Attaining to Vulnerability to HIV and AIDS in Food Insecure Settings in Sub-Saharan Africa

A synthesis report of Ethiopia, Uganda, Burundi and Mozambique

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Synopsis

This report is a synthesis of rapid assessments conducted in 4 countries (Ethiopia, Burundi, Mozambique and Uganda) on "A status analysis on community vulnerability to the effects of HIV and AIDS in food insecure settings". ACORD undertook a research on the Food Insecurity and HIV&AIDS Nexus with the aim of among other objectives; providing information for engaging the food sovereignty advocacy agenda at community, national, Pan African and global levels on the food & nutrition security imperatives and treatment needs of the affected populations. This mandate lies in one of the ACORD thematic priority area of HIV and AIDS. Developing comprehensive interventions that address the nexus between HIV and AIDS and food insecurity remains a key challenge in the race to fulfill the millennium development goals-and hence the assessments in the selected countries.

Individual consultants were contracted to undertake country specific research on vulnerability to HIV and AIDS in food insecure settings targeting pastoralist, small holder agriculture and post conflict communities in Ethiopia, Mozambique, Burundi, and Uganda. Data collection methods included review of relevant literature, unstructured key informants interviews and focus group discussions with PLHIV, OVCs and other community members. Country reports were synthesized to this present report which brings together common issues from the different settings to build into a Pan African context. The findings from the different countries were compared and contrasted in order to arrive at findings, conclusions and recommendations which represent the Pan-African situation.

It was found that PLHIV are evidently challenged in accessing sufficient, safe, nutritious food thus heightening food and nutrition insecurity among them and their families/dependants as compared to the general population. This is mainly caused by the health, social and economic impact of the HIV&AIDS. Despite the efforts to cope with effects of the scourge on food and nutrition insecurity both household and community responses are not sufficient and some are detrimental to health and heightens food nutrition insecurity. Despite these, global efforts such as the MDGs and UNGASS do not provide concrete overarching frameworks for addressing the important nexus of HIV&AIDS and food and nutrition insecurity. Programs and policy actions are needed to protect the right to food for the HIV infected and affected population groups.

It is thus concluded that promoters and advocates of food security and agricultural production in post-conflict zones and other vulnerable areas, which are hard hit by the HIV&AIDS epidemic, have the opportunity and responsibility of pushing for sound and effective food security issues into the global, regional and country programs and policy agenda. There are opportunities for advocacy for the rights and sovereignty food and nutrition security among the PLHIV and the effected population groups. These opportunities include the periodic policy reviews, government goodwill/political will, donor willingness, existence of numerous HIV&AIDS network. The following recommendations have thus been given.

Program considerations

- **Capacity building:** Capacity building and empowerment of PLHIV (skills building for better agricultural practices, among others) for self-reliance and advocacy for their food and nutrition & treatment rights.
- **Programs integration:** Enhancing integrated/comprehensive programs –especially those linking treatment programs more strongly to food and nutrition for PLHIV and those affected.
- **More resource allocation:** Government commitment and allocation of sufficient resources for integrated programs on food and nutrition security for PLHIV. Strong linkages with Abuja declaration is needed.
- **Multi-sectoral approaches:** Formation of strategic partnerships for greater synergies to enhance sustainable livelihoods e.g. partnerships with microfinance institutions for technical and financial support for PLHIV, private sector and FAO, among others.
- **Have full HIV&AIDS compliant programming.** Examine all food and nutrition security programs with 'HIV&AIDS lens' and either modify them to make them appropriate for PLHIV and the affected or have parallel programs for them.

Policy /Advocacy considerations

- **Address the global policy gaps.** Advocate for policies that address HIV&AIDS and food and nutrition nexus at global level- at MDG and UNGASS level. Global policies and frameworks which do provide guidelines for countries still do not consider the importance of the HIV&AIDS nexus.
- **Streamline/mainstream national policies to address food and nutrition security vulnerability among PLHIV and the affected.** Periodic opportunities for these policy reviews present important avenues for streamlining food and nutrition security considerations. There is a need for a strong policy which states that all HIV&AIDS programs should have food and nutrition programs integrated and vice versa.
- **Advocate for strict adherence to already existing HIV&AIDS related policies:** Stigmisation and discrimination are not yet issues of the past and compound the food and nutrition security challenges among the PLHIV.
- **Advocate for more funding targeting food and nutrition vulnerability for PLHIV and the affected:** There is need to intentionally direct funding to address the HIV&AIDS and food and nutrition insecurity nexus in addition to having funding to address the two issues separately.

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ACORD:	Agency for Cooperation and Research in Development
AIDS:	Acquired Immunodeficiency Virus
ART:	Anti-retroviral Therapy
FANTA:	Food and Nutrition Technical Assistance
FCS:	Food Consumption Score
FGD:	Focused Group Discussions
GoU:	Government of Uganda
HIV:	Human Immunodeficiency Virus
HSSP:	Health Sector Strategic Plan
MDG:	Millennium Development Goals
NSP:	National Strategic Plan
OVC:	Orphaned and Vulnerable Children
PLHA:	People Living with HIV and AIDS
PMTCT:	Prevention of Mother-To- Child Transmission
PSNP:	Productive Safety Net Program
TOR:	Terms of Reference
UNAIDS:	Joint United Nations Program on HIV/AIDS
UNGASS:	United Nations General Assembly Special Session
WHO:	World Health Organization

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Introduction

1.1 Background

There are important links between HIV and AIDS, food security and nutrition. The effects are bi-directional. Not only does HIV&AIDS precipitate and exacerbate food and nutrition insecurity, but the spread of the virus is accelerated when people-because of their worsening poverty-are forced to adopt more risky food provisioning strategies[1]. Adequate nutrition is needed to maintain the immune system, to manage opportunistic infections, to maintain healthy levels of physical activity and to support an optimum quality of life for People Living with HIV and AIDS (PLHIV). Nutrition related interventions can also help optimize the benefits of Antiretroviral Treatment (ART), and increase adherence to the treatment and/or to Prevention of Mother-To- Child Transmission (PMTCT) of HIV virus protocols[2]. The World Health Organization (WHO) recommends that evidence-based nutrition (and food) interventions should be part of all HIV care and treatment programmes[3].

The Agency for Cooperation and Research in Development (ACORD) is an Africa-led alliance working for social justice and development in Africa and with its headquarters in Nairobi (Kenya). ACORD undertook a research on the Food Insecurity and HIV&AIDS Nexus with the aim of among other objectives; provide information for engaging the food sovereignty advocacy agenda at community, national, Pan African and global levels on the food & nutrition security imperatives and treatment needs of the affected population groups. ACCORD programming activities are based on 4 thematic priorities of Livelihoods, Gender, Conflict, and HIV and AIDS, delivered in 17 countries across Africa with country and field offices.

1.2 HIV and AIDS, food sovereignty and poverty in Sub-Saharan Africa

Africa is the continent with more than 25 million people living with HIV&AIDS. At the same time it is the region of the world with the highest rates of poverty, and, despite being an agricultural continent, it also has the highest levels of people living with constant hunger. These issues are both cause and consequence of each other and the interaction between them is multiple and vicious, operating at the individual, household, community, national, regional and global levels.

To date over 33.4 million people in the world are estimated to be living with HIV and AIDS, with about 70% of these being in Sub-Saharan Africa[4].

The majority of people living with HIV and AIDS are in their prime productive years of age 15-49, with women and girls being disproportionately affected. Most of them are extremely poor and this increases their levels of vulnerability. Although once viewed as solely a health concern, the epidemic has increasingly manifested itself equally as an economic, social and political threat.

1. HIV increases vulnerability to hunger and poverty in various ways including:

Health: The virus undermines the body's ability to absorb nutrition leading to higher energy needs; adequate nutrition is needed to get full benefits of therapy and also to avoid some of the side effects.
Economic: Reduced productive capacity of the person living with HIVs competition for productive resources and assets owing to increased cost of medical considerations in affected households, usually women, often abandon or delay farming or other livelihoods activities to care for the sick family members or engage in wage labour to cover medical expenses; households may shift to less labour intensive (and less productive) subsistence farming thus impacting their income and possibly nutrition levels.

Social: responsibility within the household for ensuring a stable livelihood, including food production and food security is shifted from the once able bodied men and women to young children, orphans and the elderly; gender bias in food distribution can leave women more exposed to the consequences of decreased household food availability; HIV related stigma and discrimination, as well as exclusion from income opportunities make PLHIV more vulnerable to hunger and poverty.

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1 Gillespie S and Kadiyala S. 2005. HIV&AIDS and food and nutrition security. From evidence to action. Food policy review 7. International Food Policy Research Institute. Washington DC.

2 Banco Internacional para Reconstrução e Desenvolvimento, HIV e SIDA, Nutrição e Segurança Alimentar: O que podemos fazer, Uma síntese de princípios de orientação internacionais. 2008

3 WHO, Priority interventions: HIV&AIDS prevention, treatment and care in the health sector, 2009

4 UNAIDS 2008

2. Equally, in various ways, hunger and poverty cause increased susceptibility to the effects of the virus:

Health: Food insecurity increases risk of malnutrition and weakens the immune system, increasing susceptibility to opportunistic infections and other HIV related diseases and the rapidity of their progression
Economic: Poverty limits access to treatment poverty and hunger can lead to high-risk behaviour such as transactional or commercial sex
Social: Poverty and hunger tend to reduce the access and ability of affected households to use information on HIV prevention

It's important to bear in mind that one in three people in sub-Saharan Africa is chronically hungry and the goal of food security is waning rather than improve. Food sovereignty is an approach to the political, economic and social aspects of how to achieve food security that emphasises the production of food for people rather than the market, local and democratic shaping of policies, and care for the natural environment.

At the start of the twenty-first century it was suggested that Africa is experiencing 'new variant famine' as a result of the interactions of HIV and hunger. In 'traditional' famines most deaths are among the very young and very old and societies have today developed mechanisms that enable them, grimly, to cope. These might include such strategies as cutting down food intake, using up and selling assets, calling on kinship support, and turning to knowledge of alternative sources of food. With HIV in the mix in a new variant famine, mortality is increased among the economically active and coping mechanisms may no longer work. For instance, people living with HIV cannot physically survive on less food, assets and kinship support may already have been depleted, and with adult deaths, knowledge of alternative foods may have been lost. The concept of new variant famine is still novel and continues to be subjected to testing and revision.

1.3 Rationale

Arguably, food & nutrition security is intricately linked to an HIV and AIDS free environment. The first millennium development goal (MDG1) seeks to halve hunger and extreme poverty, for the vast population in Sub-Saharan Africa, while the sixth goal (MDG6) is aimed at reversing the spread of HIV and AIDS and achieving universal access to treatment for HIV and AIDS for all those who need it by 2010. Neither of these goals is close to being achieved and despite the critical link between food security and HIV and AIDS there still exist insufficient policy engagement on the inter-linkages between the two. Further, Article 28 of the UNGASS declaration emphasizes the need for integrating food security and HIV&AIDS as part of a comprehensive response to HIV and AIDS. Nevertheless, developing comprehensive interventions that address the nexus between HIV and AIDS and food insecurity remains a key challenge in the race to fulfill the millennium development goals.

Against this backdrop, ACORD thus undertook a research on the Food Insecurity and HIV&AIDS Nexus, "A status analysis on community vulnerability to the effects of HIV and AIDS in food insecure settings".

The findings of the research will guide the mobilization, support and empowerment of networks of people living with HIV and AIDS (PLHAs) to:

- Develop an agreed agenda on food sovereignty and HIV and AIDS;
- Engage the food sovereignty advocacy agenda at community, national, Pan African and global levels on the food & nutrition security imperatives and treatment needs of the affected;
- Make evidence – informed policy recommendations to decision makers at local, national and international levels
- Raise awareness of the issues and interactions; and
- Work in alliance with communities in taking action to strengthen resilience both to the epidemic and to hunger.

In recent years ACORD has facilitated associations of PLHIVs in more than five countries to speak up for their rights as well as hold governments accountable for their commitments to meeting their needs. PLHIVs associations at the local, national and regional level were facilitated to create a critical mass for strengthening social action against stigma and discrimination and to intensify advocacy on HIV and AIDS at Pan Africa and global level by linking local realities to global issues. With this background of experience of working with PLHIV as well as the knowledge and relationships established with actors at the regional and pan African scene, ACORD will work with networks of PLHIV and spearhead the agenda for food sovereignty and HIV and AIDS.

Introduction

1.4 Objectives

1.4.1 Broad objective

The overall objective was to conduct a multi-country research in 4 countries on the Food Security and HIV&AIDS Nexus with a focus to establishing the current status on vulnerability to HIV and AIDS in food insecure settings among pastoralist, small-holder agricultural and post conflict communities.

1.4.2 Specific objectives

1. To determine status of the vulnerability of people living with HIV and AIDS to food and nutrition insecurity. Specifically to explore:

- The current situation with regard to access to sufficient, safe, nutritious food to meet PLHIV needs
- The prevailing factors that cause vulnerability of PLHIV
- The progress made since the MDGs and UNGASS declaration with regards to Food and nutrition Security and HIV &AIDS.
- The gaps, challenges and lessons in policy implementation and development with regard to HIV&AIDS and Food & nutrition security for PLHIV at local and national levels.
- The coping strategies (at household/community level) and / or policies (at national / regional / global) level that work.

2. To augment learning from other studies and field experiences in the field of HIV and Food & nutrition security.
3. To publish a comprehensive policy brief that will inform advocacy engagement on the question of Food Sovereignty and treatment rights of PLHIV.

1.4.3 Key questions

The country assessments and this synthesis thus aimed to answer the following questions.

1. Do PLHIV have access to sufficient, safe, nutritious food to meet their needs?
2. What are the main causes of food and nutrition insecurity among the PLHIV?
3. How do the countries, communities and households cope with the food and nutrition insecurity among PLHIV?
4. What progress has been made against the MDG and UNGASS declaration on food and nutrition Security and HIV &AIDS?
5. What critical policy and programmatic gaps exist in ensuring the PLHIV have access to safe, nutritious food?
6. What are the recommendations for policy considerations that can be used for advocacy aimed at improving food and nutrition security among PLHIV?

2 Methodology

2.1 Country assessments

Individual consultants were contracted to undertake country specific research on vulnerability to HIV and AIDS in food insecure settings targeting pastoralists, small holder agriculture and post conflict communities in Ethiopia, Mozambique, Burundi, and Uganda (Figure 1). Subsequently, national level stakeholders' workshops were conducted to validate the reports.

Data collection methods included reviews of relevant literature, unstructured key informants interviews and focus group discussions with PLHIV, OVCs and other community members. The information generated was analyzed using Content and Thematic Approaches. Tapes recorded were transcribed to form texts for the discussions held.

Figure 1: Countries considered for the HIV&AIDS and food and Nutrition Security Assessment

2.2 Comments on validity of country reports

The country reports representing the situation on the vulnerability to HIV and AIDS in food insecure setting targeting were drafted along the TOR provided. Against this TOR the reports can be graded as fair- although it was found that some reports reported some section better (detailed) than others. Common areas that needed improvements included the reporting on country progress on MDGs and UNGASS and, gaps and challenges in HIV&AIDS and food and nutrition security.

2.3 Synthesis of country reports

Country reports were synthesized to this present report which brings together common issues from the different settings to build into a Pan African context. The findings from the different countries were compared and contrasted in order to arrive at findings, conclusions and recommendations which represent the Pan-African situation. In addition to the findings in the individual reports, additional literature review was done to supplement the country findings. Additional reviews were done for sections discussing coping strategies, progress on MDGs and UNGASS and, gaps and challenges in HIV&AIDS and food and nutrition security.

3 Findings

3.1 Vulnerability of people living with HIV and AIDS to food and nutrition insecurity

3.1.1 Access to food among PLHIV

Achieving food and nutrition security requires sufficient physical supplies of food, adequate household access to these food supplies, and appropriate use of food to meet people's specific dietary needs . PLHIV have increased food needs which must be met to increase their longevity and contribute effectively to their livelihood and national development. Food and nutrition security specifically contributes to the minimization of weight loss, restoration weight for the malnourished, body cell mass, and fat, enhances functional capacity, enhances immune function and improves the quality of life. An important part of food and nutrition insecurity is access to food.

In the study countries, it was found that in the marginalized and post conflict areas, PLHIV continue to be challenged in accessing sufficient food. The study areas selected were areas already vulnerable to food and nutrition. In Uganda (Gulu and Kitgum districts- Post conflict area) for instance, more than one meal a day is a luxury. PLHIV have increased food needs and one meal a day is not sufficient. In Mozambique (Lago, Sanga and Lichanga districts), only about 24% of PLHIV take three meals a day, while 57% are able to afford 2 meals a day. The indications are apparent that the same scenarios exist in Ethiopia and Burundi where the PLHIV report their increased inability to provide for themselves and other family members. It is evidence that the PLHIV are borrowing food (or money to buy food), engaging in small-scale employment and overlying on handouts to meet their already increased food needs.

3 Findings cont'd

3.1.1 Access to food among PLHIV

Apart from the quantity of food, the quality is also an issue. Most of the marginalized areas and post conflict areas are characterized by relatively fair availability of the staples (carbohydrates-rich) as compared to other types of foods. This means that access to proteins, fats, vitamins and minerals which are also vital is reduced. In cases of availability in some seasons like in Gulu and Kitgum, the purchasing power is a potential hindrance to food access. Support to the general population or specifically the PLHIV to access food in the study areas were reported to exist. However most of the supports are short-lived and not sustainable. The double burden of providing food for their increased nutrient needs and for those who depend on them at the time where there capacity to engage is the economical activities is reduced, continues to be a real challenge for PLHIV.

3.1.2 Causes of vulnerability of PLHIV to in food insecure areas

In the marginalized and the post-conflict areas, already the general population is vulnerable due to limited livelihood options and lack of capacity by the people to pursue the available options. For instance, in the study areas in Ethiopia sub-cities, poverty levels were high in the midst of relatively high HIV prevalence. In Uganda, civil strife for about two decades had caused and exacerbated vulnerability to food and nutrition insecurity. Equally Burundi had been on civil strife until negotiations with the last rebel movement were completed in 2006 resulting in positive results including the signing of a cease fire agreement. The effects of war on food insecurity and poverty are normally felt even long after the war has ended.

HIV&AIDS condition further increases the vulnerability through the negative impacts of the condition. The commonly reported impacts of HIV&AIDS on food and nutrition security have been reported by Gillespie and Kadiyala (2006)[6]. Financial impacts do directly affect food access and are categorized as those at household level and community level. These are summarized as shown in Table 1 below.

Table 1: Financial impact of HIV/AIDS on food access

	Household impact	Community impacts
1	Reduction in income and off-farm sources	Decrease in aggregate community income
2	Increased expenditure on health care, transport and funerals	Reduction in expenditures among community businesses
3	Reduced expenditure	Reduction in aggregate community savings
4	Increased expenditure on health care, transport, and funerals	Increase in demand for loans and consumption credit
5	Increased reliance on off-farm income	Decrease in demand for productive credit
6	Reduced access to credit; increased debt	Increase in price of credit
7	Liquidation of savings accounts; sale of livestock and assets, e.g., jewelry	Increase in default rate in credit markets
8	Borrowing from informal sector and/or from usurious money lenders	Increased spending on traditional and modern health care

In Ethiopia sub-cities (predominantly urban), the communities rely mainly on formal and informal employment and HIV&AIDS affected their earning propensity. Most PLHIV are incapacitated to work due to general weakness and re-occurring opportunistic diseases. Some have resorted to petty trades which only earn them merger incomes. Reduce incomes has meant that they are less disposable income to purchase food for themselves and the family members. This situation has been worsened by the inflation and the consequent upsurge of food prices. In some instances, employers demand HIV results even for the very low paying jobs and discriminate those who are HIV positive.

[6] Gillespie S and Kadiyala S. 2005. HIV/AIDS and food and nutrition security. From evidence to action. Food policy review 7. International Food Policy Research Institute. Washington DC.

'I tried several times to get a job as a house help but they asked me to bring test results for HIV, they said they fear for their children', retorted one respondent.

In Burundi reported impact of HIV&AIDS on food insecurity were fuelled mainly by illnesses, widowhood, theft and weather vagaries (drought, floods and plant diseases). In agricultural communities as exemplified by Kitgum and Gulu, the high morbidity rate among PLHIV prevented them from engaging in labor intensive but better paying activities such as rice farming. It is also reported that coincidentally more nutritious food (foods that do not only provide energy) are more labor intensive than otherwise. Sesame, millet and groundnuts are more labor intensive than sorghum or maize. For the same reasons of morbidity, cultivation of large pieces of land for much bigger harvest is not possible. In households hosting PLHIV, there is reduced important farm labor. The social support systems have also weakened in Internally Displaced People (IDP) situation where 'every one for himself' attitude is prevalent and some PLHIV have been abandoned in camps because they could not walk back home.

'In the past it was not possible to neglect your relatives, so if one fell sick, you would provide food for him/her but now…some PLHIV's were even abandoned in the camps. Our worry is that if we do not do something people living with HIV&AIDS will be greatly affected….some are even not taking their drugs regularly in the villages because they do not have food' ***(KI, District Local Government, Gulu).***

In Mozambique study sites (a mix of agricultural and non-agricultural communities), there is a shift from farming to business among the PLHIV. This is because in farming activities, they are too weak to plant and harvest, and lack micro-credit to run their faming activities. The latter is because PLHIV have been found not to pay back the money lent from financial institutions.

A key informant explained *"over 70% of the businesses being managed by PLHIV in extended families do not flourish. Even when they borrow money from the government or other lending institutions, the likelihood of failing to repay is high"*

Even those who choose to shift to business have the same challenge of high morbidity and general weakness to effectively run their businesses. For this community, as has been reported in the study communities in Ethiopia, their expenditure exceeds their reported incomes.

3.2 Coping strategies in the study communities

In the study areas, just as for the general population, PLHIV are already exposed to the vulnerabilities which force them to adopt peculiar coping strategies. In addition to these general vulnerabilities, the additional vulnerabilities brought about by HIV&AIDS force them to adopt additional coping strategies which may be different from those of the general population. These strategies differ depending on the prevalent economic activity of the area under study. For instance coping strategies in the agricultural communities differ with those of urban areas. However, these strategies are all hinged on the need to provide for themselves and their families at the time when their economic propensity is reduced, food/nutrition and medical needs have increased and discrimination preventing them to obtain income. HIV&AIDS pandemic has increased the inability of affected households to put enough food on the table, possibly because of the continued decreased productivity in these households and the high expenditure on medical costs (Bukusuba et. al, 2007)[7].

3.2.1 Coping strategy at household level

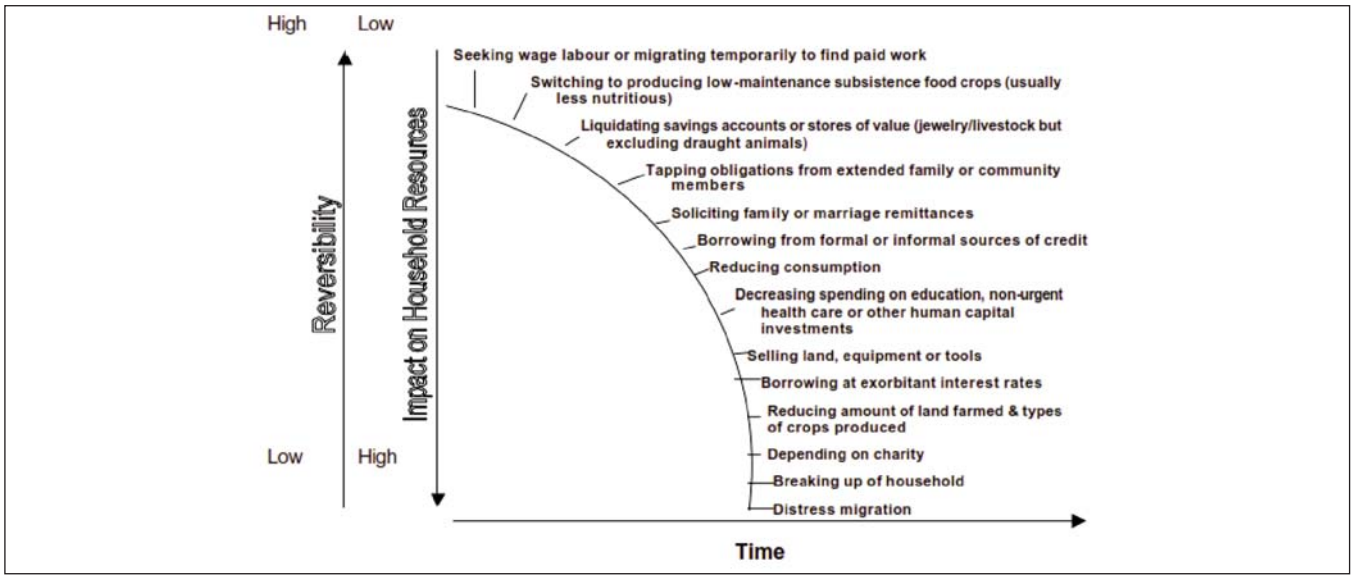
Various coping mechanisms/strategies have been widely documented. According to the World Bank[8], households respond to the impact of AIDS using three main coping strategies:

i. Altering household composition (for example, by sending one or more children to live with relatives, or inviting a relative to join the household in exchange for assistance with farming, household and childrearing tasks);
ii. Drawing down savings or selling assets (durable goods, livestock, etc.); and
iii. Utilizing assistance from other households and from informal rural institutions.

Topouzis (1998)[9] has also summarized household coping mechanisms with time factor as shown in Figure 2. Household coping mechanisms listed include seeking wage and migrating to find temporary work elsewhere. This according to Topouzis (1998) this one the first coping mechanisms. This is most likely to happen in agricultural areas where farming requires intensive labor. At the tail end of coping is distress migration which may be caused by among others, stigma.

3 Findings cont'd

Figure 2: Household coping mechanisms/strategies to HIV&AIDS



[7] Bukusuba J, Kikafunda JK, Whitehead RG. 2007. Food security status in households of people living with HIV/AIDS (PLWHA) in a Ugandan urban setting. Br J Nutr.98(1):211-7.

[8] World Bank, Confronting AIDS, op.cit.

[9] Topouzis D. 1998. Sustainable Agriculture/Rural Development and Vulnerability to HIV/AIDS, UNAIDS Best Practice Paper, FAO/UNAIDS, forthcoming. Based on Jill Donahue, Community-based Economic Support for Households Affected by HIV&AIDS, Discussion Paper on HIV&AIDS Care and Support #6, USAID, June 1998, pp. 6-7; and Anne Thomson and Manfred Metz, Implications of Economic Policy for Food Security, Figure 3.4: Responses to Household Food Shortage, FAO Training Materials for Agricultural Planning No. 40, 1997, p. 97

Other documented coping mechanisms/strategies include reduction of the number of meals, consuming smaller portion sizes of food, eating poorer quality food and more of less preferred food (Bukusuba et. al, 2007[10]; Gillespie and Kadiyala, 2005[11]).

In study sub-cities of Ethiopia, PLHIV consumed fewer meals to cope with the reduced capacity to work and provide for the traditional three meals a day for the family. The quality of food provided was also compromised. Protein foods (which were more expensive than others) were consumed only once or twice a month). They also resorted to buying cheaper grains/legumes after selling those provided as food rations. In order to cope with the increased medical and food needs, some PLHIV sold their belongings including jewelries and household belongings.

One widowed women gave her account on this by saying: *"I and my husband used to have a small tea shop. We were working hard and earned adequate amount of money for living. However, when my husband became sick we had to sell the tea shop to cover the cost of treatment. At the outset his illness was not recognized, we assumed it was something else but finally I realized he died of AIDS and I was left without any means of survival."*

[10] Bukusuba J, Kikafunda JK, Whitehead RG. 2007. Food security status in households of people living with HIV/AIDS (PLWHA) in a Ugandan urban setting. Br J Nutr.98(1):211-7.

[11] Gillespie S and Kadiyala S. 2005. HIV&AIDS and food and nutrition security. From evidence to action. Food policy review 7. International Food Policy Research Institute. Washington DC.

Begging was also reported as a common coping strategy. Begging was mostly done in churches and streets. There are indications that this survival strategy is practiced when the households that are at risk have been pushed into calamity (UNAIDS, 1999)[12]. In a study reported in Ethiopia UNGASS 2010[13] report, Food Consumption Score (FCS) results show a higher percentage of affected households had poor consumption compared to unaffected households. The affected households used more severe coping strategies as compared to unaffected households. The study found a statistically significant association of being HIV&AIDS-affected with consumption-related strategies like reducing the quantity or number of meals eaten, and going the entire day without eating.

In Burundi, the common coping mechanisms were reported as counting on less preferred and inexpensive food, borrowing food or over-reliance on assistance from friends or parents, buying food on credit, reducing the quantity of food portions during meals, cutting down consumption for adults, reducing the number of meals per day and going for several days without eating.

In Mozambique household PLHIV responded to food insecurity by reducing the number of meals consumed from 3 a day to less. Borrowing food or money from family and friends was also a common practice. Women infected with the virus also resorted to promiscuity as an easy way of getting money to buy food for themselves and their children. There was also increased mobility and migration to distant places in search of income or food.

"AIDS does not just graduate, it moves from infection to symptomatic stage, and if provisions were there for us to be able to run small scale businesses, we would have assisted not only in provision of our own food needs but also production of food to be consumed by the entire community" ***a female participant at an FGD in Lichinga.***

A considerable number of PLHIV participating in the FGDs expressed willingness to relocate to places where they may be able to find employment. Household leaders were more likely to relocate than dependents.

In Uganda, reduced number of meals taken was a common coping strategy, and there were reports that many children of PLHIV had died of starvation. The amount of food consumed was also reduced. Resorting to cheaper food was also common.

We can only eat vegetables like dodo and may eat silver fish (mukene) when we get money but it is mostly dodo because it is easy to get…it is difficult to get beans and meat around here…the cost is too high for us given the high demand and prices offered by Uganda traders who ferry them to Sudan ***(FGD, PLHIVs, Palaro, Gulu).***

[12] *UNAIDS. 1999. A review of household and community responses to the HIV/AIDS epidemic in the rural areas of sub-Saharan Africa. Geneva, Switzerland.*

[13] *UNGAS 2010. Ethiopia report on progress towards implementation of the UN Declaration of Commitment on HIV/AIDS 2010 http://www.hivalert.net/atomicDocuments/HIVAlertDocuments/20110401171134-ethiopia_2010_country_progress_report_en.pdf*

3.2.2 Coping strategy at community level

A number of community-based responses have been documented. UNAIDS (1999)[14] summarizes these responses as shown in figure 3 below.

3 Findings cont'd

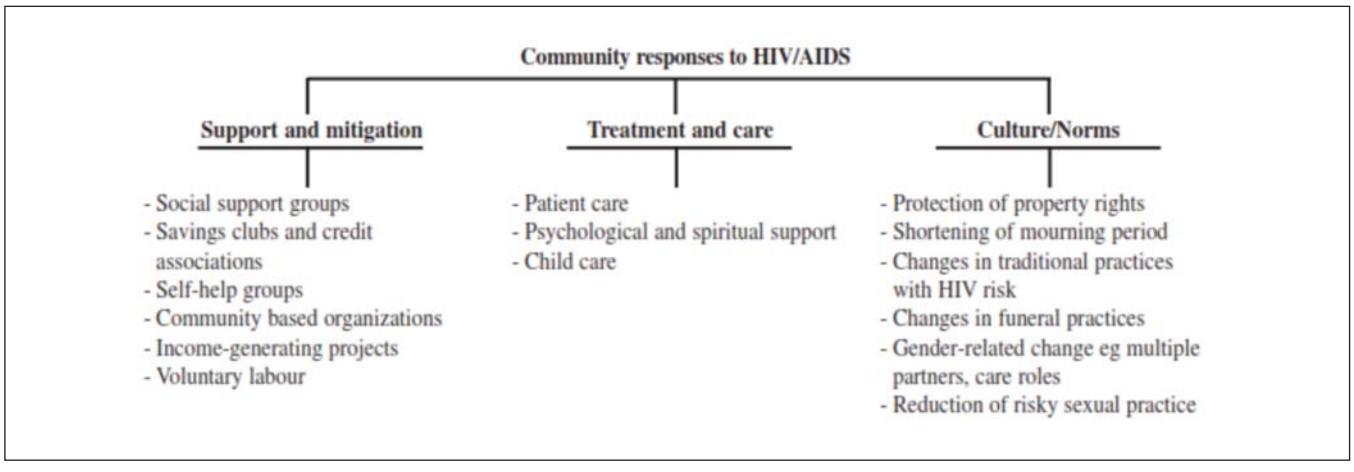


Figure 3: Community responses to HIV/AIDS

Money or services, risk reduction choices such as condoms in transactional sex were limited. It is for this reason that IDPs are among the population categories considered vulnerable and at higher risk of HIV infection than others in Uganda.

A number of these responses touch on food and nutrition security through providing PLHIV food (and medical care), income generation opportunities, and facilitate reduction of expenditures (e.g. Simplifying funeral practices to less costly). FANTA (2002)[15] also list a number of food security-focused interventions that can be implemented at local level by the community to cope with HIV&AIDS in rural set-ups. These are:

i. Encourage communal food and cash crop production.
ii. Build community grain stocks.
iii. Encourage community works to repair assets and structures.
iv. Improve social infrastructure (e.g., access to water, sanitation and health posts to reduce morbidity.
v. Create/support HIV&AIDS networks and community organizations.
vi. Modify costly customs (e.g., funerals, marriages).
vii. Modify land tenure to meet needs of women, orphans and other survivors.
viii. Provide legal aid to widows, orphans and other survivors.
ix. Include HIV&AIDS-prevention training for staff of NGOs, ministries, etc.
x. Strengthen community links to NGOs, government institutions, etc.

In the assessments areas, some few community copping strategies were found. In Ethiopia study area relatives and friends supported PLHIV by willing and volunteering to lend them money to take care of their food, medical and other needs.

[14] UNAIDS. 1999. A review of household and community responses to the HIV/AIDS epidemic in the rural areas of sub-Saharan Africa. Geneva, Switzerland.

[15] FANTA. 2010. HIV/AIDS Mitigation: Using What We Already Know. Technical Note No. 5 October 2002.

In reference to this one woman respondent said *"I was living with my relatives, when I told them my HIV status they told me to leave their house. I had nowhere to go; I was in a very desperate situation. When I disclosed my situation to my friend she encouraged me and, invited me to her house and gave me food and clothing."*

In Mozambique, the community through the support of government-led support provided food and nutritional support to PLHIV. The coverage of this support was however found to be limited only to urban and peri-urban areas. In Uganda, most organizations working in the area were integrating HIV&AIDS into their programming. To do these they have been supporting the communities to provide extra food to households hosting PLHIV. Other initiatives included encouraging income generation activities such as distribution of animals for rearing.

One of World Vision's areas of focus is distribution of goats and pigs…these animals can multiply very quickly... It is actually very important to integrate issue of health together with food security (KI, District Local Government, Gulu).

3.3 Progress on MDGs and UNGASS declaration

3.3.1 Implication of progress on MGDs on HIV&AIDS food security nexus

MDGs do not provide a specific goal for addressing food and nutrition security for PLHIV directly. It could be assumed that by eradicating extreme hunger and poverty, and by combating HIV&AIDS simultaneously may mean that food and nutrition needs for HIV&AIDS are taken care of. This remains an assumption if programs and policies would have to be directed to address the vulnerability of PLHIV to food and nutrition insecurity. The interpretation of the goal eradication of extreme hunger and poverty does not provide direct implication that special consideration will be given to vulnerable groups including PLHIV.

3.3.2 Progress on MGDs

All the countries under study subscribe to the MDG goals. MDGS have become popular for country targets in various sectors. Table 2 summarizes an analysis of the progress towards meeting two MDG targets as reported by the MDG reports 2010 and other sources. The two MDG goals[16] are directly related to food and nutrition security/HIV and AIDs namely:

1. MDG GOAL 1: Eradicate extreme hunger and poverty. All targets (Target 1A to 1C) are relevant. For these targets, progress is recorded albeit slow in Mozambique and Uganda. While there is reported appreciable improvement in poverty reduction and employment status, what pulls the progress down is the hunger as indicated by the levels of stunting (chronic malnutrition). Stunting has only reduced marginally in Ethiopia and Uganda and increased in Mozambique, signifying a challenge in providing food and medical services to curb hunger as indicated by chronic malnutrition.
2. MDG GOAL 6: Combat HIV&AIDS, malaria and other diseases. Only target 6A and 6B are relevant to this assessment. As Ethiopia and Uganda experience progress and slow progress, Mozambique does record an appreciable progress. In Mozambique, HIV rates are on the increase and less than 40% of those infected have access to Antiretroviral drugs. In Uganda, there is also only marginal decline in HIV rates and increase in the proportion of those who are HIV infected and access antiretroviral drugs.

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[16] UNITED NATIONS MILLENIUM DEVELOPMENT. http://www.un.org/millenniumgoals/poverty.shtml

In general, Ethiopia seems to be comparatively way ahead in achieving the MDG goals related to food and nutrition security and HIV&AIDS. During the last seven years, Ethiopia has made substantive economic progress. Since 2003/04 growth has been sustained, recording more than 11% average growth[17]. This growth is complemented by a strong performance in the Agriculture, Industry (construction and manufacturing) and service sectors with an average growth rate of 10%, 10% and 13.2%, respectively[18].

Ethiopia is closely followed by Uganda which is recording progress albeit slow. Studies in Uganda show that the proportion of people whose income is less than $1 a day has steadily declined over the years. For instance, between the fiscal year 2002/03 and 2005/06, the proportion of the poor in Uganda reduced from 39% down to 31%. It is even projected that the proportion of Ugandans living below the poverty line will decline from the current 31% to about 24.5% in 2014/15 above the MDG target of 28% (GoU-NDP, 2010)[19]. However, a lot more effort is required to reduce the proportion of poor Ugandans. The current poverty levels imply that nearly 8.4 million Ugandans out of the estimated 30.7 million are living in poverty. Further, the proportion of Ugandans engaged in decent and productive employment is still small. Mozambique is particularly comparatively behind all other study countries in achieving MDG goals related to food and nutrition. A review of the PARPA II (Action Plan for the Reduction of absolute Poverty II) indicates that the country is set to meet the majority of MDGs targets although marred by deficiencies in service delivery in most parts of the country. DFID country assistance plan 2008-2012 of Mozambique indicated that the country is on track to reduce poverty levels to 44% by 2015 (MDG). The hunger situation however, as confirmed by the report, also shows that Mozambique is unlikely to meet MDG 1.

17 Ethiopia 2010 MDG report: http://web.undp.org/africa/documents/mdg/ethiopia_september2010.pdf
18 Ethiopia 2010 MDG report: http://web.undp.org/africa/documents/mdg/ethiopia_september2010.pdf
19 GoU (2010); National Development Plan 2010/11 – 2014/15; Republic of Uganda, April 2010.

Table 2: Country progress on MDGs

#	MDG goal and target	Country progress (As per the country MDG reports unless additional reference provided)[20]		
		Ethiopia[21]	**Mozambique[22]**	**Uganda[23]**
	GOAL 1: Eradicate extreme hunger and poverty	**Progress registered**	**Slow progress**	**Slow progress**
i	Target: 1A: Halve, between 1990 and 2015, the proportion of people whose income is less than $1 a day	The proportion of those who live below poverty line dropped from 48% (1990) to 29.2% (2010)	The proportion of those who live below poverty line dropped from 80% (1997) to 54.7% (2009	The proportion of those who live below poverty line dropped from 56% (1992/93) to 31% (2005/06)
ii	Target 1B: Achieve full and productive employment and decent work for all, including women and young people	Not reported	New jobs created in 2005 was 64,339 and 385,732 in 2009	Proportion of employed persons living below the below poverty line reduced from 34% to 18%.
iii	Target 1C: Halve, between 1990 and 2015, the proportion of people who suffer from hunger	Moderate and severe chronic malnutrition (stunting) reduced from 64% in 2000[24] to 40.5 in 2006.	Moderate and severe chronic malnutrition (stunting) increased from 35.7 in 1997 to 44% in 2008.	Moderate and severe chronic malnutrition (stunting) reduced from 45% in 1996[25] to 38% in 2008.
	GOAL 6: Combat HIV&AIDS, malaria and other diseases	**Progress registered**	**No progress**	**Slow progress**
i	Target 6A: Have halted by 2015 and begun to reverse the spread of HIV/AIDS	HIV rates (adult) reduced by approximately 5 times from 7.3% in 1990 to 1.4-2.8% in 2010.	HIV rates (adult) increased from 8.6% in 1997 to 11.5% in 2009.	HIV rates (adult) reduced from 8.5% in 1990/91 to 7.7% in 2004/05[26].
ii	Target 6B: Achieve, by 2010, universal access to treatment for HIV/AIDS for all those who need it	Proportion those who are HIV positive receiving ART increased from 37.1% in 2006/7 to 70% in 2010.	Proportion those who are HIV positive receiving ART increased from 3% in 2004 to 37% in 2009.	Proportion those who are HIV positive receiving ART increased from 44% in 2004 to 54% in 2009.

20 Burundi MDG report was in French as not reflected in the table.
21 Ethiopia 2010 MDG report: http://web.undp.org/africa/documents/mdg/ethiopia_september2010.pdf
22 Report on Millennium Development Goals for Mozambique 2010. http:/www.undp.org.mz
23 Millennium Development Goals report for Uganda. 2010. http://www.google.co.ke/#hl=sw&sclient=psy-ab&q=mdg+report+Uganda+2010&oq=mdg+report+Uganda+2010&aq=f&aqi=&aql=&gs_sm=3&gs_upl=24736l26174l1l27744l6l6l0l0l0l4l365l2094l3-6l6l0&gs_l=serp.3...24736l26174l1l27744l6l6l0l0l0l4l365l2094l3-6l6l0&bav=on.2,or.r_gc.r_pw.r_qf.,cf.osb&fp=f2729b9f7c783517&biw=1280&bih=610
24 Progress of Nations 2000: http://www.unicef.org/pon00/leaguetos1.htm

[25] FANTA 2010. Analysis of nutrition situation in Uganda.

http://www.fantaproject.org/downloads/pdfs/Uganda_NSA_May2010.pdf

[26] HIV prevalence and Incidence in Uganda on the way up: http://www.aidsmap.com/HIV-prevalence-and-incidence-in-Uganda-on-the-way-up/page/1431438/

3.3.3 Progress on UNGASS

3.3.3.1 Key priorities of UNGASS

In 2001, the United Nations General Assembly Special Session (UNGASS)[27], the international community set targets for reducing the spread of HIV&AIDS and alleviating its impact i.e. the UNGASS Declaration. The study countries are at different stages in implementing these priorities as depicted in Table 3. Although the Declaration set wide agenda, clear 5 key priorities were spelt out as follows:

1. First, to ensure that people everywhere -particularly the young - know what to do to avoid infection. Apart from Ethiopia which seem to be making appreciable progress in HIV general and prevention awareness, others countries can only account for about one-third of awareness as indicated by proportion of youth able to identify correct ways of HIV prevention. This UNGASS priority as measured by awareness indicator is not being met adequately.
2. Second, to stop perhaps the most tragic of all forms of HIV transmission - from mother to child. Contrary to the first key priority, Ethiopia lags behind in this priority where only 8% of pregnant mothers infected which HIV have been provided with PMTCT services. Other countries have strived to reach roughly half of those pregnant mothers infected. There is still a gap to be filled in prevention of mother to child transmission of HIV.
3. Third, to provide treatment to all those infected. Not all those who are infected have access anteretroviral drugs. In Ethiopia 30% of those infected are not receiving the drugs, while in Uganda only roughly half receive the drugs. Mozambique has a gap of 70% of those not receiving the drugs. The universal access to antiretroviral drugs in the study countries is still a critical challenge.
4. Fourth, to redouble the search for a vaccine, as well as a cure. The study countries are all in support of the search of HIV vaccine. Although they do not provide financial support and gets involved only to a small extent in the technical aspect of the search, there is political willingness to these efforts. All these governments have allowed the vaccine trials to be conducted in their respective countries.
5. Fifth, to care for all whose lives have been devastated by AIDS, particularly more than 13 million orphans. Support for orphans is still a challenge in the study countries. Only up to close to 35% of orphans are provided with free basic external support in the study countries. The proportion or orphans not receiving these services is still relatively high.

3.3.3.2 Governments commitment to UNGASS

The Government of Ethiopia is making tremendous efforts towards containing the epidemic. As part of this endeavor, the Government put in place a national HIV&AIDS policy in 1998 to create an enabling environment to fight the pandemic. Overall, support and commitment in relation to HIV and AIDS has increased over the years, and progress has been made in the development of specific HIV&AIDS related legislation and revising the HIV policy to promote and protect human rights. Moreover, there have been some encouraging efforts to enforce the existing policies, laws and regulations. Civil society involvement in the process of planning, monitoring and evaluation of HIV&AIDS responses at various levels are improving.

[27] UNGASS 2001. Declaration of commitment on HIV/AIDS. United Nations.

The Mozambique Government and political leaders have been providing a remarkable political support through their active and regular involvement. In parallel, civil society organizations participation has grown considerably, namely on the formulation of HIV related policies, strategies and laws. In spite of the reported successes and the apparent stabilization of the epidemic, the Government is aware of the great investment that still needs to be done for the response to HIV& AIDS, recognizing the growing impact of the HIV epidemic in the Mozambican society. Despite the above, Uganda has committed itself to universal access to HIV&AIDS prevention, care and treatment in line with WHO/UNAIDS recommendations. In recent years, intensified efforts to re-invigorate HIV prevention have been pronounced and a Road Map towards accelerated HIV prevention developed and adopted, based on careful analysis of the current drivers of the HIV epidemic in the country. Uganda's National HIV&AIDS Strategic Plan (NSP) 2007/08-2011/12[28] and the second Health Sector Strategic Plan 2005-2010

(HSSP-11)[29] spell out the country's priority of comprehensive, evidence-based HIV response (prevention, care and treatment, social support and institutional strengthening) to be implemented on a scale commensurate with the current HIV transmission dynamics to meet the MDG and UNGASS targets (GoU-UNGASS 2010). All this notwithstanding, it is important to note that whereas there have been as noticeable interventions in the area of prevention, care and treatment, there are glaring gaps in the area of social support including food security to inflicted and affected households and, particularly PLHIVs.

3.3.3.3 UNGASS and food and nutrition security

Article 8 of the UNGASS[30] declaration recognizes food security as one of the important and key part livelihood that is affected by HIV&AIDs. This article states that:

'Noting with grave concern that Africa, in particular sub-Saharan Africa, is currently the worst-affected region, where HIV&AIDS is considered a state of emergency which threatens development, social cohesion ,political stability, food security and life expectancy and imposes a devastating economic burden, and that the dramatic situation on the continent needs urgent and exceptional national, regional and international action'

In response to this, countries under study report commitment to integrate HIV&AIDS in the mainstream response to HIV&AIDS. Ethiopia UNGASS 2010 report depicts significant increase in nutritional support to people infected and affected by HIV. In addition, HIV&AIDS services have been mainstreamed into the national Productive Safety Net Program (PSNP), which distributes cash and food to chronically food-insecure beneficiaries in rural areas, and mobilizes communities to participate in public works programs. There are many small-scale OVC care and support activities going on in Ethiopia including provision of training in business skills and management to support OVC, cash transfers through micro-finance schemes to households, and food and nutrition support. In addition, the Government of Ethiopia, in collaboration with the World Food Program (WFP), is providing food and nutrition assistance to an estimated 110,000 PLHIV (including women enrolled in PMTCT) and OVCs. A survey to review the outcomes of this intervention comparing values between 2006 and 2008 revealed that an increased proportion of PLHIV reported improving health status from 64% to 81.6%.

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[28] UAC 2008, National HIV and AIDS Strategic Plan for Uganda, 2007/08 to 2011/12, Kampala, Uganda, 2007

[29] Ministry of Health: Health Sector Strategic Plan II 2005/06-2009/2010, Volume 1. 2005, Kampala, Uganda

[30] UNGASS 2001. Declaration of commitment on HIV/AIDS. United Nations.

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Mozambique also report that people living with HIV who initiate antiretroviral treatment, and have nutritional needs, now have access to food support (food basket). Ministry of Health has assumed the provision of a food voucher scheme to PLHIV in need (cesta básica) during the first six months after initiating ARV therapy. The Ministry of Health has also approved national guidelines for nutritional support for HIV-infected patients on antiretroviral treatment with low CD4 counts. Government institutions, in coordination with their partners, are implementing various activities in the area of nutrition and HIV, including nutrition and dietary assessments, nutritional counseling, distribution of food or food supplements (for example, through the Basic Food Basket (Cesta Básica) Program for malnourished people on ART), and the treatment of moderate and severe acute malnutrition. Particularly in the areas of food distribution and income generation, several are initiatives implemented by community-based organisations, complementing Government interventions. The Ministry of Health has developed the Guideline for Nutritional Orientation for People Living with HIV (a brochure aimed at health workers) and is finalizing materials for nutritional counseling for PLHIV aimed at health workers, at activities linked to home based care, and at local NGOs.

In Uganda too, there are the guidelines for nutrition among PLHIVs – ("Improving the Quality of Life through Nutrition: Guides for Feeding People Living with HIV & AIDS"). There are various organizations in the country engaged in promotion of livelihood and HIV&AIDS activities, although their coverage is small. These organizations draw their mandate and guidance from the country's National Strategic Plan (NSP) on HIV&AIDS—2007/08-2011/12. The NSP recognizes that food insecurity and low nutritional status can be a causal factor for HIV infection as well as a consequence. As part of efforts to ensure guided integration of food security in the national response, the NSP set out to strengthen mechanisms that promote sustainable food and nutrition security to the households and communities made vulnerable by HIV&AIDS.

3 Findings cont'd

#	Key UNGASS priorities[31]	Progress in targeting the key priorities by country (as per UNGASS reports unless additional references provided)[20]		
		Ethiopia[32]	**Mozambique[33]**	**Uganda[34]**
1	To ensure that people everywhere -particularly the young - know what to do to avoid infection.	HIV prevalence reduced five times between 1990 and 2010[35]. Awareness level of 85% in 2010. 61.5% of youth 15-24 years of age use condoms every time they have sexual intercourse[36].	HIV rates (adult) increased from 8.6% in 1997 to 11.5% in 2009[37]. 34.8% of young people aged 15-24 correctly identify ways of preventing HIV transmission.	HIV rates (adult) reduced from 8.5% in 1990/91 to 7.7% in 2004/05[38]. 31.9% of men and 38.2% of women aged 15–24 correctly identify ways of preventing HIV transmission.
2	To stop perhaps the most tragic of all forms of HIV transmission - from mother to child;	8% HIV-positive pregnant women receive antiretroviral drugs to reduce the risk of mother-to-child transmission.	In 2009, 45.8% HIV-positive pregnant women receive antiretroviral drugs to reduce the risk of mother-to-child transmission.	51.6% HIV-positive pregnant women receive antiretroviral drugs to reduce the risk of mother-to -child transmission.
3	Provide treatment to all those infected.	Proportion those who are HIV positive receiving ART increased from 37.1% in 2006/7 to 70% in 2010[39].	Proportion those who are HIV positive receiving ART increased from 3% in 2004 to 37% in 2009[40].	Proportion those who are HIV positive receiving ART increased from 44% in 2004 to 54% in 2009[41].
4	To redouble the search for a vaccine, as well as a cure.	Evidence of research on HIV vaccine available[42]. President has called for increased focus and support for HIV vaccine[43].	Mozambique government to test the vaccine against HIV[44].	HIV vaccine trials on-going[45].
5	To care for all whose lives have been devastated by AIDS, particularly more than 13 million orphans.	34.6% of OVC(0-17) children receive free basic external support.	22% of OVC(0-17) children receive free basic external support	253,449 OVC receive support. No denominator available.

31 UNGASS 2001. Declaration of commitment on HIV/AIDS. United Nations.

32 UNGAS 2010. Ethiopia report on progress towards implementation of the UN Declaration of Commitment on HIV/AIDS 2010 http://www.hivalert.net/atomicDocuments/HIVAlertDocuments/20110401171134-ethiopia_2010_country_progress_report_en.pdf

33 UNGAS 2008-2009. Mozambique progress Report. http://www.unaids.org/en/dataanalysis/monitoringcountryprogress/2010progressreportssubmittedbycountries/mozambique_2010_country_progress_report_en.pdf

34 http://www.hivalert.net/atomicDocuments/HIVAlertDocuments/20110401165424-uganda_2010_country_progress_report_en.pdf

35 Ethiopia 2010 MDG report: http://web.undp.org/africa/documents/mdg/ethiopia_september2010.pdf

36 DHS 2011. Ethiopia Demographic and Health Survey. http://www.csa.gov.et/docs/EDHS%202011%20Preliminary%20Report%20Sep%2016%202011.pdf

37 Report on Millennium Development Goals for Mozambique 2010. http:/www.undp.org.mz
38 HIV prevalence and Incidence in Uganda on the way up: http://www.aidsmap.com/HIV-prevalence-and-incidence-in-Uganda-on-the-way-up/page/1431438/
39 Ethiopia 2010 MDG report: http://web.undp.org/africa/documents/mdg/ethiopia_september2010.pdf
40 Report on Millennium Development Goals for Mozambique 2010. http:/www.undp.org.mz
41 Millennium Development Goals report for Uganda. 2010. http://www.google.co.ke/#hl=sw&sclient=psy-ab&q=mdg+report+Uganda+2010&oq=mdg+report+Uganda+2010&aq=f&aqi=&aql=&gs_sm=3&gs_upl=24736l26174l1l27744l6l6l0l0l0l4l365l2094l3-6l6l0&gs_l=serp.3...24736l26174l1l27744l6l6l0l0l0l4l365l2094l3-6l6l0&bav=on.2,or.r_gc.r_pw.r_qf.,cf.osb&fp=f2729b9f7c783517&biw=1280&bih=610
42 Tsegaye A et al. 2007. HIV-1 Subtype C Gag-Specific T-Cell Responses in Relation to Human Leukocyte Antigens in a Diverse Population of HIV-Infected Ethiopians. J Acquir Immune Defic Syndr;45:389–400.
43 http://medilinkz.org/east-africa/Ethiopia/2951.html
44 http://allafrica.com/stories/201109141404.html
45 http://www.ncbi.nlm.nih.gov/pubmed/11983242

3.4 Challenges and Gaps in HIV&AIDS and Food & nutrition security for PLHA

3.4.1 Challenges faced by PLHIV in food and Nutrition security

It has taken several decades for the fight against HIV to move some strides from being viewed to be a purely medical challenge to the recognition of its effect on social and livelihood structures. However, the challenges related to food and nutrition security among PLHIV continue to persist. It is apparent from the countries under study that although efforts have been put to ameliorate the effects of HIV&AIDS on food and nutrition security, much more still needs to be done. Food and nutrition related challenges faced by PLHIV for the study countries were as follows:

1. Against the increased nutrition needs due the effects of the virus, PLHIV do not have access to sufficient foods, of the quality required. The quantity and quality of food consumed in households with PLHIV as the household heads or caregivers is reduced against the double burden of providing for their increased needs and other family members.
2. Due to the effects of opportunistic diseases and other effects of HIV, PLHIV are weak and not able to engage in livelihood activities like other healthy members of the communities. Farm and off-farm labor is reduced.
3. Increased expenditures which compete with income to be allocated to food. These expenditures include expenditures on medication, transport and funerals.
4. Reduced safety nets due to liquidation of savings account, sale of livestock and other assets. The increased need lead PLHIV to deplete the resilience propensity.
5. Stigmatization in the job market is still a challenge where PLHIV are discriminated for jobs and HIV test-results are pre-requisite for securing a job. They also have reduced borrowing potential- they are considered less credit worthy.
6. The coping strategies adopted by PLHIV are neither sufficient nor sustainable and creates a vicious negative circle/effect of food insecurity among PLHIV and the affected.

3.4.2 Programmatic gaps in HIV&AIDs and food and nutrition security

The governments, the UN agencies, NGOs and community-based organizations have all put efforts to support PLHIV to cope with people living with HIV&AIDS. However, the following gaps do exist as has been depicted in the target country studies.

1. Insufficient food and nutrition support for PLHIV. Although PLHIV are only a small proportion of the population affected by food insecurity in already marginalized areas, support is neither directed at them or very minimal support given to them.
2. There is short-lived and unsustainable support to PLHIV to access food. Most of the supports are in form of ad hoc food and non-food items which are only for a short term. Providing handouts as a show of empathy by donors, governments, NGOs and communities only serve for limited period of time after which PLHIV are back to their vulnerability.
3. Responses to food and nutrition insecurity do not integrate HIV&AIDS: No special consideration (or targeting) to PLHIV, OVCs and other affected by HIV&AIDS. General approach to food insecurity does not consider the plight of PLHIV and other affected groups. For instance in a food distribution exercise, no special (in quantities and quality) for PLHIV is provided - a blanket approach.

4. Some food and nutrition program responses are not suitable for PLHIV. For instance, food for work programs is not suitable for the already weak, hungry and sick PLHIV.
5. Not all HIV&AIDS responses integrate food and nutrition programming: Only few HIV&AIDS preventive, treatment and care programs integrate HIV&AIDS into programming. The emphasis on prevention and treatment has tended to overshadow other aspects of HIV&AIDS such as mitigation of the socio-economic impact where issues of food security and agriculture would be handled.
6. Poor resource allocation to HIV&AIDS programming and especially in tackling the food and nutrition insecurity among those infected and affected. The donor community has begun cutting resources to some countries on HIV funding and this has an automatic negative effect on food security programing targeting PLHIV and the affected.

3.4.3 Policy gaps in HIV&AIDs and food and nutrition security

All study countries have policies relating to HIV&AIDS prevention, treatment and care. There are also policies which relate to stigmatization and discrimination in employment and work place. There are also other policies in which HIV&AIDS have been mainstreamed. Gaps identified in these policies however are:

1. Global policies guiding local policies and country efforts are silent on HIV&AIDS and food and nutrition Security nexus and the need for the two issues to be integrated: African countries have subscribed to MDG and UNGASS as key guiding policies in HIV&AIDS response. These policies however, although providing overarching guidelines, do not tackle neither food nor nutrition security responses to PLHIV nor mainstreaming food and nutrition security interventions into the HIV&AIDS programs.
2. Country-level policies not streamlined to tackle the challenges faced by PLHIV in food and nutrition insecurity. The emerging challenges in food security and nutrition (see section 3.4.1), are addressed by the policies in place. These challenges present key policy gaps including:
   a. Providing subsidies to PLHIV: Although this policy is in place and effected by most countries especially on the medication side, it is under threat due to reduced HIV&AID funds in some African countries.
   b. Policies to tackle increased food needs: There is need to put in place policies that makes it mandatory to provide food assistance while providing medical support
   c. Policies on community-based responses: There is no guidance on how local communities can support PLHIV and other affected population groups. Most of community initiatives are either by individual community volition or highly donor driven. The food and nutrition security responses are thus scanty, short-term and unsustainable.
3. Poor adherence and effecting of the stigmatization and discrimination policy: Policies leaning on the equal right for everyone to engage in employment without discrimination and stigmatization do exist even when the rights of the HIV&AIDS are being violated in employment at workplace.

It is worth noting (as this assessment has found), that the FAO Strategy for addressing the impact of HIV&AIDS and other diseases of poverty on nutrition, food security and rural livelihoods (2005-2015) can serve as a guide for all possible interventions. In particular, the FAO Strategy identifies the following six priority intervention areas:

- Strengthening capacity of member countries
- Improving access to and adoption of agricultural technologies
- Strengthening capacity of local governance structures
- Empowering vulnerable communities
- Strengthening policy dialogue and advocacy
- Nutrition

3 Findings cont'd

It has to be noted that the proposed humanitarian priority interventions, with a particular relevance to FAO's mandate are the development and delivery of a minimum package of services for communities in order to ensure access to:

- Food and nutritional services
- Adequate quantities and quality of seeds and tools
- HIV&AIDS prevention, care and impact mitigation responses
- Protection from sudden onset (natural) disasters and epidemic outbreaks.

3.4.4 Opportunities available

Certain common opportunities (to reduce vulnerability to HIV&AIDS in food insecure settings) are available in the study countries. These opportunities (both programmatic and policy-related), can be harnessed to ameliorate the vulnerabilities.

1. Governments have policies which directly relate to HIV&AIDS and food and nutrition insecurity: It would have been much more challenging if these policies were non-existence.
2. The governments' policies and strategic frameworks are not static but are normally revised periodically: This provides periodic windows of opportunities to advocate for and include HIV&AID food and nutrition relevant policies.
3. Donor support available: Technical and financial support from World Bank, Global Fund, United Nations agencies and other partners in the development and implementation of HIV&AIDS and food and nutrition insecurity is available although reducing for some countries.
4. Existing political will: HIV&AIDS and food insecurity are two important issues that have always received political will even from the top most leadership- the presidents or the prime ministers.
5. Existing HIV&AIDS networks. There are many organizations from the grassroots to national and even at regional level dealing with HIV&AIDS and food and nutrition insecurity. These organizations could easily be mobilized through their existing networks.

4 Conclusions and Recommendation

4.1 Conclusions

PLHIV are evidently challenged in accessing sufficient, safe, nutritious and sustainable food thus heightening food and nutrition insecurity among them and their families/defendants as compared to the general population. This is mainly caused by the health, social and economic impact of the HIV&AIDS. Despite the efforts to cope with effects of the scourge on food and nutrition insecurity both household and community responses are not sufficient and some are detrimental to health and heightens food nutrition insecurity. Despite these, global efforts such as the MDG and UNGASS do not provide concrete overarching frameworks for addressing the important nexus of HIV&AIDS and food and nutrition insecurity. Programs and policy actions are needed to protect the right to food for the HIV infected and affected.

Promoters and advocates of food security and agricultural production in post-conflict zones and other vulnerable areas, which are hard hit by the HIV&AIDS epidemic, have the opportunity and responsibility of pushing for sound an effective food security issues onto the global, regional and country program and policy agenda.

4 Recommendation

The following recommendations are given to reduce the vulnerability to the effects of HIV and AIDS in food and nutrition insecure settings:

4.1.1 Programmatic recommendations

1. Capacity building: Capacity building and empowerment of PLHIV (skills building for better agricultural practices, among others) for self-reliance and advocacy for their food and nutrition & treatment rights.
2. Programs integration: Enhancing integrated/comprehensive programs – link treatment programs more strongly to food and nutrition for PLHIV and those affected.
3. More resource allocation: Government commitment and allocation of sufficient resources for integrated programs on food and nutrition security for PLHIV. Strong link with Abuja declaration needed.
4. Multi-sectoral approaches: Formation of strategic partnerships for greater synergies to enhance sustainable livelihoods e.g. partnerships with microfinance institutions for technical and financial support for PLHIV, private sector and FAO, among others.
5. Have full HIV&AIDS compliant programming. Examine all food and nutrition security programs with 'HIV&AIDS lens' and either modify them to make tem appropriate for PLHIV and the affected or have parallel programs for them.

4.1.2 Policy and advocacy recommendations

1. Address the global policy gaps. Advocate of policies that address HIV&AIDS and food and nutrition nexus at global level- at MDG and UNGASS level. Global policies and frameworks which do provide guidelines for countries still do not consider the importance of the HIV&AIDS nexus.
2. Streamline/mainstream national policies to address food and nutrition security vulnerability among PLHIV and the affected. Periodic opportunities for these policy revisions present important avenues for streamlining. There is a need for a strong policy that states that all HIV&AIDS programs should have food and nutrition programs integrated and vice versa.
3. Advocate for strict adherence to already existing HIV&AIDS related policies: Stigmatisation and discrimination is not yet an issue of the past and compound the food and nutrition security challenges among the PLHIV.
4. Advocate for more funding targeting food and nutrition vulnerability for PLHIV and the affected: There is need to intentionally direct funding to address the HIV&AIDS and food and nutrition insecurity nexus in addition to having funding to address the two issues separately.

Appendices

Appendix 1: Terms of Reference (TOR) for the synthesis report

Terms of Reference

Title: Review and development of a synthesis report from country studies on HIV and livelihoods

Background

The Agency for Cooperation and Research in Development (ACORD) is a Pan African organization working for social justice and development in Africa, with its headquarters in Nairobi (Kenya). For over thirty five years, ACORD has worked with marginalised communities, facilitating them to analyse the factors that hamper their development and to develop collective actions for addressing the challenges. ACORD's programming activities are based on 4 thematic priorities of Livelihoods, Gender, Conflict, and HIV and AIDS, delivered in 17 countries across Africa with country and field offices. To strengthen community empowerment processes ACORD undertakes research to provide evidence for influencing thinking, policy and practices on the different aspects of the four themes; with a view of advocating for rights of marginalised poor communities.

As part of the interventions for mainstreaming HIV and AIDS in livelihoods programmes, ACORD Conducted a multi-country research in 2010 in 5 countries,(Uganda, Kenya, Mozambique, Ethiopia and Burundi) on the Food Security and HIV&AIDS Nexus. The aim of the study was to establish the current status on vulnerability to HIV and AIDS in food insecure settings among pastoralist, small-holder agricultural and post conflict communities. In particular the study focused on determining the extent of vulnerability of people living with HIV and AIDS to food and nutrition insecurity in order to contribute to learning in the field of HIV and Food & nutrition security

The draft research studies conducted in each of the five countries are available for review and harmonisation, a process requiring additional interviews with selected staff in the different countries. In this regard, ACORD seeks to identify a skilled person to undertake the review and finalisation of the country studies in order to identify recommendations for the HIV advocacy and programming.

Appendices

Scope of the required consultancy

1. Review and harmonise the country studies.
2. Consolidate the findings from the five country studies into a synthesis report bringing together common policy issues.
3. A policy brief summarizing the key issues, findings, conclusions and recommendations that will stimulate and guide discussions on PLHA food security rights with a view to placing it at the centre of National and Pan African policy engagement around PLHA food security and treatment rights. This will also form the basis for the organization of the country level debates/discussions and Pan African level food security and HIV and AIDS conference.

Methodology

1. Desk review of HIV and food sovereignty studies to augment the country study reports.
2. Review, update and harmonise the 5 draft country study reports.
3. Discussion with key staff to feed into the gaps in the country reports.

Key deliverables

- A synthesis report presenting an analysis of the common issues in the country study reports and recommendations.
- A policy brief summarising the key findings, conclusions and recommendations

Requirements

- Academic qualifications (Masters or PHD) in related social sciences, public health, or other relevant field of study
- Demonstrable experience minimum 5years in conducting similar research and developing related policy documents
- Thorough understanding and knowledge of the Food Security and HIV & AIDS interrelationship, interaction between HIV/AIDs and conflict as well as the multi sectoral factors affecting and interplaying with HIV & AIDS in the African Context
- Demonstrable working experience with CSOs, government and inter-governmental bodies

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