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## **POLICY ISSUES**

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## **GLOBAL CHALLENGE, NATIONAL RESPONSE: WFP'S SUPPORT TO NATIONAL AIDS PROGRAMMES**

**Annual Update on WFP's Response to  
HIV and AIDS**

\* In accordance with the Executive Board's decisions on governance, approved at the Annual and Third Regular Sessions, 2000, items for information should not be discussed unless a Board member specifically requests it, well in advance of the meeting, and the Chair accepts the request on the grounds that it is a proper use of the Board's time.

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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.

Director, OEDP\*: Mr D. Stevenson tel.: 066513-2325

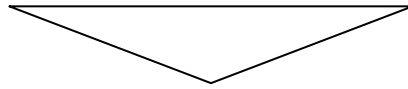
Chief, HIV/AIDS and Nutrition Policy: Mr M. Bloem tel.: 066513-2565

Should you have any questions regarding matters of dispatch of documentation for the Executive Board, please contact Ms C. Panlilio, Administrative Assistant, Conference Servicing Unit (tel.: 066513-2645).

\* Policy, Planning and Strategy Division



## DRAFT DECISION\*



The Board takes note of “Global Challenge, National Response: WFP’s Support to National AIDS Programmes – Annual Update on WFP’s Response to HIV and AIDS” (WFP/EB.2/2008/4-D).

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\* This is a draft decision. For the final decision adopted by the Board, please refer to the Decisions and Recommendations document (WFP/EB.2/2008/15) issued at the end of the session.



“Halting and reversing the spread of AIDS is not only a [Millennium Development] Goal in itself; it is a prerequisite for reaching almost all the others. How we fare in fighting AIDS will impact all our efforts to cut poverty and improve nutrition, reduce child mortality and improve maternal health, and curb the spread of malaria and tuberculosis. Conversely, progress towards the other Goals is critical to progress on AIDS – from education to the empowerment of women and girls.”

*United Nations Secretary-General Mr Ban Ki-moon, speaking at the General Assembly High-Level Meeting on AIDS in New York, June 2008.*

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## BACKGROUND

1. The Joint United Nations Programme on HIV and AIDS (UNAIDS) 2008 *Report on the global AIDS epidemic* reflects significant gains in preventing new HIV infections in many countries, and shows that combined efforts by governments, donors and communities can make a difference.
2. The rate of new HIV infections has fallen in several countries, but the trend is offset by increases in others. AIDS continues to be the leading cause of death in Africa, which is home to 67 percent of people living with HIV (PLHIV), of whom 60 percent are women; 75 percent of young PLHIV are women.
3. The drivers of the epidemic are different in different regions, so national responses need be informed by evidence and compatible with AIDS response plans. “Know Your Epidemic” is at the heart of effective national AIDS responses.
4. At the United Nations General Assembly 2008 High-Level Meeting on AIDS, States Members noted that poverty, hunger and food price increases affected the targeting of high-risk AIDS-affected populations. The Secretary-General highlighted improved nutrition as a means of reversing the negative impact of AIDS and achieving the Millennium Development Goals by 2015.
5. The report of the Secretary-General’s High-Level Panel on United Nations System-Wide Coherence recommends establishing “One UN” at the country level. The experience of UNAIDS will inform the next steps in United Nations reform. The Global Task Team, the consultations on “universal access” and joint United Nations AIDS programmes and teams are elements of WFP’s work with partners in support of national priorities and capacity development.

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## UPDATE ON THE AIDS EPIDEMIC

6. An estimated 33 million people live with HIV worldwide; there were 2.7 million new infections in 2007. The need for effective HIV prevention is increasingly obvious: for every two people who start anti-retroviral therapy (ART), five become infected.
7. At the end of 2007, 3 million people were receiving ART in low-income and middle-income countries, 950,000 more than at the end of 2006 and a 7.5-fold increase



during the past four years.<sup>1</sup> The greatest increase – 54 percent – was in sub-Saharan Africa. In most parts of the world, more women are receiving ART than men.

8. Despite progress, ART coverage remains low: 31 percent of the 9.7 million people in need were receiving ART in 2007. The epidemic is surpassing the rate at which the drugs are delivered.

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## UNAIDS AND WFP

9. WFP's nutritional response for PLHIV and their families is a matter of urgency: high food prices are jeopardizing the food security and nutritional status of the most vulnerable people, and treatment roll-out in countries with high rates of food insecurity leads to greater demand for food support.
10. WFP's lead role in dietary and nutritional support in the UNAIDS Division of Labour (DoL) will involve continued leadership in the delivery of food assistance and nutritional support and in enhancing national actions through advocacy, guidance and technical support.
11. The 2006–2007 unified budget and workplan prepared by WFP and UNAIDS outlined the response to the AIDS epidemic of the ten UNAIDS cosponsors and the UNAIDS secretariat. It includes strategic objectives, expected outcomes, activities and a budget. The 2006–2007 budget and workplan covered a period of major transition in the global HIV response.
12. WFP was responsible for three key results in 2006–2007:
  - i) Increased awareness of the role of food and nutrition in HIV, AIDS and tuberculosis (TB) programmes, with a special focus on reaching children and vulnerable groups.
    - WFP supported national actions on HIV and nutrition with advocacy, guidance and technical assistance. Beneficiary profiling and vulnerability analyses increased understanding of the impact of HIV on nutritional outcomes for children in Africa. HIV was integrated into vulnerability analysis and mapping (VAM) tools; field studies looked at the impact of nutritional supplementation on adherence to treatment and medical outcomes. At the end of 2007, 38 national HIV plans included food and nutrition components, an increase from 32 in 2005. The number of non-governmental organizations (NGOs) and international bodies that included food and nutrition in their HIV programmes rose from 440 in 2005 to 546 in 2007.
  - ii) Increased resources for food and nutrition components of HIV programmes.
    - WFP supported care and treatment, mitigation and prevention interventions for 1.8 million beneficiaries in 2007. In southern Africa, the number of countries receiving WFP technical support rose to nine, from two in 2005. Results of a costing exercise for food and nutritional support in HIV programmes were disseminated to WFP country offices and UNAIDS cosponsors. WFP continued partnerships with the private sector to expand access by transport employees to

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<sup>1</sup> WHO, UNAIDS and UNICEF. 2008. Towards Universal Access: Scaling up priority HIV/AIDS interventions in the health sector. Progress Report 2008. Geneva. Available at: [http://www.who.int/hiv/pub/towards\\_universal\\_access\\_report\\_2008.pdf](http://www.who.int/hiv/pub/towards_universal_access_report_2008.pdf)



HIV prevention and treatment, providing technical capacity for 41 countries to address nutritional components in scaling up to universal access.

- iii) Increased food and nutrition programming in global, regional and national responses to HIV.
- By the end of 2008, WFP was supporting HIV prevention, treatment and care in 20 of the 25 countries with the highest HIV prevalence. It had programmes related to HIV or TB in 50 countries in Africa, Asia and Latin America. Six staff were recruited to enable regional bureaux to improve the implementation and effectiveness of HIV programming. WFP increased technical support in programme design and development, implementation, and monitoring and evaluation (M&E), including the following:
    - ◊ The Regional Bureau Panama City (OMP) developed a guidance note on HIV and nutrition advocacy and a blueprint for national protocols on HIV and nutrition to be adapted at the country level. WFP's leadership in HIV and nutrition was reflected in inter-agency workplans and United Nations Development Assistance Frameworks (UNDAFs) in Barbados, Bolivia, Colombia, Ecuador, El Salvador, Guatemala and Panama.
    - ◊ In Malawi, Zimbabwe and other countries, WFP integrated gender issues into food and nutrition work related to HIV care and treatment. WFP and its partners supported a nutritional intervention in ART packages in, among other countries, Benin, Burundi and Mali.

## Resource Constraints and External Funding

13. Nutrition and food security are critical components of care and support for PLHIV,<sup>2</sup> but inadequate funding for WFP's HIV programmes continues to constrain its ability to provide nutritional support for people on HIV treatment, orphans and other children affected by HIV and AIDS, and their families. HIV programmes in the Regional Bureau Bangkok (OMB) and the Regional Bureau Johannesburg (OMJ) have been particularly affected.
14. To overcome resource constraints, WFP has worked to get food and nutrition included in global funding streams. At the country level, bilateral funding through the United States President's Emergency Plan for AIDS Relief (PEPFAR) and multilateral funding through the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) are new opportunities for expanding food support for HIV programmes. This has not been easy, but outreach and technical support for national AIDS commissions have begun to yield results.

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## PRESIDENT'S EMERGENCY PLAN FOR AIDS RELIEF

15. PEPFAR was initiated in 2003 as a United States foreign assistance programme providing US\$3 billion in annual funding, focusing on 15 of the most AIDS-impacted countries in Africa and Asia. In July 2008, a US\$48 billion commitment was authorized for the next five years to expand the response to AIDS.
16. Since 2006, food assistance and nutritional support have been covered in PEPFAR policy guidance and are therefore included in care and treatment programmes. In 4 of the

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<sup>2</sup> UNAIDS. 2008. HIV, Food Security and Nutrition Policy Brief. Available at: [http://data.unaids.org/pub/Manual/2008/jc1515a\\_policybrief\\_nutrition\\_en.pdf](http://data.unaids.org/pub/Manual/2008/jc1515a_policybrief_nutrition_en.pdf)



15 focus countries, WFP is working with PEPFAR to implement food and nutritional assistance for PLHIV and children affected by HIV and AIDS and is helping to build capacity in national institutions.<sup>3</sup>

### **Global Fund to Fight AIDS, Tuberculosis and Malaria**

17. In the last year, some WFP country offices have participated in submitting proposals to the Global Fund. The process is driven by governments through the Country Coordination Mechanism with involvement of stakeholders such as United Nations agencies and NGOs.
18. Global Fund proposals must be consistent with national HIV strategies; interventions must be informed by evidence. Country offices work with ministries of health and national AIDS councils to advocate for the integration of nutritional support for PLHIV into policy documents – but this does not always result in the inclusion of food assistance in Global Fund proposals nor is WFP always identified as a recipient of resources from the Fund. To date, WFP has been assisting in the implementation of the food and nutrition components of the grant. WFP is working with national governments and the Global Fund to Fight AIDS, Tuberculosis and Malaria in Burkina Faso, the Democratic Republic of the Congo, Ethiopia and Guinea.

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## **WFP SUPPORT FOR NATIONAL HIV STRATEGIES**

### **HIV and Tuberculosis Treatment Programmes**

19. WFP was one of the first agencies to provide food to expand access to ART in resource-poor settings. WFP supported ART programmes in 16 African countries, providing food support for 332,000 beneficiaries during the critical early stages of treatment.<sup>4</sup>
20. In Rwanda, for example, WFP has been collaborating with Partners in Health since November 2006 at six pilot sites. In 2007, 6,000 ART patients received dietary support in a care and treatment package; the project is scaling up to an additional 56 sites in the most food-insecure areas and plans to reach an additional 3,500 beneficiaries in 2008.
21. In India, WFP developed nutritional guidelines and counselling materials for PLHIV as part of technical assistance and capacity-building on nutrition and HIV for the National AIDS Control Organization (NACO), with support from OMB, and disseminated them to all ART centres in India. NACO plans to use the materials in counselling and testing centres.
22. In 17 countries, WFP provided food to help TB patients to complete treatment. In Burkina Faso, WFP and its partners provided 4,000 beneficiaries at 81 centres with monthly rations for the eight months of treatment in a programme implemented for the Government, supported by a grant from the Global Fund. A survey showed that food increased adherence and cure rates but had little impact on nutritional status; it indicated that individual rations may not be sufficient where food insecurity is widespread and rations are shared among family members.

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<sup>3</sup> Côte d'Ivoire, US\$500,000; Ethiopia, US\$22 million from 2007 to 2009; Mozambique, US\$2.1million; Rwanda, US\$715,000.

<sup>4</sup> WFP. 2008. WFP's Support to Anti-Retroviral Treatment Programmes. Rome.



## Home-Based and Household Food Support Programmes

23. WFP supports home-based care (HBC) programmes for chronically ill people and their families. Because HBC is one of the best ways to reach hungry people made vulnerable by HIV and AIDS, WFP expanded its support in 12 countries, reaching 828,000 people in 2007.<sup>5</sup> Such food support is generally intended to stabilize or improve the nutritional status of chronically ill patients or improve the food security of their households.
24. WFP worked with the Center for Global Health at George Washington University on a joint programme in Kenya and Uganda to address issues related to HIV, food security and nutrition. The programme was unique in that it involved local universities – Moi University in Kenya, and Makerere University and the Tropical Institute for Community Health in Uganda. It focused on improving impact in treatment and HBC programmes that included food support.
25. In Zimbabwe, food support was provided for HBC programmes in response to requests by WFP's partners Africare, the Cooperative for Assistance and Relief Everywhere (CARE), the Zimbabwe Red Cross and community-based organizations. WFP supported 30 HBC programmes implemented by these partners that have reached 300,000 people since 2003. To reduce the burden of care on women, Africare trained men as caregivers; villages in the project are now served by 40 caregivers in gender-balanced teams, who use bicycles to visit households scattered in rural areas.<sup>5</sup>

## HIV Prevention

26. Research identifies food insecurity as a risk in HIV infection.<sup>6</sup> By preventing food insecurity in areas of high HIV prevalence, WFP may help to prevent new infections. In Bangladesh, WFP worked with Family Health International in 2006 to develop an HIV awareness-raising module that has been used with NGOs to train 441,000 beneficiaries.

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## WFP AND "RESPONSIBLE TRANSPORT"

27. In the past year, WFP has improved its HIV prevention and health services for transport workers under its commitment to support "responsible transport". The wellness centre pilot project in Malawi, supported by WFP and TNT, has grown into an independent non-profit alliance called North Star Foundation (NSF) that includes UNAIDS and the International Transport Workers Federation as partners. Five NSF wellness centres are now operating – two in Malawi, one in Namibia, one in Swaziland and one in Zambia; two more in Zimbabwe will open in 2008. NSF will work with Family Health International to set up 23 wellness centres in eight east African countries over the next three years.
28. Country offices in Benin, Chad, the Democratic Republic of Congo, Ethiopia, The Gambia, Kenya and Niger have worked with United Nations and NGO partners to provide HIV training, improved access to health services and enhanced workplace HIV policies for transport workers.

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<sup>5</sup> WFP. 2008. WFP's Support to Home-Based Care (HBC) Programmes. Rome.

<sup>6</sup> Rollins, N. 2007. Food Insecurity – a Risk Factor for HIV Infection. *PLoS Med* 4(10): e301. Available at: <http://medicine.plosjournals.org/perlserv/?request=get-document&doi=10.1371/journal.pmed.0040301>.





## ORPHANS AND OTHER CHILDREN AFFECTED BY HIV AND AIDS

29. In 2007, WFP supported 1 million orphans and other vulnerable children (OVC) in 20 countries; this included innovative work to mainstream OVC activities into national strategies in Mozambique and coordination among donors to ensure that programmes in Ethiopia were comprehensive and integrated. In Uganda and Zambia, lack of resources led to scaling down of OVC activities. In Mozambique, the Ministry of Women and Social Action, supported by WFP, established provincial OVC food support committees to manage programmes that reached 43,000 children. The sustainability of OVC programmes was enhanced, and better reporting and accountability systems were developed.
30. OVC assistance in Ethiopia was extended to 11 additional towns, covering 38,000 beneficiaries: OVC and their host families received WFP rations, educational materials from the Global Fund and income-generating support from the World Bank. This holistic programming was achieved because WFP created links between local authorities responsible for the HIV response and partners funding HIV activities.
31. A 2007 study by the Institute of Development Studies on the impact of take-home rations funded by WFP and the United Nations Children's Fund (UNICEF) reaffirmed the positive role of rations in keeping OVC in family settings, alleviating short-term hunger and ensuring access to education. The study noted that beneficiary targeting must be based on degree of vulnerability in addition to socio-demographic indicators.

## HIGH FOOD PRICES AND THE IMPACT ON PEOPLE LIVING WITH HIV

32. High food prices make it difficult for households to consume diets of adequate quality and quantity. Households that were food-insecure before prices increased may have to choose cheaper staples, consume less oil and sugar, and reduce the size and number of meals. Households that were not food-insecure will buy fewer nutritious foods. Many people will therefore consume sub-optimal diets or have smaller or fewer meals. These changes have severe consequences for the health of PLHIV, people with TB, young children – especially those under 2 – and pregnant and lactating women.
33. Energy prices have also increased. Real income among poor households is reported to have fallen by as much as 25 percent and they therefore have to reduce food choices and amounts, and choose between expenditures on food, healthcare, transport or education.
34. These impacts are particularly severe among food-insecure households affected by HIV. Recent assessments caution that it is difficult to disaggregate or directly attribute the impact of high food prices because such households are already vulnerable. HIV staff in the Programme Design and Support Division (OMX) and the Policy, Planning and Strategy Division (OEDP) are using VAM to make sure that HIV concerns are taken into consideration.
35. Evidence from assessments and case studies in May–July 2008 in Burkina Faso, Kenya, Malawi and Swaziland show the following:
  - PLHIV receiving treatment and other vulnerable groups find that high transport costs constrain travel to health facilities, jeopardizing adherence to treatment. People needing frequent access to health services have to choose between buying food or obtaining healthcare, as reported in Malawi and Swaziland.
  - The impact of high food prices is felt most among urban poor and food-deficit rural households that are net buyers. In Malawi, most such households are unable to



increase work in agriculture or paid employment because family members are PLHIV. NGOs and government departments dealing with PLHIV and children affected by HIV and AIDS have had to adjust budgets and activities, with impacts on programme coverage and quality.

## National Responses

36. Most of the countries assessed were expanding safety-net programmes to include food-insecure households affected by HIV. Countries with limited AIDS care and support such as Burkina Faso, Burundi and Côte d'Ivoire are prioritizing HIV responses in light of the high food prices and consequent increased vulnerability among AIDS-affected households.

## Monitoring and Evaluation

37. Last year, WFP continued to prepare the M&E toolkit for food-assisted HIV programmes. A review of indicators and data-collection tools showed that M&E of these programmes faces particular challenges compared with non-HIV food interventions: i) the objectives of food-assisted HIV activities are different from those of non-HIV interventions and require adaptation; ii) issues related to stigma and confidentiality, especially in low-prevalence settings, make M&E more difficult; iii) HIV involves greater reliance on health services, which are usually overstretched and have low capacity; and iv) HIV interventions include HBC, OVC, ART and TB support and food support for households affected by AIDS; these have different objectives, beneficiaries, rations and durations.
38. Country offices and partners continue to learn from experience in the design and implementation of M&E systems for food-assisted HIV activities. In Mozambique, for example, WFP developed an M&E toolkit for cooperating partners and an OVC vulnerability profiling model funded by PEPFAR. The objectives were to improve beneficiary targeting and to regularly measure the outcomes of OVC food assistance.
39. In Côte d'Ivoire, WFP set up an innovative M&E system that includes basic indicators, a computerized database and tools for collecting and analysing data. Regular surveys collect qualitative data and complement standard monitoring. To integrate these activities into the national programme, WFP has trained and supported an M&E officer in the Ministry of Health. These interventions have been partly funded by PEPFAR.
40. New corporate indicators recommended for the Strategic Plan (2008–2011) were based on project-level experience in the health sector, monitoring results and the latest scientific knowledge. It was agreed that weight gain and treatment adherence should not be used at the corporate level because data on these two indicators are difficult to collect and are subject to misinterpretation, especially when aggregated at the population and outcome levels. It was decided to limit the indicators to TB treatment success rates and OVC attendance and enrolment rates. The additional HIV indicators will be used at the project level in line with activities in particular countries and the objectives of food support.

## Examples of WFP's High-Profile Advocacy

41. On World AIDS Day 2007, WFP and the Comunità di Sant'Egidio, a Rome-based NGO that supports PLHIV in Africa, hosted a seminar in Rome to discuss "Political Will, Innovation and Solutions to Hunger and Health Challenges" and to launch two publications – WFP's 2007 World Hunger Series *Hunger and Health* and a case study from



Mozambique highlighting the HIV work of Sant'Egidio. Ms Elizabeth Mataka, the United Nations Secretary-General's Special Envoy for AIDS in Africa, was the guest speaker; panellists included Alain Economides, Director-General for Development Cooperation in the Italian Ministry of Foreign Affairs, Mr James Melanson, President of the WFP Executive Board and WFP Deputy Executive Directors Sheila Sisulu and John Powell.

42. The XVII<sup>th</sup> International Conference on AIDS was held in Mexico City on 8-13 August 2008; the 24,000 delegates represented all streams of AIDS research and response. WFP was instrumental in getting nutritional issues included in the programme. With the World Health Organization (WHO), UNAIDS, and the NGOs Partners in Health and the Academic Model for the Prevention and Treatment of HIV, WFP organized sessions on the importance of nutrition for PLHIV and TB patients. WFP launched an updated cost analysis that showed how good nutrition for people on HIV treatment can be achieved for 70 US cents per day. WFP, the International Organization for Migration (IOM), the International Labour Organization (ILO) and NSF organized a session chaired by Ms Mataka on HIV vulnerability along roads in Africa.
43. WFP, WHO and UNAIDS produced a policy brief on HIV, food security and nutrition that contains action points for governments, international partners and civil society, with best practice examples.<sup>2</sup>

### Costing Analysis

44. In 2007, WFP updated its cost analysis for food and nutritional support for HIV programmes. Food and delivery costs for ART, HBC, PMTCT and OVC programmes were calculated using data from 19 countries and 29 projects. Forecasts to 2015 were calculated with UNAIDS epidemiological data, taking into account higher fuel and food costs. The cost of providing food and nutrition for HIV programmes remains affordable.

### New Guidance Materials Produced at Headquarters

45. In response to requests from country offices for detailed guidance on HIV programming, the HIV/AIDS Service (PDPH) which is now known as the HIV/AIDS and Nutrition Policy Service, worked with partners and experts in the field to produce new manuals, which are being disseminated to the field:
- *Food Assistance Programming in the Context of HIV* was developed with the United States Agency for International Development (USAID) to fill a gap in guidance materials on food security, nutrition and HIV programming and improve the design and implementation of programmes addressing HIV and food security and nutrition. It contains policy and technical information and guidance for programme managers, emphasizing options and flexibility; it will be rolled out at meetings with stakeholders. A training-of-trainers model will be used at the regional level; end-users will be trained in countries where WFP or USAID Title II<sup>7</sup> partners operate.
  - *A Ration Design Guide* was developed to guide HIV focal points through a five-step process to standardize the design of rations for HIV programmes that takes into consideration the needs of beneficiaries and the specific context. It will be rolled out to regional bureaux and country offices by the end of 2008.

<sup>7</sup> USAID, through funding provided by Public Law 480, Title II, makes commodity donations to cooperating sponsors (private voluntary organizations, cooperatives, and international organization agencies) to address the needs of food security in both five-year development projects and emergency food assistance programmes.



- *Incorporating Nutrition and Food Assistance into HIV Care and Treatment Programmes*, a joint WFP/WHO publication, gives guidance on the benefits and challenges of incorporating food and nutritional support into ART programmes, summarizes scientific evidence on food, nutritional support and treatment outcomes and addresses operational issues. The purpose is to help governments to plan and implement food assistance programmes and guide national bodies, NGOs and WHO and WFP country staff.

### **Working with the Inter-Agency Standing Committee to address HIV in Humanitarian Settings**

46. In a humanitarian crisis, it is imperative to address HIV prevention, care and mitigation as early as possible through a multi-sectoral and integrated response. WFP provided technical support for national workshops on implementing the Inter-Agency Standing Committee (IASC) *Guidelines on HIV in Emergencies* in El Salvador, Honduras and Panama. As lead agency for dietary and nutritional support, WFP worked with the IASC Task Force on HIV in Humanitarian Settings to update the guidelines on delivery and scaling-up of HIV prevention and AIDS services for populations affected by crises, with the aim of minimizing HIV transmission and ensuring that PLHIV continue to receive treatment, care and support.
47. WFP remains part of the United Nations programme to scale up AIDS services for populations of humanitarian concern. WFP has been integrating HIV treatment and support with inter-agency emergency preparedness, response and recovery activities in Latin America, the Caribbean and Africa.

### **The Way Forward**

48. WFP can help advance the debate on and deepen understanding of the nutritional needs of PLHIV and their family members, working together with UNAIDS and advocating with major funding mechanisms such as PEPFAR and the Global Fund. WFP can help ensure that national and community-level HIV and AIDS programmes, especially treatment programmes, include gender-responsive nutritional components. WFP can also support and promote scientific studies that look at the efficacy of specially formulated food products for the nutritional needs of PLHIV.



## ACRONYMS USED IN THE DOCUMENT

AIDS	acquired immune deficiency syndrome
ART	anti-retroviral therapy
CARE	Cooperative for Assistance and Relief Everywhere
DoL	UNAIDS Division of Labour
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
HBC	home-based care
HIV	human immune deficiency virus
IASC	Inter-Agency Standing Committee
ILO	International Labour Organization
IOM	International Organization for Migration
M&E	monitoring and evaluation
NACO	National AIDS Control Organization (India)
NGO	non-governmental organization
NSF	North Star Foundation
OEDP	Policy, Planning and Strategy Division
OMB	Regional Bureau Bangkok (Asia)
OMJ	Regional Bureau Johannesburg (Southern, Eastern and Central Africa)
OMP	Regional Bureau Panama City (Latin America and the Caribbean)
OMX	Programme Design and Support Division
OVC	orphans and other vulnerable children
PDPH	HIV/AIDS Service
PEPFAR	United States President's Emergency Plan for AIDS Relief
PLHIV	people living with HIV
PMTCT	prevention of mother-to-child transmission
TB	tuberculosis
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNDAF	United Nations Development Assistance Framework
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VAM	vulnerability analysis and mapping
WHO	World Health Organization