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## **POLICY ISSUES**

### **Agenda item 4**

*For approval*



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## **PROGRAMMING IN THE ERA OF AIDS: WFP'S RESPONSE TO HIV/AIDS**

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# Note to the Executive Board



**This document is submitted for approval by the Executive Board.**

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

For poor households, HIV/AIDS represents one more often massive and irreversible shock that can seriously affect their ability to sustain their livelihoods and remain food secure. As impoverished families try to cope with HIV/AIDS morbidity and mortality, they become incrementally poorer after reducing their meager assets, sometimes to a crisis point that threatens to dissolve the family unit. Faced with significantly reduced income, fewer people available to work and an unrelenting need for food and medicine, family members may be forced to adopt high-risk behaviours (such as trading sex for food) just to survive. Improving a family's food security is a means of reducing their vulnerability to HIV infection. Indeed, food security can be seen as one more way to prevent the spread of AIDS, and reduce its impact.

Poor people who are affected by HIV/AIDS need both treatment *and* food. Little work, however, has been carried out on how food, and specifically food aid, can be best integrated into programmes designed to mitigate the impact of HIV/AIDS on poor households' food security. WFP is working with partners in HIV-affected countries to identify and carry out the most appropriate and effective interventions to address the needs of HIV/AIDS-affected households. This policy paper reflects what is known so far about HIV/AIDS and food security and describes the practical considerations thus far identified that are necessary for successful project implementation.

This paper reviews the relationship between food security and HIV/AIDS and identifies specific vulnerable groups. It also identifies specific programme areas where WFP has a significant role to play in supporting the food security of families and communities affected by AIDS. It is important to note that all activities will be designed following existing policies. This paper highlights some key programming areas where a different emphasis and modified approach are necessary to meet the emerging needs of food-insecure families and individuals deeply affected by the AIDS pandemic.

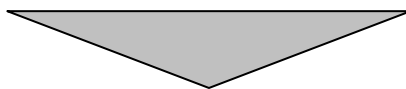
WFP's strategy must always concentrate on food insecurity brought on by HIV/AIDS, not on the disease itself. In areas of high food insecurity and high HIV prevalence, WFP food assistance can provide a safety net to catch families before they become destitute, and thus even more vulnerable to the risk of infection. AIDS is a long-term emergency that must be tackled both with the immediate needs of the most vulnerable in mind and with a longer-term recovery approach.

When associated with other inputs, food assistance in all WFP programming categories can:

- create opportunities for less risky livelihoods and strengthen household and community capacity to respond to HIV/AIDS' impact on food security through initiatives such as food for training and food for assets;
- improve and maintain human capital through nutrition programmes, food for training and school feeding;
- reduce the vulnerability of families to food insecurity and malnutrition through safety-net initiatives such as home-based care projects and mother-and-child health programmes, and initiatives targeted to child-headed households; and
- through partners, be used as a conduit for the dissemination of HIV/AIDS prevention messages and information.



## Draft Decision\*



The Board approves the policy for HIV/AIDS as put forward in the document WFP/EB.1/2003/4-B. The recommendations adopted are:

- a) WFP will incorporate HIV/AIDS concerns in all of its programming categories—Country Programmes, PRROs and EMOPs. Food insecurity driven by HIV/AIDS can be addressed directly through WFP programmes, and WFP activities can be used as platforms for other types of HIV/AIDS programmes, such as prevention education.
- b) WFP will work with local and international partners, NGOs, governments and United Nations agencies to ensure that food is incorporated into HIV activities when and where appropriate. WFP will work particularly closely with UNAIDS co-sponsors and the UNAIDS Secretariat in this regard.
- c) WFP will adjust programming tools such as needs assessments, vulnerability analysis, the design of rations and other nutrition-related activities as information and research results become available to reflect the new reality presented by HIV/AIDS.
- d) When HIV/AIDS threatens food security and influences mortality in ways similar to other disasters, WFP will consider HIV/AIDS as a basis for a PRRO, consistent with current WFP policy on PRROs.

In accordance with the decision 2002/EB.A/4, it asks that the Secretariat make the appropriate changes in the Consolidated Framework of WFP Policies: A Governance Tool (WFP/EB.A/2002/5-A/1).

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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 issued at the end of the session.



*“Some weeks ago, I was in Malawi and met with a group of women with HIV. As I always do when I meet with people living with AIDS, and other community groups, I asked them what is their highest priority. Their answer was clear and unanimous. Not care, not drugs for treatment, not stigma, but food.”*

*Peter Piot  
Nairobi, Kenya — 3 April 2001*

## INTRODUCTION

1. AIDS is causing a humanitarian catastrophe in much of the developing world. It is a challenge to traditional humanitarian paradigms and in many countries has already resulted in a severe crisis in development. In the next two decades, the AIDS pandemic will cause a decline in life expectancy in 51 countries, a demographic effect without precedent in modern times. Certain countries (such as Malawi, Swaziland, Zambia and Zimbabwe) have seen their populations' life expectancies fall to less than 40 years. In Southeast Asia, life expectancies in countries such as Thailand, Cambodia and Myanmar have lost between two and five years.<sup>1</sup> Previously at 59 years, life expectancy in Haiti is now at 51 years, owing to HIV/AIDS.<sup>2</sup>
2. Many sub-Saharan African countries have now declared HIV/AIDS to be a national disaster of epic proportions and, as declared in the Abuja Declaration,<sup>3</sup> the Heads of State of the Organization of African Unity (OAU) “consider AIDS as a State of Emergency in the continent”. The United Nations Secretary-General has made the HIV/AIDS crisis a top priority. As a follow-up to the United Nations Special Assembly Session on HIV/AIDS (UNGASS), and in line with the Millennium Development Goals (MDG) to halve and reverse the spread of HIV/AIDS by 2015, WFP is including HIV/AIDS concerns in all of its programming categories, when and where appropriate.
3. For poor households, HIV/AIDS represents one more often massive and irreversible shock that can seriously affect their ability to sustain their livelihoods and remain food secure. As impoverished families try to cope with HIV/AIDS morbidity and mortality, they become incrementally poorer after reducing their meager assets, sometimes to a crisis point that threatens to dissolve the family unit. Faced with significantly reduced income, fewer people available to work and an unrelenting need for food and medicine, family members may be forced to adopt high-risk behaviours (such as trading sex for food) just to survive. Improving a family's food security is a means of reducing their vulnerability to HIV infection. Indeed, food security can be seen as one more way to prevent the spread of AIDS, and reduce its impact.

<sup>1</sup> Stanecki, K.A., 2002, *The AIDS Pandemic in the 21<sup>st</sup> Century*, Washington, D.C.: USAID.

<sup>2</sup> Ibid.

<sup>3</sup> "Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases", Abuja Summit to Endorse African Development Forum 2001 Consensus on Fighting HIV/AIDS, Abuja, Nigeria, 26-27 April, 2001.



4. Poor people who are affected by HIV/AIDS need both treatment *and* food. Little work, however, has been carried out on how food, and specifically food aid, can be best integrated into programmes designed to mitigate the impact of HIV/AIDS on poor households' food security. WFP is working with partners in HIV-affected countries to identify and carry out the most appropriate and effective interventions to address the needs of HIV/AIDS-affected households. This policy paper reflects what is known so far about HIV/AIDS and food security and describes the practical considerations thus far identified that are necessary for successful project implementation.
5. Programming food aid in the era of AIDS requires new thinking and often, though not always, a different approach. HIV and AIDS constitute a new kind of crisis, which is neither short term regarding response nor simple regarding solutions. The challenges facing HIV/AIDS-affected households to securing adequate food and nutrition are in some ways similar to those faced in other crises, and in many ways very different. The key differentiating factor is the partial loss or disappearance of adult labour in the household. The impact of this on both food and nutrition security is often dramatic, and the irreversibility of an adult death (as opposed to the reversibility of other crises, e.g. selling off assets that can be bought back) means that the family's recovery is slow and uncertain. Research shows that families who have lost a head of household often never recover fully in terms of levels of agricultural production and cash income.<sup>4</sup> WFP is pursuing a deeper understanding of the impact of HIV/AIDS on communities and families, and is adjusting its programming to reflect the new environment shaped by HIV/AIDS and the crisis it can bring to a family's food security.
6. This paper reviews the relationship between food security and HIV/AIDS and identifies specific vulnerable groups. It also identifies specific programme areas where WFP has a significant role to play in supporting the food security of families and communities affected by AIDS. It is important to note that all activities will be designed following existing policies. This paper highlights some key programming areas where a different emphasis and modified approach are necessary to meet the emerging needs of food-insecure families and individuals deeply affected by the AIDS pandemic.

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## HIV/AIDS UPDATE TO THE EXECUTIVE BOARD

7. WFP has periodically updated the Board on its approach and activities concerning HIV/AIDS.
  - In May 2000 the Executive Board gave WFP the green light to respond to the HIV/AIDS pandemic by using food aid to support prevention efforts, mitigation activities and care and support for those infected and affected by HIV/AIDS.
  - In April 2001, UNAIDS and WFP made a joint presentation to the WFP Executive Board on the global AIDS situation and on WFP's approach to it. The joint publication by the International Food Policy Research Institute (IFPRI) and WFP, entitled HIV/AIDS, Food and Nutrition Security: Impacts and Action, was also made available to Board members during this session.

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<sup>4</sup> Yamano, S., & T. S. Jayne, 2002, "Measuring the Impacts of Prime-age Adult Death on Rural Households in Kenya", research supported by the Kenya Mission of USAID under the Tegemeo Agricultural Monitoring and Policy Analysis Project, the Food Security 11 Cooperative Agreement (PCE-A-00-00044-00) between USAID/Global Bureau, Office of Agriculture and Food Security, and the Department of Agricultural Economics at Michigan State University.



- In October 2001, WFP presented the document WFP, Food Security and HIV/AIDS, an Information Note.
  - In October 2002, WFP presented another Information Note, Update on WFP's Role in the Fight Against HIV/AIDS.
  - In February 2003, WFP presents this policy paper, Programming in the Era of AIDS: WFP's Response to HIV/AIDS, to the Executive Board for approval.
8. In addition, in June 2001, WFP sent to all its country offices guidance on HIV/AIDS and its implications for programming and staff. In 2002, it included a programme section on HIV/AIDS in its Programme Design Manual.

## HIV/AIDS: A CAUSE OF FOOD INSECURITY

9. Households that are poor and affected by HIV/AIDS are forced to resort to a number of negative coping mechanisms, which may ameliorate the immediate problem but can ultimately undermine children's long-term nutritional status and the family's ability to remain food secure. Chronic ill health and the eventual death of productive adults can:
- lead households to divest the family's assets and spend savings, while earning less;
  - prompt households to withdraw children, in particular girls, from school;
  - increase malnutrition among children; and
  - cause declines in agricultural production and productivity.
10. Unlike other shocks that threaten food security, however, HIV:
- leads to AIDS, which has no cure;
  - causes people living with HIV/AIDS (and their families) to be stigmatized;
  - jeopardizes important formal and informal social and business networks; and
  - affects the most productive members of society (aged 15–49), leaving behind the elderly and the young.
11. The results of the AIDS pandemic on food security are numerous, including:
- Children have inadequate or nonexistent agricultural knowledge and skills due to the death of the older generation.
  - Increasing numbers of children are absorbed into extended households, putting pressure on already stretched household capacity—and in some cases overwhelming that capacity, resulting in the children's being pushed out of the house and onto the street.
  - Family members are drawn away from production or income-generating activities to care for sick relatives.
  - Less labour-intensive and less nutritious crops, such as roots and tubers, are produced due to the lack of able-bodied workers.
  - The negative effect on the household may be permanent; the knowledge that premature death is certain can undermine people's incentive to accumulate assets, and the very survival of the household unit becomes threatened.
  - Community safety nets, which traditionally provide some assistance to the most vulnerable, are being stretched beyond their limits.



## HIV/AIDS: A CONSEQUENCE OF FOOD INSECURITY

12. Food insecurity increases people's vulnerability to HIV/AIDS infection in the following ways:
- People engage in high-risk survival strategies that increase their chances of contracting or spreading HIV and other sexually transmitted infections, as such strategies may be the only means of feeding one's family during desperate times of food insecurity, such as lean periods, drought, economic decline or war.
  - It is during these periods of food insecurity that male family members migrate in search of work and are separated from their wives and families for long periods of time, increasing the chances that they will take on multiple casual sex partners.
  - The fact that families often split up while fleeing insecurity can also easily contribute to the spread of HIV.

## THE "VICIOUS CIRCLE" OF MALNUTRITION AND HIV/AIDS

13. According to the Food and Agriculture Organization (FAO), in households affected by HIV/AIDS, the food consumption of *all* surviving family members frequently declines, resulting in malnutrition. Malnutrition and HIV work in deadly tandem, threatening the nutrition security of HIV-positive individuals and their families in the following ways:<sup>5</sup>
- People living with HIV and those with AIDS require more energy and more protein, along with the necessary micronutrients, than do people who are not HIV infected.
  - HIV infection increases the risk of malnutrition in the individual through opportunistic infections.
  - Malnutrition exacerbates the effects of HIV and AIDS (e.g. TB, pneumonia, diarrhoea), resulting in further deterioration of nutritional status.
  - Simultaneously, the household's access to adequate food is threatened as a result of the prolonged illness of its productive adults, compromising the nutritional status of the whole family.

## CONSIDERING THE MOST VULNERABLE

### Women

14. Whether they are wives, widows, expectant or nursing mothers, or yet-unmarried girls, women are disproportionately affected by the HIV/AIDS pandemic. Also, HIV poses specific gender considerations. Due to a combination of biological and sociocultural reasons, women are up to five times more likely than men to become infected with HIV.<sup>6,7</sup>

<sup>5</sup> United Nations Administrative Committee on Coordination, Sub-Committee on Nutrition, 2001, "Nutrition and HIV/AIDS", Nutrition Policy Paper 20, October.

<sup>6</sup> Gregson, S. et al., 2002, "Sexual Mixing Patterns and Sex-Differentials in Teenage Exposure to HIV Infection in Rural Zimbabwe," *The Lancet*, 359, 1896–1903.

<sup>7</sup> Glynn, J. R. et al., 2001, "Why Do Young Women Have a Much Higher Prevalence of HIV than Young Men? A Study in Kisumu, Kenya and Ndola, Zambia." *AIDS* 15, (Suppl. 4) S51–S60.





In sub-Saharan Africa, 58 percent of the people infected with HIV are women, representing 70 percent of infected women worldwide.<sup>8</sup>

15. The pandemic has also dramatically increased women's already enormous economic and social burden as caretakers, breadwinners and providers of food. Time and financial constraints mean that women must make painfully difficult choices when faced with HIV/AIDS, many of which directly and negatively affect their family's food security and their children's health and well-being.
16. In many countries, tradition dictates that women and girls bear the responsibility of caring for sick family members and younger children. And when one or both parents die as a result of HIV/AIDS, older girls may be forced to drop out of school to look after their younger siblings. In some heavily affected areas, elderly grandmothers and older children, often girls, are even forced to act as heads of household. The low status of women and girls in many societies means that they are more likely to be abused and exploited by older boys and men, thereby greatly increasing their chances of becoming HIV infected.
17. Women's inequality, heavy responsibilities and their high risk of becoming infected can all have devastating short- and long-term effects on household food security and nutrition. When caring for chronically ill family members, women spend less time on agricultural production and childcare, which reduces the amount of food their family eats and can adversely affect their children's nutritional status. The predominance of HIV infections in women means that in coming decades there will be far more men than women in heavily impacted countries, a situation with unknown but worrisome implications, particularly for household food security.

### **Orphans and Children Affected by HIV/AIDS**

18. Parts of the developing world are witnessing the demise of an entire generation of parents—parents who are leaving behind youngsters who lack cultural, social and familial ties, including basic farming know-how and life skills that typically pass from generation to generation. Children are being taken out of school at an alarming rate to take care of sick parents and help get enough food into the household. Nowhere is this more evident than in southern Africa, the epicentre of the global AIDS pandemic, where HIV/AIDS is part of the ongoing food crisis.
19. Globally, more than 14 million children under the age of 15 have lost one or both parents to AIDS. This figure represents 12 percent of all children in Africa, 6.5 percent in Asia and 5 percent in Latin America and the Caribbean. The number is expected to jump to 25 million by 2010. Increasing numbers of children are living with sick and dying parents or in households that have taken in orphans. Orphans are usually the first to experience the deprivation forced by poverty and food insecurity and they often suffer greatly from exclusion, abuse, discrimination and social stigma.<sup>9</sup> When children lose their parents, traditionally the extended family takes the children in and provides for their needs. However, the burgeoning numbers of orphans are seriously stretching the coping capacities of families and communities. Sometimes orphans in the care of extended or foster families can suffer from mistreatment or neglect. They also have lower rates of school enrolment and higher rates of malnutrition and depression.

<sup>8</sup> UNAIDS/WHO, 2002, "Regional HIV/AIDS Statistics and Features, End 2002", AIDS Epidemic Update.

<sup>9</sup> UNAIDS/UNICEF, 2002, "Children on the Brink 2002: A Joint Report on Orphan Estimates and Program Strategies", Washington, D.C.: TvT Associates /The Synergy Project (USAID).



20. Children who live on the street or in child-headed households are highly food insecure and are some of the most vulnerable children in the world. Street children, especially girls, are subject to exploitation and abuse by men and street boys. Out of desperation, they can be forced into trading sex for a meal or just to meet their basic daily needs. Some siblings who have lost their parents opt to stay together rather than face the compounded trauma of being separated. Such child-headed households live on the brink of survival, struggling daily to find enough food and adequate clothing and shelter.

### Refugees and Internally Displaced Persons

21. Humanitarian and political emergencies can become epicentres for the transmission of HIV, home to a lethal mix of population displacement, rape, occupying troops, women in desperate circumstances, unsafe blood supplies, drug abuse and unsafe sexual practices. Camps for refugees and IDPs can be especially fertile ground for the spread of HIV. Individuals who live in camps have lost their livelihoods—and sometimes their families—and, by definition, are removed from their traditional ways of life. The complex psychosocial nature of camps has created a “camp culture” of poverty, overcrowding, a breakdown in cultural values, sexual violence and abuse, and unemployment that encourages casual sexual liaisons that fuel the spread of HIV and other sexually transmitted infections.
22. AIDS knows no borders, so the host communities surrounding such camps are not immune to the risk of infection. Interaction between the two populations can spark a wildfire of HIV infection and result in AIDS hotspots within a country.
23. Conflict, however, can sometimes delay the spread of the epidemic. For example in Angola and the Democratic Republic of the Congo, the spread of HIV/AIDS has progressed at a slower rate. However, once such a conflict has subsided, such as in Angola, UNAIDS estimates that the scale of the epidemic is likely to increase as people return to their homes and as travel between different parts of the country is normalized. Populations most at risk in these circumstances are displaced populations and demobilized fighters.

### ADAPTING WFP PROGRAMMING IN THE ERA OF HIV/AIDS

24. The HIV/AIDS pandemic has grown from a serious public health threat into a massive and complex crisis, forcing humanitarian and development agencies to adapt their programmes to the changing nature of a world with HIV/AIDS. With the food crisis in southern Africa, for the first time it is known that AIDS is playing a major role in making a bad situation—widespread crop failure due to erratic rains and inadequate government policies—much worse. Although it may never be possible to quantify how much the presence of AIDS exacerbates the effects of the food crisis, or vice versa, it is known that the two make for a deadly combination. Moreover, recovery in the region will be seriously compromised by the devastation from HIV/AIDS.
25. Although HIV/AIDS requires an “emergency” response, such a response must be based on a long-term approach. AIDS is not like other crises. As a result, WFP will need to consider carefully how the complexities of AIDS can be accommodated within existing programming categories. For WFP’s work, the dynamic of HIV/AIDS as both a cause and a consequence of food insecurity cannot be understated.
26. WFP’s interventions should concentrate on populations whose food security has been compromised by the pandemic, in particular vulnerable children, orphans and women. The focus is first on cushioning the shock created by HIV/AIDS. In emergency operations WFP



will work with partners to integrate HIV concerns into the Common Humanitarian Action Plan within the consolidated appeals process (CAP). WFP will also programme in coordination with its partners' assistance for longer-term food security in development and recovery operations.

27. The following principles should be applied to WFP programming for HIV/AIDS:
- **The entry point for WFP involvement will always be situated in nutrition and food security.** WFP's interventions will target beneficiaries based on their food security status, not on their HIV status.
  - When and where appropriate, **WFP will take HIV/AIDS into account in all of its programming categories and in all assessments of needs.**
  - WFP's HIV/AIDS response in specific countries **will depend on the national strategy and will always fit within the given government's framework for action.**
  - In order to minimize the debilitating stigma and discrimination often associated with HIV/AIDS, **WFP will support local non-governmental organizations (NGOs) and community-based organizations,** including associations of people living with HIV/AIDS. WFP will use food aid to **complement and scale up existing government, United Nations and NGO partner activities in prevention, mitigation and care** for HIV-infected and -affected individuals and families.
  - **WFP food assistance will place special emphasis on women and vulnerable children, in particular orphans,** and will support the broader national and international response to HIV/AIDS to ensure that food is part of a larger package provided to HIV-affected households and communities.

## TARGETING

28. WFP's vulnerability analysis and mapping (VAM) capacity has been cited by other United Nations partners (such as UNDP and UNAIDS) as unique and critical to furthering the understanding of the dynamics of AIDS, and to allowing for better identification of beneficiary groups. In VAM's standard analytical framework for food insecurity and vulnerability assessment, the presence of HIV/AIDS is considered a threat to a household's food security.
29. Vulnerability assessments in Kenya and Uganda have already incorporated HIV/AIDS data in the analysis, and the emergency needs assessments carried out in the southern Africa region (Lesotho, Malawi, Mozambique, Swaziland, Zambia and Zimbabwe) have all looked carefully at HIV/AIDS prevalence to identify hard-hit areas. In these assessments, proxy indicators are being used to identify food-insecure households affected by HIV. These proxy indicators include the number of children in a household, recent death and excessive morbidity, and the age of the household head. WFP is working closely with the UNAIDS Secretariat, FAO, UNDP, UNICEF and other partners to establish standard indicators and methods for incorporating HIV/AIDS in food security and vulnerability assessments. This will assist WFP and its partners in ensuring that the link between HIV/AIDS and food security is taken into account in both targeting and project design.
30. The targeting of HIV-affected families for assistance is complex and needs to be well understood not only to be successful but also to avoid unintended consequences. First, due to the stigma attached to HIV/AIDS, singling out HIV-positive individuals for assistance can have negative consequences for those individuals and their families. Second, because



testing facilities and reliable surveillance systems are lacking in most poor countries, it is impossible to know for sure who is HIV infected. Third, even when voluntary counselling and testing services exist, many people are afraid to know their HIV status and choose not to get tested.

31. For all of these reasons WFP targets its HIV/AIDS assistance based on food insecurity indicators, and *not* on an individual's HIV status. WFP will focus on geographic zones that are food insecure and that have been particularly affected by the pandemic and, within those zones, on households whose food security is threatened by the pandemic. WFP will support established community-based organizations when carrying out HIV/AIDS activities in order to avoid the negative consequences associated with HIV stigma.<sup>10</sup>

## PROGRAMME OPTIONS FOR HIV/AIDS

32. The following sections identify those elements that need to be taken into account for successful project design for HIV-affected families and communities. These programming options should support key partner agencies and organizations in the broader response to HIV/AIDS and should be considered in all programming categories, and in situations including refugee and IDP camps where appropriate and feasible. Because camp situations present special challenges to programming for HIV activities—poor security, lack of services and the nature of camp culture—WFP is working with UNHCR to see how best to increase HIV/AIDS activities for IDPs and refugees in camps.

### Improve and Maintain Human Capital

33. Universal basic education is key to stemming the spread of HIV/AIDS. By providing food assistance to orphans and vulnerable children, to extended and foster families and, in some cases, to institutions that care for orphans, WFP can make a significant contribution to facilitating these children's access to education, improving their food security and preventing the spread of HIV. WFP is consulting with UNICEF on how the two agencies can tackle this issue together.
34. There are a few generalizable programming principles that virtually all decision-makers, implementers and beneficiaries appear to agree on.<sup>11</sup>
- Interventions aimed at improving the situation for orphans must not exclude children whose parents are still alive though ailing.
  - Reaching vulnerable children before they become orphaned, for example through school feeding, can help keep them in school and out of harm's way.
  - Food assistance should be provided to an entire household rather than just to the orphans being cared for in that household. This will prevent food rations intended for one person from being shared by an entire family. Such material assistance for extended and foster families can ease the collective burden of caring for orphans and result in more families being willing to take in orphans.

<sup>10</sup> UNAIDS, 2000, "Research into the Participation of People Living with HIV/AIDS (PLWHA) in Community-Based Organizations," UNAIDS Best Practice Collection, Geneva.

<sup>11</sup> WFP, 2002, "Food and Education: WFP's Role in Improving Access to Education for Orphans and Vulnerable Children in Sub-Saharan Africa", Policy Service, September.



35. In situations where no other option exists, an orphan may need to be cared for in an orphanage or other institution. Such arrangements should be viewed as temporary, and every effort should be made to reintegrate the child into a family structure in his or her own community.

### ⇒ **Alternative School Feeding Programmes**

36. WFP carried out missions in Côte d'Ivoire and Zambia to identify ways to improve educational opportunities for orphans and other vulnerable children. Options that emerged from those missions include take-home rations and food for training. In conjunction with national governments and NGOs, WFP should also support such innovative responses to the burgeoning orphan problem as community schools, innovative learning technologies (e.g. radio-listening groups) and apprenticeships and/or vocational training courses. Food can be provided to those who attend community schools and listening groups in the same way, and with the same objective, as it is provided in school feeding programmes. Supporting such interventions can ensure that the maximum number of food-insecure orphans and vulnerable children receive some form of education and that older children become self-reliant in the near future.
37. By addressing the needs of the chronically ill in the family context (e.g. through home-based care programmes), WFP can help children in the family stay in school. For instance, through an integrated care and support programme in Zambia, WFP provides food for school-enrolled children of people living with HIV/AIDS. Because these children come from poor, food-insecure households, the WFP food they receive at school may be all they eat all day. In many cases, the stigma often associated with HIV/AIDS can be avoided for these children by working with local community groups who are experienced and established.
38. The effectiveness of WFP's role in improving access to education for vulnerable children depends on the extent to which dynamic partnerships can be built. WFP must find ways to complement existing efforts and create synergy among government, NGO, donor and local actors already involved with programming and support to orphans and vulnerable children.
39. School feeding programmes offer an excellent opportunity for partners to introduce HIV/AIDS-prevention activities. In Sierra Leone, WFP is working with all the members of the United Nations Theme Group on HIV/AIDS, so that prevention and awareness activities can be carried out in WFP-supported primary schools. School feeding programmes should be a platform to support prevention and awareness campaigns by appropriate partners in the same way that nutrition education and deworming are incorporated into many current school feeding programmes.

### **Livelihood Diversification to Increase Food Security**

40. Training to promote livelihood diversification, including training in agricultural production and animal husbandry, should be a key element in WFP HIV/AIDS activities. The training should concentrate primarily on marketable skills that do not lead to increased out-migration and should take into consideration the possible need for daytime care of ill family members. Older orphans, child-headed households and members of families with large numbers of children are good candidates for training to increase livelihood diversification.



41. WFP has already identified a number of training activities appropriate for support. For example:
- In **Rwanda**, training programmes emphasize income-generating activities and vocational skills such as food processing/selling, retail and petty trade, metal forging and woodworking. During the launching of income-generating activities, WFP Rwanda provides food assistance to people living with HIV/AIDS to prevent their using micro-credit for daily consumption needs rather than for investment.
  - In **Uganda**, orphans and street children benefit from food-for-training programmes in vocational skills, apprenticeships, literacy and numeracy.
42. WFP should support skills training activities only after an analysis of the income-generating possibilities of those skills. This type of analysis is best carried out with local partners.
43. Because HIV-impacted households are constrained by a lack of labour resulting from the illness and death of productive adults, activities involving food for work in most situations may not be the most appropriate types of activity for diversifying livelihoods in order to strengthen household food security.

## Reducing the Vulnerability of Families

### ⇒ Ensuring Good Nutrition

44. People who are HIV positive have special nutritional and dietary needs.<sup>12</sup> In order for them to stay healthy and productive, it is essential that they have good nutrition. Moreover, for drug treatments (e.g. anti-retrovirals) to be effective, good nutrition is a prerequisite. In food-insecure areas with a high prevalence of HIV/AIDS, these special needs should be taken into account by food assistance programmes in order to:
- help people with HIV accommodate the elevated energy, protein and micronutrient needs associated with coping with the virus and fighting off opportunistic infections;
  - slow the progression of AIDS and waylay death due to opportunistic diseases;
  - maintain productive and care potential among infected and affected adults and help prevent the collapse of community care and support mechanisms for PLWHA, orphans, child and female-headed households, etc.; and
  - help provide foods of higher nutritional quality (particularly those providing protein and micronutrients), which may not be grown in such areas due to labour shortages.
45. It is especially critical that food baskets for populations with a high prevalence of HIV are nutritionally balanced and provide sufficient protein, fat and micronutrients. This is the case whether the operation is an emergency operation (EMOP), a protracted relief and recovery operation (PRRO) or a development activity. Because in most cases WFP does not know who is HIV positive and who is not, in high HIV-prevalence areas the inclusion of pulses, oil and fortified foods in all food baskets is key to any food-assisted intervention.
46. Vitamins and minerals play an essential role in strengthening the immune system and helping the body fight off infection. Increased micronutrient intake in the early stages of an illness can favourably influence that illness's progression, thus protecting the body against

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<sup>12</sup>*HIV/AIDS: A Guide For Nutrition, Care and Support*. Food and Nutrition Technical Assistance Project, Washington, D.C.: Academy for Educational Development, 2001.



increased morbidity and mortality. In populations with high HIV prevalence or for activities that assist people who know their HIV status, WFP should make special efforts to ensure that staple foods are fortified with multiple vitamins and minerals or to provide fortified blended foods. For example, in the current southern Africa EMOP, maize is being fortified with vitamins and minerals as part of local milling activities. Also, the blending of staple foods with soya concentrate is being investigated as a way to increase those foods' protein content. Fortification and blending of a staple food will ensure adequate intake of micronutrients irrespective of people's knowledge of their HIV status.

47. The implications of nutrition for HIV-positive persons are a relatively new area of research, and a number of unanswered questions remain. WFP is following closely the results of research and programme experience in this area and will adjust its programming according to any changes in the current thinking on nutrition and HIV/AIDS.
48. Adequate nutrition depends on more than just having enough food to eat. WFP should forge partnerships to combine food assistance with nutrition education and counselling to promote the consumption of optimal foods; the management of AIDS-related loss of appetite and other conditions that affect eating patterns; and water, hygiene, and food safety interventions to prevent diarrhoea. WFP is working with a variety of partners in these areas at both the local and international levels.

### ⇒ *Home-Based Care*

49. Most home-based care programmes are organized around a network of community volunteers supervised by nurses or trained health workers. Home-based care teams visit registered chronically ill patients in their homes to provide free services, such as: physical care, counselling and emotional support, pastoral support, welfare assistance for the most needy patients, supplemental food rations for the patient (and sometimes the family), HIV/AIDS prevention information for family members, and assistance to survivors. Some home-based care programmes have emerged from the cooperation between health centres, hospitals or clinics and local community volunteers, and many of these have church affiliations.
50. For very poor families, food is a key component of home-based care services. Adequate and nutritious food is essential for prolonging the lives of parents and enabling them to have a few more precious weeks, months or maybe even years to be productive, to work and to spend time with their families. Food is essential for family members, especially children, to maintain adequate nutritional status when the household head is chronically ill. To this end, and when appropriate, WFP provides, to individuals and families who are infected and affected by HIV/AIDS, dietary support that can include blended fortified foods or fortified cereals combined with a balanced food basket for optimal nutrition.
51. There are many new supplemental food products appearing on the market that claim to be specially formulated for people living with HIV/AIDS. However, not enough is known at this time about the nutritional effects of these products nor about their cost-effectiveness compared with other products such as blended foods. To help WFP make informed decisions about new food products, the United Nations University has assembled the Technical Advisory Group (TAG), to review the food safety, nutrition, storage, handling and intended use of proposed food products. Based on the information provided by these external experts WFP will be able to decide whether to accept donations or to purchase specialized foods after the products have been reviewed by TAG.
52. Volunteers fill an important role in communities hard hit by the pandemic by providing critical services and psychosocial support to the chronically ill and their families. Because they come from the very communities they serve, volunteers are more easily able to



identify others in desperate need of assistance, and in many cases they are often food insecure themselves. WFP could provide food rations to volunteers to help offset the need for them to find food elsewhere and to free up their time to serve their communities. However, WFP must make certain that such aid does not create dependency and thus undermine the very spirit associated with volunteering.

53. Careful targeting and close collaboration with community-based organizations and local NGOs are key to ensuring successful activities in this area. Concerted efforts must be made with partners, including local NGOs, to link home-based care to other types of programming, for instance, food-for-education programmes targeting orphans and other vulnerable children, and food-for-vocational training of youth to improve their income-generating potential.
54. It is likely that WFP's potential partners in this area will be different from those previously known to WFP. Likewise, the organizations working in HIV/AIDS may be unfamiliar with WFP's mandate. While there are many international and local organizations involved in different aspects of HIV prevention and care for people affected by AIDS, it is important that criteria be set to assist WFP in selecting NGO partners.<sup>13</sup>
55. Partners eligible for selection with specific reference to HIV/AIDS must:
  - be recognized by the Government; and
  - have projects that fit in with the national strategic plan to fight HIV/AIDS and are in line with national priorities.
56. Other criteria for partner eligibility might include:
  - the existence of an established referral system from hospitals, churches, etc;
  - acceptable levels of training for their home-based care staff; and
  - a policy of non-discrimination with regard to people living with HIV/AIDS.

### ⇒ **Mother-to-Child Transmission**

57. Reducing the risk of mother-to-child HIV transmission is an important component of any national HIV/AIDS strategy. The role of food assistance in preventing mother-to-child transmission, particularly as regards the use of infant formula, however, is a controversial issue and one on which there has been much debate.
58. WFP is following the discussion on the role of food assistance in helping to prevent mother-to-child transmission (MTCT) and will closely monitor new research findings as they emerge. WFP follows policy recommendations made by the World Health Organization (WHO) regarding mother-to-child transmission. Current conclusions and recommendations are found in the WHO document *New Data on the Prevention of Mother-to-Child Transmission of HIV and Their Policy Implications*. In all relevant activities, WFP follows the current advice and guidance of WHO and UNICEF. For mothers who do not know their HIV status, according to this guidance, the safest option is exclusive breastfeeding for the first six months.
59. Voluntary testing and counselling through prenatal clinics is critical to identifying HIV-infected women at risk of transmitting the virus to their unborn babies. However, at least one study has shown that although a majority of expectant mothers attending clinics

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<sup>13</sup> For more information on WFP and NGO partners, see WFP Working with NGOs: A Framework for Partnership" policy paper approved by the Executive Board in May 2001 (WFP/EB.A/2001/4-B).





agree to be tested for HIV, most are too frightened to return for their results. Some WFP country offices have been asked to provide food rations to expectant mothers as an incentive for them to get tested and counselled. With the widespread lack of adequate counselling and follow-up medical and social services available to individuals who test positive for HIV, country offices should avoid programming food assistance in this way until more is known about the best use of food rations in such situations, and there is adequate inter-agency consensus.

### **WFP Food Assistance for Institutions**

60. In most contexts, WFP does not provide food to institutions such as hospitals. Institutional feeding has generally been avoided for two reasons: (i) the inability to target only the most vulnerable, and (ii) the lack of a clear link between feeding hospital patients and improving household food security.
61. Although these concerns remain valid, HIV/AIDS is changing the environment in which WFP works. To stay relevant and responsive in the face of shifting realities, WFP may need to reconsider its position on institutional feeding. Country offices that determine a need for such assistance, and have sufficient resources for it, should keep in mind the inherent difficulties and exercise caution when programming in institutional settings. Past experience in both Cambodia and Rwanda shows that targeting poor households with a family member who is hospitalized for a specified period (e.g. as in tuberculosis-control programmes) is the most effective way to deliver food assistance in a hospital setting. In these examples, family members are provided with food rations that they then supply to the hospital patient.
62. In the case of orphanages, it is extremely important to recognize that orphans are better off in a family structure and that orphanages are the last resort—and ideally a temporary one—for those who have absolutely no other option. It is preferable when programming food assistance for orphanages to support those that provide age-appropriate educational opportunities either on site or in conjunction with educational facilities in the community.

### **Enabling Treatment Compliance**

63. Prevention and treatment of active tuberculosis (TB) is critical for individuals with HIV/AIDS, because TB is the leading cause of AIDS-related death. Prevention and treatment of TB leads to improved quality of life and longer life, and benefits the families and communities of people living with HIV/AIDS.
64. HIV infection accelerates the progression of TB infection to active tuberculosis; people with both HIV and TB infection are 30 times more likely to get active TB. In addition, recent studies have shown that TB infection may accelerate the progression of HIV infection to AIDS.<sup>14</sup> During periods of stress on household food security in areas of high HIV prevalence, incidence of TB can increase exponentially. For example, during the first six months of the current food emergency in Malawi, the number of TB cases doubled, according to the UNAIDS Country Programme Adviser there.

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<sup>14</sup> Maher, D., K. Floyd, & M. Raviglione, 2002, "A Strategic Framework to Decrease the Burden of TB/HIV, Stop TB and HIV/AIDS" (WHO/CDS/TB/2002.296), Geneva: World Health Organization.



65. The goal of TB-control programmes is to cure those infected and prevent new infections. These results can be realized only through strict adherence to the TB DOTS (directly observed treatment, short-course) regimen<sup>15</sup> for patients, which requires regular and closely supervised treatments. Treatment that is interrupted or terminated early leaves patients more susceptible to recurring bouts of TB and results in the spread of drug-resistant strains of the disease.
66. A key reason often cited for the poor not being able to complete their full treatment is the need to continue to work and earn a living in order to feed their families. As part of its programming assistance in HIV/AIDS, WFP should increase its programming for food-insecure individuals infected with TB when it can be linked to strong DOTS programmes. WFP is working closely with WHO and the World Bank to further identify viable TB programmes where food assistance to food-insecure households will improve treatment compliance.
67. WFP is currently assisting several national TB control programmes with food. In Uganda, the Holy Rosary Catholic parish in Gulu provides WFP food rations to individuals hospitalized for TB and HIV/AIDS-related illnesses. In Cambodia, the National Tuberculosis Control Programme receives WFP rations for its patients. Rations compensate the patient for work hours missed due to hospitalization or clinic attendance. In some cases, the food offsets the cost of transportation to the health centre and other indirect costs incurred by outpatients. The Cambodian programme is one of the most successful in the world, having exceeded its target cure rate. The food rations WFP supplies to it are viewed as a best practice for other countries to consider replicating.

### Prevention Activities

68. Cooperation with partners in education and prevention should be linked to all WFP's development, recovery and emergency programme interventions whenever and wherever possible. Although WFP does not have the expertise or experience to undertake prevention activities on its own, it should work with other organizations able to support education and prevention activities consistent with national HIV/AIDS strategies and appropriate for each country context.
69. Some prevention activities might include:
- using food distribution sites, such as in camps or during emergency distributions, to enable partners to raise awareness on HIV and AIDS;
  - linking partners to the community networks established for delivering food aid (e.g. using parent-teacher associations, food management camp committees and farmer associations to deliver appropriate HIV and AIDS prevention messages);
  - making certain that WFP contract staff (e.g. long-haul truck drivers contracted to transport WFP food and non-food items) are provided with risk reduction and prevention information;
  - training community health workers in methods of optimal breastfeeding practices for WFP beneficiaries; and

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<sup>15</sup> The DOTS regimen has five key components: political commitment; passive case detection and diagnosis using sputum smear microscopy; standardized short-course treatment with direct observation of therapy; ensurance of an uninterrupted supply of quality drugs; and standard recording/reporting with systematic evaluation of treatment outcome.



- training youth peer educators to provide information on STD/HIV/AIDS risk reduction and prevention and on voluntary counselling and testing.

## PARTNERSHIPS TO ADDRESS HIV/AIDS

70. Effective interventions are rooted in a community response and depend heavily on the participation of local health authorities, community representatives and people living with HIV/AIDS. The greater involvement of people living with HIV/AIDS in all aspects of related programming can be a powerful and influential factor in effective prevention, mitigation and care interventions. Because members of the community, including those who are living with HIV/AIDS, know the issues involved and the people most in need of assistance, they should be involved as much as possible in the design and implementation of all WFP HIV/AIDS interventions. The more that communities become involved in confronting the effects of AIDS, the less likely it will be that affected individuals face stigma, denial, shame and discrimination.<sup>16</sup>
71. Partnerships with government line ministries, donors, NGOs and other United Nations agencies are equally critical for designing and implementing effective HIV/AIDS interventions. In many of the countries hard hit by HIV/AIDS, WFP is working with UNAIDS co-sponsors, especially WHO, UNICEF and UNDP, to integrate food assistance into programmes supporting HIV/AIDS-affected families and individuals.
72. Below are a few examples of some key collaborations undertaken over the last year.

### Joint United Nations Programme on HIV/AIDS (UNAIDS)

73. WFP works closely with the UNAIDS co-sponsors in countries where HIV/AIDS activities are integrated into Country Programmes, EMOPs and PRROs. In many countries, WFP is an active participant in the Extended UNAIDS Theme Group on HIV/AIDS. Additionally, UNAIDS Country Teams, and in particular UNAIDS Country Programme Advisers (CPAs), provide WFP with technical support on project formulation and partnership-building at the national level. Country Teams also assist WFP in advocating food security as a priority in national AIDS strategies. Some examples of how WFP works with UNAIDS are given below:
- In **Uganda**, the UNAIDS Country Programme Adviser and her staff facilitated the implementation of a joint WFP/WHO initiative to improve the quality of life of PLWHAs and their families through improved nutrition and community home-based care. The project is in line with the Uganda Government HIV/AIDS policy and United Nations Development Assistance Framework (UNDAF) priorities on poverty alleviation.
  - In **China**, the UNAIDS country office worked with WFP to develop key information, education, communication (IEC) messages reaching some 200,000 farmers in areas where WFP has operations. The information campaign, coordinated with the Ministry of Agriculture, was intended to educate rural families on the basic facts about HIV/AIDS.

<sup>16</sup> Brown, L., L. Trujillo & K. Macintyre, 2001, *Interventions to Reduce HIV/AIDS Stigma: What Have We Learned?* Washington, D.C.: Population Council.



- In **Madagascar**, the UNAIDS CPA is working with WFP to develop IEC materials and prevention tools for integration into the school curriculum, especially in the context of WFP's school feeding initiative. The IEC materials are being used in rural areas of southern Madagascar, where WFP has an extensive presence.
- In **Cambodia**, the UNAIDS CPA has provided technical advice to WFP on how to ensure integration of HIV/AIDS into programming and planning. WFP Cambodia is an active member of the United Nations Theme Group and Technical Working Group on HIV/AIDS. In view of UNAIDS role of support within the United Nations system and to the Government, WFP Cambodia will reinforce the relationship with UNAIDS Cambodia and take more advantage of the latter's technical competence. The UNAIDS office in Phnom Penh has provided training sessions to WFP staff.
- In **Burkina Faso**, the UNAIDS CPA assisted WFP in the preparation and design of a pilot activity for AIDS-affected households, in particular, for orphans and other vulnerable children. The UNAIDS representative also helped WFP identify implementing institutions. The activity aims to improve the nutritional status of orphans and vulnerable children and to increase the participation of AIDS-affected households in training activities organized by local associations and community-based organizations (CBOs). In a related WFP initiative carried out in collaboration with WHO, the UNAIDS Secretariat will be involved in the monitoring and analysis of the impact of WFP food assistance provided to tuberculosis patients receiving treatment.
- WFP will chair a meeting of the Inter-Agency Advisory Group of UNAIDS in February 2003. WFP will use this opportunity to emphasize the critical need of addressing HIV/AIDS from a food security and nutrition perspective.

### World Health Organization (WHO)

74. In October 2001, WFP and WHO signed an agreement for joint programming under the Italian Initiative for HIV/AIDS. Since then, the two organizations have implemented activities in selected countries in eastern and southern Africa. Some examples of this collaboration include:

- In **Uganda**, the two agencies are working together in Kitgum, Pader, Gulu, Hoima and Kampala. The partnership has involved the provision of food aid to PLWHAs and their family members, including nutrition counselling and education.
- With special emphasis on the needs of women, young people and orphans in selected food-insecure districts, WFP and WHO in the **United Republic of Tanzania** have pooled their technical and operational resources to improve the coping mechanisms of PLWHAs and AIDS-affected households. The programme focuses on the provision of vocational training and income-generating activities supported with family food packages. As a result of the excellent collaboration between the two agencies, the Italian Cooperation increased its contribution to WFP AIDS-specific initiatives in 2001.
- In **Mozambique**, WFP and WHO have been working together closely in the Sofala Province since 2001, where WFP food has been integrated into the existing home-based care programme. WFP food complements existing services involving home-based care packages for PLWHAs and their families. WFP food is also being provided to volunteer caregivers and to orphans and other vulnerable children through non-formal education, day-care centres, and vocational training in Maputo, Manica, Sofala and Tete provinces.



## Rome-based United Nations Agencies

75. WFP and the Rome-based agencies have advocated jointly on nutrition, food security and HIV/AIDS in a number of United Nations and international fora. Two of the most important of such collaborations in 2002 are described below:
- Throughout 2002 WFP has been working closely with **FAO** as members of the Inter-Agency Standing Committee (IASC) Reference Group on HIV/AIDS in Emergency Settings. The reference group is producing a checklist of priority activities to be used in the field and is working towards operational guidelines. WFP's expertise in humanitarian operations combined with FAO's technical expertise in food security has made these two Rome-based agencies a driving force in ensuring that food security and nutrition issues are taken into consideration in the response to the HIV/AIDS pandemic in emergency situations.
  - At the 14<sup>th</sup> World AIDS Conference in Barcelona, Spain, **FAO and IFAD** joined WFP and **WHO** in organizing a satellite meeting. The event, entitled "The Challenges of Food Security and Nutrition to HIV/AIDS," provided a forum for academics, NGOs and others to discuss an integrated approach to addressing HIV/AIDS from a sustainable livelihood and food- and nutrition-security perspective.

## Local Partners

76. Partnerships with NGOs, government and others in civil society involved in HIV/AIDS responses have been key to WFP's strategy of providing much-needed food assistance to AIDS-affected households. WFP seeks to support local actors in all of its HIV/AIDS activities, understanding that food is one of several key elements for effective assistance to HIV/AIDS-impacted families.
77. WFP works with a variety of local actors such as the Salvation Army and the Catholic Development Commission in Malawi, the Ministry of Local Government and Social Affairs in Rwanda, the Association of People Living with HIV/AIDS in Eritrea, and the *Associazione Volontari per il Servizio Internazionale* and World Vision in Uganda, to name a few.

## The Global Fund for HIV/AIDS and Health

78. In 2001, WFP welcomed the creation of the Global Fund for HIV/AIDS and Health. Expectations concerning the level of donations to the Fund, however, have not been met. Although WFP, and the United Nations in general are not eligible to submit proposals directly to the Fund, wherever possible WFP country offices should work closely with the Country Coordination Mechanisms in order that food security and nutrition issues be part of country proposals to the Fund. Currently, food and nutrition are not specifically mentioned in the guidelines for the Fund's uses. WFP is ready to work with FAO and others to try to have food and nutrition activities qualify for resources from the Global Fund.

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## HIV/AIDS IN THE WORKPLACE

79. With strong support voiced by the United Nations Secretary-General and reinforced by UNAIDS, the entire United Nations system is urged to foster a work environment of compassion and understanding. All United Nations agencies are called on to conduct a systematic information campaign aimed at reaching United Nations staff and their families with AIDS prevention information. As a responsible employer, WFP is committed to



protecting its entire staff, including contract workers such as long-haul truck drivers who transport WFP food and non-food items. WFP staff can serve as role models for their communities in their willingness to discuss HIV/AIDS prevention, accurately and credibly, and in demonstrating their compassion for those already affected.

80. WFP is working in several different ways to respond to this call to action, including by incorporating HIV/AIDS information in its specialized staff training on security awareness, emergency response and peer counselling. Country offices are strongly encouraged to conduct HIV/AIDS awareness and prevention training for all WFP international and national, professional and support staff, and their families. WFP's Human Resources Department has developed and disseminated two standard HIV/AIDS awareness and prevention training modules for use in the field and a number of country offices have conducted awareness and prevention sessions.
81. WFP is organizing a southern Africa region-wide training intervention on the prevention of sexual exploitation and abuse for all individuals who are part of the humanitarian response in southern Africa. The training is an inter-agency collaborative initiative managed jointly by WFP, UNICEF and Save the Children/UK. The programme will be designed for five separate target groups: managers and decision-makers, implementers (food aid monitors, warehouse managers, etc.), community leaders (those responsible for the selection of beneficiaries), transporters (truckers), and commercial transport company owners/managers.
82. Within the prevention components, issues related to HIV/AIDS will be incorporated into these sessions. However, due to the high prevalence rates throughout the region and the impact on the beneficiary population, WFP is including an additional half-day session specifically on HIV/AIDS. The first day and a half will focus on the prevention of sexual exploitation and abuse, with HIV/AIDS-related issues embedded in the programme, and the last half-day will focus on HIV/AIDS alone.

## SUMMARY

83. HIV/AIDS is threatening food and nutrition security in a way that is significantly different from all other crises. For those affected by HIV/AIDS, its impact can be as devastating as war, drought or other "traditional" catastrophes. In food-insecure communities affected by HIV/AIDS, WFP must take AIDS into account in its project design and adapt its programming as and when new information on food security, nutrition and HIV/AIDS becomes available. WFP's strategy must always concentrate on food insecurity brought on by HIV/AIDS, not on the disease itself. In areas of high food insecurity and high HIV prevalence, WFP food assistance can provide a safety net to catch families before they become destitute, and thus even more vulnerable to the risk of infection. AIDS is a long-term emergency that must be tackled both with the immediate needs of the most vulnerable in mind and with a longer-term recovery approach.
84. When associated with other inputs, food assistance in all WFP programming categories can:
  - create opportunities for less risky livelihoods and strengthen household and community capacity to respond to HIV/AIDS' impact on food security through initiatives such as food for training and food for assets;
  - improve and maintain human capital through nutrition programmes, food for training, school feeding and TB programmes;



- reduce the vulnerability of families to food insecurity and malnutrition through safety-net initiatives such as home-based care projects and mother-and-child health programmes, and initiatives targeted to child-headed households; and
- through partners, be used as a conduit for the dissemination of HIV/AIDS prevention messages and information.

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## RECOMMENDATIONS

- a) WFP will incorporate HIV/AIDS concerns in all of its programming categories—Country Programmes, PRROs and EMOPs. Food insecurity driven by HIV/AIDS can be addressed directly through WFP programmes, and WFP activities can be used as platforms for other types of HIV/AIDS programmes, such as prevention education.
- b) WFP will work with local and international partners, NGOs, governments and United Nations agencies to ensure that food is incorporated into HIV activities when and where appropriate. WFP will work particularly closely with UNAIDS co-sponsors and the UNAIDS Secretariat in this regard.
- c) WFP will adjust programming tools such as needs assessments, vulnerability analysis, the design of rations and other nutrition-related activities as information and research results become available to reflect the new reality presented by HIV/AIDS.
- d) When HIV/AIDS threatens food security and influences mortality in ways similar to other disasters, WFP will consider HIV/AIDS as a basis for a PRRO, consistent with current WFP policy on PRROs.

