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WFP HIV AND AIDS POLICY

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NOTE TO THE EXECUTIVE BOARD

This document is submitted to the Executive Board for approval

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, PS*:	Mr D. Stevenson	tel.: 066513-2325
Chief, PSN**:	Mr M. Bloem	tel.: 066513-2565

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

* Policy, Planning and Strategy Division
** Nutrition and HIV and AIDS Service

EXECUTIVE SUMMARY

As of December 2008, an estimated 33.4 million people were living with HIV, including 2.7 million people newly infected in 2008. The epidemic is not under control: there are five new infections for every two people who start anti-retroviral therapy. The epidemic differs among regions, countries and provinces, and current responses may already be outdated; there has also been a dramatic convergence of the HIV and tuberculosis epidemics.

HIV puts infected people at high risk of weight loss and wasting, often compounding existing malnutrition. It affects the ability to ingest and digest food, and the body requires more calories to mount an immune response to AIDS than before infection. Even with treatment, HIV patients often suffer from weight loss, which puts them at risk of disease progression and mortality. In low-income countries HIV contributes to food insecurity and malnutrition; it disrupts livelihoods as people living with HIV lose the ability to work, which exacerbates food insecurity; and such people are often excluded from informal safety nets because of the stigma associated with the disease.

Although advances in anti-retroviral therapy have enabled many people living with HIV to lead relatively healthy lives and have significantly reduced HIV-related mortality and morbidity, fewer than half of those in need have access to treatment in 2010. The importance of nutrition interventions has been recognized by the Joint United Nations Programme on HIV/AIDS and the World Health Organization; as a result, HIV-related activities are funded by the Global Fund to Fight AIDS, Tuberculosis, and Malaria and the United States President's Emergency Plan for AIDS Relief. As a Cosponsor of the Joint United Nations Programme on HIV/AIDS, WFP has helped people living with HIV to address nutrition and food security challenges. WFP's 2003 HIV and AIDS policy made it a recognized partner in the response to AIDS with responses tailored to each epidemiological and social context. Since 2006, WFP has been responsible for nutrition and/or food support under the Division of Labour of the Joint United Nations Programme on HIV/AIDS.

In 2009, the Joint United Nations Programme on HIV/AIDS confirmed that WFP's experience positions it to make significant contributions to three priority areas of its Joint Outcome Framework: i) ensuring that people living with HIV receive treatment; ii) preventing them from dying of tuberculosis; and iii) enhancing social protection for people affected by HIV. The WFP Strategic Plan (2008–2013) mandates that WFP help governments to find and implement evidence-based interventions and innovative delivery modalities. These are applicable to HIV in humanitarian contexts, where sudden emergency or chronic underdevelopment makes people vulnerable to HIV and TB.

WFP's HIV and AIDS policy guides its interventions as part of the United Nations response and in line with the five-year Strategic Plan (2011–2015) of the Joint United Nations Programme on HIV/AIDS; it aims to ensure that food-insecure people receiving anti-retroviral treatment in low-income countries receive nutritional support and that people affected by HIV or tuberculosis do not use negative coping mechanisms to address increasing expenses and reduced household incomes. WFP will, therefore, endeavour to: i) ensure nutritional recovery and treatment success through nutrition and/or food support; and ii) mitigate the effects of HIV and AIDS through sustainable safety nets.

DRAFT DECISION*

The Board approves "WFP HIV and AIDS Policy" (WFP/EB.2/2010/4-A).

* 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.

POLICY OBJECTIVES

1. WFP will address its obligations under the Joint United Nations Programme on HIV/AIDS (UNAIDS) Joint Outcome Framework (JOF) by:

   - ensuring nutritional recovery and treatment success through nutrition and/or food support; and
   - mitigating the effects of AIDS on individuals and households through sustainable safety nets.

INTRODUCTION

2. This policy outlines the purpose and objectives of WFP's HIV and AIDS programmes, the delivery methods and the tools for measuring success. It aims to give direction to WFP's HIV and AIDS programme activities. It is inspired by a vision of a world in which nutritional support is integrated into treatment programmes so that food-insecure people on anti-retroviral therapy (ART) in low-income countries receive adequate nutritional support.

3. The emergency response to drought in southern Africa in 2002 was the first time that WFP and its partners recognized the special needs of people living with HIV (PLHIV)[1,2] and the social impact. As a result, WFP's first HIV and AIDS policy in 2003 focused on protecting and restoring food security and mitigating the impact of AIDS.

4. Since 2003, coverage of treatment in low-income countries has increased, and new evidence has emerged of the importance of nutrition and food support in treatment success. WFP became a UNAIDS cosponsor in 2003.[3]

5. UNAIDS coordinates support for governments and civil society in preventing new HIV infections, provides treatment for PLHIV, and mitigates the impact of the epidemic. It is a prime example of the United Nations Delivering as One initiative. Since 2006, under the UNAIDS Division of Labour, each agency has responsibility in its area of comparative advantage. WFP, which is responsible for nutrition and food support, has received funds from the UNAIDS budget[4] and is accountable to its partners and the UNAIDS board.

6. In view of these changes, this policy supersedes the 2003 policy.[5] It is guided by the WFP Strategic Plan (2008–2013), WFP's commitments to UNAIDS, recent evidence and the lessons learned in reviews of its work. This policy follows a 2008 external evaluation of WFP's AIDS response and takes into account the lessons learned and encouragement to improve. It is consistent with the UNAIDS five-year Strategic Plan (2011–2015), which guides the work of the Secretariat and Cosponsors. The Strategic Plan will build on

[1] The increased energy needs and commensurate protein and fat increases of PLHIV documented by the World Health Organization (WHO) in 2001 were introduced into the calculations for population-level nutritional requirements in emergency situations (SPHERE standards).

[2] Ration standards were increased to 2,200 kcal and additional corn-soya blend was provided in the relief rations to facilitate care for chronically ill people.

[3] UNAIDS coordinates the Office of the United Nations High Commissioner for Refugees (UNHCR), the United Nations Children's Fund (UNICEF), WFP, the United Nations Development Programme (UNDP), the United Nations Population Fund (UNFPA), the United Nations Office on Drugs and Crime (UNODC), the International Labour Organization (ILO), the United Nations Educational, Scientific and Cultural Organization (UNESCO), the World Health Organization (WHO) and the World Bank.

[4] As a UNAIDS Cosponsor, WFP received US$8.5 million for the 2010–2011 biennium from the UNAIDS budget, a 21 percent increase over the 2008–2009 allocation.

[5] WFP/EB.1/2003/4-B.

existing Cosponsor HIV strategies and the current UNAIDS Outcome Framework will be made operational through the rolling Unified Budget and Performance Workplan.[6] The timeline of the policy is 2010 to 2015.

7. An important component of WFP's HIV and AIDS policy is the inclusion of tuberculosis (TB) in view of the dramatic convergence of the HIV and TB epidemics.[7] TB is the main opportunistic infection when the immune systems of PLHIV deteriorate. A third of the global population have latent TB, which often develops into active infection when the immune system weakens, for example because of HIV infection or malnutrition.

STATE OF THE EPIDEMIC

8. Significant changes related to HIV and AIDS have occurred since the previous HIV and AIDS policy paper in 2003. As of December 2008, an estimated 33.4 million people were living with HIV, including 2.7 million people infected in 2008.[8] Access to HIV treatment has been expanded, and the pace of new HIV infections is 30 percent lower than in 1996. Despite progress, however, global coverage remains low: in 2008, only 42 percent of those needing treatment had access. However, in middle-income and low-income countries, 4 million people had access to ART by the end of 2008. WFP reached an estimated 5.7 percent of these patients through ART programmes in 2009.

9. This progress has not reversed the trajectory of the epidemic: for every two people who start treatment, another five are infected. HIV is the leading fatal infectious disease in the world and the primary cause of death among women of reproductive age. In countries with high prevalence rates, most people infected with HIV are aged 15 to 49—the most economically productive age group. Countries with large numbers of PLHIV are often affected by high levels of food insecurity and malnutrition, which create a downward spiral of mutually reinforcing effects.

10. HIV has dramatic consequences for entire communities, especially where malnutrition and food insecurity are prevalent. Of the two billion people suffering from micronutrient deficiencies, many are in countries with high HIV and TB prevalence and high levels of malnutrition. Both diseases exacerbate malnutrition and food insecurity, with particularly negative consequences for children in the form of wasting and stunting.

11. The effects of the epidemic are especially pronounced in southern Africa, where the nine countries with the highest HIV prevalence are located. Life expectancy declined from 62 years in 1994 to 50 years in 2009, and is projected to fall further by 2011; Swaziland saw the most dramatic decline, from 60 years in 1994 to 34 years in 2009, which effectively negated decades of development. HIV-related mortality reduces life expectancy and has far-reaching social and economic impacts. The shifting mortality patterns are shown in Figure 1, which uses the example of South Africa.[9] Mortality among women is

[6] The Unified Budget and Workplan – as of late 2010 to be referred to as the Unified Budget and Accountability Framework – is a unique instrument in the United Nations system. It combines in a joint programme the work of the ten UNAIDS Cosponsors and a secretariat in a biennial budget and workplan that maximizes the coherence, coordination and impact of the United Nations response to AIDS.

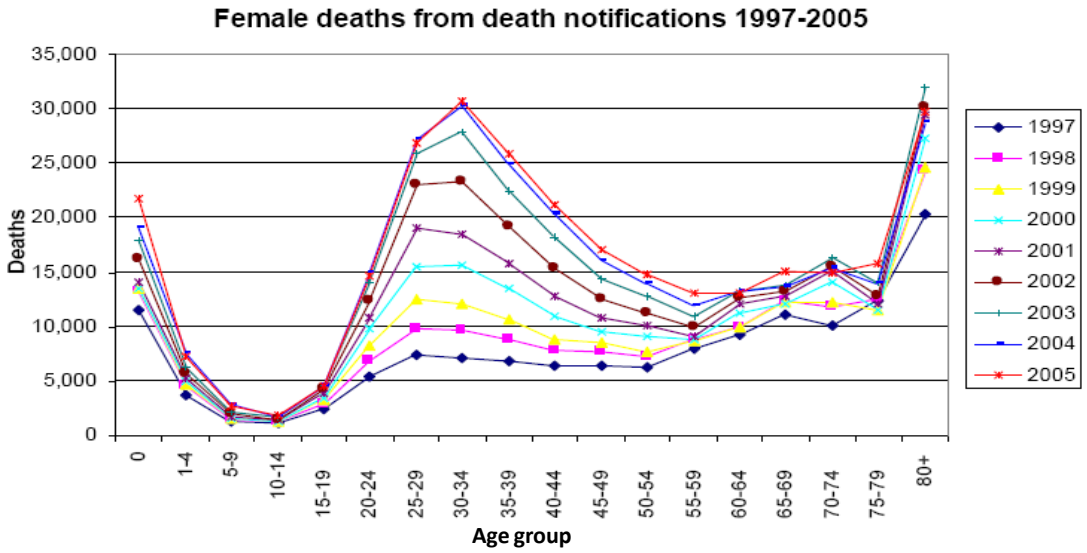
[7] The terms "TB/HIV" or "HIV/TB" are used to describe the intersecting epidemics. WHO/HTM/TB/2009.414 and WHO/HTM/HIV/09.01, available at: http://www.who.int/tb/publications/2009/en/index.html

[8] UNAIDS. 2009. *AIDS Epidemic Update 2009*. Geneva. Available at: http://www.unaids.org/en/KnowledgeCentre/HIVData/EpiUpdate/EpiUpdArchive/2009/default.asp

[9] Development Bank of Southern Africa. 2008. *Road Map Process*. Available at: http://www.dbsa.org/Research/Documents/Health%20Roadmap.pdf

highest between the ages of 25 and 39; mortality among men peaks later. The South African Government has called these mortality statistics "war-like."

Figure 1. Mortality of Women by Age Range in South Africa, 1997–2005



12. The social impact of such large-scale premature mortality combined with frequent droughts, weak government capacity, and limited resilience in communities amounts to a humanitarian disaster. Evidence from the recent economic and financial crisis illustrates the low resilience of PLHIV to external shocks.[10]

13. No region has been spared by HIV. In many Asian countries, HIV is prevalent in most-at-risk populations (MARPs) such as intravenous drug users, men who have sex with men, and sex workers. In Bangladesh, India, and Papua New Guinea, heterosexual transmission is also significant.[11] In most of Latin America, HIV is concentrated among MARPs, but the escalating rate of infections among women and girls shows that it is becoming more generalized. In the Caribbean, prevalence rates are significantly higher, and HIV is often spread through heterosexual transmission, men who have sex with men, and sex workers.

14. HIV epidemics are influenced by cultural, political, and economic factors. Heterosexual transmission accounts for an increasing share, and in south Asia and sub-Saharan Africa new epidemiological patterns have emerged in which older adults in stable relationships represent a growing proportion of people being infected.[12]

[10] UNAIDS/World Bank. 2009. *Global Economic Crisis and HIV Prevention and Treatment Programmes. Vulnerabilities and Impact.* Geneva. Available at: www.unaids.org/en/KnowledgeCentre/Resources/PressCentre/PressReleases/2009/20090706_PR_UNAIDS_WB_Report.

[11] UNDP. 2007. *HIV-Related Stigma and Discrimination in Asia: A Review of Human Development Consequences*. UNDP Regional HIV and Development Programme for Asia-Pacific. Colombo.

[12] UNAIDS. 2009. *AIDS Epidemic Update 2009*. Geneva. Available at: http://www.unaids.org/en/KnowledgeCentre/HIVData/EpiUpdate/EpiUpdArchive/2009/default.asp

LESSONS LEARNED: ACHIEVEMENTS AND CHALLENGES

15. WFP has spent seven years designing, implementing and evaluating programmes related to HIV and TB. This section considers lessons learned in programming and the challenges encountered. A WFP desk review in 2010 found that 3.0 million PLHIV, including children, in 47 countries benefited in 2009 from nutritional rehabilitation, safety nets or a combination of these either through clinics or by reductions in the burden on households. Many PLHIV may also benefit from other WFP programmes that do not target them: examples include school feeding and food-for-assets programmes.

TABLE 1: BENEFICIARY FIGURES BY HIV AND AIDS PROGRAMME CATEGORY, 2009[13]

Objective 1: Ensuring nutritional recovery and treatment success through nutrition and/or food support – Care and treatment	1 859 655*
Objective 2: Mitigating the effects of AIDS on affected individuals and households through sustainable safety nets – Mitigation and safety nets	1 126 346

* Of which 488,279 are patients and 1,371,376 are household members.

Evidence-Based Programmes Deliver Results

16. WFP has worked with its partners on research to build an evidence base. For example, "Food Assistance Programming in the Context of HIV," the first practical guidance, was developed in partnership with the United States Agency for International Development through Food and Nutrition Technical Assistance (FANTA).[14]

17. WFP has developed a Monitoring and Evaluation Guide for Food-Assisted HIV Programming, which defines the main HIV and AIDS programming categories and results frameworks. The guide helps programme staff to design their own monitoring and evaluation (M&E) systems in line with national M&E systems. The guide is based on the 2008–2013 Strategic Results Framework complemented by the indicator compendium, which has the information needed to conduct baseline and follow-up surveys, identify indicators, set targets and establish frequency of data collection. The annual standard project reports are used to generate output and outcome data by activity, complemented by periodic reports from regional bureaux on achievements in programmes funded by the UNAIDS Unified Budget and Performance Workplan.[15]

18. In preparing this paper, WFP worked with universities to review the evidence related to nutrition and HIV, nutrition and TB, and food insecurity and HIV. Three background papers summarized the state of the evidence. Although significant gaps remain, our current knowledge is sufficient to produce well-designed interventions. WFP will continue to dialogue and update its programmes accordingly.

[13] These numbers are a mix of index patients (PLHIV enrolled in treatment programmes or TB patients receiving WFP nutrition or food support) and household members; they reflect the cumulative number of people supported in 2009.

[14] FANTA and WFP. 2007. *Food Assistance Programming in the Context of HIV*. Washington, DC.

[15] Revisions of the M&E guide are ongoing to align it with the changes proposed to the Strategic Results Framework following the recently approved Board paper on the programme category review. Once the new framework is approved, all changes relevant to HIV and AIDS will be incorporated in the guide, which will be distributed to field offices and partners.

19. WFP recognizes the importance of hand-over strategies. HIV is a lifelong chronic disease, but WFP's food and nutrition interventions are finite: They address the acute phase of the clinical stage of HIV and related income shocks. WFP and governments need to work on the development of hand-over strategies.

20. WFP will, therefore, work with partners to create linkages to livelihood activities to enable transition from its support without reinforcing stigma by singling out PLHIV, and bearing in mind that hand-over strategies must reflect situations of widespread poverty

21. Failure to develop hand-over strategies may result in patients on ART entering, exiting and re-entering WFP's nutritional support programmes because biomedical indicators will improve while they receive support but deteriorate when they are discharged. Even if ART prevents the recurrence of AIDS-induced wasting, other longer-term nutritional issues may need to be considered: examples are designing diets that enable PLHIV to manage symptoms, and addressing the higher risks of developing cardiovascular problems, cancer or diabetes. Helping beneficiaries to become healthy, productive and food-secure is the only way to prevent them from being trapped in a vicious cycle.

22. WFP is increasingly implementing programmes in partnership with ministries of health to ensure that hand-over is considered from the start. The current development of a food-by-prescription (FBP) programme in Swaziland with the National Nutrition Council, which is part of the Ministry of Health, is an example of this approach. The new programme has been included in the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) proposal for Round 10 submitted in August 2010. Another example is the Mozambique pilot for development of a voucher-based system to make a basic food basket available to malnourished ART patients: the pilot is being developed at the request of the Ministry of Health, which allocated World Bank funds through WFP for this purpose.

23. The support programme for orphans and other vulnerable children (OVC) in Namibia was designed to assist the Government in establishing a grant programme to promote nutrition among children. WFP introduced food assistance into the communities most affected by identifying the most vulnerable children, thus facilitating the introduction of a cash-transfer programme. As the grant programme expanded its reach, WFP phased out food assistance.

Targeting in HIV and AIDS Differs from Many Other WFP Programmes

24. WFP recognizes the importance of targeting vulnerable populations and of continuous M&E. To be consistent with the Three Ones,[16] which prescribe one national M&E system, and to improve understanding of food and nutrition requirements, WFP should continue its work with governments and national AIDS authorities to design sound M&E systems. WFP implements the Three Ones mainly through the joint United Nations AIDS teams. United Nations joint programmes offer opportunities to integrate food and nutrition issues into national HIV responses, particularly through the Delivering as One initiative.

25. Targeting in HIV and TB programming differs from WFP's traditional targeting mechanisms. Nutrition and food support in the context of treatment is focused on an individual's nutritional status rather than on the household. This shift from geographical targeting is made because PLHIV are often referred to WFP from the health-care sector on

[16] One agreed HIV/AIDS action framework that coordinates the work of all partners, one national AIDS coordinating authority and one country-level M&E system.

the basis of anthropometric criteria measuring undernutrition in terms of body mass index (BMI) or mid-upper arm circumference.

26. Temporary food assistance can prevent irreversible negative coping behaviours in households rather than merely mitigate the consequences of HIV. WFP must analyse HIV-induced vulnerability further at the individual and household levels; it is increasingly integrating HIV and AIDS-related proxy indicators into vulnerability assessments and seeking ways to use programme data to accumulate evidence of the benefits of food and nutrition assistance in ART and TB programmes. New indicators, which link to the two main objectives stipulated in this policy, have been approved to measure the results of food assistance interventions in the health sector; outcomes and long-term impacts are outlined in Annex I.

Broad Partnerships are Essential to Allow WFP to Deliver its Promise

27. WFP recognizes the importance of partnerships in addressing the needs of PLHIV. In line with the "Three Ones" principle, its main partners are governments and national AIDS authorities. WFP's interventions aim to complement programmes managed by these authorities, often in cooperation with non-governmental organizations (NGOs). WFP's goal is that national actors design and implement their own AIDS programmes. It will, therefore, continue to support governments in establishing food and nutrition as integral parts of HIV care and treatment. Contexts of low income and capacity may require WFP to design programmes, but WFP's role will generally focus on advocacy and capacity development.

28. WFP has benefited from its partnerships with UNICEF to address social protection and respond to the needs of children affected by HIV and AIDS; it has worked with WHO to refine nutrition protocols for HIV and develop new protocols for TB. WFP will continue to develop these partnerships. Other partners include the GFATM[17] and the United States President's Emergency Plan for AIDS Relief (PEPFAR), both of which recognize nutrition and food support as integral elements of treatment. Many WFP programmes in HIV can be funded from these sources, but country offices find it difficult to engage with PEPFAR or country coordinating mechanisms administering GFATM grants. WFP needs to empower its offices to access these resources and ensure that governments understand the benefits of WFP's technical assistance.

29. WFP will continue to foster partnerships with networks of PLHIV, community-based organizations, NGOs and civil-society organizations. It cannot be effective without the knowledge and experience of the NGOs, which are advocates for the rights of PLHIV and TB patients and are best placed to reach MARPs; their support is essential in implementing

[17] WFP's role in GFATM grants can range from technical advice to governments on food and nutrition, facilitation of food supply-chain management and helping governments and partners to implement comprehensive food and nutrition activities for PLHIV. WFP increasingly builds coalitions in recipient countries to champion food and nutrition issues and provide technical advice and assistance in developing the food and nutrition components of GFATM proposals.
The WFP Policy, Planning and Strategy Division conducted in cooperation with regional bureaux, George Washington University and the Albion Street Center research in 2010 to find ways to reduce barriers experienced by WFP country offices in engaging with GFATM. Country visits were made to Djibouti, Ethiopia, Ghana, the Lao People's Democratic Republic, Swaziland and Zimbabwe before and during their applications for Round 10 funds. The work resulted in a manual and training programme to build the capacity of staff to adopt best practices.
The manual will be leveraged in coming years to ensure that more countries give food and nutrition a prominent place in their GFATM applications. This work should channel more funding to food and nutrition programmes in the context of HIV and TB, in line with the scientific evidence and this policy.

programmes and establishing M&E. With local partners, WFP will emphasize stigma reduction and raise awareness of the services available and the right of access.

30. The challenges of HIV and AIDS are too large for any single actor. Some of WFP's objectives are shared by the private sector, which can contribute expertise and resources to solutions for PLHIV. WFP will continue to work with major food companies and organizations such as the Global Alliance for Improved Nutrition and FANTA. With WFP and universities, the private sector can lead the way in developing nutritious products to meet the needs of people on treatment for HIV and TB.

HOW DOES WFP FIT INTO THE UNAIDS RESPONSE TO HIV?

31. UNAIDS coordinates United Nations support for governments and civil society in preventing new HIV infections, providing treatment and care for PLHIV, and mitigating the impact of the epidemic. Under the UNAIDS Division of Labour, in which each agency is responsible in its area of comparative advantage, WFP is responsible for nutrition and food support. WFP has received significant funds from the UNAIDS budget[18] for its contribution to the global response to HIV and AIDS and is accountable to its partners and the UNAIDS Board.

32. UNAIDS recognizes the importance of food assistance and nutrition as integral parts of treatment as stipulated in the JOF for 2009–2011, which outlines priorities for amplifying the response to HIV, contributing to the development agenda, and guiding Cosponsors in investing resources to contribute to the joint response. The Joint Outcome Framework (JOF) assigns to WFP the responsibility for helping governments to implement food and nutrition interventions for PLHIV and TB patients and creating safety nets.

33. The JOF is based on the goal of universal access (UA) under ten priority areas with a view capitalizing on comparative advantages, supporting national priorities and producing optimum results.[19] UNICEF, for example, will focus on children affected by HIV and AIDS and prevention of mother-to-child transmission.

[18] As a UNAIDS Cosponsor, WFP received US$8.5 million for the 2010–2011 biennium from the UNAIDS budget, a 21 percent increase over the 2008–2009 allocation.

[19] UNAIDS. 2009. Joint Action: Outcome Framework 2009–2011. Geneva.

34. WFP will focus on activities under three of the ten JOF priorities:

- **Ensure that PLHIV receive treatment**

  WFP will advocate with governments to ensure that nutrition and/or food support are integrated within treatment programmes so that no person receiving ART in a low-income country goes without adequate nutrition and/or food support. Adequate food and nutrition support can reduce early mortality and improve treatment success. Nutrition assessment, education, and counselling are required for all ART patients, whereas food should strictly be provided based on nutritional status, usually determined based on anthropometric indicators. In cases where governments lack such capacity, WFP will work with its partners to provide this support.

- **Prevent PLHIV from dying of TB**

  WFP will contribute to the effective, integrated delivery of services for HIV and TB, including nutrition and/or food support for people infected with TB.

- **Enhance social protection for people affected by HIV**

  WFP will advocate for safety nets for people affected by HIV, including people experiencing hunger, poor nutrition, and food insecurity as well as orphaned and other vulnerable children.[20] Where governments lack capacity, WFP may assist them in providing safety nets. WFP will advocate with governments to make existing social protection systems inclusive of PLHIV.

35. WFP will collaborate with UNHCR to prioritize food and nutrition interventions for HIV and AIDS in humanitarian settings and food crises. PLHIV are also the first to suffer in emergencies because their treatment may be interrupted and lack of clean water, nutritious food and adequate hygiene may result in poor adherence and increased risk of opportunistic infections. WFP will therefore prioritize the needs of PLHIV and other vulnerable groups in emergency situations.

36. WFP is well positioned to help governments to establish effective programmes for nutrition, food support, and safety nets[20] with a view to achieving the Millennium Development Goals. WFP leadership will continue to facilitate country-level dialogues on the inclusion of food and nutrition strategies in HIV programming.

37. Nutrition and/or food support are essential factors in UA. HIV, AIDS and TB affect food security at the individual and household levels and devastate economies and societies in high-prevalence settings. Food insecurity resulting from a sudden emergency or chronic underdevelopment makes people vulnerable to HIV because it may induce risky coping behaviours.

38. Nutrition and food support must be provided as part of national responses to AIDS: this may be achieved under WFP's programme categories and Strategic Objectives. WFP's food and nutrition support for HIV and AIDS is also applicable under United Nations Development Assistance Frameworks: WFP programmes will therefore adapt outputs and outcomes to each context on the basis of evidence of vulnerability to food insecurity and HIV and AIDS.

39. PLHIV may also qualify for support programmes such as food or cash for work, food for training or assets, or school feeding, even though the main targeting criterion is not HIV status. WFP is committed to addressing the needs of PLHIV through inclusion in programmes, adaptation of targeting criteria, and sensitization of WFP and partner staff to possible discrimination.

[20] UNAIDS. 2009. *Letter to Partners*. Geneva. Available at: http://data.unaids.org/pub/BaseDocument/2009/20090210_exd_lettertopartners_en.pdf

WFP'S POLICY FRAMEWORK: OBJECTIVES AND GUIDING PRINCIPLES FOR IMPLEMENTATION

40. WFP's policy has two main objectives:

i) ensuring nutritional recovery and treatment success through the provision of nutrition and/or food support; and
ii) mitigating the effects of AIDS on individuals and households through sustainable safety nets.

Objective I: Ensuring Nutritional Recovery and Treatment Success through the Provision of Nutrition and/or Food Support

41. Despite the impressive increase in anti-retroviral (ARV) treatment coverage in low-income countries, HIV mortality is too high in many cases. Scientific research shows that mortality in the first months of treatment is two to six times higher in low-income countries than in high-income settings.[21] This is probably related to malnutrition, which weakens the immune system beyond the effects of HIV. People in low-income settings typically present for treatment only at an advanced stage of the disease, when their malnutrition may be partly disease-induced. Nutrition and food support – when they are integral to life-saving treatment – can reduce mortality; they also reduce the side-effects of medications, the likelihood and severity of opportunistic infections, and long-term metabolic complications such as dyslipidemia, obesity and resistance to insulin.

42. The effects of inadequate nutrition are most evident at the start of treatment and during the first three to six months, when patients experience the side effects of ART and may need to recover from weight loss induced by the disease. These side effects challenge patients' ability to adhere to ART or cause fear among those not yet enrolled. Treatment uptake and regular adherence may also be hampered by real and opportunity costs and stigma; similar challenges are experienced by TB patients starting directly observed treatment, shortcourses (DOTS).[22]

43. Food assistance programmes in the context of ART or DOTS address these challenges by integrating nutrition rehabilitation into treatment packages. Patients' nutritional well-being is routinely monitored, for example by BMI, to inform initiation and termination of nutrition rehabilitation. Food assistance typically consists of nutritional assessment, education and counselling; it is often augmented with an individual nutritional supplement. It normally lasts for six to eight months, depending on speed of recovery and programme design. This category of programmes is sometimes known as food by prescription (FBP).

44. Such programmes should be adjusted to each context. The choice of foods used in different phases of treatment must reflect nutritional status, effectiveness, and cost; the purpose of food assistance, special nutritional requirements, recovery period, ration sharing, and operational considerations must be taken into account.

[21] Thiers, B.H. 2006. Mortality of HIV-1-infected patients in the first year of anti-retroviral therapy: comparison between low-income and high-income countries. *The Lancet* 367: 817–824.

[22] DOTS combines diagnosis of TB and registration of patients followed by standardized multi-drug treatment with a secure supply of high quality anti-TB drugs, individual patient outcome evaluation to ensure cure and cohort evaluation to monitor the performance of the programme. See: http://www.tbalert.org/worldwide/DOTS.php

45. WFP's understanding of the nutritional challenges facing PLHIV will help it to define its responses. WFP's nutrition improvement approach will help to meet more effectively the nutritional needs of PLHIV receiving treatment: it focuses on improving problem analysis before food assistance interventions and encourages the use of the best cost-effective modality from an expanded toolkit to address the nutritional needs of each target group. The enlarged toolkit includes a variety of new food products, cash, and vouchers. The nutrition improvement approach also calls for a focus on the needs of vulnerable populations such as young children and PLHIV. In some situations, preventive interventions may be more cost effective than treating existing malnutrition.

46. WFP recognizes that such programmes will succeed only when effective systems and infrastructures are in place. It, therefore, works with national health services to ensure that nutrition rehabilitation protocols and programme management are in line with health service delivery systems and that they enhance national capacities, infrastructures, and supply mechanisms.

47. Food and nutrition support programmes respond to disease-induced nutritional deficiencies across geographical and food security zones. Because HIV and TB make infected individuals food insecure, most patients in low-income settings require nutritional assessment, education, counselling, and nutritional supplements for a limited time. The importance of nutrition for treatment success has been recognized not only by scientists, but also by UNAIDS and WHO; as a result, GFATM and PEPFAR fund related activities.

Objective II: Mitigating the Effects of AIDS on Individuals and Households through Sustainable Safety Nets

48. Interventions under this objective provide food assistance, including through innovative modalities such as voucher schemes or cash transfers, to prevent people affected by HIV and AIDS from engaging in negative coping behaviours and to mitigate the effects of the disease. Target groups include patients in care and treatment, chronically ill people without access to treatment, and OVC and their caregivers. Such interventions should be limited in time and provided on the basis of food insecurity and socio-economic assessments.

49. HIV and AIDS impose an enormous cost on societies and significantly slow down economic development. When a productive household member is infected with HIV and falls ill, the household faces rising care costs and significant income loss, sometimes compounded by social stigma. Food assistance can complement support provided by extended and host families, communities, and institutions and will support basic education, vocational training, and livelihood opportunities.

50. Support for OVC is provided in many forms, with consideration for the overall well-being of the child; it often reflects basic needs in national plans of action for OVC.[23] The food assistance is designed on the basis of the context in which it is provided to maximize the impact of the support package.[24]

51. Reliable figures are often unavailable at the community level, so the threshold for designing support programmes in food-insecure settings should be driven by estimated HIV or TB prevalence rates. The rationale is that the natural ability of families and communities to cope with HIV and TB is indirectly proportional to prevalence and is thus quickly exhausted in low-income and food-insecure settings.

[23] WFP. 2009. *WFP School Feeding Policy*. Rome.

[24] WFP/EB.2/2009/4-A.

52. Food assistance provided under this objective should enable households or individuals to cope with the shock of HIV and AIDS and prevent deterioration of individual and household well-being. Such safety nets can protect individuals and households from further deterioration and in some cases improve food security, but they should not be expected to address the causes of poverty. WFP will help governments and partners to refer able-bodied but food-insecure PLHIV to broader safety nets that provide sustainable income-earning opportunities and support long-term adherence to treatment. Where treatment programmes are not yet widely available, chronically ill people may have difficulty in accessing services and rely on community and home-based support. Food assistance can help patients to regain strength and reduce the burden of family care, contribute to household activities and give the household respite from short-term coping strategies. It is essential to show at the outset that support will be of limited duration to ensure patients' participation and ownership.[25]

⇒ *Broad safety nets*

53. WFP has helped governments to build systems such as the Productive Safety Net Programme in Ethiopia. Such safety nets are designed to address food insecurity rather than HIV, but they are important in preventing the spread of HIV and addressing the needs of PLHIV. Child grants, old-age pensions, and disability grants are typically available at the national level: greater access to adequate food on a seasonal or routine basis can make a critical contribution to national responses to AIDS.

54. Such safety nets protect people's livelihoods and prevent them from engaging in coping behaviours that could expose them to HIV. When treatment has helped PLHIV and TB patients to recover medically and nutritionally, they can be referred to safety nets linked to national social protection schemes. Where such safety nets do not exist, WFP will advocate for their creation and work with governments to ensure that they include PLHIV.

⇒ *Prevention activities*

55. United Nations agencies are committed to preventing the spread of HIV. WFP can contribute by working to break the vicious cycle of food insecurity – HIV – worsened food insecurity. WFP has identified several entry points for preventing new HIV infections:

- HIV treatment helps to prevent transmission. PLHIV receiving treatment have substantially lower viral loads, which improves their quality of life and makes them less contagious. WFP contributes to treatment programmes through its intervention under the first objective.
- There is evidence that mobile populations such as transport workers in WFP operations are particularly vulnerable to HIV. WFP, therefore, works with partners such as the International Transport Forum, TNT, UNAIDS, the North Star Alliance, and governments to expand UA to cover prevention, treatment, care, and support along transport corridors.
- WFP will improve its implementation of the ten minimum standards of the UN Cares programme[26] and its HIV and AIDS in the Workplace programme by enhancing HIV

[25] Evidence shows that where broad treatment coverage is achieved, home-based care must not be stopped but converted into community-based support ranging from adherence counselling and psycho-social support to livelihood activities.

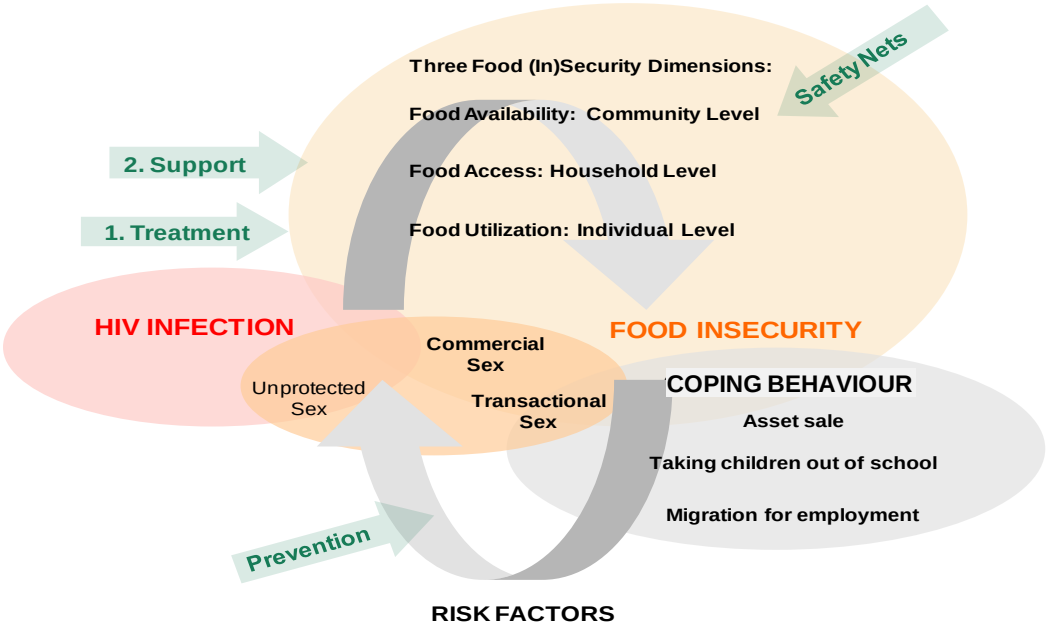
[26] This is designed to help United Nations personnel and their families to access the rights in the 1991 United Nations HIV/AIDS Personnel Policy, the International Labour Organization (ILO) *Code of Practice on HIV/AIDS, and the World of Work* and to recognize their responsibilities in relation to HIV.

support for staff regardless of duty station or contract type. WFP will work in accordance with the ILO International Labour Standard[27] on HIV and AIDS, which is the first international human rights instrument to focus on the issue in the world of work.

- Provided that it is practical and that there are qualified partners, WFP should use its food-delivery platforms to maximize the opportunity to reach beneficiaries with HIV-prevention messages.

56. Figure 2 shows how WFP designs interventions to address HIV and food insecurity in line with its policy and to highlight the importance of broad safety nets and prevention.

Figure 2. Ways in which Interventions Can Disrupt the Causal Pathways from Food Insecurity to HIV and from HIV to Food Insecurity



Guiding Principles

57. Under its primary objectives, WFP will support governments in implementing HIV and AIDS programmes in line with the following principles:

- Know your epidemic, know your response. Every programme response should be tailored to the epidemiological and socio-political context.
- Keep in mind the "Three Ones" and national ownership. WFP is committed to the "Three Ones": its HIV and AIDS activities should respond to national programmes to reinforce national ownership of responses.
- Integrate food and nutrition into comprehensive responses. Food and nutrition interventions should be integrated into health and social welfare programmes; they should not be stand-alone activities.
- Implement evidence-based, cost-effective programmes with sound M&E. Food and nutrition interventions in HIV and TB programmes should be based on the latest

[27] The standard is the first internationally sanctioned legal instrument intended to enhance the contribution of the world of work to UA and HIV prevention, treatment, care and support. It contains provisions on potentially life-saving prevention programmes and anti-discrimination measures at the national and workplace levels; it also emphasizes the importance of employment for workers and PLHIV, particularly in terms of continuing treatment.

evidence; a sound M&E system is necessary to guide and improve interventions and to provide accountability.

- Incorporate collaboration and partnerships. WFP should choose partners with comparative advantages. It should continue to cooperate with UNAIDS Cosponsors to respond as one and work with partners such as GFATM and PEPFAR, civil society, faith-based initiatives, universities, and the private sector organizations.
- Include community participation and ownership, including PLHIV. Civil society has a critical role in HIV and AIDS response: the involvement of PLHIV in WFP's HIV and AIDS programming should be increased.
- Buy food locally. Local procurement of food is one way to achieve sustainability and to stimulate economies.
- Maintain predictable and reliable funding. This is necessary for scaling up and support programmes: nutrition and food assistance must be part of government planning and budgeting, and should depend on short-term financing only in emergencies.
- Consider gender. WFP will use gender analysis to understand the social aspects of gender relations and gender-based norms in addition to laws as they relate to HIV. WFP will continue to integrate gender aspects into HIV food and nutrition activities.
- Do no harm. HIV and AIDS responses must not make a bad situation worse, for example by contributing to stigma, creating situations in which HIV can be transmitted, diverting resources, or drawing healthcare staff away from other programmes.

POLICY RATIONALE: FOOD ASSISTANCE AND HIV AND AIDS

58. WFP's new policy reflects the changes in the HIV and AIDS situation over the last seven years. Recent scientific evidence has enhanced the understanding of the dynamics of food insecurity and HIV, HIV/TB co-infection, and the role of nutrition in prevention, treatment, and care. Treatment has improved the lives of millions and has redefined WFP's role in AIDS response. This section summarizes the evidence on which WFP has built its policy, focusing on food insecurity and malnutrition, increased energy requirements, negative coping strategies, TB, and food assistance. Figure 3 summarizes the shift from HIV to food insecurity and from food insecurity to HIV.

⇒ *HIV contributes to food insecurity and malnutrition*

59. HIV has profound consequences for nutritional status. Although people are often food insecure and malnourished before infection, HIV quickly becomes a cause of malnutrition in its own right. HIV puts people at high risk of disease-induced weight loss and wasting. Once infected, the body mounts an immune response that requires more energy than normal. WHO estimates this increased energy at 10 percent in the asymptomatic stage, increasing to 30 percent for adults in the later stages. Symptomatic HIV-positive children have calorie needs 50 percent to 100 percent greater than those of HIV-negative children;[28] young children often struggle to consume twice the amount of calories, especially when they do not have access to energy-dense foods. These factors also impose financial burdens on families. If increased energy demands are not met, PLHIV begin to lose fat and muscle tissue. As energy needs go up, symptoms of untreated HIV reduce people's food intake and can interfere with the body's ability to absorb and utilize nutrients.[29] HIV can create a

[28] WHO. 2003. *Nutrient Requirements for People Living with HIV/AIDS*. Geneva.

[29] Semba, R.D. and Tang, A.M. 1999. Micronutrients and the pathogenesis of human immunodeficiency virus infection. *Br J Nutr* 81:181–189.

paradoxical situation in which people reduce their nutrient intake just as their bodies require an increase, making nutritional support[30] a critical component of HIV treatment.

60. Regaining the lost weight requires an appropriate diet. It also means that HIV infection and opportunistic infections such as TB need to be brought under control. Where weight loss is not controlled by treatment and nutritional support, low BMI puts PLHIV at risk of accelerated disease progression and increased mortality. The higher mortality risk related to low BMI is most pronounced at the start of treatment and stabilization in the first three to six months, when patients experience the side-effects of ART for the first time and need to regain weight. Low BMI is a major risk factor for HIV-disease progression and mortality, independent of immune system performance.[31] TB patients have similar challenges.

61. The quality of diet and its palatability matter as well as the quantity of food consumed. Current evidence suggests that PLHIV and TB patients need at least one recommended nutrient intake of essential vitamins and minerals. In low-income settings, regular diets often fall short of this requirement.

62. Further research is needed to update the evidence and provide guidance on the macronutrient and micronutrient needs of PLHIV at different stages of infection.[32]

Food Insecurity Can Lead to Negative Coping Strategies and Increased Exposure to HIV

63. Food insecurity frequently induces coping behaviours that have negative and possibly irreversible consequences such as selling assets, removing children from school, migrating, and engaging in transactional sex. These behaviours may bring short-term relief, but they exact a substantial price in the long term, including increased exposure to HIV.

64. Education is vital to enable young people to understand and manage risk. Studies have shown that for every additional year a child spends in school the likelihood of contracting HIV is reduced. Mobile populations such as people who migrate to deal with food insecurity give up their social context and often become more vulnerable to HIV.

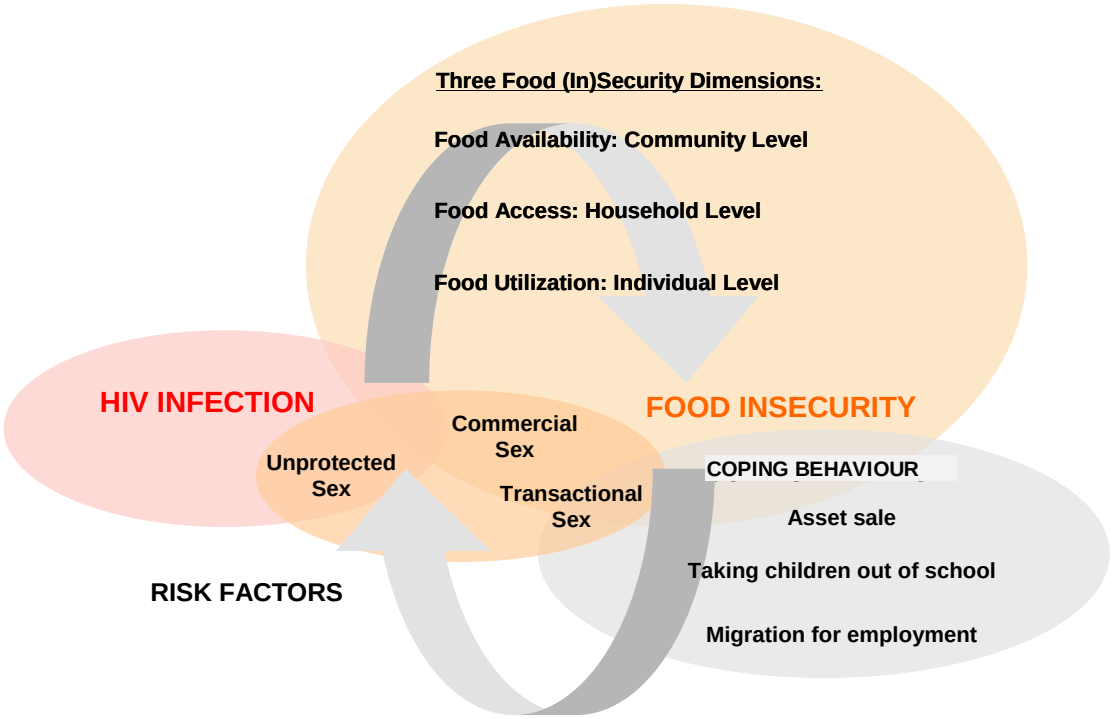
[30] Nutritional support is intended to ensure adequate nutrition and includes assessment of dietary intake, nutritional status, and food security; nutrition education and counselling are used to ensure a balanced diet, to mitigate side effects of treatment and infections, and to ensure access to clean water and, where necessary, food supplements or micronutrient supplementation.

[31] Babameto, G. and Kotler, D.P. 1997. Undernutrition in HIV infection. *Gastroenterol Clin North Am* 26: 393–415.

[32] WFP background paper on HIV and nutrition submitted for publication in 2010.

65. Destitution and despair brought on by negative coping behaviours may increase the risk that a person will resort to trading unprotected sex for food.[33]

Figure 3: HIV Infection Leads to Food Insecurity While Food Insecurity can Increase the Risk of Becoming Infected with HIV



HIV and TB

66. HIV infection and malnutrition are significant risk factors for latent TB becoming active; HIV infection increases the risk of developing TB after infection with *Mycobacterium tuberculosis*. Like HIV, TB has significant nutritional implications for the body: wasting is a common symptom, and it increases mortality in TB patients. Malnutrition is generally more severe in people with HIV/TB co-infection than in people with either disease alone. Wasting is difficult to reverse while the patient suffers from active infection. Food must provide the right quantity and quality of nutrients and micronutrients to recover lost weight and muscle mass.[34]

67. In low-resource settings, which are often characterized by chronic malnutrition irrespective of HIV or TB, food assistance takes on new meaning and relevance. Nutritional support is an essential factor in i) enabling patients to take up treatment, ii) promoting initial adherence, iii) managing side effects, iv) improving treatment success,

[33] Weiser, S. et al. 2007. Food insufficiency is associated with high-risk sexual behaviour among women in Botswana and Swaziland. *PLoS Medicine* 4(10).

Gillespie, S. 2007. *Food Prices and the AIDS Response*. Washington DC, International Food Policy Research Institute (IFPRI). Gillespie, S., Jere, P. et al. 2009. *Food Prices and the HIV Response: Findings from a Rapid Regional Assessment in Eastern and Southern Africa*. Washington DC, IFPRI. Gillespie, S. and Kandiyala, S. 2005. *HIV/AIDS and Food and Nutrition Security: from Evidence to Action*. Washington DC, IFPRI.

De Waal, A. and Whiteside, A. 2003. New variant famine: AIDS and food crisis in Southern Africa. *The Lancet* 362:1234–1237. Naysmith, S., de Waal, A. and Whiteside, A. 2009. Revisiting the new variant famine: the case of Swaziland. *Food Security* 1:251–260.

[34] WFP background paper on TB, nutrition and HIV co-Infection. Submitted for publication in 2010.

and v) bringing about nutritional recovery. Nutritional assessment, education, and counselling need to be complemented for a limited time by a nutrition supplement: depending on the nutritional problem and the regular diet, this could be a ready-to-use food, a fortified blended food, a lipid-based nutrient supplement, or a micronutrient supplement.

68. Addressing nutritional issues is important in that most drugs used in ART and the treatment of HIV-related infections interact with food intake and absorption. Mortality among patients who begin ART while they are malnourished is two to six times higher than among those who are not.[34] Regaining muscle tissue is a complex process that requires ART, treatment of secondary infections, mitigation of treatment side effects and symptoms of the infection, and a full diet.[35]

69. Recommendations to extend treatment may affect food and nutrition issues. In December 2009, WHO[36] raised the recommended CD4[35] count threshold for initiating treatment from 200 to 350/mm^3 in light of evidence that starting treatment earlier reduces morbidity and mortality among PLHIV in the long term. This has financial and operational implications for progress towards UA: a higher CD4 count threshold increases the number of people entitled to treatment, thereby increasing the cost, and may affect the type of nutrition interventions required in conjunction with treatment. If governments implement the new guidelines and if more people are tested earlier, it may be assumed that in the medium-to-long term HIV will progress to AIDS in fewer patients. The role of nutritional assessment, education, and counselling may take on increased importance, particularly as PLHIV on treatment have an increased risk of cardiovascular diseases or diabetes.

CONCLUSION

70. WFP's enhanced focus on nutrition; its engagement with UNAIDS partners, universities, and the private sector to create innovative food-based nutrition programmes; and its willingness to go beyond household-based vulnerability analyses have enabled WFP to realize its vision with regard to HIV, malnutrition, and food insecurity. The HIV and AIDS epidemic continues to grow, and WFP must intensify its efforts to assist.

71. WFP will continue to accumulate scientific evidence, build partnerships, implement cutting-edge programmes and establish robust monitoring systems to enable it to be accountable to governments and its UNAIDS partners and to have lasting effects on the HIV epidemic.

72. This policy will be shared with field staff – many of whom have contributed significantly to it – at regional workshops where Headquarters, regional and country office staff will explore ways of implementing it in regional and epidemiological contexts. A strategy will be developed to continue to improve programmes in line with this policy. WFP's new corporate HIV learning strategy will be leveraged as a platform for disseminating the policy and relevant guidance.

[35] The CD4 is the immunofunctionality threshold. See Hsu, J. W.-C., Pencharz, P.B., Macallan, D. and Tomkins, A. 2005. *Macronutrients and HIV/AIDS: a Review of Current Evidence*. Geneva, WHO.
[36] WHO. 2009. *Rapid Advance: Anti-Retroviral Therapy for HIV Infection in Adults and Adolescents*. Geneva.

ANNEX I: HIV AND AIDS LOGIC MODEL

TYPE	INPUT	OUTPUT	TYPE OF OBJECTIVES	OUTCOMES	IMPACTS
Enhancing treatment success through nutritional support	**Special food products, ready-to-use foods, medical need programmes, etc.**	**Number of index patients supported, amount of food distributed, number of clinics supported**	***Treatment success***	Increased survival rate **Indicator: %** patients known to be on treatement at 6 and 12 months after initiation of ART	Improved health and nutritional status for a productive life
				Improved TB treatment success **Indicator:** % of TB cases registered under TB-DOTS in a given year that have successfully completed treatment	
				Improved nutrition recovery **Indicator:** % of adult ART patients found to be malnourished at initiation of food support who are considered to have recovered from malnutrition on completion of food support	
				Increased adherence **Indicator**: % of patients achieving > 95% adherence to their medication in the course of the previous month	
				Reduced default rate **Indicator:** % of patients defaulting from ART programmes during the reporting period	
				Increased uptake **Indicator:** % increase in enrolment of patients	
Mitigating the effects of AIDS through safety nets	**General food basket foods, vouchers, cash**	**Number of participants and beneficiaries by activity, amount of food distributed**	***Household food security***	Adequate food consumption **Indicator:** household food consumption score	Improved household food secuirty for health, physical and human capital development
				Increased access to livelihoods; **Indicator:** household asset score	
				Reduced negative coping mechanisms **Indicator:** coping strategy index	
				Increased OVC participation in care and protection activities **Indicator:** % OVC enrolled and attending school	
Support for national action plans	**Technical support and advocacy**	**Number of countries with food and nutrition component in national AIDS and sexually transmitted disease Programme; number of countries with funded nutrition and food support programmes; number of countries with HIV-sensitive safety nets; number of counterpart trainings, number of countries assisted with HIV nutrition guidelines**	***Capacity development***	Increased national ownership of HIV food and nutrition programmes. **Indicator:** % of countries with a costed food and nutrition component in national social-protection schemes	Increased government ownership and hand-over of food assistance and nutrition components.
				Increased HIV-sensitive safety nets **Indicator:** % of countries that have HIV-sensitive safety nets	

In the context of Strategic Objective 4, **household assets** include **natural** (land, water, forests etc.), **human** (health and nutrition status, physical capacity, education level etc.) and **financial** (credit, loans, savings etc.) assets.

ACRONYMS USED IN THE DOCUMENT

AIDS	acquired immune deficiency syndrome
ART	anti-retroviral therapy
BMI	body mass index
DOTS	directly observed treatment, shortcourse
FANTA	Food and Nutrition Technical Assistance
FBP	food by prescription
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
HIV	human immune-deficiency virus
JOF	Joint Outcome Framework
M&E	monitoring and evaluation
MARP	most-at-risk population
NGO	non-governmental organization
OVC	orphans and other vulnerable children
PEPFAR	United States President's Emergency Plan for AIDS Relief
PLHIV	people living with HIV
TB	tuberculosis
UA	universal access
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNHCR	Office of the United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
WHO	World Health Organization