

## **Presentation to WISHH workshop 25 February 2004: How to ensure the food and nutrition elements of the crisis and response are addressed**

I know some of you will be familiar with the work WFP is doing to fight HIV, as you are our partners in the struggle. However, I would like to take this opportunity to present the broad lines of WFP's current approach to deal with the pandemic. WFP has activities related to HIV/AIDS in 41 countries. It is present in 22 of the 25 countries most affected by HIV/AIDS.

Our current interventions range from:

- Providing food rations through groups giving home-based care to people with HIV and their families
- Supporting people with HIV and their affected families through maternal and child nutrition programs and prevention-of-mother to child transmission (PMTCT) programs.
- Giving food to widows while they attend training sessions and micro-credit schemes.
- Using food to provide an opportunity for orphans and street children to attend school.
- Incorporating AIDS into needs assessments, vulnerability analysis, ration designs, and other programming tools.
- Encouraging our partners to talk about AIDS prevention at WFP food distribution points.
- Making sure our staff, implementing partners and contractors (e.g. truck drivers) have information and training on how to prevent HIV.
- Advocating at all levels to ensure that the nutritional needs of people with HIV are addressed.

### **Who are we working with in the fight against AIDS?**

Partnerships are indispensable at every level in the fight against AIDS. On the ground, we're working with local grass roots organizations, whose members are often people living with HIV.

At the national level, we are working with the health, social welfare and/or departments of national governments engaged in the battle. We're also participants in the UN Theme Groups on HIV/AIDS worldwide. Close programmatic collaboration is being established with UNICEF, FAO and WHO.

At the global level, WFP has signed Memoranda of Understanding with UNAIDS and the World Health Organization, outlining concrete ways we can work together to fight AIDS. We also became a Cosponsor of UNAIDS in October 2003.

FANTA (Food and Nutrition Technical Assistance Project) and the International Food Policy Research Institute (IFPRI) have collaborated on furthering the research into the relationship between HIV and malnutrition. And we are working with Columbia

University's Mother To Child Transmission-Plus group in New York and on site in Africa.

In the field, we hear it time and time again: food is a high priority for people living with HIV/AIDS. In many poor communities, it is not medicine or money but food that is requested. Peter Piot, Executive Director, UNAIDS has said: "The first thing people with HIV/AIDS ask for is food." 7 million farmers have been lost to AIDS in Africa alone, the continent with the worst food security problems in the world. Eight out of 10 farmers in Africa are women, mostly subsistence farmers, and women are disproportionately affected by the disease. Ending AIDS is not a battle we will win with medicine alone -- we need proper nutrition, education, clean water.

Good nutrition not only helps to expand survival time and improve the quality of life, it also strengthens the body's ability to fight opportunistic infections. Better nutrition allows those who are HIV-positive to be more productive, longer, helping to stabilize families and communities.

In prevention efforts among the poor and uninfected, a combination of food aid and HIV prevention education may offer the most effective protection against the risks that can lead to infection.

Malnutrition has known effects on the immune system. Our bodies need good nutrition to fight off infections, regain strength, live productively. There is no reason to think that the interaction between malnutrition and infection would be any different with HIV. But this issue needs to be studied more – we still don't know enough about the interplay at different times in the infection cycle. Not to mention that we do not know enough about the use of anti retroviral drugs in populations with generally poor nutritional status – quite simply because it currently does not happen. There are still only about 50,000 people on ARVs in Sub-Saharan Africa, overall, only 5% of HIV positive people in the developing world have access to ARV treatment.

As you know, one of the major objectives of the President's Emergency Plan for AIDS Relief is to reach 2 million people with treatment by 2008. Some ARVs require food - they are not to be taken on an empty stomach. Clean water is also needed. And good – adequate – nutrition can help enhance the impact of the medical treatment. Combining food aid with ARV drugs has the potential to restore AIDS patients to full health and productivity. It is also clear that providing food can enable patients to comply with the protocol, and hence improve the efficacy of and adherence to these drugs. This has already been demonstrated in TB treatment programmes. For a number of years in countries like Cambodia, Lesotho and Uganda, WFP has successfully used food rations as an incentive to keep TB patients coming back for the full course of drug treatment which is critical in preventing mutations that cause everyone concern, even here in the United States. The issue is the same with ARVs.

Scientific knowledge about the interplay between HIV/AIDS and nutrition is growing rapidly, and there is, despite many persisting gaps, enough evidence to begin to develop

nutrition interventions. WHO has also recommended that nutritional interventions should be an integral part of HIV treatment programmes. WFP is ready to step up and start doing this, and is working with national governments to provide input on nutritional support and food assistance for people affected by HIV to the Country Coordinating Mechanisms (CCM). The CCM is responsible for proposals to the Global Fund, and also plays a crucial role in proposals to PEPFAR. Some governments have already incorporated food/nutrition intervention into their national response plans that they are or will be submitting for funding.

So, how do we ensure that food and nutrition elements of the HIV/AIDS crisis and response in the developing world are addressed?

First of all, we need to get the issue higher on the agenda – on everybody’s agenda – not just the food aid community. It is not good enough that people recognize that nutrition plays an important part in the fight against the pandemic. It also needs to be made clear that good nutrition doesn’t happen by itself – it has to be planned, programmed, and funded.

The message is clear. To ensure adequate nutrition for people living with HIV/AIDS is important. And the linkages are easily understood once they are pointed out to people: hunger aggravates the effects of the pandemic, both on the infected individual and the affected communities, and HIV/AIDS can contribute to increased food insecurity and hunger.

There is however, still a need for more operational research and pilot initiatives to look at what works, what is needed, how we can best meet the needs of affected populations. There is a lot of anecdotal information out there, but more solid data is needed. We need also to look at intelligent ways to change the traditional food basket - people with HIV have higher energy requirements than uninfected people (WHO, 2003). And studies have indicated that micronutrient deficiencies are associated with faster disease progression and people with HIV die sooner if they do not have sufficient micronutrients (vitamins and minerals).

There often seems to be a preconceived notion that food aid will automatically follow treatment efforts, so that the nutrition aspects of a treatment programme will be taken care of. There is a common perception that there is enough food aid out there to take care of nutritional needs related to the crisis. But this is not the case.

WFP’s original mandate is to assist the poorest of the poor, in least developed and most food insecure areas. For certain countries in southern Africa, WFP’s VAM unit has combined food security data and high prevalence data into maps that show that food insecurity and high prevalence rates do not necessarily overlap. For instance, in Zambia, the traditional food aid for the drought affected areas will not necessarily cover the high prevalence areas.

We cannot reprogram food away from food insecure areas to assist HIV/AIDS affected populations. Additional resources are needed, and we also need to work together to rethink the way we are programming food aid in the context of the HIV pandemic.

The key objectives of the President's Emergency Plan For AIDS Relief (PEPFAR) are: treat 2 million HIV infected people; prevent 7 million new infections; care for 10 million HIV infected and AIDS orphans.

As mentioned, there seems to be some level of consensus that food/nutrition is important, but at the same time, a lack of commitment to ensure funding for nutritional interventions as part of HIV/AIDS programmes. Food and nutrition is not necessarily perceived as being directly linked to the objectives of PEPFAR and the impact that they are striving to make. We all need to continue to advocate for the importance of food and nutrition for the success of any large scale response to the pandemic, be it on treatment, prevention or care.

Right now – and for the foreseeable future – there is no cure for AIDS, there is only help. Nutrition can bring hope while a cure is being found – we can give people valuable time. ARVs are wonderful – but even these new ambitious objectives are not even close to being sufficient. For many, anti-retroviral drugs will come too late or not at all. Even under the most hopeful scenarios, millions of people won't have access to them soon. I'm talking about poor people who live in poor communities with no clean water source and no health clinic. Rural communities and poor subsistence farmers may well be last in line once ARV therapies are more widely available and that will have a clear economic impact on agriculture. So while we certainly need to get involved and on board on the treatment side, we need to continue to work together on other ways to address the crisis. We must help the communities deal with the crisis, not just from a medical point of view, but a more holistic and sociological perspective. The large numbers of orphans takes its toll – we need to focus on education so that another generation won't be lost. We need to think about agriculture and food production - HIV often affects the most productive (usually adult) members of families; when they become sick or die, much of the family's income is lost and access to food becomes difficult.

There is so much that needs to be done, and we need to better coordinate our efforts to maximize the resources available. And so I would like to tell you about a project that WFP here in Washington has initiated. It was actually conceived during an informal discussion over lunch with ASA staff, and some of you in this room have already been approached for your involvement or assistance in making it happen. We are working to create a simple, user-friendly, searchable database that is meant to become a planning tool for HIV/AIDS interventions. The database will collect data on who-does-what-where, primarily in the 14 countries targeted by PEPFAR.

WFP had some seed money that we could put into getting the project started, and the initial work on the design, template for data collection has already started. But we need partners and sponsors to make this a lasting product. It is not a WFP project nor is it meant to be of use only for WFP. The objective is to make it accessible for anyone with

an interest in knowing what is going on in the field, and we believe it will become a valuable tool for all of us when planning interventions. We want to avoid duplication of efforts, to create synergies, to make it easier to find partners to team up with. The database will also provide an excellent forum for cross pollination of lessons learned – we may not have to reinvent the wheel each time. It will be a great planning tool for all of us – once we get it up and running.

We have hosted one first working meeting/brainstorming session on the database, and are planning to host another one in early April, and would hope that as many as possible would be interested in participating, and/or learning more about the project. So I urge you to be in touch with me for more information on how to get on board!