

AIDS: THE NEW CHALLENGE TO FOOD SECURITY

by Peter Piot and Per Pinstrup-Andersen

When you ask people living with AIDS in rural communities in the developing world what their highest priority is, very often their answer is food. Not care, not drugs for medical treatment, not relief from stigma, but food.

It is easy to forget in the complicated world of global AIDS politics that for many people around the world, AIDS is one additional burden on top of many others. AIDS does not occur in a vacuum. People's basic concerns remain the same as they have always been: a secure, decent livelihood for themselves and their families.

In Africa, where the pandemic is currently the most serious, AIDS emerged against a backdrop of extreme poverty, hunger, conflict, and inadequate infrastructure. The impact of AIDS has been to make pre-existing problems and their consequences far worse, and to create daunting new problems. By killing people in the prime of their lives, when they would normally be raising their children and practicing their professions, AIDS erodes the social capital that makes communities function. AIDS has decimated the very generation of young adults poised to take Africa's future into their own hands.

THE PROBLEM IS MASSIVE

AIDS is one of the greatest threats to global development and stability and a long-term humanitarian crisis of unprecedented proportions. The death and misery it has caused in the past 20 years dwarfs all of the natural disasters that have occurred in that time combined.

Since the epidemic started, more than 60 million people worldwide have been infected with the virus, equivalent to the population of France or Britain, or nearly double the population of California. Twenty million have died.

HIV/AIDS is by a large margin the leading cause of death in Sub-Saharan Africa and the fourth-biggest global killer. AIDS has caused average life expectancy in Sub-Saharan Africa to drop from 62 to 47 years. In 2001 alone, an estimated 5 million people became infected with HIV, and half of them were between the ages of 15 and 24. An estimated 800,000 children under 15, mainly infants, were infected with HIV in 2001, and 580,000 children died of AIDS.

Sub-Saharan Africa is the region of the world where the epidemic has hit hardest and where its impact increasingly threatens the stability of whole societies. Average prevalence in Sub-Saharan Africa is 8.8 percent in the adult population (15 to 49 years old). There are seven countries, all in the southern cone of Africa, where more than one in five adults is HIV-positive, and another nine countries where infection rates exceed 10 percent.

While the scale and impact of AIDS in Sub-Saharan Africa is the worst in the world, HIV is rapidly expanding in other regions. In Asia, China, and India, overall prevalence is relatively small, but because of their huge populations, each country has large numbers of HIV-positive people. For example, the Indian states of Maharashtra, Andhra Pradesh, and Tamil Nadu, each with over 50 million people, have HIV rates above 3 percent for pregnant women, over four times the national average.

In Southeast Asia, Thailand and Cambodia have brought major epidemics under control, but there are emerging epidemics in Myanmar and elsewhere. In the Caribbean and Central America, a number of countries are over the 2 percent prevalence level. In Eastern Europe, the epidemic has been explosive, with a staggering 1,300 percent increase in infections between 1996 and 2000, mainly among young people, and fuelled by injection drug use.

This list of the most affected countries is depressingly familiar to those who have worked on food security and nutrition for many years. It is no coincidence that the maps of HIV prevalence and malnutrition overlap. The HIV epidemic is increasingly driven by the very factors that cause malnutrition: poverty, conflict, and inequality. Malnutrition exhausts the immune system, making people more susceptible to tuberculosis, malaria, and other infectious and parasitic diseases, even in the absence of AIDS.

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AIDS IS DIFFERENT

AIDS is not just another health or development problem. By its nature and effects, AIDS is unique.

- AIDS kills the most productive—and reproductively active—members of society, thus

increasing the number of dependent household members, reducing household productivity and caring capacity, and interrupting the transfer of local knowledge and skills from one generation to the next. The effect on the household may be permanent.

- HIV is socially invisible, though the ravages of AIDS are everywhere apparent. The private nature of sex and the complex cultural attitudes toward it lead to silence, denial, stigma, and discrimination at many levels. Moreover, 90 percent of those living with HIV have no access to HIV testing. This makes effective prevention and mitigation efforts difficult.
- HIV has a very long incubation period between infection and major illness, during which the virus can be transmitted. Combined with invisibility, this increases the chances of HIV transmission.
- HIV/AIDS affects both rural and urban populations. The death of one or more income earners in rural households often forces survivors to migrate to seek work in cities. The death of an urban worker may force survivors to

send children back to rural areas to be raised in extended families. Migrant workers who become infected in cities go back home to their villages to die.

- HIV/AIDS infects people of all income levels throughout the developing and developed world. Everywhere, the poor face the most severe impact. AIDS prolongs and deepens poverty, making it harder to escape.
- HIV/AIDS affects both sexes but is not gender-neutral. Women, especially younger ones, are biologically more susceptible to contracting HIV than men in a given sexual encounter. The low social status of women in the developing world magnifies their vulnerability. Where women are marginalized and powerless, they are unable to negotiate sexual relations with men or control their reproductive lives. In many cultures, women are forced into early marriage, obliged to marry a dead husband's brother even if he is HIV-positive, and unable to refuse sexual relations with husbands who frequent prostitutes. Women in war zones are at great risk of sexual assault, including gang rape. Dire poverty and the inability to feed their children drive many women into prostitution, making exposure to HIV increasingly probable.

- As the pandemic intensifies, local capacity to respond decreases. Teachers, medical practitioners, and other essential professionals are dying in large numbers, leaving huge gaps in the social services most needed at this time. Organizations and businesses located in areas with high HIV/AIDS prevalence suffer high absenteeism, high staff turnover, loss of institutional memory, and reduced innovation. As individuals in government and non-governmental organizations die, the capacity gap—between what is needed and what can be delivered—is becoming an abyss.

These are some of the unique features of the HIV epidemic. But just how does HIV/AIDS relate to food and nutrition security? And what type of remedial policy and programmatic responses does such a relationship suggest?

Vicious synergies are at work from the individual to the macroeconomic and societal levels. After an individual becomes infected with HIV, the progression of the disease and the person's worsening nutritional status reinforce each other in a downward spiral that ends in death. At the household level, HIV/AIDS and food security are also linked by negative synergies. An HIV-affected household's risk



of food insecurity and malnutrition increases because sick family members can't work, well family members must spend time caring for the sick person instead of working, income declines, healthcare expenses increase, and less time is available for competent adults to care for young children. Food insecurity, in turn, may lead to the adoption of livelihood strategies that increase the risk of contracting HIV as well as rendering the household more and more vulnerable as the disease progresses. Important community-level impacts go beyond the aggregated household impacts.

But consider for a moment what is happening at the macro level. AIDS has a direct impact on rates of economic growth in the most affected developing countries. There is a direct relationship between the extent of HIV prevalence and the severity of negative GDP. When the rate of HIV in a population reaches 5 percent, per capita GDP can be expected to decline by 0.4 percent a year. And when HIV reaches 15 percent, a country can expect an annual drop in GDP of more than 1 percent.

The cumulative impact of HIV on the total size of economies is even greater. By the beginning of the next decade, South Africa, which represents 40 percent of Sub-Saharan Africa's economic output, is facing a real gross domestic product 17 percent lower than it would have been without AIDS.

In settings where subsistence agriculture predominates, measured economic productivity only scratches the surface of the total impact of HIV on livelihoods. For example, AIDS reduces long-term capacity for agricultural production, since livestock is often sold to pay funeral expenses and orphaned children lack the skills to cultivate crops or tend livestock.

AIDS kills people, not just economic activity. We should reflect on what it means for a society when 10, 20, or 30 percent of the population is HIV-infected. With today's rates of infection, a 15-year-old boy in Botswana has more than an 80-percent lifetime risk of dying from AIDS. Nurses and teachers are dying faster than they can be replaced. Last year, around 1 million African schoolchildren lost their teachers to AIDS. In Malawi, 6 to 8 percent of the teaching workforce dies each year. AIDS has orphaned nearly 14 million children. In Sierra Leone, the war left 12,000 children without families; AIDS has already orphaned five times that number.

WHAT WE CAN DO

We are not powerless in the face of AIDS. The tide is turning. Over the past few years, there has been a revolution in the world's thinking about HIV. The epidemic has been understood not only as a health issue, which it will always remain, but



also as a major threat to development and to human security. HIV/AIDS is being mainstreamed across sectors in increasingly unified national responses.

But just how can sectors such as agriculture help? How should government policies be altered to meet the needs of the poor within the context of the HIV/AIDS pandemic? What should a minister of agriculture do? Should s/he accelerate and intensify the implementation of agricultural development and poverty reduction policies and programs, or should they be redesigned first? If so, how?

Filtering the problem of food insecurity through an HIV/AIDS lens is a way to re-view the relationship between hunger and HIV/AIDS and can help people in the agricultural sector choose livelihood strategies that minimize risk and/or mitigate impacts. Indeed, the very notion that the agricultural sector can ameliorate the consequences of the pandemic in the medium to long term is new to many. The fresh angle of vision further highlights the need to avoid compartmentalizing responses into prevention, care, support, and mitigation. Food and nutrition are clearly critical in the care and support of people with HIV/AIDS. But the ways in which livelihoods could be adopted and adapted to ensure that families avoid the virus have only recently been appreciated.

The HIV/AIDS lens will be fine-tuned over time based on improving knowledge, and will be different in different contexts, ruling out one-size-fits-all blueprint planning. In addition to re-viewing food security pro-

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grams through the HIV/AIDS lens, we can and should be re-viewing AIDS programs from the perspective of availability, utilization, and access to food.

THE BIG CHALLENGES

Despite what we know about how to combat the epidemic, we are still a long way

from achieving success. The major challenges for timely research and action on HIV/AIDS and food security are highlighted below.

Include HIV-impact statements in all development plans. Major investments for development are being planned as if HIV were occurring on another planet. We need to improve our understanding of the impact of rural development on the spread of HIV. Just as environmental impact assessment has become an integral part of development programs and major projects, HIV impact assessments should also become the norm. HIV has not yet been fully integrated into poverty reduction strategies, multilateral development bank programs, or in regional and global development strategies. Fortunately this is changing.

Will agricultural development plans break up family structures and add to HIV risk? What plans are there for addressing HIV risk if new transport routes are created? What is the HIV-related impact of cash cropping on food security? These are important questions to be addressed from the very outset of development planning processes, and need to be an integral part of the World Bank's Poverty Reduction Strategy Papers, as well as health planning.

Break the link between food insecurity and HIV vulnerability. Along with responding to the immediate impacts of AIDS, we must continue to pay attention to program sustainability and to overcoming long-term vulnerability. What crops are nutritious enough to substitute for commonly raised labor-

intensive crops? For example, cassava requires very little labor but contains very little protein. What are the long-term nutritional effects of switching to cassava for populations that require more protein?

How do we keep children in school when there is so much pressure for them to replace the labor of sick or dying parents? The United Nations Children's Fund (UNICEF), one of eight cosponsoring UN agencies that comprise the Joint United Nations Programme on HIV/AIDS (UNAIDS), is extending the role of schools as community resource centers. The World Food Programme (WFP) is using food aid to provide an incentive for children to stay in school. Along with the International Service for National Agricultural Research (ISNAR), IFPRI is working with local partners in several Sub-Saharan African countries as part of a newly launched multi-country initiative that aims to strengthen local capacity while undertaking action-oriented research on priorities generated at national stakeholder workshops.

Include nutrition as a core component of HIV care. Too often, care and treatment of people with HIV/AIDS is reduced to the issue of antiretroviral drug prices. This



reductive debate misses the complexity of the broad care issues facing people living with HIV. It also fails to recognize the synergies possible by advancing the care agenda simultaneously on multiple fronts. The UNAIDS Secretariat and cosponsors have delineated a care agenda that includes providing psycho-

social care, reducing the stigma against people living with HIV, and ensuring access to essential AIDS medicines, including anti-retrovirals and treatment for opportunistic infections. The increased affordability of antiretroviral drugs should be used as an opportunity to demand that medications be provided with clean water supplies and with food. We are not dealing with step-by-step solutions, but solutions where progress in one area will support progress in others.

Give HIV-infected women real options to protect their infants. We know that breastfeeding by HIV-infected mothers carries a significant risk of transmission, up to 20 percent in the absence of drug therapy. We also know that exclusive breastfeeding for the first six months of life is one of the cheapest, most cost-effective practices in public health and social development. Currently, HIV-infected mothers are advised to avoid all breastfeeding when replacement feeding is acceptable, feasible, affordable, sustainable, and safe. But we are a long way from either exclusive breastfeeding or universal access to safe replacement feeding, and even further away from offering voluntary and confidential HIV testing and counseling as a routine component of antenatal care. A great deal of work

is required before mothers will be able to make an informed choice about breastfeeding. Such work is already underway by UNAIDS and its cosponsors, especially UNICEF, and by governments in the most affected countries, with boosted support from philanthropic foundations.

Eliminate the stigma of HIV/AIDS.

Stigma causes great social suffering, but it is also a nutrition issue. People with HIV have been thrown out of their homes or their villages and left hungry. One of the barriers to reaching those impoverished by AIDS with effective food replacement programs is the stigma-driven reluctance to identify those in most need. In order to overcome this problem, food programs are targeting AIDS-affected villages and areas rather than individual families. We also know that a woman may breast-feed in public to avoid stigma, but use formula in private to avoid transmission, unwittingly exposing her infant to the worst combination of feeding strategies.

Face the gender dimensions of AIDS.

Addressing relationships between men and women is at the core of successful behavioral change to prevent the spread of HIV, including gender inequalities that make the impact of HIV fall harder on women, such as inheritance laws that prevent women from holding land or livestock upon the death of their husbands. We know that women are the caregivers for children who have lost their parents. They also provide more than half the care for those sick with AIDS. Women do more than half the food gathering and production work. Now, they

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make up more than half of those living with HIV in Africa. Who takes care of the caretakers? When the women die, who will care for family members then?

Take action on a scale commensurate with the epidemic.

The time for pilot or demonstration projects is over. Piecemeal approaches

waste money and accomplish little. We must mainstream every aspect of our work. Success comes from long-term commitment. We make a real difference when we ensure that local actors have the information they need to respond to the epidemic, and when systems and necessary resources are in place. By delivering responses that are rooted in communities, we build to the scale of response required.

AIDS, like malnutrition, is complex. The solutions to complex problems lie in adhering to the facts, and in building new partnerships, better coordination, and sustainable change. The partnership between those whose primary concern is food and nutrition security and those whose focus is HIV is in its very early stage and growing rapidly. We can be confident that the partnership will continue to grow, based on the knowledge that food and nutrition policies are integral to winning the race against AIDS.

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