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Update on WFP's Response to HIV and AIDS

Executive Summary

At the request of the Board, WFP provides regular updates on implementation of its HIV policy. The policy[1] is in line with the 2030 Agenda, the strategies for 2011–2015 and 2016–2021[2] and the Division of Labour of the Joint United Nations Programme on HIV/AIDS (UNAIDS), and the WFP Strategic Plan (2017–2021).

Under the UNAIDS Division of Labour, WFP is the convening agency for ensuring that food support is integrated into national programmes for people living with HIV. WFP and the Office of the United Nations High Commissioner for Refugees are co-convenors for HIV response in humanitarian emergencies, ensuring that the special needs of people living with HIV are considered in emergency responses.

UNAIDS strategy for 2016–2021 highlights that while the response to HIV contributes to the achievement of Sustainable Development Goal 3 on good health and well-being, its goals and targets are linked to four other Sustainable Development Goals: goal 5 on gender equality; goal 10 on reduced inequalities; goal 16 on peace, justice and strong institutions; and goal 17 on partnerships. HIV/AIDS is one of many areas of vulnerability, and WFP's capability to link its work to several Sustainable Development Goals will become increasingly valuable. Under the 2030 Agenda, as the focus on technical support and capacity development for governments increases at the global level, and HIV response is mainstreamed, WFP will need to adapt its work to remain relevant and effective. WFP's contributions to HIV response leverage several entry points including food and health systems, social protection, logistics, and emergency response.

As a Cosponsor of UNAIDS, WFP has contributed to the joint HIV/AIDS response for many years. In 2016, it was Chair of the UNAIDS Committee of Cosponsoring Organizations, leading joint work on analysing the impacts of reduced funding for UNAIDS and its global-level initiatives, with the participation of the Executive Director.

In 2016, although HIV-specific funding continued to decline, WFP maintained its sustainable, holistic approach to HIV programming, leveraging its context-appropriate entry points and partnerships to provide: i) support for HIV-sensitive social safety nets, including activities for strengthening

[1] http://docustore.wfp.org/stellent/groups/public/documents/eb/wfp225092.pdf

[2] http://www.unaids.org/sites/default/files/media_asset/20151027_UNAIDS_PCB37_15_18_EN_rev1.pdf

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economies in Ethiopia; ii) support to vulnerable people living with HIV in humanitarian emergencies, including in countries affected by El Niño; iii) technical support to governments and national partners, including work with the National HIV/AIDS Council in the Dominican Republic to promote the inclusion of women living with HIV in social protection programmes; iv) support to patients receiving prevention of mother-to-child transmission services, including in Djibouti, Ethiopia, Myanmar and Swaziland; v) support to vulnerable and food-insecure people living with HIV, including in Liberia as a Global Fund sub-recipient; vi) school meals and other activities to address the needs of children and adolescents while promoting school attendance and reducing risk-taking behaviour, including in South Sudan; and vii) support to supply chains to prevent supply gaps in HIV treatment and prevention activities in humanitarian settings and fragile contexts, through partnerships, including with the Global Fund.

HIV and Tuberculosis in 2016

1. HIV remains one of the world's most serious challenges: in 2015, 36.7 million people were living with HIV, including 2.1 million who were newly infected.[3] Adolescent girls and young women are at disproportionate risk, accounting for 62 percent of all HIV-infected adolescents at the global level, and 71 percent in sub-Saharan Africa.[4] Structural, legal, policy and socio-cultural factors continue to restrict access to HIV services, resulting in increased transmission among "key populations",[5] in which people are 12 to 49 times more likely to be living with HIV than other adults of reproductive age.

2. The rapid scale-up of life-saving treatment has helped reduce AIDS-related deaths by 45 percent since 2005.[6] Globally, the number of people living with HIV (PLHIV) on anti-retroviral therapy (ART) reached 18.2 million in June 2016, having exceeded the Millennium Development Goal target of 15 million by 2015. While this is a considerable achievement, it is also crucial to ensure that PLHIV adhere to treatment through improved retention in care. Worldwide, AIDS is still the leading cause of death among women of reproductive age and the second leading cause among children and adolescents aged 10–19 years.[5]

3. New HIV infections are declining, particularly among infants. Worldwide, 150,000 children were infected with HIV in 2015 – approximately 50 percent fewer than in 2000; 77 percent of pregnant women living with HIV now have access to ART, preventing new infections among children.[3]

4. In 2015, an estimated 10.4 million people fell ill with tuberculosis (TB), of whom 11 percent were HIV-positive;[7] of the 1.4 million people dying from TB, 0.4 million were HIV-positive. TB is a major cause of death among PLHIV, and deaths from HIV-associated TB have decreased by only 18 percent since 2010.[5] Countries report improved integration of HIV and TB services, but only 78 percent of HIV-positive TB patients were on ART in 2015.[7]

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[3] UNAIDS. 2016. *Global AIDS Update*. 2016. Geneva. Available at: http://www.unaids.org/sites/default/files/media_asset/global-AIDS-update-2016_en.pdf

[4] UNAIDS. 2015. *UNAIDS 2016–2021 Strategy. On the Fast-Track to End AIDS*. Geneva.

[5] UNAIDS. 2015. *How AIDS changed everything – MDG 6: 15 years, 15 lessons of hope from the AIDS response.* Geneva. These populations comprise sex workers, people who inject drugs, transgender people, prisoners, gay men and other men who have sex with men.

[6] UNAIDS. 2016. *Fact sheet November 2016.* Available at: http://www.unaids.org/sites/default/files/media_asset/UNAIDS_FactSheet_en.pdf

[7] WHO 2016. *Global Tuberculosis Report*. Geneva. Available at: http://apps.who.int/iris/bitstream/10665/250441/1/9789241565394-eng.pdf?ua=1

WFP and UNAIDS

5. WFP is one of 11 Cosponsoring Organizations of the Joint United Nations Programme on HIV/AIDS (UNAIDS). Under the UNAIDS Division of Labour, WFP is the convener on food security issues, as reflected in its 2010 HIV policy. HIV is addressed through multiple entry points and partnerships, in line with Sustainable Development Goal (SDG) 17. With treatment starting earlier, malnutrition is less prevalent among PLHIV, and WFP has widened the scope of its HIV response from its original focus on malnourished PLHIV, leveraging work in areas such as social protection, logistics and emergency response. For example, WFP is increasingly linking ART clients to social protection programmes and livelihood-strengthening activities to sustain long-term health gains, as PLHIV have to remain in treatment programmes for life. WFP and the Office of the United Nations High Commissioner for Refugees (UNHCR) are co-convenors for HIV in humanitarian emergencies, ensuring that the special needs of people living with HIV are considered in emergency responses.

6. In 2016, WFP was the Chair of the UNAIDS Committee of Cosponsoring Organizations (CCO), which serves as the forum for regular meetings of Cosponsors to consider matters of major importance and provide inputs for UNAIDS policies and strategies. During 2016 – a particularly challenging year for UNAIDS – WFP brought the Cosponsors' perspective into discussions and led development of the report to the UNAIDS Programme Coordinating Board (PCB), jointly with the UNAIDS Secretariat. Other Cosponsors welcomed the strong participation of WFP's Executive Director.

7. The UNAIDS strategy for 2016–2021, "On the Fast-Track to End AIDS", is one of the first in the United Nations system to be aligned with the SDGs, and aims to advance progress towards the "three zeros" – zero new HIV infections, zero discrimination against PLHIV, and zero AIDS-related deaths – to end the AIDS epidemic as a public health threat by 2030. The new UNAIDS strategy is grounded in evidence and rights-based approaches and in line with the 90–90–90 treatment targets.[8]

The Changing Context – SDGs and Funding of the HIV Response

8. UNAIDS faced a severe funding shortfall in 2016. Many traditional donors introduced major cuts, and UNAIDS has not been successful in attracting new donors. Of an approved budget of USD 242 million, UNAIDS raised only USD 168 million in 2016. This resulted in a 50 percent cut to Cosponsors, with WFP's 2016 funds being reduced to USD 2.45 million.

9. Recognizing that the funding reductions represented a major challenge to the UNAIDS' work programme, the PCB asked UNAIDS to analyse how the budgetary shortfall would affect the ability of UNAIDS to achieve the strategic results defined in its strategy. WFP and the other Cosponsors worked with the UNAIDS Secretariat on this analysis, which revealed that the cuts had resulted in extensive scale-down of programmes and operations, with significant implications for delivering on the Fast-Track agenda and leveraging additional funds for HIV response at the global and regional levels.

10. As a Cosponsor, WFP receives funding from UNAIDS and is accountable under the Unified Budget, Results and Accountability Framework, which brings together the responses to AIDS of all United Nations agencies, promoting coherence and coordination in planning and implementation and channelling catalytic funding for agencies' HIV responses. Rather than WFP's own programmes, this funding is for increasing capacity and resources for HIV response at the country, regional and global levels as part of multi-sectoral initiatives. With reduced

[8] The 90–90–90 treatment targets for 2020 are: i) 90 percent of PLHIV know their HIV status; ii) 90 percent of people with diagnosed HIV receive sustained ART; and iii) 90 percent of people receiving ART have viral suppression.

funding from UNAIDS, WFP has prioritized the most vulnerable areas and Fast-Track countries for its activities.[9]

11. Through the SDGs, the global community is calling for multi-sector, interconnected responses to all issues, including HIV, as stated in the UNAIDS strategy for 2016–2021 and the 2030 Agenda. Actions to prevent HIV infection are linked to broader determinants of health, and effective and mutually beneficial integration with wider health, development and humanitarian work requires agencies to be open to reform.

12. The Global Review Panel on the future of UNAIDS is tasked with formulating recommendations on how to make UNAIDS sustainable and fit for purpose. One of the challenges it has noted is that the "relative isolation" of the AIDS units of some Cosponsoring organizations has affected "their ability to fulfil responsibilities and optimize linkages between AIDS work and the broader health and development contributions of the organization". In WFP, HIV response is increasingly recognized as the best area for contributing towards SDG 17 on partnerships.

WFP's Contribution to the Goals of the UNAIDS Strategy for 2016–2021

Strategic result area 1: Children and adults living with HIV have access to testing, know their status and are immediately offered and sustained on affordable quality treatment (outputs 1.1, 1.2, 1.3, 1.5 and 1.6)[10]

13. WFP's work to address HIV focuses on linking food and health systems through the provision of food assistance for better health outcomes, such as nutritional recovery for PLHIV/TB, retention in care programmes, and treatment success. WFP contributes through advocacy and communication; partnerships; inclusion of food security issues in comprehensive HIV/AIDS national plans to address the needs of vulnerable PLHIV; and technical support, capacity development and support to implementation. WFP provides support – including food and cash-based transfers (CBTs) – at the individual and household levels to facilitate improved access and adherence to treatment. WFP also supports HIV and TB prevention and care, including during humanitarian emergencies.

14. In 2016, WFP provided technical assistance to governments, for example, through vulnerability assessments among PLHIV in Burundi, Democratic Republic of the Congo, Ethiopia, Ghana, Guinea, Kenya, Myanmar, Rwanda, Sierra Leone, South Sudan, Swaziland, Tajikistan and Uganda; and through its food-by-prescription programmes in Cameroon, Central African Republic, Swaziland and other countries.

15. Reduced funding has affected WFP's ability to address the specific needs of PLHIV. In 2016, WFP discontinued several vulnerability assessments and government capacity development initiatives, including socio-economic profiling of Ebola survivors in West Africa. As a result, countries are losing knowledge of the nature and magnitude of vulnerabilities such as food insecurity among PLHIV, and their impact on treatment success.

16. During humanitarian emergencies, forced displacement, food insecurity, poverty, sexual violence, breakdown of rule of law and collapse of health systems may lead to increased vulnerability to HIV infection or interruption of treatment. Given the scale and scope of humanitarian emergencies, which currently affect 125 million people, the number of people vulnerable to HIV in these contexts is estimated to have increased.

17. In the UNAIDS Division of Labour, UNHCR and WFP lead the HIV response in humanitarian emergencies. In the last two years, the importance of addressing HIV in humanitarian contexts has received more political support than ever before, as highlighted in the UNAIDS strategy for 2016–2021 and the engagement in emergency responses of the United States President's

[9] The UNAIDS Fast-Track countries are Angola, Botswana, Brazil, Cameroon, Chad, China, Côte d'Ivoire, Democratic Republic of the Congo, Ethiopia, Ghana, Haiti, India, Indonesia, Islamic Republic of Iran, Jamaica, Kenya, Lesotho, Malawi, Mali, Mozambique, Myanmar, Namibia, Nigeria, Pakistan, Russian Federation, South Africa, South Sudan, Swaziland, Uganda, Ukraine, United Republic of Tanzania, United States of America, Viet Nam, Zambia and Zimbabwe.

[10] 1.1 HIV testing and counselling; 1.2 HIV treatment cascade; 1.3 Children and adolescents; 1.5 Humanitarian emergencies; and 1.6 Access to medicines and commodities.

Emergency Plan for AIDS Relief (PEPFAR) and the Global Fund to Fight AIDS, TB and Malaria (the Global Fund).

18. For 2016–2017, PEPFAR has provided USD 13.3 million to support WFP's HIV response activities in El Niño-affected countries – Lesotho, Malawi, Mozambique, Swaziland and Zimbabwe. With this award WFP is supporting 225,216 vulnerable beneficiaries affected by HIV, including orphans and other vulnerable children, clients of prevention of mother-to-child transmission (PMTCT) programmes and pregnant and lactating women. PEPFAR also provided WFP with USD 11.5 million for managing the procurement and supply chain of specialized foods for children and adults in pre-ART, ART and PMTCT programmes in Mozambique.

19. WFP continued to provide food and/or CBTs to vulnerable people, including PLHIV/TB in emergency and refugee contexts in the Central African Republic, Haiti, Myanmar, South Sudan, Ukraine, the Horn of Africa, the Lake Chad Basin and countries affected by El Niño. In Ukraine, WFP's HIV/TB activities reached 11,153 food-insecure people and targeted food-insecure PLHIV with low adherence to ART and at risk of discontinuing treatment.

20. In 2014, WFP and the Global Fund signed a Memorandum of Understanding (MOU) for a logistics partnership that improves access to commodities for the HIV response, especially during emergencies, through WFP's deep field supply chain networks. A core component of the MOU tasks WFP with building the capacity of Global Fund recipients to strengthen distribution systems. In 2016, WFP provided four air cargoes and three ocean cargoes to Burundi and Yemen to prevent supply gaps in HIV treatment programmes.

Strategic result area 2: New HIV infections among children are eliminated and the health and well-being of the children's mothers are sustained (output 2.1)[11]

21. Demand-side barriers to access and adherence to PMTCT services[12] include food insecurity. Comprehensive services that include food assistance enable more women to start and adhere to PMTCT programmes.

22. WFP works with governments and other partners to support PMTCT programmes and provide mother-and-child health and nutrition (MCHN) services to vulnerable pregnant women. WFP programmes in many contexts target pregnant and lactating women, PMTCT clients and children, and can have an impact on adherence to PMTCT and on health outcomes for newborn babies. In Ethiopia, 96 percent of PMTCT clients receiving WFP food assistance in 2016 attended all their clinical appointments, and 99 percent of the babies born were HIV-negative.

Strategic result area 3: Young people, especially young women and adolescent girls, have access to combined prevention services and are empowered to protect themselves from HIV (output 3.2)[13]

23. WFP contributes to strengthening national capacities to meet the goals for HIV prevention among young people and adolescents through its HIV-sensitive school meal programmes and its country-level partnerships with the United Nations Population Fund (UNFPA) and the United Nations Children's Fund. WFP's school meals benefit more than 17 million schoolchildren annually. In South Sudan, WFP's food for education programme reached more than 200,000 children in 2016. By staying in school longer, many of these young people are less exposed to high-risk behaviour that can lead to acquiring HIV.

24. WFP support targets children and adolescents living with HIV in Myanmar, Senegal and other countries, including those affected by El Niño in Southern Africa.

[11] 2.1 PMTCT.

[12] WFP. 2014. Economic and social factors are some of the most common barriers preventing women from accessing maternal and newborn child health (MNCH) and prevention of mother-to-child transmission (PMTCT) services: A literature review. *AIDS and Behaviour*, 18(Suppl. 5): S516–30.

[13] 3.2 Young people and adolescents.

25. Reduced funding limits WFP's capacity to address the specific needs of adolescents, including through platforms such as school meals. Reduced capacity to provide thematic advocacy and communication and to collaborate among different sectors could lead to reduced attention to the linkages between food security and education for adolescent girls in global and country-level messaging, thereby missing an opportunity for leveraging partnerships to reach the SDGs. In the longer term, reduced recognition of these linkages could also result in adolescent girls having fewer opportunities to acquire education, refrain from risk-taking behaviour such as transactional sex, and obtain testing and treatment for HIV.

Strategic result area 7: AIDS response is fully funded, and efficiently implemented based on reliable strategic information (output 7.2)[14]

26. As CCO chair in 2016, WFP highlighted the importance of addressing emergencies and the structural drivers of HIV and AIDS, including food insecurity, as a critical part of the HIV response. During El Niño-related emergencies in southern Africa, WFP led the Cosponsors in advocating for addressing the needs of PLHIV in the region, which led to a major funding contribution (detailed in paragraph 18) from PEPFAR.

27. WFP's vulnerability assessments inform HIV responses in several countries. In Burundi, for example, WFP assessed the nutrition status and vulnerability profile of PLHIV during development of the national Strategic Plan for Fighting against HIV/AIDS (2017–2021).

Strategic result area 8: People-centred HIV and health services are integrated into stronger health systems (outputs 8.1 and 8.2)[15]

28. WFP contributes to the empowerment of PLHIV through its HIV-sensitive social protection programmes, including by supporting national governments in designing, operationalizing and evaluating cost-effective safety net and social protection mechanisms for PLHIV and other vulnerable populations, including in fragile and challenging contexts.

29. For example, in Ethiopia, WFP worked with PEPFAR to provide social safety nets and services to PLHIV, orphans and other vulnerable children and PMTCT clients. Engagement in economic-strengthening activities has proven to be correlated with improved retention in HIV care, adherence to ART, access to health services, and health-related quality of life.

30. In the challenging funding environment, WFP is seeking opportunities to co-finance coordinated work that produces HIV-related benefits, rather than focusing on funding for HIV-specific interventions. Findings from a study by WFP and the London School of Hygiene and Tropical Medicine suggest that investment in ending hunger could contribute to improved adherence to treatment and retention in care, and reduced HIV transmission, while co-investing in HIV and food interventions could enhance the efficiency of HIV treatment and prevention efforts.

The Year in Numbers

31. In 2016, WFP assisted 318,555 PLHIV, TB patients and their households in 24 countries through HIV-specific programmes (Table 1).

TABLE 1: HIV AND TB PROGRAMME BENEFICIARY NUMBERS (HIV-SPECIFIC), 2016*	
UNAIDS Fast-Track countries[9]	209 991
Other countries	96 563
Total	**318 555**

* Based on preliminary results of 2016 Standard Project Reports.

[14] 7.2 Technological innovations.

[15] 8.1 Integration; and 8.2 Social protection.

32. Through its HIV-sensitive interventions – such as general food distributions, school feeding, food assistance-for-assets activities and MCHN services – WFP also reached PLHIV and TB patients who are not directly counted in Standard Project Reports. WFP is shifting from implementation of programmes towards development of national capacities. These factors, combined with the decrease in HIV-specific funding, explain the declining numbers of beneficiaries in recent years.

Partnerships

33. WFP is working with Global Fund partners in implementation and supply chains – including the United Nations Development Programme in Zimbabwe, UNFPA in Yemen and the Partnership for Supply Chain Management in Burundi – to prevent supply gaps in HIV treatment and prevention programmes. These partnerships are ideal examples of working towards SDG 17 and illustrate how WFP's supply chain can be leveraged for HIV- and health-related impacts.

34. WFP and UNHCR co-convene the Inter-Agency Task Team (IATT) on HIV in Emergencies, whose initiatives in 2016 included updating the *Inter-agency Field Manual on Reproductive Health in Humanitarian Settings*; convening the IATT sub-working group on El Niño; developing standard operation procedures – including for HIV responses in climate-related emergencies – with the World Health Organization, the Office for the Coordination of Humanitarian Affairs, the Food and Agriculture Organization of the United Nations and the United Nations Special Envoys on El Niño and Climate; developing a toolkit for addressing HIV in humanitarian crises in West Africa, with UNHCR; and engaging with the cluster system to integrate HIV issues into emergency responses. These IATT initiatives are good examples of working the humanitarian–development nexus, which was identified as a priority at the World Humanitarian Summit.

35. WFP works with the South African non-governmental organization *Kheth'Impilo* on enhancing the knowledge base for community-based approaches to improving HIV treatment and health outcomes. WFP and *Kheth'Impilo* organized country missions to strengthen the sustainability of in-country HIV programmes.

36. WFP and New York University organize courses for programme leaders on the system approach to health and food systems to build the capacity of WFP's staff in the era of the SDGs and in line with WFP's Integrated Road Map processes, including country strategic planning. During the course, participants explore models and theories for investigating outcomes and identifying social, behavioural, economic and environmental variables that affect population health and health disparities in different settings.

Outlook in 2017

37. WFP's Executive Director will represent the Cosponsors in the UNAIDS Global Review Panel, providing WFP with an opportunity to raise the profile of linkages among food and health systems and emergencies in the HIV response.

38. WFP will continue to link food and health systems to HIV/AIDS response. In the current funding environment, focus will increasingly be on UNAIDS Fast-Track and other countries with existing programmes to address the needs of emergency-affected populations.

39. WFP will continue to provide general food assistance or CBTs to vulnerable people, including PLHIV/TB in humanitarian contexts in the Central African Republic, Haiti, Myanmar, South Sudan, Ukraine, the Horn of Africa, the Lake Chad Basin and countries affected by El Niño.

40. WFP's El Niño response programming will continue to target vulnerable PLHIV in southern Africa. WFP will also advocate for funding to address the needs of PLHIV affected by extreme food insecurity in the Horn of Africa.

41. Through its partnership with the Global Fund, WFP will build the capacity of Global Fund implementers to develop and strengthen distribution systems and prevent supply gaps in HIV and health-related activities.

42. WFP and the London School of Hygiene and Tropical Medicine will finalize and disseminate the results of their joint study on the investment returns of food-based interventions for ART patients in East and Southern Africa. Potential platforms for dissemination include the International Conference on AIDS and Sexually Transmitted Infections in Africa in Côte d'Ivoire.

Acronyms Used in the Document

ART	anti-retroviral therapy
CBT	cash-based transfer
CCO	Committee of Cosponsoring Organizations
IATT	Inter-Agency Task Team
MCHN	mother-and-child health and nutrition
MOU	Memorandum of Understanding
PCB	Programme Coordinating Board
PEPFAR	United States President’s Emergency Plan for AIDS Relief
PLHIV	people living with HIV
PMTCT	prevention of mother-to-child transmission
SDG	Sustainable Development Goal
TB	tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNHCR	Office of the United Nations High Commissioner for Refugees