

**WFP
HIV AND AIDS POLICY**



INFORMAL CONSULTATION

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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 The epidemic differs among regions, countries and provinces, and current responses may already be outdated; there has also been a dramatic convergence of the HIV and tuberculosis epidemics.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.

Advances in anti-retroviral therapy have enabled many people to lead relatively healthy lives and have significantly reduced HIV-related mortality and morbidity, but less than half of the people living with HIV have access to treatment in 2010. 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/AIDS policy made it a recognized partner in the response to AIDS with tailored responses to each epidemiological and social context. Since 2006 WFP has been responsible for nutrition and/or food support under the Joint United Nations Programme on HIV/AIDS Division of Labour, which is critical to treatment uptake, adherence and success, and nutritional recovery.

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) ensure that people living with HIV receive treatment; ii) prevent them from dying of tuberculosis; and iii) enhance social protection for people affected by HIV. WFP's Strategic Plan (2008–2013) mandates helping governments to find and implement evidence-based interventions and innovative delivery modalities.

WFP's HIV/AIDS policy guides its interventions as part of the United Nations response and 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 endeavour to: i) ensure nutritional recovery and treatment success through nutrition and/or food support; and ii) mitigate the effects of HIV/AIDS through sustainable safety nets.

POLICY OBJECTIVES

1. WFP will address its obligations under the Joint United Nations Programme on HIV and 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/AIDS programmes, the delivery methods and the tools for measuring success. It aims to give direction to WFP's HIV/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/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 co-sponsor 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 (DoL), each agency has responsibility in its area of comparative advantage. WFP is responsible for nutrition and food support: it has received funds from the UNAIDS budget⁴ and is accountable to its partners and the UNAIDS Board.

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 ten United Nations organizations in AIDS response: 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. WFP became a UNAIDS Cosponsor in 2003.

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.

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.
7. An important component of WFP’s HIV/AIDS policy is the inclusion of tuberculosis (TB) in view of the dramatic convergence of the HIV and TB epidemics (HIV/TB).⁶ 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 relating to HIV/AIDS have occurred since the previous HIV/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 2008.⁷ 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.
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.⁸ Mortality among women is highest between the ages of 25 and 39; mortality among men peaks later. The South African Government has called these mortality statistics “war-like”.

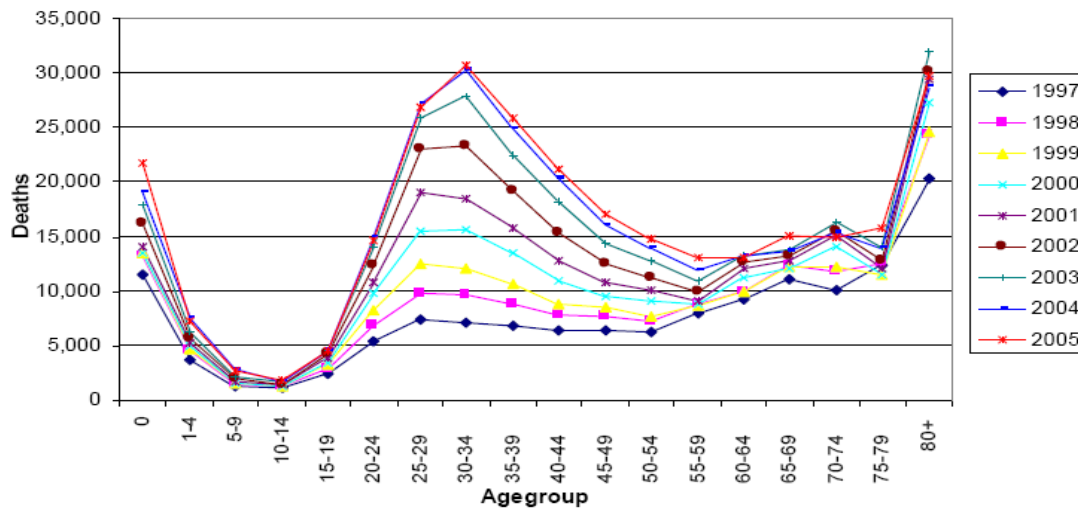
⁵ WFP/EB.1/2003/4-B

⁶ 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>

⁷ UNAIDS. 2009. *AIDS Epidemic Update 2009*. Geneva. Available at: <http://www.unaids.org/en/KnowledgeCentre/HIVData/EpiUpdate/EpiUpdArchive/2009/default.asp>

⁸ Development Bank South Africa. 2008. Road Map Process.

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.⁹
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 (MSM), and sex workers. In Bangladesh, India and Papua New Guinea heterosexual transmission is also significant.¹⁰ 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, MSM, 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.¹¹

⁹ 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.

¹⁰ 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.

¹¹ 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.

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).¹²
17. WFP developed a “Monitoring and Evaluation Guide for Food-Assisted HIV Programming”¹³ to improve the effectiveness of HIV/AIDS interventions: this is based on the 2008–2013 Strategic Plan Results Framework and indicator compendium and covers baselines and follow-up surveys, indicators, targets and data collection. WFP also developed “Getting Started – Tuberculosis” to help with programme design and implementation.
18. In preparing this paper, WFP worked with universities to review the evidence relating 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 the dialogue and update its programmes accordingly.
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 on discharge. Even if ART prevents the recurrence of AIDS-induced wasting, other longer-term nutritional issues may need to be addressed such as 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.

Targeting in HIV/AIDS Differs from many other WFP Programmes

22. WFP recognizes the importance of targeting vulnerable populations and of continuous monitoring and evaluation (M&E). In line with the “Three Ones” country level M&E system, and to improve understanding of nutritional and food requirements, WFP should continue its work with governments and national AIDS authorities to design sound M&E systems.

¹² FANTA and WFP. 2007. Food Assistance Programming in the Context of HIV. Washington, DC.

¹³ WFP. 2009. Draft HIV Monitoring and Evaluation Guide for Food Assisted HIV Programming. Rome.

23. 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 the basis of criteria such as body mass index (BMI).
24. 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/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 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 on its Promise

25. 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. In contexts of low income and capacity, this may require the design of programmes, but WFP's role will generally focus on advocacy and capacity development.
26. WFP has benefited from its partnerships with UNICEF to address social protection and respond to the needs of children affected by HIV/AIDS, and has worked with WHO to refine nutrition protocols for HIV and develop new protocols for TB. WFP will continue to develop these partnerships.
27. Other partners include the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) 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.
28. 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 programmes and establishing relevant M&E. With local partners, WFP will emphasize stigma reduction and raise awareness of the services available and the right of access.
29. 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?

30. 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, 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 budget¹⁴ for its contribution to the global response to HIV/AIDS, and is accountable to its partners and the UNAIDS Board.
31. 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 JOF makes WFP responsible for helping governments to implement food and nutrition interventions for PLHIV and TB patients and creating safety nets.
32. 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.¹⁵ UNICEF, for example, will focus on children affected by HIV/AIDS and prevention of mother-to-child transmission; other Cosponsors will work in their areas of comparative advantage.
33. 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. Nutrition assessment, education, and counselling are required for all ART patients, whereas food should strictly be provided based on need, 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.¹⁶ 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.

¹⁴ 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.

¹⁵ UNAIDS. 2009. *Joint Action: Outcome Framework 2009–2011*. Geneva.

¹⁶ UNAIDS. 2009. *Letter to Partners*. Geneva. Available at: http://data.unaids.org/pub/BaseDocument/2009/20090210_exd_lettertopartners_en.pdf

34. WFP will collaborate with UNHCR to prioritize food and nutrition interventions for HIV/AIDS in humanitarian settings and food crises. PLHIV are disproportionately vulnerable to the consequences of shocks, so WFP should prioritize their needs with those of other vulnerable groups to increase their resilience.
35. WFP is well positioned to help governments to establish effective programmes for nutrition, food support and safety nets¹⁷ 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 into HIV programming.
36. 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.
37. 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. PLHIV are particularly vulnerable in emergencies because their treatment may be interrupted and they suffer from poor hygiene, insufficient nutrition and reduced access to food, all of which can lead to opportunistic infections. WFP's food and nutrition support for HIV/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/AIDS.
38. PLHIV may also qualify for support from food or cash for work, food for training or assets and school feeding programmes, 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.

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

39. WFP's policy has two main objectives:
 - ensuring nutritional recovery and treatment success through the provision of nutrition and/or food support; and
 - mitigating the effects of AIDS on individuals and households through sustainable safety nets.

¹⁷ UNAIDS. 2009. *Letter to Partners*. Geneva. Available at: http://data.unaids.org/pub/BaseDocument/2009/20090210_exd_lettertopartners_en.pdf

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

40. Despite the enormous success of an increase in access to anti-retroviral treatment (42 percent) in less-developed countries, the mortality rate for people starting ART in low-income settings is four times higher than for people in high-income settings. Nutrition and food support must therefore be integral parts of treatment:¹⁸ they enable uptake and initial adherence to ART and nutritional recovery, which reduce mortality and enhance ART effectiveness. Nutrition and food support reduce the side effects of medications, opportunistic infections and long-term metabolic complications such as dyslipidemia, obesity and insulin resistance.
41. 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).¹⁹
42. 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).
43. Such programmes should be adjusted to each context. The decision as to 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.
44. 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 enlarged 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.
45. 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

¹⁸ 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.

¹⁹ 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 overall programme performance. See: <http://www.tbalert.org/worldwide/DOTS.php>

service delivery systems and that they enhance national capacities, infrastructures and supply mechanisms.

46. 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 Affected Individuals and Households through Sustainable Safety Nets

47. Interventions under this objective provide food assistance, including through innovative modalities such as voucher schemes or cash transfers, to prevent people affected by HIV/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 orphans and other vulnerable children (OVC) and their caregivers. Such interventions should be limited in time and provided on the basis of food insecurity and socio-economic assessments.
48. 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 families, communities and institutions and will support basic education, vocational training and livelihood opportunities
49. Support for OVC is provided in many forms to reflect the needs identified in national plans of action for OVC. Food assistance complements support provided by host families, communities and institutions and provides vocational training and livelihood opportunities; it is designed for the context in which it is provided to maximize the impact of the support package.²⁰
50. 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.
51. 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. 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 safety nets that provide sustainable income-earning opportunities and support long-term adherence to treatment.

²⁰ WFP/EB.2/2009/4-A

⇒ *Broad safety nets*

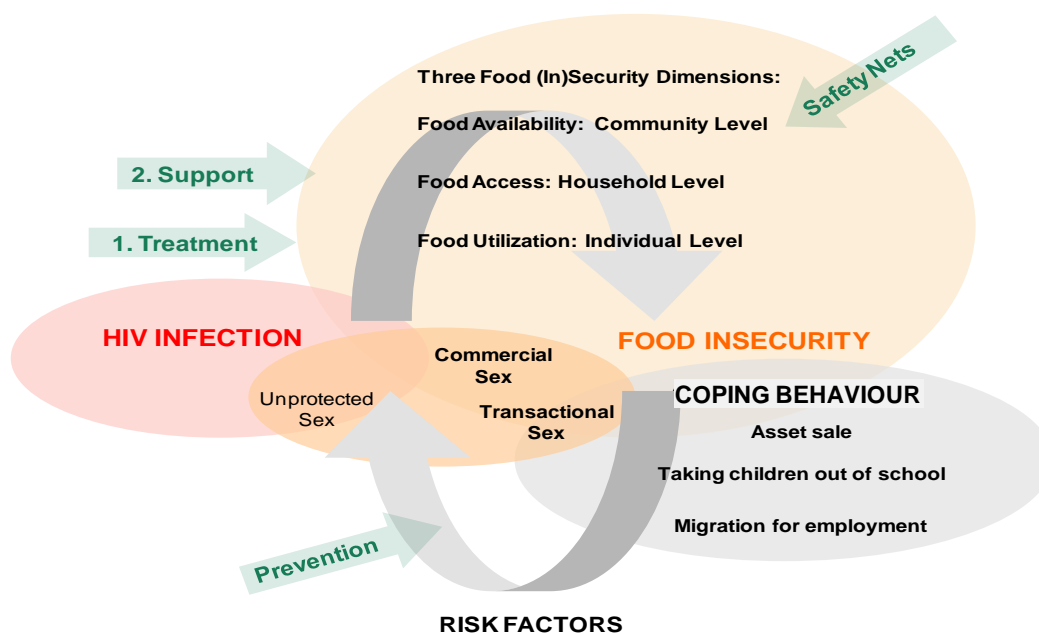
52. WFP has helped governments to build systems such as the Productive Safety Net Programme in Ethiopia. Such safety nets are designed to address food insecurity rather than HIV, but they are important in preventing the spread of HIV and addressing the needs of PLHIV. Child grants, old age pensions and 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.
53. 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*

54. 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 and 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 programme²¹ and its HIV/AIDS in the Workplace programme by enhancing HIV support for staff regardless of duty station or contract type.
55. Figure 2 shows how WFP designs interventions to address HIV and food insecurity and the importance of safety nets and prevention.

²¹ 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 Code of Practice on HIV/AIDS and the World of Work and to recognize their responsibilities in relation to HIV.

Figure 2: Interventions Can Disrupt the Causal Pathways from HIV to Food Insecurity and from Food Insecurity to HIV



Guiding Principles

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

- Know your epidemic, know your response. Every programme response should be tailored to the epidemiological and socio-political context.
- The “Three Ones”²² and national ownership. WFP is committed to the “Three Ones”: its HIV/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.
- Evidence-based, cost-effective programmes with sound M&E. Food and nutrition interventions in HIV and TB programmes should be based on the latest evidence; a sound M&E system is necessary to guide and improve interventions and to provide accountability.
- 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.
- Community participation and ownership, including PLHIV. Civil society has a critical role in HIV/AIDS response: the involvement of PLHIV in WFP’s HIV/AIDS programming should be increased.

²² 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.

- Buy food locally. Local procurement of food is one way to achieve sustainability and stimulate economies.
 - ◇ 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.
 - ◇ Gender. WFP will use gender analysis to understand the social aspects of gender relations and gender-based norms, and 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 where HIV can be transmitted, diverting resources or drawing healthcare staff away from other programmes.

POLICY RATIONALE: FOOD ASSISTANCE AND HIV/AIDS

57. WFP's new policy reflects the changes in the HIV and AIDS situation over the last seven years. Recent scientific evidence has enhanced 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.

⇒ *HIV contributes to food insecurity and malnutrition*

58. HIV has profound consequences for nutritional status. People are often food-insecure and malnourished before infection, and disease becomes a cause of malnutrition through its effect on the metabolism and the ability to ingest and digest food. It disrupts livelihoods in that PLHIV often lose the ability to earn an income, thereby leading to more food insecurity. Where there is stigma, PLHIV are often excluded from community-based safety nets.²³

⇒ *Increased energy requirements*

59. 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 needs: 10 percent more at the asymptomatic stage, increasing to 30 percent for adults in the later stages. Symptomatic HIV-positive children have calorie needs that are 50 percent to 100 percent greater than those of HIV-negative children;²⁴ young children often struggle to consume twice the amount of calories, especially when they do not have access to energy-dense foods. These factors impose financial burdens on families.

60. If these increased energy demands are not met, PLHIV begin to lose fat and muscle tissue. Low BMI is a major risk factor for HIV-disease progression and mortality, independent of immune system performance.²⁵ As energy needs go up, symptoms of HIV

²³ UNDP. 2007. *HIV-Related Stigma and Discrimination in Asia: a Review of Human Development Consequences*. Colombo.

²⁴ WHO. 2003. *Nutrient Requirements for People Living with HIV/AIDS*. Geneva.

²⁵ Babameto, G. and Kotler, D.P. 1997. Undernutrition in HIV infection. *Gastroenterol Clin North Am* 26: 393–415.

reduce people's food intake and can interfere with the body's ability to absorb and utilize nutrients.²⁶ HIV can create a paradoxical situation where people reduce their nutrient intake just as their bodies require an increase, making nutritional support²⁷ a critical component of HIV treatment.

61. The quality of diet matters as well as the quantity of food consumed and palatability. 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.²⁸

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. Destitution and despair brought on by negative coping behaviours may increase the risk that a person will resort to trading unprotected sex for food.^{29,30}
65. Figure 3 summarizes the causal dynamics that lead from HIV to food insecurity, and often from food insecurity to HIV.

²⁶ Semba, R.D. and Tang, A.M. 1999. Micronutrients and the pathogenesis of human immunodeficiency virus infection. *Br J Nutr* 81:181–189.

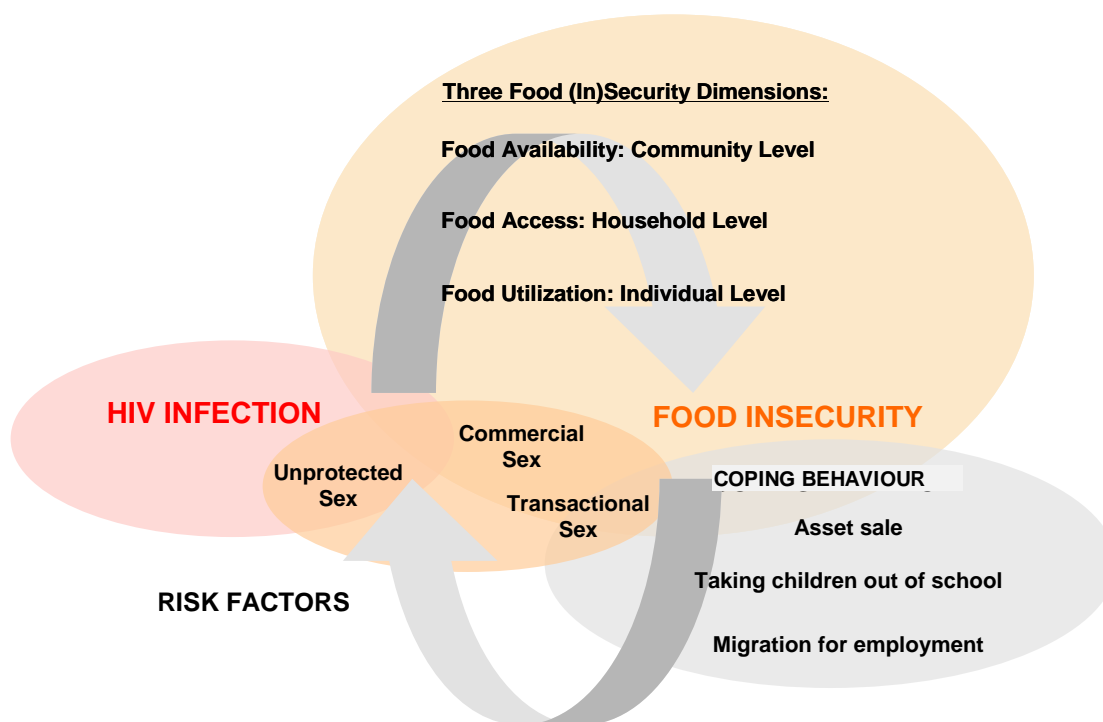
²⁷ Nutritional support aims to ensure adequate nutrition, and includes assessment of dietary intake, nutritional status and food security; nutrition education and counselling aim to ensure a balanced diet, mitigate side effects of treatment and infections and ensure access to clean water and where necessary food supplements or micronutrient supplementation.

²⁸ WFP background paper on HIV and nutrition submitted for publication in 2010.

²⁹ Weiser, S., Leiter, 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.

³⁰ 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.

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 TB/HIV 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.³¹
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; 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

³¹ WFP Background Paper on Tuberculosis and Nutrition and HIV Co-Infection . Submitted for publication in 2010.

than among those who are not.³¹ 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.³²

69. Recommendations to extend treatment may affect food and nutrition issues. In December 2009, WHO³³ raised the recommended CD4³² count threshold for initiating treatment from 200 to 350/mm³ in the 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 fewer clients with HIV will progress to AIDS. 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.
70. Treatment also reinforces food security, especially in high-prevalence countries. Once a client starts to benefit from treatment, physical health and productivity can be maintained or restored, thereby mitigating many of the negative effects of HIV. There are also positive effects on prevention work in that people on treatment have lower viral loads and are consequently less infectious.

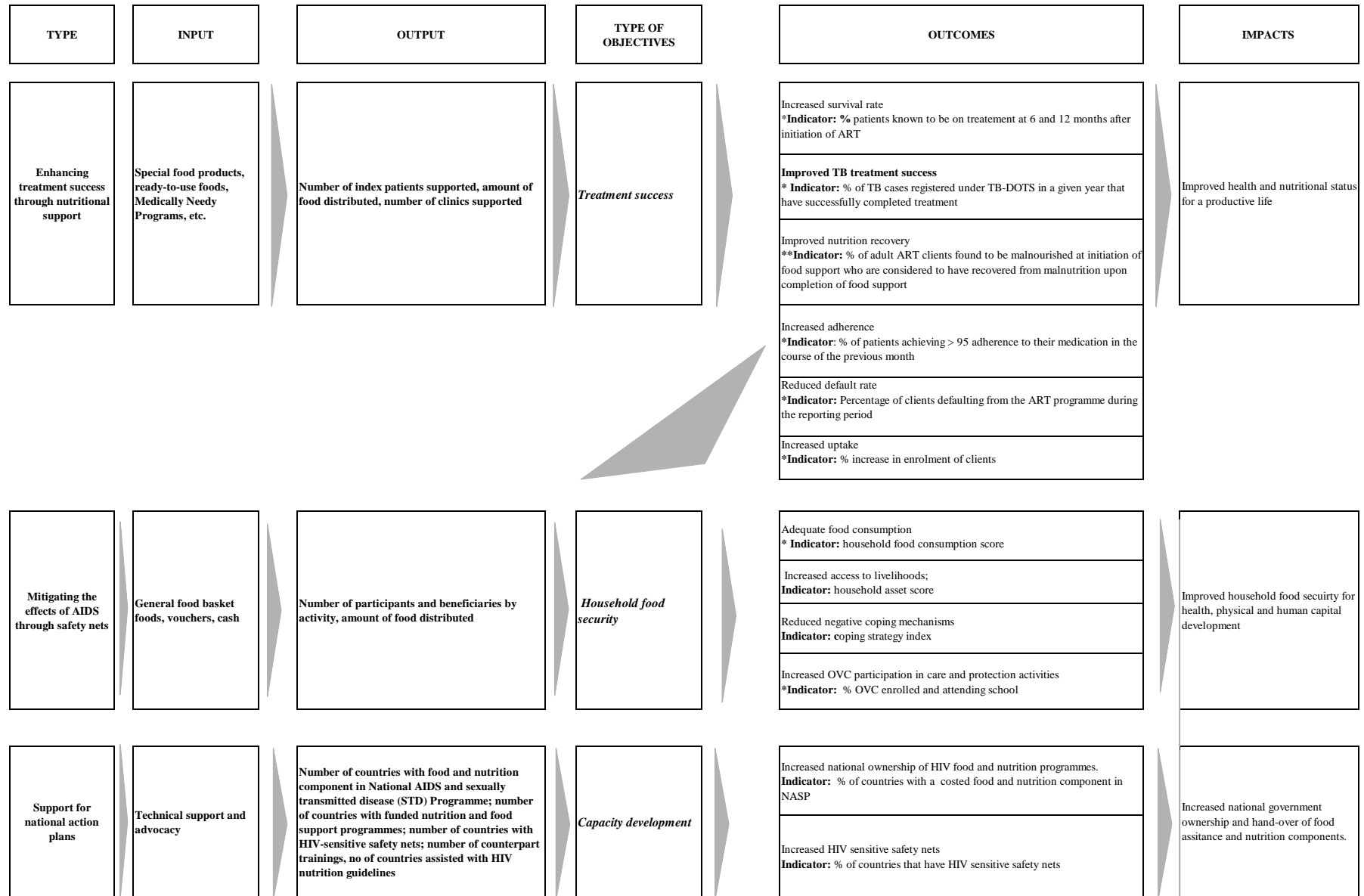
CONCLUSION

71. 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.
72. 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.

³² Hsu, J. W.-C., Pencharz, P.B., Macallan, D. and Tomkins, A. 2005. *Macronutrients and HIV/AIDS: A Review of Current Evidence*. Geneva, WHO.

³³ WHO. 2009. *Rapid Advance: Anti-retroviral Therapy for HIV Infection in Adults and Adolescents*. Geneva.

ANNEX I: HIV/AIDS LOGIC MODEL



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, anti-retroviral treatment
BMI	body mass index
DoL	Division of Labour [UNAIDS]
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 immuno-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 and 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