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*For information**

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 focal point indicated below, preferably well in advance of the Board's meeting.

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EXECUTIVE SUMMARY

At the request of the Board, WFP provides regular updates on the implementation of its HIV policy. The policy[1] is in line with the Joint United Nations Programme on HIV/AIDS (UNAIDS) strategy for 2011–2015 "Getting to Zero",[2] the UNAIDS Division of Labour, the WFP Strategic Plan (2014–2017) and the new 90-90-90 UNAIDS strategy.

WFP is the lead UNAIDS agency for ensuring that food and nutrition support are 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 in humanitarian emergencies, and ensure that the special needs of people living with HIV are considered.

WFP's two-pronged approach involves working with governments to ensure that food and nutrition support is included in national HIV and tuberculosis strategies and programmes and to implement food and nutrition support for people living with HIV and tuberculosis clients.

WFP's HIV and tuberculosis programmes reached approximately 700,000[3] beneficiaries in 29 countries in 2014. This involved 386,388 clients on anti-retroviral treatment and 155,993 tuberculosis clients and their households, along with interventions to prevent mother-to-child transmission, support for 118,166 orphans and other vulnerable children, and food and nutrition support in refugee camps.

In the Central African Republic, the Democratic Republic of the Congo, Sierra Leone and South Sudan, and in refugee camps in Cameroon, Kenya, Nepal and Rwanda, people living with HIV were reached by general food distributions along with HIV-specific interventions. Although HIV-specific funding is declining, WFP adopted a sustainable holistic approach to HIV programming: i) food assistance was connected to economic activities to foster long-term sustainability; ii) work on HIV and tuberculosis was further integrated with nutrition programmes; iii) support for HIV-sensitive social safety nets was increased; iv) cash and voucher schemes for HIV programmes were increased; and v) partnerships were established with the United Nations Population Fund and the United Nations Children's Fund to reach women and girls through Health 4+, which works with countries to strengthen national health systems, and the Adolescent Girls Initiative. In recognition of WFP's logistics expertise, deep-field presence and provision of logistics support for Global Fund grants, WFP and the Global Fund signed a Memorandum of Understanding (MOU) for a logistics partnership.

[1] WFP/EB.2/2010/4-A

[2] UNAIDS. 2011. *Getting to Zero 2011–2015*. Geneva.

[3] Preliminary data from ongoing 2014 Standard Project Reports (SPRs).

HIV AND TUBERCULOSIS IN 2014

1. HIV remains one of the most serious challenges of our time: there are 35 million people living with HIV (PLHIV) – more than ever before.[4] Sub-Saharan Africa is home to 71 percent of the global total and 1.5 million people became infected in 2013. HIV prevalence among adolescent girls is high: more than 40 percent of new infections among women aged 15 years old and over occur among women aged between 15 and 24.

2. The annual number of AIDS-related deaths worldwide fell by 35 percent between 2005 and 2013, but deaths among people aged 10 to 19 living with HIV increased by 50 percent between 2005 and 2012.[5] AIDS is the second leading cause of death among adolescents globally, and the leading cause of death among adolescents in sub-Saharan Africa.[6]

3. New HIV infections are declining, particularly among infants. The 2014 UNAIDS Gap Report showed that 240,000 children had been recently infected with HIV – 58 percent fewer than in 2002. Access to antiretroviral medicines for pregnant women living with HIV has prevented 900,000 new HIV infections among children since 2009. The proportion of pregnant women living with HIV who did not receive anti-retroviral medicines has declined from 67 percent to 32 percent over the past five years, but incidence of HIV among key populations such as men who have sex with men, prisoners, migrants and sex workers has risen in several parts of the world.[4]

4. The full benefits of HIV treatment are realized when PLHIV are given the support and care required for optimal adherence: in such cases, 86 percent of adults remain in treatment 12 months after initiation. Some people move from one clinic to another, but recent evidence suggests that in southern Africa 30 percent of patients who discontinued treatment have died.[4] Research and better support for adherence may help to ensure sustainable treatment for PLHIV.

5. Among prevention interventions evaluated in random controlled trials, HIV treatment has the most substantial effect on HIV incidence: clearly, such treatment saves lives and prevents new infections.[7]

6. A World Health Organization (WHO) report in 2013 showed that an estimated 9 million new cases of tuberculosis (TB) had occurred, of which 1.1 million – 13 percent – were cases of co-infection with HIV, and that 1.5 million people had died from TB, of whom 360,000 were HIV-positive. TB is a major cause of death among PLHIV. The integration of HIV and TB services has improved: in 2013, 48 percent of TB clients had a documented HIV test result and 64 countries reported 5.5 million people with TB infection enrolled in HIV care, up from 4.1 million in 62 countries in 2012.[8]

[4] UNAIDS. 2014. *The Gap Report*. Available at: http://www.unaids.org/sites/default/files/en/media/unaids/contentassets/documents/unaidspublication/2014/UNAIDS_Gap_report_en.pdf

[5] UNAIDS. 2014. *90-90-90: An ambitious treatment target to help end the AIDS epidemic*. Geneva.

[6] WHO. 2014. Health for the world's adolescents. Available at: http://apps.who.int/adolescent/second-decade/

[7] Karim, S.A.S. and Karim, Q.A. 2011. Antiretroviral prophylaxis: a defining moment in HIV control. *The Lancet* 378: e23-e25.

[8] WHO. *Global Tuberculosis Report 2014*. Available at: http://apps.who.int/iris/bitstream/10665/137094/1/9789241564809_eng.pdf?ua=11

EFFECTS OF CHANGES IN FUNDING FOR FOOD AND NUTRITION FOR HIV RESPONSE

7. Donors for HIV treatments have urged partners to ensure that people have access to treatment, especially women and girls, men who have sex with men, people who inject drugs, migrant workers and prisoners. But because of the difficult global economic situation, HIV programming is financially strained, and future funding from traditional donors is expected to decline. In this context, it may be difficult to secure funding earmarked for food and nutrition that supports HIV clients, unless it is combined with social safety net approaches.

8. The Global Fund remains one of the largest source for HIV-specific funding. Since the pilot phase of the new Global Fund funding model in 2013, 70 countries have expressed interest in applying for funding. In 2014, 111 concept notes were screened by the Technical Review Panel and the Grant Approvals Committee,[9] and WFP provided technical support for food and nutrition or logistics components in national strategic plans and protocols, and for Global Fund grants in 17 countries.

9. For WFP, the likely decline in donor resources points to the need to combine HIV-specific and HIV-sensitive programmes.[10] In particular, WFP is focusing on linking health and food systems and integrating HIV issues into broad-based social safety nets; this includes livelihood promotion to support long-term adherence to anti-retroviral therapy (ART). As people affected by HIV start treatment earlier and live longer, HIV is emerging as a chronic disease with new complications and co-morbidities that require sophisticated systems for disease management. Social-protection schemes, including food and nutrition support, can help people to gain access to health services and thus contribute to increase uptake and adherence and reduced mortality. Increasingly, WFP supports children affected by HIV through school feeding programmes, for example in Lesotho and Swaziland, to reduce stigma and discrimination.

WFP AND UNAIDS

10. In June 2011, the UNAIDS Programme Coordinating Board (PCB) endorsed a USD 485 million Unified Budget, Results and Accountability Framework (UBRAF) for 2012–2015, and WFP is working with UNAIDS cosponsors to develop the 2016–2021 strategy and UBRAF. At the 35th meeting of the UNAIDS PCB in December 2014, Member States requested that the strategy be updated and extended in line with the call to fast-track the HIV response over the next five years to end AIDS as a public health threat by 2030.

[9] See: http://www.theglobalfund.org/documents/fundingmodel/progressupdate/FundingModel_2015-01-Progress_Update_en/

[10] HIV-sensitive interventions are not set up with HIV or TB as a primary focus, but they should take into account HIV/TB-linked vulnerabilities. HIV-specific interventions focus exclusively on people living with HIV and households affected by HIV or TB. WFP's HIV-specific interventions are located in two programme pillars: Care and Treatment, and Mitigation and Safety Nets.

11. As a UNAIDS Cosponsor, WFP shares the vision of achieving zero new infections, zero AIDS-related deaths and zero discrimination by 2015. Under the UNAIDS Division of Labour, WFP's mandate is to convene with other Cosponsors on food and nutrition issues with a view to ensuring that food and nutrition are integrated into comprehensive packages of care, treatment and support for PLHIV and TB clients at the country level, in line with its own policy.

12. WFP's 2010 HIV policy emphasized the need to embed WFP activities in country-led responses and to cooperate with its UNAIDS partners on food and nutrition in relation to HIV and TB, reflecting the emphasis on enabling country-level HIV responses in the 2012–2015 UBRAF.

13. The UNAIDS strategy for 2011–2015 seeks to: i) revolutionize HIV prevention; ii) catalyse the next phase of treatment; and iii) advance human rights and gender equality. These areas are subdivided into ten goals, to which WFP contributes as described below.

14. In December 2013, the UNAIDS PCB mandated support for country-led and regional work to establish scaled up targets for HIV treatment beyond 2015. The 90-90-90 treatment targets for 2020 are: i) 90 percent of PLHIV will know their HIV status; ii) 90 percent of people with diagnosed HIV will receive sustained ART; and iii) 90 percent of people receiving ART will have viral suppression.

UNAIDS STRATEGY GOALS

Universal Access to ART for PLHIV Who Are Eligible for Treatment

15. Improving the efficiency and effectiveness of treatment services is central to the long-term success of the HIV response. WFP works with governments and partners to ensure that treatment is accompanied by assessments of nutritional status, counselling on nutrition to maintain body weight and health and to mitigate side-effects, and when necessary, nutritious food to treat malnutrition. Household rations may complement this support to defray the costs of initial care and promote adherence to treatment and retention in care.

16. The current UBRAF asks Cosponsors to prioritize their interventions and focus on 38 high-priority countries that account for 70 percent of the disease burden. In 2014, WFP helped governments to address the food and nutrition needs of PLHIV and TB clients in 24 of these countries;[11] WFP implemented HIV-specific interventions in 19 of them.[12]

17. The Nutrition Assessment, Counselling and Support programming guide for adolescents and adults living with HIV adopted by WFP, WHO, UNAIDS and the President's Emergency Plan for AIDS Relief informs policymakers and programme managers about the role of food and nutrition in HIV/TB care with a view to improving access and adherence to treatment and retention in care. WFP's new HIV/TB programme and monitoring and evaluation guidelines set out the steps required to create an in-country programme plan in line with global frameworks.

[11] Burundi, Cambodia, Cameroon, the Central African Republic, Chad, Côte d'Ivoire, Djibouti, the Democratic Republic of the Congo (DRC), Ethiopia, Ghana, Guatemala, Haiti, Indonesia, Kenya, Lesotho, Malawi, Mozambique, Myanmar, Rwanda, South Sudan, Swaziland, the United Republic of Tanzania, Zambia and Zimbabwe.

[12] Burundi, Cameroon, Central African Republic, Côte d'Ivoire, DRC, Djibouti, Ethiopia, Ghana, Haiti, Kenya, Lesotho, Malawi, Mozambique, Myanmar, Rwanda, Swaziland, South Sudan, the United Republic of Tanzania and Zimbabwe.

18. In view of its experience in logistics, its extensive field presence and its history of providing logistics support through Global Fund grants, WFP has signed a Memorandum of Understanding with the Global Fund for a partnership to promote access to items such as anti-retroviral drugs through WFP's storage and shipping networks. WFP will build capacities among Global Fund implementers with a view to improving distribution systems and ensuring timely and cost-effective delivery.

Tuberculosis Deaths Among PLHIV Reduced By Half

19. HIV infection leads to increased numbers of HIV-related TB cases. The Stop TB strategy integrates TB and HIV/AIDS programmes to benefit TB clients and PLHIV. In Swaziland, WFP helped the Government to increase access to food by prescription for co-infected clients, to integrate nutrition indicators for HIV and TB, and to improve referral and follow-up for HIV and TB care programmes.

20. In 2014, WFP: i) provided food and nutrition assistance for TB clients in 15 countries[13] to increase adherence to treatment; ii) continued to promote integrated programming with United Nations and governmental counterparts to ensure that TB clients are tested for HIV and vice versa, especially where HIV prevalence is high; and iii) helped countries to integrate food and nutrition into national TB strategies, protocols and guidelines and Global Fund proposals on TB.

Vertical Transmission of HIV Eliminated and AIDS-Related Maternal Mortality Reduced by Half

21. Among the demand-side barriers to prevention of mother-to-child transmission (PMTCT) services identified in WFP's paper in the journal *AIDS and Behaviour*,[14] food assistance was identified as a factor that helps access and adherence, and pregnant women with HIV were shown to be more prone to food-insecurity than other women because they have greater nutrient requirements. This evidence supports the policy of addressing food insecurity in pregnant women and their children to improve adherence to care and treatment.

22. WFP continued to integrate its programme for PMTCT clients into mother-and-child health and nutrition services to prevent HIV transmission and ensure that mothers and infants have access to growth monitoring, vaccinations, micronutrient supplements, nutrition assessments, education, counselling and complementary foods.

23. Implementing comprehensive services that include food assistance enables more women to start and adhere to PMTCT programmes. In line with global trends, WFP has integrated many of its PMTCT programmes into programmes such as prevention and treatment of moderate acute malnutrition. This does, however, make it more difficult for WFP to distinguish PMTCT beneficiaries.

[13] Based on 2014 SPRs for the Congo, DRC, Djibouti, Guinea-Bissau, Lesotho, Madagascar, Malawi, Myanmar, Nepal, Sierra Leone, Somalia, South Sudan, Swaziland, Tajikistan and Zimbabwe.

[14] Claros, J.M., de Pee, S. & Bloem, M.W. 2014. Adherence to HIV and TB care and treatment, the role of food security and nutrition. *AIDS Behav.* 18: S459−S464.

24. WFP provided technical support for national PMTCT programmes and the development of guidelines in 2014. In Guatemala, WFP assisted the Ministry of Health in updating infant feeding guidelines; in the DRC it supported the national HIV/AIDS programme for nutritional counselling for pregnant and lactating women attending PMTCT services, and assessed the reasons for defaulting. In Lesotho, WFP and the United Nations Children's Fund provided nutrition support in "waiting homes" provided for pregnant women.

PLHIV and Households Affected by HIV Are Addressed in All National Social Protection Strategies and Have Access to Essential Care and Support

25. In 2014, WFP expanded the use of vouchers in HIV and TB programming. In the Congo they were provided via mobile telephone for vulnerable households, including people affected by HIV and TB, pregnant and lactating women and out-of-school children on condition that the children were enrolled in school and that pregnant and lactating women, ART and TB clients visited health centres. In Mozambique, vouchers were provided via mobile telephones to enable beneficiaries to buy food.

26. WFP continued to explore linkages with livelihood-promotion activities. In Ethiopia, for example, PLHIV receive food vouchers for six months during training in business skills and assistance in setting up village saving and credit associations that provide start-up loans for income-generating activities. After the training, they get help in preparing business plans and receive matching funds for starting up.

27. In 2014, a joint mission by WFP and the South African non-governmental organization (NGO) *Kheth'Impilo* documented good practices for linking communities, health systems and social-protection services to overcome access barriers such as food insecurity and generate demand for HIV and health services. The lessons were shared with Cosponsor members of the Inter-Agency Task Team (IATT) on Food and Nutrition and served as a launching point for knowledge-building related to the linking of systems.

28. WFP worked with the governments of the Congo, Ethiopia, Mozambique, Swaziland and others to ensure that nutritional support was integrated into national social-protection programmes. National ownership has guaranteed coordination of service delivery and improved referral systems.

Reduce Sexual Transmission of HIV

29. WFP continues its partnership with the North Star Alliance to extend services along transport corridors through 30 road wellness centres in Botswana, DRC, the Gambia, Kenya, Malawi, Mozambique, South Africa, Swaziland, Uganda, the United Republic of Tanzania, Zambia and Zimbabwe, which account for many new HIV infections. In 2014, North Star Alliance served 226,000 clients and distributed 1.29 million condoms; WFP provided emergency food assistance for vulnerable, food-insecure and displaced individuals and households to prevent the adoption of coping mechanisms such as transactional sex that increase the risk of HIV transmission.

HIV IN EMERGENCIES

30. The links between HIV and humanitarian emergencies are complex in that responses must take into account the needs of PLHIV as well as others. Vulnerability to the virus can be increased through greater exposure to sexual violence and reliance on transactional sex to meet basic needs. Health services and HIV intervention programmes may become difficult to access or may not exist.

31. An IATT meeting was held in January 2014 and two regional workshops were coordinated with the Office of the United Nations High Commissioner for Refugees (UNHCR) to integrate HIV into contingency planning and emergency preparedness WFP drafted a proposal on HIV in emergencies for the 36th PCB in June 2015 and contributed to a paper on ensuring the continuity of HIV and TB services during the Ebola crisis; it also contributed to ten case studies of the effect of emergencies on the continuity of HIV and TB treatment to inform use of the Emergency Fund. In addition, WFP supported HIV work in emergency settings in the Central African Republic and South Sudan.

2014 IN NUMBERS

32. WFP assisted 660,547 PLHIV, TB clients and their households in 29 countries through nutrition rehabilitation, mitigation and safety-net activities (Table 1).

TABLE 1: HIV AND TB PROGRAMME BENEFICIARY NUMBERS (HIV-SPECIFIC), 2014*

Objective 1: Ensure nutrition recovery and treatment success through nutrition rehabilitation – Care and treatment	– 320,687 ART and PMTCT clients and their households – 120,785 TB clients on directly observed treatment, short course and their households **441,472 total**
Objective 2: Mitigate the effects of HIV through sustainable safety nets – Mitigation and safety nets	– 65,701 ART clients and their households – 118,166 orphans and other vulnerable children – 35,208 TB clients and their households **219,075 total**
TOTAL	**660,547**

*Based on preliminary results of 2014 SPRs, which were not complete at the time of writing.

33. WFP reached PLHIV through HIV-sensitive interventions that took into account vulnerability related to HIV/TB, general food distributions, and school feeding and food-assistance-for-assets activities. Pregnant and lactating women were reached primarily through mother-and-child health and nutrition services. These factors, combined with the decrease of HIV-specific funding, explain the falling number of beneficiaries in recent years.

PARTNERSHIPS

34. As the convenor of the IATT on Food and Nutrition, WFP organized a meeting in December 2014. A sub-group on South Africa was created in 2014 and a joint mission to KwaZulu-Natal was conducted with the South African NGO *Kheth'Impilo* in December.

35. The WFP article in *AIDS and Behaviour*[14] considered barriers to uptake and retention in HIV and TB treatment and ways in which food and nutrition assistance can help to overcome them.

36. With UNHCR, WFP is the co-convener of the IATT on HIV in Emergencies, which aims to improve HIV preparedness and responses during emergencies. Activities at the global level included a satellite session on fragile states at the 20th International AIDS Conference held in Melbourne from 20 to 25 July 2014, organized by WFP and UNHCR.

37. WFP and the Institute of Development Studies ran a nutrition and HIV capacity-development course from 17 to 19 June 2014 for staff, including senior management, from regional bureaux and country offices in African countries with high prevalence of HIV.

OUTLOOK FOR 2015

38. WFP will support governments in integrating food and nutrition programmes into the health sector and linking them with community-based initiatives and social-protection strategies, providing cash and vouchers to prevent the overburdening of health systems.

39. Even though a third of PLHIV leave their treatment and care within three years, access to treatment is not a focus of attention. WFP and its partners will conduct country case studies to demonstrate the effectiveness of food and nutrition interventions within care and support packages in increasing treatment adherence. WFP will partner with *Kheth'Impilo* on community-based approaches to improving HIV treatment, health systems, food systems, education and social protection with a focus on the variances in approaches in southern Africa.

40. The increasing interest in HIV-sensitive social protection is an important opportunity for WFP to review and analyse its activities using an HIV-sensitive lens to ensure that they reach vulnerable PLHIV and their families.

ACRONYMS USED IN THE DOCUMENT

ART	anti-retroviral therapy
DRC	Democratic Republic of the Congo
IATT	Inter-Agency Task Team
NGO	non-governmental organization
PCB	Programme Coordinating Board
PLHIV	people living with HIV
PMTCT	prevention of mother-to-child transmission
SPR	Standard Project Report
TB	tuberculosis
UBRAF	Unified Budget, Results and Accountability Framework
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNHCR	Office of the United Nations High Commissioner for Refugees
WHO	World Health Organization