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UPDATE ON WFP'S RESPONSE TO HIV AND AIDS

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NOTE TO THE EXECUTIVE BOARD

This document is submitted to the Executive Board for information

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

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EXECUTIVE SUMMARY

The HIV and AIDS policy[1] approved by the Board in late 2010 is in line with the Joint United Nations Programme on HIV/AIDS (UNAIDS) five-year strategy for 2011-2015,[2] its Joint Outcome Framework[3] and its Division of Labour, and with the WFP Strategic Plan (2008-2013).[4] Under the strategy, WFP is tasked with supporting four of the ten goals of the long-term vision of "Getting-to-Zero":

- provide universal access to anti-retroviral therapy for people living with HIV who are eligible for treatment;
- reduce by half tuberculosis deaths among people living with HIV;
- prevent mother-to-child transmission; and
- ensure that people living with HIV and households affected by HIV are addressed in national social protection strategies and that they have access to care and support.

Under the 2010 Joint United Nations Programme on HIV/AIDS Division of Labour, WFP is the sole convener for food and nutrition and a co-convener with the Office of the United Nations High Commissioner for Refugees for humanitarian emergencies. In view of its experience with nutrition and food security, WFP has a critical role in scaling up such programmes in partnership with Joint United Nations Programme on HIV/AIDS, governments and civil society.

During the current period of financial constraint, good investments are more important than ever. There is a move among donors away from "vertical" funding towards "horizontal" funding for broad objectives such as enhancement of health systems, which can be achieved with integrated HIV, food and nutrition interventions. Such interventions can also increase returns on investment in existing HIV treatment, care and support programmes. Food and nutrition interventions can reduce mortality and morbidity, improve quality of life and, when combined with treatment, improve uptake of and adherence to treatment.

Integrated HIV and AIDS responses require that the strengths of health services and communities are leveraged. Only health services can ensure that nutritional status is considered part of treatment, but they are too overburdened to support individual households. Research is needed to find ways to link health service treatment programmes with community care and support to guarantee continued comprehensive care for patients and their households based on a system of referrals between health facilities and communities.

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

[2] http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2010/JC2034_UNAIDS_Strategy_en.pdf

[3] http://data.unaids.org/pub/BaseDocument/2010/jc1713_joint_action_en.pdf

[4] http://documents.wfp.org/stellent/groups/public/documents/communications/wfp228800.pdf

In view of the increasing complexity of the HIV situation WFP is adopting a more specific role, shifting from mitigation to enabling access to treatment and positive outcomes through nutritional support. The new HIV and AIDS policy focuses WFP's interventions and adapts its toolkit to the current situation, which differs considerably from the previous decade. This information note outlines the new policy approach and shows how it is being implemented at the regional and country levels.

DRAFT DECISION*

The Board takes note of "Update on WFP's Response to HIV and AIDS" (WFP/EB.A/2011/5-E).

* 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.

INTRODUCTION

1. According to the latest report on the global AIDS epidemic there are 33.3 million people living with HIV (PLHIV), of whom 22.5 million are in sub-Saharan Africa.[5] Access to HIV treatment has been significantly expanded and the pace of new HIV infections is 30 percent lower than in 1996. But global coverage remains low: of the 15 million PLHIV in low-income and middle-income countries who need treatment, only 5.2 million have access to support and care such as anti-retroviral therapy (ART).[5]

2. Where resources are limited, PLHIV face barriers such as poverty and food insecurity that can undermine long-term adherence to treatment. To ensure that PLHIV do not have to interrupt or stop their treatment, which undermines the outcomes and may subsequently necessitate more expensive treatment, actors addressing HIV must address the barriers, for example by providing appropriate enablers.

3. The importance of food and nutrition interventions is recognized by the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the World Health Organization (WHO). In 2010:

- WFP's new HIV and AIDS policy was presented, giving new direction to HIV and AIDS programmes.
- Three papers on nutrition and food insecurity in relation to HIV, AIDS and tuberculosis (TB) were published in the December 2010 *Food and Nutrition Bulletin Supplement*.
- The UNAIDS Programme Coordinating Board held a thematic session on food and nutrition security as parts of HIV programming.
- The United States Congress increased the United States President's Emergency Plan for AIDS Relief (PEPFAR) funds from US$100 million to US$130 million for programmes that address food security as components of HIV and AIDS responses and for development and implementation of nutrition support, guidelines and care for PLHIV.
- The Global Fund to Fight AIDS, TB and Malaria (GFATM) acknowledged that food and nutrition were not included in some of its reference material even though countries increasingly invest money in related activities; WFP is helping GFATM to fill this gap.

[5] UNAIDS. 2010. *Report on the Global AIDS Epidemic*. Available at: http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2010/20101123_globalreport_en.pdf

UPDATE ON WFP'S HIV AND AIDS PROGRAMMING

4. WFP cooperates with the main stakeholders in the fields of food, nutrition, HIV and TB, choosing partners with clear comparative advantages such as United Nations agencies, GFATM, PEPFAR, civil society, faith-based organizations, universities and private-sector organizations.

5. A programme review in 2010 found that 3 million PLHIV and people affected by HIV in 47 countries, including children, had benefited in 2009 from nutritional rehabilitation, safety nets or mitigation of the burden on households by a combination of these means. Many PLHIV may benefit from other WFP programmes such as school feeding and food-for-assets programmes.

TABLE 1: BENEFICIARY FIGURES BY HIV AND AIDS PROGRAMME CATEGORY, 2009[6]

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

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

SUPPORT FOR HIV AND TUBERCULOSIS TREATMENT PROGRAMMES

6. In the UNAIDS Division of Labour, WHO is the sole convener in the two areas of treatment and TB. WFP works with WHO and partners to ensure that nutrition and/or food support are integrated into treatment to improve nutritional status and adherence to initial treatment to increase cost-effectiveness and reduce mortality.

7. As treatment coverage increases, there will be a shift from enrolling people in treatment to ensuring that they adhere to it. Adherence needs to be 95 percent for treatment to be effective, to prevent resistance and obviate the need for more expensive subsequent treatment.

8. WFP works with governments and partners to ensure that treatment is accompanied by assessments of nutritional status, education and counselling on nutrition to maintain body weight and health and mitigate side effects, and where necessary provide nutritious food to treat malnutrition.

9. Research shows that 25 percent of PLHIV are malnourished, 22 percent moderately and 3 percent severely, including those before and during ART. In Zambia, 33.5 percent of adults initiating ART were moderately malnourished with a body mass index between 16 and 18.5, and 13.5 percent were severely malnourished.[7] WFP has a critical role in helping vulnerable PLHIV, who may be unable to access and adhere to ART and who are prone to food insecurity and malnutrition.

[6] These numbers, which include PLHIV enrolled in treatment programmes and TB patients receiving WFP nutrition or food support and household members, reflect the total number of people supported in 2009.

[7] Food and Nutrition Technical Assistance. 2010. Draft Guidelines for Nutritional Care and Support of PLHIV. Available at: http://www.fantaproject.org/about/zambia.shtml

10. A milestone in the HIV response is the use of cash transfers or vouchers. Vouchers are used to provide specific foods and reduce logistics requirements and stigma. In Zambia, vouchers entitled affected households to soap provided by the United Nations Children's Fund (UNICEF), maize meal, vegetable oil and pulses for a specified period through shops and government health centres. The voucher system, which is in use in the Democratic Republic of the Congo (DRC), Kenya, Mozambique and the Sudan, also enables WFP to reduce logistics cost and benefit local economies.

11. In Zimbabwe, WFP consulted with partners to re-orient its HIV support programmes from relief and recovery to integration of food and nutrition services in health sector care-and-treatment programmes. Food-by-prescription (FBP) principles were introduced to encourage nutrition assessment, education and counselling and the prescription of nutritional supplements for nutrition rehabilitation; a voucher scheme provided complementary household food support.

12. In Kenya, WFP is a partner with the Academy for Educational Development in providing complementary food and nutrition support for PLHIV on ART; the academy provides individual supplements, and WFP provides household support. A research partnership with the academy on the relative impacts of individual and household food assistance is under discussion.

13. In Kenya, Lesotho, Malawi, Mozambique, Rwanda and Swaziland, WFP increased training in FBP for staff and partners, and developed materials and supplied equipment to enhance the use of anthropometric measures in clinic-based nutrition assessments.

14. An important aspect of WFP's new policy is addressing TB in the context of the convergence of the HIV and TB epidemics. In 2010, WFP provided nutritional support for TB treatment for nearly 1 million beneficiaries in 28 countries, which accounted for 30 percent of food support in care and treatment programmes.

15. In sub-Saharan Africa, the triple burden of HIV, TB and malnutrition calls for nutrition and food support. A person with TB symptoms in a country with high HIV prevalence is likely to have nutritional needs similar to those of an HIV and AIDS patient; a co-infected individual will face even greater nutritional challenges. In Zambia, for example, HIV and AIDS prevalence among people aged 15–49 is 13.5 percent, up to 70 percent of whom are co-infected with TB.[8]

16. In Bangladesh, Cambodia, India, the Lao People's Democratic Republic and Myanmar, WFP addressed co-infection in HIV activities, for example by providing regular updates for HIV focal points about programmes integrating food and nutrition support into HIV/TB treatment, care and support.

17. WFP piloted food vouchers for TB programmes for 7,000 patients in two states in the north of the Sudan to facilitate transition of ownership to national authorities. In Georgia, WFP provided technical assistance for the national AIDS programme, the national TB programme and stakeholders to develop a national strategy on nutrition support for PLHIV and TB patients.

[8] UNAIDS. 2010. *Report on the Global AIDS Epidemic*. Available at: http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2010/20101123_globalreport_en.pdf

18. Achievements include recognition of the role of nutrition support in directly observed treatment short courses in Djibouti and Swaziland, where food and nutrition support for TB was approved by GFATM. Following its technical support for the GFATM grant proposals, the governments of both countries invited WFP to assist in the design and implementation of integrated food and nutrition approaches.

SUPPORT FOR SOCIAL PROTECTION PROGRAMMES FOR PEOPLE AFFECTED BY HIV

19. In line with the new policy, WFP, UNICEF and the World Bank work to enhance social protection for PLHIV and people affected by HIV. WFP support for HIV-sensitive social protection involves advocating for and helping governments to develop and implement social protection safety nets, which can be in the form of food support, vouchers or cash.

20. WFP has helped governments to build systems such as the Productive Safety Net Programme in Ethiopia, which are designed to address food insecurity rather than HIV but which help to prevent the spread of HIV and address the needs of PLHIV, for example by helping them to access care and adhere to care and support such as ART. Such safety nets protect livelihoods and prevent coping behaviours that could expose people to HIV. When treatment has helped patients to recover medically and nutritionally, they can be referred to national safety net schemes; where such safety nets do not exist, WFP will advocate their creation and work with governments to ensure that they include PLHIV.

21. WFP will work with the World Bank, UNICEF and the International Labour Organization to ensure that national social protection mechanisms and national frameworks are HIV-sensitive. Despite the trend towards broad-based national HIV-sensitive social protection schemes, smaller community-based programmes managed by non-governmental organizations (NGOs) constitute an opportunity for WFP to partner with these organizations and help to harmonize their social protection approaches.

22. Social protection has expanded in recent years, especially in Latin America, and safety nets have been used to achieve nutrition and health outcomes. In Botswana, Lesotho, Mozambique, Namibia and South Africa, pension schemes and child or disability grants are now a feature of social protection schemes. In line with the Strategic Plan (2008–2013), WFP is positioned to respond to requests from countries and communities for assistance in improving their capacities to implement social protection programmes.

SUPPORT TO PREVENTION OF MOTHER-TO-CHILD TRANSMISSION PROGRAMMES

23. WFP, UNICEF and WHO cooperate in prevention of mother-to-child transmission (PMTCT) programmes in Ethiopia, Lesotho, Malawi, Mozambique and Swaziland. WFP provided the food and nutrition components, and technical assistance for governments, mainly in Uganda and the United Republic of Tanzania, with a view to integrating PMTCT into national mother-and-child health and nutrition programmes. These programmes help to prevent HIV transmission and contribute to health outcomes by enabling mothers and infants to access growth monitoring, vaccinations, micronutrient supplementation, nutrition assessment, education and counselling, and complementary food. Barriers to uptake and adherence for pregnant and lactating HIV-positive women could be reduced by providing more comprehensive services; food is an important motivation to attend follow-up appointments.

HIV AND AIDS PREVENTION

24. The World Bank and the United Nations Population Fund are UNAIDS co-conveners for the reduction of sexual transmission of HIV. WFP contributes by addressing the food insecurity and economic vulnerability of households affected by HIV through school feeding, food-for-assets or livelihood support, helping to delay the onset of sexual activity among school-age girls and minimizing negative coping behaviours such as transactional sex, thereby reducing the sexual transmission of HIV.

25. Evidence from Botswana and Swaziland shows that as individuals fall into worsening poverty and hunger they tend to adopt risky behaviours to obtain food;[9] and once people are infected with HIV, their food insecurity is likely to increase. WFP works to prevent this vicious cycle by targeting food assistance to vulnerable populations in regions of high HIV prevalence, contributing directly to HIV prevention in 12 countries.[10]

26. Mobile populations such as transport workers in WFP operations are particularly vulnerable to HIV and other sexually transmitted infections: they interact with large numbers of vulnerable women such as sex workers and often have concurrent partnerships. WFP also works with North Star Alliance, a public–private partnership founded jointly with TNT in 2006. Support from WFP, TNT, UNAIDS, the International Transport Workers' Federation, ORTEC and 60 partners enabled North Star Alliance to open an additional 14 roadside wellness centres in 2010, bringing the total to 21 in DRC, Kenya, Malawi, Namibia, South Africa, Swaziland, the United Republic of Tanzania, Zambia and Zimbabwe and extending health services to tens of thousands of people in the transport industry or sex work. The North Star Alliance received a GFATM grant to expand its activities in 2011.

MAINSTREAMING HIV AND AIDS CONSIDERATIONS IN HUMANITARIAN EMERGENCIES

27. WFP and UNHCR are UNAIDS co-convenors for HIV and for humanitarian emergencies, which pose particular challenges in terms of delivering integrated food and nutritional assistance for PLHIV.

28. In 2010 the Inter-Agency Standing Committee guidelines on HIV and AIDS interventions in emergencies were revised to reflect the latest experiences of governments, the United Nations, NGOs and the Red Cross and Red Crescent movements. The guidelines acknowledge that ART and related medical care can be provided in low-resource settings and conflict zones and include the latest guidance on food security, nutrition and livelihood support, and they help to ensure that HIV is included in humanitarian response interventions.[11] One of WFP's main aims in emergencies is to ensure that food insecurity and malnutrition are not barriers to treatment and that access to ART, TB treatment and PMTCT is maintained.

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[9] Weiser, S.D., Leiter, K., Bangsberg, D.R., Butler, L.M., Percy-de Korte, F., Hlanze, Z., Phaladze, N., Iacopino, V. and Heisler, M. 2007. Food Insufficiency is Associated with High-Risk Sexual Behaviour Among Women in Botswana and Swaziland. *PLoS Med*, 4(10): 1589–97

[10] Republic of the Congo, DRC, Ethiopia, Kenya, Lesotho, Malawi, Mozambique, Rwanda, the Sudan, Swaziland, the United Republic of Tanzania and Zambia.

[11] IASC. 2010. *Guidelines for Addressing HIV in Humanitarian Settings*. Geneva. Available at: http://www.humanitarianinfo.org/iasc/pageloader.aspx?page=content-products-products&productcatid=9

29. In 2010, support for PLHIV was integrated into emergency operations in DRC and Somalia, refugee operations in Kenya, the United Republic of Tanzania and Zambia, and protracted relief and recovery operations in Kenya, Uganda and Zimbabwe. Colleagues in DRC and Zimbabwe helped to roll out training on the new guidelines for HIV in emergency settings.

WFP CAPACITY AT COUNTRY LEVEL

30. WFP continues to provide technical guidance and operational expertise in integrating food and nutrition into national AIDS strategies, working with governments, AIDS authorities and civil society on policy regarding integrated food and nutrition support. It is also increasingly implementing programmes with ministries of health with a view to enabling government-led programmes rather than stand-alone activities; examples include an FBP programme in Swaziland and a pilot project involving voucher-based basic food baskets for malnourished people on ART in Mozambique.

31. To enable staff to focus on nutrition care, training in FBP is to be rolled out as an e-learning tool on WFP's global learning platform for project managers and officers. It will complement the HIV literacy starter pack with a view to improving the quality of programme design, priority setting and implementation of food and nutrition in support of national HIV responses.

32. An example of WFP's country-level commitment is Lesotho, where the Government is scaling up action on malnutrition in partnership with UNICEF, WHO, the Food and Agriculture Organization of the United Nations and WFP through their Joint United Nations Nutrition Programme, which addresses the causes and consequences of malnutrition.

WFP AND GLOBAL FUNDING MECHANISMS

33. To enhance the effectiveness of national AIDS responses, WFP is increasing its assistance for partners to develop proposals for GFATM and PEPFAR that address the food and nutrition needs of PLHIV and TB patients under the Memorandum of Understanding between UNAIDS and GFATM.

34. Food and nutrition support is a relatively small investment to maximize the effectiveness of money spent on treatment and care. In the current context of funding constraints and increasing needs, some donors are considering painful trade-offs. But strategies should focus on linkages: food and nutrition have a significant impact on ART uptake, adherence and effectiveness, and should be seen as enablers of universal access to prevention, treatment, care and support.

35. In 2010, the Policy, Planning and Strategy Division, the Nutrition and HIV/AIDS Service and the regional bureaux sought better ways of integrating food and nutrition into GFATM proposals, with visits to Djibouti, Ethiopia, Ghana, the Lao People's Democratic Republic, Swaziland and Zimbabwe for Round 10 applications.[12] Five of these countries integrated food and nutrition into their proposals – the Lao People's Democratic Republic did not apply – and Djibouti identified WFP as a secondary recipient of funds; in Swaziland, WFP became sub-recipient for the Round 10 TB grant and the recipient of unspent Round 4 and Round 7 funds for PMTCT.

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

36. Through campaigning and engagement with country offices during the GFATM proposal process, 12 countries in West Africa integrated a nutrition component into their proposals. Proposals from Burkina Faso, Cameroon and Guinea for HIV and from Liberia and Mali for TB were approved, so five of the countries where WFP operates may receive substantial funding for food and nutrition support for PLHIV and other food-insecure groups.

37. Major findings were the need to start the process early, to demonstrate long-term commitment to HIV care and support rather than engaging at the last minute, and to build a coalition of stakeholders with a common interest in enhancing food and nutrition interventions in response to HIV and TB with a view to improving adherence and reducing mortality, thus "making the money invested in treatment work".

38. As a result of work in 2010, WFP now has a manual that will be helpful in its support in 2011 for round 11 applications and country coordinating mechanisms in 10–15 countries in partnership with the Food and Nutrition Technical Assistance Project (FANTA II), PEPFAR and WHO. Work will be carried out jointly in selected countries and will also include more generally the refinement of tools to enable countries to integrate food and nutrition into GFATM proposals.

WFP'S STRATEGIC INFORMATION, RESEARCH, MONITORING AND EVALUATION AND HIGH-LEVEL ADVOCACY

39. In preparing its new HIV and AIDS policy, WFP worked with universities to review evidence related to nutrition and HIV and TB along with food insecurity and HIV. Three papers were published in the Food and Nutrition Bulletin Supplement.[13]

40. In view of the greater need to improve and standardize outcome and impact indicators for food and nutrition interventions in HIV and TB, WFP, WHO, FANTA and PEPFAR are working on a set of global indicators for elements such as nutrition care and HIV, PMTCT and food security and HIV. When these are agreed, WFP will finalize its monitoring and evaluation toolkit and roll it out in support of the new policy.

41. The need to integrate food and nutrition into HIV responses was recognized at the 27th Meeting of the Programme Coordinating Board in Switzerland in December 2010, where the thematic segment focused on the issue. WFP was tasked with the formation of a global network on integrating food and nutrition into the HIV response.[14]

[13] i) Frega, R., Duffy, F., Rawat, R. and Grede, N. Food insecurity in the context of HIV/AIDS: A framework for a new era of programming. *Food Nutr. Bull.*, 31(S4): 292S–312S; ii) De Pee, S. and Semba, R.D. Role of nutrition in HIV infection: Review of evidence for more effective programming in resource-limited settings. *Food Nutr. Bull.*, 31(4): 313S–344S; iii) Semba, R.D., Darnton-Hill, I. and de Pee, S. Addressing tuberculosis in the context of malnutrition and HIV coinfection. *Food Nutr. Bull.*, 31(S4): 345S–364S.

[14] See: http://www.unaids.org/en/aboutunaids/unaidsprogrammecoordinatingboard/pcbmeetingarchive/name,52815,en.html.

42. In 2010, WFP signed a Memorandum of Understanding with the Thai Red Cross AIDS Research Centre, which is a pioneer in the region in providing anonymous counselling and testing for HIV and for systematically incorporating nutritional support into its protocols. The model created by the centre could serve as a learning platform for many countries in the Asia-Pacific region and elsewhere. Pilot training for staff from Bangladesh, Cambodia, India, the Lao People's Democratic Republic and Timor-Leste and counterparts from WHO, UNICEF and UNAIDS took place in December 2010; it will be followed by additional training in 2011, which will include staff and cooperating partners from other regions.

43. In July 2010 WFP was among the 25,000 participants at the XVIII International AIDS Conference in Vienna, where it helped to promote understanding of the importance of food and nutrition in the treatment of HIV and AIDS and provided technical advice for governments seeking GFATM funding.

44. At the September 2010 PEPFAR HIV and AIDS Implementers' Meeting in Uganda, WFP advocated for a comprehensive approach that addresses the needs of PLHIV and people affected by HIV in places where food insecurity overlaps with high HIV prevalence.

CONCLUSION

45. WFP's HIV and AIDS and TB programmes are being realigned with the new policy with a view to integrating nutrition into treatment and care, enhancing social safety nets and promoting social protection and livelihood strategies for PLHIV and people affected by TB.

46. In responding to HIV and AIDS under the new policy, WFP will continue to build on evidence-based programmes that complement those of its partners and to integrate nutritional support into the context of universal access.

ACRONYMS USED IN THE DOCUMENT

ART	anti-retroviral therapy
DRC	Democratic Republic of the Congo
FANTA	Food and Nutrition Technical Assistance Project
FBP	food by prescription
GFATM	Global Fund to Fight AIDS, TB and Malaria
NGO	non-governmental organization
PEPFAR	United States President's Emergency Plan for AIDS Relief
PLHIV	people living with HIV
PMTCT	prevention of mother-to-child transmission
TB	tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNICEF	United Nations Children's Fund
WHO	World Health Organization