSION OF HIV ELIMINATED AND AIDS-RELATED MATERNAL MORTALITY REDUCED BY HALF

24. Women and girls are a priority for WFP, as women play a central role in guaranteeing food security for their households. Women are the primary caregivers and produce, purchase and prepare food for the household.

25. A recent review by WFP, due for publication later in 2013, confirmed that food insecurity and hunger are frequently cited as hindering access to health services and can act as an economic barrier that prevents women from seeking PMTCT services. Providing food along the PMTCT continuum facilitates women's access to PMTCT services and the so-called PMTCT cascade, contributing to the elimination of MTCT and improving adherence to treatment and retention in care for both women and their HIV-exposed children.[17]

26. PMTCT programmes are best integrated into mother-and-child health and nutrition services. This prevents HIV transmission and improves health outcomes by ensuring that mothers and infants have access to growth monitoring, vaccinations, micronutrient supplementation, nutrition assessment, education and counselling, and complementary foods. The provision of comprehensive services that include 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 its curative nutrition programmes. However this makes it harder for WFP to count PMTCT beneficiaries. Curative nutrition programmes were already related to the prevention and treatment of moderate acute malnutrition, but with less focus on antenatal care. In addition to PMTCT programmes in DRC, Ethiopia, Lesotho, Swaziland, the United Republic of Tanzania and Zimbabwe,

[17] Micheal O'hIarlaithe, Nils Grede, Saskia de Pee, Martin Bloem. *Economic and Social Factors are some of the most Common Barriers Preventing Women from Accessing Maternal and Newborn Child Health (MNCH) and Prevention of Mother-to-Child Transmission (PMTCT) Services – a Literature Review.* To be published.

WFP reaches HIV-positive women and their HIV-exposed infants with food and nutrition support through curative nutrition programmes in 59 other countries, of which 27 are UNAIDS high-impact countries.[18]

27. For example, in Ethiopia, 2,000 pregnant and lactating women (PLW) received food transfers in exchange for utilizing PMTCT services. In-kind food support was converted to voucher support, allowing beneficiaries to improve the food basket by including fresh vegetables, eggs and milk. In 2012, 97 percent of the babies of mothers on food assistance tested HIV-negative.

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

28. The 2011 Political Declaration on HIV/AIDS[19] pledges to use the momentum from the HIV response to strengthen health and community systems and to integrate HIV into health and development efforts and – particularly – social protection programmes. In line with its policy and the UNAIDS Division of Labour, WFP works with the United Nations Children's Fund (UNICEF), the World Bank and the International Labour Organization (ILO) to enhance social protection for PLHIV and people affected by HIV. The broad definition of social protection adopted by UNAIDS suggests that all the beneficiaries of WFP HIV-specific and HIV-sensitive programmes could be included in this category. Thus, all 2.8 million of the beneficiaries currently receiving WFP support could be classified as receiving social protection.[20]

29. Transfers of food, cash or vouchers, combined with community-based care, facilitate access to services and adherence to treatment. Social protection has a clear role in improving the HIV response. Collaboration between HIV and social protection experts must be fostered to ensure that expanding social protections systems cater to the needs of PLHIV.

30. WFP is exploring ways of integrating the provision of food and nutrition services into health sector-based care and treatment programmes, through cash or voucher schemes operating at the community level. Under this approach, the health sector determines the eligibility for food support of PLHIV and, possibly, their household members, and WFP provides support through cash or vouchers that can be redeemed for specific foods at a store or outlet in the community. This system limits the burden on the health care system and brings services closer to clients. In Zimbabwe, commodity vouchers for obtaining food from selected retail outlets in Harare, Bulawayo and Gweru are given to clients or their designated household members at voucher distribution points at selected health institutions. Vouchers are redeemable at selected local retail outlets where beneficiaries can obtain corn-soya blend, pulses and vegetable oil and a contribution of US$5 to purchase other food staples. This solution ensures beneficiaries' access to nutritious food,

[18] Burundi, Cambodia, Cameroon, Central African Republic, Côte d'Ivoire, Djibouti, DRC, Ethiopia, Ghana, Guatemala, Haiti, India, Indonesia, Kenya, Lesotho, Malawi, Mozambique, Myanmar, Namibia, the Niger, Rwanda, the Sudan, Swaziland, Uganda, the United Republic of Tanzania, Zambia and Zimbabwe.

[19] United Nations. 65/277 *Political Declaration on HIV/AIDS: Intensifying our Efforts to Eliminate HIV/AIDS Progress.*

[20] Social protection definitions can be obtained at:
http://www.unaids.org/en/media/unaids/contentassets/documents/priorities/JC1992_SocialProtection_en.pdf

while relying on local markets for food supplies. It thus reduces the need for the health sector to receive, store and distribute food and allows beneficiaries to pick up their rations closer to their place of residence and at a time of their choosing, while protecting their privacy. It is expected that more and more countries will switch to such mixed models in the future.

31. During 2012, several country offices invested time and resources in improving WFP's understanding of how to strengthen the livelihoods of PLHIV who have recently recovered from malnutrition. As many PLHIV were already poor and food-insecure before contracting HIV, they are at risk of relapsing into malnutrition after exiting from food assistance if they are unable to generate sufficient income for themselves and their households. WFP Swaziland, for example, is exploring ways of linking graduates of its food-by-prescription programme to livelihood activities, to help them overcome poverty and find a sustainable source of income. WFP Swaziland collaborates with local non-governmental organizations (NGOs) and the University of Swaziland, with which it has submitted a related research proposal to PEPFAR.

32. Building on a renewed partnership with PEPFAR in Ethiopia – with multi-year funding of US$56 million and plans to reach 89,000 beneficiaries in the first year – WFP interventions are tackling malnutrition among PLHIV, promoting ART and PMTCT uptake, addressing food insecurity and providing economic strengthening activities. For example, 6,600 PLHIV graduating from nutrition assistance were co-opted into economic strengthening initiatives to rebuild their livelihoods. Market and value chain assessments were conducted, and beneficiaries with suitable potential formed a village savings group, through which they received training in financial management, business planning and other technical skills. In partnership with a national programme for orphans and other vulnerable children (OVC), 63,000 children were assisted with food vouchers to enable them to attend school. The programme has met with considerable success: 95 percent of the OVC have enrolled in school and their attendance rate is 98 percent.

33. WFP is a GFATM sub-recipient in Swaziland, where it provides food assistance through neighbourhood care points to 52,000 children attending early-childhood care and development services. Swaziland has the world's highest HIV prevalence and an estimated 250,000 children will be single or double orphans by 2015. Unsurprisingly, the country also has high and stagnant rates of stunting. Reaching vulnerable preschool children, including many orphans, can make an important contribution to ensuring that they grow up to lead healthy and productive lives.

UNAIDS STRATEGY GOAL: REDUCE THE SEXUAL TRANSMISSION OF HIV

34. The World Bank and the United Nations Population Fund (UNFPA) are the UNAIDS co-conveners for efforts to reduce the sexual transmission of HIV. Given the shift towards nutrition in scaled-up treatment, and the role of treatment in prevention, the focus of WFP's activities has changed: prevention strategies are no longer the principal objective, except for in its prevention-focused work in the transport sector.

35. Mobile populations such as transport workers involved in WFP operations are particularly vulnerable to HIV and sexually transmitted infections: they are more likely to interact with sex workers and have multiple sex partners; and, given their mobile lifestyle, they have limited access to health services.

36. North Star Alliance, which was founded jointly by WFP and TNT in partnership with other organizations, continued to receive financial support from WFP in 2012, as well as funds from a Southern Africa Development Community (SADC) GFATM grant, designed to address HIV at 30 cross-border locations throughout southern Africa. This support enabled North Star Alliance to expand its roadside wellness centres, extending health services to tens of thousands of sex workers and people in the transport industry in DRC, Kenya, Malawi, Namibia, South Africa, Swaziland, Uganda, the United Republic of Tanzania, Zambia and Zimbabwe.

37. Programmes that address food insecurity and poverty through school feeding, food-for-assets activities or livelihood support also contribute indirectly to preventing HIV transmission, for example by delaying the onset of sexual activity among school-age girls and by minimizing negative coping behaviours such as transactional sex.

WFP'S HIV AND TB WORK IN 2012 IN NUMBERS

38. In 2012, WFP assisted 2.8 million PLHIV, TB patients and people affected by either condition in 33 countries, with nutrition rehabilitation and/or mitigation and safety net activities. Table 1 shows the breakdown of beneficiaries by condition and principal programme objective.

TABLE 1: BENEFICIARY NUMBERS, BY HIV AND TB PROGRAMME CATEGORY, 2012*

Total – 1 565 000	
Objective 1: Ensure nutritional recovery and treatment success through nutrition rehabilitation – care and treatment	HIV-specific 924 000 total - 818 000 ART and PMTCT clients and their households - 106 000 TB-DOTS clients and their households
Objective 2: Mitigate the effects of HIV on affected individuals and households through sustainable safety nets – mitigation and safety nets	HIV-specific 641 000 total - 126 000 ART clients and their households - 261 000 OVC beneficiaries - 254 000 TB clients and their households

* Total numbers of PLHIV enrolled in treatment programmes, TB patients receiving WFP nutrition or food support, and household members supported in 2012. WFP 2012. Source: WFP. 2013. 2012 SPR Analysis: HIV and TB Programmes. Nutrition and HIV/AIDS Unit. Rome.

39. In addition, WFP reached an estimated 1.2 million PLHIV through its broader, HIV-sensitive programmes such as school feeding and broader curative nutrition programmes. These numbers are only estimates because WFP does not – and should not – keep records of the HIV status of beneficiaries in its broader safety net programmes; the estimates are based on the HIV prevalence rates in some of WFP's main areas of operation.

40. A 2011 gap analysis documents country offices' progress in implementing the 2010 HIV policy.[21] The report concludes that most programmes are well aligned or fast aligning with the two principal programme objectives of the policy: care and treatment, and mitigation and safety nets. It commends WFP's focus on building national counterpart capacity for improved sustainability, while noting that some programmes are also creating successful linkages to income-generating activities. The transition may have been slower in countries where WFP found significant barriers to the incorporation of nutritional assistance into treatment response. Joining UNAIDS, strengthening the evidence base and achieving global recognition for the importance of food and nutrition for PLHIV were all instrumental in accelerating the shift towards care and treatment activities.

41. As food assistance in WFP's HIV and TB programmes is now for specific periods, and is usually tied to strict, often anthropometric, entry and exit criteria, the total number of beneficiaries in these programmes is declining, in line with expectations.

42. Given the difficult funding environment, country offices such as those in Cambodia, the United Republic of Tanzania and Zambia have exited their HIV-specific work altogether or have transitioned to activities for strengthening governments' capacity to implement food and nutrition programmes in line with national policies. Although funding constraints reduced beneficiary numbers from 581,000 in 2011 to 408,000 in 2012, Zimbabwe still has WFP's single largest HIV programme. Haiti, Malawi and Mozambique have also seen decreases in beneficiary numbers, while numbers increased in Côte d'Ivoire, Lesotho and Madagascar in 2012. Several country offices – including Benin, Côte d'Ivoire, Djibouti, Liberia and Swaziland have successfully integrated food and nutrition into GFATM proposals, thereby ensuring funding for future programmes.

REINVIGORATING PARTNERSHIPS AND STRENGTHENING THE EVIDENCE BASE

43. In July 2012, at the 19th International AIDS Conference in Washington DC, WFP highlighted the need to integrate food and nutrition into HIV programming, and sponsored a joint panel on food, nutrition and HIV with Partners in Health and the Harvard Medical School. WFP's Ethiopia Country Office presented two related research documents.

44. WFP took advantage of the presence of many technical experts and partners at the conference to hold a one-day round table, which was attended by about 40 professionals from the United Nations, academia and civil society. One outcome of the round table was the establishment of an Inter-agency Task Team (IATT) for HIV and nutrition. Led by WFP, the IATT aims to enhance collaboration among researchers, policy-makers and programme implementers in the field of HIV and nutrition. Quarterly follow-up conference calls have been hosted, and three sub-working groups have been set up: resource mobilization and advocacy, research, and programmes.

45. WFP also co-chairs the IATT for HIV in humanitarian contexts and took part in the discussions of several other IATTs, for example for PMTCT and social protection.

[21] WFP Programme Design Service Nutrition and HIV & AIDS. 2012. *WFP HIV & TB Policy Implementation: 2011 Gap Analysis for Programme Strengthening.* Rome.

46. WFP increased its efforts to strengthen the evidence base. In an era in which many donors face funding constraints, evidence on the cost-effectiveness of interventions is critical in ensuring that money is invested to achieve good results. For example, a long-term research partnership between WFP and the University of California in San Francisco is expected to lead to the publication of four co-authored articles over the 2012–2014 period.

47. In 2012, WFP initiated a research project designed to improve understanding of the food preferences of malnourished adult PLHIV in different cultural settings. The goal is to identify the products, textures and flavours that are preferred by malnourished adults in the early stages of treatment in Asia and Africa. This will lead to the development of new and more suitable products for treating malnutrition among adult PLHIV on ART or TB treatment. Initial research is being carried out with Wageningen University, the Thai Red Cross and Project Peanut Butter in Malawi, with some private-sector support.

48. In 2012, a long-standing tripartite partnership involving the Thai Red Cross AIDS Research Centre, Australia's Albion Street Centre and WFP led to the foundation of the Asia Pacific Collaborating Centre on HIV Nutrition. The centre will train health professionals in the Asia-Pacific Region in HIV and nutrition; support research; advocate with policy-makers on the need to integrate food and nutrition into HIV responses; and support selected WFP country offices and governments in their attempts to integrate food and nutrition into GFATM proposals. A first training session with more than 20 participants from four countries was held in the first quarter of 2012, and a second in January 2013.

OUTLOOK FOR 2013

49. The year 2013 will be crucial for WFP as it completes the fit-for-purpose realignment exercise designed to make the organization more effective and efficient, and also finalizes the new Strategic Plan for 2014–2017.

50. In line with global trends in taking HIV out of isolation, there is likely to be increasing convergence of WFP's HIV- and TB-related work with its nutrition programmes, as both are delivered through the health sector with the Ministry of Health as the principal counterpart. This evolution is already obvious in the case of PMTCT clients, who are included increasingly in WFP's general curative nutrition programmes. It will be critical to ensure that integration does not mean a loss of services tailored to the needs of HIV-positive PLW, especially during the antenatal period. Convergence is expected to enhance the mainstreaming of HIV and TB into new UNAIDS Strategic Plan, placing HIV and TB under the health sector rather than leaving them as a stand-alone programmatic area.

51. WFP's HIV and TB activities have always had a strong focus on food assistance, not as an end in itself, but rather to enable broader health outcomes such as nutritional recovery, retention in care and treatment success. WFP's work in HIV and TB has been designed and implemented though standard government processes earlier and more consistently than its work in other programme areas.

52. WFP is therefore expected to focus increasingly on supporting government efforts to run food and nutrition programmes within the health sector while linking them to community-based initiatives. To make sure that the additional burden of work does not disrupt the health system's ability to deliver health services, it will be critical to find a more optimal link between health and food systems than the simple provision of food to clinics. Several WFP programmes are already developing such links through the use of vouchers or combined distribution models. Some WFP country offices are breaking new ground in connecting PLHIV who have recovered from malnutrition to safety nets linked to livelihood activities, to consolidate health gains. Such activities aim to create a virtuous cycle in which PLHIV in good health return to productivity, ensuring food and nutrition security for themselves and their households, and positive impacts on retention in care and treatment success.

53. As international resources decline, WFP will have a crucial role in facilitating governments' access to catalytic and strategic funding for integrating food and nutrition into health systems without overburdening existing programmes. For example, innovative technologies such as the use of mobile phone vouchers to deliver food can be used in national health initiatives. Linkages can be made to community-based work and to investments in related activities designed to deliver measurable results.

ACRONYMS USED IN THE DOCUMENT

ART	anti-retroviral therapy
DOTS	directly observed treatment, short-course
DRC	Democratic Republic of the Congo
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
IATT	Inter-Agency Task Team
MTCT	mother-to-child transmission
NGO	non-governmental organization
OVC	orphans and other vulnerable children
PCB	Programme Coordinating Board
PEPFAR	United States President's Emergency Plan for AIDS Relief
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
UNICEF	United Nations Children's Fund
WHO	World Health Organization