



Overseas Development Institute

Humanitarian Policy Group

**DRAFT 1**

**HIV/AIDS: the implications for humanitarian action**

**A literature review**

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## Executive Summary

### Introduction

The crisis in southern Africa during 2002 highlighted the complex interactions between HIV/AIDS, food insecurity and humanitarian action. James Morris, the UN Special Envoy to Southern Africa, argues that:

*'The HIV/AIDS situation in Southern Africa is challenging the paradigm of humanitarian assistance.'* (World Food Programme 2002)

The impact of HIV/AIDS in sub-Saharan Africa is already devastating and will continue to be so for decades to come, as demonstrated by the fact that 2.4 million Africans are estimated to have died of HIV/AIDS in 2002 alone. This report reviews the growing literature on HIV/AIDS and food security, examines where emergency relief should be situated within the wider response to the HIV/AIDS epidemic and considers how humanitarian aid agencies need to take HIV/AIDS into account in the programming of emergency aid.

### HIV/AIDS and Food Security

An understanding of the complex and diverse ways in which the epidemic affects livelihoods is necessary to begin to map the ways in which the epidemic is increasing underlying vulnerability and potentially contributing to emergencies. What the literature on food security and AIDS suggests, is the possibility of substantially increased vulnerability to other shocks, such as drought or conflict, the emergence of new types of vulnerability, the erosion of some capacities and skills for coping with shocks and adaptation and emergence of new capacities in response to these threats.

In order to capture the diversity and complexity of the interactions between HIV/AIDS and food security a clear conceptual model is needed and the report builds on existing literature to examine the interactions using the sustainable livelihoods framework. HIV/AIDS must be considered across the full spectrum of the sustainable livelihoods framework. It increases levels of vulnerability, impacts on the assets of households, affects the policies, institutions and processes that influence livelihoods, forces adaptations to livelihood strategies and results in changing livelihood outcomes. At a macro level it reduces overall levels of economic growth, erodes the ability of governments to provide public services such as health and education and may potentially impact on governance and security issues.

The HIV/AIDS epidemic in southern Africa is taking place in a context of already fragile economies. Recent work on the 2002 crisis in southern Africa suggests four main factors causing rising vulnerability in southern Africa; growth failures, market liberalisation failures, HIV/AIDS and politics and governance issues (Ellis 2003). Disentangling the relative impact of HIV/AIDS on food security in Zimbabwe from the current economic collapse, for instance, would be difficult. Perhaps the more important point is that these issues are mutually reinforcing. HIV/AIDS deepens existing vulnerabilities and underlying political weaknesses limit the ability of governments to respond adequately to HIV/AIDS.

AIDS impacts on human capital through chronic illness and death, reducing the amount of labour available to households, and adding to the burden of care for those having to look after the sick and orphans. AIDS also impacts on the ability of people to transfer knowledge from one generation to the next. Studies to date have largely focused on HIV/AIDS negative impact on agricultural production. The literature is therefore a long way from reflecting the impact of HIV/AIDS on the diverse range of activities and income sources that poor people juggle to survive.

HIV/AIDS affects financial capital by increasing household expenditure and reducing the amount of income that a household has available. The costs of illness and death include medical care, drugs, transport and funeral expenses. In order to finance these additional costs people may have to draw down their savings and sell key assets such as jewellery and livestock. Peoples' ability to pay for these additional costs is also affected as HIV/AIDS contributes to declining incomes. For example, reduced labour may lead to less income from casual labour and trading and less ability to invest in cash crops.

It can be hypothesised that, as AIDS begins to affect whole communities, social capital will begin to be overstretched. Household levels studies suggest that the majority of support that people receive following a death comes from family and friends. Research is also suggesting that the impact of HIV/AIDS is starting to be felt across whole communities. Shah et al (2002) found that the proportion of households affected by chronic sickness in villages in Malawi ranged from 22% to 64%. As the impact of AIDS spreads, community support is likely to become increasingly uneven, with poorer households being excluded, what Baylies (2002) calls, 'a safety net with holes'.

HIV/AIDS impacts on natural and physical capital through its effects on land tenure and the possible sale of key productive assets. Studies have shown that widows and orphans are particularly vulnerable to losing their access and rights to land following the death of a male head of the household.

The literature on food security and HIV/AIDS has mainly focused at the household level. However, the policies, institutions and processes that shape livelihoods are clearly a key part of the overall picture. HIV/AIDS has important macro level impacts that crucially influence individual livelihoods. By restricting economic growth, reducing government capacity and producing further declines in access to key services HIV/AIDS has clear negative impacts on the institutions that influence livelihoods.

The gender dimensions of the impact of AIDS are crucial and must form a central part of analysis and response to AIDS. In sub-Saharan Africa, women now form the majority of those living with HIV/AIDS. Women are infected on average 6-10 years younger than men and are biologically more susceptible to contracting HIV. The low social status of women in the developing world magnifies their vulnerability to being infected with HIV/AIDS and constrains their ability to deal with its impact. Many of the additional burdens of HIV/AIDS at a household level fall upon women, as they are the main producers of food and the main carers for the sick and children.

The literature has increasingly recognised that the ways in which people are dealing with the impact of HIV/AIDS has important similarities with the ways in which rural households deal with other shocks to food insecurity. These responses have traditionally been labelled as coping strategies but the HIV/AIDS literature has questioned on the grounds that people may in the end fail to cope, and that short-term survival strategies may be dangerous and undermine future livelihoods.

The relationship between HIV/AIDS and food security is two way. HIV/AIDS impacts on food security and food insecurity can increase the risks of HIV/AIDS transmission. Food insecurity increases vulnerability to HIV/AIDS at several levels. At a biological level there is a vicious circle between HIV/AIDS and malnutrition, with malnutrition increasing the risks of HIV/AIDS transmission. At the household level food insecurity can increase vulnerability by putting people at additional risk, for example through distress migration or erosive coping strategies such as transactional sex.

The complex series of ways in which HIV/AIDS interacts with livelihoods and contributes to food insecurity are magnified in conflict situations. The limited literature has focused on the increased risks of HIV/AIDS transmission through displacement and sexual violence. Increased vulnerability to food insecurity from HIV/AIDS is likely to present a greater threat to livelihoods in wars due to the undermining and restriction of coping strategies that takes place in conflicts.

The literature and understanding of how HIV/AIDS impacts on livelihoods is at an early stage. There is starting to be a strong body of evidence that HIV/AIDS has severe negative consequences on livelihoods but many key gaps remain in our knowledge. Table 1 summarises impact of HIV/AIDS, the coping strategies adopted and possible responses that emerge from the literature within the sustainable livelihoods framework.

## Impacts of AIDS on livelihoods using a sustainable livelihoods framework and possible responses

Sources of household Capital	Impact	Coping / Survival Strategies	Possible Interventions to Support Livelihoods encompassing relief and development
<p><i>Human Capital</i></p> <p>Represents the skills, knowledge, ability to labour and health that together enable people to pursue different livelihood objectives.</p>	<p><i>Reduced labour availability</i> People get sick reducing the amount they are able to work Other household members have to care for the sick. Funeral attendance Additional care pressures in looking after orphans Death permanently reduces the amount of labour in the household and may increase the dependency ratio. Growing burden on the elderly to care for sick and orphans and to continue to generate income.</p> <p><i>Impact of reduced labour</i> Less time for the households own production, leads to lower productivity and declining agricultural production. Less ability to undertake casual labour, paid employment, gathering of wild foods and other income generating activities. Less time for other key activities such as social capital generation</p> <p><i>Knowledge</i> Death of adults damages transfer of knowledge between generations Children withdrawn from school learn less. Key agricultural knowledge may be lost, especially where gender divisions of labour are strict.</p>	<p><i>Agricultural Adaptations</i> Shift to less labour intensive crops Reduction in range of crops per household Decrease in area cultivated / more land left fallow Use of labour saving technologies if available Better off families may hire labour or replace labour with technology. Withdrawal from marketing into pure subsistence Grain saving schemes</p> <p><i>Coping with less labour</i> Withdraw children from school as they are needed to work. Increased reliance on labour of orphans Relocation of household members to wider social networks, such as sending children to live with relatives. Diversification of activities to ones that demand less labour Relying on the elderly, children and extended family networks to cover for ill or deceased household members Bringing new members into the household. Labour sharing schemes</p> <p><i>Adaptation to loss of knowledge</i> May have to cease growing certain crops; for example cash crops that only men knew how to market or wild foods that only women knew where to collect.</p>	<p>R&amp;D into low input, low labour crops. Changes in agricultural extension to promote adaptation and to adjust to new target groups Training / support to livelihood diversification Promotion of light ploughs, labour saving technology Marketing support – e.g. to widows to help them market cash crops. Basic health care including treatment for opportunistic infections and ARVs Nutrition programmes to treat HIV/AIDS related malnutrition.</p> <p>Agricultural input programmes including seed and tool distributions that reflect new cropping systems. Labour intensive public works that cater for the chronically sick. School feeding Support for paying or waiver of school fees Home based care and orphan support programmes Food aid that is nutritionally balanced and provides sufficient protein, fat and micronutrients</p> <p>Innovative responses to the growing number of orphans such as community schools, radio listening groups, apprenticeships and vocational training.</p>
<p><i>Financial Capital</i></p> <p>The financial resources that people use to achieve their livelihood objectives – including flows (income) and stocks (savings).</p>	<p><i>Additional Expenses – Spending More</i> Costs of treatment for sick household members (transport to health facilities, drugs etc.) High cost of funerals More people to feed if number of orphans taken in are greater than number of deaths.</p> <p><i>Reductions in Household Income – Earning Less</i> Loss of remittances due to sickness or death of relatives Loss of access to credit as affected households are considered higher risk by lenders Less able to grow cash crops due to lack of funds for inputs, less willingness to take on risk, less labour or skills for marketing. Reductions in livestock assets due to distress sale or slaughter</p>	<p><i>Coping / Adapting by Spending less</i> Eating less, reductions in quality of food being eaten. Use of purchased inputs (seed, fertiliser) are reduced. Avoid use of formal health care system</p> <p><i>Coping / Adapting by finding other income sources</i> Drawing down savings. Going into debt Selling assets such as jewellery, livestock, household goods Finding new income generating activities – such as transactional sex. Some household members migrate to look for work. Begging, relying on help from friends and relatives, attempting to access outside help (relief, home based care). Participate in informal institutions such as savings or burial clubs Sale or rental of land</p>	<p>Better governance – reduced tax burden, less corruption, better resource allocation</p> <p>Cash grants for HIV/AIDS affected households Safety net employment provision adapted to labour restrictions of affected households. Agricultural input grants or subsidies. Livestock interventions such as restocking. Support for income generation activities.</p> <p>Support to Micro-finance institutions that offer products suitable to affected households. Support to savings clubs, ROSCAs Waiver of school fees, health care user fees. Increase in pensions, safety net support, free health care for the elderly.</p>

Sources of household Capital	Impact	Coping / Survival Strategies	Possible Interventions to Support Livelihoods encompassing relief and development
<p><i>Social Capital</i></p> <p>The social resources on which people draw in pursuit of their livelihood objectives. Networks and connectedness Membership of more formalised groups. Relationships of trust, reciprocity and exchange</p>	<p><i>Institutions / Organisations</i></p> <p>Institutions (churches / CBOs) are weakened by deaths and illness. Increased risk of default may weaken informal credit institutions and reduce access to credit and savings for chronically ill. Risk that institutions will become more exclusive, possibly stigmatising those with HIV/AIDS.</p> <p><i>Customs, rules and practice</i></p> <p>Traditional customs governing remittances are over-burdened Child adoption customs are over-burdened Households cannot fulfil customary roles during other shocks to food security (e.g. sharing between kin during drought) Land tenure is inadequate to address needs for example of widows and orphans. Rich households are equally affected and so are less able to play key social support roles. Reversal of urban-rural support networks</p>	<p><i>Institutional Adaptation</i></p> <p>Some evidence that new institutions are emerging to address AIDS Adaptation of existing institutions to address HIV/AIDS</p> <p><i>Changing Customs / Practices</i></p> <p>Funeral practices change to lessen costs and reduce time commitment Orphan care left to the elderly, emergence of child headed households.</p>	<p>Support to civil society institutions and CBOs that are responding to the epidemic.</p> <p>Promote changes to customary land tenure that strengthen rights of vulnerable groups such as widows and children.</p> <p>Promote adaptations to customs and institutions governing participation in markets – eg allowing widows to market cash crops.</p> <p>Supporting changes to customs and practice – e.g. transformation of gender roles, gender empowerment.</p>
<p><i>Natural Capital</i></p> <p>The natural resource stocks from which resource flows and services are derived (trees, land)</p>	<p><i>Land tenure</i></p> <p>Widows and orphans lose title to land due to lack of secure land tenure</p> <p><i>Land use / Farming systems</i></p> <p>Farming systems and land use patterns change Common property assets such as rangeland are not maintained. Compromising critical land conservation and soil protection activities, leads to further reductions in productivity.</p>	<p>Sale, mortgaging or rental of land to generate income. Changing cropping patterns. Remarriage to gain access to a new piece of land. Involuntary celibacy to gain permission of in-laws to retain use of late spouses' land. Acceptance of the practice of wife inheritance</p>	<p>Changing rules governing land tenure to strengthen rights of widows and orphans.</p> <p>Strengthening land rights and flexibility of land use laws – e.g. making it easier for households to sub-let and mortgage land when they can no longer farm it without losing title.</p>
<p><i>Physical Capital</i></p> <p>The basic infrastructure and producer goods needed to support livelihoods (water, transport, shelter)</p>	<p>Sale of productive equipment (draught animals, plows) Sale or slaughter of livestock Productive assets such as irrigation systems or grain storage are not maintained. Household assets are not maintained (roofing, household items) or replaced when needed. Less time available for fuel collection</p>	<p>Distress sales of livestock, key productive assets. CBOs that carry out house repairs for affected families</p>	<p>Provision of key non-food items during emergencies in addition to food aid. Water and sanitation interventions take into account restricted mobility and labour of affected households. Support to CBOs in activities such as house repair</p>

## **HIV/AIDS and Humanitarian Crises**

Is the growing vulnerability to food insecurity caused by HIV/AIDS a development or a relief problem? The HIV/AIDS epidemic requires us to re-examine our understandings of famine, emergencies and development. The devastating impact of HIV/AIDS will be felt for decades and there is clearly a need for both humanitarian and development assistance in mitigating its impact.

There is therefore a need for clarity in understanding where humanitarian aid fits within the wider response to HIV/AIDS. In the nascent literature on HIV/AIDS and emergencies it is possible to distinguish four main arguments:

1. The argument that HIV/AIDS in and of itself should be seen as an emergency issue worthy of a relief response due to the devastating impact it is having on mortality, morbidity and livelihoods.
2. The argument that the HIV/AIDS epidemic is an additional shock to livelihoods that has greatly increased the food insecurity of people making them more vulnerable to other shocks. There is therefore a possibility that natural and complex disasters will start earlier, last longer and be triggered more easily. The humanitarian community will need to adjust its way of doing business to take this hugely increased vulnerability to shocks into account.
3. The argument that the impact of HIV/AIDS on livelihoods means that some form of safety net or welfare system will be needed for those worst affected. At the same time development processes will need to mainstream HIV/AIDS issues in devising appropriate mitigation strategies. Relief will be needed as a long-term safety net in conjunction with other, more development orientated interventions.
4. HIV/AIDS can be seen as threatening a descent into permanent or periodic crisis in which underlying vulnerability is so great that there is a permanent emergency or chronic crisis, similar to that previously only seen in long running conflicts. This is the argument put forward by De Waal that the HIV/AIDS epidemic is causing or will cause 'new variant famines'. The impacts of HIV/AIDS are so devastating that we are facing, 'a new kind of acute food crisis in which there is no expectation of a return to either sustainable livelihoods or a demographic equilibrium'.

None of these positions are necessarily mutually exclusive. Long-term safety nets may be needed for those worst affected by HIV/AIDS, emergencies resulting from other shocks will need to take the underlying vulnerability of AIDS into account and, as the impact of AIDS mounts, the possibility of chronic crisis will grow.

The HIV/AIDS epidemic can be seen as further blurring the distinction between emergencies and development. It fulfils some of the traditional criteria for an emergency – massively increased mortality and morbidity. However, emergencies have traditionally been seen as short term crises and the fact that the impact of HIV/AIDS will be felt for decades makes defining it as an emergency problematic.

The impact of HIV/AIDS in southern Africa has led to renewed calls for stronger links between relief and development. WFP (2003) argue that ‘although HIV/AIDS requires an emergency response, such as response must be based on a long term approach.’ A recent workshop in southern Africa on AIDS and emergencies concluded that, ‘interventions in any community should always combine development, relief and rehabilitation aspects.

The last decade, however, has seen a series of important criticisms of the linking relief and development debate. Macrae (2001) argues that preserving the distinction between humanitarian and development aid is crucial to maintaining the integrity and efficacy of both forms of aid, as they often have different objectives and starting points. Linking relief and development also risks a creeping acceptance of higher levels of vulnerability, malnutrition and morbidity.

These criticisms have usually been made in the context of long running conflicts. However, they have some relevance to the question of how relief and development aid mechanisms should interact in the response to HIV/AIDS. Firstly, there is the argument that because the HIV/AIDS epidemic is starting to create growing levels of vulnerability, mortality and morbidity it too brings with it a risk of creeping acceptance and a process of normalisation. If these growing levels of mortality and morbidity become accepted as ‘normal’ and addressed within a development framework there is a danger of failing to address real human distress and provide what could be called either emergency relief or social support, that is not sustainable and represents a long term welfare commitment.

Secondly, even in countries that are not currently in conflict, there may be a need for humanitarian aid that is depoliticised and maintains key principles of neutrality and impartiality. Certainly, this is true in Zimbabwe where the current political crisis has led to the suspension of most forms of development assistance.

The issue, therefore, is not as straightforward as thinking of ways that relief and development can be better linked in the response to HIV/AIDS. There are strong arguments for maintaining the distinctiveness of humanitarian aid. This does not mean, however, that ways for the development and relief systems to interact more constructively cannot be suggested. This could take several forms;

- A recognition on the part of the development aid system and national governments that HIV/AIDS is likely to exacerbate and prolong crises and may lead to permanent low level crises that will require emergency response. The development system therefore needs to become more willing to accept the need for resources to be committed to relief or social protection and better at identifying and responding to crises (early warning).
- Donors and governments could accept that there is a need for resources to be committed to long-term welfare or social protection support in the worst affected countries as part of development funding.
- The humanitarian aid system could inform the development of long-term social protection systems by bringing to bear expertise in areas such as targeting, distribution of inputs and delivery systems.

- The humanitarian aid system could endeavour to improve the ways in which it links with ongoing development activities, governments and civil society whilst maintaining impartiality and distinctive modalities.

Whatever label is attached to emergencies in the context of an HIV/AIDS epidemic (new variant famine, chronic crisis, emergency or development problem) it is clear that aid agencies must take HIV/AIDS into account, both in terms of policy and practical programming approaches.

## **Humanitarian Programming**

This report takes a preliminary look at the experience of the international community in dealing with the links between HIV/AIDS and acute food insecurity in southern Africa. It will be built upon following field work in southern Africa.

The southern Africa crisis raises a series of practical questions around the programming of humanitarian aid in the context of an HIV/AIDS epidemic. For example, do areas such as assessment, targeting and service delivery need to be adapted? The ongoing relief operation in southern Africa has left humanitarian agencies grappling at the field level with these questions. Practitioners on the ground have had to forge ahead with developing tools such as assessment and targeting methodologies but this practice remains largely within a grey literature of project documents and reports.

The challenge for humanitarian agencies is to mainstream HIV/AIDS issues throughout the programming cycle, what Gillespie and Loevinsohn (2003) call an 'HIV/AIDS lens.' Oxfam (2002) usefully defines mainstreaming as, 'how an organisation and the programmes it delivers must change in order to take account of the changing context that has been caused by the pandemic.' The crucial gender dimensions of AIDS means that mainstreaming AIDS also implies the need for humanitarian aid to continue to strive to be gender sensitive in programme delivery.

The report highlights ways in which HIV/AIDS needs to be addressed throughout the programme cycle and across various sectors. This includes the addition of HIV/AIDS prevention and awareness campaigns for staff and beneficiaries attached to relief distributions and the design of programmes to minimise the risks of HIV/AIDS transmission. Emergency assessment procedures and early warning systems will also need to be adapted, to take HIV/AIDS into account and baseline indicators for malnutrition and mortality may need to be revised. The question of how to target households affected by HIV/AIDS without adding to the stigma that they may be facing is a difficult and critical point. Agencies have attempted to address this by working with existing community based organisations but this raises further difficult issues about scale and capacity.

The response to the southern Africa crisis overwhelmingly focused on food aid and so this provides the main body of experience. People affected by HIV/AIDS may require different types of food aid. The decreased mobility of households affected by HIV/AIDS suggests that additional efforts may need to be made to reach them. Food for work programmes may also have to be adapted to take into account the labour constraints of affected households and allow the elderly and sick adults to participate.

The fact that HIV/AIDS prevalence rates are higher in urban areas may also require aid agencies to consider urban and peri-urban food insecurity. The combination of HIV/AIDS and economic collapse in Zimbabwe is starting to produce some relief programmes targeting urban areas. HIV/AIDS also produces a number of challenges for nutrition programmes. These include the increased risks of cross transmission of infectious diseases in therapeutic centres due to weakened immune systems, higher case fatality rates, the need for children with HIV/AIDS to stay in centres for longer periods and the need to address adult malnutrition. These new factors may reinforce the arguments for moving towards home based models of care, where possible.

Support to health systems was a comparatively neglected issue in the southern Africa crisis. The most likely explanation for this neglect is that support to the health sector is seen as a long-term development problem that is not amenable to a short term response in the same way as food aid. However, there is a clear need for health care during emergencies in the context of an HIV/AIDS epidemic. Just as the impact of HIV/AIDS on food security implies the need for long term welfare provision, it also implies the need for long-term and more adequate support and financing for health care systems.

HIV/AIDS affects peoples livelihoods in complex and diverse ways and food aid is clearly not the only possible response. In agricultural support programmes the HIV/AIDS epidemic suggests a need to re-visit the types of packages that are being provided. There has been little experience in 2002 and 2003 in southern Africa with alternative interventions to support livelihoods such as cash grants. This may be an important avenue for further investigation, given that many of the immediate impacts of HIV/AIDS are financial.

The long-term nature of the HIV/AIDS epidemic, and the need for long-term relief or welfare assistance, raises the question of the most appropriate providers of assistance. The relief response in southern Africa was dominated by international aid agencies, with national governments much less involved than in 1991/92 and national NGOs marginalised because of the vast scale of the regional response and questions of capacity. However, long-term welfare needs certainly implies a need for international aid agencies to make increased efforts to engage with local capacity.

Many of the key questions relating to how to provide assistance in the context of an HIV/AIDS epidemic remain unanswered and good practice is only beginning to develop. Box 1 sets out a series of very preliminary general principles based on experience to date.

## **Preliminary Principles for Humanitarian Programming in the Context of an HIV/AIDS Epidemic**

1. Aid agencies should endeavour to analyse and understand the complex ways in which HIV/AIDS is affecting peoples' livelihoods and how people are responding to these challenges.
2. HIV/AIDS is a long-term crisis. Humanitarian aid has a role to play in the response to the crisis, but agencies should recognise that it is only part of a wider response and be clear about what humanitarian aid can and can't achieve.
3. Humanitarian agencies need to mainstream consideration of HIV/AIDS issues throughout the programme cycle and across the different sectors of response.
4. Early warning systems and assessments need to incorporate analysis of HIV/AIDS. This should include attempts to disaggregate prevalence rates at local levels. Agencies should also attempt to gauge the severity and scale of the wider impact of HIV/AIDS on food insecurity.
5. Additional research is needed to examine the impact of HIV/AIDS on key indicators of crisis, such as underlying mortality and malnutrition rates.
6. The emergence of new types and areas of vulnerability due to HIV/AIDS should be considered in assessment and targeting. In particular, food insecurity and vulnerability in urban and peri-urban areas may need to be assessed.
7. Targeting people affected by HIV/AIDS as part of a relief response will need to remain sensitive to the possibility of increasing levels of stigma and discrimination.
8. The HIV/AIDS epidemic reinforces the existing need for humanitarian programmes to be gender sensitive. This should include attempts to involve both men and women in decision making, for risks of sexual violence and the need for protection to be recognised and for agencies to strive for gender transformative or empowering approaches where possible.
9. Emergency interventions must aim to ensure that they do not increase peoples' vulnerability and susceptibility to HIV/AIDS. Prevention and awareness activities should be integrated into humanitarian programmes. Programme design must include assessment of ways to minimise vulnerability to HIV transmission.
10. Food aid in the context of HIV/AIDS epidemics should consider the appropriateness of existing ration sizes and types of food. Issues of the number of distribution points, distances people have to travel, time they have to wait and amounts they have to carry should also be considered in the light of additional HIV/AIDS related vulnerabilities.
11. Labour intensive public works programmes (cash or food for work) should consider the needs of labour constrained and elderly headed households and the chronically ill.
12. HIV/AIDS issues should be addressed in the design of nutrition programmes. HIV/AIDS may reinforce the case for a move to community based programmes where possible and away from centre based therapeutic feeding.
13. HIV/AIDS reinforces the need for humanitarian response to include access to basic health care and treatment.
14. Support to livelihoods in emergencies may also include cash grants, support to agricultural production and distribution of non-food items. Broader support to livelihoods may be particularly appropriate in the context of an HIV/AIDS epidemic due to the complex and diverse ways in which AIDS impacts on livelihoods.
15. Support to agricultural production such as support to seed systems needs to recognise adaptations that households are making in response to HIV/AIDS.
16. HIV/AIDS requires a commitment on the part of donors and governments to long-term welfare provision. Aid agencies should endeavour to link humanitarian aid programming where possible to the development of local capacity for long-term welfare provision.

# **HIV/AIDS: what are the implications for humanitarian action?**

## **A Literature Review**

### **1 INTRODUCTION**

The crisis in southern Africa during 2002 highlighted the complex interactions between HIV/AIDS, food insecurity and humanitarian action. James Morris, the UN Special Envoy to Southern Africa, argues that:

*'The HIV/AIDS situation in Southern Africa is challenging the paradigm of humanitarian assistance.'* (World Food Programme 2002)

The impact of HIV/AIDS in sub-Saharan Africa is already devastating and will continue to be so for decades to come, as demonstrated by the fact that 2.4 million Africans are estimated to have died of HIV/AIDS in 2002 alone. The scale of the epidemic, and the impact of the HIV/AIDS epidemic on livelihoods, poses a series of challenges to the international aid system. Conventional definitions of emergency and development assistance and the architecture of aid delivery may need to be re-examined. There will clearly be a need for both humanitarian aid and development assistance in mitigating the impact of HIV/AIDS and therefore a need for clarity in understanding where emergency relief should be situated within the wider response to the HIV/AIDS epidemic.

There is a growing literature on the impact of HIV/AIDS on food security. An understanding of the complex and diverse ways in which the epidemic affects livelihoods is necessary to begin to map the ways in which the epidemic is increasing underlying vulnerability and potentially contributing to emergencies such as the recent crisis in southern Africa. This report reviews this literature in Section 2 and draws on existing work to demonstrate how the impact of HIV/AIDS can be conceptualised using the sustainable livelihoods framework.

Is the growing vulnerability to food insecurity caused by HIV/AIDS a development or a relief problem? Section 3 reviews the nascent literature on AIDS and emergencies and revisits the long and somewhat tortuous debates about linking relief and development in the context of the HIV/AIDS epidemic. It distinguishes four main arguments;

5. The argument that HIV/AIDS in and of itself should be seen as an emergency issue worthy of a relief response due to the devastating impact it is having on mortality, morbidity and livelihoods.
6. The argument that the HIV/AIDS epidemic is an additional shock to livelihoods that has greatly increased the food insecurity of people making them more vulnerable to other shocks. There is therefore a possibility that natural and complex disasters will start earlier, last longer and be triggered

more easily. The humanitarian community will need to adjust its way of doing business to take this hugely increased vulnerability to shocks into account.

7. The argument that the impact of HIV/AIDS on livelihoods means that some form of safety net or welfare system will be needed for those worst affected. At the same time development processes will need to mainstream HIV/AIDS issues in devising appropriate mitigation strategies. Relief will be needed as a long-term safety net in conjunction with other, more development orientated interventions.
8. HIV/AIDS can be seen as threatening a descent into permanent or periodic crisis in which underlying vulnerability is so great that there is a permanent emergency or chronic crisis, similar to that previously only seen in long running conflicts. This is the argument put forward by De Waal that the HIV/AIDS epidemic is causing or will cause 'new variant famines'. The impacts of HIV/AIDS are so devastating that we are facing, 'a new kind of acute food crisis in which there is no expectation of a return to either sustainable livelihoods or a demographic equilibrium'.

None of these positions are necessarily mutually exclusive. Long-term safety nets may be needed for those worst affected by HIV/AIDS, emergencies resulting from other shocks will need to take the underlying vulnerability of AIDS into account and, as the impact of AIDS mounts, the possibility of chronic crisis will grow.

Whatever label is attached to emergencies in the context of an HIV/AIDS epidemic (new variant famine, chronic crisis, emergency or development problem) it is clear that aid agencies must take HIV/AIDS into account, both in terms of policy and practical programming approaches. This is the subject of Section 4, which aims to summarise the lessons learnt by the humanitarian community in dealing with the links between HIV/AIDS and acute food insecurity from the crisis in southern Africa and suggest possible avenues for future good practice. This is based on a review of the growing grey literature resulting from the southern Africa crisis and initial interviews and correspondence with aid agencies. Further field-work will be conducted in southern Africa to build on this preliminary work.

## **2 HIV/AIDS AND FOOD SECURITY: a critical literature review**

### **2.1 Introduction**

This section reviews the literature on HIV/AIDS on food security. It briefly highlights the dimensions of the epidemic and presents a sustainable livelihoods conceptual framework for understanding the impact of HIV/AIDS on food security.

It is important to understand what the existing literature can tell us and what it can't and to situate the existing work on impact into a clear theoretical framework in order to adequately begin to think about the interactions between AIDS, livelihoods and emergencies. How we perceive, define and explain the problem to an extent dictates the types of response, and whether they are classified as emergency or development assistance.

What the literature on food security and AIDS suggests is the possibility of substantially increased vulnerability to other shocks such as drought or conflict, the emergence of new types of vulnerability and vulnerable groups, the erosion of some capacities and skills for coping with shocks and the emergence of new capacities in response. By considering the full range of ways in which AIDS is impacting on peoples' livelihoods, the analysis will suggest the need to consider a wide range of possible responses. The danger of restricting the analysis to one particular area, for example the impact of AIDS on agricultural smallholder production, is that it potentially restricts the range of possible ways of mitigating impact and supporting livelihoods.

The illness and death that result from HIV/AIDS have a serious impact on the livelihoods of affected households. As prevalence rates climb, the negative impact of HIV/AIDS on livelihoods is increasingly felt across whole communities. Research on the complex ways in which HIV/AIDS impacts on livelihoods is, however, at an early stage and many gaps remain in our knowledge. In order to capture the diversity and complexity of the interactions between HIV/AIDS and food security a clear conceptual model is needed. This section builds on existing literature to examine the interactions using the sustainable livelihoods framework.

An increasing body of research has demonstrated the profound effects that HIV/AIDS is having on livelihoods in sub-Saharan Africa. This literature on HIV/AIDS and food security has been developing rapidly in the last few years. Several useful summaries of it exist (White and Robinson 2000; Barnett and Whiteside 2002; Baylies 2002; Haddad and Gillespie 2001). Thus far the literature on HIV/AIDS and food security has focused almost exclusively on sub-Saharan Africa, with a few studies in Asia. This review will also focus on Africa.

There is a two way relationship between HIV/AIDS and livelihoods. HIV has an impact on peoples' livelihoods, reducing food security through illness and death. Peoples' food security and livelihood options also contribute to risks of and resistance to HIV. The main focus of this section will be on the first part of this relationship. The

second part has been well summarised elsewhere (Gillespie and Loevinsohn 2003) and will be briefly summarised in this report in section 2.10.

This section summarises what the literature can tell us about food security and HIV/AIDS but also what its limitations are. Several key points should be noted at the start. First, that the impact of HIV/AIDS is characterised by diversity, so care should be taken not to extrapolate the results of individual studies, to the whole of sub-Saharan Africa. Second, that many gaps remain in our knowledge. These include the impact of AIDS on urban and peri-urban food security, and the impact of AIDS on livelihood systems other than rural subsistence farmers (such as pastoralists, and commercial farm workers). Also, the extent to which the epidemic is affecting whole communities, as well as individuals and the ways in which impact is differentiated between different livelihood groups and different regions of countries. The literature on HIV/AIDS and food security largely focuses on countries at peace and does not consider the interactions between HIV/AIDS and conflict. A largely separate literature does consider conflict and this will be briefly discussed in section 2.11.

Most of the literature depends on quantitative economic household studies. These have a number of important limitations. The focus on the household does not capture community level impact, one off surveys may miss households that dissolve and so underestimate impact, and surveys tell us little about the processes of impoverishment. The economic focus of most studies has also largely ignored the political economy of HIV/AIDS. As De Waal (2002) points out some households may also be benefiting from HIV/AIDS, through for example acquiring land from vulnerable widows or orphans or by benefiting from additional labour from older orphans. Increased mortality may lead wages to rise. A study in Botswana (BIDPA 2000) predicted that those who survive may have higher incomes per head.

## **2.2 The dimensions of the epidemic**

The HIV/AIDS epidemic is often described as a long-wave crisis that will last for decades. Its impact is already huge and is rapidly increasing. UNAIDS (2002) estimate that 28.5 million adults and children live with HIV/AIDS in Africa and that 2.4 million Africans died of AIDS in 2002 alone. Comparing this level of mortality to other disasters is difficult as mortality figures are notoriously inadequate in emergencies. However, IRC's estimate of excess mortality of 3.3 million in the Democratic Republic of Congo from 1998 to 2002 provides one point of comparison. The scale of the epidemic raises the question about whether or not HIV/AIDS is a disaster in its own right meriting an emergency response. This will be considered in section 3.

Table 1 summarises the latest figures on HIV/AIDS for southern Africa. Prevalence rates in southern Africa are the highest in the world and have already risen above thresholds of what was once thought possible (30%). The impact on society can be seen in the massive numbers of AIDS deaths now taking place annually and the growing numbers of children orphaned. Almost 15 million people in southern Africa were living with HIV at the end of 2001 and an estimated 1.1 million died of AIDS (UNAIDS 2002). It is clear that these figures have major implications for the ways in which people in Africa secure, or fail to secure their livelihoods

**Table 1: AIDS figures for Southern Africa in 2001**

	Estimated number of people living with HIV/AIDS 2001			AIDS orphans 2001	New AIDS deaths 2001
	Total	Adults	Adult Rate		
Zimbabwe	2,300,000	2,000,000	33.7%	780,000	200,000
Zambia	1,200,000	1,000,000	21.5%	670,000	120,000
Mozambique	1,100,000	1,000,000	13%	420,000	60,000
Malawi	850,000	780,000	15%	470,000	80,000
Lesotho	360,000	330,000	31%	73,000	25,000
Swaziland	170,000	150,000	33.4%	35,000	12,000

Source: UNAIDS Report on the Global Epidemic 2002

These aggregate figures hide huge variations both within and between countries. As Ngwira (2002) argues, 'Infection rates and trends are sometimes found to vary dramatically sometimes over quite short distances.' This is illustrated by table 2 which shows HIV prevalence rates by province in Zimbabwe.

**Table 2: HIV Prevalence Rates by Province in Zimbabwe (women 15-49 years in ante-natal clinics)**

Province	HIV%
Mashonaland Central	19.1%
Mashonaland East	34.7%
Mashonaland West	25.6%
Midlands	46.2%
Masvingo	42.7%
Manicaland	17.7%
Matabeleland South	33.6%
Matabeleland North	28.2%

Source: Ministry of Health 2002, based on data from 2000

HIV prevalence rates only present part of the story of the impact of HIV/AIDS. Barnett and Whiteside (2002) describe HIV/AIDS as a 'long wave event' the impact of which takes place over many decades and see HIV/AIDS impoverishment as an event that will last as long as a century. They point out that; 'by the time the wave of HIV infection makes itself felt in the form of AIDS illnesses in individuals, the torrent of the epidemic is about to overwhelm medical services, households, communities.' (Barnett and Whiteside 2002: 16).

A key question for assessing the likely impact of HIV/AIDS on food security is the stage that the epidemic has reached in particular countries and indeed districts within countries. Often overall prevalence rates of HIV/AIDS are the only figures available but it is the number of HIV infected people that have developed full blown AIDS

rather than just the prevalence rate that is most important in considering the impact on food security and livelihoods.

The case of Ethiopia in particular points out the need to also refine the concept of AIDS impact. It is argued that although Ethiopia has high adult prevalence rates, HIV/AIDS still has a relatively low impact at population or community wide levels, especially in remote rural areas and that, therefore, the impact of AIDS on the current food security crisis is relatively small (Topouzis pers comm). Similarly, recent work in Zambia, looking at the contribution of AIDS to the crisis in 2002 has emphasised that rural prevalence rates are relatively low, at around 11% compared to 23% in urban areas (Zambia VAC 2003; Scott and Harland 2003).

#### **Box 1: Phases of HIV infection**

**Acute Infection:** HIV causes symptoms of acute infection (such as fever and body ache) that clear up spontaneously, generally within 1 to 6 weeks after infection.

**Seroconversion:** An individual undergoes seroconversion when the body begins to produce antibodies to HIV, which generally takes place 6 to 12 weeks after HIV infection.

**Asymptomatic period:** In most cases there is usually a prolonged period (several years) when an infected person feels well and has no symptoms of infection.

**Early symptomatic infection:** During this period, the first symptoms of a weakened immune system occur.

**Late symptomatic infection:** This stage officially constitutes the condition called AIDS.

In industrialised countries, the average length of time between HIV infection and AIDS diagnosis is 8 to 10 years. In developing countries this may be shortened by exposure to pathogens and infectious diseases, poor health care and malnutrition.

Source: Piwoz and Preble 2000: 4

### **2.3 Conceptual Frameworks for Understanding HIV/AIDS and Livelihoods**

Different theoretical and conceptual frameworks and literatures are being drawn upon to understand the impact of HIV/AIDS on food security. The most commonly used framework is the sustainable livelihoods framework (Stokes 2003; Gillespie and Loevihnsohn 2003; Haddad and Gillespie 2001). The HIV/AIDS and food security literature has also drawn heavily on the extensive literature on coping strategies (Corbett 1988; Davies 1996).

The focus of the literature on HIV/AIDS and food security has tended to be on the impact of AIDS on household assets (financial, human, natural, physical and social). For example; 'Each of the five capital assets – human financial, natural, social and physical capital is demonstrated to be impacted by the epidemic. The framework views even the poorest households as possessing assets that allow them to adjust to shocks'. (Stokes 2003: 2).

This section argues that the sustainable livelihoods framework does provide a useful conceptual model for considering the complex interactions between HIV/AIDS and livelihoods. It suggests the various ways in which HIV/AIDS needs to be considered within the framework and argues that we need to look beyond the impact on household assets to consider how AIDS is affecting vulnerability, policies, institutions and processes and livelihood strategies. The focus will mainly be on the impact of HIV/AIDS on food security at the household and to a lesser extent the community level. Clearly, HIV/AIDS also has impacts at the macro level. There is a large literature on the impact of HIV/AIDS on overall levels of GDP growth, a small literature on its impact at a sectoral level in areas such as health, education and ministries of agriculture and a developing literature on its potential impact on governance and security. These macro level impacts will be briefly considered in a section on policies, institutions and processes that influence livelihoods.

The sustainable livelihoods framework itself builds on earlier approaches referred to as the 'asset vulnerability framework (Swift 1989; Moser 1998). DFID summarise the framework as follows:

*'The framework views people as operating in a context of vulnerability. Within this context, they have access to certain assets or poverty reducing factors. These gain their meaning and value through the prevailing social, institutional and organisational environment. This environment also influences the livelihood strategies – ways of combining and using assets – that are open to people in pursuit of beneficial livelihood outcomes (DFID 1999).'*

Figure 1 attempts to show diagrammatically how AIDS could be considered throughout the sustainable livelihoods framework.

Firstly, HIV/AIDS affects the vulnerability context for households and communities. For an individual household, HIV/AIDS can be seen as a shock, in which illness and death increase the vulnerability of the household. Stokes (2003) argues that HIV/AIDS represents an extreme source of livelihood and food insecurity shock that requires multiple adjustments on the part of farm households to this threat to their survival (Stokes 2003). This is where the effects of illness have traditionally been placed with the framework. For example, the DFID (1999) sustainable livelihoods guidance sheets list human health shocks as one of the aspects of the vulnerability context.

AIDS is unusual in that the impact of illness and death is not a short or a sudden shock but continues over the long term for both households, as more family members become sick, and for communities. HIV/AIDS can also therefore be seen as a trend in increasing vulnerability over the long term, for example through worsening dependency ratios or diminishing economic opportunities. As Barnett and Whiteside (2002) argue, 'it is useful to begin thinking about impact as a continuum between a sharp shock and slow and profound changes'. HIV/AIDS can also impact on seasonality, the third leg of the vulnerability context. For example, a deepening trend of vulnerability may extend the hungry season for poor households.

The shock of HIV/AIDS and the trend of deepening vulnerability due to HIV, impacts on peoples' livelihood assets. This is how the impact of HIV/AIDS has usually been described in the existing literature on HIV/AIDS and food security. The range of possible impacts on human, financial, social, natural and physical capital are summarised in table 2 and discussed in more detail below.

HIV/AIDS also needs to be considered in the context of the box on policies, institutions and processes in the sustainable livelihoods framework. HIV/AIDS has impacts on government, private sector and civil society structures and customs, culture and practices. There is a developing literature showing the extent to which HIV/AIDS is eroding the capacity of governments to deliver social services such as health and education, especially in rural areas (Topouzis 2003; Bollinger and Stover 1999) Mutagandura (1999) has shown how civil society institutions are both weakened by HIV/AIDS but are also adapting to the impacts of the epidemic. HIV/AIDS also affects customs and culture and in response to AIDS funeral, inheritance and marriage customs are changing.

Livelihood strategies are also being adapted in response to HIV/AIDS. This is where the substantial literature and debate on coping strategies can best be considered within the sustainable livelihoods framework. People do their best to cope with the impact of AIDS by adapting their livelihoods. Sometimes these adaptation are erosive or destructive (for example when young women are forced into transactional sex) and households are sometimes unable to cope.

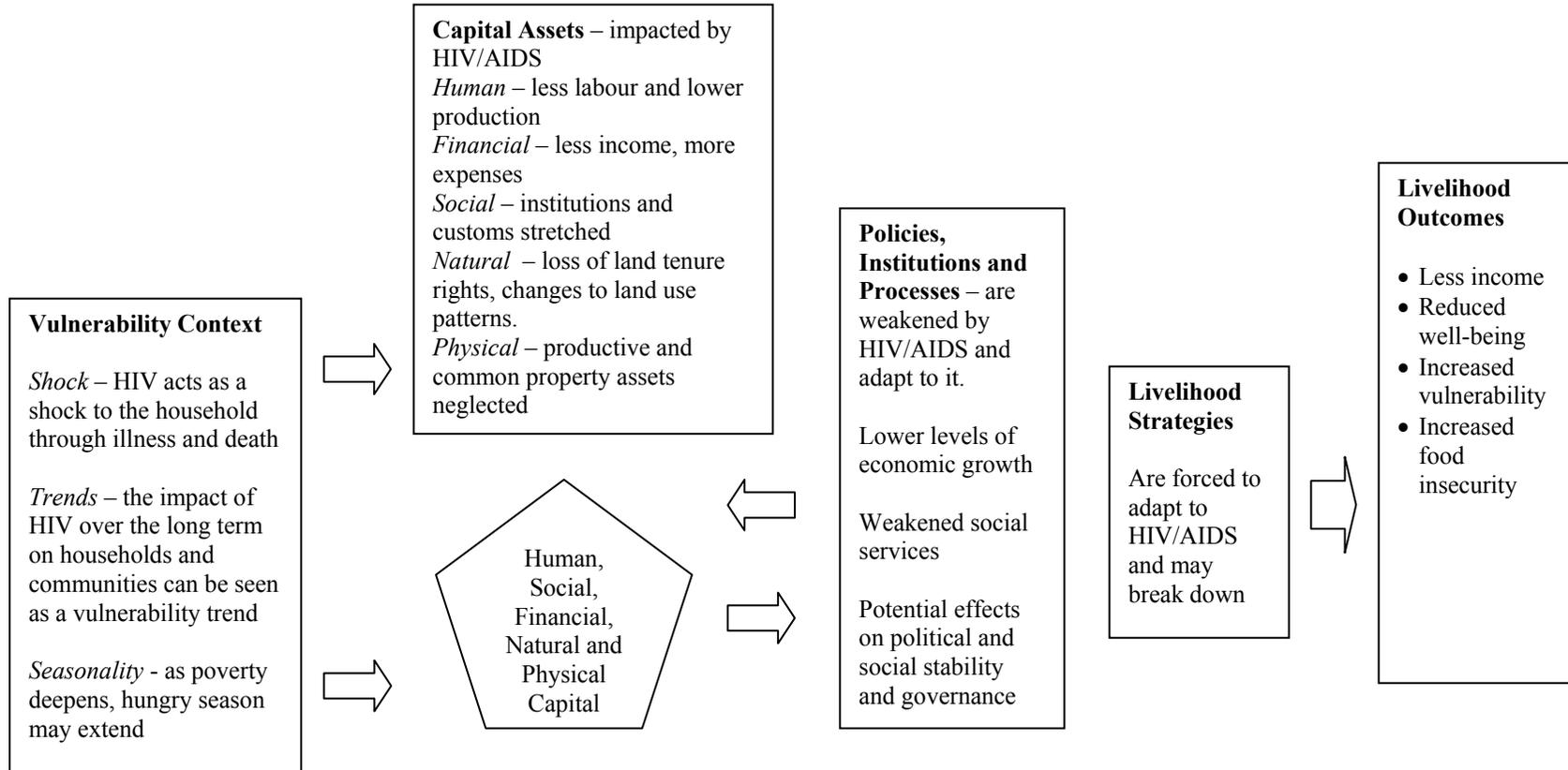
Finally, of course, HIV/AIDS is affecting the livelihood outcomes of large numbers of households. Household affected by HIV/AIDS usually have less income, increased vulnerability and reduced food security.

As can be seen from Diagram 1, HIV/AIDS therefore must be considered across the full spectrum of the sustainable livelihoods framework. It increases households' vulnerability, impacts on the assets of households, affects the policies, institutions and processes that influence livelihoods, forces adaptations to livelihood strategies and results in changing livelihood outcomes. At a macro level it reduces overall levels of economic growth, erodes public services such as health and education and may potentially impact on governance and security issues.

Table 2 attempts to summarise the ways in which HIV/AIDS impacts on the different forms of livelihood capital and the coping strategies that households are adopting to attempt to deal with these impacts.

The following sections examine in more detail the impact of HIV/AIDS on livelihoods. It starts with the impact on the five sets of livelihood assets (human, financial, natural, social and physical), considers the interactions between HIV/AIDS and policies, institutions and processes that influence livelihood assets and examines the ways in which peoples' livelihood strategies are adapting to the impacts of HIV/AIDS.

## Sustainable Livelihoods Framework in the Context of an HIV/AIDS Epidemic



**Table 3: Impacts of AIDS on livelihoods using a sustainable livelihoods framework**

<b>Sources of household Capital</b>	<b>Impact</b>	<b>Coping / Survival Strategies</b>
<p><i>Human Capital</i></p> <p>Represents the skills, knowledge, ability to labour and health that together enable people to pursue different livelihood objectives.</p>	<p><i>Reduced labour availability</i>                      People get sick reducing the amount they are able to work                      Other household members have to care for the sick.                      Funeral attendance                      Additional care pressures in looking after orphans                      Death permanently reduces the amount of labour in the household and may increase the dependency ratio.</p> <p><i>Impact of reduced labour</i>                      Less time for the households own production, leads to lower productivity and declining agricultural production.                      Less ability to undertake casual labour, paid employment, gathering of wild foods and other income generating activities.                      Less time for other key household activities.</p> <p><i>Knowledge</i>                      Death of adults damages transfer of knowledge between generations                      Children withdrawn from school learn less.                      Key agricultural knowledge may be lost, especially where gender divisions of labour are strict.</p>	<p><i>Agricultural Adaptations</i>                      Shift to less labour intensive crops                      Reduction in range of crops per household                      Decrease in area cultivated / more land left fallow                      Use of labour saving technologies if available                      Better off families may hire labour or replace labour with technology.                      Withdrawal from marketing into pure subsistence</p> <p><i>Coping with less labour</i>                      Withdraw children from school as they are needed to work.                      Increased reliance on labour of orphans                      Relocation of household members to wider social networks, such as sending children to live with relatives.                      Diversification of activities to ones that demand less labour                      Relying on the elderly, children and extended family networks to cover for ill or deceased household members</p> <p><i>Adaptation to loss of knowledge</i>                      May have to cease growing certain crops; for example cash crops that only men knew how to market or wild foods that only women knew where to collect.</p>
<p><i>Financial Capital</i></p> <p>The financial resources that people use to achieve their livelihood objectives – including flows (income) and stocks (savings).</p>	<p><i>Additional Expenses – Spending More</i>                      Costs of treatment for sick household members (transport to health facilities, drugs etc.)                      High cost of funerals                      More people to feed if number of orphans taken in are greater than number of deaths.</p> <p><i>Reductions in Household Income – Earning Less</i>                      Loss of remittances due to sickness or death of relatives                      Loss of access to credit as affected households are considered higher risk by lenders                      Less able to grow cash crops due to lack of funds for inputs, less willingness to take on risk, less labour or skills for marketing</p>	<p><i>Coping / Adapting by Spending less</i>                      Eating less, reductions in quality of food being eaten.                      Use of purchased inputs (seed, fertiliser) are reduced.</p> <p><i>Coping / Adapting by finding other income sources</i>                      Drawing down savings.                      Going into debt                      Selling assets such as jewellery, livestock, household goods                      Finding new income generating activities – such as transactional sex.                      Some household members migrate to look for work.                      Begging, relying on help from friends and relatives, attempting to access outside help (relief, home based care).                      Participate in informal institutions such as savings or burial clubs</p>

<b>Sources of household Capital</b>	<b>Impact</b>	<b>Coping / Survival Strategies</b>
<p><i>Social Capital</i></p> <p>The social resources on which people draw in pursuit of their livelihood objectives. Networks and connectedness. Membership of more formalised groups. Relationships of trust, reciprocity and exchange</p>	<p><i>Institutions / Organisations</i></p> <p>Institutions (churches / CBOs) are weakened by deaths and illness. Saving club and group lending scheme defaults stress local informal credit institutions. Risk that institutions will become more exclusive, possibly stigmatising those with HIV/AIDS</p> <p><i>Customs, rules and practice</i></p> <p>Traditional customs governing remittances are over-burdened. Child adoption customs are over-burdened. Households cannot fulfil customary roles during other shocks to food security (e.g. sharing between kin during drought). Traditions such as funerals are adjusted or transformed. Land tenure is inadequate to address needs for example of widows and orphans. Rich households are equally affected and so are less able to play key social support roles. Reversal of urban-rural support networks</p>	<p><i>Institutional Adaptation</i></p> <p>Some evidence that new institutions are emerging to address AIDS. Adaptation of existing institutions to address HIV/AIDS</p> <p><i>Changing Customs / Practices</i></p> <p>Funeral practices change to lessen costs and reduce time commitment. Orphan care left to the elderly, emergency of child headed households.</p>
<p><i>Natural Capital</i></p> <p>The natural resource stocks from which resource flows and services are derived (trees, land)</p>	<p><i>Land tenure</i></p> <p>Widows and orphans lose title to land due to lack of secure land tenure</p> <p><i>Land use / Farming systems</i></p> <p>Farming systems and land use patterns change. Compromising critical land conservation and soil protection activities.</p>	<p>Changing rules governing land tenure to strengthen rights of widows and orphans</p> <p>Sale or mortgaging of land to generate income</p>
<p><i>Physical Capital</i></p> <p>The basic infrastructure and producer goods needed to support livelihoods (water, transport, shelter)</p>	<p>Sale of productive equipment (draught animals, plows). Sale or slaughter of livestock. Productive assets such as irrigation systems or grain storage are not maintained. Common property assets such as rangeland are not maintained. Household assets are not maintained (roofing, household items) or replaced when needed.</p>	<p>Distress sales of livestock</p>

## 2.4 Human Capital

*'Human capital represents the skills, knowledge, ability to labour and health that together enable people to pursue different livelihood objectives' (DFID 1998)*

HIV/AIDS impacts on human capital in a number of ways. Firstly it adds to the burden of illness for a household. Individuals with AIDS become chronically ill suffering from a series of opportunistic infections before dying of AIDS. Illness related to AIDS is particularly damaging because it is often more chronic and prolonged. AIDS is particularly destructive of human capital because it disproportionately affects prime age adults. Rugalema (1999) estimates that an HIV/AIDS afflicted household may lose about two person years of labour by the time of the death of a person with AIDS. Not only does this affect the individual who is unable to work but it also reduces the amount of labour other members of the household have for productive activities as they have to care for the sick person.

When someone dies of AIDS their labour is permanently lost to the household and further labour is lost in attending funerals. HIV/AIDS usually strikes more than one household member and the shock of multiple deaths within a household can be particularly devastating. The levels of household dissolution and the emergence of elderly headed and child head households will be indicators of the levels of AIDS impact. However, the extent of household dissolution is currently unclear.

The human capital of households that foster the increasing numbers of orphans created by the HIV/AIDS epidemic is also affected. However, the impact of this is unclear. On the one hand, they will have a higher burden of care. However, it is also possible that orphans will contribute to household labour.

Finally, HIV/AIDS impacts on the ability of people to transfer knowledge from one generation to the next, due to the death of adults in their prime and by the fact that children are often withdrawn from school as a response to HIV/AIDS.

The net result of this is reduced household labour available for productive activities. In rural households dependent on agriculture for their livelihood, studies have shown measurable falls in agricultural production as a result of HIV/AIDS. The effect of reduced labour on other livelihood strategies is less clear, due to a lack of evidence.

There is a growing body of evidence that HIV/AIDS has a substantial impact on the agricultural production of rural households and there are several good summaries (Topouzis 2000; Haddad and Gillespie 2001). Some of the key household level studies and their findings regarding agricultural production are shown in table three below.

**Table 4: Studies on the Impact of AIDS on Agricultural Production and Household Labour**

Study	Impact on Agricultural Production and Household Labour
Yamano et al 2002 Kenya	Death of a household head decreased net output by 68% and a spouses' death reduced total net output by 46%.
Kwaramba 1997	A study of the smallholder sector in Zimbabwe which found reductions in production in households with an AIDS death ranging from 61% for maize to 29% for cattle.
Shah et al 2000 Malawi	Decreased agricultural productivity was experienced by 72% of households affected by chronic sickness.
Lemi Abate et al 2001 Namibia	62% of farmers interviewed thought that HIV/AIDS had reduced labour availability for agricultural activities. Reduction in cultivated area (70%) was the dominant response with significant numbers also reporting increased use of child labour (20%).
Tibaijuka 1997 Tanzania	When a household contained an AIDS patient, 29% of household labour was spent on AIDS related matters including care of the patient and funeral duties.

Falling agricultural production can be explained by a series of responses that households are forced to make in adapting to the loss of labour from HIV/AIDS. FAO (2002: 8) categorises the ways in which AIDS can affect agricultural production are shown in Box 2.

Studies of the impact of HIV/AIDS on human capital have mainly focused on the effects of illness and death on household agricultural production. The literature has overwhelmingly focused on subsistence smallholder production with very few studies of the impact of other types of livelihoods, such as pastoralists or of its impact on areas of poor peoples' livelihoods such as casual labour, and small-scale income generation. The impact literature is therefore a long way from reflecting the full diversity of rural people livelihoods and the impact of HIV/AIDS on the full range of activities and income sources that poor people juggle to survive (Ellis 2000). Poor peoples' livelihoods are often made up of a diverse range of activities that include migration, petty trading, casual labour and non-farm activities. This is highlighted by the Food Economy Group (2002: 3); 'research conducted at the household level indicates that the poorest economically active households tend to rely more directly on cash income to secure food than agricultural production. A study by the Food Economy Group and FEWSNET in Zambia found that more than 40% of poor household food needs were purchased and covered by income from petty trade and piece work. These activities are critical to survival, labour intensive and likely to be severely affected by HIV/AIDS, but as yet un-researched in the literature on the impact of HIV/AIDS.

**Box 2: Ways in which HIV/AIDS can affect agricultural production (FAO 2002)**

*A reduction in the area of land under cultivation*

The sickness followed by death of adult members of the household may force people to leave land fallow and/or sell land.

*Declining Yields*

Yields may decline as a result of delays or poor timing in essential farming operations. Subsistence farming requires labour at critical times. If labour is not available for planting, weeding or tillage and cannot be hired then production will suffer. Households may also lack the labour to keep up with important land conservation measures such as irrigation maintenance. Post production operations such as food storage and processing may also be affected by labour constraints. Cash and credit available for agricultural production and purchase of key inputs such as seed and fertiliser may be diverted to meeting medical and funeral expenses

*Declines in crop variety and changes in cropping patterns*

Cash crops may be abandoned if the household does not have enough labour for both cash and subsistence crops or if surviving members of the household lack key knowledge and experience in marketing cash crops. For example, in rural Kenya the death of an adult male resulted in less land being devoted to high value cash crops (Yamano and Jayne 2002). Switching from labour intensive crops to less labour intensive ones, often containing lower nutritional values, is another commonly cited response strategy of HIV/AIDS affected households.

*Declines in livestock production*

Households may have to sell livestock to meet the costs of illness and death. For example, in Kenya Yamano and Jayne (2002) found that prime age death resulted in lower levels of small animals (goats, sheep and chickens) suggesting a sell off or consumption over time. Animal husbandry practices may deteriorate from the impact of AIDS on the labour force, medical costs may force the sale of livestock and funeral practices may involve the slaughtering of animals.

*Loss of Agricultural skills*

HIV/AIDS can interrupt the normal transmission of knowledge between generations both through the death of parents and the interruption of schooling. This is discussed in more detail below (section 2.4.2).

It is also important to remember that HIV/AIDS is only one of a complex web of factors that impact on rural people's livelihoods and that it is often difficult to disentangle the effects of AIDS from other environmental, political and economic events and trends. It is noticeable, for example, that in southern African countries over the past five years, cereal production has fallen whilst cassava production has risen. One of the factors behind these aggregate figures may be that households affected by HIV/AIDS are switching to less labour intensive crops (De Waal and Tumushabe 2003; De Waal and Whiteside 2002). However, these figures should be cited with caution as the role of HIV/AIDS remains unclear at this level of aggregation.

An example of the dangers of unsubstantiated aggregation can be seen in statements such as the following from a workshop report. ‘HIV/AIDS has contributed to significant declines in agricultural production in southern Africa. For example, in Zambia – one of the countries hardest hit by HIV/AIDS – maize production has declined by two thirds in the last decade’ (USAID 2003). Whilst it may be true that HIV/AIDS has contributed to declines in maize production in Zambia, there is as yet little research to disentangle the effect of HIV/AIDS from other possible causes.

This raises a wider and important point that the HIV/AIDS epidemic in southern Africa is taking place in a context of already fragile economies. Recent work on the 2002 crisis in southern Africa suggests four main factors causing rising vulnerability in southern Africa; growth failures, market liberalisation failures, HIV/AIDS and politics and governance issues (Ellis 2003). Disentangling the relative impact of HIV/AIDS on food security in Zimbabwe from the current economic collapse, for instance, would be difficult. Perhaps the more important point is that these issues are mutually reinforcing. HIV/AIDS deepens existing vulnerabilities and underlying political weaknesses limit the ability of governments to respond adequately to HIV/AIDS and increases its impact on food security, through, for example, the inadequacy of primary health care systems to provide treatment and care both for HIV/AIDS and related illnesses.

#### **2.4.1 Dependency Ratios and Household Dissolution**

The impact of HIV/AIDS on the dependency ratio of households is the source of much debate. Clearly, deaths due to HIV/AIDS change the size and composition of households and, because prime age adults are disproportionately affected, it seems likely that dependency ratios will increase.

Available information concerning changing dependency ratios as a result of HIV/AIDS is limited. A study by the World Bank examining dependency ratios in Kagera, Tanzania using data collected between 1991 and 1994 concluded that, ‘HIV/AIDS has not greatly affected dependency ratios’ (World Bank 1997). This one example suggests a fluidity of household structures and that households may often be able to cope with shocks through some rebalancing of their dependency ratios. Similar results were found in Rakai Uganda where household dependency ratios increased from 1.2 to 1.5 as a result of an adult death from HIV/AIDS (Menon et al 1998) (in White and Robinson 2000). Similarly, a recent study in Rwanda (Donovan et al 2003) found that the households that had suffered a death did not have less labour suggesting that they are able to maintain their labour through new members. This may reflect the fact that households respond to HIV/AIDS by bringing new adults into the household or by sending children to live with relatives.

The Yamano and Jayne (2002: 12) study of mortality in Kenya provides a good overview of the issue of household composition;

‘Because the death of an adult reduces the household’s supply of labour and adversely changes its dependency ratio, surviving members may pursue a number of options to change the composition of the household. Small children may be sent to relatives’ homes, or productive adults may be called back or

adopted into the household. Under some circumstances, the death of a core adult member may cause other household members to move away.’

The study also shows the complexity of household responses to death and the importance of disaggregating death and responses by gender. The decline in male and female adults was partly compensated for by an increase in the number of boys in the household, suggesting that boys may have been adopted to compensate for the loss of adult labour. In households where the male head of household had died, the study found a reduction in the numbers of adult women which, may partially reflect a strategy of marrying older daughters for bride doweries in times of financial stress. Where a prime age woman who was at the core of the household had died, the study found a reduction in the number of younger boys and girls in the household, possibly reflecting the strategy of sending children to relatives’ following the death of the mother. The death of a non core female member by contrast resulted in an increase in the number of boys in the household, most likely to help out with household activities formerly handled by the non core female. Despite these strategies to try to replace lost labour the study found that overall households in rural Kenya are not able to offset the loss of core adult members, the death of the head or spouse of the household, decreases the size of the household by more than one.

Shah et al (2002) notes that in Malawi there is ‘a very fluid identity of the household and the composition and location of the household see frequent changes’. It is this very fluidity that makes it extremely difficult to track what is happening to dependency ratios.

In the midst of an HIV/AIDS epidemic, a growing percentage of adults are chronically sick and should not necessarily be counted in the productive side of the equation when calculating dependency ratios. It has been suggested that what is needed is an ‘effective dependency ratio’ which counts chronically sick adults as dependents (Shell 2000; De Waal 2002).

Aggregate data on dependency ratios also does not capture the costs of adjustments to households. As Barnett and Whiteside (2002) point out sending children to stay with relatives means that the effect of the adult death will be felt beyond the sending family and whoever takes care of the children will have to spend resources.

Studies may tend to under-estimate impact because they do not track dissolved households. Mutangadura’s (2000) study in Zimbabwe found that 65% of the households studied where the deceased adult female used to live before her death were no longer in existence. Household dissolution is an effect that has tended to be under-reported because of the methodologies being used to study impact. These have relied on household surveys, where households that have dissolved are often excluded from the analysis. A study from Kisesa, Tanzania, for example, found that after the death of a male household head, 42.5% of households had dissolved within one year after the death (Urassa et al 2001). The exclusion of dissolved households from much of the research on impact raises the possibility that the impact of HIV/AIDS is more severe than has been so far shown. We also know little about what happens to the members of these dissolved households.

## 2.4.2 Knowledge Transmission

Human capital is also about knowledge and the transmission of knowledge between generations. The fact that HIV/AIDS kills adults in their prime may impact on the transfer of knowledge between generations and the coping strategy of withdrawing children from school may reduce their ability to acquire knowledge. For example Ayieko (1997) found that one tenth of orphan headed households possessed adequate knowledge of agricultural production techniques. However, quantitative data on inter-generational transmission of knowledge is thin on the ground. Topouzis (2000) suggests possible indicators for measuring the loss of agricultural knowledge such as the percentage of women or orphans cognisant of land preparation practices or grain storage techniques. The gender dimensions of knowledge transmission are also important here. One of the ways in which HIV/AIDS can impact on households is through the loss of gender specific knowledge. For example, some studies have found that the death of a male household head has led to a move away from cash crops due to a loss of knowledge and skills in marketing cash crops (Yamano and Jayne 2002).

## 2.5 Financial Capital

*Financial capital: the financial resources that people use to achieve their livelihood objectives – including flow (income) and stocks (savings). (DFID 1998)*

HIV/AIDS damages financial capital by increasing household expenditure and reducing the amount of income that a household has available. Illness due to HIV/AIDS can be very costly for households that have to find additional income to finance all of the costs of sickness such as medical care, transport, drugs, and payments to traditional healers. Funerals are also a major drain on household assets. In order to finance these additional costs people may have to draw down their savings and sell key assets such as jewellery and livestock. Peoples' ability to pay for these additional costs is also affected as HIV/AIDS contributes to declining incomes. For example, reduced labour may lead to less income from casual labour and trading and less ability to invest in cash crops. A study in rural Kenya found that mean reductions in off-farm income were 35-40% for house afflicted by adult death, compared to only 12% for households not experiencing adult mortality (Yamano et al 2002).

Households affected by HIV/AIDS may have less access to credit due to stigma or because they are seen as more likely to default. Reduced income and additional expenditure may also reduce the households' ability to invest in key productive areas such as seeds and fertilisers contributing to a vicious cycle of increasing impoverishment.

It is also possible that HIV/AIDS is affecting income from remittances, although there has been little or no research into this area. A crucial part of rural livelihoods for many households in Africa has been remittances from relatives in urban areas. As HIV rates are higher in urban areas the added strain on urban households may cause remittances to decline.

Studies have shown the effect of AIDS on income, although these have been limited and most have focused on the impacts of death rather than illness. Table ?? summarises these studies.

**Table 5: Studies showing the impact of HIV/AIDS on household income and assets**

<b>Study</b>	<b>Impacts</b>
World Bank 1997 Kagera Tanzania	Households experiencing an adult death: Spent less during a persons' illness but a greater proportion on medical care. Food purchases decreased. Income was diverted, but may also have been reduced as the number of hours worked was cut.
Cote D'Ivoire Bechu 1998	Households with an HIV/AIDS patient spent twice as much on medical expenses as other households. When the person with AIDS died or moved away consumption fell by as much as 44% in the following year.
Namposya-Serpell 2000 Zambia	Monthly disposable income of more than two-thirds of the families in this study fell by more than 80%.
Uganda Menon et al 1998	Asset ownership declined following an AIDS related death but remained stable following deaths related to other causes.
Yamano et al 2002 Kenya	Death of a household head is associated with a significant reduction in the quantity of farm equipment, non farm assets and off-farm income.

Previous work that looked at the costs of ill health also demonstrates the high costs of sickness (Corbett 1989). A study in an urban slum in Bangladesh in the 1980s found that 24% of households reported labour days lost in the previous month due to sickness and for the poorest income quartile this led to an average loss of monthly income of 74% in affected households. A study in Thailand found that 60% of involuntary land sales were due to high medical bills (Pryer 1989; Abel-Smith 1986).

The vulnerability assessments carried out during the 2002 crisis in southern Africa also provide evidence of the impact of HIV/AIDS on income. Table 5 shows the results from a December 2002 assessment in Malawi;

**Table 6: Effects of HIV/AIDS proxies on household income in Malawi**

<i>HIV/AIDS proxy present in household</i>	<i>% difference in income per capita</i>	<i>% difference in income per household</i>
Extremely high dependency ratio	-37%	-65%
No active adults	-31%	-55%
Recent active adult death	-35%	- 24%
More than 1 chronic ill active adults	-66%	-49%
Chronic ill active adult	-4%	-3%

There is also some evidence about the impact of HIV/AIDS on access to credit. Lundberg and Over (2000) revisit data collected in the 1990-94 panel survey of households in Kagera, Tanzania and conclude that wealthier households rely more on private transfers whereas poorer households rely on credit. Using the same data the World Bank (1997) found that 51% of the 80 households that experienced an adult death were members of savings and credit associations. By the end of the survey participation had dropped to 36%.

The idea that HIV/AIDS affected households are less able to access credit is also supported by anecdotal evidence. For instance the study conducted by CARE in Malawi found that; 'It was also mentioned that no-one wants to lend money to a household that has been affected by HIV/AIDS' (Shah et al 2002: 58).

## 2.6 Social Capital

*Social Capital: The social resources on which people draw in pursuit of their livelihood objectives. Networks and connectedness, membership of more formalised groups and relationships of trust, reciprocity and exchange. (DFID 1998)*

There is a rich and extensive literature on social capital. The term itself is a relatively recent one and it draws on previous literatures on civil society and the moral economy. The impact of HIV/AIDS on social capital needs to be thought through in a number of different ways.

- The impact of HIV/AIDS on the organisations and institutions that influence people's livelihoods.
- The impact of HIV/AIDS on customs, rules and practices

HIV/AIDS impact on social capital is likely to depend on the extent to which the epidemic is affecting the whole community. There is some evidence from southern Africa that HIV/AIDS is starting to have impacts on whole communities. For instance Shah et al (2002) in a study in Malawi found that the proportion of households affected by chronic sickness in a village ranged from 22% to 64%. The Zambia vulnerability assessment found that 26% of households were caring for chronically ill members (Zambia VAC 2003).

In Tanzania, Rugalema (1999) found that in the study community 32% of households were AIDS afflicted in that they had experienced direct illness or the death of one or more family members in the last 10 years. A further 29% had been affected through what Rugalema calls 'ripple effects' such as fostering orphans, providing labour or cash to help care for the sick person and providing for survivors in an afflicted household.

It can be hypothesised that, as AIDS begins to affect whole communities this will lead to the over-stretching of social capital. Families affected by chronic illness and death will have to rely on social capital networks for support, but as more and more families call on these networks they are likely to become over-burdened. This is then likely to

increase vulnerability to other shocks as social capital networks will be less able to provide an initial community based safety net.

It is important to stress that this remains at the level of speculation. Social capital is notoriously difficult to measure and there have been almost no studies that have been able to document the impact of AIDS on social capital. However, it has been shown that families affected by AIDS have to rely on social capital networks. Of the households studied by Nalugoda et al (1997) in Rakai Uganda 40% received support for medical and burial costs from extended family members. Lundberg et al (2001) found that the majority of assistance to household in Kagera Tanzania following an adult death came from private transfers. Shah et al (2002) include a useful diagram included as figure 2 which illustrates the complex network of support that a family in Malawi was able to draw upon.

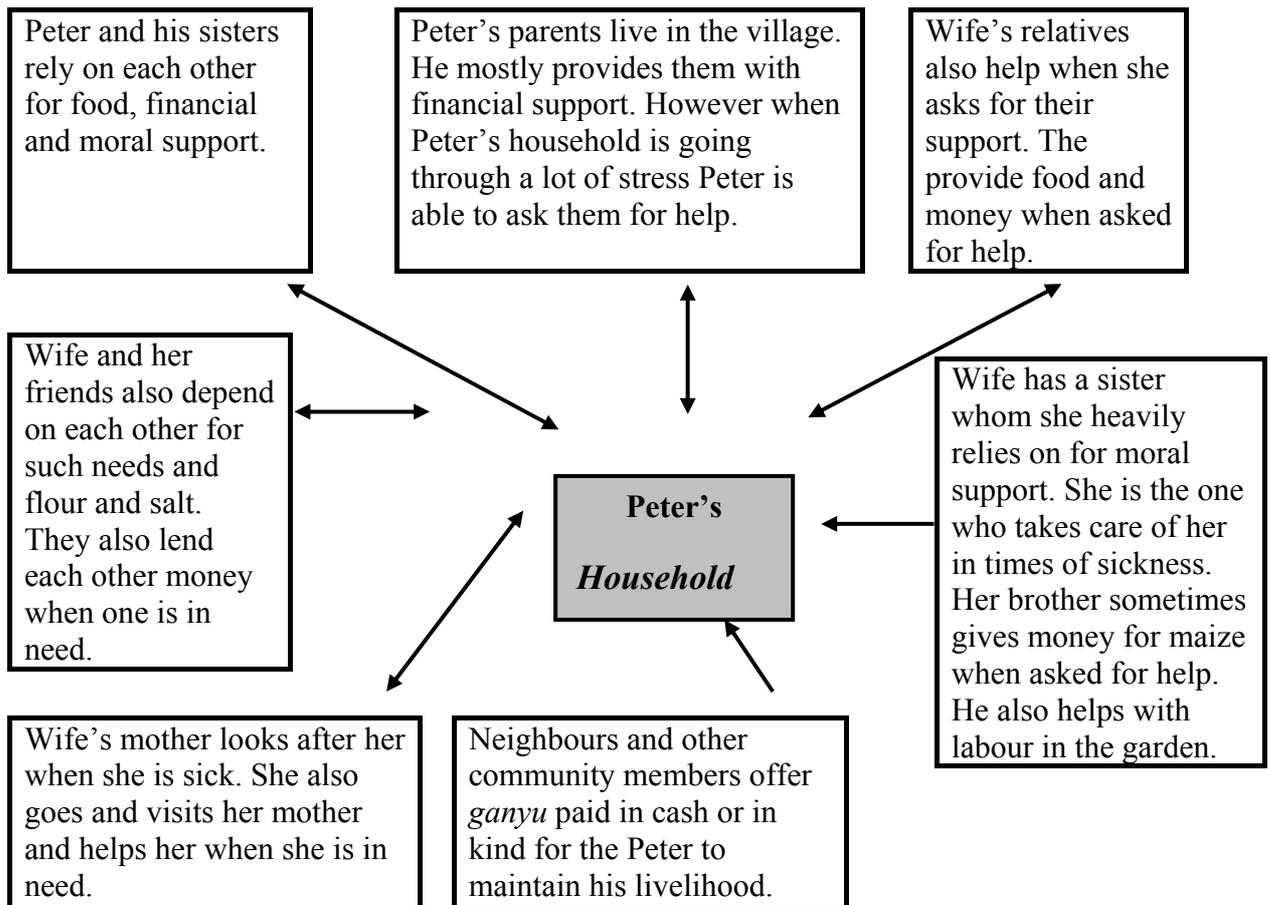
But there are limits to this assistance. Baylies (2002) describes social capital as a 'safety nets with holes' and quotes a respondent in Zambia; 'who is going to help you in Zambia if you have no money'. As well as being fragile, safety nets are uneven in their availability to households and, even when available, can systematically discriminate among potential beneficiaries. AIDS also undermines social capital – which crucially demands investments of time and resources to cultivate. 'In spite of their wish to do so, individuals and households find themselves unable to give of their time or resources to the community (Baylies 2002). Stigma associated with AIDS can also weaken social capital. The Lundberg et al (2001) study showed that richer families are more likely to be able to access assistance. Baylies (2002) makes the important point that, 'entitlement varies according to ones place in a network, with some able to claim far more than others.' (Baylies 2002)

This is not new, Scott (1976) pointed out that; 'in order to be a fully functioning member of village society, a household needs a certain level of resources to discharge its necessary ceremonial and social obligations as well as to feed itself adequately and continue to cultivate. To fall below this level is not only to risk starvation, it is to suffer a profound loss of standing within the community and perhaps to fall into a permanent state of dependence.'

Studies by the Food Economy Group (2002) point out that HIV/AIDS affects rich as well as poor households and that, 'when richer households get sick, poorer households often suffer economic losses as well.' They found in a study in Makueni District in Kenya that over 50% of households work for the top 20-30% of households and that when richer household is afflicted with HIV/AIDS it is likely to have a direct bearing on the income and food of at least three poorer households.

**Figure 2: Peter’s Kinship Support- Chambwinja Village, Dedza.**

Peter’s household belongs to the poor wealth category. He is in his second marriage because his first wife died in 1993 due a short illness. After his wife’s death, Peter decided to take full responsibility of his children despite the fact that his parents in-law offered to help him raise the children. Generally, Peter has very good relationship with his parents, sister, in-laws and friends. They have reciprocal relationships and support each other in times of need. The give each other food, clothes, money and help each other with other small needs. The diagram below shows the type of help that is shared between the households in this network. The arrows show the direction of help.



AIDS has in some cases led to the formation of new social capital in community efforts to mitigate its impact. These are detailed in Mutangadura et al (1999) with new AIDS groups springing up and existing CBOs adding efforts around AIDS to former activities. Many of the existing studies find that people affected by HIV/AIDS access help principally from family, neighbours, community institutions and local informal organisations. The World Bank (1999) Kagera study 90% of the assistance received by families where the head of the household had died came from family and community groups. Mutangadura (1999) presented community responses to HIV/AIDS as follows:

**Table 7: Community Responses to HIV/AIDS**

<i>Support and Mitigation</i>	<i>Treatment and Care</i>	<i>Culture / Norms</i>
Social support groups – burial societies, grain saving and labour schemes Savings clubs and credit associations New associations in areas such as help with mourning costs, re-building houses, support to sick patients. Self help groups of PLWA Community based organisations Income generating projects Voluntary labour	Patient care Psychological and spiritual support Child care Home based care	Protection of property rights Shortening of mourning periods Changes in traditional practices with HIV risks Changes in funeral practices Gender related changes Reduction in risky sexual practices

Source: Adapted from Mutangadura 1999

The responses of societies to HIV/AIDS, however, are not necessarily positive. It is important to remember that social capital may be deeply anti-social. HelpAge has been receiving increasing numbers of reports of older women being accused of witchcraft in relation to HIV/AIDS. For example, in Zimbabwe there are reports of groups of self appointed witch hunters accusing widows of bewitching people with AIDS (AfricaNews March 2002).

## 2.7 Natural and Physical Capital

*Natural Capital: the natural resource stocks from which resource flows and services are derived.*

*Physical Capital: the basic infrastructure and producer goods needed to support livelihoods (water, transport, shelter).*

The main ways in which HIV/AIDS may impact on natural and physical capital are through its effects on land tenure and land rights and the possible sale of key productive assets. Yamano and Jayne (2002) found that the death of a male household head resulted in significant declines in the value of farm equipment.

An often cited possible impact of HIV/AIDS is on the land rights of surviving household members following an adult death in the household. It is suggested that widows and orphans may be vulnerable to losing their access to land following the death of a male head of the household.

A study in Malawi (Mbaya 2002) found the following:

- Shortage of land in Malawi and the stigma of AIDS means that people living with AIDS are at risk of being denied access to land by community leaders.
- Often, widows living under patrilineal systems and some matrilineal systems are denied continued access to matrimonial land holdings that they enjoyed prior to the death of their spouse.

- AIDS also has serious implications for orphans' access to landholdings that they should inherit with frequent disputes over community management of such land.
- Allowing relatives to use land or renting it out when people become too sick to use it.
- HIV/AIDS also has unexpectedly increased access to land for some. For instance older relatives that are given custodianship over land for orphans.
- In areas of high land pressure the the overall productivity of land remains high, but the benefits shift.
- Women employ a range of strategies to ensure that they have continued access to land such as remarriage, celibacy (to secure the permission of in-laws to continue to have access to the late spouses land) and acceptance of the practice of wife inheritance.

Also cited as a possible impact, although not yet backed by field research, is the possibility that AIDS could impact negatively on the maintenance of shared common property assets.

### **2.7.1 Livestock**

Where livestock fits in the sustainable livelihoods framework is unclear. It is possible to regard it as a form of savings and therefore to be considered as a type of financial capital or to regard it as a type of physical capital.

Some AIDS afflicted households have been observed to turn to livestock production as an alternative to crop production when soils become infertile and crop management practices too demanding for the available labour (White and Robinson 2000 citing FAO 1995).

Other households sell cattle more frequently to pay medical bills and funeral expenses. A trend has also been identified whereby households raise smaller stock such as pigs and poultry, a much less labour intensive activity (White and Robinson 2000)

A study on adult death in Kenya, by contrast found that households suffering a death held on to productive cattle and even found an increase in cattle ownership amongst households where the male head of household had died, possibly due to bride doweries after daughters marry.

A study in Uganda by FAO and UNDP (Halswimmer 1994) found various impacts on livestock:

- Richer families selling off cattle to meet the costs of medical care and drugs during sickness and after death the cost of funerals and ongoing survival.
- Poultry keeping has increased in AIDS afflicted households.
- Pig rearing is a new activity started especially by widows. Pigs are less labour demanding and new crops (cassava and sweet potatoes) provide feed.

A study on the impact of AIDS on the livestock sector in Namibia (Engh et al 2000) found that a common strategy for meeting the direct costs of sickness and death was

the sale of livestock. Interestingly, effects on household resources in one area were found to be different for households where husbands died and those where wives died, probably due to the matrilineal property inheritance culture. A common observation in Oshana households where the husband died was the practice of taking livestock away from the remaining family (wife and children). The study also noted the fact that children who had lost both parents lacked skills for livestock management, resulting in the death of the few livestock inherited.

The impact of HIV/AIDS on pastoralist livelihoods remains almost completely unstudied although some research is currently underway.

## **2.8 Policies, Institutions and Processes**

*The institutions, organisations, policies and legislation that shape livelihoods. It embraces a complex range of issues associated with power, authority, governance, laws, policies, public service delivery, social relations, institutions (laws, markets, land tenure) and organisations (NGOs, government agencies and the private sector). (DFID 2000)*

The literature on food security and HIV/AIDS has mainly focused at the household level. However, the policies, institutions and processes that shape livelihoods are clearly a key part of the overall picture. There are two main points to be made here. Firstly, that HIV/AIDS also has important macro level impacts that crucially influence individual livelihoods. By restricting economic growth, reducing government capacity and producing further declines in access to key services HIV/AIDS has clear negative impacts on the institutions that influence livelihoods. Secondly, that HIV/AIDS is only part of the macro-level picture influencing livelihoods in sub-Saharan Africa and that the epidemic is taking place in political economies that were already fragile.

As we suggested in the sustainable livelihoods framework diagram, policies, institutions and processes are themselves influenced by HIV/AIDS. Usually, this is described as institutions and organisations being weakened by the impact of HIV/AIDS and this is certainly a major factor. However, it is also important to realise the dynamism of the situation and that organisations, institutions and norms and values are themselves adapting in response to the HIV/AIDS epidemic.

There are a growing body of studies that have examined the macro-economic effects of HIV/AIDS and this is a large and complex literature in its own right (Over 1992; Cuddington 1993; Bonnel 2000). The overall picture is that national economies are likely to grow more slowly as a result of the impact of HIV/AIDS. For example, a study of Botswana estimated that GDP growth would fall from 3.9% a year without AIDS to between 2 and 3.1% a year with AIDS (BIDPA 2000). Some studies have argued that in some of the worst affected countries such as Zambia and Zimbabwe, HIV/AIDS has the potential to push economies into decline and keep them there (BER 2001).

HIV/AIDS is also likely to impact on the ability of governments to focus resources on poverty alleviation and social services, both through lower levels of growth and therefore revenue and through weakening key government institutions such as

ministries of health and education. These effects are taking place just as demand for health care is growing due to HIV/AIDS and in already weak states in much of sub-Saharan Africa. Arndt and Lewis (2000) for example estimate that AIDS means South Africa will require a real annual increase in health expenditure of 6.9% per annum from 1997 to 2010. BIDPA (2000) estimate that the government of Botswana will have to spend between 7 and 18% more by 2010, to maintain current levels of service (mainly on health and poverty alleviation), even without the provision of anti-retroviral therapies.

HIV/AIDS undermines organisations through high absenteeism, high turnover and a loss of institutional memory. Key organisations that support peoples' livelihoods are increasingly under strain in the worst affected countries. Sector level studies of the impact of AIDS are still rare but suggest that institutional capacity is increasingly being eroded. Certainly anecdotal evidence suggests high mortality and morbidity amongst teachers, nurses, doctors and agricultural extension staff. For many poor households in Africa, access to key services such as health, education and agricultural extension were already extremely limited. HIV/AIDS is likely to erode this access further.

There is also a growing recognition of the potential effects of HIV/AIDS on political and social stability and governance. The US national intelligence council in 2000 identified AIDS as a disease that could, 'exacerbate social and political instability in key countries' (National Intelligence Council 2000) and the threat of HIV/AIDS was debated by the UN Security Council in January 2000. As yet, however, the effects on governance and security remain largely at the level of speculation.

## **2.9 Gender**

The gender dimensions of the impact of AIDS are crucial and must form a central part of analysis and response to AIDS. In sub-Saharan Africa, women now form the majority of those living with HIV/AIDS (UNAIDS 2002). They are infected on average 6-10 years younger than men. Women are biologically more susceptible to contracting HIV than men in any given sexual encounter. The low social status of women in the developing world magnifies their vulnerability to being infected with HIV/AIDS and constrains their ability to deal with its impact.

Many of the additional burdens of HIV/AIDS at a household level fall upon women, as they are the main producers of food and the main carers for the sick and children. Oxfam (2002: 34):

'Gender roles powerfully influence vulnerability to HIV infection and the impact of the epidemic and therefore will significantly shape the possible response in different communities. Both men and women can be infected but vulnerability to impact differs. Women may have additional care responsibilities for ill husbands, take on orphans, engage in further work to ensure income, and engage in risky sexual behaviour during transactional and commercial sex'.

Analysis of the gender dimensions of impact, need to consider the complex ways in which gender relationships influence impact. These are myriad, diverse and context specific. Some of the most commonly cited are suggested below:

- HIV/AIDS widows may not have secure land tenure or rights
- In agricultural systems where men have primary responsibility for cash crops, a male death may lead to the loss of crucial knowledge in areas such as marketing. Women may not be able to participate in cash crop production due to gender stereotypes and prejudice.
- Deaths of an adult female may mean the household is more likely to disintegrate due to women's crucial role as carers. Mutangadura (2000) found in a study in Zimbabwe that 65% of households surveyed that had experienced an adult female death had dissolved and the children were fostered by relatives.
- Where women have primary responsibility for household food production, a female death may lead to the loss of crucial knowledge and experience.
- Increasing levels of female mortality may increase the vulnerability of children to malnutrition, as women are the primary carers.
- Women's role as the primary carers for the sick may mean that the labour impacts of HIV/AIDS fall disproportionately on women, leaving them particularly time poor.
- Women may be forced into transactional sex or other erosive coping strategies as a result of increasing impoverishment due to HIV/AIDS.

However, gender differentiated impacts of HIV/AIDS will vary according to the agricultural system, the livelihoods of those affected, the relative power or powerlessness of women and many other factors. What is needed, therefore, is for context specific, gender differentiated analysis.

The Yamano and Jayne (2002) study of the effects of prime age mortality in Kenya highlights the importance of disaggregating the effects of death by gender and status (the role and position of the individual within the household). It found important gender and status differences in how adult mortality affects household livelihoods. These are summarised in box 2 below.

### **Box 3: Gender differences in the impact of mortality from Kenya**

Yamano and Jayne (2002) found that the impact of a death varied according to gender.

The death of a male household head is associated with a 68% reduction in the value of household crop production and the effects are less dramatic for other household members.

The gender of the deceased adult affects the type of crop suffering a shortfall. Grain crops are adversely affected by female mortality and cash crops by male mortality.

Although women provide most of the labour input for crop cultivation a male household head's death has the most dramatic effect on crop production, due to male specialism in high value cash crops and the loss of labour from the departure of older daughters, which seems to be most prevalent in households where the male head died.

## 2.10 Livelihood Strategies, Coping Strategies and HIV/AIDS

Initially, the HIV/AIDS literature was slow to take on board the rich existing literature on how rural households deal with food insecurity. As White and Robinson (2000) argued; ‘Much of the household level research has not drawn on the substantial existing literature on shocks to rural households and the corresponding coping strategies they adopt.’

Over the last few years the literature has increasingly recognised that the ways in which people are dealing with the impact of HIV/AIDS have important similarities with the ways in which rural households deal with other shocks to food insecurity. However, there has also been a growing criticism of the very term ‘coping’ to describe the strategies adopted. Rugalema (2000) argues that households are not coping but struggling. Barnett and Whiteside (2002) argue that; ‘people who are forced to sell the clothes of the dead or their own clothes can hardly be said to be coping; these are the actions of the desperately impoverished’. Also, that ‘the very notion of ‘coping’ is deeply ideological and may smack of the rich telling the poor how to manage their own poverty.’ Gillespie and Loevinsohn (2003) argue for using the value neutral term responding to that of coping. Baylies (2002) argues that coping is ‘elevated to a moral virtue’ partly due to the minimal capacity of states in Africa, meaning that household capacity to deal with illness is critical.

It seems somewhat unfair to take the coping strategies literature to task on these grounds. It has always acknowledged that the final stage of coping strategies is that people fail to cope. Indeed it developed out of an attempt to understand the processes by which households were driven into destitution and ultimately starvation in famines. The literature has also always recognised the problems with the term coping with various alternatives and additions being at different times proposed. Hence we have Davies (1996) distinction between coping and adaptive strategies, the use of the term survival strategies as an alternative, and a distinction between erosive and non-erosive strategies. De Waal (2002) proposes the following distinction; Strategies that allow for a return to the former way of life are ‘coping strategies’; those that leave the household at a significantly lower socio-economic level are ‘survival strategies’. The balance between the two reflects the resilience of a society.

The term coping strategies remains both widely used and understood and will be used in this study with several caveats. People and households may in the end fail to cope, coping strategies that people adopt may be deeply erosive and coping strategies may undermine their future livelihoods.

A wide range of coping strategies have been observed in response to AIDS and these are summarised in box 4.

## **Box 4: Coping Strategies**

### **Human Capital**

#### *Agricultural Adaptations*

Shift to less labour intensive crops  
Reduction in range of crops per household  
Decrease in area cultivated / more land left fallow  
Use of labour saving technologies if available  
Better off families may hire labour or replace labour with technology.  
Withdrawal from marketing into pure subsistence

#### *Coping with less labour*

Withdraw children from school as they are needed to work.  
Increased reliance on labour of orphans  
Relocation of household members to wider social networks, such as sending children to live with relatives.  
Diversification of activities to ones that demand less labour  
Relying on the elderly, children and extended family networks to cover for ill or deceased household members.  
Bringing new members into the household

#### *Adaptation to loss of knowledge*

May have to cease growing certain crops; for example cash crops that only men knew how to market or wild foods that only women knew where to collect.

### **Financial Capital**

#### *Coping / Adapting by Spending less*

Eating less, reductions in quality of food being eaten.  
Use of purchased inputs (seed, fertiliser) are reduced.

#### *Coping / Adapting by finding other income sources*

Drawing down savings.  
Going into debt  
Selling assets such as jewellery, livestock, household goods  
Finding new income generating activities – such as transactional sex.  
Some household members migrate to look for work.  
Begging, relying on help from friends and relatives, attempting to access outside help (relief, home based care).  
Participate in informal institutions such as savings or burial clubs  
Getting daughters to marry in order to get bride doweries

### **Social Capital**

#### *Institutional Adaptation*

New institutions are emerging to address AIDS  
Adaptation of existing institutions to address HIV/AIDS

#### *Changing Customs / Practices*

Funeral practices change to lessen costs and reduce time commitment  
Orphan care left to the elderly

### **Natural and Physical Capital**

Changing rules governing land tenure to strengthen rights of widows and orphans  
Sale or mortgaging of land to generate income

Various attempts have been made to categorise these strategies. Mutangadura (1999) distinguishes between strategies aimed at coping with food insecurity such as reduced consumption, strategies aimed at raising and supplementing income such as income diversification and strategies aimed at alleviating the loss of labour such as withdrawing children from school.

Another common distinction is between erosive and non-erosive strategies. Here some strategies are seen as positive responses that could be supported such as income diversification whereas others are damaging to livelihoods and may increase current or future vulnerability such as transactional sex, withdrawing children from school or reducing consumption.

The AIDS literature has also adopted the idea of sequencing from the more general literature on coping strategies. The suggestion is that coping mechanisms are adopted in three main stages; reversible mechanisms, disposal of productive assets and destitution (Sauerborn 1996; Donahue 1998; Hunter et al 1997).

Empirical evidence about the extent and scope of these coping strategies is thin on the ground. Studies often repeat a fairly standard list of generic strategies with little consideration of the extent to which they are actually being employed. As Yamano and Jayne (2002) point out, very little is known about the dynamics of household behavioural response to adult death in Africa and the limited information that does exist suggests great heterogeneity.

Where evidence does exist it sometimes runs counter to expectations. For example, Ainsworth et al (2000) in a review of the impact of adult mortality on primary school enrolment in Tanzania using the 1991 to 1994 Kagera data, find that Tanzanian households are coping with adult deaths by delaying enrolment of young children (7-10). However, it also found that delayed enrolment was already the norm in Tanzania, that the enrolment of older children (11-14) was maintained and that children in households headed by grandparents were just as likely to be in school.

## **2.11 Neglected Livelihoods**

In reviewing the literature on HIV/AIDS and food security one of the striking aspects is the relative neglect of urban livelihoods and rural livelihoods that do not fit the conventional picture of the small subsistence smallholder.

The largely neglected question of urban poverty seems misguided for several reasons:

- there are increasingly significant and growing urban populations in Africa
- HIV prevalence rates are often higher in urban areas
- there is often significant urban poverty

However, due to the current paucity of the literature there is as yet very little that can be said other than that it remains a crucially neglected area. In Zimbabwe, the humanitarian community is gradually coming to accept that there is a need to assess urban as well as rural food insecurity.

A study of HIV/AIDS affected families in Zambia (Nampanya-Serpell 2000) found that family displacement was a major issue for HIV/AIDS affected families in urban areas. 61% of the sample had been forced to move from their original home, 22% had lost electricity, 39% had lost piped water and of the families that didn't move, half now had to rent out some of the rooms resulting in over-crowding. The same study found that the families in urban areas were more likely to have to withdraw their children from school following an adult death.

The impact of HIV/AIDS on rural livelihoods such as those of pastoralists and fishing communities that do not fit the conventional model of subsistence smallholder production are also hugely under-researched.

## **2.12 Vulnerability**

HIV/AIDS can be seen as greatly increasing the underlying vulnerability of populations. This section looks in more detail at the question of vulnerability and at which groups within populations affected by the epidemic should be seen as particularly vulnerable. Certain standard groups such as orphans and the elderly tend to be routinely identified as vulnerable with little analysis. Whilst these groups may well represent the most vulnerable, it is important to consider other groups that may also suffer from increased vulnerability but have been neglected in the literature. As Ellis (2003: 8) argues; 'there is a risk that the same vulnerable groups are always unthinkingly ascribed with heightened vulnerability, leading to neglect of new vulnerable groups that are created by emerging events (for example laid off estate workers in Malawi).

The concept of vulnerability is at the core of the sustainable livelihoods framework, which represents an extended version of a preceding approach referred to as the 'asset vulnerability framework' (Swift 1989; Moser 1998). A good summary of the concept of vulnerability is provided by Ellis (2003: 7)

'Vulnerability is defined following Devereux (2002) as degree of exposure and sensitivity to livelihood shocks; or, in short, living on the edge. At the micro-level of the household it seeks to describe the risks that people confront, the anticipatory management of those risks and what happens when one or other (or a combination of) uncertain events come to pass, in the form of mitigation, coping and outcomes. Vulnerability potentially has a broader application. Peoples' livelihood chances are not just determined by local level events, but by political, social and economic trends that are national, regional and global in character.'

The extent of vulnerability varies between different social groups and an understanding of these variations plays a key role in the targeting of interventions. Ellis (2003) provides examples of groups that are routinely identified as vulnerable:

- Children under five (vulnerable especially to malnutrition and infectious diseases.
- Pregnant and lactating mothers (vulnerable to malnutrition during pregnancy and nursing)

- Orphans, especially those that fall out of the extended care system (street children and child headed households).
- The elderly (due to the increased burden of care for the sick and for orphans).
- Female headed households, widows and divorced women (due to loss of access of rights to land, lack of time to cultivate land and loss of previous partner's contribution to livelihood)
- People with disabilities (lack of access to production or earning opportunities; social exclusion).
- Households with members with HIV/AIDS or other chronic illness or that have suffered recent deaths of prime age adults (lack of labour, disposal of assets, lowered income etc.)
- Remote rural populations (due to over-reliance on single livelihood sources, high transport costs, poor information).

It can be seen from this list that HIV/AIDS is only one of a range of predisposing factors leading to vulnerability. There are a number of points relating to the identification of vulnerable groups that are important to bear in mind:

- Vulnerable groups are often identified 'routinely' with little analysis
- Even within a vulnerable group, some members will not be vulnerable
- The idea of vulnerable groups tends to be determinedly apolitical, thus avoiding identification of groups made vulnerable by political action (e.g. farm workers in Zimbabwe)

The routine identification of vulnerable groups may exclude groups. For example, a standard targeting criteria has sometimes been the chronically ill. This can mean that households cease to be eligible for assistance once a chronically ill member of the household has died, just at the moment when assistance is most needed to cope with funeral expenses.

### **2.12.1 Orphans**

Globally, more than 15 million children under the age of 15 have lost one or both parents due to AIDS. This figures represents 12% of all children in Africa. Orphans are often the first to suffer deprivation forced by poverty and food insecurity and they often suffer greatly from exclusion, abuse, discrimination and social stigma (WFP 2003). Orphans have lower rates of school enrolment and higher rates of malnutrition and depression. The SADC (2003) study found that in Zimbabwe 20% and in Zambia 30% of households were caring for orphans.

The overall impact of orphans on the livelihood of a household will depend on a wide range of factors. Orphans that are able to work may have a net positive impact on food security. As the SADC (2003: 7) study argues, 'the net impact of orphans on the ratio between household production and consumption will vary according to several factors including the age and sex of the orphan and the socio-economic and demographic characteristics of the host household.'

The SADC (2003) study found that female headed households were more likely than male headed households to be caring for orphans and that elderly headed households have the highest reported rates of caring for orphans. It found that the number of child

headed households was very small in Malawi, Zambia and Zimbabwe, never exceeding 1% of the total.

### **2.12.2 Elderly**

The elderly are often carers and providers for those orphaned and ill from HIV/AIDS and are themselves at risk of infection from the virus. The highest number of HIV/AIDS deaths occur in the middle generation, leaving a larger proportion of older people and young children to deal with the impacts of the epidemic (HelpAge 2003).

A large proportion of adults with HIV/AIDS are nursed at home by their parents in their 60s and 70s. Elderly people also often take on the care and guardianship of grandchildren. This burden of care falls disproportionately on older women.

#### **Box 5: The burden of care on the elderly**

Ongoing surveys carried out by HelpAge International in five villages in Changara District, Tete Province, Mozambique since September 2001 have identified 774 older people caring for a total of 2187 orphans, most of them under the age of ten. Over half of all the older people in the area are caring for an average of three orphans. The number of orphans and older carers in the villages has increased five and four fold respectively over the year and a half the programme has been in operation.

Source: HelpAge 2003

HelpAge (2003) also make a number of important points about how the old people are often excluded and ignored in analysis and response to HIV/AIDS. These include:

- Old people do have sex and therefore they remain at risk of infection.
- Old people can face exclusion from community activities due to stigma, and lack of time and money due to the burden of care.
- Lack of understanding of the impact of AIDS on old people means that they are often excluded from policies and interventions. They find themselves marginalised as beneficiaries of most care and treatment services and do not have access to information and support programmes.
- HIV/AIDS has been found to increase the incidence of violence and abuse against older people. In Africa, HelpAge has been receiving increasing numbers of reports of older women being accused of witchcraft.

### **2.13 Food Security and transmission of HIV/AIDS**

The relationship between HIV/AIDS and food security is two way and food insecurity can also increase transmission of HIV/AIDS. The issues are briefly summarised here but have been addressed in more detail elsewhere (Loevinsohn and Gillespie 2003). Food insecurity increases vulnerability to HIV/AIDS at several levels. At a biological level there is a vicious circle between HIV/AIDS and malnutrition, with malnutrition increasing the risks of HIV/AIDS transmission. At the household level food insecurity

can increase the risks of transmission by increasing the situations in which people are at risk.

At the microbiological level, an individual's nutritional status has an important influence on the progress of HIV/AIDS. The probability that exposure to HIV/AIDS results in infection is also influenced by the presence of prior infections, notably STDs.

There is a vicious cycle between HIV /AIDS and malnutrition. Malnutrition increases the risk of HIV transmission from mothers to babies and the progression of HIV infection. HIV infection accelerates the cycle of inadequate dietary intake and disease that leads to malnutrition.

#### **Box 6: HIV/AIDS and malnutrition**

An HIV infected person is more at risk for malnutrition for the following reasons:

*Reduced food intake:* Adults with HIV/AIDS suffer from appetite loss and have difficulty eating. Reasons for people reducing their food intake include infections such as mouth sores or fever, side effects from medications, depression and social stigma.

*Poor Absorption:* HIV/AIDS affects how the body uses foods that are consumed, resulting in poor absorption of nutrients (protein, carbohydrates, fats, vitamins, minerals and water).

*Changes in metabolism:* With poor nutrient absorption, individuals may not be able to digest foods efficiently and therefore the body may not be able to use the nutrients properly.

*Chronic infections and illnesses:* Fevers and infections that accompany an HIV infection lead to greater nutrient requirements and poor use of nutrients by the body. People who are chronically ill may also have a reduced appetite leading to weight loss. In particular, anorexia, diarrhea, fever, nausea, thrush and anemia are illnesses commonly caused by HIV infection that have nutritional consequences that can lead to malnutrition.

Research suggests that the chance of infection with the HIV virus might be reduced in individuals who have good nutritional status, the onset of disease and death might be delayed where HIV positive individuals are well nourished and diets rich in protein, energy and vitamins might reduce the risks of vertical transmission (Friis 1998 in Gillespie and Loevinsohn 2003). Micro-nutrient deficiencies may increase the likelihood of mother to child transmission (Piwoz and Preble 2000).

Food insecurity also affects the transmission of HIV/AIDS by forcing them to adapt their livelihood strategies leading to greater susceptibility and risk of infection. This can occur in many different ways. Some of the most commonly cited are:

- Food insecurity can further undermine women's autonomy placing them in situations of risk. 'women feel obliged to find food for their families and will sell sex for cash or kind as a last resort (Gillespie and Loevinsohn 2003).

- Risk increased through market activity – e.g. rural weekly markets and trading centres in Malawi – (Shah et al 2002, Ngwira 2002)
- Food insecurity may increase levels of migration to look for work and this may increase the risks of transmission.

Actual empirical research in this area, is again thin on the ground. It is hypothesised that food insecurity increases people's risk of getting HIV and anecdotal evidence supports this.

The ways in which food insecurity increases the susceptibility of people to HIV infection become even more pronounced in emergency situations. As the situation becomes more desperate the likelihood that people will be forced into risky behaviours increases. This has important implications for humanitarian action. Programmes need to be careful not to place people at additional risk of infection and there is a clear role for prevention activities as part of humanitarian action, in order to address the increased risks of transmission created by the crisis.

## **2.14 Conflict and HIV/AIDS**

The complex series of ways in which HIV/AIDS interacts with livelihoods and contributes to vulnerability and food insecurity are magnified in conflict situations. The links between HIV/AIDS and conflict are also at a relatively early stage of being explored and researched. What little work exists has focused on the links between conflict and the increased risk of infection. As Smith (2000: 1) argues, 'the destruction, disruption and displacement that emergencies typically cause can exacerbate vulnerability by increasing the risk of infection among affected populations'.

Displacement creates additional vulnerabilities to HIV infection. Migration, for whatever reasons, always tends to increase the risks of HIV transmission. Conflict related displacement also leads to increased poverty, dependency and powerlessness, which, in turn can increase the likelihood of sexual coercion or bartering, sexual violence and consensual unprotected and unsafe sex. There is increasing evidence of the use of rape by combatants to terrorise civilian populations (Elliot 1999). People displaced by emergencies may also have lost access to basic services and the protection afforded by family and community and the safeguards of legislation against violence and discrimination. Military forces often have very high HIV infection rates and the circumstances of conflict make soldiers more vulnerable to infection and more likely to spread HIV infection among local populations.

Conflict undermines livelihoods and increases vulnerability. De Waal (1990: 488) pointed out how conflict can critically add to the risk of famine by undermining coping strategies.

'Coping strategies become much less effective; in the extreme, they disappear. There is greater social disruption; in the extreme there is social collapse. This creates more severe health crises. Violence also typically serves to hamper food and medical relief.'

In conflicts, therefore, we can expect that the increased vulnerability to food insecurity caused by HIV/AIDS will present an even greater threat to peoples' livelihoods due to the undermining of coping strategies from violence. As Smith (2000: 3) argues, 'emergencies – whether conflict related or the result of a natural disaster – typically reinforce or make more acute pre-existing factors of vulnerability within a population.' However, very little is known about the extent of HIV/AIDS in African conflicts and ways in which conflict and HIV/AIDS are interacting.

## **2.15 Conclusion**

We are at an early stage in our knowledge of how HIV/AIDS impacts on food security and livelihoods. There is starting to be a strong body of evidence that HIV/AIDS has severe negative consequences for the livelihoods of households and communities.

The literature so far has largely focused on smallholder agricultural production. Research on livelihoods in Africa has, however, demonstrated that people survive by drawing on a complex range of livelihood strategies of which agriculture is often only part. There is therefore an urgent need for research to consider the full range of ways in which HIV/AIDS impacts on livelihoods.

This paper suggests that a good way of conceptualising this is to use a sustainable livelihoods framework to capture the complexity of the way in which HIV/AIDS impacts on livelihoods. This is important because it leads to a wider range of policy options for supporting the livelihoods of people affected by HIV/AIDS. This is summarised in table 3 which adds an extra column to the table on impact and coping strategies. To date, policy suggestions have often remained restricted according to the focus of the research; agricultural policy institutes have recommended agricultural policy options, micro-finance practitioners have urged expansion and adaptation of micro-finance institutions and health professionals have urged health solutions.

Table 7 aims to show the wide range of policy options for tackling the impact of HIV/AIDS on livelihoods. If the impact of HIV/AIDS is ever to be adequately addressed it is important that all of these options are considered by policy makers.

What this table begins to suggest is the difficulty of disentangling relief interventions from development ones. The question of the role that humanitarian aid should play in responding to the impact of HIV/AIDS and the impact that HIV/AIDS is likely to have on emergencies is considered in the next section.

**Table 8: Impacts of AIDS on livelihoods using a sustainable livelihoods framework and possible responses**

Sources of household Capital	Impact	Coping / Survival Strategies	Possible Interventions to Support Livelihoods encompassing relief and development
<p><i>Human Capital</i></p> <p>Represents the skills, knowledge, ability to labour and health that together enable people to pursue different livelihood objectives.</p>	<p><i>Reduced labour availability</i></p> <p>People get sick reducing the amount they are able to work Other household members have to care for the sick. Funeral attendance Additional care pressures in looking after orphans Death permanently reduces the amount of labour in the household and may increase the dependency ratio. Growing burden on the elderly to care for sick and orphans and to continue to generate income.</p> <p><i>Impact of reduced labour</i></p> <p>Less time for the households own production, leads to lower productivity and declining agricultural production. Less ability to undertake casual labour, paid employment, gathering of wild foods and other income generating activities. Less time for other key activities such as social capital generation</p> <p><i>Knowledge</i></p> <p>Death of adults damages transfer of knowledge between generations Children withdrawn from school learn less. Key agricultural knowledge may be lost, especially where gender divisions of labour are strict.</p>	<p><i>Agricultural Adaptations</i></p> <p>Shift to less labour intensive crops Reduction in range of crops per household Decrease in area cultivated / more land left fallow Use of labour saving technologies if available Better off families may hire labour or replace labour with technology. Withdrawal from marketing into pure subsistence Grain saving schemes</p> <p><i>Coping with less labour</i></p> <p>Withdraw children from school as they are needed to work. Increased reliance on labour of orphans Relocation of household members to wider social networks, such as sending children to live with relatives. Diversification of activities to ones that demand less labour Relying on the elderly, children and extended family networks to cover for ill or deceased household members Bringing new members into the household. Labour sharing schemes</p> <p><i>Adaptation to loss of knowledge</i></p> <p>May have to cease growing certain crops; for example cash crops that only men knew how to market or wild foods that only women knew where to collect.</p>	<p>R&amp;D into low input, low labour crops. Changes in agricultural extension to promote adaptation and to adjust to new target groups Training / support to livelihood diversification Promotion of light ploughs, labour saving technology Marketing support – e.g. to widows to help them market cash crops. Basic health care including treatment for opportunistic infections and ARVs Nutrition programmes to treat HIV/AIDS related malnutrition.</p> <p>Agricultural input programmes including seed and tool distributions that reflect new cropping systems. Labour intensive public works that cater for the chronically sick. School feeding Support for paying or waiver of school fees Home based care and orphan support programmes Food aid that is nutritionally balanced and provides sufficient protein, fat and micronutrients</p> <p>Innovative responses to the growing number of orphans such as community schools, radio listening groups, apprenticeships and vocational training.</p>
<p><i>Financial Capital</i></p> <p>The financial resources that people use to achieve their livelihood objectives – including flows (income) and stocks (savings).</p>	<p><i>Additional Expenses – Spending More</i></p> <p>Costs of treatment for sick household members (transport to health facilities, drugs etc.) High cost of funerals More people to feed if number of orphans taken in are greater than number of deaths.</p> <p><i>Reductions in Household Income – Earning Less</i></p> <p>Loss of remittances due to sickness or death of relatives Loss of access to credit as affected households are considered higher risk by lenders Less able to grow cash crops due to lack of funds for inputs, less willingness to take on risk, less labour or skills for marketing. Reductions in livestock assets due to distress sale or slaughter</p>	<p><i>Coping / Adapting by Spending less</i></p> <p>Eating less, reductions in quality of food being eaten. Use of purchased inputs (seed, fertiliser) are reduced. Avoid use of formal health care system</p> <p><i>Coping / Adapting by finding other income sources</i></p> <p>Drawing down savings. Going into debt Selling assets such as jewellery, livestock, household goods Finding new income generating activities – such as transactional sex. Some household members migrate to look for work. Begging, relying on help from friends and relatives, attempting to access outside help (relief, home based care). Participate in informal institutions such as savings or burial clubs Sale or rental of land</p>	<p>Better governance – reduced tax burden, less corruption, better resource allocation</p> <p>Cash grants for HIV/AIDS affected households Safety net employment provision adapted to labour restrictions of affected households. Agricultural input grants or subsidies. Livestock interventions such as restocking. Support for income generation activities.</p> <p>Support to Micro-finance institutions that offer products suitable to affected households. Support to savings clubs, ROSCAs Waiver of school fees, health care user fees. Increase in pensions, safety net support, free health care for the elderly.</p>

Sources of household Capital	Impact	Coping / Survival Strategies	Possible Interventions to Support Livelihoods encompassing relief and development
<p><i>Social Capital</i></p> <p>The social resources on which people draw in pursuit of their livelihood objectives. Networks and connectedness Membership of more formalised groups. Relationships of trust, reciprocity and exchange</p>	<p><i>Institutions / Organisations</i></p> <p>Institutions (churches / CBOs) are weakened by deaths and illness. Increased risk of default may weaken informal credit institutions and reduce access to credit and savings for chronically ill. Risk that institutions will become more exclusive, possibly stigmatising those with HIV/AIDS.</p> <p><i>Customs, rules and practice</i></p> <p>Traditional customs governing remittances are over-burdened Child adoption customs are over-burdened Households cannot fulfil customary roles during other shocks to food security (e.g. sharing between kin during drought) Land tenure is inadequate to address needs for example of widows and orphans. Rich households are equally affected and so are less able to play key social support roles. Reversal of urban-rural support networks</p>	<p><i>Institutional Adaptation</i></p> <p>Some evidence that new institutions are emerging to address AIDS Adaptation of existing institutions to address HIV/AIDS</p> <p><i>Changing Customs / Practices</i></p> <p>Funeral practices change to lessen costs and reduce time commitment Orphan care left to the elderly, emergence of child headed households.</p>	<p>Support to civil society institutions and CBOs that are responding to the epidemic.</p> <p>Promote changes to customary land tenure that strengthen rights of vulnerable groups such as widows and children.</p> <p>Promote adaptations to customs and institutions governing participation in markets – eg allowing widows to market cash crops.</p> <p>Supporting changes to customs and practice – e.g. transformation of gender roles, gender empowerment.</p>
<p><i>Natural Capital</i></p> <p>The natural resource stocks from which resource flows and services are derived (trees, land)</p>	<p><i>Land tenure</i></p> <p>Widows and orphans lose title to land due to lack of secure land tenure</p> <p><i>Land use / Farming systems</i></p> <p>Farming systems and land use patterns change Common property assets such as rangeland are not maintained. Compromising critical land conservation and soil protection activities, leads to further reductions in productivity.</p>	<p>Sale, mortgaging or rental of land to generate income. Changing cropping patterns. Remarriage to gain access to a new piece of land. Involuntary celibacy to gain permission of in-laws to retain use of late spouses' land. Acceptance of the practice of wife inheritance</p>	<p>Changing rules governing land tenure to strengthen rights of widows and orphans.</p> <p>Strengthening land rights and flexibility of land use laws – e.g. making it easier for households to sub-let and mortgage land when they can no longer farm it without losing title.</p>
<p><i>Physical Capital</i></p> <p>The basic infrastructure and producer goods needed to support livelihoods (water, transport, shelter)</p>	<p>Sale of productive equipment (draught animals, plows) Sale or slaughter of livestock Productive assets such as irrigation systems or grain storage are not maintained. Household assets are not maintained (roofing, household items) or replaced when needed. Less time available for fuel collection</p>	<p>Distress sales of livestock, key productive assets. CBOs that carry out house repairs for affected families</p>	<p>Provision of key non-food items during emergencies in addition to food aid. Water and sanitation interventions take into account restricted mobility and labour of affected households. Support to CBOs in activities such as house repair</p>

### **3 HIV/AIDS and Humanitarian Crises: What is the role for emergency relief in the overall response to HIV/AIDS?**

#### **3.1 Relief and Development in the response to HIV/AIDS**

The preceding section reviewed the literature on the impact of AIDS on food security. It is striking that without exception this literature focused on the impact of AIDS in 'normal' situations. The countries studied were not at war and at the time of the studies were not being impacted by natural disasters. This presents a somewhat distorted view of the reality of livelihoods in large parts of Africa which are crucially impacted by emergencies. Large parts of the continent are affected by conflict, periodic shocks and chronic acute food insecurity.

It is therefore crucial to consider the impact that AIDS has on food security in emergency situations. However, the literature on AIDS and emergencies is much sparser than the already patchy literature on AIDS and food security. It is also noticeable that the two literatures developed almost completely separately with almost no links being made until recently. The slim literature on AIDS and emergencies largely focused on conflict and refugee situations and to a lesser extent quick onset natural disasters (Smith 2002; UNAIDS 1997; Khaw et al 2000). The focus has largely been on the increased risk of infection among affected populations caused by the destruction and disruption resulting from emergencies and ways in which humanitarian responses can reduce vulnerabilities to infection.

The current southern Africa crisis is challenging conceptions of what defines famine and crisis. Even the terms famine and crisis themselves rely, in part, on a consensus about what is normal and the notion that crises are transitory. Just as some long running conflicts in Africa have introduced the concept of permanent crisis or the 'normalisation of crisis', the HIV/AIDS pandemic and levels of poverty in large parts of Africa raises the spectre of chronic crisis in countries at peace (Bradbury 2000).

The epidemic requires us to re-examine fundamental definitions of famine, emergencies and development. The devastating impact of the HIV/AIDS epidemic will be felt for decades and there is clearly likely to be a need for both humanitarian and development assistance in mitigating its impact.

There is, therefore, a need for clarity in understanding where humanitarian aid should be situated within the wider response to the HIV/AIDS epidemic. At the moment, there appears to be growing confusion between different arguments being made about the relationship between HIV / AIDS and food insecurity and what should be done in mitigation. In the introduction we distinguished four main arguments in the literature, summarised again here for convenience.

1. The argument that HIV/AIDS in and of itself should be seen as an emergency issue worthy of an emergency response due to the devastating impact it is having on mortality, morbidity and livelihoods.

2. The argument that the HIV/AIDS epidemic is an additional shock to livelihoods that has greatly increased the food insecurity of people making them more vulnerable to other shocks. There is therefore a possibility that natural and complex disasters will start earlier, last longer and be triggered more easily. The humanitarian community will need to adjust its way of doing business to take this hugely increased vulnerability to shocks into account.
3. The argument that the impact of HIV/AIDS on livelihoods means that some form of safety net or welfare system will be needed for those worst affected. At the same time development processes will need to mainstream HIV/AIDS issues in devising appropriate mitigation strategies. Relief will be needed as a long-term safety net in conjunction with other, more development orientated interventions.
4. HIV/AIDS can be seen as threatening a descent into permanent or periodic crisis in which underlying vulnerability is so great that there is a permanent emergency or chronic crisis, similar to that previously only seen in long running conflicts. This is the argument put forward by De Waal that the HIV/AIDS epidemic is causing or will cause 'new variant famines'. The impacts of HIV/AIDS are so devastating that we are facing, 'a new kind of acute food crisis in which there is no expectation of a return to either sustainable livelihoods or a demographic equilibrium'.

In fact, none of these positions seem to be mutually exclusive. One can argue the need for long-term safety nets for those worst affected by HIV/AIDS at the same time as needing to analyse the likely impact of the epidemic on other types of shocks and what this means for humanitarian action. A worst case scenario for the impact of the epidemic is outlined in the new variant famine hypothesis. In responding to a crisis in the context of an HIV/AIDS epidemic, humanitarian agencies clearly need to take HIV/AIDS into account, both in terms of policy and practical programming approaches.

The question of whether or not HIV/AIDS should be seen as an emergency in its own right depends on how one defines an emergency. Surprisingly, there is very little agreement within the humanitarian system about this fundamental concept and, as Darcy and Hoffman (2003: 2) argue, 'there is no shared definition of the humanitarian agenda'. They suggest four core elements for a humanitarian agenda; the protection of life, health, subsistence and physical security, where these are threatened on a wide scale.

Emergencies are generally considered in terms of acute shocks to peoples' livelihoods and there are many different definitions and classifications. Some of the most commonly used terms are presented below:

- Conflict based – a term used to describe emergencies caused by war
- Quick onset natural disasters – emergencies triggered by natural events such as a flood or earthquake
- Slow onset natural disasters – an emergency triggered by a natural disaster, usually drought, where the emergency develops slowly and the dividing line between normality and crisis is often blurred.

- Permanent emergencies – where there is a very large problem of structural poverty and a need for more or less permanent welfare.
- Complex emergencies – this term has become widely accepted shorthand to describe emergencies with a complex combination of causes, usually conflict related.

Traditionally emergencies were seen in terms of acute shocks to peoples' livelihoods that precipitated a crisis from which there was then a process of recovery and a return to development or normality. This simple formulation has increasingly been recognised as inadequate. The process of development often takes place in areas that are at serious risk of disaster, where conflict is frequent or where underlying vulnerability is such that development and emergency assistance take place at the same time. Emergencies in conflicts have often gone on for decades and the recovery process is often characterised by periods of uneasy peace and renewed conflict.

The HIV/AIDS epidemic can be seen as further blurring the distinction between emergencies and development. The epidemic fulfils some of the traditional criteria for an emergency – massively increased mortality and morbidity. However, emergencies are traditionally seen as short term crises, and the fact that impact of HIV/AIDS will be felt for decades makes defining it as an emergency problematic.

There are a number of ways to disentangle this question. One is to examine the question of the severity and scale of the impact of HIV/AIDS and to ask the question; is the impact of HIV/AIDS on livelihoods severe, acute and widespread enough to be deemed an emergency? A second approach is to consider the different modalities of emergency and development assistance and their appropriateness in responding to HIV/AIDS. These questions are examined further in the following sections.

### **3.2 Relief and Development: Where does the humanitarian community fit in?**

The HIV/AIDS epidemic requires a re-examination of the interface between the development and humanitarian communities, as any adequate response to the epidemic must clearly encompass both relief and development assistance.

The impact of the HIV/AIDS epidemic is already devastating and will continue to be so for decades to come. Attempts to mitigate its impact by governments, individuals, communities and the international community must therefore clearly adopt a long-term approach.

As emergency relief is frequently portrayed as a short term response there have been calls for the donor community to adopt a development rather than a relief response:

‘The donor community therefore needs to adopt a more developmental approach rather than a disaster relief approach, combining agricultural development programmes with food programmes and livelihood programmes (USAID 2003).

Others, however, have called for the HIV/AIDS epidemic to be classified, in its own right, as a humanitarian emergency;

‘The representative of the FAO ... suggested that the meeting identify HIV/AIDS as an emergency requiring an emergency response (UNAIDS and RIASCO 2002).’

WFP (2003: 10) argue that; ‘although HIV/AIDS requires an emergency response such a response must be based on a long-term approach’. They recommend that HIV/AIDS be considered as a basis for long-term relief programmes, a modality previously only used in long running conflicts.

‘When HIV/AIDS threatens food security and influences mortality in ways similar to other disasters, WFP will consider HIV/AIDS as a basis for a PRRO (protracted relief and recovery operation)’ (WFP 2003: 23)

A recent workshop highlighted the need for approaches to development to encompass areas traditionally seen as belonging in an emergency relief box;

‘Given the reality of AIDS, the entire approach to development must change. Interventions in any community should always combine development, relief and rehabilitation aspects. Without increased support through safety nets and other forms of ongoing social protection, standard development practice will not suffice for the most vulnerable’ (SARPN Workshop report 2003: 1)

This is not just an academic argument. These distinctions between relief and development can also be seen in the reality of the response of the international community to the food crisis in southern Africa in 2002 and 2003. In southern Africa, prior to the current food crisis, there were the normal plethora of government, UN and aid agency long-term development programmes addressing aspects of food security, agricultural development and HIV/AIDS. As a response to the food crisis gathered pace in 2002 a completely separate architecture of humanitarian response was developed to provide emergency relief. Aid agencies brought in separate emergency teams, new committees were formed and separate management structures created.

Emergency and development assistance have long been separated within the architecture of the international aid system. Western donors usually have distinct modalities and instruments for the funding of emergency and development aid. Development aid is generally delivered through states and is associated with building the capacity of the state and with the concept of sustainability. Emergency assistance, by contrast, is seen as the aid instrument of last resort, is associated with welfare and free provision of services and is more often used to fund non government organisations, the UN and Red Cross, bypassing governments. Development assistance is often provided with conditionality whereas emergency aid is politically unconditional.

The interface between relief and development, and calls for better links between them, has a long history in the academic literature (Buchanan Smith and Maxwell 1994). Increasingly, it was recognised that the traditional conception of a neat linear or sequential relief to development continuum was inadequate and that relief, rehabilitation and development assistance often took place simultaneously (Longhurst 1994; Walker 1994).

The last decade has also seen a series of important criticisms of the linking relief and development debate. Macrae (2001) argues that preserving the distinction between humanitarian and development aid is crucial to maintaining the integrity and technical efficacy of both forms of aid. In conflicts and complex emergencies, linking relief and development risks a process of normalisation characterised by a creeping acceptance of, ‘higher levels of vulnerability, malnutrition and morbidity’ (Bradbury 2000). Macrae and Leader (2000) also point out how work on relief to development links became linked to the debate on coherence and using aid for conflict reduction. This is problematic because it can threaten key humanitarian principles. Macrae et al (2002: 64) argue that the goals of humanitarian assistance need to be clear and distinct from development aid;

‘This suggests reinforcing the idea of humanitarian assistance as a distinct form of aid, subject to different rules that govern conditional development assistance. In other words humanitarian aid is unconditional and provided proportionate to need.’

The relevance of these criticisms to countries that are not in conflict is open to debate, but there are two main ways in which they can be seen to be relevant. Firstly, there is the argument that because the HIV/AIDS epidemic is starting to create growing levels of vulnerability, mortality and morbidity it too brings with it a risk of creeping acceptance and a process of normalisation. If these growing levels of mortality and morbidity become accepted as ‘normal’ and addressed within a development framework there is a danger of failing to address real human distress and provide what could be called either emergency relief or social support, that is not sustainable and represents a long term welfare commitment.

Secondly, even in countries that are not currently in conflict, there may be a need for humanitarian aid that is depoliticised and maintains key principles of neutrality and impartiality. Certainly, this is true in Zimbabwe where the current political crisis has led to the suspension of most forms of development assistance.

The issue, therefore, is not as straightforward as thinking of ways that relief and development can be better linked in the response to HIV/AIDS. There are strong arguments for maintaining the distinctiveness of humanitarian aid. This does not mean, however, that ways for the development and relief systems to interact more constructively cannot be suggested. This could take several forms;

- A recognition on the part of the development aid system and national governments that HIV/AIDS is likely to exacerbate and prolong crises and may lead to permanent low level crises that will require emergency response. The development system therefore needs to become more willing to accept the need for resources to be committed to relief or social protection and better at identifying and responding to crises (early warning).
- Donors and governments could accept that there is a need for resources to be committed to long-term welfare or social protection support in the worst affected countries as part of development funding.
- The humanitarian aid system could inform the development of long-term social protection systems by bringing to bear expertise in areas such as targeting, distribution of inputs and delivery systems.

- The humanitarian aid system could endeavour to improve the ways in which it links with ongoing development activities, governments and civil society whilst maintaining impartiality and distinctive modalities.

### 3.3 The impact of HIV/AIDS on emergencies?

The southern Africa crisis forced the issue of HIV/AIDS in non-conflict situations to the top of the humanitarian agenda. The argument that HIV/AIDS was a central component to the southern Africa crisis came about gradually. Initially defined as a food crisis caused by a combination of bad weather, bad governance and underlying poverty, AIDS was moved to the forefront of the agenda following the visit of the Special Envoy to southern Africa in 2002 (Darcy et al 2002, WFP 2002). De Waal's 'new variant famine' hypothesis and the argument that HIV/AIDS was a key factor in the southern Africa crisis has raised much debate about the extent to which HIV/AIDS was a major cause of the crisis (De Waal 2002; Morris 2003).

A study by the SADC (2003) suggests that HIV/AIDS did have strong negative impacts on some households but the scale of these impacts remains unclear. 'It is commonly agreed that HIV and AIDS have contributed to the depth of problems faced by rural households in southern Africa in the context of the 2002 food emergency. What is much less well understood is the extent of that contribution and how it varies by demographic structure and mortality and morbidity profile of households (SADC 2003: 1).

One way of looking into the question of scale would be to make an initial attempt to consider the number of households affected and in what ways, for an individual country and within a country at a district level. For example:

- Number of orphans / number of households fostering orphans
- Number of households affected by a prime age adult death in last 2 years
- Number of people infected by HIV/AIDS that are in the final stage of full blown AIDS and are therefore chronically ill.

At the moment these figures are simply not available, and one of the arguments that we will come to later is that maybe they need to start being collected as part of any early warning or monitoring system in countries badly affected by the epidemic. A very rough and ready attempt to do it has been made for Zimbabwe.

**Table 9: Rough estimation of the scale of AIDS impact on food security in Zimbabwe**

Estimated number of people living with full blown AIDS (approx 25% of people living with HIV/AIDS)	575,000
New AIDS deaths 2001 and 2002	400,000
AIDS Orphans 2001	780,000
Total	1,755,000
Total population of Zimbabwe	12,552,000
People likely to be acutely affected by AIDS related food insecurity as a percentage of population	14%

It should be stressed that this is just a very rough attempt to consider the question of scale. It counts the total number of orphans, not all of whom will be acutely vulnerable. It arbitrarily counts households that have had an AIDS death in the last 2 years and this could easily be extended. It also does not distinguish between the scale of impact in rural and urban areas, but prevalence rates and so the scale of impact currently remain much lower in many rural areas. Finally, it tells us nothing about the equally important question of the severity of impact.

What it brings to suggest is that HIV/AIDS in countries with very high prevalence rates will affect a significant enough percentage of the population to be a major contributory factor in food security crises. By undermining the livelihood security of significant numbers of people it will mean that smaller shocks are more likely to trigger emergencies and that these are likely to last longer and be more difficult to recover from. Whether the impact of AIDS on food security will become significant enough to create permanent crises remains unclear.

As the southern Africa crisis developed, Alex De Waal published a series of articles (De Waal and Tumushabe 2003; De Waal and Whiteside 2002; De Waal 2002) which argued that:

‘HIV/AIDS has such far reaching adverse implications that we are witnessing a ‘new variant famine’ (De Waal and Whiteside 2002).

The hypothesis argues that the models which have been developed for understanding peacetime famine in Africa depend on assumptions about household labour supply, skills endowments and long-term viability, which no longer necessarily apply in an HIV/AIDS epidemic. De Waal and Whiteside (2002) highlight four new factors, which characterise those affected by the HIV/AIDS epidemic; household labour shortages, loss of assets and skills due to adult mortality, the burden of care for sick adults and orphans and the vicious interactions between malnutrition and HIV. The impact of these new factors is that the effectiveness of traditional strategies used to cope with famine are reduced and in some cases rendered impossible or dangerous. For example, reducing food consumption is particularly dangerous for HIV positive individuals who have higher than normal nutritional needs. They conclude that in ‘new variant famine’ the prospects for a sharp decline into famine are increased, and the possibilities for recovery are reduced. The model is similar to that developed by De Waal (1990) for analysing conflict in which he argued that conflict resulted in more severe famines by preventing or undermining traditional coping strategies.

The core of De Waal’s argument for the possibility of ‘new variant famine’ is that existing coping strategies that have been used to survive famines in the past are likely to be fatally undermined by the impact of HIV/AIDS. Table 10 summarises the ways in which AIDS may undermine coping strategies.

‘New variant famine’ is presented as a hypothesis that has not yet been validated by research; ‘the hypothesis cannot be considered proven, but it provides a framework for policy-making, relief provision, monitoring and research’ (De Waal and Whiteside 2002). It is important to stress this point because the power and plausibility of the

argument has led to it being widely quoted and adopted as fact rather than hypothesis, for example;

*Unlike previous emergencies in Africa, the 'new variant' famine arising from HIV/AIDS impacts the core productive cohort of adults, rather than the marginal producers' (USAID 2002).*

There is a risk that a hypothesis about the possible future impact of HIV/AIDS can get transformed into an explanation of the current crisis.

**Table 10: How HIV/AIDS undermines coping strategies**

<b>Coping Strategies usually adopted in famines / periods of acute food insecurity</b>	<b>The likely role of HIV/AIDS</b>
<p>Adults go hungry, reducing food intake to the minimum</p> <p>Collection and consumption of wild foods (highly labour intensive and wholly female activity)</p> <p>Asset sales to cover immediate food needs or taking out loans</p> <p>Short term wage labour or labour migration, usually at very long hours for very low pay, often payment in kind</p> <p>Asking better-off relatives and friends for assistance, including placing children in their care for the duration of the famine (burden shifting to the better off)</p> <p>Reliance on the lowest end of the informal sector (firewood sales, commercial sex work)</p>	<p>Adults with HIV and AIDS cannot go hungry without running high health risks. Their food needs to stay healthy are increased.</p> <p>Most coping strategies are highly labour dependent. Households that have lost one or more adults, or which are caring for AIDS patients may lack labour to collect wild foods or work for money.</p> <p>Many coping strategies require specialist skills (wild food collection requires knowledge about the properties of roots, berries and grains). Typically this knowledge is passed from mother to daughter but AIDS may interrupt this.</p> <p>Effective coping strategies require strategic planning. Many are seasonal. This requires expertise born of experience. Without the requisite adults this expertise may be absent.</p> <p>Family and kin assistance networks are already overstrained by caring for orphans and the sick.</p> <p>The scarcity of adult women is particularly damaging to the successful pursuit of coping strategies.</p> <p>Many households have depleted their assets (including land and rights to land) to try to provide for the sick or orphans.</p> <p>Casual employment opportunities may be reduced</p> <p>Reliance on survival sex may increase.</p> <p>Crime may increase.</p> <p>Fewer are able to cope and return to their pre-famine livelihoods. More merely survive and suffer long-term livelihood loss.</p>

Adapted from De Waal (2002)

The 'new variant famine' hypothesis has served to galvanise the debate on AIDS and famine. However, a number of objections to it have been raised. Ellis (2003: 16) argues that, 'there is something rather too static about the endpoint of the new variant famine hypothesis. At household and community levels, HIV/AIDS adaptation, like other factors in evolving livelihoods, is a continuing process, not a linear sequence of events with a single definite destination.'

There have also been objections about the implied use of the new variant famine to explain the 2002 southern Africa crisis when in fact a famine did not occur, in the conventionally understood sense of high levels of acute malnutrition and excess starvation related mortality. Scott and Harland (2003) sought to assess the validity of the new variant famine scenario in Zambia. They found that HIV prevalence rates in rural areas were probably still at a relatively low 11%. They also pointed out that production of relatively labour intensive cotton has been growing fast throughout southern and eastern Zambia in the early 1990s, suggesting that shortages of labour from HIV/AIDS are not a dominant issue at the aggregate level. They concluded that; 'there is no evidence in Zambia to support the new variant famine scenario' (Scott and Harland 2003: 24). They argue that a misrepresentation of the HIV problem risks causing inappropriate programming in response to HIV/AIDS and risks a neglect of equally important problems affecting rural areas.

The emphasis on HIV/AIDS risks marginalising other factors, particularly political ones, and, therefore, could be used as a new and convenient way of depoliticising food crises. As Bird and Booth (2003) argue, limited linkages are made between politics, poverty and food insecurity, de-politicising debates which then focus on technical issues. The enthusiastic and rapid adoption of HIV/AIDS as a key explanation of the crisis in southern Africa can almost be seen as a development narrative in the making. Development narratives are a way of analysing the simplifying assumptions that enable policy makers to act (Roe 1991). Regardless of their truth, narratives serve to standardise, package and label problems. Often these development discourses serve to depoliticise poverty and powerlessness so that they can be portrayed as a set of technical problems (Ferguson 1990). Neglect of political factors is a frequent risk in work on natural disasters and emergencies and there is a clear risk that HIV/AIDS will be adopted as central explanation for crisis by actors keen to minimise political or governance issues. This could include governments but also aid agencies, that are often happier dealing with problems that are amenable to technical solutions and additional funding and resources.

This is not meant to suggest that work on the new variant famine hypothesis had any intention of minimising political issues. Indeed De Waal and Whiteside (2002: 8) explicitly make this point; 'the analysis does not neglect the role of factors such as drought and macro-economic disparities and mismanagement. Rather it points to the ways in which HIV/AIDS accentuates the existing difficulties.'

It is clear, is that HIV/AIDS will remain only one of a host of complex causes of food insecurity in sub-Saharan Africa and it is important that these are not overly marginalised in the new found enthusiasm on the part of the international aid community for addressing the links between AIDS and food security.

### 3.4 Conclusions

Emergency relief is only part of a much larger international response to the impact of the HIV/AIDS epidemic. It is important to be clear about what the relief system can do and what it can't. This study argues that the humanitarian system does have a role to play in the long-term response to the HIV/AIDS epidemic in two main areas. These are:

- Informing safety net design and welfare assistance as part of a long-term overall response to the impact of HIV/AIDS.
- Responding to crises which are exacerbated by the increased underlying vulnerability due to HIV/AIDS.

Whether or not the eventual impact of the epidemic will lead to permanent crisis or 'new variant famine' and hence a need for sustained emergency relief to be provided remains to be seen.

## **4 Humanitarian Programming: Current Practice in dealing with HIV/AIDS and towards identifying good practice**

### **4.1 Introduction**

This section will aim to summarise the lessons learnt by the humanitarian community from the crisis in southern Africa in dealing with the links between HIV/AIDS and acute food insecurity and suggest possible avenues for future good practice.

This section will be considerably expanded in the final report, following field work in southern Africa. In this inception report, it sketches out some preliminary findings based on interviews conducted in the UK, a review of the existing grey literature and correspondence with key stakeholders.

As Haddad and Gillespie (2001) argue, a HIV/AIDS ‘lens’ is needed. The study will make a start in holding this ‘HIV lens’ up to humanitarian programming (Gillespie and Loevinsohn 2003).

The southern Africa crisis raises a series of practical questions around the programming of humanitarian aid in the context of an HIV/AIDS epidemic. For example, do areas such as assessment, targeting and service delivery need to be adapted and should a wider response beyond the focus on food delivery be considered? The ongoing relief operation in southern Africa has left humanitarian agencies grappling at the field level with these questions. This has started to produce a body of practice in terms of responding to widespread food insecurity in the context of an HIV/AIDS epidemic (UNAIDS and RIASCO 2002; World Food Programme 2003, FANTA 2002). Practitioners on the ground have had to forge ahead with developing tools such as assessment and targeting methodologies but this practice remains largely within a grey literature of project documents and reports. There is therefore a need for research and policy to catch up with practice on the ground and clearly document what has already been achieved. This section will highlight some of the key programming issues and suggest ways in which aid agencies are currently addressing HIV/AIDS throughout the programme cycle and in different sectors.

The two over-arching questions guiding this section are:

- a. How has the humanitarian community incorporated the impact of the HIV/AIDS epidemic into its programming in response to the crisis in southern Africa?
- b. What areas need to be developed in applying a HIV/AIDS lens to humanitarian programming in order to develop recommendations for good practice?

## 4.2 Humanitarian Response and HIV/AIDS: A Brief History

The humanitarian system has been relatively slow to take on board the scale and the impact of the HIV/AIDS epidemic. Smith (2002) found that;

‘Many agencies providing humanitarian assistance have not included considerations of HIV/AIDS in their written policies or strategies for emergencies. In agencies’ thinking and policy development, HIV/AIDS has, at best, generally been understood as a sub-topic within broader subjects, notably medical practice, sexual health and sexual violence. Policies specifically addressing HIV/AIDS in emergencies exist but tend to focus on technical and biomedical issues, or on minimising the risks of infection faced by humanitarian workers.’ (Smith 2002: 13)

However, some progress has been made. Key developments include:

- UNAIDS produces Guidelines for HIV Interventions in Emergency Settings (1996).
- UNAIDS produces a technical update on Refugees and AIDS in 1997
- UNHCR updates its policy on HIV/AIDS and refugee populations in 1998
- Security Council debates HIV/AIDS in January 2000 and resolution 1308 calls for a coordinated response to HIV in peacekeeping operations.
- UN General Assembly declaration in June 2001 recognised that populations destabilised by armed conflict, humanitarian disasters and natural disasters are at increased risk of exposure to HIV and called on UN agencies and NGOs to incorporate HIV prevention, care and awareness strategies into their programmes.

The focus of these guidelines tended to be on HIV prevention, with comparatively little attention given to mitigation and care aspects and little or none to the wider impact of HIV/AIDS on poverty, food security and vulnerability to emergencies.

The focus on prevention was also narrow and largely focused on biomedical aspects, such as contaminated blood, inadequate sterilisation facilities or deficient health education (Smith 2002).

In the past two years, the issue of HIV/AIDS and emergencies has leapt to the top of the humanitarian policy agenda. This was prompted by a number of inter-linked processes. The revision of the Sphere Handbook provided an opportunity for HIV/AIDS issues to be incorporated. The Inter-Agency Standing Committee is in the process of producing a revised set of guidelines on HIV/AIDS and emergencies.

The greatest driver, however, was the response to the humanitarian crisis in southern Africa. As the humanitarian system began to gear up to provide large volumes of humanitarian aid in 2002, HIV/AIDS became increasingly cited as a major contributory factor to the crisis. This in turn galvanised the production of

policy at a headquarters level and led to, or coincided with, a number of policy documents. These include:

- Oxfam's (2002) draft guidelines on Mainstreaming and Integrating HIV/AIDS in Emergencies
- Christian Aid (2003) draft guidelines on HIV and food security in sub-Saharan Africa
- WFP programming guidelines (2003)

These are beginning to take a much broader view of the intersection between HIV/AIDS and emergencies and recognise the role that HIV/AIDS is playing in contributing to chronic food insecurity.

### **4.3 Mainstreaming HIV/AIDS**

It is increasingly realised that HIV/AIDS cannot be addressed as a separate issue or sector. The challenge for humanitarian agencies is to mainstream HIV/AIDS issues throughout the programming cycle, what Gillespie and Loevinsohn (2003) call an 'HIV/AIDS lens'.

Oxfam (2002: 6) usefully define mainstreaming as; 'how an organisation and the programmes it delivers must change in order to take account of the changing context that has been caused by the pandemic'. They see mainstreaming as both an internal organisational and an external challenge and define mainstreaming externally as;

'How our programmes must change to remain effective in an era of HIV/AIDS. For example, recognising that people may be too sick to access distributions they are entitled to and ensuring that another system is put in place to accommodate this fact or that the chronically ill may have increased water needs and ensuring that they are provided with extra storage containers or that tap stands are sited closer to their homes.'

The HIV/AIDS lens (Gillespie and Loevinsohn 2003) is a useful conceptual tool to first, help understand the dynamic interactions of HIV infections and AIDS impacts on different sectoral concerns and second, to identify appropriate policy and program modifications in the face of HIV/AIDS realities.

### **Box 7: The HIV/AIDS lens**

Existing development actions need to be subject to the following questions:

How do such actions affect people's susceptibility to HIV?

- Positive, negative, neutral?
- In what specific ways?

How do such actions affect people's vulnerability to HIV/AIDS impacts?

- Positive, negative neutral?
- In what specific ways?

Are these effects anticipated? Are they planned for?

Are the assumptions on which they were designed still valid?

Are the actions still relevant and appropriate, as currently designed?

Are there opportunities for strengthening resistance and resilience?

What needs to be done?

1. Do the same as before
2. Stop the programme or policy
3. Develop a new programme or policy
4. Modify the programme or policy by changing the:
  - Design (nature emphasis)
  - Implementation process
  - Target (ie who it should benefit)

#### **4.3.1 Gender**

The gender dimensions of the impact of AIDS are crucial and must therefore be reflected in humanitarian assessment and programming. There is an important literature that emphasises the need for gender sensitive programming in emergencies (Byrne and Baden 1995) and one on gender and AIDS (Tallis 2002; Baden and Heike 1999, Baylies and Bjura 2000). Gender issues also need to be taken into account in emergency response and one of the typical responses of programmes managers to HIV/AIDS is a resigned sigh at yet another issue that needs to be mainstreamed. However, gender sensitive and HIV sensitive approaches are closely linked and complementary.

Oxfam (2002: 47) for example, in their guidelines on mainstreaming and integrating AIDS in emergencies, make the following point;

‘There should be a continuing focus on gender analysis, given the close link between gender inequity and vulnerability to HIV. Many of the ideas outlined in this book are relevant to a gender aware approach also and focus particularly on preventing sexual and gender based violence. Gender and protection are also therefore inextricably linked.’

Gupta (2000) has provided a useful typology of responses to HIV/AIDS ranging from gender damaging to gender empowering approaches, shown in Box 8. These apply equally to humanitarian as to development programming.

Some examples of ways in which humanitarian programming may need to take gender and HIV/AIDS into account that have emerged from the southern Africa response are given below:

- Gender sensitive service delivery – e.g food distributions that take place at times that are suitable for women, that minimise risks of gender based violence
- Capacity building – a recognition in working with CBOs, and in developing community based targeting of need, for both men and women to be represented and able to have a real voice.
- HIV awareness and prevention campaigns linked to emergency programming are gender sensitive.

**Box 8: Gender and Programming: A Typology of Responses (Gupta 2000)**

*Gender Damaging Programming:* interventions that reinforce damaging gender and sexual stereotypes.

Examples: Prevention campaigns that foster predatory, violent and irresponsible images of male sexuality and portray women as powerless victims or repositories of infections. For example, using a macho image of men to sell condoms.

*Gender neutral programming:* approaches that do no harm to gender and sexual stereotypes. They are often less than effective because they fail to respond to the gender specific needs of individuals.

Examples: Prevention messages that are not targeted to any one sex such as ‘be faithful’. Also, treatment and care services that make no distinction between the needs of women and men.

*Gender Sensitive Approaches:* that recognises and responds to the differential needs and constraints of individuals based on their gender and sexuality.

Examples: Providing women with a female condom or microbicide. Efforts to integrate STD treatment services to help women access such services without fear of social censure.

*Gender transformative approaches:* that seek to transform gender roles and create more gender equitable relationships.

Examples: Programmes that seek to foster constructive roles for men in sexual and reproductive health and reduce violence against women. Efforts to work with couples, such as couple counselling in HIV testing clinics. Intervening early to influence the socialization of young boys.

*Gender empowering approaches:* that seek to empower or free women and men from the impact of destructive gender and social norms.

Examples: Programs that empower women by improving their access to information, skills, services and technologies, but also go further to encourage participation in decision making

#### 4.4 Prevention

One of the key principles must be that emergency interventions do not increase peoples' vulnerability and susceptibility to HIV/AIDS. Prevention can be viewed at several levels:

- Awareness raising and education on HIV/AIDS issues for aid agency staff
- HIV/AIDS prevention activities linked to relief programmes
- Structuring relief programmes to minimise the risks of HIV transmission through, for example, sexual violence

Prevention activities has thus far taken two main forms; educating programme staff about HIV/AIDS risks and conducting prevention campaigns for beneficiaries linked to relief distributions.

Oxfam (2002) argue that staff awareness raising must be a priority in order to avoid the staff of aid agencies acting as vectors of transmission. A recent study of sexual exploitation in West Africa demonstrated the risk that staff in positions of power will abuse their positions (UNHCR and Save the Children 2002).

In an information note intended to outline WFP's approach to addressing HIV/AIDS WFP (2001: 7) stated that;

‘cooperation with partners in education and prevention should be linked to all of WFP's development, recovery and emergency programme interventions, whenever and wherever possible’

Aid agencies in southern Africa have begun to attach HIV/AIDS prevention activities to their food programming. Examples include:

- In a WFP urban food aid programme in Zambia: Training of drama and theatre groups to develop plays and music that are intended to raise awareness of HIV/AIDS. The groups perform their plays and songs just before the beneficiaries receive their rations (UNOCHA 9 June 2003 brief)
- UNICEF and WFP are working on sensitisation and HIV/AIDS awareness through drama during food distribution (UN RIASCO update April 4 2003)
- WFP, UNICEF and Save the Children conducted training on the protection of women and children from sexual exploitation. The workshops were aimed at field staff, truck drivers, transport managers and distribution managers. (UN RIASCO update April 4 2003)

#### 4.5 Minimising Risk

Aid agencies are also beginning to examine how relief programmes can be structured so as to minimise the risks of HIV/AIDS transmission. For example, food distribution sites, in a similar way to rural weekly markets and trading centres, may be important sites of social and sexual contact and thereby create situations of risk. Thought needs to be given to where distribution sites are situated, when distributions are conducted

and the environment that is created, in order to reduce situations of risk. This applies across sectors so, for example, water and sanitation interventions need to consider the siting of water points in order to minimise risk.

What this means in practical terms is, as yet unclear. Minimising waiting times may be one suggestion. With reference to weekly markets it has been suggested that if markets opened and closed earlier some of these risks could be reduced and the same might apply to relief distributions (Bota et al 2001; Ngwira et al 2002).

#### **4.6 Assessment and Early Warning**

Assessments and early warning systems will increasingly need to take HIV/AIDS issues into account. De Waal and Tumushabe (2003) point out that early warning systems will need substantial methodological revision to take account of new vulnerability factors. Early warning systems are currently based on models that assume a geographic basis for vulnerability and a time bound crisis that may not be relevant for HIV/AIDS related food insecurity.

Emergency assessments will also need to be adapted. Oxfam (2002), for example, states that; ‘assessments must establish basic data on HIV prevalence’. However, attempts to do this are at an early stage and at the moment there are as many questions as answers about what information needs to be collected, how best to do this and how information on HIV/AIDS should inform programme design.

Some of the key outstanding questions are:

- What new tools have already been developed? How can HIV/AIDS issues best be incorporated into existing assessment methodologies?
- What new indicators are being developed and are needed? How can these be integrated into existing systems?
- How was AIDS taken into account or not in existing early warning systems in southern Africa?
- Is there a need to overlay HIV prevalence figures on existing vulnerability models in early warning systems?
- Are prevalence figures robust and differentiated enough for this and what would it mean in practice?

The assessment process in Southern Africa has led to the development and use of set of proxy indicators to try and assess the impact of HIV/AIDS on vulnerability (Zambia VAC 2003; WFP 2003). These have included;

- Chronic illness: have any adults been ill for more than 3 months during the last 12 months?)
- Mortality: has any adult died in the last year? After being ill for more than 3 months?
- Orphans: number of orphaned children in the household who have come from other households?
- Recent Deaths

- Age of the household head

These groups were seen as potentially more vulnerable to food insecurity and prioritised for assistance. However, as argued in SADC (2003: 17); ‘it would be a mistake to allow concern for high rates of HIV/AIDS to overly bias decisions concerning geographic targeting of emergency and recovery interventions after a shock that affects both high and low HIV/AIDS prevalence areas.’

Oxfam (2002: 56) recommends that the following elements are included in the terms of reference for an initial emergency assessment;

- Is HIV/AIDS relevant to the proposed project?
- Is the project operating in an area where labour is a constraint?
- Is the project operating in social sectors affected by HIV/AIDS?
- How are women affected by the emergency and what risks do they face of sexual and gender based violence?
- Will there be increased mobility of the labour force?
- Will the project have employee benefits increased by HIV/AIDS related illness?
- What potential impact might the project have on HIV/AIDS?
- Will certain groups be disadvantaged by the project?

#### **4.6.1 Indicators and Measurement**

Aid agencies currently use a variety of key indicators in the process of assessing need. Mortality rates are used as an indication of crisis. A crude mortality rate of greater than 1 is taken to indicate a crisis and 2 to indicate an emergency. This is based on an assumption that the baseline CMR is 0.5. The excess mortality arising from HIV/AIDS brings this assumption into doubt.

If the baseline CMR is in fact significantly higher there is a risk that assessments will argue that mortality rates indicate a short term crisis when what higher mortality rates are in fact reflecting is the long term underlying increase in mortality from HIV/AIDS.

At the moment this remains speculative and hypothetical. Yamano and Jayne (2002: 1) point out that, ‘in parts of Africa, mortality rates in the 15 to 54 cohort have risen dramatically since the onset of AIDS.’

The other main quantitative indicator of crisis used by the humanitarian system is malnutrition rates. These may similarly be affected by HIV/AIDS in ways that are not yet clear, raising the risk that assessments will trigger a response based on assumptions about a short term crisis, when in fact the figures are showing the long term impact of HIV/AIDS. These issues are discussed in more detail in the section on nutrition.

## 4.7 Targeting

Targeting HIV/AIDS affected households for assistance raises a great number of difficult issues. Firstly, there is the problem that most people are not aware of their HIV status, so it is not possible to simply target people with HIV/AIDS. For those people that chronically ill from HIV/AIDS or household where adults have recently died, there is a risk that targeting them for assistance could increase the stigma already attached to HIV/AIDS and deepen their vulnerability. If the aim of assistance programmes is to address food insecurity then HIV/AIDS may be only one of many factors contributing to vulnerability. In targeting HIV/AIDS affected households for assistance there is therefore huge scope for both inclusion errors (including people without HIV/AIDS) and exclusion errors (excluding people in need of assistance).

In southern Africa in 2002, the vulnerability assessment process used proxy indicators such as chronic illness and number of orphans to target various HIV affected groups for assistance. Target groups included orphans and their carers, households affected by chronic illness, elderly headed households, and households with a recent adult death.

One of the key issues in targeting based on HIV/AIDS is to ensure that people need the assistance. WFP (2003) has adopted the following principle;

‘WFP targets its HIV/AIDS assistance based on food insecurity indicators and not on an individual’s HIV status. WFP will focus on geographic zones that are food insecure and that have been particularly affected by the pandemic and within those zones, on households whose food security is threatened by the pandemic.’

This of course begs a number of questions, notably;

- What about when areas of high HIV/AIDS prevalence don’t overlap with areas of high food insecurity?
- What about urban areas?
- If proxy indicators of HIV/AIDS (chronic illness, numbers of orphans) are used as food insecurity indicators, then assistance may still be targeted based on HIV status and not food security.

SADC (2003) argue that two of the proxies used in the vulnerability assessment process in southern Africa should be considered by agencies for targeting; the chronic illness of the head of a household and elderly headed households. However, they also make the point that these would need to be cross checked with wealth group analysis as taken separately they may not be robust indicators of vulnerability.

### 4.7.1 Stigma

The question of how to target households affected by HIV/AIDS without adding to the stigma that these families might be facing is a difficult and critical point. Oxfam (2002: 48) suggest the following principle:

‘Targeting of people living with HIV/AIDS may increase stigma and discrimination against this group so should only be undertaken after careful consideration and with the participation and consent of the beneficiary group.’

One of the ways in which organisations are approaching the dilemma of supporting people affected with HIV/AIDS without increasing stigma is to aim to work with existing community organisations that are already working with HIV/AIDS affected households. For example, WFP (2003: 12) states;

‘WFP will support established community based organisations when carrying out HIV/AIDS activities in order to avoid the negative consequences associated with HIV stigma.’

However, this raises problems of scale, capacity and the equity of community based targeting. Existing CBOs are unlikely to be able to reach large numbers of food insecure people. In 2002 food aid in southern Africa was distributed largely by international NGOs with food aid targeted by relief committees at a village level.

Relying on community targeting, or community safety nets may mean accepting discrimination, the use of power, and the likelihood that the poorest and the weakest will lose out. Howell (1988) describes a programme in Ethiopia in which committees drawn from local institutions excluded certain sections of the community. Community safety nets necessarily reflect the entitlements embedded in prevailing power structures within a given community. Baylies (2002: 624) makes the important point that, ‘to the extent that HIV feeds on structured inequalities and power relations (not least those around gender) reliance for assistance on structures and mechanisms which reinforce rather than challenge those inequalities is of questionable value.’

Some agencies have found that if households and communities see that there are real benefits to be accrued in terms of support then people may be more willing to acknowledge HIV status and stigma can be reduced. (Christian Aid pers comm.)

There is of course of a wider question raised by the difficulties of attempting to target assistance at the most food insecure people. Given the limitations in capacity of governments, international aid agencies and civil society in the worst affected countries it is unlikely that sufficient resources will be available to target effectively using administrative or community targeting techniques. This raises the question of whether there should be consideration of some form of universal benefits, which do not require targeting. In South Africa, for example, research has shown that pensions have huge positive impacts in enabling elderly people to cope with the additional burdens of care created by HIV/AIDS. In Botswana, support is given to all families that are supporting orphans. Recent research by ODI in India (Farrington et al 2003) suggests that small cash payments based on universal entitlements are much more effective and less prone to corruption than targeted in-kind transfers.

#### **4.8 Food Programming**

The response to the southern Africa crisis was overwhelming focused on food aid (Darcy et al 2002). The bulk of experience in humanitarian programming during an

AIDS epidemic is therefore in the food aid sector and this has also attracted the majority of the slim literature on humanitarian programming and AIDS (FANTA 2000, WFP 2003, Bonnard 2002).

Again, however, the humanitarian system is at an early stage in adjusting to the implications of the HIV/AIDS epidemic and many key questions remain open. Some of the key questions are considered here;

- When is food aid appropriate as a resource?
- Are different rations sizes needed?
- Do the number and frequency of distributions have to be increased?
- Do adjustments have to be made to nutrition programmes?

#### **4.8.1 Food Aid Appropriateness**

Food aid continues to often be seen as a free or additional resource. There seems to be have been a widespread assumption in southern Africa that food aid is available and its appropriateness as opposed to other possible interventions has rarely been assessed. This is clearly a much wider question than it is possible to address here, but some guidelines have been suggested for when food aid can be appropriately used.

FANTA (2000: 11) do outline ‘situations where providing food aid is not an appropriate or desirable response.’ These are:

- Where the risk is high of stigmatising PLWA or affected households
- When short term interventions cannot be sustained to match longer-term needs
- When individuals or affected households are able to meet their own food needs
- When cash is more appropriate than food, but monetization is not possible due to a disincentive effect on local markets
- When available foods for food aid are inappropriate for dietary needs or cultural conditions.

WFP (2001) has argued that food can be a key resource in mitigation activities that focus on reducing the impact felt by families or communities whose food security has been jeopardised by HIV/AIDS. They argue:

‘The provision of food to HIV affected households enables those households to retain some of the resources that might otherwise be spent on purchasing food and medicine.. It may also enable foster families to welcome orphans while maintaining their households’ food and nutrition security.’ (WFP 2001: 7)

WFP also outlines a set of key principles for food aid programming for mitigation of HIV impacts. These are shown in Box 9 (WFP 2003: 11):

### **Box 9: Principles for WFP programming for HIV/AIDS**

The entry point for WFP involvement will always be situated in nutrition and food security. WFP's interventions will target beneficiaries based on their food security status, not their HIV status.

When and where appropriate, WFP will take HIV/AIDS into account in all of its programming categories and in all assessments of needs.

WFP's HIV/AIDS response in specific countries will depend on the national strategy and will always fit within the government's framework for action.

In order to minimise the debilitating stigma and discrimination often associated with HIV/AIDS, WFP will support local non-government organisations and community based organisations, including associations of people living with HIV/AIDS. WFP will use food aid to complement and scale up existing government, United Nations and NGO partner activities in prevention, mitigation and care for HIV affected HIV infected and affected individuals and families.

WFP food assistance will place special emphasis on women and vulnerable children, in particular orphans, and will support the broader national and international response to HIV/AIDS to ensure that food aid is part of a larger package provided to HIV affected households and communities.

### **4.8.2 Ration Types**

People with HIV/AIDS require more energy and protein. This has led to calls to revise the both the scale and type of rations being provided in emergencies in countries with high rates of HIV/AIDS prevalence. However, the difficulty of targeting only people with HIV/AIDS with increased rations raises difficult resource questions.

Research has suggested that compared with an average adult an individual with HIV requires 10-15% more energy a day and 50-100% more protein per day (Woods 1999 in Oxfam 2002: 72). However, these recommendations are currently being revisited by a WHO working group on HIV/AIDS and nutrition and may be adjusted.

In the early stages of HIV infection adequate nutrition can help to slow the progression to HIV/AIDS and diets rich in protein, energy and micronutrients are likely to help build immune resistance to opportunistic infections. This has led for calls for rations to be revised to reflect the needs of people living with AIDS. WFP fortified maize that had to be milled in southern Africa, in part as a response to the additional nutritional needs of people with HIV/AIDS. Save the Children and Oxfam called for adaptations to food rations during the 2002 food crisis.

‘food rations must be adapted to the specific needs of people living with HIV/AIDS. Donors need to supply non-maize food with high nutritional values, such as oils, beans, pulses, Corn Soya Blend for infants etc’ (Save the Children and Oxfam 2002: 5).

FANTA (2001: 49) provide detailed guidelines for calculating appropriate ration sizes and composition for people living with HIV/AIDS. They suggest that food aid programmes should address the following issues in developing rations:

- Does the food to be included meet the nutritional needs of adults and children? Is it well tolerated and easily digestible by a child or an adult who is sick with AIDS?
- For many young children and infants, there are limits in the volume and bulk that can be digested.
- For a person sick with AIDS, poor absorption of foods is common.
- For young children and HIV-infected persons, foods that are high in protein and micronutrient content (such as fortified corn soy blend) are more beneficial and easily digestible

In practice providing people living with AIDS with different and additional foods is likely to be very difficult, given the fact that most people do not know their HIV status, the stigma surrounding AIDS and difficulties of targeting. The question then becomes whether or not general rations sizes should be increased for all people in areas of particularly high HIV prevalence, a policy that would have huge resource implications.

#### **4.8.3 Distribution Issues raised by HIV/AIDS**

The labour constraints and burden of illness in high HIV/AIDS prevalence areas raises a question about how far it is appropriate for people to travel to distributions, how long they should wait and how much they should be expected to carry. Ntata (2003: 12) raised these questions in Malawi,

‘two issues in the design of the current EMOP seem to be particularly insensitive to the HIV/AIDS affected target group, namely long walking distances to Final Distribution Points and heavy sacks of food.’

Ntata recommended considering reducing the weight of commodities that had to be transported either by more frequent distributions of smaller amounts or through village level storage.

HIV/AIDS places increasing labour responsibilities on children. In 2002, it was argued that children were sometimes responsible for collecting food distributions and that this was impacting on schooling. A Save the Children representative noted, ‘young peoples’ schooling is being undermined through poor planning by food distributors as many were forced to leave their schools to go and get food’ (UNAIDS and RIASCO 2002). The Zimbabwe December 2002 vulnerability assessment asked whether female headed households, child headed households and chronically ill headed households faced particular difficulties in accessing food aid. The main problems cited were:

- Multiple responsibilities; the lack of time to seek food, engage in income earning activities and care for children, the elderly and/or the sick
- Their relative lack of strength in situations of ‘first come, first served’ and lack of mobility preventing people from getting to distribution points.

- The lack of representation, especially for children or the chronically ill, meaning that they may not get registered for food aid or Grain Marketing Board (GMB) food.

Of course, having more distribution points and distributing smaller amounts of food more often would significantly raise distribution costs. In Malawi, food was trucked straight to extended delivery points and distributed without being stored. This saved on storage costs for WFP and its partners, but meant that beneficiaries often had very long waiting times for food when there were delays in the delivery chain.

SADC (2003: 17) argue that;

‘Due to the decreased mobility of households affected by HIV/AIDS, special efforts will need to be made to reach them. Simply distributing food at a central distribution point may not be enough. Agencies will need to consider how they can work with communities to ensure that HIV/AIDS affected households receive their quota. This may involve provision of transport and/or increasing the number of distribution points.’

#### **4.8.4 Non Emergency Food Aid Programming**

The question of whether and how food aid should be used in development programming is a thorny issue that has been long debated outside the context of HIV/AIDS, with some commentators calling for food aid to be more tightly focused on emergency relief and others maintaining that food aid has a role in development. HIV/AIDS can be seen as providing a new justification for the continuation of developmental food aid programming. Certainly, in southern Africa as the immediate emergency needs declined HIV/AIDS has been cited as the main justification for the continuation of food aid programmes.

C-Safe is a collaboration between CARE, Catholic Relief Services and World Vision. It aims to, ‘provide a coordinated response to the food shortage in southern Africa and the related complexities of the existing HIV/AIDS pandemic’ (World Vision 2003). In Malawi, for example World Vision is targeting the chronically ill and orphans with continuing food aid programmes.

WFP (2003 and 2001) suggests the following programming options for food aid, related to HIV/AIDS mitigation;

- School feeding, with take home rations for families caring for orphans
- Food support for orphans and their families
- Food for training in livelihood diversification
- Food for home based care services
- Food assistance to TB patients
- Food for vocational training for street children and orphans
- Food for work and food for training
- Food assistance for those that are ill and their families

School feeding programmes are currently being promoted as particularly beneficial, both in terms of their nutritional benefits and in reducing the drop out rate.

HIV/AIDS raises important issues with regard to the design of food for work programmes, due to the labour constraints of affected households. SADC (2003) for example make the point that the type of work should be within the capacity of the elderly and adults that are not at their peak health. They also argue for food programmes that are not labour dependent, such as ones focused on skills development or awareness campaigns that are accessible to the elderly and children.

#### **4.8.5 Urban Programmes**

Agencies are starting to grapple with the issue of urban food insecurity in southern Africa and particularly in Zimbabwe. As HIV/AIDS prevalence rates are often higher in urban and peri-urban areas it is likely that HIV/AIDS related food insecurity will be particularly high in urban areas.

In May 2003 FEWSNET recommended for Zimbabwe that; food aid assistance should be scaled up in innovative forms in urban areas including food monetisation and programmes that target orphans and HIV/AIDS patients.

Examples of urban programmes are:

- C-Safe (consortium of southern Africa food emergency) is providing 15,000 MT of sorghum through the market in a monetization programme aimed at Bulawayo in Zimbabwe. (FEWSNET May 2003)
- A WFP urban intervention programme in Zambia that targets 60,000 orphans and vulnerable children and their caretaking families (UNOCHA 9 June 2003)
- WFP pilot urban intervention in Bulawayo, implemented by HelpAge to provide food aid to families with children under five who demonstrate signs of 'growth faltering'. (UN relief and recovery unit, Zimbabwe 24 March 2003)

#### **4.9 Nutrition**

In emergency situations nutritional programmes have conventionally focused on supplementary and therapeutic feeding for acutely malnourished children under five. Pregnant and lactating women are also sometimes included in supplementary feeding programmes. Adult malnutrition is often not addressed. The HIV/AIDS epidemic challenges conventional nutrition programmes in a number of key areas.

In areas where prevalence rates are very high, significant numbers of children may have HIV/AIDS due to mother to child transmission. These children are likely to be disproportionately represented in therapeutic feeding centres because of the vicious cycle between AIDS and malnutrition. A recent study on drought, AIDS and child malnutrition in southern Africa (Mason et al 2003: 12) estimate that about 10% of children less than 36 months may have AIDS and be failing to grow as a result. After the age of three these children mostly die.

'Thus the age distribution of growth failure may be changing; prevalence of children 6-36 months may measure a mix of AIDS and deprivation, whereas in

the 36-60 months age group is expected the more familiar underweight due to malnutrition.’

The study analysed available nutrition survey data from southern Africa to come to some initial conclusions. These were:

- There may be a trend for significantly increased underweight prevalence in 1-2 year old children and decreased or steady underweight prevalence in 4-5 year olds which may be due in part to AIDS and to mortality changes.
- Sharp deterioration in nutrition status may be occurring in peri-urban areas (around Lilongwe, south of Lusaka, near Maputo), more pronounced in younger children.
- HIV prevalences show strong associations with underweight prevalence but in a complex way. High HIV prevalence areas are thought to be those nearer urban areas, and certainly tend to have lower prevalences of underweight. However, high HIV areas are showing more deterioration in underweight prevalence.
- Orphans have at least double the prevalence of underweight compared to those with either or both parents alive.

A problem with therapeutic feeding centres has always been the health risks of cross transmission of opportunistic infections from gathering a large number of sick children together in one place. The weakened immune system of people living with AIDS means that these risks are increased.

Children with HIV/AIDS and acute malnutrition are less likely to recover as quickly in therapeutic feeding centres. Children having to remain in centres for longer periods will increase the costs of nutrition programmes. As FANTA (2001: 54) point out; ‘the timeframe for rehabilitating a malnourished child is generally four to six weeks, for HIV infected adults and children, however, weight gain may not be sufficient and programmes will need to assess whether nutritional care or more intensive medical treatment is needed.’

It is also likely that a HIV/AIDS will produce a higher case fatality rate for children in TFCs suggesting a possible need to revise baseline indicators and minimum standards.

HIV/AIDS may also increase the prevalence of acute adult malnutrition and suggest the need for nutrition programmes to further develop protocols for evaluating, admitting and treating adults.

An interesting development in recent years in the nutrition field has been a growing body of experience with community based forms of therapeutic care using take home food rations such as plumpinut (Collins 2003) These may have added value in the context of an HIV/AIDS epidemic by reducing cross infection risks and reducing the labour demands on the main carer of acutely malnourished children, given the labour constraints on the household from HIV/AIDS.

## 4.10 Other sectors

The response to the 2002 crisis in southern Africa was overwhelmingly focused on food aid. Darcy et al (2002) argue that there was a need to consider health and other sectors. Some of the main questions are:

- Does the HIV/AIDS epidemic suggest that a wider response to need is required?
- If so, what other interventions are priorities?
- What additional interventions have been tried and how have they worked in southern Africa?
- How should health service provision in emergencies incorporate HIV/AIDS issues?
- How do livelihood promotion activities including seed and tool distributions need to take HIV/AIDS issues into account?

### 4.10.1 Health

Support to health systems was a comparatively neglected issue in the 2002 crisis. As Darcy et al (2002) argue; ‘the provision of food aid, while potentially crucial to the welfare of those with HIV/AIDS and their families, cannot in itself be said to constitute an adequate humanitarian response’. In a case study of the assessment of need in southern Africa they found that, ‘the options for preventive interventions, basic curative care, for palliative care, for support to families with affected members, for the treatment of opportunistic infections leaving aside the possibilities of anti-retroviral drug treatment – all with the aim to keep as many people as healthy as possible for as long as possible, form an agenda that seems still to be strangely neglected by humanitarian agencies (Darcy et al 2002: 33).

The most likely explanation for this neglect is that support to the health sector is seen as a long term and a development problem that is not amenable to a short term humanitarian response in the same way as food aid. As Darcy et al argue it is harder to understand the health sector in terms of deficits below a certain norm. In Malawi, less than 50% of the population had access to basic health care before the current crisis and the health system was already struggling to cope with the increasing burden of disease related to HIV/AIDS. Humanitarian health responses tend to be triggered by short term increases in the disease burden, for example from cholera outbreaks, or when population movements create a clear risk of additional disease and clear need for additional services.

There is a clear need for health care during emergencies in the context of HIV/AIDS epidemics, just as an adequate diet is necessary for people living with AIDS so is adequate basic health care. However, the extent to which health systems are already degraded and access to basic care eroded in many African countries, means that the obvious response of support to strengthen existing health systems is seen as beyond the scope of humanitarian response. There are links here to the idea from the literature on conflicts of the normalisation of crisis. What should be unacceptably low levels of access to treatment and care become normalised and accepted over time.

This is not to say that response is not possible and indeed there are some interesting pilot schemes. For example, MSF in one district of Ethiopia is providing an integrated programme of support to the Ministry of Health that includes the provision of anti-retroviral treatments.

Just as the impact of HIV/AIDS on food security implies the need for the long-term welfare provision, it also implies the need for long-term and more adequate support and financing for health care systems.

#### **4.10.2 Water and sanitation**

Frequent exposure to parasitic and diarrhoeal illnesses associated with poor water and sanitation can speed the progress of HIV/AIDS infection to full blown AIDS. Those people with weakened immune systems are more susceptible to parasitic infections. Oxfam (2002: 69) highlight the following issues (mainly from a camp perspective) in water and sanitation provision in areas of high HIV/AIDS prevalence;

##### **Box 10: Water and sanitation Programming Issues (Oxfam 2002)**

Consider the out of sight needs of chronically ill bedridden people. They need a lot of water for washing due to the fevers, vomiting and diarrhoea that they suffer from.

Carers may be unable to look after sick people and collect adequate amounts of water. Consider closer tap stands, assistance in gathering water, or special deliveries of water to bedridden people.

Place latrines, water points, washing facilities, shelter in locations decided by the women in the community in places believed to be safer.

Install lighting to improve the security of latrines, washing facilities, shelter

People who are chronically sick may have difficulty in using latrines – consider provision of bedpans for these groups if acceptable.

#### **4.10.3 Livelihood Support**

HIV/AIDS affects peoples' livelihoods in complex and diverse ways. Food aid may not be the only possible response. Support to livelihoods is a broad term for a wide range of possible responses ranging from seeds and tools to cash grants. However, experience with broader livelihood responses in emergencies remains limited.

In southern Africa, non food interventions in 2002 and 2003 have focused mainly on support to agricultural production, mainly seed distributions. HIV/AIDS raises a number of issues for seed distribution. Firstly, there is the question of what types of seeds are most appropriate. If, as has been suggested, there is a need to promote low input, low labour cropping systems then the types of seeds that are appropriate may be different from standard packages. Equally, if tools are provided then there may be a need for adaptations. Examples of AIDS related innovation cited in the literature include tools that are light enough for use by children and the elderly. Of course, recent innovations in seed programming suggest that distributing seed may be less

effective than alternative interventions such as seed vouchers and seed fairs, leaving the choice of seed in the hands of individual farmers and stimulating local seed markets (Longley and Sperling 2002).

There has been little experience in 2002 and 2003 in southern Africa with alternative interventions such as cash grants. This may be an important avenue for further exploration given that many of the most immediate impacts of HIV/AIDS are financial.

#### **4.11 Partners**

The long-term nature of the HIV/AIDS epidemic and so the possible need for long-term relief assistance for the most vulnerable raises the question of the most appropriate providers of assistance. The stigma attached to HIV/AIDS and the consequent difficulties in targeting have also been raised as arguments for increasing the involvement of community based organisations in relief assistance. The central question that this section will look at is:

- Who are the most appropriate deliverers of humanitarian assistance in the context of what will possibly become a longer term crisis?

The 2002 response relied heavily on international aid agencies notably WFP, the Red Cross movement and a relatively small number of large international NGOs. National governments were much less involved than in the 1991/92 crisis. The reasons for this vary. In Zimbabwe, government was deliberately marginalised to the extent possible due to the political nature of the crisis and fears about the manipulation of aid for political advantage. In Malawi, donors were concerned about government corruption, especially as it related to the sale of the strategic grain reserve and so key donors deliberately used international aid agencies rather than government to manage the response. In general throughout the region, government capacity is seen to have declined in the past decade.

The extent to which these international aid agencies involved local partners varied from agency to agency. In Malawi there was certainly a perception on the part of local organisations that they had been marginalised (Borton pers comm.). Ntata (2003) writing about Malawi called for the involvement of more locally based organisations in the structure of the food distribution operation and the provision of support to build their capacity. Organisations specifically involved in ongoing HIV/AIDS mitigation and care programmes have been put forward as possible partners with the suggestion that they would be better able to successfully target HIV/AIDS affected families without bringing stigmatisation problems.

The IFRC used its existing home based care programmes to carry out food distributions in 2002, explicitly targeting HIV/AIDS affected families as a complement to the wider WFP food distribution programme. Churches are also often heavily involved in home based care and have been used as partners by international church based organisations such as CAFOD, Christian Aid and Tear Fund.

‘The explosive combination of acute food shortages and HIV/AIDS in southern Africa has called for the continuation of the food security operations beyond July 2003. The Federation and national societies in Southern Africa have developed an extensive network of home based care programmes, which provide basic care and assistance to people living with AIDS and their families. Through the Home Based Care programmes and local Red Cross clinics, the Federation and the national societies have been able to channel supplementary food rations to people infected and affected by HIV/AIDS. The initiatives have proved particularly effective in Zimbabwe where the magnitude of food crisis and the magnet of food aid have brought to light many HIV infected and affected people who were earlier obscured by stigma in the communities. There has been dramatic increase in both the number of home based care clients and orphans. This has stretched the capacity of the existing Red Cross HBC programmes, and indicates a need for more resources to support the programmes (IFRC 2003)’.

However, it is important to guard against an uncritical enthusiasm for greater involvement of local CBOs and NGOs in relief programming in the context of the HIV/AIDS epidemic. There are clearly huge questions about the capacity of these relatively small organisations to manage large-scale relief programmes. The 2002 response required food to be provided to over 14 million people across 6 countries with very little planning and preparation time and, in this context, some marginalisation of small local organisations was probably inevitable. Greater involvement of local organisations could have huge resource costs in terms of the time and resources that would need to be devoted to capacity building. Often, local organisations also have ongoing activities that risk being neglected during a relief response.

Oxfam (2002) raises the point that assumptions underpinning partnerships may need rethinking, given the impact of HIV/AIDS on institutional capacity (sickness, absenteeism, death, loss of institutional learning etc.)

An equally important, but so far less openly debated question is the role of government. Clearly, governments are the appropriate providers of long-term safety nets. Given that, the extent to which there should be greater government involvement in relief response and whether international aid agencies should be trying to devolve responsibility for ongoing welfare support back to governments are key issues.

#### **4.12 Monitoring and evaluation**

As humanitarian aid programmes increasingly recognise HIV/AIDS issues in their programming, monitoring and evaluation systems will also need to incorporate HIV/AIDS issues. The extent to which this has already happened in southern Africa is, as yet unclear. There are several key evaluations either ongoing or about to start; the UK National Audit Office, WFP’s real-time evaluation and the DEC evaluation. Once these become available the picture will be clearer.

## 5 CONCLUSION

The HIV/AIDS epidemic raises profound challenges for the system of international assistance, which are only just beginning to be fully appreciated. The role that emergency relief and humanitarian agencies should play in the response to HIV/AIDS remains unclear. This review of the existing literature suggests two main areas.

1. Responding to crises which are exacerbated by the increased underlying vulnerability due to HIV/AIDS
2. Informing the design of long-term welfare assistance, safety nets and social protection systems, as part of the overall international response to the HIV/AIDS epidemic.

The starting point for analysis of these issues should be a clearer understanding of the complex and poorly understood range of ways in which HIV/AIDS impacts on livelihoods and food insecurity increases vulnerability to HIV/AIDS. The review of the existing literature in this study highlighted the diversity of ways in which HIV/AIDS impacts on livelihoods and the dynamism of the ways in which households, communities and societies are responding to the epidemic. This leads us to caution against a narrow range of responses to the effects of HIV/AIDS on food security.

The contribution of HIV/AIDS to food insecurity was brought to the forefront of international attention by the recent crisis in several countries in southern Africa. However, the relative contribution of HIV/AIDS as an explanatory factor of the crisis remains unclear and disputed.

What does seem clear is that HIV/AIDS is contributing to underlying vulnerability and exacerbating existing food insecurity. Whether this creates chronic crises, permanent emergencies, new variant famines or not and which of these labels are most appropriate remains to be seen. In the meantime humanitarian agencies are already providing emergency relief in the context of an HIV/AIDS epidemic. For practitioners there is therefore already an urgent need to inform practice and reflect on what applying an HIV/AIDS lens to humanitarian programming means in practical terms.

This paper has mapped some of the existing attempts by humanitarian agencies to address the fundamental questions raised by the HIV/AIDS epidemic, based on the existing grey literature and preliminary interviews with aid agencies. Many of the key questions relating to how to provide assistance in the context of an AIDS epidemic remain unanswered and good practice is only beginning to develop. The box below sets out a series of general principles based on experience to date.

## **Box 11: Preliminary Principles for Humanitarian Programming in the Context of an HIV/AIDS Epidemic**

17. Aid agencies should endeavour to analyse and understand the complex ways in which HIV/AIDS is affecting peoples' livelihoods and how people are responding to these challenges.
18. HIV/AIDS is a long-term crisis. Humanitarian aid has a role to play in the response to the crisis, but agencies should recognise that it is only part of a wider response and be clear about what humanitarian aid can and can't achieve.
19. Humanitarian agencies need to mainstream consideration of HIV/AIDS issues throughout the programme cycle and across the different sectors of response.
20. Early warning systems and assessments need to incorporate analysis of HIV/AIDS. This should include attempts to disaggregate prevalence rates at local levels. Agencies should also attempt to gauge the severity and scale of the wider impact of HIV/AIDS on food insecurity.
21. Additional research is needed to examine the impact of HIV/AIDS on key indicators of crisis, such as underlying mortality and malnutrition rates.
22. The emergence of new types and areas of vulnerability due to HIV/AIDS should be considered in assessment and targeting. In particular, food insecurity and vulnerability in urban and peri-urban areas may need to be assessed.
23. Targeting people affected by HIV/AIDS as part of a relief response will need to remain sensitive to the possibility of increasing levels of stigma and discrimination.
24. The HIV/AIDS epidemic reinforces the existing need for humanitarian programmes to be gender sensitive. This should include attempts to involve both men and women in decision making, for risks of sexual violence and the need for protection to be recognised and for agencies to strive for gender transformative or empowering approaches where possible.
25. Emergency interventions must aim to ensure that they do not increase peoples' vulnerability and susceptibility to HIV/AIDS. Prevention and awareness activities should be integrated into humanitarian programmes. Programme design must include assessment of ways to minimise vulnerability to HIV transmission.
26. Food aid in the context of HIV/AIDS epidemics should consider the appropriateness of existing ration sizes and types of food. Issues of the number of distribution points, distances people have to travel, time they have to wait and amounts they have to carry should also be considered in the light of additional HIV/AIDS related vulnerabilities.
27. Labour intensive public works programmes (cash or food for work) should consider the needs of labour constrained and elderly headed households and the chronically ill.
28. HIV/AIDS issues should be addressed in the design of nutrition programmes. HIV/AIDS may reinforce the case for a move to community based programmers where possible and away from centre based therapeutic feeding.
29. HIV/AIDS reinforces the need for humanitarian response to include access to basic health care and treatment.
30. Support to livelihoods in emergencies may also include cash grants, support to agricultural production and distribution of non-food items. Broader support to livelihoods may be particularly appropriate in the context of an HIV/AIDS epidemic due to the complex and diverse ways in which AIDS impacts on livelihoods.
31. Support to agricultural production such as support to seed systems needs to recognise adaptations that households are making in response to HIV/AIDS.
32. HIV/AIDS requires a commitment on the part of donors and governments to long-term welfare provision. Aid agencies should endeavour to link humanitarian aid programming where possible to the development of local capacity for long-term welfare provision.

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