

Regional Consultation on
Nutrition and HIV/AIDS:
Evidence, lessons and recommendations
for action in South-East Asia

Bangkok, Thailand, 8-11 October 2007



**World Health
Organization**

Regional Office for South-East Asia

SEA-NUT-172
Distribution: General

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New Delhi

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New Delhi, February 2008



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Abbreviations

AIDS	Acquired immunodeficiency syndrome
ART	Antiretroviral Therapy
AFASS	Acceptable, feasible, affordable, sustainable and safe
BFHI	Baby-Friendly Hospital Initiative
BMI	Body Mass Index
FANTA	Food and Nutrition Technical Assistance
FAO	Food and Agriculture Organization
GFATM	Global Fund to fight AIDS, Tuberculosis and Malaria
HAART	Highly active antiretroviral therapy
HIV	Human immunodeficiency virus
IAEA	International Atomic Energy Agency
IATT	Inter-agency Task Team
ICDDR,B	The International Centre for Diarrhoeal Disease Research, Bangladesh
ICN	International Conference on Nutrition
IYCF	Infant and Young Child Feeding
KHANA	Khamar HIV/AIDS NGO Alliance
MI	Micronutrient Initiative
NICHD	National Institute of Child Health and Human Development
NIH	National Institutes of Health

OVC	Other vulnerable children
PEPFAR	President's Emergency Plan for AIDS Relief
PLWHAs	People living with HIV/AIDS
PMTCT	Prevention of mother-to-child transmission
RUTF	Ready to use therapeutic foods
SAM	Severe acute malnutrition
SCN	Standing Committee on Nutrition
SEAR	South-East Asia Region
TRC	Tuberculosis Research Centre
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VCT	Voluntary Counselling and Testing
WFP	World Food Programme
WHA	World Health Assembly

Executive summary

1. Introduction

An estimated 39.5 million people were living with HIV/AIDS at the end of 2006, of which 4 million were in the South-East Asia Region. The HIV/AIDS epidemic continues to have a devastating impact on health, nutrition, food security and overall socioeconomic development of the population affected by the disease. HIV and nutrition are strongly related to each other. Immune deficiency as a result of HIV infection leads to malnutrition which in turn, leads to immune deficiency, worsens the effect of HIV and contributes to more rapid progression to AIDS. Malnutrition rates are also high in the South-East Asia Region. Good nutrition for people living with HIV increases resistance to infection, maintains weight, improves the quality of life as well as drug compliance and efficacy.

This joint regional consultation was proposed as a direct response to the 2006 World Health Assembly resolution WHA 59.11 on Nutrition and HIV/AIDS whereby the Member States requested the Director-General to strengthen technical guidance to Member States for incorporating HIV/AIDS issues in national nutrition policies and programmes; and to support the development and dissemination of science-based recommendations, guidelines and tools on nutritional care and support for people living with HIV/AIDS. This consultation was jointly sponsored by WHO, the US National Institutes of Health, FAO, UNICEF and WFP.

The consultation also aimed to build on the successful experience of the Durban consultation in 2005 on nutrition and HIV/AIDS which mobilized most countries in Sub-Saharan Africa to include nutrition within their HIV/AIDS policies and response.

Some Member countries in the South-East Asia Region have initiated efforts to integrate nutrition into HIV-control related activities but these are insufficient, few and scattered. There is a need to strengthen these efforts, develop more political commitment and implement nutrition activities for care, support and treatment of HIV/AIDS.

2. Inauguration

Dr. P.T. Jayawickramarajah, WR Thailand welcomed the participants and delivered the inaugural address of Dr. Samlee Plianbangchang, WHO Regional Director for South-East Asia. Dr. Samlee stated that South-East Asia faces multiple and diversified HIV epidemics occurring in different population groups and in different geographical areas at varying rates. Adequate nutrition can help people living with HIV stay healthier, live longer, comply with drug therapy and lead to a better quality of life. Scaling up care and antiretroviral therapy cannot be addressed without appropriate support for nutrition.

H.E. Dr Mongkol na Songkhla, Minister of Public Health, Thailand, who inaugurated the consultation said that HIV had significant nutrition-related implications and consequences for individuals, families and communities. He remarked that Thailand had been very successful in dealing with its problems of under-nutrition as well as HIV prevention and control. He added, however, that the work in HIV/AIDS was far from over.

Dr Aye Thwin, Short-term Professional, Nutrition for Health and Development (NHD) unit, WHO-SEARO, introduced the participants. The consultation was attended by 105 participants including representatives from SEAR Member countries and four countries from the Western Pacific Region (China, Laos, Cambodia and Viet Nam), temporary advisers, UN agencies (UNICEF, FAO, UNAIDS, FAO, UNHCR, WFP and IAEA) funding and partner agencies as US National Institutes of Health, USAID, MI, GFATM, PEPFAR, and WHO Collaborating Centres (Albion Street Centre, Institute of Nutrition at Mahidol University), NGOs such as the Thai Red Cross AIDS Research Centre, Project Concern International, Concern Worldwide, FANTA and HIV/AIDS alliance Cambodia, PLWHA groups, as well as staff from WHO HQ, AFRO and SEARO.

Prof. Charles Gilks, HIV Department, WHO- HQ presented the global perspectives on nutrition and HIV and said that although the number of people receiving ART in resource-limited settings continued to increase, nutrition care to support ART treatment had not been adequate.

3. Objectives

Mrs Randa Saadeh, Scientist at the Department of Nutrition for Health and Development, WHO-HQ provided an overview of the consultation. She said that based on the discussions of the working groups, a statement would be issued by the participants which would list the recommendations and the key actions for the countries.

Dr. Aye Thwin, STP, NHD unit, WHO-SEARO, explaining the objectives of the consultation said that these were to integrate nutrition as a fundamental part of the overall response to HIV/AIDS in the South-East Asia Region. The specific objectives were to:

- Review lessons learnt from the global and regional experiences of integrating nutrition as a fundamental part of the response to HIV/AIDS.
- Identify gaps, challenges and opportunities to formulate evidence-based programmes for integrating nutrition as a fundamental part of the response to HIV/AIDS.
- Formulate and recommend action plans at the national and regional levels ensuring nutrition as a fundamental component of the comprehensive package of HIV/AIDS care, support and treatment programme, including a research agenda with a regional perspective, for support of evidence-based programming.

4. Technical sessions

The technical sessions included plenary sessions, country poster sessions and group work.

Role of nutrition in HIV

Mr JVR Prasada Rao, Regional Director, UNAIDS Regional Support Team Asia Pacific presented the importance of nutrition in HIV. He stated that UNAIDS recommends strengthening political commitment to nutrition and HIV within the national health agenda; reinforcing nutrition components in HIV policies and programmes; and incorporating HIV issues into national nutrition policies and programmes.

Nutrition and HIV: Where do we stand and what are the gaps

Prof. Charles Gilks, HIV Department, WHO-HQ, discussed about what is known and what is not known about nutrition in HIV. From the lessons learnt in other countries, HIV and nutrition programmes rely on the importance of integrating nutrition, early and accurate diagnosis, multisectoral collaboration, strong monitoring and evaluation, HIV-specific nutritional counselling, self-reliance capacity of PLWHA and resource mobilization.

Nutrition cost of HIV

Prof. Nigel Rollins, Maternal and Child Health, University of KwaZulu-Natal, South Africa, said that there are high nutrition costs associated with HIV infection and the opportunistic infections associated with HIV. Energy needs increase for both HIV-infected adults and children. Efficiency of energy utilization is also influenced by the availability of micronutrients. Thus, it is important to provide a balanced diet which has all the nutrients (macro as well as micronutrients).

Overview of the HIV epidemic and national responses in Asia

Dr Po-Lin Chan, HIV officer, WHO India, presented an overview of the HIV epidemic in Asia. She said that there is a huge unmet need for HIV prevention, care and treatment services. There has been a successful scale-up of the ART programme in Thailand and VCT services in Cambodia. Scaling-up of HIV services are urgently needed across the Region.

Nutrition supplementation and HIV including micronutrients

Dr Friis Henrik, Professor of International Nutrition and Health, University of Copenhagen, Denmark, discussed the role of nutrition interventions in HIV. HIV infection per se impairs status with respect to nutrients of importance to growth and development, pregnancy outcomes, physical activity and working capacity, and resistance to infections. Nutrition interventions are therefore likely to improve all these general outcomes, but may also have effects on the HIV infection itself. There is a need for more well-designed trials to allow evidence-based recommendations for nutrition for HIV-infected individuals.

Nutrition and ART – an update on the evidence base

Dr Daniel Raiten, Programme Officer, US National Institutes of Health provided an update on the evidence base on nutrition and ART. While it is known that highly active antiretroviral therapy (HAART) saves lives, it is also known that HAART use may cause metabolic changes, including insulin resistance, dyslipidemia, fat redistribution and bone-related problems. These conditions may place HIV-infected people at risk for other chronic diseases, such as cardiovascular disease and osteoporosis. Not only is nutritional status prior to initiation of ART an important predictor of response but each of the known metabolic complications has nutritional consequences. While there are still many knowledge gaps and challenges to research and care, the role of diet and nutrition is incontrovertible. Thus, we must move forward with the full integration of dietary and/or nutritional management into all aspects of care and treatment.

Food insecurity/risk and HIV

Mr Brian Thompson, Senior Nutrition Officer, FAO, highlighted that HIV/AIDS has a devastating impact on agriculture, food and nutrition security and livelihoods. One of the most disturbing effects of HIV/AIDS is the rapidly growing population of children who are orphaned by AIDS. He presented how FAO is supporting to improve food and nutrition security of orphans and HIV/AIDS affected children in Lesotho and Malawi through various initiatives such as Junior Farmer Field and Life Schools.

Framework for priority actions for integrating nutrition into HIV

Mrs Randa Saadeh, Scientist, NHD, WHO/HQ, presented a “framework for integrating food and nutrition activities into HIV/AIDS policies and prevention, care, treatment, support and mitigation programmes”. The framework outlined five priority actions for the governments. Dr Anirban Chatterjee, Adviser, Nutrition and HIV Care and Support, UNICEF-HQ, presented a guidance note for integrating nutrition and HIV for children. He stated that there are an increasing number of children infected with HIV, especially in countries most affected by the epidemic. The programming elements for nutrition and HIV for children include: (1) Infant and Young Child Feeding (IYCF)/Baby Friendly Hospital Initiative (BFHI); (2) Treatment of malnutrition; (3) Food security and nutrition; (4) Prevention of mother to child transmission (PMTCT); (5) Paediatric HIV care, and (6) Other vulnerable children (OVC).

Dr Aye Thwin, WHO/SEARO, presented a situation analysis of SEAR Member countries which highlighted nutrition activities in care, support and treatment of HIV/AIDS. The situation analysis was based on desk reviews and on inputs provided by Member countries. Some countries have initiated actions to incorporate nutrition care and support for HIV/AIDS and are at varying stages of integrating these interventions – ranging from advocacy level to implementation. However, much needs to be done before the Member countries can fully incorporate nutrition into care, support and treatment for HIV-infected and affected families.

This technical session provided a direction for the group work for integrating nutrition into HIV/AIDS.

Nutritional considerations for opportunistic infections in ART and TB treatment programmes

Dr Soumya Swaminathan, Deputy Director, Tuberculosis Research Centre (TRC), India, said that TB is one of the leading causes of illness and death among people living with AIDS in developing countries. The South-East Asia Region carries the

highest burden of TB and the second highest burden of HIV in the world. Prevalence of HIV among TB patients in the Region is 0-5%. There is evidence that the nutritional status of HIV+ TB+ persons is worse compared to HIV+ and non-uninfected persons and that nutritional supplementation can improve the nutritional parameters of both TB and HIV/TB patients.

HIV and treatment of severe acute malnutrition

Dr Tahmeed Ahmed, Head, Nutrition Programme, ICDDR, Bangladesh, explained how HIV influences the treatment of severe acute malnutrition (SAM) in children. Risk factors for severe malnutrition in areas with high HIV prevalence are different. Children with HIV and severe acute malnutrition can be managed at the facility and/or community levels. WHO guidelines for management of severe malnutrition should be followed for acutely ill children with HIV and SAM. For ambulant children without any acute illness, local diets with appropriate micronutrients or locally produced ready to use therapeutic food (RUTF), if available, should be given.

HIV, infant feeding and child survival

Mrs Randa Saadeh, NHD, WHO-HQ, reviewed the Global Strategy on Infant and Young child feeding. Dr Stephen Atwood, Regional Adviser, Health and Nutrition, UNICEF/EAPRO, discussed how nutrition forms a critical link to child survival. Under-nutrition contributes to over 50% of deaths among children under 5 years of age. There is a growing importance of the neonatal period as deaths of newborns have decreased more slowly than those of older infants in the last few years in the developing world.

Dr Peggy Henderson, Scientist, Child and Adolescent Health and Development, WHO-HQ, presented a technical update on HIV and infant feeding. She gave updated recommendations based on new evidence included in the Consensus Statement issued by WHO/HIV and Infant Feeding Technical Consultation on behalf of the Inter-agency Task Team (IATT) on Prevention of HIV Infections in Pregnant Women, Mothers and their Infants, held in Geneva, from 25-27 October 2006. Some of the key recommendations are:

- The most appropriate infant feeding option for an HIV-exposed infant depends on the individual circumstances of the mother and infant, including consideration of the health services, counselling and support available.
- Exclusive breastfeeding for the first six months of life is recommended if replacement feeding is not acceptable, feasible, affordable, sustainable

and safe (AFASS), with repeated assessments, including at the time of early infant diagnosis and at six months. If replacement feeding is AFASS, then complete avoidance of breastfeeding is recommended.

- Breastfeeding mothers of infants and young children who are known to be HIV-infected should be strongly encouraged to continue breastfeeding.

These recommendations apply globally, including in low-prevalence settings.

Dr Nigel Rollins, reviewed WHO guidelines for an integrated approach to the nutritional care of HIV-infected children between 6 months--14 years. The guidelines provide direction about a) how to assess and classify a child's growth and develop a nutrition care plan b) how to implement the nutrition care plan and c) how to care for HIV-infected children with special considerations such as those with specific needs e.g. diarrhoea, mouth sores etc., and children on ART. Using these guidelines, Dr Rollins discussed a case study for integrating nutrition into the care of HIV-infected children.

Monitoring and evaluation: Integrating nutrition and HIV/AIDS programming

The monitoring and evaluation sessions were facilitated by Ms Elena Janine Schooley, Project Concern International, Mr Robert Mwadine, FANTA/AED, Mrs Randa Saadeh, WHO/HQ, Ms Louise Houtzer, Albion Street Centre, and Mr Simon Sadler, WFP.

The facilitators suggested that monitoring and evaluation plans for incorporation of nutrition into HIV/AIDS should be developed at the design stage of the programme and integrated with the overall implementation processes.

Programmatic and clinical aspects are the two rationale for monitoring and evaluation in nutrition and HIV/AIDS programmes. Nutrition and HIV departments need to coordinate very closely to develop monitoring tools and integrate with other HIV data collection and reporting systems. Since monitoring and evaluation is a cross-cutting issue, it is important to establish systems which clearly define who owns the data, who collects which data and who has access to which data. Currently, internationally validated monitoring and evaluation indicators for food and nutrition support within HIV/AIDS programmes are not available. Countries need to define their own indicators specific to their food and nutrition activities.

Programme experiences on nutrition and HIV from India, Africa and Cambodia were shared to understand the lessons learned, issues and challenges for integrating nutrition activities into HIV.

Resource mobilization

A panel discussion with GFATM, NIH, PEPFAR, UNICEF and WHO was held on resource mobilization for addressing nutrition problems in the South-East Asia Region. Ms Cathernie Bilger for GFATM, Ms. Nithya Mani, PEPFAR and Dr Daniel Raiten, NIH, briefly presented the principles and process for funding proposals on nutrition and HIV/AIDS. They are currently accepting proposals which incorporate nutrition as part of care, support and treatment for HIV/AIDS.

WHO (Randa Saadeh) and UNICEF (Anirban Chatterjee) also gave their Organizations' perspective on resource mobilization efforts. The document, "Framework for defining food and nutrition activities in HIV programming" was presented by Dr Charles Sagoe-Moses, Regional Adviser/IYCF, WHO/AFRO. He also suggested how best to effectively incorporate food and nutrition into plans that could be part of applications to GFATM but also for funding opportunities including PEPFAR, the World Bank and other foundations. He shared some success stories from the African Region.

Poster sessions

Countries participated in poster sessions on nutrition activities for HIV-infected people. The poster sessions were very informative, interactive and stimulating.

Group work

Two group work sessions were held to facilitate an expanded discussion and to formulate specific conclusions and recommended actions.

Group 1 identified key interventions and challenges to integrating nutrition with HIV and how to overcome them. These are summarized below:

Key interventions: (1) Advocacy for political commitment (2) Integration of nutrition and HIV in the policy documents and national strategy and guidelines (3) Multi-sectoral collaboration (4) Training guidelines and modules (5) Hiring of nutritionists (6) Capacity building (7) Nutritional assessment and counseling (8) Monitoring and evaluation.

Challenges: (1) Poor political commitment (2) Lack of adequate funds (3) Lack of skilled human resources (4) Donor-driven objectives (5) Lack of coordination between departments (6) Ensuring sustainability of programmes.

Group 2 focused on developing priority targets to be achieved in the next two years on the basis of entry points for integrating food and nutrition into HIV/AIDS. The entry points were: (1) Nutrition and PMTCT (2) Food security as it relates to other vulnerable children (OVC) (3) Nutrition and ART in co-morbidities – HIV, TB and malaria (4) Nutrition in comprehensive care including home-based care.

Media and communication

The consultation was supported by a media and communication strategy to disseminate the key recommendations of the consultation and generate wider awareness and media interest on the issue of HIV and nutrition in the Region. A Press Release was issued from the Regional Office and the WHO Bangkok office simultaneously on the opening day of the consultation, and interested journalists were invited to interview experts attending the consultation. Wide coverage was received from the international and national press such the Deutsche Presse-Agentur (German press agency), Inter Press Service (IPS) news wire, the largest circulation Thai newspaper 'Thairath', among others. In addition, a media folder containing a backgrounder with frequently asked questions and answers, an executive summary of the scientific update, the SEARO paper, the World Health Assembly resolution on the subject and other relevant documents was distributed to the Media.

5. Conclusion and recommendations

- (1) There is a strong need for advocacy and visibility at the global and country levels for incorporating nutrition into HIV/AIDS programmes. Forums like the International Conference on Nutrition (ICN) in 2009, upcoming HIV meetings, ministerial meetings, publication in Standing Committee on Nutrition (SCN) and the newly-launched Lancet series on nutrition should be used.
- (2) Countries should compile regional-specific data on nutritional status of PLWHA which should serve as a advocacy tool for policy makers.
- (3) International agencies should allocate a part of their budget (a figure of 5% was suggested) in the countries for nutrition support and care for HIV-affected people. Resources should be allocated to fill the gaps.
- (4) Countries should develop a plan of action for nutrition and HIV with all other partners in a well coordinated way to avoid duplication of efforts. The full range of interventions should be used to meet the macro and micronutrient requirements including nutrition counseling.

5. WHO/SEARO has developed a workplan for 2008-09 where budget has been allocated for follow-up activities. Countries should promote monitoring and evaluation mechanisms. At least 2-3 critical indicators should be identified to collect information on nutrition and HIV.
6. **Participants' Statement:** Based on the discussions during the consultation and recommendation of the working groups, a Statement was issued by the participants which listed the recommendations and the key actions for the countries.

Introduction

An estimated 39.5 million people were living with HIV/AIDS at the end of 2006, of which 4 million were in the South-East Asia Region. The HIV/AIDS epidemic continues to have a devastating impact on health, nutrition, food security and overall socioeconomic development of the population affected by the disease. HIV and nutrition are strongly related to each other. Immune deficiency as a result of HIV infection leads to malnutrition and malnutrition leads to immune deficiency, worsens the effect of HIV and contributes to more rapid progression to AIDS. Malnutrition rates are also high in the South-East Asia Region. Good nutrition for HIV-affected people increases resistance to infection, maintains weight, improves quality of life as well as drug compliance and efficacy.

In 2003, WHO initiated a collaborative effort to develop approaches based on the latest available scientific evidence with respect to the macronutrient needs of HIV-infected people, the special nutritional needs of HIV-infected pregnant and lactating women and their children, and the nutritional needs of HIV-infected adults and children receiving antiretroviral treatment. The detailed scientific review was submitted at the technical consultation in Durban, South Africa in 2005. Recognizing the gravity of the problems due to HIV/AIDS, participants at the consultation called for the integration of nutrition into an essential package of care, treatment and support for people living with HIV/AIDS (PLWHA).

In May 2006, the World Health Assembly adopted resolution WHA 59.11 on Nutrition and HIV/AIDS. The resolution urges Member States to make nutrition an integral part of their response to HIV/AIDS by identifying nutrition interventions for immediate integration into HIV/AIDS programming.

This regional consultation on Nutrition and HIV/AIDS was proposed as a direct response to the above resolution whereby the Member States requested the Director-General to strengthen technical guidance to Member States for incorporating HIV/AIDS issues in national nutrition policies and programmes; and

to support the development and dissemination of science-based recommendations, guidelines and tools on nutritional care and support for people living with HIV/AIDS. The consultation was jointly sponsored by WHO, US National Institutes of Health, FAO, UNICEF and WFP.

The consultation was also aimed to build on the successful experience of the Durban consultation in 2005 on nutrition and HIV/AIDS which mobilized most of the Sub-Saharan Africa countries to include nutrition within their HIV/AIDS policies and response.

Some Member countries in the South-East Asia Region have initiated efforts to integrate nutrition into HIV but these are insufficient, few and scattered. There is a need to strengthen the efforts, develop more political commitment and implement nutrition activities for care, support and treatment of HIV/AIDS.

Inauguration

Dr P.T. Jayawickramarajah, WHO Representative to Thailand, welcomed the participants and delivered the inaugural address of Dr Samlee Plianbangchang, WHO Regional Director for South-East Asia. Dr Samlee stated that South-East Asia faces multiple and diverse HIV epidemics occurring in different population groups and in different geographical areas at varying rates. Adequate nutrition can help people living with HIV stay healthier, live longer, comply with drug therapy and lead to a better quality of life. It forms an integral part of a comprehensive package of care, support and treatment of HIV/AIDS. High malnutrition rates persist in some of the Member countries in the Region. Scaling up care and antiretroviral therapy cannot be addressed without appropriate support for nutrition. Dr Samlee further stated that building on global experiences and knowledge, this consultation is intended to identify opportunities and mechanisms to integrate nutrition into HIV/AIDS programming and develop action plans to address these issues.

H.E. Dr Mongkol na Songkhla, Minister of Public Health, Thailand, said in his inaugural address that HIV was one of the most dreaded communicable diseases in the history of mankind. HIV has significant nutrition-related implications and consequences for individuals, families and communities. He further remarked that Thailand has been very successful in dealing with its problems of under-nutrition as well as HIV prevention and control. On the treatment side, more than 100,000 AIDS patients in Thailand can access ARVs. However, work in HIV/AIDS programme is still far from over, he added.

Dr Aye Thwin, Short-term Professional, Nutrition for Health and Development (NHD) unit, WHO/SEARO, introduced the participants (list of participants is at Annex 1 and the consultation programme is at Annex 2). The 105 participants included representatives from SEAR Member countries and four countries from the Western Pacific Region (China, Laos, Cambodia and Viet Nam), temporary advisers, UN agencies (FAO, IAEA, UNAIDS, UNICEF, UNHCR, and WFP) funding and partner agencies such as US National Institutes of Health, USAID, MI, GFATM,

PEPFAR and WHO Collaborating Centres (Albion Street Centre, Institute of Nutrition at Mahidol University), NGOs and the Thai Red Cross AIDS research centre, Project Concern International, Concern Worldwide, Food and Nutrition Technical Assistance (FANTA) and HIV/AIDS alliance Cambodia, PLWHA groups, as well as staff from WHO/HQ, and the Regional Offices for the Africa and South-East Asia Regions.

Professor Charles Gilks, Coordinator, HIV/AIDS Department, WHO/HQ presented the global perspective on nutrition and HIV/AIDS. He said that globally there has been a steady increase in ART access for people with HIV/AIDS. By early 2007, over 2 million people were receiving ART in resource-limited settings. But nutritional care to support ART treatment has been dismal and needs to be improved. Nutrition should form a key component of a comprehensive care package for HIV/AIDS. Nutrition plays a very important role in the daily life of PLWHA and affected households. There is evidence that HIV-infected people can live as long as 65-70 years with ART with adequate nutrition, care and support.

Dr Praphan Phanupak (Thailand) was nominated as Chairperson, Dr Ina Hernawati (Indonesia), Co-Chairperson and Dr Htin Aung (Myanmar) as Rapporteur of the consultation.

Overview and objectives

Mrs Randa Saadeh, Scientist at the Department of Nutrition for Health and Development, WHO/HQ, providing an overview of the consultation said that food and nutrition interventions are critical components of a comprehensive response to the HIV pandemic. The goal is to ensure that nutritional care and support are provided for people infected and affected with HIV. Workable solutions need to be developed at this consultation and a consensus reached of what needs to be done and by whom. She added that based on the discussions a statement would be issued by the participants which would list the recommendations and the key actions for the countries.

Dr Aye Thwin, WHO/SEARO, explained the objectives of the consultation to the participants. The overall objectives of the consultation were to integrate nutrition as a fundamental part of the overall response to HIV/AIDS in the South-East Asia Region whereas the specific objectives were to:

- Review lessons learnt from the global and regional experiences of integrating nutrition as a fundamental part of response to HIV/AIDS.
- Identify gaps, challenges and opportunities to formulate evidence-based programmes for integrating nutrition as a fundamental part of response to HIV/AIDS.
- Formulate and recommend action plans for national and regional levels ensuring nutrition as a fundamental component of the comprehensive package of HIV/AIDS care, support and treatment programme, including a research agenda with a regional perspective, for support of evidence-based programming.

Technical sessions

The technical sessions included plenary sessions, country poster sessions and group work.

Role of nutrition in HIV

Mr J. V. R. Prasada Rao, Regional Director, UNAIDS Regional Support Team Asia Pacific, highlighted the importance of nutrition in HIV. He stated that nutrition should become an integral part of countries' response to HIV/AIDS. The main objectives of nutrition interventions were to improve efficacy of treatment, reduce wasting, disease progression and mortality in HIV-infected people. UNAIDS recommends: strengthening political commitment to nutrition and HIV within the national health agenda; reinforcing nutrition components in HIV policies and programmes; and incorporating HIV issues into national nutrition policies and programmes.

Nutrition and HIV: Where do we stand and what are the gaps

Prof. Charles Gilks, HIV Department, WHO/HQ, discussed the current scenario of nutrition care and support in HIV programmes. He said that the number of people receiving ART in resource-limited settings continues to increase and the rate of scale up is also increasing. Unfortunately nutrition care to support ART treatment has not been adequate and needs to be improved. Nutrition should form a key component of the package of comprehensive care. The WHO Public Health strategy does not include nutrition. He mentioned that it is known that nutrition is a key component of the continuum of care. Body mass index is a strong predictor of death/ART response. The importance of safe infant feeding (AFASS) as a core

component of PMTCT was recognised. However, there were some gaps in knowledge e.g. the specific role of micronutrients, impact of nutritional deficiency and different diets on ARV toxicities, long-term growth monitoring in children and implementation strategies related to food and nutrition supplementation. From the lessons learnt in other countries, HIV and nutrition programmes rely on the importance of integrating nutrition, early and accurate diagnosis, multisectoral collaboration, strong monitoring and evaluation, HIV specific nutritional counselling, self-reliance capacity of PLWHA and resource mobilization.

Nutrition cost of HIV

Prof. Nigel Rollins, Maternal and Child Health, University of KwaZulu-Natal, South Africa, said that there are high nutrition costs associated with HIV infection and the opportunistic infections associated with HIV. Energy needs increase by:

- 10% even when asymptomatic
- 25-30% with TB, chronic lung disease and persistent diarrhoea
- 50-100% when severely malnourished.

These extra energy needs are in addition to an adequate and appropriate dietary intake. Efficiency of energy utilization is also influenced by the availability of micronutrients. Thus, it is important to provide a balanced diet which has all the nutrients (macro as well as micronutrients). Decreased appetite and intake are major causes of HIV-associated weight loss and wasting. Growth failure in HIV-infected children is common and reflects HIV disease progression and reduced survival. Diarrhoea in HIV children is very common and is also associated with growth failure.

He further stated that HIV-infected adults and children tend to lose lean body mass (muscle) more than fat. BMI <18 is a significant independent predictor of mortality in adults. Poor growth in children is independently associated with mortality. Routine monitoring of weight is valuable and can be done at home.

It was discussed if BMI can be used in children to monitor growth. In routine settings, there is a difficulty in taking height /length of children. So, monitoring weight is all that is needed for the majority of settings.

If antiretroviral drugs are being provided to children then height should be measured to guide the dosage. Mid upper arm circumference is a good representative of lean mass. However, sensitivity of weight measurement is good and a satisfactory predictor of survival for the majority of programme settings.

Adequate nutrition is essential if full benefit of antiretroviral drugs is to be achieved. Nutrition support can improve the adherence to ART. There is also growing concern about children becoming obese as a result of over nutrition while being on ART and continuing nutrition support beyond the time of nutritional recovery.

Overview of HIV epidemic and national responses in Asia

Dr Po-Lin Chan, HIV officer, WHO India country office, presented an overview of the HIV epidemic in Asia. She said that Asia faces diverse epidemics in different population groups and with large populations at risk. HIV prevalence is decreasing in some countries e.g. Thailand and Myanmar, but new epidemics continue to occur. There has been successful scale-up of the ART programme in Thailand and VCT services in Cambodia. But, there is a huge unmet need for HIV prevention, care and treatment services. Less than one in ten adults know their HIV status. Less than one in 4 persons who need treatment has access to it and less than one in 20 pregnant women receive PMTCT services in South-East Asia. Scaling-up of HIV services is urgently needed across the Region.

Nutrition supplementation and HIV including micronutrients

Dr Henrik Friis, Professor of International Nutrition and Health, University of Copenhagen, Denmark, discussed the role of nutrition interventions in HIV. He said that infections impair nutritional status and, in turn, malnutrition may impair immune functions. Since HIV infection per se impairs status with respect to nutrients of importance to growth and development, pregnancy outcomes, physical activity and working capacity, and resistance to infections, nutrition interventions are likely to improve all these general outcomes. In addition, there is biological plausibility and some evidence to suggest that nutrition interventions may reduce risk of HIV transmission, as well as progression of HIV infection, and risk of opportunistic infections.

He reviewed the scarce literature on the effect of micro- and macronutrient interventions. Interventions to increase the intake of micronutrients may reduce or even increase the risks of transmission or progression of HIV infection, and it is still not possible to give evidence-based recommendations. Only a few studies have assessed the effect of macronutrient interventions compared to no intervention and none of the studies were from low-income settings. Most studies aimed at increasing the energy intake by 600-900 kcal. The analysis showed that if the

energy intake was increased by 367 kcal/d and the protein intake by 17 g/d, there were no effects on body weight, fat- or fat-free mass or CD4 counts. There were no data on morbidity and mortality.

Evidence-based nutritional interventions have not been developed and integrated into HIV programmes. The reasons for this are a) ethical considerations b) complexities and methodological difficulties and c) HIV infection being the domain of the infectious disease speciality - which has made considerable advances over the last 50 years but in which nutrition is no longer considered to be important.

Thus, there is need for more well designed trials to allow evidence-based recommendations for nutrition for HIV-infected individuals.

Nutrition and Antiretroviral Therapy (ART) – an update on the evidence base

Dr. Daniel Raiten, Programme Officer, US National Institute of Child Health and Human Development (NICHD) of the US National Institutes of Health (NIH) provided an update on the evidence base on nutrition and ART. He said that the key points from the original review (2005) remain true:

- ART is essential to save lives and efforts to achieve universal access must continue.
- A substantial body of evidence exists with regard to the impact of ART on the metabolism of adults and children, which have dietary and nutritional implications.
- Certain foods (e.g. garlic, African potato) affect the bioavailability of ARV medications.
- Use of “traditional medicines” may also affect ARV use (adherence) and efficacy.
- Wasting continues to be an issue in the era of HAART. The reasons are not known but potential factors identified pre-HAART are still in play and need to be monitored.

Additional research since the original review has reinforced several points including:

- ART is associated with increased energy requirements.
- Body Mass Index (BMI) at time of entry for treatment is an independent and significant predictor of mortality in PLWHA receiving ART.

- Metabolic complications of ARVs are seen in adults and children and have nutrition implications. These complications include:
 - “ART Metabolic Syndrome”: derangements in lipid storage resulting in changes in body composition and dyslipidemias, (indicative of high CVD risk), insulin resistance/impaired glucose tolerance (possible role for dietary management)
 - Bone Related Problems: Derangements include osteopenia and osteoporosis (possible role for Vitamin D)
 - Lactic acidemia; generally associated with the class of ARV (NRTI) (possible role of specific micronutrients in either etiology and/or treatment).

With specific reference to conditions in the South-East Asia Region, it was noted that approximately 20-25% of urban HIV-uninfected South Asians have evidence of the “metabolic syndrome” (combination of obesity, hypertension, dyslipidemias, insulin insensitivity) indicating a potential predisposition to these complications of HIV and its treatment.

Dr. Raiten concluded by noting that while many knowledge gaps remain as challenges to research and care, the core conclusions from the initial review remain the same i.e.:

- HAART saves lives, but its use may cause metabolic changes, including insulin resistance, dyslipidemia, fat redistribution. These conditions may place patients at risk for other diseases.
- Switching drugs is one response to addressing these concerns. However, the role of dietary and/or nutritional management should also be considered.
- Knowledge of these effects is critical in the implementation of appropriate nutritional policies in conjunction with HAART use.

Food insecurity/risk and HIV

Mr Brian Thompson, Senior Nutrition Officer, FAO, highlighted that HIV/AIDS has a devastating impact on agriculture, food and nutrition security and livelihoods. HIV/AIDS through increased mortality and infection of the agricultural labour force has a negative impact on agriculture as the reduced ability to work leads to drastic reduction in area, yields and diversity. There is loss of earnings, knowledge and skills. One of the most disturbing effects of HIV/AIDS is the rapidly growing population of children who are orphaned by AIDS. There are about 12

million AIDS orphans in Africa. In addition to orphans, there are other vulnerable children who are caring for infected family members and dropping out of school because of lack of financial support and are going hungry or are undernourished. He presented how FAO is supporting national and local efforts to improve food and nutrition security of orphans and HIV/AIDS-affected children in Lesotho and Malawi through various initiatives including Junior Farmer Field and Life Schools.

Ms Robin Jackson, Chief, HIV/AIDS Service, WFP, and Dr Micheline Diepart HIV/AIDS, WHO/HQ, introduced a WHO/WFP manual to the participants produced with the support of Albion Street Centre, Australia. The manual provides operational guidance on integrating nutrition and food assistance into HIV care and treatment programmes.

Framework for priority actions for integrating nutrition into HIV

Mrs Randa Saadeh, Scientist, NHD, WHO/HQ, presented a “framework for integrating food and nutrition activities into HIV/AIDS policies and prevention, care, treatment, support and mitigation programmes”. The framework was needed to a) reflect the scientific evidence b) ensure coordination and collaboration between all partners and actors to comprehensively address nutrition and HIV c) provide guidance for action and d) spell-out key actions that would make a difference while identifying responsibilities and obligations.

The framework outlined five priority actions for governments as follows:

- (1) Integrate nutrition and HIV/AIDS into existing policies and guidelines
- (2) Improve and maintain the nutrition of people infected and affected by HIV/AIDS
- (3) Integrate nutrition care and support into prevention of MTCT programmes
- (4) Improve food security
- (5) Support monitoring and evaluation and research in the area of nutrition and HIV/AIDS.

She further discussed the challenges facing integration of nutrition into HIV/AIDS. These are:

- Low priority given to nutrition
- Scientific evidence base growing but not as solid and comprehensive, and in addition there are limited studies on efficacy and effectiveness

- Nutrition is not defined beyond food. A comprehensive scope and clear distinction is needed between food security and nutrition programme components
- Not enough documentation to measure how things work – (i.e. output and outcomes).

Dr Anirban Chatterjee, Adviser, Nutrition and HIV Care and Support, UNICEF/HQ, presented a guidance note for integrating nutrition and HIV for children. He informed that there are an increasing number of children infected with HIV, especially in countries most affected by the epidemic. In 2006, an estimated 2.3 million children under 15 years of age were living with HIV/AIDS, a total of 530,000 were newly infected and 380,000 died. The UN General Assembly Special Session for Children had set the HIV/AIDS targets to reduce the proportion of infants infected with HIV by 20% by 2005 and by 50% by 2010.

HIV-free survival in children as well as nutrition care and support to HIV-infected and affected children involves integrated programming which means focusing on the child; services rather than just programmes; and better outcomes i.e. reduced PMTCT, morbidity and U5MR.

Basic principles of integrated programming are:

- linkages with different programmes,
- IYCF and treatment of malnutrition as a continuum of care rather than stand- alone programmes
- a family centered approach.

Dr Chatterjee further added that programming elements for nutrition and HIV for children include:

- Infant and Young Child Feeding (IYCF)/Baby Friendly Hospital Initiative (BFHI)
- Treatment of malnutrition
- Food security and nutrition
- Prevent of mother to child transmission (PMTCT)
- Paediatric HIV care
- Other vulnerable children (OVC)

Programming strategies involve working at the policy level – creating awareness and advocating for increased funding for nutritional care and treatment within HIV programmes; developing paediatric guidelines and tools; implementation of the framework for priority action; nutrition assessment for mother and child; referral and linkages, and monitoring and evaluation.

Dr Aye Thwin, WHO/SEARO, presented a situation analysis of Member countries in the Region which highlighted nutrition activities in care, support and treatment of HIV/AIDS. The situation analysis was based on desk reviews and on inputs provided by Member countries. Some Member countries have initiated actions to incorporate nutrition care and support for HIV/AIDS-affected people and are at varying stages of integrating these interventions – ranging from advocacy level to implementation. Dr Thwin further explained the key constraints/challenges faced by SEAR countries in incorporating nutrition care and support for those affected by HIV/AIDS. These are: nutrition interventions not well recognized as a part of HIV/AIDS among policy makers and programme managers, lack of financial and human resources and lack of coordination among different stakeholders. Member countries have also identified some opportunities which are: many national and international NGOs working in the area of HIV/AIDS and referral hospitals for care, support and treatment of PLWHA. However, he emphasized that much needs to be done before the Member countries can fully incorporate nutrition into care, support and treatment for HIV-infected and affected families. (Executive Summary of the Situational Analysis is attached in Annex 3)

This technical session provided direction for the group work sessions for integrating nutrition into HIV/AIDS.

Nutritional considerations for opportunistic infections in ART and TB treatment programmes

Dr Soumya Swaminathan, Deputy Director, Tuberculosis Research Centre (TRC), India said that TB is one of the leading causes of illness and death among people living with AIDS in developing countries. The majority of people infected with HIV develop TB as the first manifestation of HIV/AIDS. The South-East Asia Region carries the highest burden of TB and the second highest burden of HIV in the world. Prevalence of HIV among TB patients in the South-East Asia Region is 0-5%. She further highlighted that tuberculosis has additive and adverse effects on the nutritional status of HIV patients. In HIV, co-infection with TB causes loss of body cell mass and fat mass. Nutritional status of HIV+ TB+ persons is worse compared to HIV+ and HIV-uninfected persons. She shared a WFP-collaborative

study done to assess the impact of nutrition supplementation on weight and body mass of HIV+ individuals in Tamil Nadu. The findings of the study showed that after six months of nutritional supplementation, there was a significant increase in weight, BMI and mid-upper arm circumference (MUAC) of HIV+ intervention group. CD4 cell count remained unchanged in the intervention group but decreased significantly in controls without nutritional supplementation. This shows that nutrition supplementation in PLWHA could improve nutritional status and delay progression of HIV disease.

HIV and treatment of severe acute malnutrition

Dr Tahmeed Ahmed, Head, Nutrition Programme, ICDDR, Bangladesh, explained how HIV influences the treatment of severe acute malnutrition (SAM). He indicated that the rate of disease progression is much more rapid in children compared to adults; majority of children have symptoms within 12 months of detection of HIV infection. High viral load, chronic diarrhoea and other opportunistic infections impair growth in children. There is 50% mortality by the age of 24 months. HIV is associated with child malnutrition. It complicates the management of severe malnutrition and increases the case fatality of children with severe acute malnutrition (SAM). In an area with high transmission of HIV, children with severe underweight are three times more likely to be HIV-infected. In such areas, HIV prevalence among children suffering from SAM ranges from 15-40%. He further explained that risk factors for severe malnutrition in areas with high HIV prevalence are different. Children whose parents had died had 38 times higher risk of developing severe malnutrition. Persistent diarrhoea and thrush are more common in HIV children with SAM. HIV-infected children with SAM can be managed at the facility and /or community levels. For the facility-based management of an acutely ill child, WHO guidelines for management of severe malnutrition should be followed. During nutritional rehabilitation, local diets may be tried, provided essential micronutrients are adequately supplied. At the community level, acutely ill children with SAM and HIV should be referred to a facility or a stabilization centre and managed using WHO guidelines. For ambulant children without any acute illness, local diets with appropriate micronutrients or locally produced ready to use therapeutic food (RUTF), if available, should be given. There are gaps in knowledge of HIV infection and SAM and these should be addressed by research. The areas identified for research include pharmacokinetics and safety of anti-retrovirals (ARVs) in SAM, the time to start ARVs (early versus late phase of nutritional rehabilitation), mainstreaming nutrition and HIV into a single health system, and increasing coverage of management of HIV and SAM.

HIV, infant feeding and child survival

Mrs Randa Saadeh, NHD, WHO/HQ, reviewed the Global Strategy on Infant and Young Child Feeding. The aim of the strategy is to improve, through optimal feeding -the nutritional status, growth and development, health and thus the survival of infants and young children. Globally 10.8 million children under-five years of age die annually. More than half of these deaths are associated with malnutrition. Most of these deaths are attributed to poor infant feeding practices. Exclusive breastfeeding (only breast milk) in the first six months of life and introduction of complementary feeding at the end of six months while continuing to breastfeed well into the second year of life and beyond could reduce the annual number of deaths of children under five by 1.3 million, or 13%. However, exclusive breastfeeding rates remain very low in some of the countries in the Region with Thailand as low as 6%. The HIV pandemic and the risk of mother- to -child transmission poses unique challenges to the promotion of breastfeeding, even among unaffected families. The absolute risk of HIV transmission through breastfeeding for more than one year-globally between 10% and 20% needs to be balanced against the increased risk of morbidity and mortality when infants are not breastfed.

Dr Stephen Atwood, Regional Adviser, Health and Nutrition, UNICEF/EAPRO, discussed how nutrition forms a critical link to child survival. He said that under-nutrition contributes to over 50% of child deaths under 5 years of age. Maternal under-nutrition manifested by decreased maternal height (stunting), below normal pre-pregnancy weight and pregnancy weight gain are among the strongest predictors of delivery of a LBW infant. Iron deficiency anaemia among pregnant women is associated with maternal death.

Dr Atwood added that neonatal mortality contributes to nearly two-thirds of infant mortality in the developing world. Delayed breastfeeding increases the risk of neonatal mortality. There is growing recognition of the importance of the neonatal period as deaths of newborns have decreased more slowly than deaths of older infants in the last few years in the developing world.

Dr Peggy Henderson, Scientist, Child and Adolescent Health and Development, WHO/HQ, provided a technical update on HIV and infant feeding. A WHO HIV and Infant Feeding Technical Consultation on behalf of the Inter-agency Task Team (IATT) on Prevention of HIV Infections in Pregnant Women, Mothers and their Infants was held in Geneva on October 25-27, 2006. A consensus statement was issued which gives updated recommendations based on the new evidence on HIV and infant feeding for HIV-positive women. Some of the key recommendations are:

- The most appropriate infant feeding option for an HIV-exposed infant depends on the individual circumstances of the mother and infant,

including consideration of the health services, counselling and support available.

- Exclusive breastfeeding for the first *six* months of life is recommended if replacement feeding is not acceptable, feasible, affordable, sustainable and safe (AFASS), with repeated assessments, including at the time of early infant diagnosis and at six months. If replacement feeding is AFASS, then complete avoidance of breastfeeding is recommended.
- Breastfeeding mothers of infants and young children who are known to be HIV-infected should be strongly encouraged to continue breastfeeding.

These recommendations apply globally, including in low-prevalence settings.

Dr Henderson further discussed that there is also some evidence to show that:

- Early breastfeeding cessation is associated with increased morbidity and mortality in HIV-exposed infants.
- Improved adherence and a longer duration of exclusive breastfeeding can be achieved in HIV-infected and HIV-uninfected mothers when they are given consistent messages and frequent, high quality counselling.
- HIV-infected mothers who need ARVs for their own health should have them, and this is likely to decrease transmission through breastfeeding. However, evidence is awaited on the safety and efficacy of this approach.
- The severity of disease in mothers who are not yet on ARVs is an important risk factor, but AFASS criteria are still critical for determining the best outcome for the infant.

Dr Henderson highlighted that mothers require support to choose and implement infant feeding options at least at three critical points, i.e. before delivery; in the first months; and at six months when infant feeding practices change. Continued support for appropriate implementation of choices is always required.

Dr Nigel Rollins reviewed WHO guidelines for an integrated approach to the nutritional care of HIV-infected children aged six months to 14 years. These guidelines are evidence-based and provide clear and concise advice that can be easily implemented in programme settings. The guidelines provide direction about a) how to assess and classify a child's growth and develop a nutrition care plan b)

how to implement the nutrition care plan and c) how to address HIV-infected children with special considerations such as those with specific needs e.g. diarrhoea, mouth sores etc. and children on ART. Using these guidelines, Dr Rollins discussed a case study for integrating nutrition into the care of HIV-infected children.

Monitoring and evaluation: Integrating nutrition and HIV/AIDS programming

The monitoring and evaluation sessions were facilitated by Ms Elena Janine Schooley, Project Concern International, Dr Robert Mwadine, FANTA/AED, Mrs Randa Saadeh, WHO/HQ, Ms Louise Houtzer, Albion Street Centre, and Mr Simon Sadler, WFP.

The facilitators said that monitoring and evaluation plans for incorporation of nutrition into HIV/AIDS should be developed at the programme design stage and integrated with the overall implementation processes.

It was stated that there are two rationales for monitoring and evaluation in nutrition and HIV/AIDS programmes - programmatic and clinical. The programmatic aspects focus on improving the quality of life, detecting changes over time (short, medium and long term), assessing nutrition interventions, identifying constraints and ways to overcome them and reporting to the donors. The clinical aspects focus on assessing the nutritional status of PLWHA and ensuring adherence to ART. Assessment of nutritional status includes assessment of clinical signs (e.g. signs of wasting), anthropometry (e.g. BMI) and dietary pattern with or without ART.

Indicators may measure inputs, processes, outputs, outcomes and impact. Indicators can be developed under four heads – prevention, care, mitigation and treatment for nutrition and HIV/AIDS. There are several ways of developing indicators e.g. link indicators to objectives and activities, build on existing indicators, and use a mixture of indicators.

It was discussed that the Nutrition and HIV departments at the country level need to coordinate very closely to develop monitoring tools and integrate with other HIV data collection and reporting systems. Since monitoring and evaluation is a cross-cutting issue, it is important to establish systems which clearly define who owns the data, collects which data and has access to which data.

Currently, we do not have internationally validated monitoring and evaluation indicators for food and nutrition support within HIV/AIDS programmes. Countries need to take initial steps for development of indicators. If the programmes can

clearly define their objectives, target groups, inputs and the processes, then monitoring and evaluation can be easier to define.

Some process indicators which are used in nutrition and HIV/AIDS programming were presented. However, countries need to define their own indicators, specific to each of their food and nutrition activities.

Data collected should be used for decision making at all levels and must help both the service provider and the client. To illustrate this, a brief exercise was completed through small groups to understand how data can be used to improve clinical outcomes, programme performance, advocacy and marketing/resource mobilization.

Experiences from the field

Programmatic experiences from India, Africa and Cambodia were shared to understand the lessons learned, issues and challenges for integrating nutrition activities into HIV. Dr Jagdeesan, Tamil Nadu AIDS Control Society, NACO, presented his experience from a WFP-supported pilot project in Tamil Nadu. Implemented since June 2007, the project provides nutrition support (including nutrition supplements) to adults and children attending ART centres. Some of the challenges faced are: maintaining quality supply chain and logistics, lack of trained manpower, storage and acceptability of product. The project is implemented to gather evidence about how integration occurs and create a model for replication by the government.

Dr Robert Mwadine, Regional Senior HIV and Nutrition Adviser, FANTA, shared his experiences from Africa after the Durban consultation in 2005. He said that countries in the Africa region have made progress at varying levels in integrating nutrition into HIV programmes. These include enhanced political commitment, integration of nutrition into HIV in the national strategy, increased human capacity (hiring nutritionists/dieticians), capacity building, developing guidelines, training manuals, IEC materials and monitoring and evaluation. Some of the challenges faced are: conflicts between departments, poor linkages between services and with community and sustainability of resources.

Professor Koum Kanal, Director, National Maternal Child Health Centre, shared infant feeding experiences from Cambodia in the context of HIV. He said that Cambodia developed national PMTCT policy and guidelines in 2005. In the PMTCT programme, infant feeding counseling is given to all HIV-positive women before and after delivery. However, a recent review of PMTCT programme showed that the programme faced challenges including weak implementation, insufficient

capacity, lack of confidence of health care workers in providing infant feeding counseling and insufficient monitoring.

Dr Khimuy Tith, Director of KHANA (Khamar HIV/AIDS NGO Alliance) presented the evaluation report of KHANA/WFP food assistance programme for PLWHA and OVC families. The report highlights the improvement in household food security including nutrition status, livelihood and contribution to education and longer-term development efforts as well as the scope for improving the need for integration of nutrition Information, Education and Communication.

Resource mobilization

A panel discussion with GFATM, NIH, PEPFAR, UNICEF and WHO was held on resource mobilization for addressing nutrition problems in the South-East Asia Region with regard to HIV/AIDS. Ms Cathernie Bilger for GFATM, Ms. Nithya Mani, PEPFAR and Dr Daniel Raiten, NIH, briefly presented the principles and process for funding proposals on nutrition and HIV/AIDS. They are currently accepting proposals which incorporate nutrition as part of care, support and treatment for HIV/AIDS. WHO (Mrs Randa Saadeh) and UNICEF (Dr Anirban Chatterjee) also gave their Organizations' perspectives on resource mobilization efforts. The document, "Framework for defining food and nutrition activities in HIV programming" was presented by Dr Charles Sagoe-Moses, Regional Adviser/IYCF WHO/AFRO. He also provided concrete suggestions on how best to accomplish the effective incorporation of food and nutrition into plans that could be part of applications to GFATM but also other funding opportunities including PEPFAR, World Bank and other Foundations. He gave some success stories from the African Region.

Poster sessions

Countries had been requested to prepare posters for which some general guidelines had been provided. Countries where nutrition activities have been initiated for HIV-infected people shared their posters. The poster sessions were very informative, interactive and stimulating.

Group work

Two group work sessions were held to facilitate an expanded discussion and to formulate specific conclusions and recommended actions.

Group work 1

Country representatives were divided into four working groups. The issues for discussions were:

- Rationale for integrating food and nutrition into national strategies.
 - Opportunities and mechanisms to integrate nutrition into national nutrition and HIV policies, budgets and plans
- What are feasible possibilities, knowledge needs and resources needs?
- What contributes to success? What obstacles are likely to be encountered?

Expected outcomes were focused on key interventions and challenges to integrating nutrition with HIV and how to overcome them. These are summarized below:

Key interventions

- Advocacy for political commitment
- Integration of nutrition and HIV in the policy documents and national strategy and guidelines
- Multisectoral collaboration and linkages
- Training guidelines and modules
- Hiring of nutritionists
- Capacity building
- Nutritional assessment and counseling
- Monitoring and evaluation

Challenges

- Poor political commitment
- Lack of adequate funds
- Lack of skilled human resources
- Donor-driven objectives
- Lack of coordination between departments
- Sustainability of programmes

Group work 2

Country representatives were divided into four working groups according to their preferred area of interest.

The group work focused on developing priority targets to be achieved in the next two years on the basis of the entry point for integrating food and nutrition into HIV/AIDS. The entry points were:

- Nutrition and PMTCT
- Food security as it relates to OVCs
- Nutrition and ART in co-morbidities - HIV, TB and malaria
- Nutrition in comprehensive care including home-based care

Priority targets set by different groups for the next two years are summarized as follows:

- Nutrition and PMTCT:
 - Update the existing policy and guidelines –especially in infant feeding, care, safe motherhood, BFHI to include considerations for HIV
 - Increase PMTCT service coverage including the nutrition component
 - Adapt high quality counseling tools available elsewhere for local use
 - Increase infant and young child feeding service coverage, especially among HIV-positive mothers
- Food security as it relates to OVCs
 - Advocacy at the policy level including development of advocacy tools
 - Assessment/analysis of relevant national plans/policies and integration of food and nutrition security with HIV policies
 - Establish family-centered package of care
 - Address stigma, discrimination and barriers to access
 - Define targeting criteria and rely on communities for identification of vulnerable households
- Nutrition and ART in co-morbidities - HIV, TB and malaria

- Nutrition assessment and counseling for all HIV+. Include nutrition indicators in national M&E tools
- Nutrition support for patients beginning ART, children and pregnant women
- Capacity building for expertise in nutrition and HIV at national level and at ART centres
- Generate resources to support above
- Clarity in defined goals among donors
- Nutrition in comprehensive care including home-based care
 - Assessment of nutritional situation in specific contexts/groups at high risk of HIV
 - Create practical examples and models for nutrition and HIV integration (cost and share lessons)
 - Identify clear and measurable indicators for programme monitoring and also for individual progress in care.

Resources available for nutrition and HIV/AIDS

Mrs Randa Saadeh gave a brief overview of the resources available to support countries in planning, implementing and monitoring nutrition activities for HIV people. These are available as (a) review of the evidence (b) guidelines, tools and frameworks (c) tools for capacity building (d) resource mobilization and (e) monitoring and evaluation and development of indicators. The resources can be accessed at: <http://www.who.int/nutrition/topics/hivaids/en/index.html>; <http://www.who.int/nutrition/topics/infantfeeding/en/index.html>, and <http://www.who.int/child-adolescent-health/NUTRITION/infant.htm>

Mrs Randa Saadeh also demonstrated the dedicated webpage on the consultation to the participants. The webpage contains all the background papers, the SEAR paper, meeting specific information, the media materials and several relevant links, including links to websites of all partner agencies. The webpage can be found at: www.who.int/nutrition/topics/hiv_regional_consultation_bangkok/en/index.html

Media and communication

The consultation was supported by a media and communication strategy to disseminate the key recommendations of the consultation and generate wider awareness and media interest on the issue of HIV and nutrition in the Region. A Press Release was issued from the Regional Office and the WHO Bangkok office simultaneously on the opening day of the consultation, and interested journalists were invited to interview the experts at the consultation. Wide coverage was received from the international and national press such as the Deutsche Presse-Agentur German press agency, Inter Press Service (IPS) news wire, the largest circulation Thai newspaper 'Thairath', among others. In addition, a media folder containing a backgrounder with frequently asked questions and answers, an executive summary of the scientific update, the SEARO paper, the World Health Assembly resolution and other relevant documents were also prepared for distribution to the media.

Conclusions and recommendations

1. There is a strong need for advocacy and visibility at the global and country level for incorporating nutrition into HIV /AIDS programmes. Forums like ICN meeting in 2009, upcoming HIV meetings, ministerial meetings, publication in SCN and the newly-launched Lancet series on nutrition should be used.
2. Countries should come up with region specific data on nutritional status of PLWHA which should serve as an advocacy tool for policy makers.
3. International agencies should allocate part of the budget (5% was suggested) in the countries for nutrition support and care for HIV-affected people. Resources should be allocated to fill the gaps.
4. Countries should develop a plan of action for nutrition and HIV with all other partners in a well coordinated way to avoid duplication of efforts. A full range of interventions should be used to meet the macro- and micronutrient requirements including nutrition counseling.
5. WHO/SEARO has developed a workplan for 2008-09 with a budget allocated for follow-up activities. Countries should promote monitoring and evaluation mechanisms. At least 2-3 critical indicators should be identified to collect information on nutrition and HIV.
6. **Participants' Statement:** Based on the discussions during the meeting and on the recommendations of the working groups, a statement was issued by the participants which listed the recommendations and the key actions for the countries (Annex 4).

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Programme

Monday, 8 October 2007

- 1600-1730 Registration
- 1730-1830 Inaugural Session
- Welcome by WR Thailand, Dr P.T. Jayawickramarajah
 - Inaugural address- Regional Director, Dr. Samlee Plianbangchang, WHO-SEARO
 - Key note address by H.E. Dr. Mongkol na Songkhla, Minister of Public Health,
 - Introduction of participants by Dr. Aye Thwin, WHO-SEARO
 - Global perspective on HIV/AIDS and Nutrition by Dr. Charles Gilks, WHO-HQ
- 1830-1930 Reception hosted by the Ministry of Public Health, Royal Thai Government

Tuesday, 9 October 2007

- 0900-0910 Introduction (Dr Jayawickramarajah)
- 0910-0920 Overview and remarks (Mrs Randa Saadeh)
- 0920-0930 Objectives/process and expected outcomes (Dr Aye Thwin)
- 0930-1000 Nutrition and HIV: where do we stand and what are the gaps? (Prof. Charles Gilks)
- Overview of HIV epidemic and national responses in Asia (Dr Po-Lin Chan)
- 1000-1030 Nutrition cost of HIV in the individual – summarize evidence (Prof Nigel Rollins)
- 1030-1100 *Tea/Coffee*

1100-1145	Nutritional supplementation and HIV including micronutrients (Prof Henrik Friis)
1145-1205	Nutrition and ART: update on the evidence base (Dr Dan Raiten)
1205-1215	Discussion
1215-1245	Experiences from field: India (Dr M. Jagadeesan) Progress, achievements and gaps after Durban (Dr Robert Mwadime) Discussion
1245-1400	<i>Lunch</i>
1400-1430	Integrating nutrition and food assistance into HIV care and treatment. The WHO/WFP manual (Ms Robin Jackson and Dr. Micheline Diepart)
1430-1500	Food insecurity/risk and HIV (Dr Brian Thompson)
1500-1730	Country Based Group work 1: Situational Context Summary presentation of the situation analysis (Dr Aye Thwin) Why the integration? How is it done? Can we have a framework for priority actions? (Mrs. Randa Saadeh) Integrating nutrition and HIV for children - a guidance note (Dr Anirban Chatterjee) Group work I: To identify <ul style="list-style-type: none"> • Opportunities and mechanisms to integrate nutrition into national/ local nutrition and HIV plans • Knowledge, resource and other gaps • Efforts to integrate nutrition into HIV and obstacles
1800-1845	Meeting of Drafting Statement Committee

Wednesday, 10 October 2007

0800-0900	Feedback from country based group work 1
0900-0930	Nutritional considerations and opportunistic infections in ART and TB treatment programmes (Dr Soumva Swaminathan)
0930-1000	How does HIV influence the treatment of severe acute malnutrition (Dr Tahmeed Ahmed)
1000-1030	<i>Tea/Coffee</i> Distribution of initial draft of Participants' Statement

- 1030-1230 Global strategy for infant and young child feeding and child survival (Mrs Randa Saadeh)
Regional perspective on infant feeding and child survival (Dr Steve Atwood)
Technical update and recommendations (Dr Peggy Henderson)
Country experience: Cambodia (Dr Koum Kanal)
Tools and resources available to help countries in implementation (Dr. Charles Sagoe-Moses)
- 1230-1400 *Lunch*
Collecting initial feedback on Participants' Statement
- 1400-1700 Thematic Group Work 2: Action Plan Development
To develop priority targets for next two years for following entry points
- Nutrition and PMTCT
 - Food security as it relates to OVCs
 - Nutrition, ART and co-morbidities (HIV, TB and Malaria)
 - Nutrition in comprehensive care including home-based care
- 1700-1800 Panel session: Resource mobilization for addressing nutrition problems in South-East Asia Region: Global Funds, US NIH, PEPFAR, UNICEF, WHO (Dr Dan Raiten & Mrs Randa Saadeh)

Thursday, 11 October 2007

- 0800-0840 Feedback from Group work 2
- 0840-0900 Statement by UNAIDS Regional Director – role of nutrition in HIV epidemic (Mr J.V.R. Prasada Rao)
Release second draft of Participants' Statement
- 0900-0910 Monitoring and evaluation on nutrition and HIV-Session overview (Ms Janine Schooley)
- 0910-0925 Monitoring and evaluation clinical issues on nutrition and HIV (Ms Louise Houtzager)
- 0925-0940 Nutrition assessment, use of data for programme development/review (Mr Simon Sadler)
- 0940-0955 Monitoring nutrition and HIV programme, use of data (Dr Robert Mwadime)
- 0955-1000 Indicators for monitoring and evaluation nutrition and HIV (Mrs Randa Saadeh)
- 1010-1020 Questions and Answers

- 1020-1100 Working groups' discussion (Ms Janine Schooley): To propose recommendations relating to
- (a) clinical quality
 - (b) programmatic performance
 - (c) advocacy/policy dialogue
 - (d) marketing/resource mobilization
- 1100-1130 *Tea/Coffee*
- 1130-1230 Nutritional care of children with HIV - a case study (Prof Nigel Rollins)
- 1230-1400 *Lunch*
- 1400-1445 Voices from the field
(Thai Red Cross/TACHIN - K. Nat Cambodian video)
- 1445-1530 Resources available. Summary of manuals/courses/guidelines to assist countries in moving forward (Mrs Randa Saadeh/Ms Sharad Agarwal)
Proposed next steps and moving forward
- 1530-1630 Review of Participants' Statement
- 1615-1630 Closing ceremony

Nutrition activities in care, support and treatment of HIV/AIDS in countries of South-East Asia Region – situation analysis

Executive summary

The HIV/AIDS epidemic continues to have a devastating impact on health, nutrition, food security and overall socioeconomic development in countries that have been greatly affected by the disease. Nutrition plays a critical role in comprehensive care, support and treatment of HIV-infected people. There are complex interactions between nutrition and HIV/AIDS. HIV progressively weakens the immune system and leads to malnutrition. Malnutrition worsens the effects of HIV and contributes to more rapid progression to AIDS. HIV also has a negative impact on food and nutrition security. In fact, the linkages between HIV/AIDS and food security are bi-directional: HIV/AIDS is a determining factor of food insecurity as well as a consequence of food and nutrition insecurity.

In May 2006, the World Health Assembly adopted resolution WHA 59.11 on Nutrition and HIV/AIDS. The resolution urges Member States to make nutrition an integral part of their response to HIV/AIDS by identifying nutrition interventions for immediate integration into HIV/AIDS programming.

An estimated 39.5 million people worldwide were living with HIV at the end of 2006. In the South-East Asia Region, an estimated **4 million** people were living with HIV at the end of 2006.

South-East Asia faces multiple and diverse epidemics occurring in different population groups and in different geographical areas at varying rates. The majority of the HIV burden in the Region is concentrated in five countries, namely: India, Indonesia, Myanmar, Nepal and Thailand. It is useful to note here that although

Bangladesh, Bhutan, Maldives, Sri Lanka, and Timor-Leste have low prevalence (<0.1%), they remain highly vulnerable to HIV infection. Long standing HIV epidemics have resulted in a large number of people living with HIV/AIDS in countries of the South-East Asia Region who need prevention, care, support and treatment services.

The Durban consultation meeting on Nutrition and HIV/AIDS in 2005 identified six important areas which require immediate consideration in care, support and treatment of HIV/AIDS people. Thus, providing early and adequate nutrition support and care may be one of the most important interventions for people with HIV. WHO and the UN community have responded in several ways to facilitate incorporation of nutrition into a comprehensive response to HIV/AIDS.

Some of the Member countries in the Region have initiated actions to incorporate nutrition care and support for HIV/AIDS. A nutrition policy workshop to strengthen advocacy for the role of nutrition interventions as part of HIV was recently organized in Bangladesh supported by WFP and other UN agencies. In Indonesia, a policy for nutrition and HIV/AIDS has been incorporated into the National Policy of HIV/AIDS. In Nepal, the National Nutrition Policy includes as one of its objectives addressing HIV transmission through breastfeeding. The national strategy on HIV/AIDS for 2006-2011 also emphasizes the importance of nutrition for HIV/AIDS.

In India, the national guidelines on infant and young child feeding revised in 2004, incorporate feeding options for HIV-infected women. In Indonesia, the 2004 National Guidelines for Care, Support and Treatment for People Living with HIV/AIDS include nutrition. In Thailand, specific guidelines for nutritional care of individuals for programme implementation at the health facility have been developed by concerned national authorities. In Timor-Leste, guidelines for infant and young child feeding have also been developed which include feeding options for mother with HIV/AIDS.

In the SEA Region, the WHO Regional Office, along with the WHO Indonesia country office, organized an Inter-country Training of Trainers workshop at Jakarta, from 4 – 7 October 2005 to provide practical knowledge about nutrition care and support and communication skills for caregivers of people living with HIV/AIDS. Subsequently, Thailand and Myanmar organized national workshops for the local staff in their country.

In India, several activities have been initiated to incorporate nutrition into HIV/AIDS programming. In 2004, WFP signed a MOU with the government to provide technical expertise in nutrition (including food) for HIV. Since 2005, the Tamil Nadu AIDS Control Society has been providing a comprehensive range of

HIV/AIDS care, support and treatment services including nutrition services through three family-centered continuums of care and ARV treatment programmes. In 2007, the Tamil Nadu Government in partnership with WFP launched the free nutritional supplement support programme for PLWHA registered at all 15 Anti-retroviral Therapy (ART) centres in Tamil Nadu. In 2007, the National AIDS Control Organization approved a programme to provide nutritional supplement to children enrolled under their ART programme in the country. Under this programme, fortified powdered supplements would be provided free of cost to children receiving ART. Since early 2007, Family Health International is leading a multipartner, five-year project known as *Balasyoga programme* to support children and families affected by HIV/AIDS in Andhra Pradesh, India. The programme includes nutrition support.

The Y R Gaitonde Centre for AIDS Research and Education (YRG CARE), a non-profit referral centre in Chennai, Tamil Nadu, provides prevention, care, treatment and support services to PLWHA and their families. The services also include nutrition counseling.

The Indonesia HIV/AIDS Prevention and Care Project, a collaborative project between the Government of Indonesia and the Government of Australia in one of its areas in Jakarta and Makassar, in South Sulawesi has incorporated nutrition intervention as part of HIV programming. It has included HIV nutrition advocacy, health and community workers and peer based nutrition education through the involvement of local community-based organizations.

Myanmar has been implementing its programmes using two approaches- PMTCT and home-based. Currently, 36 PMTCT institutions are functioning nationwide. The PMTCT mothers receive nutrition counseling on optimal infant feeding practices and feeding options for HIV mothers. Since 2004, WFP has been providing food aid for the Home-based Care (HBC) Programme in one area, which is a dry zone where malnutrition and HIV/AIDS are both highly prevalent. WFP provides family rations to around 400 beneficiary households that care for at least one chronically ill person, most of whom are HIV/AIDS patients and/or patients with tuberculosis precipitated by HIV/AIDS. Recently, WFP further extended its food aid for HIV+ people in partnership with international nongovernmental organizations.

In Thailand, the Bamrasnaradura Infectious Diseases Institute provides individual nutrition counseling for the HIV-patients who have weight loss and malnutrition problems. The Thai-Australian Collaboration in HIV Nutrition (TACHIN) project is a large project currently being implemented by the Thai Red Cross in Bangkok. TACHIN is a collaborative project between the Thai Red Cross AIDS Research Centre, Institute of Nutrition, Mahidol University and the Albion Street Centre, Australia. The project provides many nutrition interventions such as nutrition

assessment, nutrition counseling, community-based initiatives, nutrition education for health and community workers and operational research.

In Timor-Leste, integration of nutrition and HIV/AIDS programme is not recognized as a priority at this stage. One of the main reasons is that HIV/AIDS prevalence is very low.

There is a separate national policy and strategy for both nutrition and HIV/AIDS exist. However, integration of nutrition in care, support and treatment of HIV/AIDS is not recognized in any of the policy/strategy.

Some of the key constraints/challenges which countries in the South-East Asia Region face are: nutrition interventions are not well recognized as part of HIV/AIDS among policy makers and programme managers; there is lack of financial and human resources, and lack of coordination among different stakeholders. Some of the opportunities identified are: presence of many national and international NGOs working in the area of HIV/AIDS and referral hospitals for care, support and treatment of PLWHA.

Thus, it can be seen that Member countries in the South-East Asia Region are at varying stages of incorporating nutrition interventions into HIV/AIDS and ranging from advocacy to implementation of programmes. However, much remains to be done before the Member countries can fully incorporate nutrition into care, support and treatment for those infected with HIV and the affected families.

Participants' statement

There is now conclusive and compelling evidence that nutrition is essential for health and that malnutrition impacts the survival and livelihoods of adults and children living with HIV. While knowledge gaps continue to exist, these should neither confuse nor delay the immediate provision of nutritional care and support because it is well established that the benefit of providing food and nutrition support far outweighs the cost of inaction.

Recognizing the strong commitment of nations to meeting the goal of universal access to prevention, treatment, care and support and in light of the evidence supporting its role in HIV infection and its co-morbidities, nutrition must be incorporated into all aspects of prevention, care and treatment as a high priority.

Of the approximately 40 million people living with HIV/AIDS worldwide in 2006, nearly 4 million live in South-East Asia. At the same time, 79% of the world's malnourished children reside in this Region and several countries report over 40% stunting, indicating persistent chronic malnutrition. This Region, with its large and rapidly growing populations, widespread malnutrition and burden of infectious and chronic disease, is particularly vulnerable to the HIV epidemic.

In response to this vulnerability, countries from the South-East Asian Region gathered in Bangkok from 8 to 11 October 2007, together with scientists, researchers, programmers, decision makers, UN agencies, NGOs, civil society groups, caregivers, PLWHA groups, donors and bi-laterals, to review the scientific evidence, analyse current challenges and opportunities, listen to voices from the field and arrive at workable strategies for incorporating nutrition into national HIV prevention, care and treatment programmes.

This Region has long recognized the importance of nutrition as an essential component of health, and has played a leadership role aimed at the prevention, treatment and care of HIV. The challenge now is to build the complementarity of

these two historic strengths so as to ensure a comprehensive response that incorporates nutrition as an integral part of the continuum of care.

‘Nutrition care and support’ in this context should be hereafter defined broadly to include not only the provision of food and livelihood security but also the creation, and/or revision of clinical care guidelines to include nutrition, counseling, capacity building to support the integration of food and nutrition into prevention, care and treatment programmes as well as operational research to support successful implementation of such programmes. Health providers at different levels are encouraged to recognize nutrition in this broader framework.

We, the participants, recognize that:

- (1) Food and nutrition support is a critical component of a comprehensive response to HIV;
- (2) HIV compromises the nutritional status of infected people;
- (3) Malnutrition (under and over-nutrition) can worsen the effect of the disease and can make treatment less effective;
- (4) Nutrition interventions can help break this cycle by helping people living with HIV manage symptoms, reduce susceptibility to opportunistic infections and improve nutritional status;
- (5) Nutrition promotes compliance with medical treatment and improves overall quality of life;
- (6) Food insecurity and impaired nutrition increases the likelihood of HIV and co-morbidities; and
- (7) Prevention of mother-to-child transmission of HIV and overall HIV-free survival of exposed infants can be improved through appropriate infant feeding practices.

Recognizing the importance, and in many cases, the urgency of the situation, we call for stronger commitment from policy makers and donors to integrate nutrition and HIV/AIDS into existing policies and make adequate resources available.

To achieve these goals, we call for immediate action to:

- Advocate for greater awareness amongst policymakers and donors of the critical link between nutrition and HIV and the responsibility to incorporate nutrition and HIV considerations into existing national food, nutrition and HIV policies and plans;

- Increase awareness and build competency for nutritional support within the universal access for prevention, treatment, care and support programme of HIV and other co-morbidity programmes such as TB;
- Meet the nutritional needs of adults and children living with HIV according to global recommendations and mitigate the larger nutritional consequence of HIV including improving food security and livelihoods of families and communities affected by HIV;
- Review and update existing policies, programmes, plans of action and guidelines to reflect the nutritional requirements of people living with HIV/AIDS;
- Promote and support optimal infant feeding practices for all children, including those infected with HIV, and meet the nutritional needs of HIV-positive pregnant and lactating women;
- Involve adults and children living with HIV in the design and provision of nutritional support interventions and actively pursue gender equity and elimination of stigma as obstacles to food security and access to health services;
- Urgently and rapidly collect country-specific HIV and related nutritional surveillance data;
- Continue building the evidence base through bio-medical, socio-cultural and operational research;
- Ensure multisectoral coordination and adequate resource allocation;
- Call for actions and commitments at the country level and urge country teams (Ministries/UN/NGOs) to draw action plans that address these recommendations and regularly follow-up and evaluate progress, preferably every two years; and
- Make the highest level representation by UN agencies through global and regional forums such as SAARC, ASEAN, Regional Ministerial meetings, the ICN 2009, the 2008 Annual Session of the Standing Committee on Nutrition, 2008 Mexico AIDS Conference, WHO Regional Committees, World Health Assembly, UNAIDS Regional Directors' Forum and through specifically organized meetings and workshops as needed.

We, the representatives of countries, UN agencies, civil society, people living with HIV/AIDS (PLWHA), scientists and researchers, donors and bi-laterals, hereby affirm our acceptance of our respective responsibilities and commit to acting effectively and urgently to achieve our collective goals.



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