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The evolution of food assistance for HIV care and treatment 2000 to 2009: a decade of institutional innovations

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1. Introduction

The fight against HIV and AIDS is firmly established as a global health priority. The number of people living with HIV infection continues to grow, and AIDS-related illnesses are projected to remain among the leading causes of premature mortality in the coming decades. Sub-Saharan Africa is still the region most heavily affected by HIV worldwide, accounting for more than two-thirds, or 67 percent, of all people living with HIV and nearly three-quarters, or 72 percent, of AIDS-related deaths in 2008 (UNAIDS, 2009a).

In countries with high prevalence rates, the majority of people infected with HIV are in the most economically productive age group of 15 to 49 years. HIV-related mortality lowers national life expectancy rates and has far-reaching social and economic impacts on households, communities, businesses, public services and national development and growth. Countries with heavy HIV burdens are often affected by high levels of food insecurity and malnutrition, a dual threat that creates a downwards spiral of mutually reinforcing effects. However, the roll-out of antiretroviral therapy (ART) is enabling people to regain health, dignity and productivity, and WFP's support to Food by Prescription (FBP) programmes plays a significant role in their success. In addition, WFP's social safety net programmes mitigate the impact of HIV on affected families, helping to preserve household integrity and improving the life trajectories of vulnerable children and other household members.

This chapter traces the evolution of WFP's programming in the context of HIV care and treatment over the past decade. It demonstrates how scientific advances and developments in the political landscape have shaped programming directions and approaches. The first section gives a brief introduction to the linkages among HIV, AIDS, food and nutrition and is followed by an exploration of the past ten years, reflecting on changes in WFP programme approaches and their associations with global events. In conclusion, the chapter considers the important challenges and opportunities that have emerged as lessons from the experience of innovation, reflecting on the increasing professionalization in this field, the need for further programme rationalization and adaptation, the role of global advocates, funding challenges, and the importance of forging linkages that make global nutrition a priority.

2. HIV, food and nutrition

2.1 Regional variations

HIV epidemics throughout the world continue to evolve at their own pace, each on a trajectory influenced by multiple cultural, political and economic factors. The slowing but unrelenting rise in the global prevalence rate is attributed to both increased longevity among the infected, which is related to treatment success, and the high numbers of new infections in Eastern Europe, Central Asia and other parts of Asia. Sub-Saharan Africa's epidemics vary significantly from country to country, with most appearing to have stabilized, although often at very high prevalence levels, particularly in Southern Africa. Drivers of the epidemic also vary widely, generating different vulnerability profiles among countries or even among areas of the same country. The substantial diversity of national epidemics underscores the importance of tailoring food assistance strategies to local contexts, while supporting decentralized AIDS response mechanisms.

The Joint United Nations Programme on HIV/AIDS and World Health Organization (UNAIDS/WHO) 2009 Epidemic Update reports continued improvement in the numbers of adults and children receiving ART, which had reached 4 million by December 2008; however, overall global ART coverage still stands at only 42 percent (UNAIDS, 2009a). WFP's Southern, Eastern and Central Africa region currently accounts for half of the total people living with HIV and AIDS (PLHIV) in sub-Saharan Africa (UNAIDS, 2009a). Many of the countries in this region are experiencing serious chronic and recurrent food insecurity, and show high levels of chronic malnutrition among children – a sign of broad underlying nutritional vulnerabilities within the population at large. In comparison, West and

Central Africa is characterized by a relatively low HIV prevalence. With an average adult HIV prevalence of 1 percent, the Caribbean is the second-most affected region in the world, after sub-Saharan Africa, and AIDS has become the leading cause of death among both men and women aged 15 to 44 years.

In most of Latin America, HIV is classified as concentrated among the groups most at-risk, but the escalating rate of new infections among women and girls shows that the epidemic is becoming more generalized. The HIV epidemic in Asia presents a contrast to other parts of the world, with vulnerable groups such as injecting drug users, men who have sex with men, and sex workers tending to be the most at risk of HIV (UNAIDS, 2008).

2.2 HIV, AIDS and food security

As already mentioned, HIV epidemics exhibit regional diversity and have different interrelationships with food security. There is clear evidence that HIV affects all three components of food security: availability, accessibility, and utilization. Although epidemic contexts vary, PLHIV all tend to identify food as an important priority need. Families with an HIV-infected member are more likely to be poor and food-insecure. Being infected with HIV limits productivity, leading in turn to loss of income, while increasing health care costs. At the same time, individuals who are food-insecure may be more likely to engage in transactional sex or to become mobile, increasing their risk of contracting HIV (Weiser *et al.*, 2007).

2.3 HIV, AIDS and nutrition

Nutrition plays a vital role in the immune systems of all people, including PLHIV. Good nutrition strengthens the immune system, while HIV infection and malnutrition – including micronutrient deficiencies – have the cumulative effect of damaging it. People living with HIV and AIDS are more vulnerable to malnutrition than the general population, and their nutrition status is a strong predictor of mortality risk, independent of cluster difference 4 (CD4) count.

HIV itself puts PLHIV at high risk of disease-induced weight loss and wasting due to lower food intake resulting from reduced appetite, diarrhoea, mouth sores, etc. on the one hand, and increased nutrient needs and poorer utilization on the other hand. Once infected with HIV, the body mounts an immune response that requires energy above and beyond usual needs;¹ malnutrition is known to affect HIV and TB infection negatively by further weakening the immune system and negatively affecting disease progression.

HIV infection also increases micronutrient needs, owing to more frequent illness and increased losses. Ensuring that PLHIV consume at least the recommended nutrient intake (RNI) of micronutrients is therefore very

important and may require the use of micronutrient supplements or specific fortified food commodities (De Pee and Semba, forthcoming).

ART drugs, although highly beneficial in countering HIV's attack on the immune system, have an impact on the metabolism and affect nutritional well-being as a result of reduced food intake and utilization owing to nausea, anorexia, etc., particularly in the first phase of treatment. The combined nutrition challenges of AIDS-related illnesses and initial ART side-effects are cause of great concern regarding client survival and treatment success.

Figure 13.1a Milestones in HIV/AIDS care and treatment

<i>Global</i>	2000	<i>WFP</i>
		<ul style="list-style-type: none"> Emerging issues paper (EB)
	2001	
<ul style="list-style-type: none"> MSF starts treatment in poor countries WFP presents "Food Security, Livelihoods and HIV/AIDS" paper at ACC/SCN Hunger, Poverty and HIV/AIDS joint panel presentation at UNGASS (WFP, FAO, IFAD, IFPRI) 		<ul style="list-style-type: none"> 5 country missions conducted (Cambodia, Ethiopia, Kenya, Uganda and Zambia) WFP Information note on food security, food aid, and HIV/AIDS Fast-track project proposals for food, nutrition and HIV
	2002	
<ul style="list-style-type: none"> Triple threat emerges in Southern Africa Global Fund ATM established IAC Barcelona: FAO, WHO, WFP session on The Challenges of Food Security and Nutrition to HIV/AIDS 		<ul style="list-style-type: none"> Southern Africa drought response highlights impact of HIV and AIDS

3. Programme innovations: following and informing global developments

3.1 Early support: before 2000

Although aligned to global developments, WFP's HIV policy development process before 2000 was largely guided by community-based organizations' increasing demand for food assistance to PLHIV and affected households.

One of the first reported HIV food support activities was established in northwestern United Republic of Tanzania in the mid-1990s, supporting chronically ill people. In 1999, requests emerged from the adjacent region in Uganda through with The AIDS Support Organization (TASO). In both cases, WFP provided household food support through home-based care (HBC), encouraging testing, counselling and frequent programme attendance by clients, and promoting child care and livelihood support for their families.

3.2 Rapid scale-up: 2000 to 2002

HIV/AIDS was first brought to the attention of WFP's Executive Board (EB) in the paper on *Emerging issues relevant to WFP* presented to the EB in May 2000. This was also the first time that WFP's EB was asked to consider adding a corporate programme response to a disease-related problem. The EB noted the serious negative impact of AIDS, and recommended that WFP should "explore, with its partners and consistent with its mandate, specific areas of intervention concerning HIV/AIDS and tuberculosis" (WFP, 2000a).

In 2001, about 18 years into the epidemic, the response to AIDS was stagnating. Although UNAIDS was the designated lead for a consolidated United Nations response, there were widespread lethargy and little political commitment. The necessary push to reactivate the response occurred when the United Nations General Assembly Special Session (UNGASS) on HIV/AIDS was held – the first time the United Nations convened over a single global health issue. All agencies were compelled to act swiftly, and were expected to report at UNGASS on what actions they were taking.

A joint task force was established at WFP Headquarters to support country offices in formulating programme responses. The task force put together a panel from WFP, the International Fund for International Development (IFAD), the United Nations Food and Agriculture Organization (FAO) and the International Food Policy Research Institute (IFPRI) to present at UNGASS; this was the first high-level, high-profile exposure of HIV, food and nutrition issues and the first time that WFP was publicly and prominently linked to AIDS response. A letter was sent to country offices and regional bureaux requesting them to prioritize the response to AIDS, using a new mechanism designed to fast-track projects for approval (WFP, 2001d). Headquarters

then initiated country missions, funded by the Canadian Grant, to Cambodia, Ethiopia, Kenya, Uganda and Zambia, to gauge the needs and identify possible activities and areas of intervention. In 2001, the first regional workshop on HIV/AIDS was held in Kigali, Rwanda to discuss emerging issues in this new programming area, followed by the release of WFP's first HIV programme guidance note (WFP, 2001c).

WFP partnered HBC providers across East and Southern Africa, contributing to comprehensive care and support for chronically ill people without access to treatment, referred to as “food in-lieu of medicine” in Uganda and Rwanda. Peter Piot's feedback after a mission to Malawi in April 2001 highlighted PLHIV need for food in addition to, or even above, care and treatment.

“Some weeks ago, I was in Malawi and met with a group of women with HIV. As I always do when I meet with people living with AIDS, and other community groups, I asked them what is their highest priority. Their answer was clear and unanimous. Not care, not drugs for treatment, not stigma, but food.”

Peter Piot, UNAIDS Executive Director, Nairobi, Kenya, 3 April 2001

Targeting the most food-insecure areas, food assistance was provided in the form of household rations; in addition to supporting the chronically ill household member, the aim was also to support livelihood stability through appropriate food-for-assets (FFA), food-for-training (FFT) and income-generating activities, in the United Republic of Tanzania and Burundi. In Rwanda, food assistance was introduced to enable community care volunteers to scale up peer counselling and HIV literacy and life skills training for PLHIV and AIDS-affected households. Food assistance was widely used in the region to support home care volunteers in the absence of formal remuneration arrangements.

In 2002, the theory that HIV and AIDS is both a cause and a consequence of food insecurity started to emerge in the unfolding Southern Africa food crisis, which affected six countries. As a result, national governments declared AIDS a national emergency. The “triple threat” – the cumulative effect of frequent droughts and other shocks, the impact of AIDS, and a weak governance structure – was recognized as the driving factor. A “new-variant famine” hypothesis was conceived to explain why and how HIV/AIDS aggravates the food crisis. A strong case was emerging for concluding that these uniquely negative and aggravating factors were irreversible, unlike other shocks (De Waal and Whiteside 2003; Arrehag, de Waal and Whiteside, 2006). WFP's emergency response to the drought in Southern Africa recognized the special nutritional needs of the target population² by increasing the ration standards to 2,200 kcal and providing additional corn-soya blend (CSB) in relief rations to facilitate care for chronically ill people.

At the 14th World AIDS Conference in Barcelona, Spain in 2002, WFP, FAO and WHO held a session on the challenges of nutrition and food security in the context of HIV/AIDS. At that time, the focus was on the impact of AIDS in rural areas, particularly on agriculture; WFP and FAO collaborated to support knowledge sharing and joint programme planning.

In 2002, to accelerate the response to AIDS and other high-burden diseases, the Global Fund to Fight AIDS, Tuberculosis and Malaria was established to attract, coordinate and disburse large-scale funding for prevention and treatment.

Figure 13.1b Milestones in HIV/AIDS care and treatment

<i>Global</i>	2003	<i>WFP</i>
<ul style="list-style-type: none"> WHO commits to 3 by 5 PEPFAR established WHO reviews nutritional requirements of PLHIV 		<ul style="list-style-type: none"> EB Approves WFP Policy Paper on HIV ART food support Pilots in Uganda and Mozambique Multi country mission to explore PMTCT options WFP becomes UNAIDS 9th co-sponsor HIV unit established in WFP HQ WFP/UNHCR explore improving HIV/AIDS prevention, care and treatment in refugee camps
	2004	
<ul style="list-style-type: none"> UN SG Calls for an expanded and comprehensive response to HIV/AIDS IAC Bangkok Guidelines on HIV in emergency settings by the Inter-agency Standing Committee on HIV/AIDS 		<ul style="list-style-type: none"> MOU with Clinton Foundation New guidance: <ul style="list-style-type: none"> - PMTCT and food assistance
	2005	
<ul style="list-style-type: none"> Durban meetings HIV and Nutrition and HIV and Food Security (WHO and IFPRI) DFID funds 3-year programme to scale up HIV/AIDS services for populations of humanitarian concern UNAIDS Division of Labour: WFP lead on Food and Nutrition 		<ul style="list-style-type: none"> Collaboration with WHO on ART and nutrition guidance HIV food assistance costing exercise Review of social assistance mechanisms in support of HIV

3.3 Settling in for the long haul: 2003 to 2005

WFP's first HIV/AIDS policy, *Programming in the Era of AIDS: WFP's Response to HIV/AIDS*, was approved by the EB at its first regular session in 2003 (WFP, 2003). Based on what was then known about HIV/AIDS and food insecurity, the paper highlighted modifications to the main programming areas, with a focus on mitigating the impact of AIDS on affected households.

With the policy approved, an HIV/AIDS Unit was created at WFP Headquarters to provide technical support and strategic guidance to country offices, and to steer the nutrition and food security agenda at the global level. An initial strategy for implementing the policy was prepared, and 11 United Nations Volunteers were deployed to country offices to provide programme support. With the Southern Africa food crisis at its peak, the then WFP Executive Director, James Morris, was appointed as the Special Envoy to the United Nations Secretary General for Humanitarian Needs in Southern Africa, further raising WFP's profile.

In the same year, WFP became the ninth UNAIDS co-sponsor, alongside WHO, the World Bank, the United Nations Children's Fund (UNICEF), the United Nations Population Fund (UNFPA), the International Labour Organization (ILO), the United Nations Office of Drugs and Crime (UNDOC), the United Nations Development Programme (UNDP) and the United Nations Educational, Scientific and Cultural Organization (UNESCO).

At the programme level, drugs were made increasingly available to a select group of PLHIV, through limited coverage, strict entry criteria, triage, etc., and food assistance was introduced to support treatment roll-out, with a focus on improving uptake, retention and adherence to ART care and treatment regimes. Stigma contributed to a lack of disclosure and limited ART uptake, and eligible PLHIV also reported fear of starting treatment in the absence of adequate food to manage the treatment side-effects. Food assistance offered encouragement and support during the first six to 12 months of ART.

Although ART coverage steadily increased, HBC continued to provide critical palliative care for those without access to treatment programmes. Food-assisted HBC expanded in response to increasing recognition of the nutritional needs of PLHIV.

The nutritional needs of PLHIV were now widely acknowledged, and nutrition care and support guidelines were released globally by FAO and WHO (WHO/FAO, 2002). WFP continued to provide household food rations in recognition of the profound impact of HIV and AIDS on whole households, rather than on just PLHIV. Concerns about ration sharing, and thus reduced intervention effectiveness, also informed ration design. Where possible, food rations included fortified cereal flours and blended foods to meet special

nutrition requirements and reduce food processing labour and costs.

In prevention of mother-to-child transmission (PMTCT) programmes, it was observed that far fewer women were taking prophylactic drugs around the time of delivery than had first presented for testing. To help minimize the number of clients lost to the programme, food assistance aimed to encourage and enable frequent ante-natal care attendance, thus increasing exposure to PMTCT education and counselling, in Ethiopia, Burundi and Mozambique.

Interest increased in appropriate complementary/replacement feeding for children over 6 months of age whose mothers had ceased breastfeeding in accordance with international guidance. CSB, when available in clinics, was sometimes used to fill the gap, but is not nutritionally adequate on its own. To encourage return visits for routine surveillance and for HIV testing of the child, food assistance was continued from pregnancy to 18 months after birth.

Health services were becoming the centre of attention in providing life-

Box 13.1 Government ownership – supporting the national AIDS response

HIV food assistance has, by its very nature, contributed to WFP's corporate interest in developing national hunger solutions. With the overriding objective of contributing to national AIDS responses, WFP's HIV support programmes aim to enhance government ownership, develop national programme infrastructure and strengthen local food assistance management capacities.

WFP food assistance programmes offer a platform for building food assistance programme models, testing emerging approaches, consulting on national strategies and exploring technical considerations. Ongoing programmes also offer opportunities for analysing the cost and institutional requirements of taking programme approaches to a national scale, thus contributing to national planning and budgeting.

The Government of Malawi has shown how a partner-supported nutrition rehabilitation scheme can be integrated into the national treatment protocol, successfully drawing on Global Fund resources for programme roll-out at the national level.

When partnering governments to explore national strategies and design model interventions, recognition of ministerial mandates and public administration processes such as planning and budgeting is critical. Although the fragmentation of programme components is avoided for the benefit of the client, offering appropriate strategic components to relevant counterpart ministries may increase their ability to adopt these components at the national level. Building bridges among national institutions is essential.

Equity principles in public services delivery^a should be respected when considering national ownership. Programmes need to be designed accordingly.

^a All clients with equal needs, anywhere in the country, must have equal right to services and should have reasonable access to appropriate assistance.

extending support to PLHIV, and food assistance was not a perfect substitute for the eroded health sector capacities. Recognizing the burden that the provision of food assistance would place on already overstretched facilities, WFP explored the options for integrating food assistance into social welfare mechanisms, addressing the needs of clients and households as one (Greenblott, 2007).

Livelihood support for AIDS-affected households continued to be of critical importance. In Southern Africa, guidelines for the appropriate adjustment of FFA and FFT activities were introduced to accommodate AIDS-affected households with limited able-bodied labour capacity, with the aim of including these households in mainstream programmes rather than HIV-exclusive activities, in Malawi, Lesotho and Zambia (C-SAFE, 2004).

By 2003, the impact of ART in prolonging lives had become an accepted fact, and halting the deaths due to AIDS became urgent. However, ART was still not widely accessible to the millions who needed it, mainly owing to high costs. It was at this time, that WHO and UNAIDS launched the “3 by 5” initiative as a global target, aiming to provide 3 million people with life-prolonging ART by the end of 2005 (WHO, 2003). At almost the same time, the United States President’s Emergency Plan for AIDS Relief (PEPFAR) was established, as the largest commitment in history made by any nation to combat a single disease.

With HIV programmes starting to take shape, the need for programming guidance was widely recognized. WFP, together with the Food and Nutrition Technical Assistance project (FANTA) and the United States Agency for International Development (USAID), started to prepare a programme handbook, which was finalized in 2007.

As ART became more readily available, the need for proper nutrition became more evident. In 2005, WHO hosted the Durban Consultation on Nutrition and HIV/AIDS in Africa, which was instrumental in building consensus on the role of nutrition in HIV and AIDS (WHO, 2005). At the same time and location, IFPRI organized a consultation on HIV and food security, which emphasized the vicious and mutually reinforcing cycles of HIV/AIDS as a cause and a consequence of food insecurity.

Figure 13.1c Milestones in HIV/AIDS care and treatment

<i>Global</i>	2006	<i>WFP</i>
<ul style="list-style-type: none"> ▪ PEPFAR Policy Guidance on the Use of Emergency Plan Funds to Address Food and Nutrition Needs ▪ Universal access campaign initiated ▪ IAC Toronto (Stephen Lewis makes special appeal for food and nutrition needs) 		<ul style="list-style-type: none"> ▪ Dedicated regional HIV capacity in 6 regional bureaux ▪ First PEPFAR funds for WFP food assistance programmes ▪ JFFLS and Alliance for orphaned and vulnerable children, social protection and livelihoods ▪ New guidance: <ul style="list-style-type: none"> - HIV and transport - HIV, AIDS and gender - HIV, food and social protection
	2007	
<ul style="list-style-type: none"> ▪ ICASA Abuja (session on PMTCT and food security and nutrition) ▪ CAAP, Colombo (session on Nutrition and HIV) 		<ul style="list-style-type: none"> ▪ OMB Workshop on HIV Nutrition/Food Security ▪ WFP supporting ART in 16 countries ▪ New guidance: <ul style="list-style-type: none"> - FANTA/WFP Food assistance programming in context of HIV - Food assistance and TB care - HIV and food ration design
	2008	
<ul style="list-style-type: none"> ▪ High food and fuel prices, followed by financial crisis 		<ul style="list-style-type: none"> ▪ PEPFAR funds WFP HIV support programmes in 4 countries ▪ HIV thematic evaluation ▪ New guidance: <ul style="list-style-type: none"> - Orphaned and vulnerable children food assistance

3.4 Rationalizing food assistance: 2006 to 2008

In 2006, the 3 by 5 initiative was replaced by the Universal Access to Prevention, Treatment, Care and Support initiative, with the goal of making HIV and AIDS prevention, treatment, care and support universally accessible by 2010. In the same year, the 59th World Health Assembly adopted the WHO Resolution on Nutrition and HIV/AIDS, which called for Member States to pay special attention to integrating nutrition into all HIV/AIDS policies and programmes. In New York, a United Nations General Assembly high-level meeting on AIDS urged countries to revise national AIDS strategic plans to integrate food and nutrition support.

At the XVI International AIDS Conference in Toronto, the HIV community reaffirmed food and nutrition support as integral to comprehensive HIV treatment and care. WFP's role in advocating for the integration of food and nutrition support in national AIDS strategies and programmes was recognized in speeches by Stephen Lewis, United Nations Special Envoy for AIDS in Africa, and Paul Farmer, a well-known AIDS activist and clinical practitioner. For the first time, PEPFAR funded WFP-supported HIV and AIDS programmes, in Ethiopia and Mozambique.

With uptake and retention rapidly improving, owing to improved access and declining stigma,³ the role of food moved towards addressing specific nutritional needs, because low body mass index (BMI)⁴ was found to increase mortality in clients starting ART. The incentive/enabler effect of household food assistance remained relevant, particularly in lower-prevalence settings. HBC was shifting towards treatment support while continuing to offer assistance to those with limited access to clinics. WFP's beneficiary figures showed a shift towards increased support for ART clients, away from addressing general chronic illness.

Box 13.2 Shifting from HBC towards ART

From 2006 to 2008, the number of WFP-supported ART programmes increased by 131 percent, from 16 to 37. From 2007 to 2008, ART beneficiaries – clients plus their families – increased by 87 percent, from 332,000 to 621,049.

This was a result of efforts by national governments and international communities to make ART treatment accessible to all, and also of increasing awareness of the role of nutrition and food support in treatment.

Most likely as a direct result of this, WFP's HBC activities decreased from 13 countries in 2007 to ten countries in 2008.

As a UNAIDS co-sponsor, in 2006 WFP was identified as the lead in coordinating nutrition and dietary support. In this context, it continued its external and internal advocacy efforts, including by commissioning research papers and participating in high-level meetings to ensure that food security and nutrition remain on the global agenda. Internally, global meetings were organized for all WFP HIV focal points to learn about the latest developments and share experiences. In 2007, WFP chaired the UNAIDS Committee of Co-sponsoring Organizations (CCO), a standing committee of the Programme Coordinating Board, and worked with the secretariat to prepare the 2008–2009 UNAIDS Unified Budget and Workplan. Findings from the independent HIV thematic evaluation were presented to the EB in 2008 and have informed WFP's latest policy and programme directions.

Assessments by both WFP and partners showed that the 2008 high food and fuel price crises had a negative impact on both HIV programmes and their beneficiaries. PLHIV and their families were recognized as vulnerable groups owing to pre-existing vulnerabilities, and were prioritized for WFP support. The new WFP 2008–2011 Strategic Plan, launched in 2008, reaffirmed WFP's commitment to HIV/AIDS and TB response. WFP continued to build credible partnerships, and four WFP country offices – Rwanda, Côte d'Ivoire, Mozambique and Ethiopia – received funding from PEPFAR for HIV programming.

During this period, governments increasingly integrated PMTCT with regular mother-and-child health (MCH) services, calling for a rethink of the role of food assistance; although uptake remained a challenge, the focus shifted towards ensuring the nutritional well-being of mothers and children. This was because concerns about low birth weight compromising child development also apply to HIV-negative mothers, thus requiring an integrated, broad-based mother-and-child health and nutrition (MCHN) approach. WFP country offices that previously provided dedicated PMTCT support considered either exiting from the programme or expanding/integrating their support to cover MCH clients, as in Rwanda and Mozambique. In Mozambique, Plumpy Nut®, originally designed to support the nutrition rehabilitation of severely malnourished children, was introduced by UNICEF to support at-risk⁵ infants over 6 months of age.

Figure 13.1d Milestones in HIV/AIDS care and treatment

<i>Global</i>	2009	<i>WFP</i>
<ul style="list-style-type: none"> ▪ UNAIDS Joint Action Framework recognizes importance of food and nutrition ▪ WHO recommends ART starts at CD4 350 ▪ WHO recommends PLHIVs on ART and continuation of breastfeeding 		<ul style="list-style-type: none"> ▪ WFP commits to JAF: support ART, TB-DOTS and social protection programming ▪ GAIN, UNAIDS, WFP Food by Prescription paper ▪ Preparation of new policy paper (3 background papers) ▪ New guidance: <ul style="list-style-type: none"> - M&E guide
	2010+	

3.5 Continuing innovations: 2009–2010 and beyond

The recent efforts to integrate nutrition and food assistance into treatment are reflected in the Joint Outcome Framework (JOF) 2009–2011, launched by UNAIDS' Programme Coordinating Board in 2009, which outlines priorities for amplifying the AIDS response and contributing to the broader development agenda in nine priority areas (UNAIDS, 2009c). WFP has committed its efforts to three of these JOF priority areas:

- 1) ensuring that PLHIV receive treatment, by integrating nutrition support into treatment programmes;
- 2) preventing PLHIV from dying of TB, by ensuring effective integrated service delivery for HIV and TB, including nutrition support in all settings;
- 3) enhancing social protection for people affected by HIV, by providing social safety nets for them, including for people experiencing hunger, poor nutrition and food insecurity, and orphaned and vulnerable children.

Most food assistance programmes are beginning to distinguish individual nutritional supplements provided as part of comprehensive treatment, such as Food by Prescription (FBP), from household food support components delivered through home care and social welfare mechanisms. Livelihood assistance and/or back-to-work programmes are also considered relevant for supporting long-term treatment adherence and the productive recovery of clients and their households. An FBP landscape review conducted in 2009 recognizes these three distinct but

complementary, intervention components, each with its own purpose (Greenaway, 2009).

Eligibility for nutritional rehabilitation relies on clinic staff's ability to recognize malnutrition as measured by BMI or extreme weight loss.⁶ The management of nutritional well-being through nutrition education, assessment and counselling is expected to be an integral part of ART. The international community's increasing interest in strengthening health systems has led to the training of health staff and the introduction of new cadres of personnel to allow such integration. However, introducing new and additional tasks to already overstretched workloads remains a challenge.

Underlying household vulnerability is measured through socio-economic indicators, which requires the expertise of social workers, relying heavily on referral mechanisms. In some instances, NGO partners with broad mandates are able to manage both clinical and social safety net programmes. However, the operational management of food supplies in clinical and social welfare settings raises considerable challenges for logistics and staff capacity.

As the need to distinguish clients' needs from those of their households is increasingly recognized, questions arise regarding the nutritional adequacy of food products in supporting the nutritional rehabilitation of malnourished ART clients, particularly adults. While CSB remains the main product for addressing this problem in most cases, some programmes introduce new products, such as ready-to-use therapeutic foods (RUTFs). The Government of Malawi, with

Box 13.3 From "food plus" to "plus food"

Given the broad orientation of the global response to AIDS, it has always been clear that food cannot function as stand-alone support to PLHIV and AIDS-affected households. From the outset, WFP's interventions have been integrated, consolidated and complementary.

In the absence of widely available treatment, in the early days, food took centre stage, while WFP and partners sought complementarity from counselling, education, livelihoods support, etc.: *food plus*.

With the introduction of affordable drugs, the strengthening of health systems and the identification of comprehensive care and treatment approaches, food was increasingly identified as *complementary* to the core medical programme: *plus food*. This new orientation calls for WFP to identify appropriate ways of integrating food assistance into care and support structures, mainly clinics and treatment outreach services. Familiarization, appreciation and adaptation are required to fit food assistance into its new environment – a steep learning curve!

support from NGOs and United Nations partners, established a standard nutrition support programme as part of comprehensive ART, using the RUTF Plumpy Nut®. In Kenya, the PEPFAR-supported nutritional rehabilitation programme introduced a new line of fortified blended foods (FBFs) aimed at meeting the specific needs of selected subgroups.

Alongside the development of FBP approaches and protocols for nutrition improvements, WFP country offices are developing innovative ways of improving access to food for household support through complementary social and productive safety net mechanisms, many of which are aligned with governments' greater interest in building national support schemes. In Zambia, ART clients are identified as a priority target group and receive electronically registered vouchers through a broad-based safety net programme; the vouchers can be redeemed at retail outlets. In Ethiopia, treatment clients obtain access to household food support through a comprehensive network of social actors. WFP, USAID/AMPATH and PEPFAR partners in Kenya have agreed on standard approaches for FBP, while seeking complementary support for livelihood protection and promotion from non-clinical partners. In Mozambique, WFP works with the government to explore operational modalities for increasing access to a basic food basket through voucher systems. WFP in Swaziland, Lesotho and Namibia are establishing strategic partnerships to develop food assistance methods that match national needs and service delivery capacities.

Box 13.4 HIV versus poverty: equity in livelihood protection and promotion

As ART regimes provide greater opportunities for physical recovery among PLHIV, questions arise regarding the appropriateness of prolonged exclusive livelihood assistance to PLHIV and their families when large numbers of other community members are experiencing similar poverty and food insecurity. Some may argue that continued support secures long-term treatment adherence, while others may emphasize that treatment investment facilitates productive recovery, and thus greater returns to community economic well-being.

Where vulnerability to food and nutrition insecurity are explicitly an impact of HIV and AIDS, the exclusive targeting of HIV-related subgroups, such as malnourished ART clients, can be considered appropriate. However, to address long-term non-HIV-specific livelihood vulnerabilities, inclusive approaches that reach out to the broader community should be considered. Of course, service providers' mandates and funding abilities determine the feasibility for such broad-based approaches. Although programmes may target PLHIV, stakeholders should consider the consequences for community dynamics and equity principles, particularly when designing national strategies.

New developments continue to affect the design and implementation of food assistance programmes. Some of the most critical developments are related to the basic protocols for ART and PMTCT services, unrelated to food and nutrition issues:

- In 2009, WHO introduced new guidelines for PMTCT, encouraging the enrolment of HIV-positive pregnant women in ART programmes, irrespective of clinical eligibility, and facilitating mothers' continued breastfeeding beyond 6 months. This will require reconsideration of the special nutrition needs of infants and young children born to HIV-positive mothers, as well as of the needs of the women themselves in relation to the nutritional impact of ART drugs.
- New ART guidance from WHO recommends increasing the ART eligibility standard to CD4 count⁷ 350, up from the 200–250 currently used in many developing countries. The implications on the nutrition needs of clients are still unknown. It may be assumed that patients with higher CD4s will not have progressed to AIDS, so will not have increased their energy requirements or lost weight to the same extent as current ART clients. However, the drug effect may still cause some clients to lose weight when starting treatment. Household food security conditions are expected to be better, as patients will not have divested their assets to cover illness-related costs, discontinued productive and economic activities and/or lost employment owing to recurrent and/or chronic illness. Of course, this assumes timely testing and treatment initiation.

Nutrition-specific developments are also continuously evolving and contributing to programme guidance:

- WHO and technical partners, including WFP, plan to review existing evidence on HIV, AIDS and nutrition in 2010, and have initiated a review of the linkages between and effectiveness of TB and nutrition interventions; both reviews are expected to inform new guidance.
- New food products available for the treatment and prevention of malnutrition among children are raising expectations of appropriate products for adult nutritional rehabilitation, which plays an important role in the successful start of ART. This includes the development of a new range of ready-to-use foods, similar to but not the same as Plumpy Nut®, such as chickpea-sesame paste, which is used by Valid International for initial treatment of people with AIDS, and Supplementary Plumpy®, for treating moderate malnutrition.
- Technical, programme and operational guidance is expected to emerge from ongoing FBP programme reviews in selected countries and associated partnerships among WFP, the Global Alliance for Improved Nutrition

(GAIN), FANTA and other major stakeholders.

Meanwhile, on a global level, there is still a significant gap in treatment access; many eligible PLHIV are waiting to start. Many of them are registered in clinics and receive an alternative treatment regime consisting of broad-spectrum antibiotics and targeted treatment for diagnosed opportunistic infections. There is growing demand for introducing nutritional rehabilitation or preventive nutritional care for this group, to prepare them for a smoother transition on to ART. Their regular clinic attendance offers opportunities for nutrition counselling and support. At the other end of the spectrum, greater ART success is increasing the occurrence of long-term side-effects, calling for greater attention to associated nutrition linkages and appropriate responses.

Box 13.5 While treatment progressed: care and support for orphaned and vulnerable children

Given the immense impact of AIDS on adult mortality, the number of children orphaned and made vulnerable by AIDS has been growing exponentially in East and Southern Africa. WFP's original orientation towards household food assistance saw a peak in support to orphaned and vulnerable children in the early years of engagement. Questions regarding the duration of food support, child and household "graduation" ability and/or WFP exit strategies have restricted expansion, in many cases resulting in reduced programme size.

WFP partnered UNICEF and FAO to help countries identify the critical needs of and associated services for orphaned and vulnerable children, in National Plans of Action for Orphaned and Vulnerable Children; to explore the possibilities for livelihood and life skills training for older adolescents, at Junior Farmer Field and Life Schools (JFFLS); and to support national strategy development regarding orphaned and vulnerable children, livelihoods and social protection. Food and nutrition remain a critical component of comprehensive care and support to orphaned and vulnerable children.

As debate emerges around national cash transfer schemes – old-age pensions, child grants etc. – it is also argued that a limited focus on food does not satisfy the broader needs of children and their families. Successful food assistance programmes are integrated into local and national governance and aligned with other support mechanisms: in Kenya, food assistance complements cash grants for orphaned and vulnerable children during the lean season, when food prices increase; WFP's food assistance in Mozambique is implemented by partner organizations offering at least two other basic services, identified in the National Plan for Action, complements a national cash transfer scheme, and is coordinated through provincial committees; and in Namibia, food assistance facilitates the identification and registration of orphaned children, who are later transferred into the national cash grant programme, thus resulting in a gradual phase out of WFP's engagement.

4. Conclusions

The history of HIV programming in WFP reflects a decade of evolution and continuous innovation, responding to rapid scientific, epidemiological and political developments while contributing to global and national priority setting.

Before it embarked on HIV support in the early 2000s, WFP had no precedent for this type of food assistance, which involved dealing with: a rapidly changing environment; initial reluctance to recognize the importance of food and nutrition in this context; evolving evidence of the linkages and of intervention effectiveness; a need to integrate into and adapt to national service delivery; and, most important, a need to guide and be guided by national AIDS responses.

4.1 Challenges

WFP entered this area by building on its available expertise and common sense, mostly from routine food assistance programmes and experiences in TB support and child nutritional rehabilitation. As the requirements for food assistance became more specific, expertise from health and social sectors was called on to help redesign programmes. The increasing specialization and professionalization of food assistance in support of HIV and AIDS will continue to challenge WFP's expertise in this area.

Programme guidance relied on good practice examples emerging from field-level implementation of what were often creative and experimental country initiatives, thus requiring time to allow for trial and error. Good practice guidance followed the establishment of programmes originally initiated as pilots. Although many donors called for evidence-based/guided programming, the evidence came as the programmes matured over time, through learning by doing.

Programme models are an important way of encouraging effective interventions' replication and integration into national plans. The widely varying characteristics of the pandemic across the East and Southern African region, the African continent and the world at large limit the possibility for prescribing standard approaches. Differences in prevalence, drivers, cultural considerations, political interest, systems' capacities, etc. determine the application of basic HIV, food and nutrition programme principles. Increasing staff competence and confidence⁸ are required to adapt common programme parameters to specific operating environments.

Although food and nutrition are globally recognized as critical components of comprehensive HIV care, treatment and support, funding lags behind. This is not necessarily intentional. With the introduction of effective treatment, the world is committed to continuing support to those who have initiated and those waiting to start treatment. Changing the CD4 eligibility criteria will increase the

expected ART uptake in high-burden countries. The pressure of maintaining treatment coverage is enormous and costly, and includes not only drugs but also staff and institutional capacities, laboratory and pharmacy services, etc.⁹ Treatment absorbs the major share of Global Fund resources, leaving limited funding for complementary services such as food and nutrition support.¹⁰ The share of PEPFAR's funding allocated to food and nutrition support, while much appreciated, is also limited in comparison with the needs.

4.2 Opportunities

Successfully embarking on a new area of food assistance in a rapidly changing environment relied on innovation, the seizing of opportunities, creativity and initiative, and space, time and support for developing and reshaping appropriate programme approaches. The commitment, ingenuity and tenacity of staff and partners in the most-affected countries have made WFP's HIV support portfolio what it is today.

While originally responding emotionally to an equally emotional demand for food support, WFP has recognized the need for a strategic, intelligent and visionary approach to take interventions to a scale that provides a relevant contribution to national and global AIDS responses. Rationalization, evaluation and continuous reflection on effectiveness and relevance are critical ingredients for WFP's continued engagement in this area, as the environment continues to change.

Although those on the ground never doubted the importance of food and nutrition in responding to AIDS, recognition at the global level relied on critical events and the advocacy of strategic actors. The emergency drought response in Southern Africa highlighted HIV and AIDS and its links to food and nutrition insecurity. For the first time, the pandemic's impact on entire countries, their resilience to shocks, weak governance structures and limited capacities for service delivery were exposed. The appointment of WFP Executive Director James Morris as United Nations Special Envoy for the humanitarian crisis in the region brought HIV to a new global humanitarian platform, and emphasized the importance of food and nutrition considerations. The widely publicized confrontation of Peter Piot, UNAIDS Executive Director, with PLHIV requesting food rather than care or medicines, and the support to WFP's food assistance to PLHIV publically expressed by Stephen Lewis, United Nations Special Envoy for AIDS in Africa, during the Toronto International AIDS Conference have made tremendous contributions to furthering the HIV, food and nutrition agenda.

It is often argued that HIV has given global nutrition strategies a new impetus to move forward and seek innovative approaches. In turn, WFP's recent endorsement of a corporate nutrition improvement approach offers a similar impetus back to HIV, food and nutrition programming. Exploring the use of new

nutritionally enhanced food products in HIV nutrition support programmes, for both treatment and prevention, may offer WFP a new position in treatment support. At the same time, the introduction of innovative food assistance modalities such as food, cash and vouchers in social and productive safety nets may facilitate the repositioning of WFP in the HIV social protection debate.

4.3 In conclusion

Global funding for HIV rose from US\$1.6 billion in 2001 to an estimated US\$13.8 billion in 2008. Despite this impressive increase in resources, however, the estimated global requirement of US\$25 billion for achieving universal access to treatment in 2010 will not be reached. The challenges facing the response to AIDS have been exacerbated by the global financial and economic crisis, which has increased poverty, malnutrition and food insecurity, while often also reducing the delivery of government services.

WFP will continue to emphasize scientific evidence, build strong partnerships and coalitions, implement cutting-edge programmes based on the latest evidence, and establish robust monitoring systems to measure results.

WFP will strengthen its advocacy efforts and continue to build evidence for the importance of nutrition as an integral part of AIDS treatment. Within UNAIDS, and on behalf of PLHIV and TB patients, it is WFP's responsibility to ensure that nutrition receives adequate focus and funding in the global response to AIDS.

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- ¹ Energy requirements go up by 10 percent in the asymptomatic stage. Once the CD4 count drops, unless treatment has begun, the energy required for basic bodily functions increases by about 30 percent. Symptomatic HIV-positive children need 50 to 100 percent more energy than HIV-negative children (WHO, 2005).
 - ² PLHIV increased energy needs and commensurate increases in protein and fat needs, documented by WHO in 2001, were introduced into the calculations for population-level nutritional requirements in emergency situations in the SPHERE Standards.
 - ³ However, stigma is still an issue in many countries of East and Southern Africa. Food by Prescription in Kenya experiences high client drop-out due to challenges in status disclosure within the family.
 - ⁴ Measured as weight/height² (kg/m²) using cut-offs of 18.5 and 16 to determine moderate and severe malnutrition respectively.
 - ⁵ Including those born to HIV-positive mothers.
 - ⁶ Weight loss of more than 10 percent between two monthly weighings.
 - ⁷ The need for ART is determined by CD4 count and/or staging of disease progression. The CD4 count is a clinical measure of the number of CD4 immune cells in the blood that serves as an indicator of a person's immune system. Higher CD4 counts indicate a higher degree of immune function.
 - ⁸ In 2010, WFP is launching an organization-wide learning programme on HIV, food and nutrition.
 - ⁹ Following the food and fuel price increases and financial crisis of 2007/2008, the costs of delivering treatment services have increased while the national revenues available to cover such costs declined.

Countries known to be financially stable and in full control of their ART financing, such as Botswana, have reported possible treatment ceilings in the absence of newly identified funds.

- ¹⁰ In 2010, WFP is embarking on a partnership with George Washington University to explore the possibilities for funding food and nutrition programmes through Global Fund resource mechanisms.