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HIV/AIDS and humanitarian action

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Executive summary

The crisis in southern Africa during 2002 and 2003 highlighted the complex interactions between HIV/AIDS, food security and famine. The UN Special Envoy argued that HIV/AIDS was 'challenging the paradigm of humanitarian assistance'; Alex De Waal contends that it threatens 'new variant famine'. Others have asked whether the importance of HIV/AIDS as a factor in the crisis has been overstated, and whether an undue focus on HIV/AIDS risks neglect of other equally important issues.

There are a number of reasons why HIV/AIDS must concern humanitarian actors working in the context of an epidemic:

- The mortality and suffering created by HIV/AIDS is a humanitarian concern in its own right. The impact of the epidemic is growing and will be felt for decades.
- HIV/AIDS has clear negative effects on household food security, adding another burden to already vulnerable households. This will make communities more vulnerable to other shocks, such as drought or conflict.
- HIV/AIDS has particular characteristics that may create new types of vulnerabilities and exacerbate existing ones, and this will need to be recognised in responding to crisis.
- Emergency situations may increase people's susceptibility to the transmission of HIV/AIDS, further fuelling the epidemic.

To the extent that humanitarian response is concerned with increased levels of mortality and morbidity, it is clear that HIV/AIDS can be described as an emergency. But it is also a long-term crisis, with impacts that will be felt for years. HIV/AIDS therefore raises a number of critical challenges for both relief and development assistance.

This report examines the implications of HIV/AIDS for our understanding of crisis and of the role of humanitarian aid. It focuses on the humanitarian response in southern Africa in 2002 and 2003. HIV/AIDS prevalence rates in southern Africa are the highest in the world, but they are continuing to rise in the rest of Africa and elsewhere. A better understanding of the impact of AIDS in southern Africa may therefore provide more broadly applicable lessons, as the impact of the epidemic spreads and deepens. In addition to this report, a resource guide has also been produced, which is available on the HPG website.

HIV/AIDS and livelihoods

Chapter 2 reviews the literature on HIV/AIDS. This shows that the disease has clear negative impacts on food security at a household level, and that these impacts are complex, wide-ranging and gender-specific. However, original research is limited; there has been a tendency to focus on agriculture at the expense of other aspects of livelihoods, and there is little information about the scale of the impact of HIV/AIDS on food security at national and regional levels.

There is a two-way relationship between HIV/AIDS and food security. HIV has an impact on people's livelihoods, reducing food security through illness and death; meanwhile, food insecurity and poverty fuel the HIV epidemic as people are driven to adopt risky strategies in order to survive. Ultimately, HIV/AIDS impacts on the livelihood outcomes of households. Households affected by HIV/AIDS usually have less income, increased vulnerability and reduced food security. This is likely to leave them more vulnerable to other shocks, such as drought. If it is severe enough, the impact of HIV/AIDS could result in destitution and households becoming dependent on external assistance.

The impact of HIV/AIDS is an additional burden on already-vulnerable households in sub-Saharan Africa. It also affects food security in ways that create particular types of vulnerabilities. The fact that it kills predominantly prime-age adults and that it clusters in households; the gender specificity of impact; and the way in which HIV/AIDS interacts with malnutrition are all factors that must be understood and taken into account in providing humanitarian relief in the context of an HIV/AIDS epidemic.

HIV/AIDS, humanitarian action and emergencies

Chapter 3 examines the implications of HIV/AIDS for our understanding of crisis and of the role of humanitarian aid therein. Traditionally, the slim literature on HIV/AIDS and emergencies largely focused on HIV/AIDS in conflict and refugee situations and, to a lesser extent, quick-onset natural disasters. The focus was on the increased risk of infection among affected populations caused by the violence, displacement and militarisation resulting from emergencies. During 2002 and 2003, however, the issue of HIV/AIDS and emergencies leapt to the top of the humanitarian policy agenda, prompted by the southern Africa crisis, the publication of Inter-Agency Standing Committee (IASC) guidelines on HIV/AIDS and emergencies and the revision of the Sphere Handbook, where HIV/AIDS was seen as a cross-cutting issue.

HIV/AIDS and famine

It is important to understand how the impact of HIV/AIDS interacts with other factors, such as drought and conflict, to create acute humanitarian crises. HIV/AIDS acts at many different levels:

- HIV/AIDS is one of many factors contributing to underlying vulnerability.
- HIV/AIDS undermines the ways in which people have traditionally coped with famine.
- HIV/AIDS may increase mortality in famines, as people with AIDS will be less able to cope with reduced food intake and additional disease burdens.
- Issues associated with crisis may add to the risks of transmission of HIV/AIDS and contribute to the spread of the epidemic.

There is a danger of the debate becoming stuck in trying to quantify HIV/AIDS' relative contribution to crisis, or in arguing about whether or not it is, as the UN Special Envoy argued, the 'most fundamental underlying cause of the southern Africa crisis'. Instead, this report suggests that HIV/AIDS should be understood as one of the underlying processes that predisposes poor people to the possibility of famine. However, HIV/AIDS is not just a contributory factor to vulnerability: it also influences the outcomes of the emergency. It increases the risk of heightened mortality in emergencies due to the ways in which it interacts with malnutrition, undermines coping strategies and leaves people less able to cope with other illness. This is the process that De Waal and Alan Whiteside have called 'new variant famine'.

HIV/AIDS and the southern Africa crisis

The argument that HIV/AIDS was a central component to the southern Africa crisis came about gradually. Initially defined as a food crisis caused by a combination of bad weather, bad governance and underlying poverty, AIDS later moved to the forefront of the agenda, and was increasingly cited as a major factor in the crisis.

There has, however, been a backlash against both the 'new variant famine' hypothesis and the increased focus on HIV/AIDS. The extent to which HIV/AIDS has been a contributory factor to the crisis has been questioned. It has been argued that its importance has been over-emphasised and that other, equally or more important, factors risk being neglected. There has been concern on the part of some donors and NGOs about the way in which HIV/AIDS is being used to justify a need for continued humanitarian aid in some countries, and there has been scepticism about the underlying empirical evidence of the links between HIV/AIDS and food insecurity.

Disentangling the relative importance of HIV/AIDS compared to bad governance or bad weather is, and will remain, difficult. The current data means that the scale and severity of HIV/AIDS' contribution to both acute and chronic food insecurity is simply unknown. What is perhaps more important is the way that additional vulnerability relating to HIV/AIDS interacts with other shocks undermining people's livelihoods. HIV/AIDS is likely to leave people more vulnerable to, less able to cope with, and less able to recover from, additional shocks such as drought, economic collapse or conflict.

HIV/AIDS as an emergency and its implications for relief and development

The core of the humanitarian agenda is commonly understood to be the humanitarian imperative to save lives and alleviate suffering. In this sense, HIV/AIDS is clearly a humanitarian problem. Huge numbers of people are dying from and suffering with HIV/AIDS in sub-Saharan Africa.

Labelling HIV/AIDS as an emergency may be useful in trying to generate additional action. For national governments, declaring HIV/AIDS an emergency may serve particular purposes, such as demonstrating political commitment or allowing the importing of generic drugs to treat the disease. Calling something an emergency also has important practical implications for aid agencies and donors in terms of what funding is available, from which budget lines and with what sort of timelines and conditions attached. Perhaps the best way to describe the challenges presented by the HIV/AIDS epidemic is as a long-term crisis. But whatever label is applied, HIV/AIDS clearly requires both a humanitarian response to suffering, and a long-term perspective.

In considering the challenge of HIV/AIDS for development and relief assistance, it is important to be clear about different aspects of the impact of HIV/AIDS on livelihoods, and the appropriate responses to those impacts. There are three linked but to some extent distinct challenges faced in the response to HIV/AIDS.

1. The impact of HIV/AIDS as a health crisis in its own right, in terms of massive and increasing levels of mortality, morbidity and suffering over a period of decades, perhaps best seen as a long-term emergency. This will require a long-term response to HIV/AIDS, encompassing prevention, care, treatment and mitigation.
2. HIV/AIDS as increasing underlying vulnerability, adding to the impact of other shocks and meaning that acute crises may be triggered more easily and be more difficult to recover from. HIV/AIDS will need to be taken into account as a cross-cutting issue in short-term humanitarian relief for acute suffering.
3. HIV/AIDS as one of many contributory factors to long-term and chronic food insecurity, poverty and destitution. HIV/AIDS therefore adds to the existing need for safety nets and long-term welfare, as part of the overall response to poverty. Welfare may need to be a particular focus, due to the likelihood that HIV/AIDS will increase levels of destitution.

HIV/AIDS raises a series of humanitarian challenges for development. The impact of HIV/AIDS on livelihoods reinforces the need for some form of social protection or welfare safety net for the poorest. By increasing underlying vulnerability, HIV/AIDS may also mean that crises are triggered more easily, and this reinforces the need for development actors to invest more in disaster preparedness and mitigation. Much of the current focus of HIV/AIDS response is on the need to expand access to treatment. In countries like Malawi, where a significant percentage of the population does not have access to basic primary health care, this implies a need to focus on basic health care delivery. These are not new challenges. There is a danger in considering the broader impacts of HIV/AIDS on livelihoods of 'AIDS exceptionalism', privileging AIDS over other diseases in health systems or focusing unduly on the impact of AIDS in food security programmes.

There is a need for clarity in distinguishing between the different challenges that the HIV/AIDS epidemic creates for both relief and development assistance. Humanitarian aid is only part of a much larger international response to the impact of the HIV/AIDS pandemic, and it is important to be clear about what the relief system can and cannot do. The overall response to HIV/AIDS needs to take place over decades, and requires a rethinking of relief modalities,

development modalities and of the links between humanitarian aid and development. The response of development assistance actors may need to draw on expertise and experience available within the humanitarian system, and vice versa.

A response across entire countries and regions over a period of decades is obviously ill-suited to the ways in which humanitarian aid is currently delivered, based as it is on short-term time horizons and funding cycles. The core business of humanitarian relief should remain focused on saving lives and alleviating suffering in response to acute crises. In doing this in the context of an HIV/AIDS epidemic, it is important to apply an 'HIV/AIDS lens' to humanitarian programming across the different sectors of response and across the programme cycle.

HIV/AIDS and humanitarian programming

The HIV/AIDS epidemic presents a set of difficult challenges for humanitarian assistance, which are the subject of Chapter 4. The southern Africa crisis has raised a series of practical questions around the programming of humanitarian aid in the context of an HIV/AIDS epidemic. These range from whether and how food aid rations need to be adapted, to the question of whether AIDS-related stigma affects participation in relief programmes. This report finds that HIV/AIDS issues need to be 'mainstreamed' by aid agencies both internally, in terms of training and organisational policies, and externally, in terms of how humanitarian aid programmes are structured and delivered.

Box 1: Humanitarian programming in the context of an HIV/AIDS epidemic

- Early-warning systems and assessments need to incorporate analysis of HIV/AIDS and its impact on livelihoods.
- The emergence of new types and areas of vulnerability due to HIV/AIDS should be considered in assessment and targeting. Groups such as widows, the elderly and orphans may be particularly vulnerable, and urban and peri-urban areas may need to be assessed.
- Targeting and the delivery of aid must be sensitive to the possibility of AIDS-related stigma and discrimination.
- The HIV/AIDS epidemic reinforces the existing need for humanitarian programmes to be gender-sensitive.
- Emergency interventions must aim to ensure that they do not increase people's susceptibility to infection with HIV/AIDS.
- Food aid in the context of HIV/AIDS should review ration sizes and types of food and assess delivery and distribution mechanisms in the light of HIV/AIDS-related vulnerabilities, such as illness, reduced labour and increased caring burdens.
- Labour-intensive public works programmes should consider the needs of labour-constrained households, the elderly and the chronically ill.
- HIV/AIDS reinforces the need for health issues to be considered as part of a humanitarian response.
- Support to agricultural production (including seed distribution) should recognise adaptations that people are making in response to HIV/AIDS.

Conclusion

HIV/AIDS has profound humanitarian consequences, both by directly causing illness and death and in terms of the wider impact it is having on societies, and these will inevitably deepen as the impact of the epidemic grows. These consequences will develop over a period of decades, meaning that existing models of humanitarian aid, constructed around the idea of a short-term response to acute need, may not be an appropriate instrument for responding to the long-term crisis of HIV/AIDS. Equally, existing models of development assistance are likely to prove inadequate. The pandemic, therefore, raises profound challenges for the system of international assistance. These challenges are only beginning to be fully appreciated.

Responses to HIV/AIDS will need to encompass the prevention, treatment and mitigation of HIV/AIDS, taking HIV/AIDS into account in humanitarian relief and as a contributory factor to poverty over the long term. Some of the key implications for humanitarian action and its role in this wider response to HIV/AIDS are:

- HIV/AIDS is a long-term crisis. Humanitarian aid has a role to play in the response to the crisis, but agencies should recognise that it is only part of a wider response, and should be clear about what humanitarian aid can and cannot achieve.
- Humanitarian agencies need to mainstream the consideration of HIV/AIDS issues both internally, in organisational policies, and externally, throughout the programme cycle and across the different sectors of response.
- HIV/AIDS may increase the likelihood and severity of acute crises. This reinforces the existing need for greater investment in disaster preparedness and mitigation.
- HIV/AIDS will increasingly add to the burden of chronic poverty and destitution in Africa. This implies greater investment in social protection and long-term welfare. Given the limited capacity and resources of many African governments, this will call for long-term commitment by donor governments.
- There is a need for greater understanding of the complex ways in which HIV/AIDS is affecting people's livelihoods and the impacts of livelihood insecurity on HIV/AIDS, particularly in relation to non-agricultural livelihoods.
- Aid agencies should endeavour to link humanitarian aid programming where possible to the development of local capacity for long-term welfare provision.

Chapter 1 Introduction

The crisis in southern Africa during 2002–2003 highlighted the complex interactions between HIV/AIDS, food security and humanitarian action. According to James Morris, the UN Special Envoy for southern Africa, 'HIV/AIDS is challenging the paradigm of humanitarian assistance' (Morris, 2002: 5). Alex De Waal contended that the HIV/AIDS epidemic in southern Africa raised the possibility of a new kind of famine, which he labelled 'new variant famine' (De Waal, 2002; De Waal and Whiteside, 2003). Meanwhile, aid agencies involved in a massive relief response in southern Africa, largely focused on food aid, grappled with what, if anything, the HIV/AIDS epidemic meant for the practicalities of humanitarian programming.

This report provides guidance to aid agencies dealing with these difficult questions. It tackles four main areas:

- how HIV/AIDS impacts on livelihoods, and how this interacts with other factors leading to humanitarian crises;
- the role of humanitarian aid in the context of the HIV/AIDS epidemic;
- the implications of HIV/AIDS for the relationship between humanitarian aid and development assistance; and
- the ways in which humanitarian aid programming needs to mainstream HIV/AIDS issues.

1.1 Scope and methodology

This study focuses on the emergency response in southern Africa in 2002–2003. This focus is intended to illuminate the issues faced by humanitarian agencies operating in the context of an HIV/AIDS epidemic. HIV prevalence rates in southern Africa are the highest in the world. To the extent that prevalence rates are continuing to rise elsewhere, the situation currently being faced in southern Africa may thus provide lessons for other parts of the world in the future. Clearly, however, there are limits to the extent to which the issues in southern Africa can be seen as more generally applicable. The connections between HIV/AIDS and conflict are only touched upon, and the growing literature on HIV/AIDS and refugees is not addressed.

This study has involved analysis of primary and secondary literature, complemented by interviews with key informants in aid agencies and donor bodies, at both field and headquarters levels. Field visits were conducted to Zambia, Zimbabwe, Malawi and South Africa between August and October 2003. Actors involved in the relief response were interviewed, including representatives of international and local NGOs, donor agencies, governments and UN agencies. A total of 109 people were interviewed (see Annex 1 for a list of interviewees). These interviews used a semi-structured format to explore the ways in which agencies had responded to the perceived crisis in 2002/2003; the extent to which HIV/AIDS had been seen as an issue of concern; and the ways in which HIV/AIDS had been addressed in practical terms in relief programmes. Only a limited time (10–14 days) was spent in each country, so the interviews were restricted to capital cities, and largely at heads-of-agency level. These interviews served to cross-check and validate interpretations from the secondary and grey literature, and to illuminate common views and key debates and issues. With these generic purposes in mind, and given some respondents' desire not to be quoted, individual interviews are not directly referenced in the text. Interviews were also conducted with aid agency personnel in Nairobi, Kenya, and in the US, where 45 people were interviewed by staff from Tulane University. The interviews conducted in Nairobi and the US are summarised in a background paper which has been drawn on in preparing this report (Murphy, 2004). An extensive literature review and a limited number of interviews with key aid agency staff in the UK were also conducted, focusing on the interface between HIV/AIDS, food security and emergencies (Harvey, 2003). This was widely disseminated for comment and feedback in mid-2003. A peer review group, drawn from the UN, NGOs and academia, commented on the report in draft.

This report uses the term 'southern Africa crisis' in the sense of the six southern African countries that were included in the UN's consolidated appeal (these were Mozambique, Malawi, Zambia, Zimbabwe, Swaziland and Lesotho). It recognises that there is an ongoing debate about the extent of the crisis in 2002–2003, indeed whether it was a crisis at all, and that the choice of the six countries was a construct of the international system (Darcy et al., 2003). There was much debate about whether to include Angola in the 'southern Africa crisis', and the country was part of the Disasters Emergency Committee (DEC) appeal on behalf of UK agencies (Valid International, 2004). The grouping of the six countries made sense for fundraising, logistical and coordination purposes, but it sometimes obscured the distinct and differing needs of the national crises in each. Whilst recognising the importance of these debates, this report uses the term 'southern Africa crisis' as a convenient shorthand.

1.2 Structure

Chapter 2 examines the ways in which HIV/AIDS and livelihoods interact, based on a review of existing literature. It considers both what this literature can tell us, and the gaps that remain. An understanding of how HIV/AIDS impacts upon food security and livelihoods is a necessary first step in considering how the effects of AIDS are likely to interact with other shocks in emergency situations.

Chapter 3 considers what this literature on HIV/AIDS and food security means for how emergencies are conceptualised and responded to. It considers whether HIV/AIDS should be seen as an emergency in its own right; how HIV/AIDS may interact with other emergencies; and what this means for humanitarian response. It also assesses the implications for how humanitarian action interacts with development assistance, and the humanitarian challenges that HIV/AIDS poses for the international development system.

Chapter 4 focuses on the ways in which humanitarian programming may or may not need to be altered in the context of the HIV/AIDS epidemic. It looks in particular at how aid agencies in southern Africa have adapted their programmes to reflect particular vulnerabilities relating to HIV/AIDS.

Chapter 5 concludes by summarising the implications of the HIV/AIDS epidemic for humanitarian action.

Chapter 2
HIV/AIDS and livelihoods

2.1 Introduction

This chapter reviews the relationship between HIV/AIDS and livelihoods based on a review of the available literature.[1] The majority of research on HIV/AIDS has tended until recently to have a relatively narrow focus on health, although there were important early studies of the impact of AIDS on agricultural systems (Barnett and Blaikie, 1992; Drinkwater, 1993; FAO, 1995; Baier, 1997). The literature on the links between HIV/AIDS and food security has tended to look at the effects on agriculture, and other aspects of livelihoods have been neglected. There is also very little information about the scale of the impact of HIV/AIDS on food security at national and regional levels, or the ways in which the impact of HIV/AIDS interacts with other factors creating food insecurity.

The literature nonetheless shows that HIV/AIDS has clear negative impacts on food security at a household level, and that these impacts are complex, wide-ranging and gender-specific. There is a two-way relationship between HIV/AIDS and food security. HIV has an impact on people's livelihoods, reducing food security through illness and death, and food insecurity and poverty fuel the HIV epidemic as people are driven to adopt risky strategies in order to survive (FAO, 2003). The impact of HIV/AIDS on food security leaves households more vulnerable to other shocks, such as drought, and ultimately can result in destitution and households becoming dependent on external assistance. The question of how HIV/AIDS connects with other shocks in emergencies, and indeed what HIV/AIDS implies for our understanding of what constitutes an emergency, is examined in Chapter 3.

First, however, it is necessary to develop a more detailed understanding of the ways in which HIV/AIDS undermines livelihoods. This chapter highlights some of the dimensions and key characteristics of the HIV/AIDS epidemic. It then examines the epidemic's impact, drawing on the sustainable livelihoods framework as a conceptual model, to map the ways in which HIV/AIDS affects how people survive. The literature on HIV/AIDS and food security has tended to look at the household level, and this will be the main focus of this chapter. One of the debates within the field is why the devastating impact of HIV/AIDS at the household level is not yet being seen in national statistics (De Waal, 2003).

2.2 Dimensions and key characteristics of the epidemic

The impact of the HIV/AIDS epidemic is already huge, it is rapidly increasing and it will last for decades. UNAIDS and WHO (2003) estimate that 28.5 million adults and children in Africa are living with HIV/AIDS, and that 2.4m Africans died of AIDS in 2002 alone.

HIV/AIDS prevalence figures for southern Africa (see Table 1) are the highest in the world. The figures in Table 1 are based on data from ante-natal clinics. Population-based surveys in a number of countries have produced lower prevalence figures and created a heated debate about levels of prevalence (Sunday Times South Africa, 2004; HSRC, 2002; Bennell, 2003a). There is not space here to enter into this debate, and the fact that there is uncertainty about exact prevalence rates should not divert attention from the seriousness of the epidemic. It is also important to note that aggregate prevalence figures may hide large variations within countries.

Table 1: AIDS figures for southern Africa in 2001

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

HIV prevalence rates tell only part of the story of the impact of HIV/AIDS. Barnett and Whiteside (2002) describe HIV/AIDS as a 'long wave event', the impact of which is felt over many decades, and see HIV/AIDS impoverishment as lasting as long as a century. A key question for assessing the likely impact of HIV/AIDS on food security is the stage that the epidemic has reached in particular countries, and indeed districts within countries. Often, overall prevalence rates are the only figures available, but a range of other data is also important in considering the scale of impact on food security and livelihoods, such as the numbers of people currently ill with AIDS, numbers of recent deaths and numbers of orphans. These figures are often unavailable, making it difficult to make judgements about the impact of HIV/AIDS on food security at national levels.

2.2.1 Is AIDS different?

In terms of its impact on livelihoods, in some senses HIV/AIDS is no different from other diseases. It makes people ill and it kills them, and this has effects on the households and communities afflicted. HIV/AIDS is adding to the already huge burden of ill-health in developing countries. Clearly, a focus on the impact of HIV/AIDS should not neglect the consequences of malaria, diarrhoeal diseases or measles. There are, however, important factors that are peculiar to

[1] A more detailed review of the literature is available as a background paper to this study (Harvey, 2003). A resource guide has also been developed, and is available on the HPG website at www.odi.org.uk/hpg/aidsresources.html.

HIV/AIDS (Haddad and Gillespie, 2001; De Waal and Whiteside, 2003; UNICEF, UNAIDS and WHO, 2002):

- It is becoming the dominant form of illness and death in the worst-affected countries, creating huge burdens on already inadequate health services.
- Illness relating to AIDS is often particularly damaging because it is chronic, prolonged and fatal.
- It disproportionately affects prime-age adults, killing the most productive members of society, increasing household dependency ratios, reducing productivity and caring capacity and impairing knowledge transfer between generations.
- It is creating growing numbers of orphans and increasing burdens on the elderly.
- It is often associated with stigma, creating further disadvantages for the people and families affected.
- As the pandemic intensifies, creating a need for action, the capacity to act is decreasing, as mortality relating to AIDS weakens key institutions.

Children orphaned by HIV/AIDS and the elderly face particular vulnerabilities. Globally, more than 15m children under the age of 15 have lost one or both parents due to AIDS. Up to 13% of all children in southern Africa are orphans (defined as having lost their mother or both parents). More than half of these children have been orphaned by HIV/AIDS. Orphans are often the first to suffer deprivation due to poverty and food insecurity, and they often suffer greatly from exclusion, abuse, discrimination and social stigma (Family Health International, 2002; Subbarao et al., 2001; UNICEF, UNAIDS and WHO, 2002; WFP, 2003). Orphans have lower rates of school enrolment and higher rates of malnutrition and depression.

The elderly are often carers and providers for those orphaned and ill from HIV/AIDS, and are themselves at risk of infection from the virus. The highest number of HIV/AIDS deaths occurs in the middle generation, leaving a larger proportion of older people and young children to deal with the impacts of the epidemic (HelpAge, 2003; Ainsworth and Dayton, 2001). A large proportion of adults with HIV/AIDS are nursed at home by their parents in their 60s and 70s. Elderly people also often take on the care and guardianship of grandchildren. This burden falls disproportionately on older women.

2.2.2 Gender

The gender dimensions of the impact of AIDS are crucial. In sub-Saharan Africa, women now form the majority of those living with HIV/AIDS (UNAIDS, 2002). They are infected on average 6–10 years younger than men. Women are biologically more susceptible to contracting HIV than men in any sexual encounter. The low social status of women in the developing world magnifies their vulnerability to infection and constrains their ability to deal with its impact. As Human Rights Watch (2003: 9) argues, 'the subordination of women and girls in Africa and related human rights abuses constitute a major driving force of the AIDS epidemic on the continent'. Many of the additional burdens of HIV/AIDS at a household level fall upon women, the main producers of food and the main carers for the sick and children (Tallis, 2002; Baden and Wach, 1998; Baylies and Bjura, 2000; Bridge, 2003; Oxfam, 2002; Holden, 2003; Gupta, 2000; Whelan, 1999).

Gender relationships influence impact in complex, diverse and context-specific ways, so it is clearly dangerous to make generalisations. However, some of the most commonly cited gender dimensions of impact within the literature are:

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

2.2.3 Susceptibility to HIV infection

Analysis of HIV/AIDS and food security within the literature has focused largely on the impact of HIV/AIDS on food security. However, the relationship is two-way: food insecurity may force people to adapt their livelihood strategies in ways that make them more susceptible to infection (Loevinsohn and Gillespie, 2003b). This section highlights the areas where the existing literature suggests that food insecurity may increase susceptibility to HIV/AIDS. Empirical research in this area is, however, limited, and has not moved far beyond the hypothetical and anecdotal.

Food insecurity can place women in situations of risk: 'women feel obliged to find food for their families and will sell sex for cash or kind as a last resort' (Loevinhsohn and Gillespie, 2003b: 8). Poverty is often linked to reduced access to information, including lower educational status, possibly leaving poor people more vulnerable to infection. Food insecurity may also increase levels or change types of migration in search of work, and this may increase the risks of transmission. Young women may only be able to find employment in areas which increase their susceptibility to HIV infection – as house maids or bar girls, for instance. Men who migrate to find work are often separated from their family, and this is associated with higher numbers of sexual partners (Save the Children UK, 2003; Holden, 2003). When men migrate, women that have remained behind may also be more susceptible to HIV infection.

2.2.4 Nutrition and HIV/AIDS

There is a vicious cycle between HIV/AIDS and malnutrition.

Malnutrition increases the progression of HIV infection, and may also increase the risk of transmission from mothers to babies. In turn, HIV infection accelerates the cycle of inadequate dietary intake and disease that leads to malnutrition (ACC/SCN, 2001; Egal and Valstar, 1999; Piwoz and Preble, 2000; Haddad and Gillespie, 2001).

People with HIV or AIDS have different nutritional requirements. However, precisely what these are has been the source of heated debate. The recommendations on nutritional requirements for people with HIV/AIDS have been revisited by a WHO working group (WHO, 2003; FANTA, 2004). This has found that, as HIV infection progresses, nutrient requirements change and distinguish between the asymptomatic and the symptomatic phases of HIV and AIDS.

Research suggests that the chance of infection with HIV might be reduced in individuals who have good nutritional status; that the onset of disease and death might be delayed where HIV-positive individuals are well-nourished; and that diets rich in protein, energy and vitamins might reduce the risks of vertical transmission from mother to child (Friis, 1998). Nutritional supplements, particularly antioxidant vitamins and minerals, may improve immune function and other HIV-related outcomes, especially in nutritionally vulnerable populations (FANTA, 2001). However, there is still much uncertainty about the interactions between HIV/AIDS and malnutrition. The WHO working group concludes that 'new knowledge is urgently needed to provide the scientific base required for making nutrition recommendations for rapid implementation' (WHO, 2003: 9).

A study on drought, AIDS and child malnutrition in southern Africa (Mason et al., 2003: 12) analysed available nutrition survey data from southern Africa and made the following initial conclusions about the impact of HIV/AIDS:

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

During 2002–2003, wasting remained within acceptable ranges in most of the countries in southern Africa. Deterioration of nutrition status in 2002–2003 was usually slow rather than acute. This seems to be in line with other data indicating that, amongst HIV-positive children, underweight levels and stunting are higher in prevalence than in non-infected children, and that wasting is uncommon except in paediatric AIDS cases (Piwoz and Preble, 2000; Hudspeth, 2003). Overall, there was a disproportionately high level of severe malnutrition as a proportion of global acute malnutrition than would normally be expected, and this could be related to HIV/AIDS (Hudspeth, 2003). The deterioration of nutrition status that the Mason et al. (2003) study found in peri-urban areas in southern Africa suggests that HIV/AIDS may make it increasingly important to assess and respond to urban as well as rural vulnerability.

2.2.5 HIV/AIDS and conflict

The links between HIV/AIDS and conflict are also at a relatively early stage of exploration and research (Khaw et al., 2000; Holmes, 2003; Pfeiffer, 1999). Conflict-related displacement leads to increased poverty, dependency and powerlessness. This in turn can increase the likelihood of sexual coercion or bartering, sexual violence and consensual unprotected and unsafe sex. Women are more likely than men to suffer from rape and sexual violence (Holden, 2003). People displaced by emergencies may also have lost access to basic services, the protection afforded by family and community and the safeguards of legislation against violence and discrimination. Military forces often have very high HIV infection rates, and the circumstances of conflict make soldiers more vulnerable to infection and more likely to spread infection among local populations. On the other hand, the limited data suggests that countries that have experienced widespread warfare have apparently lower rates of HIV infection than countries that have not; why this may be so is unclear.

The question of HIV/AIDS in conflict and refugee settings and relief agencies' efforts to address HIV/AIDS in these situations is not directly addressed in this study, and is a clear limitation. In one sense, the broader perspectives on how HIV/AIDS impacts on food security and livelihoods, and lessons in how to deal with this from southern Africa, apply equally to relief in conflict situations. More specific questions about the role of conflict and violence in increasing the risks of transmission of HIV/AIDS cannot be addressed here, but there is a developing literature on the subject and a clear need for further research (ARC, 2003; CAFOD, 2001; Holmes, 2003; Smith, 2002). There is also a growing literature specifically addressing questions around HIV/AIDS in refugee settings (Lubbers, 2003; UNAIDS, 1997; UNHCR, 2002 and 2003; Women's Commission for Refugees and Children, 2002; Bruns and Spiegel, 2003).

2.3 HIV/AIDS and livelihoods

The huge scale of the HIV/AIDS epidemic and its unique characteristics mean that it is having a profound impact on people's livelihoods, particularly in the worst-affected countries of sub-Saharan Africa. HIV/AIDS affects people's livelihood assets and the policies, institutions and processes that influence livelihoods. In turn, livelihood strategies are being adapted in response to HIV/AIDS, sometimes in erosive or destructive ways. Sometimes, households are simply unable to cope. At a macro level, HIV/AIDS reduces overall levels of economic growth, erodes public services such as health and education and may potentially affect governance

Box 2: Livelihood assets

- Human capital: the skills, knowledge, ability to labour and health that together enable people to pursue different livelihood objectives
- Financial capital: the financial resources that people use to achieve their livelihood objectives – including flow (income) and stocks (savings)
- Social capital: the social resources on which people draw in pursuit of their livelihood objectives. Networks and connectedness, membership of more formalised groups and relationships of trust, reciprocity and exchange
- Natural capital: the natural resource stocks from which resource flows and services are derived
- Physical capital: the basic infrastructure and producer goods needed to support livelihoods (water, transport, shelter)

DFID, 1998.

and security. The result can be seen in the livelihood outcomes of households, which become less food secure and more vulnerable to other shocks.

An understanding of how HIV/AIDS affects livelihoods is a necessary first step in considering the role of HIV/AIDS in emergencies, and the appropriate contribution of humanitarian aid in the response to HIV/AIDS. Different theoretical and conceptual frameworks and literatures are being drawn upon to understand the impact of HIV/AIDS on food security. The most commonly used model is the sustainable livelihoods framework (Stokes, 2003; Loevinsohn and Gillespie, 2003; Seeley and Pringle, 2003; DFID, 1998; Carney, 2002). The framework draws heavily on entitlements theory, and hence is clearly linked to the idea that famine occurs when livelihoods or entitlements collapse (Sen, 1981; Moser, 1998).

Figure 1 illustrates how the impact of AIDS must be considered at all levels of the sustainable livelihoods framework. For an individual household, HIV/AIDS can be seen as a shock, in which illness and death increase the household's vulnerability. AIDS is unusual in that the impact continues over the long term, both for households, as more family members become sick, and for communities. HIV/AIDS can also be seen as increasing vulnerability over the long term, for example through worsening dependency ratios or diminishing economic opportunities. Barnett and Whiteside (2002: 161) argue that 'it is useful to begin thinking about impact as a continuum between a sharp shock and slow and profound changes'.

HIV/AIDS impacts on people's livelihood assets and on the policies, institutions and processes that influence livelihoods. In turn, livelihood strategies are being adapted in response to HIV/AIDS. Ultimately, HIV/AIDS leads to increasing poverty and destitution. There is an important feedback loop that must be considered. Increased food insecurity may increase levels of HIV/AIDS transmission, feeding back into a vulnerability context of growing levels of illness and death due to HIV/AIDS.

There are, however, key limitations to the literature on the impact of HIV/AIDS on livelihoods. Work has focused on rural livelihoods at the household level and on the impact of HIV/AIDS on agricultural production. There have been few studies of the impact of HIV/AIDS on other livelihood groups, such as pastoralists or the urban poor. The impact of HIV/AIDS on areas such as casual labour and small-scale income generation is also poorly understood. Work is therefore a long way from reflecting the full diversity of rural people's livelihoods, or the impact of HIV/AIDS on the full range of activities and income sources that poor people use to survive (Ellis, 2000; Wolmer and Scoones, 2003). Poor people's livelihoods are often made up of a wide range of activities, including migration, petty trading, casual labour and non-farm activities. These are critical to survival, labour intensive and likely to be severely affected by HIV/AIDS. The literature on the impact of HIV/AIDS has also tended to consider the epidemic in isolation from other factors influencing food security. HIV/AIDS is only one of many issues affecting livelihoods. In sub-Saharan Africa, the epidemic has taken hold where livelihoods are already fragile, where there is widespread poverty and weak government. There is a need to understand how these processes interact (Ellis, 2003).

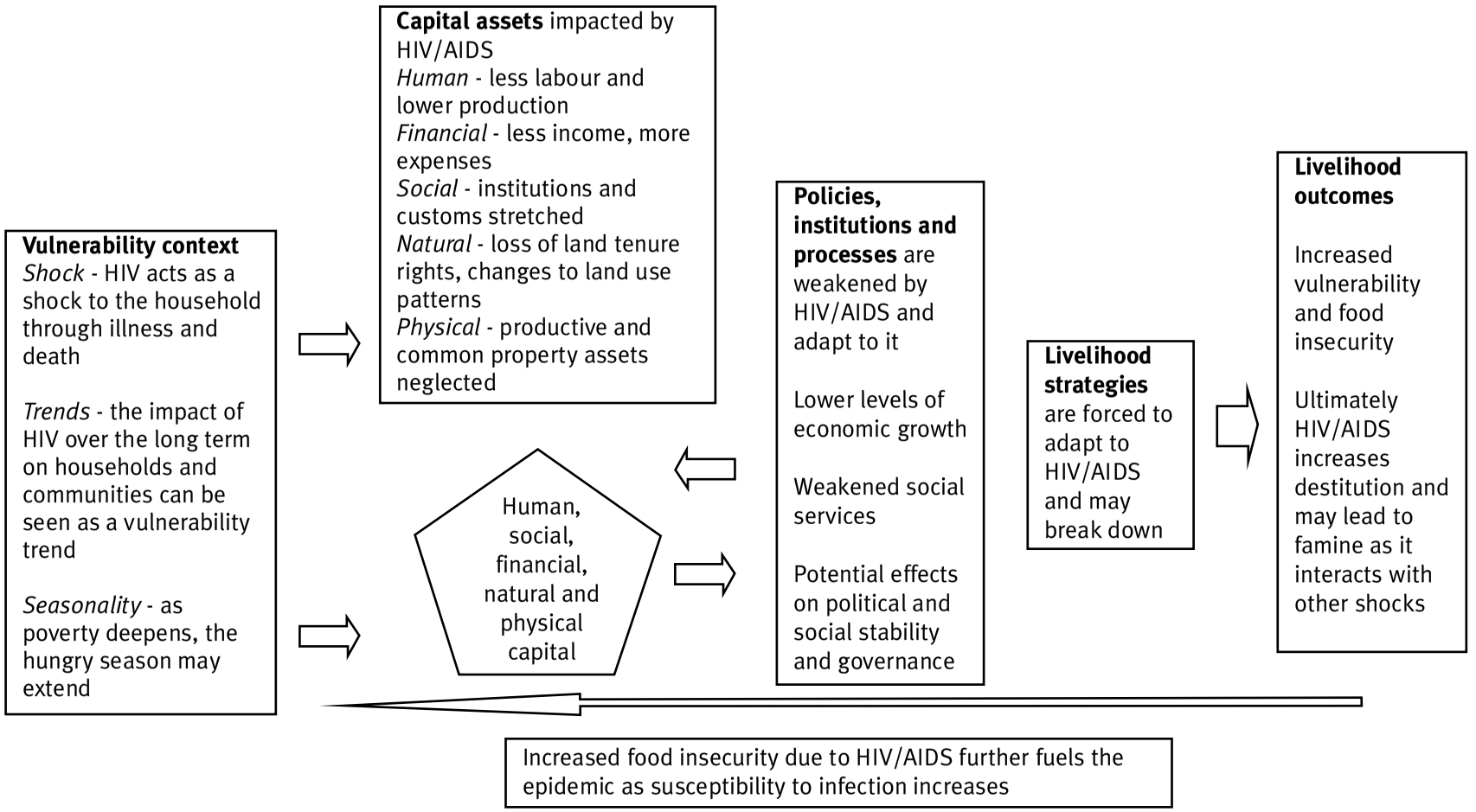
The following sections examine in more detail the ways in which HIV/AIDS impacts on livelihoods, using the sustainable livelihoods framework as a conceptual model.

2.3.1 Human capital

HIV/AIDS affects human capital in a number of ways. First, it adds to the burden of illness for a household. Individuals become chronically ill, suffering from a series of opportunistic infections before dying of AIDS. Illness related to AIDS is particularly damaging because it is often chronic and prolonged, and disproportionately affects prime-age adults. Illness reduces both the labour of the person who is ill and of the people who have to care for the sick. In rural households dependent on agriculture for their livelihood, studies have shown measurable falls in production as a result of HIV/AIDS (Yamano and Jayne, 2002; Kwaramba, 1997; Shah et al., 2002; National Agricultural Advisory Services, 2003).

When someone dies of AIDS, their labour is permanently lost to the household and further time is spent in attending funerals. HIV/AIDS usually strikes more than one household member, and the shock of multiple deaths within a household can be particularly devastating. People who adopt orphans will also take on additional levels of care, although it is also possible that orphans will contribute to household labour. Finally, HIV/AIDS damages the transfer of knowledge from one generation to the next, due to the death of adults in their prime and by the fact that children are often withdrawn from school as a response to HIV/AIDS. Ayieko (1998) found that just one-tenth of orphan-headed households possessed adequate knowledge of agricultural production techniques. The gender dimensions of knowledge transmission are also

Figure 1: Sustainable livelihoods in the context of an HIV/AIDS epidemic



important. HIV/AIDS can mean the loss of gender-specific knowledge, for instance in growing and marketing cash crops, which is typically the preserve of men.

The evidence on the impact of illness and death on household dependency ratios is mixed. Studies suggest that household structures are fluid and respond to HIV/AIDS by, for instance, sending small children to live with relatives and bringing in productive individuals from elsewhere (Donovan et al., 2003; World Bank, 1999). However, conventional methods of calculating dependency ratios may not capture the burden of chronic illness, and it may be more appropriate to calculate an 'effective dependency ratio' which counts the sick as dependants (De Waal and Whiteside, 2003). Aggregate data on dependency ratios also do not capture the costs of adjustments to households, and studies may underestimate the impact of HIV/AIDS because they cannot track dissolved households (Mutangadura, 2000; Barnett and Whiteside, 2002).

2.3.2 Financial capital

HIV/AIDS damages financial capital by increasing household expenditure and reducing the amount of income that a household has available. Illness due to HIV/AIDS can be very costly for households that have to finance medical care, transport, drugs and payments to traditional healers. Funerals are also a major drain on household assets. In order to meet these additional costs, people may have to draw down their savings and sell key assets such as jewellery and livestock. People's ability to pay for these additional costs is also affected as HIV/AIDS contributes to declining incomes. For example, reduced labour may lead to less income from casual labour and trading and less investment in cash crops. A study in rural Kenya found that mean reductions in off-farm income were 35–40% for households afflicted by adult death, compared to only 12% for households not experiencing adult mortality (Yamano and Jayne, 2002). Other household studies have shown falls in income following adult deaths from HIV/AIDS (World Bank, 1999; Bechu, 1998; Nampanya-Serpell, 2000; Menon et al., 1998).

Households affected by HIV/AIDS may have less access to credit due to stigma or because they are seen as more likely to default (Lundberg and Over, 2000; World Bank, 1999). Reduced income and additional expenditure may also make it more difficult for households to invest in key productive areas such as seeds and fertilisers, increasing impoverishment. It is also possible that HIV/AIDS is affecting income from remittances, although there has been little research into this.

Evidence about the impact of HIV/AIDS on livestock is limited; what there is suggests that it can be highly variable and context-specific (Yamano and Jayne, 2002; Halswimmer, 1994; Engh et al., 2000). Some AIDS-afflicted households have been observed to turn to livestock production as an alternative to crops when soils become infertile and crop management too demanding for the available labour. Other households sell cattle more frequently to pay medical bills and funeral expenses. A trend has also been identified whereby households raise smaller stock such as pigs and poultry, a much less labour-intensive activity (White and Robinson, 2000).

2.3.3 Social capital

The impact of HIV/AIDS on social capital needs to be considered both in terms of organisations and institutions, and in terms of the customs and practices that influence people's livelihoods. Families affected by chronic illness and death rely on social networks for support, but as calls on these networks increase, so they are likely to become over-burdened. This is then likely to increase vulnerability to other shocks.

Social capital is notoriously difficult to measure, but qualitative information from a range of studies suggests that it is becoming increasingly overstretched by the growing demands related to HIV/AIDS (Shah et al., 2002; Nalugoda et al., 1997; Rugalema, 1999; De Waal and Whiteside, 2003). It has been shown that families affected by AIDS rely on social networks. Lundberg et al. (2001), for example, found that the majority of assistance to households in Kagera, Tanzania, following an adult death came from private transfers. HIV/AIDS further undermines social capital, which demands investments of time and resources to cultivate. 'In spite of their wish to do so, individuals and households find themselves unable to give of their time or resources to the

Box 3: Ways in which HIV/AIDS can affect agricultural production (FAO, 2002)

A reduction in the area of land under cultivation
The sickness followed by death of adult members of the household may force people to leave land fallow and/or sell land.

Declining yields
Yields may decline as a result of delays in, or poor timing of, essential farming operations. Households may also lack the labour to keep up with important land conservation measures and post-production operations, such as food storage and processing. Cash and credit may be diverted away from such things as seed and fertiliser to meet medical and funeral expenses.

Declines in crop variety and changes in cropping patterns
Cash crops may be abandoned if the household does not have enough labour for both cash and subsistence crops, or if surviving members of the household lack knowledge and experience in marketing cash crops.

Declines in livestock production
Households may have to sell livestock to meet the costs of illness and death. Animal husbandry practices may deteriorate from the impact of AIDS on the labour force, medical costs may force the sale of livestock and funeral practices may involve the slaughtering of animals.

Loss of agricultural skills
HIV/AIDS can interrupt the normal transmission of knowledge between generations both through the death of parents and the interruption of schooling.

community' (Baylies, 2002: 623). People stigmatised by HIV/AIDS may be excluded from participation in social institutions.

HIV/AIDS can also lead to the formation of new social capital in community efforts to mitigate its impact, and to the adaptation of existing institutions and customs. New groups are emerging in response to HIV/AIDS, and community organisations such as burial societies are adding efforts around AIDS to existing activities. New methods of organising labour are emerging, such as labour-sharing schemes, and customs relating to funeral practices, marriage and inheritance are changing (Mutangadura, 1999). The responses of societies to HIV/AIDS, however, are not necessarily positive, and may be deeply anti-social. For example, HelpAge (2003) has noted an increase in older women being accused of witchcraft in relation to HIV/AIDS.

2.3.4 Natural and physical capital

HIV/AIDS may affect natural and physical capital through its impact on land tenure and land rights, and the possible sale of key productive assets. Widows and orphans may lose their access to land following the death of a male household head (Drimie, 2002 and 2003; Mphale et al., 2002; Aliber and Walker, 2003). Mbaya (2002) found that Malawian women employ a range of strategies to ensure that they have continued access to land, such as remarriage and celibacy (to secure the permission of in-laws to continued access to the late spouse's land). In a study in Kenya, Human Rights Watch (2003) found widespread property rights violations (see Box 4). Beyond the focus on land, there has been initial research into the use of medicinal plants, indigenous knowledge systems and wild foods to offset the impact of AIDS-related illness and concern that HIV/AIDS could affect the maintenance of common property resources such as forests or grazing land (Dwasi, 2002; Loevinsohn and Gillespie, 2003b).

2.3.5 Policies, institutions and processes

In the sustainable livelihoods framework, livelihood strategies are influenced by the institutions, organisations and social relations that mediate access to capital assets, and by the broader economic and political context. It is important therefore both to situate HIV/AIDS within the wider context of the macro-level factors affecting livelihoods, and to understand the ways in which HIV/AIDS is itself influencing these macro-level factors.

Box 4: Violations of property rights in Kenya

An in-depth study of property rights violations in Kenya by Human Rights Watch found many reports of women excluded from inheriting property, evicted from their lands and homes by in-laws, stripped of their possessions and forced to engage in risky sexual practices in order to keep their property. Many widows were forced into the customary practice of 'wife inheritance', whereby a widow is taken as a wife by a relative of her late husband, or ritual 'cleansing', whereby widows are obliged to have sex (usually unprotected) with a man who is a social outcast. Injustices in women's property rights have been ignored for decades by governments across Africa, and redressing them seems to figure nowhere in HIV/AIDS policies and programmes.

Source: Human Rights Watch, 2003.

There is a large and complex literature examining the macro-economic effects of HIV/AIDS (Over, 1998; BIDPA, 2000; Bell at al., 2003; Forsythe, 2002; MacFarlan and Sgherri, 2001). The overall picture is that national economies are likely to grow more slowly as a result of the impact of HIV/AIDS, although the extent of this impact is unclear and disputed. HIV/AIDS is also likely to make it more difficult for governments to focus resources on poverty alleviation and social services, both through lower levels of growth and therefore revenue, and through weakening key government institutions such as ministries of health and education (BIDPA, 2000; Ainsworth et al., 2000; Kelly, 2000). HIV/AIDS undermines organisations through high absenteeism, high turnover and the loss of institutional memory. There is also a growing discussion of the potential effects of HIV/AIDS on political and social stability and governance (De Waal, 2002a; Manning, 2002; Moran et al., 2003). In 2000, the US government identified AIDS as a disease that could 'exacerbate social and political instability in key countries' (National Intelligence Council, 2000), and the threat of HIV/AIDS was debated by the UN Security Council in January 2000. As yet, however, the effects on governance and security remain largely hypothetical.

HIV/AIDS is only part of the macro-level environment in sub-Saharan Africa. The epidemic is taking place in economies that are already fragile, and in the context of a neo-patrimonial politics of personalised exchange, clientelism and corruption (Bird, Booth and Pratt, 2003: 8; Chabal and Daloz, 1999; Van de Walle, 2001). The literature on HIV/AIDS tends to assume a functioning state, able and interested in delivering services to its citizens, that is weakened by HIV/AIDS. The fact that, in a significant number of African states, this may not be the case has important implications for policy relating to the response to HIV/AIDS (Bird, Booth and Pratt, 2003).

2.3.6 Livelihood strategies, coping strategies and HIV/AIDS

The literature on HIV/AIDS has increasingly recognised that the ways in which people are dealing with the impact of the disease have important similarities with the ways in which rural households deal with other shocks to food insecurity. Accordingly, researchers have drawn on the existing literature on coping strategies and famines (Corbett, 1988; Davies, 1996; Maxwell, 1996). However, there has also been growing criticism of the very term 'coping' to describe the strategies adopted. Barnett and Whiteside (2002) argue that 'people who are forced to sell the clothes of the dead or their own clothes can hardly be said to be coping; these are the actions of the desperately impoverished'. Gillespie and Loevinsohn (2003) argue for using the value-neutral term 'responding'. The term 'coping strategies' nonetheless is widely understood, and will be used in this study, albeit with caveats. People and households may in the end fail to cope and be forced into destitution. Some strategies are clearly damaging to livelihoods and may increase current or future

Box 5: Coping or response strategies

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

Agricultural adaptations
Shift to less labour-intensive crops and a reduction in the range of crops per household
Decrease in area cultivated/more land left fallow
Use of labour-saving technologies if available
Better-off families may hire labour or replace labour with technology
Withdrawal from marketing into subsistence

Adaptation to loss of knowledge
Cease growing certain crops, such as cash crops that only men knew how to market

Financial capital
Coping/adapting by spending less
Eating less, reducing the quality of the food being eaten
Use of purchased inputs (seed, fertiliser) is reduced

Coping/adapting by finding other income sources
Drawing down savings and going into debt
Selling assets such as jewellery, livestock and household goods
Finding new income-generating activities, migrating to look for work
Begging, relying on help from friends and relatives, attempting to access outside help
Participating in informal institutions such as savings or burial clubs
Marrying off daughters for bride dowries

Social capital
Institutional adaptation
New institutions emerge, existing ones adapt to address AIDS

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

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

vulnerability, such as transactional sex, withdrawing children from school or eating less. The literature distinguishes between these 'erosive' strategies and non-erosive strategies such as income diversification.

A wide range of strategies has been employed in response to AIDS, and these are summarised in Box 5. This reproduces the limitations of the literature in its focus on rural populations and on agricultural production. Little is known about coping strategies in urban and peri-urban areas, or about non-agricultural responses. Empirical evidence about the extent and scope of coping strategies is thin, and there is little consideration of the degree to which these various strategies are actually being employed. As Yamano and Jayne (2002) point out, very little is known about the dynamics of household behavioural response to adult death in Africa, and the limited information that does exist suggests great heterogeneity.

2.4 Chapter summary

This chapter has sketched some of the key dimensions and characteristics of the HIV/AIDS epidemic and reviewed the growing literature on how HIV/AIDS impacts upon livelihoods. Livelihoods that have been undermined by HIV/AIDS will be more vulnerable to famine and acute crisis. It has suggested a number of reasons why HIV/AIDS must concern humanitarian actors working in the context of an HIV/AIDS epidemic.

- The mortality and suffering created by HIV/AIDS is clearly a humanitarian concern in its own right. The impact of the epidemic is growing, and will be felt for decades.
- There are many gaps in current knowledge about how and in what degree HIV/AIDS affects livelihoods. There is therefore a need for caution around policy prescriptions for coping with the impact of HIV/AIDS, and a need to recognise that HIV/AIDS is only one of many factors affecting food security.
- HIV/AIDS is increasing the food insecurity of significant numbers of households, adding another burden to the already vulnerable. This will make communities more vulnerable to other shocks, such as drought or conflict.
- HIV/AIDS has particular characteristics that may create new types of vulnerabilities and exacerbate existing ones, and this will need to be recognised in responding to crisis – the growing number of orphans; increasing burdens on the elderly; gender-specific issues such as the rights of widows.

There is an urgent need for research to examine the full range of ways in which HIV/AIDS affects livelihoods. Recognising gaps in current knowledge is important when the focus of attention moves from understanding impact to suggesting policy options for mitigating it. Policy suggestions to date have often remained restricted according to the focus of the research: agricultural policy institutes recommend agricultural options; micro-finance practitioners urge the expansion and adaptation of micro-finance institutions (Donahue, 2000; Du Guerny, 1999 and 2002).

The breadth and complexity of the ways in which HIV/AIDS impacts upon livelihoods suggest a wider range of policy options for supporting the livelihoods of affected people. This is summarised in Table 2 (page 16), which also attempts to describe the strategies people adopt in response and the wide range of interventions that could be considered to mitigate the impact of HIV/AIDS. It does not claim to be comprehensive, and the possible interventions are not intended to follow directly from the impacts.

It seems clear from the literature that HIV/AIDS has a significant and growing impact on food security at the household level. The fact that it kills predominantly prime-age adults and that it clusters in households; the gender-specific nature of impact; and the way in which HIV/AIDS interacts with malnutrition are all factors that must be understood and taken into account in providing humanitarian relief in the context of an HIV/AIDS epidemic.

Table 2: Examples of Possible Impacts of AIDS on livelihoods and responses to mitigate impact

Sources of capital	Impact	Coping/survival strategies	Possible interventions to support livelihoods
Human capital Represents the skills, knowledge, ability to labour and health that together enable people to pursue different livelihood objectives	Reduced labour availability • Death, sickness, caring for the sick and orphans and funeral attendance reduce labour available to the household *Impact of reduced labour* • Declining agricultural production and productivity • Less ability to undertake casual labour, paid employment, and other income-generating activities *Knowledge* • Death of adults damages transfer of knowledge between generations • Children withdrawn from school learn less • Key agricultural knowledge may be lost, especially where gender divisions of labour are strict	*Agricultural adaptations* • Shift to less labour-intensive crops • Reduction in range of crops per household • Decrease in area cultivated/more land left fallow • Use of labour-saving technologies if available • Withdrawal from marketing into pure subsistence *Coping with less labour* • Withdraw children from school • Send children to live with relatives • Diversify activities to less labour-intensive ones • Rely on the elderly, children and extended family networks for additional labour *Adaptation to loss of knowledge* • May have to cease growing certain crops, for example cash crops, after a male death	• Research into low-input, low-labour crops • Changes in agricultural extension • Promotion of labour-saving technology • Marketing support – e.g. to widows to help them market cash crops • Health care, including ARTs • Seed and tool distributions that reflect new cropping systems • School feeding • Home-based care and orphan support • Food aid that provides sufficient protein, fat and micronutrients • Innovative responses to the growing number of orphans, such as community schools
Financial capital The financial resources that people use to achieve their livelihood objectives	*Additional expenses – spending more* • Costs of treatment for the sick and funerals • Expenses involved in looking after orphans *Reductions in household income – earning less* • Loss of remittances (sickness or death of relatives) • Loss of access to credit as affected households are considered higher risk • Less able to grow cash crops due to lack of funds for inputs, greater reluctance to take on risk	*Coping /adapting by spending less* • Eating less, reductions in quality of food being eaten • Use of purchased inputs (seed, fertiliser) reduced • Avoid use of formal health care system *Coping /adapting by finding other income sources* • Drawing down savings, selling assets, going into debt • Finding new income-generating activities • Some household members migrate to look for work • Begging, help from friends and relatives, relief • Informal institutions such as burial clubs • Sale or rental of land	• Cash grants • Safety net employment provision adapted to labour restrictions of affected households • Agricultural input grants or subsidies • Livestock interventions such as restocking • Support for income-generation activities • Support to micro-finance institutions that offer products suitable for affected households • Support to savings clubs, ROSCAs • Waiver of school fees, health care user fees • Increase or introduction of pensions
Social capital The social resources on which people draw in pursuit of their livelihood objectives	*Institutions/organisations* • Institutions are weakened by deaths and illness • Risk that institutions will become more exclusive, possibly stigmatising those with HIV/AIDS *Customs, rules and practice* • Traditional customs in areas such as remittances or child adoption are over-burdened • People less able to help kin during other shocks • Reversal of urban–rural support networks	*Institutional adaptation* • institutions emerge to address AIDS • Adaptation of existing institutions to HIV/AIDS *Changing customs/practices* • Funeral practices change to reduce costs and time commitment • Orphan care left to the elderly, emergence of child-headed households	• Support to civil society institutions that are responding to the epidemic • Promote changes to customary land tenure that strengthen rights of vulnerable groups • Promote adaptations to customs governing participation in markets – e.g. allowing widows to market cash crops • Supporting changes to customs and practice – e.g. transformation of gender roles
Natural capital The natural resource stocks from which resource flows and services are derived	*Land tenure* • Widows and orphans lose title to land *Land use/farming systems* • Farming systems and land use patterns change • Common property assets are not maintained	• Sale, mortgaging or rental of land to generate income • Remarriage to gain access to a new piece of land • Involuntary celibacy to gain permission of in-laws to retain use of late spouse's land	• Changing rules governing land tenure to strengthen rights of widows and orphans • Strengthening land rights and flexibility of land-use laws
Physical capital The basic infrastructure and producer goods to support livelihoods	• Sale of productive equipment (draught animals) • Sale or slaughter of livestock • Productive assets such as irrigation systems and household assets are not maintained • Less time available for fuel collection	• Distress sales of livestock, key productive assets • CBOs carry out house repairs for affected families	• Provision of key non-food items during emergencies in addition to food aid • Water and sanitation interventions take into account restricted mobility and labour of affected households

Chapter 3
HIV/AIDS, humanitarian action and emergencies

3.1 Introduction

The previous chapter detailed the complex ways in which HIV/AIDS undermines people's livelihoods. However, the literature in this area has largely focused on the impact of HIV/AIDS in 'normal' situations, ignoring the effects of conflict and natural disasters. This presents a distorted view of the reality of livelihoods in large parts of Africa which are affected by conflict and periodic shocks, leading to acute food insecurity. It is therefore crucial to consider the impact that HIV/AIDS has on food security in emergency situations, and the ways in which emergencies create additional susceptibilities to HIV/AIDS, as a result of impoverishment, displacement, loss of assets and disruption to support networks.

The literature on HIV/AIDS and emergencies is much sparser than that on AIDS and food security. It is also noticeable that the two literatures developed largely separately, with few links being made between them until recently. Typically, what work there was on HIV/AIDS and emergencies largely focused on conflict and refugee situations, and to a lesser extent quick-onset natural disasters (Smith, 2002; UNAIDS, 1997; Khaw et al., 2000). The emphasis was on the increased risk of infection among affected populations caused by the violence, displacement and militarisation resulting from emergencies; and ways in which humanitarian responses can reduce susceptibility to infection. Comparatively little attention was given to mitigation and care aspects, and little or none to the wider impact of HIV/AIDS on poverty, food security and vulnerability to emergencies. The focus was on prevention and on the biomedical aspects of prevention, such as contaminated blood, inadequate sterilisation facilities or deficient health education (Smith, 2002).

During 2002 and 2003, however, the issue of HIV/AIDS and emergencies leapt to the top of the humanitarian policy agenda. This was prompted by a number of linked processes. The revision of the Sphere Handbook provided an opportunity for HIV/AIDS issues to be incorporated. The Inter-Agency Standing Committee (IASC) produced a revised set of guidelines on HIV/AIDS and emergencies (IASC, 2003), and various other publications and guidelines began to take a much broader view of the intersection between HIV/AIDS, food insecurity and emergencies. There is a growing body of empirical studies, and new research is being planned (Holden, 2003; WFP, 2003; UNHCR, 2002b; UNHCR and UNAIDS, 2003; Loevinsohn and Gillespie, 2003; TANGO, 2003). The greatest driver, however, was the response to the humanitarian crisis in southern Africa. As the humanitarian system began to gear up to provide large volumes of humanitarian aid in 2002, HIV/AIDS became increasingly cited as a major contributory factor to the crisis (Darcy et al., 2003; Morris and Lewis, 2003; Oxfam, 2003b).

Despite the increased attention given to the connections between HIV/AIDS and emergencies, a number of key questions remain. Crucially, we need to understand more fully:

- how additional food insecurity related to HIV/AIDS interacts with all of the other factors that contribute to food insecurity; and
- how HIV/AIDS contributes to the mechanisms by which chronic poverty tips over into acute emergency need.

These are difficult questions, and ones which have become increasingly confused both in the growing literature on HIV/AIDS and emergencies, and in the debate about the causes and extent of the crisis in southern Africa. The multiplicity of viewpoints, assumptions and recommendations in the literature and in agency policies and programmes suggests a need for greater awareness and precision in situating humanitarian aid within the wider response to the HIV/AIDS epidemic. Four main arguments can be distinguished:

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

2. The HIV/AIDS pandemic undermines livelihoods and greatly increases food insecurity, making people more vulnerable to other shocks. Natural and complex disasters could start earlier, last longer and be triggered more easily. The humanitarian community will need to adjust its way of working to take this increased vulnerability to shocks into account.

3. The impact of HIV/AIDS on livelihoods means that some form of safety net or welfare system will be needed for those worst affected. At the same time, development processes will need to mainstream HIV/AIDS issues in devising appropriate mitigation strategies. Relief will be needed as a long-term safety net in conjunction with other, more development-oriented interventions.

4. HIV/AIDS threatens a descent into crisis in which underlying vulnerability is so great that there is a permanent or chronic emergency, similar to that previously only seen in long-running conflicts.

None of these positions seems mutually exclusive, although the first and fourth are more contentious. HIV/AIDS reinforces the existing need for safety nets for the poorest, and there is a need for analysis of its impact on other types of shocks, and what this means for humanitarian action. Depending on the severity of the unfolding impact of the epidemic, its interaction with other factors creating food insecurity and the response of governments, there is a risk of the permanent crisis outlined in the new variant famine hypothesis.

The following sections disentangle these questions. Section 3.2 analyses the role of HIV/AIDS in famines. Section 3.3 develops this analysis by examining the role of HIV/AIDS in the crisis in southern Africa in 2002–2003. Section 3.4 assesses whether HIV/AIDS should be seen as an emergency, and Section 3.5 looks at the interface between relief and development in the response to HIV/AIDS.

3.2 HIV/AIDS and famine

3.2.1 Defining 'famine'

Perhaps surprisingly, there is little agreement around the definition of famine. Sen (1981: 39–40) sees it as a particularly virulent manifestation of starvation causing widespread death. A definition that explicitly links famine to the sustainable livelihoods framework used in the previous chapter is provided by Walker (1989: 6):

> *Famine is a socio-economic process which causes the accelerated destitution of the most vulnerable, marginal and least powerful groups in a community, to a point where they can no longer, as a group, maintain a sustainable livelihood.*

None of the current definitions, however, provides clear operational guidance about when it is appropriate to use the emotionally loaded and politically charged term 'famine' to describe a crisis. Controversy has surrounded its application to crises in Sudan in 1998, Ethiopia in 1999/2000 and Malawi in 2002. The introduction of the term 'new variant famine' relating to HIV/AIDS has added to the controversy (De Waal, 2002b; Howe and Devereux, 2003; Field Exchange, 2003). This has led to attempts to propose an operational definition of famine (Darcy and Hofmann 2003; Howe and Devereux, 2003). These suggest an intensity scale with agreed cut-off points for mortality and malnutrition levels to distinguish between chronic food insecurity and famine, and the need for a magnitude scale that would distinguish between famines based on the levels of mortality.

3.2.2 HIV/AIDS and famine

Even in the worst-affected countries of southern Africa, it does not appear that the impact of HIV/AIDS in its own right has led to famine for sizeable populations over a large area, in the sense of crisis levels of mortality and malnutrition. On its own, HIV/AIDS seems more likely to exacerbate chronic food insecurity. However, HIV/AIDS is clearly only one of a host of factors contributing to food insecurity. What is important, therefore, is to understand the ways in which HIV/AIDS interacts with these other factors, and how this might affect the possibility and trajectory of famines. As Devereux (2000: 25) argues, 'it is the interaction between underlying processes and shock events that produces famine'.

This suggests a way forward for understanding the contribution of HIV/AIDS to famine. There is a danger of the debate becoming stuck in trying to quantify HIV/AIDS' relative contribution to crisis, or becoming bogged down in arguments about whether it is the 'most fundamental underlying cause of the southern Africa crisis' (Morris and Lewis, 2003: 6). Instead, it might be better to look at HIV/AIDS as one of the underlying processes that predisposes poor people to possible famine. The challenge then becomes to understand how the additional vulnerability created by HIV/AIDS is likely to relate to other shocks – drought, conflict or economic collapse – that may, together, create famine or humanitarian crisis.

'New variant famine' provides a conceptual model for understanding these interactions. According to this hypothesis, the models which have been developed for understanding peacetime famine in Africa depend on assumptions about household labour supply, skills endowments and long-term viability which no longer necessarily apply in an HIV/AIDS epidemic. De Waal and Whiteside (2003) highlight four new factors: household labour shortages; loss of assets and skills due to adult mortality; the burden of care for sick adults and orphans; and the vicious interactions between malnutrition and HIV. These new factors reduce the effectiveness of traditional strategies used to cope with famine, and in some cases render them impossible or dangerous. For example, reducing food consumption is particularly dangerous for HIV-positive individuals who have higher than normal nutritional needs. De Waal and Whiteside conclude that the prospects for a sharp decline into famine are increased, and the possibilities for recovery are reduced. The model is similar to that developed by De Waal (1990) for analysing conflict, in which he argued that conflict resulted in more severe famines by preventing or undermining traditional coping strategies. The 'new variant famine' hypothesis suggests that coping strategies that have been used to survive famines in the past are likely to be fatally undermined by the impact of HIV/AIDS. Table 3 summarises the ways in which AIDS may do this.

This suggests that it is not sufficient just to view HIV/AIDS as one among many factors contributing to underlying vulnerability: because of the way in which the illness interacts with malnutrition and undermines coping strategies, it brings the risk of heightened mortality in emergencies. This reinforces the need for adequate levels of humanitarian aid in times of crisis, as communities will be less able to rely on their own resources, and individuals will be less able to cope with poor nutrition. This can be seen diagrammatically in Figure 2.

However, disentangling the relative contribution of HIV/AIDS and food insecurity to mortality is extremely difficult. If someone with AIDS is under-nourished due to a combination of AIDS and acute food insecurity and dies earlier than they would have done had they had an adequate diet, have they died of food insecurity or of HIV/AIDS? To measure, attribute and understand causes of mortality in emergencies occurring in the context of an AIDS epidemic, we would need to know both the underlying mortality rate prior to the crisis, including AIDS deaths, and how this compares to mortality rates as the crisis develops. This is far beyond the scope of present data collection and monitoring and evaluation systems.

This section has suggested that the way to understand the interaction between HIV/AIDS and famines is not to see

Table 3: HIV/AIDS and coping strategies

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

Source: Adapted from De Waal (2002)

HIV/AIDS as the sole cause of famine, but as one of many contributory factors. It both contributes to the underlying vulnerability of populations, and may accentuate the impact of acute crises once they develop. These issues are explored further in the next section, which examines how HIV/AIDS has been used to explain the 2002–2003 crisis in southern Africa.

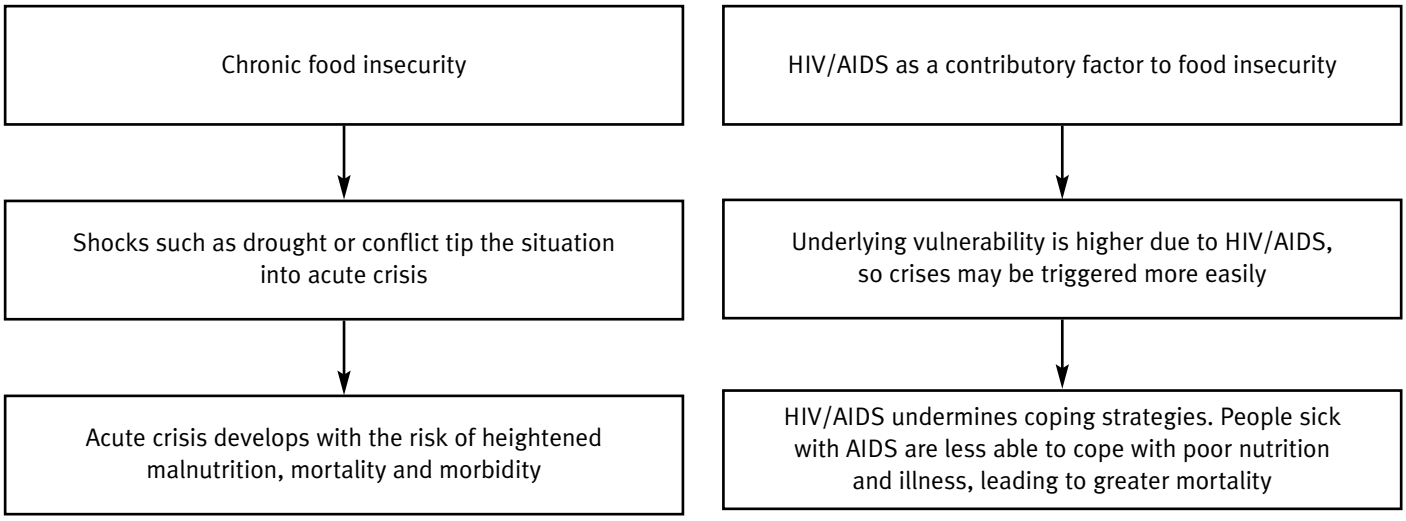
3.3 HIV/AIDS and the southern Africa crisis

The southern Africa crisis in 2002–2003 was initially defined as a food crisis caused by a combination of bad weather, bad governance and underlying poverty. AIDS moved to the forefront of the agenda following the visit of James Morris, the UN Special Envoy for southern Africa, and Stephen Lewis, the UN Special Representative for HIV/AIDS, in January 2003. Their subsequent report argued that the simultaneous effects of HIV/AIDS meant that 'agencies, donors and governments must realise that the current crisis challenges the humanitarian paradigm, and requires a different kind of response' (Lewis and Morris, 2003: 3). Agencies such as the IFRC (2003b) also called for an end to 'business as usual'. Simultaneously, the 'new variant famine' hypothesis was galvanising debate on the role of HIV/AIDS in the crisis.

There has been a reaction against both the new variant famine hypothesis and the Lewis and Morris report. The question of the extent to which HIV/AIDS has been a contributory factor to the crisis has been questioned, and there are doubts about the underlying empirical evidence for the links between HIV/AIDS and food insecurity. It has been argued that its importance has been over-emphasised and that other, equally or more important, factors risk being neglected (Scott and Harland, 2003). It has also been suggested that the focus on HIV/AIDS could obscure political factors behind the crisis, and so serve as a convenient depoliticising narrative (Bird, Booth and Pratt, 2003). There has been scepticism among some donors and NGOs about the way in which HIV/AIDS is being used to justify continued humanitarian aid, especially food aid, in countries where, nationally, harvests were adequate in 2003, and there are concerns that this has diverted attention and resources from other, equally deserving populations in the Horn and Eastern Africa (Murphy, 2004).

There have been attempts to analyse the contribution made by HIV/AIDS to the southern Africa crisis, but the results have been mixed and it is not yet possible to draw firm conclusions. An analysis of data from vulnerability assessments carried out in 2002 and 2003 suggests that

Figure 2: HIV/AIDS' contribution to the trajectory of crisis



HIV/AIDS did have strong negative impacts on some households, but the scale of these impacts remains unclear (SADC FANR, 2003). The analysis showed that, in households where proxy indicators for HIV/AIDS (chronic illness, recent adult deaths, high dependency ratios) were present, agricultural production was lower, income was reduced and the household engaged in distress coping strategies earlier than households where these indicators were absent (Mdladla et al., 2003). The April 2003 vulnerability assessment in Zambia found that households where proxies for HIV/AIDS were present were more likely to remove children from school and sell livestock. But the Zambia Vulnerability Assessment Committee (VAC) survey of the May 2003 harvest found no real differences between proxy and non-proxy households. The VAC concluded that the data:

> *failed to provide hard evidence to support the notion of 'new variant famine' operating in the country. It would appear that climatic conditions, food pricing policies, the lack of agricultural support and extension services, environmental degradation, a lack of infrastructure and poverty play a larger role in inadequate harvests than HIV/AIDS (Zambia VAC,* 2003: 32).

Scott and Harland (2003) found that HIV prevalence rates in rural areas in Zambia were probably still at a relatively low 11%, and concluded that 'there is no evidence in Zambia to support the new variant famine scenario' (Scott and Harland, 2003: 24).

Clearly, empirical evidence about the scale and severity of HIV/AIDS' impact on food insecurity in southern Africa remains weak. The pool of surveys is small and the geographical areas they cover are scattered, case studies are small-scale and the analysis of the data is problematic in large-scale assessments. It is important to stress that both the SADC and Zambia VAC studies were opportunistic, in the sense that they made use of existing data and were not designed to investigate the interactions between HIV/AIDS and food crisis in a systematic manner. Further research is clearly needed before any firm conclusions can be drawn.

As for the concern that the emphasis on HIV/AIDS may marginalise other factors, particularly political ones, Bird, Booth and Pratt (2003) argue that limited linkages are made between politics, poverty and food insecurity, depoliticising debates which then focus on technical issues. The enthusiastic and rapid adoption of HIV/AIDS as a key explanation of the crisis in southern Africa can almost be seen as a development narrative in the making: a way of depoliticising poverty and powerlessness so that they can be portrayed as a set of more manageable technical problems that can be addressed by development and relief agencies (Roe, 1991; Leach and Mearns, 1996; Ferguson, 1990). Neglect of political factors is a common concern in work on natural disasters and emergencies, and there is a clear risk that HIV/AIDS will be adopted as a central explanation for crisis by actors keen to minimise political or governance issues. Governments, donors and aid agencies are often happier dealing with problems that appear amenable to technical solutions and additional resources.

This discussion is not meant to suggest that proponents of the new variant famine hypothesis or aid agencies involved in the response to the crisis had any intention of minimising political issues, or that they have not robustly acted to protect humanitarian space from the risk of political interference, especially in Zimbabwe (Valid International, 2004). Indeed, De Waal and Whiteside (2002: 8) explicitly make this point:

> *the analysis does not neglect the role of factors such as drought and macro-economic disparities and mismanagement. Rather it points to the ways in which HIV/AIDS accentuates the existing difficulties.*

It is important to emphasise that 'new variant famine' was presented as a hypothesis that had not been validated by research. What seems to have happened is that a hypothesis about the possible future impact of HIV/AIDS has been presented, in some places, as an explanation of the current crisis. One of the main objections to this was that a famine did not occur in southern Africa, in the conventionally understood sense of high levels of acute malnutrition and

excess mortality related to starvation. Mortality and acute malnutrition rates in the six southern African countries that were the focus of the UN regional appeal showed few signs of rising above normal levels (Mason et al., 2003). Famine in these countries appears to have been largely averted in 2003, in part by the massive relief response and in part due to the usual underestimation of the resilience of people's survival strategies. However, this does not disprove the hypothesis or refute the possibility that an HIV/AIDS epidemic may lead to heightened mortality in acute crises: it simply suggests that this did not happen in southern Africa in 2002–2003. Even this conclusion must be hedged with some caveats. The humanitarian system is notoriously poor at measuring and understanding mortality rates, and the evidence from southern Africa on mortality is in fact very limited (Darcy et al., 2003).

Disentangling the relative importance of HIV/AIDS compared to bad governance or bad weather is and will remain difficult. The state of the current data means that the scale and severity of HIV/AIDS' contribution to both acute and chronic food insecurity are simply unknown. Greater clarity over these issues might contribute to more appropriate responses, and there is a clear need for further research. What is perhaps more important, in considering the practicalities of how to respond, is the way in which additional vulnerability relating to HIV/AIDS interacts with other shocks undermining people's livelihoods. Other equally important causes of food insecurity must not be marginalised in the new-found enthusiasm for addressing the links between HIV/AIDS and food security.

3.4 Is HIV/AIDS an emergency?

The core of the humanitarian agenda is commonly understood to involve saving lives and alleviating suffering. In this sense, HIV/AIDS is clearly a humanitarian problem. Huge numbers of people are dying from and suffering with HIV/AIDS in sub-Saharan Africa. A strong case can be made, and many people interviewed for this study passionately made it, that these levels of mortality alone constitute an emergency. However, it is also clear that the HIV/AIDS pandemic in sub-Saharan Africa presents a different type of emergency that does not easily fit into existing frameworks. Arguments for an emergency response are countered by calls for a long-term 'developmental' approach.

Surprisingly, there is very little agreement within the humanitarian system around definitions of emergencies (Darcy and Hoffman, 2003). Emergencies are generally considered in terms of acute shocks to people's livelihoods, and there are many different definitions and classifications. Some of the most commonly-used terms are presented below:

- Conflict-based – a term used to describe emergencies caused by war.
- Quick-onset natural disasters – emergencies triggered by natural events such as a flood or earthquake.
- Slow-onset natural disasters – an emergency triggered by a natural event, usually drought, where the emergency develops slowly and the dividing line between normality and crisis is often blurred.
- Permanent emergencies – where there is a very large problem of structural poverty and a need for more or less permanent welfare.
- Complex emergencies – emergencies with a complex combination of causes, usually conflict-related.

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

The HIV/AIDS epidemic fulfils some of the traditional criteria for an emergency, in that it causes massively increased mortality and morbidity, and indeed could be described as a permanent or complex emergency as per the definitions presented above. However, in spite of the fact that conflicts have sometimes gone on for decades, humanitarian relief is still structured on the assumption that emergencies are short-term crises. The fact that the impact of HIV/AIDS will be felt for decades makes defining it as an emergency problematic, both conceptually and in terms of what aid instruments are seen as appropriate for responding to HIV/AIDS. This can be seen in the wide range of views as to what aid modalities are best suited for addressing the challenge of HIV/AIDS. Thus, USAID (2003a: 4) states that the donor community 'needs to adopt a more developmental approach rather than a disaster relief approach, combining agricultural development programmes with food programmes and livelihood programmes'. Conversely, FAO has asked whether extreme levels of AIDS prevalence could be construed as a disaster requiring a response 'of an emergency nature' (FAO, 2001: 2); WFP contends that 'Although HIV/AIDS requires an emergency response such a response must be based on a long-term approach' (WFP, 2003: 10), and that 'When HIV/AIDS threatens food security and influences mortality in ways similar to other disasters, WFP will consider HIV/AIDS as a basis for a PRRO [Protracted Relief and Recovery Operation]' (WFP, 2003: 23).

Part of the confusion can be explained by the different uses which are attached to the concept of 'emergency'. There is an important question about who determines that an emergency exists, and at what level. Traditionally, national governments declare an emergency, and several governments in sub-Saharan Africa have done so with respect to HIV/AIDS. This may serve particular purposes, such as demonstrating political commitment or allowing the importation of drugs to treat HIV/AIDS. Kenya, for example, has declared HIV/AIDS an emergency, but it remains unclear what has changed in terms of real policies and resource allocation (Murphy, 2004; Stabinski et al., 2003). WHO has declared HIV/AIDS a global

health emergency, and at the global level this label may also be a useful way of generating action and mobilising resources.

Calling something an emergency also has important practical implications for aid agencies and donors in terms of what funding is available, from which budget lines and with what sort of timelines and conditions attached. Some NGO respondents felt that being able to access emergency funding lines in relation to HIV/AIDS would be helpful because of lower expectations of sustainability. Other people interviewed for this study felt that labelling HIV/AIDS as an emergency might narrow the types of support available and limit assistance to inappropriately short-term interventions. There may also be important institutional implications; donors sometimes cannot provide humanitarian funding until an emergency has been officially declared (Murphy, 2004).

Perhaps the challenges presented by the HIV/AIDS epidemic are best described as a long-term crisis. But whatever label is applied, it is clear that HIV/AIDS requires both a humanitarian response to suffering, and a long-term perspective. This introduces the much-debated question of how the relief system should interact with development assistance.

3.5 Relief, development and HIV/AIDS: where does humanitarian aid fit?

Humanitarian aid remains organised around short-term funding cycles and the concept that emergencies are temporary interruptions of normal processes. It is true that humanitarian aid has been provided for long periods in chronic conflicts such as Sudan, Burundi and Somalia, but the humanitarian system is essentially ill-equipped to engage with a crisis like HIV/AIDS, which will go on for decades and whose effects stretch across whole countries and regions. The funding cycles of donors remain largely short-term and project-based, and the capacity of the system is arguably already fully stretched. This implies the need for a re-examination of the interface between the development and humanitarian communities, as any adequate response to the HIV/AIDS epidemic must clearly encompass both relief and development assistance.

Emergency and development assistance have long been separated within the architecture of the international aid system. Western donors usually have distinct modalities and instruments for funding emergency and development aid. Development aid is generally delivered through states, and is associated with building the capacity of the state, civil society and market institutions. Sustainability is a key concern. Emergency assistance, by contrast, is seen as the aid instrument of last resort, is associated with welfare and the free provision of services and often bypasses governments, being used to fund NGOs, the UN and Red Cross. Development assistance is often provided with conditionality, whereas emergency aid is politically non-conditional.

These distinctions are not just the stuff of academic debate – they can clearly be seen in the response of the international community to the southern Africa emergency. Prior to the food crisis, there was the normal plethora of long-term development programmes addressing aspects of food security, agricultural development and HIV/AIDS. As a response to the food crisis gathered pace in 2002, a largely separate architecture of humanitarian response was developed to provide emergency relief. Aid agencies brought in separate emergency teams, new committees were formed and separate management structures created. This led to tensions within and between agencies, and the perceived disruption of long-term development programmes.

The interface between relief and development, and calls for better links between them, has a long history in the academic literature (Buchanan-Smith and Maxwell, 1994). The conception of a neat linear or sequential relief-to-development continuum was seen as inadequate, and it was recognised that relief, rehabilitation and development assistance often take place simultaneously (Longhurst, 1994). The last decade has also seen a series of important criticisms of the linking-relief-and-development debate. Macrae (2001) argues that preserving the distinction between humanitarian and development aid is crucial to maintaining the integrity and technical efficacy of each. In conflicts and complex emergencies, linking relief and development risks a 'process of normalisation characterised by a creeping acceptance of higher levels of vulnerability, malnutrition and morbidity' (Bradbury, 2000: 3). This has been highlighted in Sudan and Somalia, where levels of malnutrition that would once have triggered a crisis response came to be accepted as normal and dealt with in developmental terms. Macrae and Leader (2000) also point out how work on relief-to-development links became attached to the debate on 'coherence' and the use of aid for conflict reduction. This is problematic because it can threaten key humanitarian principles. As Macrae (2002: 64) argues:

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

These criticisms have focused on the delivery of humanitarian aid in conflict situations, but there are several important ways in which they can be seen to be relevant in countries at peace. First, there is the argument that, because the HIV/AIDS epidemic is starting to create growing levels of vulnerability, mortality and morbidity, it too brings with it a risk of Bradbury's 'creeping acceptance' and normalisation. If these growing levels of mortality and morbidity become accepted as 'normal', to be addressed within a development framework, then there is a risk that real human distress will not be addressed. Second, even in countries that are not in conflict there may be a need for humanitarian aid that is depoliticised and maintains key principles of neutrality and impartiality. This is certainly true in Zimbabwe, where political crisis has led to the suspension of most forms of development assistance.

The issue is thus not as straightforward as thinking of ways that relief and development can simply be better linked in the

response to HIV/AIDS. Rather, there are strong arguments for maintaining the distinctiveness and clarity of humanitarian aid. The core business of humanitarian relief should remain focused on saving lives and alleviating suffering in response to acute crises, and there is a need to maintain the distinctiveness of modalities for delivering impartial humanitarian action. At the same time, humanitarian actors may be able to inform the overall response to HIV/AIDS, for example by contributing to the development of long-term welfare safety nets. A key challenge for NGOs will be whether they are able to sustain welfare-type support to the most vulnerable over the long term. In southern Africa, many agencies have started providing food aid and other assistance to people in home-based care programmes (Lorey, 2003; Khogali, 2003). Whether these will be maintained once funding from emergency budget lines ends remains unclear.

There are also good reasons to reconsider the nature of 'development' interventions and how these prepare people and societies to handle disasters and shocks. According to a workshop in southern Africa in 2003:

> *Given the reality of AIDS, the entire approach to development must change. Interventions in any community should always combine development, relief and rehabilitation aspects. Without increased support through safety nets and other forms of ongoing social protection, standard development practice will not suffice for the most vulnerable* (HSRC, 2003: 3).

The prospect that crises could be triggered more easily, due to the greater underlying vulnerability created by HIV/AIDS, reinforces the need for greater investment in disaster preparedness and mitigation, and for disaster preparedness to be addressed more centrally within the international development system (Twigg, 2004). The crisis in southern Africa in 2002–2003 once again highlighted the failings of the international development assistance system and of national governments to adequately prepare for the inevitable occurrence of periodic crises (Holloway, 2003).

HIV/AIDS also reinforces the need for long-term approaches to social protection and the provision of welfare safety nets for the poorest. As Devereux (2003: 23) argues, 'the food crisis of 2001/02 made a strong case for stepping up social protection interventions to support PLWA [people living with AIDS], AIDS orphans and their carers alongside stepping up support to agriculture'. Three countries in southern Africa – Botswana, Namibia and South Africa – provide non-contributory pensions to their elderly citizens, and research has suggested that pensions have huge positive impacts in enabling elderly people to cope with the additional burdens of care created by HIV/AIDS. In Botswana, help is given to all families supporting orphans. Many governments in Africa clearly face what Devereux (2003: 5) describes as the 'Catch 22 of social protection – the greater the need for social protection, the lower the capacity of the state to provide it'. However, as he also points out, in highly aid-dependent countries the real issue is donors' willingness to pay for social programmes. The Starter Pack/Targeted Inputs Programme in Malawi is an example of a safety net programme that seems to have produced positive impacts on food security, through the universal provision of benefits in a country where the majority of the rural population is poor (Levy, 2003; Levy and Barahona, 2002). Clearly, the appropriate form of safety net will vary according to context and according to the willingness of the government and donors to commit resources. HIV/AIDS is likely to increase the need for social welfare, and reduce governments' capacity to deliver it in countries where the impact is severe. There is thus an implied need for a greater commitment on the part of donors to fund long-term welfare support.

An issue here is the extent to which projects aimed at providing long-term welfare should be specifically targeted at people affected by HIV/AIDS. An example would be the provision of food for people in home-based care programmes. If this is the only source of welfare support in a community, there is a risk that people who do not have HIV/AIDS, but who are in need of welfare for other reasons, will be unsupported. This is not meant to imply that programmes specifically aimed at mitigating the impact of HIV/AIDS are not both appropriate and important. They should not, however, be the only welfare response in a situation where HIV/AIDS is only one of many factors contributing to food insecurity and poverty.

Any long-term response to HIV/AIDS also, of course, needs to involve prevention, care and treatment for the disease itself (Farmer et al., 2002). Huge resources are starting to become available for the worst-affected countries; the US, for example, has committed $15 billion over five years for AIDS prevention, treatment and care (Whitehouse, 2003). Treatment programmes in developing countries are expanding, and in 2003 WHO launched its '3 x 5' commitment to ensuring that three million people are on anti-retroviral (ART) treatment by 2005 (WHO and UNAIDS, 2003). MSF has played a leading role amongst NGOs in implementing programmes aimed at showing that treatment is possible in resource-poor environments, and sees the mortality caused by the epidemic as creating a humanitarian imperative to act (MSF, 2002; Kasper et al., 2003). The question of how these funds should best be utilised is a vast one in its own right, and is beyond the scope of this paper (Grubb et al., 2003). For aid agencies involved in the emergency response in southern Africa and in long-term food security programming, a key unanswered question is whether any of these additional funds will be available for efforts that deal with the wider impacts of HIV/AIDS, or whether they will be exclusively focused on health aspects.

3.6 Chapter summary

This chapter has argued that there is a need for clarity in distinguishing between the different challenges that the HIV/AIDS epidemic creates, both for relief and for development assistance.

This study proposes the following typology for clarifying the different conceptual challenges faced in formulating and labelling the response to HIV/AIDS in sub-Saharan Africa:

1. The long-term response to HIV/AIDS, encompassing the need for prevention, care, treatment and mitigation, perhaps best seen as a long-term, chronic crisis.
2. HIV/AIDS as increasing underlying vulnerability and adding to the impact of other shocks, meaning that it needs to be taken into account as a cross-cutting issue in short-term humanitarian relief for acute suffering.
3. HIV/AIDS as one of many contributory factors to food insecurity, adding to the existing need for safety nets and long-term welfare as part of the overall response to poverty.

The most appropriate role for aid agencies in addressing these different challenges will vary according to the different types of expertise and capacity within the humanitarian system. For the medical agency MSF, for example, HIV/AIDS presents a long-term humanitarian challenge, and its role is to expand access to treatment.

Humanitarian aid is only part of a much larger international response to the impact of the HIV/AIDS pandemic. It is important to be clear about what the relief system can and cannot do. The overall response to HIV/AIDS needs to take place over decades, and requires a rethinking of relief modalities, development modalities and the links between humanitarian aid and development. This rethinking needs to take place both in the fundamental sense of how emergencies are defined and understood but also in the practical sense of aid instrumentation in response to the challenges raised by HIV/AIDS. Development assistance actors may need to draw on expertise and experience from within the humanitarian system, and vice versa.

Humanitarian aid as currently configured is obviously ill-suited to mounting a response across entire countries and regions over a period of decades. The core business of humanitarian relief should remain saving lives and alleviating suffering in response to acute crises. In doing this in the context of an HIV/AIDS epidemic, it is important to apply an 'HIV/AIDS lens' to humanitarian programming across the different sectors of response and across the programme cycle (Loevinsohn and Gillespie, 2003b). The practical ways in which HIV/AIDS may need to be mainstreamed in humanitarian aid is the subject of the next chapter.

Chapter 4
Humanitarian programming and HIV/AIDS

4.1 Introduction

This chapter summarises the lessons learnt from the crisis in southern Africa, or at least the issues it has raised and the solutions being tried by the humanitarian community. The crisis presented a series of practical questions around the programming of humanitarian aid in the context of an HIV/AIDS epidemic. Issues raised by staff of donor, technical, implementing and other agencies involved in addressing the crisis span a wide spectrum of concern. They include:

- What skills, awareness and knowledge are needed to understand the context and design programmes? What demands do these new concerns place on our programming and human resources?
- What responsibility do humanitarian actors have to minimise the additional risks of transmission of HIV/AIDS that may arise in emergency settings?
- How do early warning, needs assessment, targeting and service delivery need to be adapted in the context of HIV/AIDS?
- How should the stigma relating to HIV/AIDS be addressed?

The relief operation in southern Africa left humanitarian agencies grappling with these questions at the field level. Whilst it is too soon to provide answers to many of them, the rich discussions and debates have catalysed a growing body of practice around responding to food insecurity in the context of an HIV/AIDS epidemic. Practitioners on the ground have developed tools such as assessment and targeting methodologies, but this practice remains largely within a grey literature of project documents and reports.

There is a need for research and policy to catch up with practice on the ground, to document what has been achieved, and what critical gaps remain. To this end, this chapter highlights some of the key programming issues and maps ways in which aid agencies are currently addressing HIV/AIDS. The issue of how to mainstream HIV/AIDS within emergency response is a relatively new one and many of the approaches outlined in this chapter have not yet been fully evaluated. We are therefore probably some way from being able to prescribe specific good practice. But aid agencies should at least be asking the right sort of questions and attempting to develop the tools and analysis that would enable them to develop answers.

This chapter is based on interviews conducted with aid agencies in Zambia, Zimbabwe, South Africa and Malawi. These were complemented by discussions with policy-level and global staff of donors and others engaged in the response. Interviews were also carried out in East Africa, providing additional understanding on the common issues facing all actors, whilst highlighting the distinctiveness of the southern Africa situation. The chapter is divided into two main sections. The first addresses cross-cutting and organisational issues relating to HIV/AIDS, focusing on gender, staff training, minimising risks, stigma, assessment, targeting, partners and monitoring and evaluation. The second section explores the impact of HIV/AIDS on the key programme sectors of food, nutrition, health, water and sanitation and broader livelihood support.

Humanitarian agencies span a spectrum, from those dedicated to emergency relief to actors that engage in both relief and development, with a range of skills and sector specialities. The variation in how agencies approach the 'mainstreaming' of HIV/AIDS is, therefore, hugely broad: not all of the experience discussed here will apply equally to all actors, and there will inevitably be gaps, both in terms of the sectors analysed and the issues addressed. (The term mainstreaming is used here to describe 'how an organisation and the programmes it delivers must change in order to take account of the changing context that has been caused by the epidemic' (Oxfam 2002: 6).) The chapter highlights the questions that were of most concern to aid agencies in southern Africa, so sectors and issues that were not a priority in the relief response are relatively neglected. The chapter does not examine in any detail the question of interventions directly focused on HIV prevention and AIDS care, except in the sense that these were integrated into, or related to, the emergency response, and issues particular to HIV/AIDS in conflict and refugee settings are not addressed. This chapter is not intended to be a comprehensive guide to HIV/AIDS programming in emergencies. Various guidelines are available, such as the IASC guidelines for HIV/AIDS in emergency settings, Oxfam's guide to mainstreaming AIDS in development and humanitarian programmes and World Vision's toolkit for HIV/AIDS programming (IASC, 2003; World Vision, 2003b; Holden, 2003).

4.2 Cross-cutting and organisational issues

4.2.1 Gender

The gender dimensions of the impact of AIDS are crucial, and must therefore be reflected in humanitarian assessment and programming. There has been much emphasis on the need for gender-sensitive programming in emergencies (Byrne and Baden, 1995), and there is an important literature on gender and AIDS (Tallis, 2002; Baden and Wach, 1998; Baylies and Bjura, 2000; Gupta, 2000). Gender-sensitive and HIV-sensitive approaches are closely linked and complementary. Oxfam (2002: 47), for example, argues that 'there should be a continuing focus on gender analysis, given the close link between gender inequity and vulnerability to HIV'. Gupta (2000) points to the need for HIV programmes to aim beyond gender sensitivity to approaches that seek to transform gender roles and create more equitable gender relationships.

The southern Africa response suggests a number of ways in which humanitarian programming may need to take gender and HIV/AIDS into account:

- Gender-sensitive service delivery – for example, food distributions that take place at times and locations that are suitable for women, and that minimise the risks of gender-based violence.
- Capacity-building – in working with CBOs and developing community-based targeting, both men and women need to be represented and need to have a real voice.
- The need for women as well as men to be involved in the practical work of relief distribution and in the control and supervision of supplies.
- Gender-sensitive HIV awareness and prevention campaigns linked to emergency programming.

However, the extent to which the response in southern Africa took gender issues into account is unclear. The DEC evaluation found that gender analysis was weak and that there was little analysis by agencies of the impact of aid on labour and responsibility within the household (Valid International, 2004). Efforts were made by aid agencies to ensure that women were fairly represented in the village relief committees that were often responsible for targeting, and which served as the main interlocutor between the agency and the community. The VAC assessments also made significant efforts to analyse gender issues, such as the additional vulnerabilities faced by female-headed households.

4.2.2 Staff training and workplace policies

Before issues around HIV/AIDS can be addressed effectively in programming, there is a need to focus on agencies' own staff and organisational policies. Oxfam describes this as 'internal mainstreaming' to 'enhance the ability of an organisation and its staff to anticipate, minimise and cope with illness and death associated with the pandemic' (Oxfam, 2002a: 2).

National staff within aid agencies will themselves be affected, in one way or another, by HIV/AIDS. For example, they may be looking after increased numbers of orphans, and some members of staff are likely to be HIV-positive. They will also be affected by the general stigmatisation of HIV/AIDS within the local culture, and may find the issues being raised difficult to talk about or address openly. The ability of organisations to operate effectively may be harmed: there may be higher levels of absenteeism, reduced productivity, increased financial costs, higher staff turnover, lower morale and falling levels of staff experience and quality (Oxfam, 2002a: 1). These impacts, of course, are not restricted to aid agencies and equally affect government departments, community-based organisations and businesses.

There is therefore a need for agencies to put in place mechanisms for staff training, and to develop clear workplace policies for how HIV/AIDS will be addressed within the organisation. It should be noted that workplace policies on HIV/AIDS are not just about treatment – they include many complicated issues such as insurance coverage, part-time work, levels of absenteeism, loan provisions for funeral costs and access to counselling and testing. Organisations may also need to carry out assessments of the impact of HIV on the organisation, and consider the wider implications of issues such as increased levels of illness and staff turnover and the relative costs and benefits of providing treatment (Holden, 2003).

These questions clearly apply both to long-term development and humanitarian aid programmes. However, emergencies raise particular difficulties with regard to staff training and workplace policies. Large numbers of staff on short-term contracts are likely to be hired within a short period, making it difficult to ensure that they all receive adequate training. Workplace policies may also have to be different for short-term and long-term staff. For example, a commitment to provide ART treatment for staff with HIV/AIDS and their families may not be possible for short-term contracted personnel. However, policies that distinguish between short-term emergency staff and long-term personnel may create resentment.

4.2.3 Minimising the risks of transmission

A key principle for aid agencies should be that emergency interventions do not increase people's susceptibility to HIV/AIDS. This can be viewed at several levels:

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

The need to review how relief programmes are structured to minimise risk must be a requirement for all humanitarian actors engaging in an emergency situation. From this perspective, HIV-related training is also a necessity for all aid agency staff and volunteers. Whether it is appropriate for agencies to engage in HIV awareness-raising activities will depend on context, skills, opportunities and appropriateness in different situations. This section contains some discussion of these issues in the context of southern Africa, but this is by no means comprehensive. Fuller accounts are provided in the IASC guidelines for HIV/AIDS in emergencies (IASC, 2003b) and in Smith (2002).

Staff awareness-raising must be a priority to minimise the risk of personnel acting as vectors of transmission. A study in 2002 of sexual exploitation in West Africa demonstrated the risk that staff in positions of power will abuse their positions (UNHCR and Save the Children, 2002). Relief programming raises particular risks for the staff of aid agencies, involving as it does the recruitment of large numbers of short-term, predominantly male staff, working away from their homes. Of course, sexual activity engaged in by staff may not be exploitative, but in a context of HIV/AIDS it can still be risky, both for staff and for local people.

Aid agencies are beginning to examine how relief programmes can be structured so as to minimise the risks of HIV/AIDS transmission. For example, food distribution sites

may be important places of social and sexual contact, and thereby situations of risk. Thought needs to be given to where distribution sites are located, when distributions are conducted and the environment that is created, in order to reduce this risk. This applies across sectors: water and sanitation interventions, for instance, need to consider the siting of water points.

What this means in practical terms is as yet unclear. Minimising waiting times may be one possibility. With reference to weekly markets, which also act as important social points, it has been suggested that opening and closing earlier in the day may reduce some of these risks, and the same might apply to relief distributions (Ngwira et al., 2002; Ntata, 2003). Aid agencies in southern Africa had made efforts to schedule distributions during daylight, mainly for security reasons, but this may also have helped to reduce the likelihood of risky sexual behaviour.

WFP, UNICEF and Save the Children conducted training throughout southern Africa on the protection of women and children from sexual exploitation. The workshops were aimed at field staff, truck drivers and transport and distribution managers, and reached over 5,000 trainees (RIASCO, 2003b). Most aid agencies took part, but few engaged in further follow-up or active monitoring and sexual exploitation was not perceived as a major problem. An evaluation conducted in Malawi found that sexual exploitation had not been reported by food distribution recipients (Westen, 2002). There is at least a possibility, however, that in some cases the hiring of large numbers of mostly male staff, who were then posted to remote rural areas away from their families, did create increased risks.

There is a clear issue here about follow-up and the extent to which a one-off training event is a sufficient response. CARE in Zimbabwe established complaint committees at village level (Valid International, 2004). There were isolated examples of active measures being taken beyond the provision of training for staff. An agency in Malawi that was using truck drivers hired their spouses as monitors, which meant that drivers travelled with their partners. In Zimbabwe, CARE made active efforts to set up accountability mechanisms at community level which would allow people to complain if they felt aid was being abused; the Red Cross in Zimbabwe had a complaint desk operating at each distribution site (Valid International, 2004). However, given the reluctance of beneficiaries to complain for fear of losing the benefits of assistance, and the likelihood that sexual activity between aid agency staff and beneficiaries will be hidden, there is probably a need for active monitoring.

One of the ongoing debates in southern Africa was over whether it was appropriate or effective to attach HIV/AIDS awareness and prevention activities to relief distributions. There seemed to be broadly two schools of thought. The first was that relief distributions provided both a captive audience of thousands of people waiting at distribution sites, and an opportunity to contact many people in remote rural areas that might not otherwise be reached with HIV/AIDS awareness and prevention messages. The second questioned whether relief distribution sites were appropriate places for awareness activities, and whether relief agencies had the necessary skills and expertise. It was also questioned whether the simple provision of more awareness messages was effective in encouraging behavioural change. CARE (2003a: 1) warns that 'the addition of AIDS focused work alongside existing livelihoods work can lead to poor quality AIDS work, while also undermining the quality and relevance of the core livelihoods work'.

Box 6: UNICEF, World Vision and CARE emergency HIV/AIDS prevention project in Zambia

- 380,000 copies of an HIV/AIDS leaflet were printed and distributed with assistance from Coca-Cola Zambia.
- Three series of HIV/AIDS cartoon strips were designed and printed (34,000 copies).
- 354 drama groups from 17 districts were trained on the basic facts of HIV/AIDS, record keeping and participatory approaches to theatre.
- From November 2002 to June 2003, 251 drama performances were conducted at emergency food distribution points.
- Sixty mobile video sessions were conducted in ten districts from April to June 2003.

(Mwale et al., 2003).

Prevention and awareness activities were tried by aid agencies during 2002 and 2003, although there were relatively few evaluations and little monitoring of their effectiveness. They included providing written materials with food aid, the use of drama groups at distribution sites and the distribution of condoms alongside food aid. Box 6 describes an HIV/AIDS prevention project carried out in Zambia by UNICEF, World Vision and CARE. Aid agencies also started to explore how they could draw on expertise and best practice within the wider response to HIV/AIDS and the development system. For example, World Vision in Zimbabwe subcontracted Population Services International, a not-for-profit social marketing organisation, to carry out awareness-raising activities around its food aid programme. A successful pilot project was set up in 2003, and the agency planned to expand the work. Other agencies planned to look into linking more effectively with district AIDS committees and home-based care providers. There was a perception that, during the relief response in 2002–2003, aid agencies had failed to work sufficiently with the smaller and more local organisations involved in long-term HIV/AIDS work.

4.2.4 Assessment and early warning

Assessments and early-warning systems will increasingly need to take HIV/AIDS into account. However, attempts to adapt these systems are at an early stage, and more research and experience is necessary before clear recommendations can be made. De Waal and Tumushabe (2003) point out that early-warning systems may need substantial methodological revision to take account of new vulnerability factors. Models that assume a geographic basis for vulnerability and a time-bound crisis may not be relevant for HIV/AIDS-related food

insecurity. Emergency assessments may also need to be adapted. Oxfam (2002), for example, states that 'assessments must establish basic data on HIV prevalence'. However, there are as many questions as answers about what information needs to be collected, how best to do this and how information on HIV/AIDS should inform programme design.

Early assessments in southern Africa in 2002 tended not to address the issue of HIV/AIDS directly. The FAO/WFP crop assessments and the first vulnerability assessment committee (VAC) reports did not consider the question of HIV/AIDS-related vulnerabilities. There were attempts in later VACs to incorporate proxies for HIV/AIDS, such as chronic illness, households looking after orphans and households where there had been a recent adult death. Proxy indicators have clear limitations in discriminating between households affected by HIV/AIDS and those not affected, and there are important methodological problems around using the VAC data to analyse the links between HIV/AIDS and vulnerability, particularly as it was not designed for that purpose (Mdadla et al., 2003). Nonetheless, this at least enabled some examination of the impact of HIV/AIDS on food security (Mdadla et al., 2003). A preliminary analysis of this data was attempted in a report by the Southern African Development Community (SADC) in 2003. This study suggests that HIV/AIDS did have strong negative impacts on some households, but their scale remains unclear:

> *It is commonly agreed that HIV and AIDS have contributed to the depth of problems faced by rural households in southern Africa in the context of the 2002 food emergency. What is much less well understood is the extent of that contribution and how it varies by demographic structure and mortality and morbidity profile of households (SADC, 2003: 1).*

Relatively few assessments were carried out outside of the VAC process. The focus also remained largely on food security, and within that on measuring food aid needs. Assessment of other needs arising from acute livelihood insecurity was patchy. The narrowness of the humanitarian assessment process is clearly a wider issue (Darcy and Hoffmann, 2003; Darcy et al., 2003). However, in the context of HIV/AIDS it has several important implications. The focus on food security and food aid needs has tended to lead to an emphasis on food aid as a response to the impact of HIV/AIDS on food security, and a relative neglect of a wider range of possible livelihood interventions. The health needs of vulnerable populations, including those related to HIV/AIDS, have also tended to be both under-assessed and under-responded-to.

New methods are being developed. For example, national VACs have begun to explore whether it will be possible to include rates of HIV prevalence disaggregated by district and combined with food security and vulnerability indicators to build up a picture of geographic vulnerability. Save the Children is developing methods based on analysis of individual households. The Labour Assets and Allocation Model (LAAM) is concerned with the allocation of labour and other assets at household level, and can be used to categorise the household impacts of HIV/AIDS based on assets, demography and context (Petty, 2003a and 2003b). The Food Economy Group (2002a and 2002b) has also begun analysing the links between HIV/AIDS and household food security.

Prevalence rates for HIV/AIDS are often higher in urban and peri-urban areas than rural areas. Emergency assessments usually exclude urban areas, on the assumption that these are more food secure. HIV/AIDS calls this assumption into question, especially in the context of growing urbanisation and urban poverty. In Zimbabwe, the combination of economic collapse, rapid inflation, rising prices and HIV/AIDS has led to a perceived need to conduct urban vulnerability assessments, and these were under way at the time of writing (Sherman and Shumba, 2003). However, in all of the other southern African countries, vulnerability in urban areas remained largely opaque and unassessed. Urban assessments require different methodologies and skills, and these will need to be developed.

Whilst new indicators have been developed and used in the southern Africa response, there are not yet clear models for integrating information about HIV/AIDS into information systems for humanitarian action. In general, it appears that indicators need to be chosen carefully, used in multiple (redundant and triangulating) ways, disaggregated by sex and age and more nuanced and carefully interpreted. Sampling must be more careful to avoid or acknowledge potential bias.

4.2.5 Targeting

In providing emergency relief or addressing food insecurity, it is questionable whether people with HIV/AIDS should be a specific target group. HIV/AIDS may deepen vulnerability and lead to food insecurity, but this does not mean that the presence or absence of HIV/AIDS needs to be a specific criteria for targeting assistance. Existing targeting mechanisms that aim to identify the poorest and most vulnerable should also be able to identify vulnerability relating to HIV/AIDS. Of course, if the intention is to specifically target people with HIV/AIDS as part of an HIV/AIDS-focused programme such as home-based care, then the targeting challenges are different. The presence of HIV/AIDS, however, does require practitioners to examine existing targeting criteria and expand these where appropriate to include particular vulnerabilities.

WFP (2003: 12) has adopted the following principle in relation to targeting:

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

In southern Africa during 2002–2003, the targeting of food aid and other relief commodities (largely agricultural inputs) was largely done on a geographic basis, and then by NGOs using community-based methods to identify the most vulnerable within those communities. Proxies for HIV/AIDS

were widely used as one of the indicators of vulnerability. The chronically ill, households looking after orphans and elderly-headed households were seen as potentially more vulnerable to food insecurity and prioritised for assistance. It is important to recognise that community targeting may reflect embedded inequities, and that there may be added difficulties in targeting HIV/AIDS-affected households in a context where the disease is highly stigmatised, or where people may not know their HIV status (Baylies 2002).

Various issues were highlighted in interviews conducted with aid agency staff. The first is over the usefulness of the proxy indicators for HIV/AIDS, in particular chronic illness. From the VAC process, it is clear that chronic illness is a problematic indicator producing widely varying rates, depending on how the people that conduct assessments are trained, and how the question is phrased. One of the conclusions from a workshop on HIV/AIDS and vulnerability in South Africa in 2003 was the need for further investigation. In a baseline survey carried out in Malawi, the NGO consortium C-Safe found little, if any, significant difference in wealth categories among these definitions of vulnerability (Hagens, 2003).

World Vision (2002) highlighted a concern that HIV/AIDS increased the risk that household status might change over the period of a relief distribution. Hence, there may be a need for registration lists to be more regularly updated to capture households newly affected by illness or death. Finally, there seemed to be a risk that proxies for HIV/AIDS could be used as indicators of vulnerability without sufficient consideration of other indicators and of standard wealth criteria. SADC (2003), for example, stressed that indicators such as chronic illness and elderly-headed households could be considered as possible targeting criteria, but should be cross-checked with wealth group analysis, because taken separately they may not be robust indicators of vulnerability. Clearly, it is possible for households to be both relatively well off and have a chronically ill member, and to be relatively well off and looking after a number of orphans. Resources such as food aid, aimed at alleviating food insecurity, should be targeted based on an assessment of whether or not a household is food insecure based on wealth and poverty criteria, not just on the existence of proxies for HIV/AIDS. It must be stressed that the interviews for this study were not evaluating the work of particular agencies, so this argument relates to the perception of a possible generalised risk rather than any specific practice.

4.2.6 Stigma

The question of how to target households affected by HIV/AIDS without adding to the stigma that these families might be facing is a difficult and critical issue. Stigma relating to HIV/AIDS may take different forms. There is a risk of self-exclusion, where people are too ill or too ashamed to participate in community meetings and are therefore left out of relief programmes not because they were actively discriminated against, but because they could be easily ignored. There is also, of course, the possibility of active discrimination, where people known or thought to be HIV-positive or who are chronically sick are deliberately excluded from assistance.

One of the ways in which organisations are approaching this problem is to work with existing community organisations already dealing with HIV/AIDS-affected households. For example, WFP states that it 'will support established community based organisations when carrying out HIV/AIDS activities in order to avoid the negative consequences associated with HIV stigma' (WFP, 2003: 12). However, this raises problems of scale, capacity and the equity of community-based targeting. Existing CBOs are unlikely to be able to reach large numbers of food-insecure people. Relying on community targeting or community safety nets may mean accepting discrimination, the abuse of power and the likelihood that the poorest and weakest will lose out. Baylies (2002: 624) makes the point that 'to the extent that HIV feeds on structured inequalities and power relations (not least those around gender) reliance for assistance on structures and mechanisms which reinforce rather than challenge those inequalities is of questionable value'. Oxfam (2003c: 48) suggests that, since targeting people with HIV/AIDS may increase stigma and discrimination against them, it should only be undertaken 'after careful consideration and with the participation and consent of the beneficiary group', but this may be difficult in the context of a large-scale relief response.

How far stigma associated with HIV/AIDS was actually a problem in the southern Africa relief response remains unclear. It was widely seen as a potential difficulty in the targeting and provision of assistance, and as a problem within the broader development context. However, most aid agencies interviewed felt that, in practice, stigma had not been a major obstacle. It was argued that, because HIV/AIDS had not been specifically mentioned and proxies such as chronic illness were used instead, relief assistance was less closely associated with HIV/AIDS, and the risk of stigma was reduced.

Some agencies questioned the extent to which it was appropriate to continue avoiding specific mention of HIV/AIDS, and whether, by using proxies, staff were in fact perpetuating silence and stigma around the disease. How far open discussion of HIV/AIDS was possible was, however, unclear. Conversely, there was a feeling that the provision of additional assistance had helped to reduce the stigma associated with HIV/AIDS. Certainly, it seemed to be the case that providing additional benefits as part of relief packages encouraged people to take part in HIV/AIDS-related programmes. The Red Cross in Zimbabwe found that the numbers of people on its home-based care programme climbed dramatically once food aid was provided as part of the support package.

Stigmatisation is by definition largely hidden: people are unlikely to openly admit to discriminating against others, and people that are stigmatised or feel ashamed about their illness are unlikely to participate or speak up in community meetings. Unless aid agencies actively look for exclusion relating to stigma, they are unlikely to find it. The perception that stigma was not a major problem within the relief response contrasts with findings from studies that specifically look at this issue. For example, CARE in Malawi found that 'focus group discussions suggested that persons suspected to have HIV/AIDS are either blatantly or subtly excluded from

social structures and support' (Hagen, 2003: 10). A Red Cross assessment in Zimbabwe in October 2002 found that, in one rural district, households categorised as very poor were receiving less food aid than households in the poor and middle categories, which the assessment felt might reflect the combined stigma of poverty and HIV/AIDS facing this group (ZRCS, 2002: 12). A Concern Worldwide post-distribution monitoring exercise in Malawi reported a low level of households registered as chronically sick, which may suggest that individuals were unwilling to be seen by their peers as part of this subset due to fears of stigmatisation (Concern Worldwide, 2003).

Another aspect of exclusion relating to HIV/AIDS might be that traditional registration processes fail to capture new types of vulnerabilities, such as orphans and dissolved households. A study for CARE examining targeting methodologies for HIV/AIDS-affected households in Zimbabwe, which compared results from an intensive participatory exercise with an earlier vulnerability study conducted in April 2003, suggested that villagers did not self-select into vulnerable groups for fear of being stigmatised and associated with HIV/AIDS (Tango, 2003). The study concluded that, rather than the largely survey-based quantitative exercises used with the vulnerability assessment process, in-depth participatory approaches may be needed to get at issues of stigma. It also found that conducting exercises in separate gender groups was important, and that participatory methods were at least as efficient in terms of time as quantitative methods.

4.2.7 Partnerships

The possible need for long-term relief assistance arising from the HIV/AIDS epidemic raises the question of whether greater local and governmental involvement is called for in the provision of relief assistance. New inter-agency partnerships are emerging among humanitarian and development actors in explicit recognition that the interactions between HIV/AIDS and food security require different kinds of technical skills and knowledge. It has already been noted how relief agencies are increasingly looking to develop stronger partnerships with locally-based HIV/AIDS organisations, particularly in developing awareness and prevention activities. Organisations providing support to people living with HIV/AIDS are also seen as potential partners for targeting and delivering longer-term assistance. The IFRC used its existing home-based care programmes to carry out food distributions in 2002, explicitly targeting HIV/AIDS-affected families as a complement to the wider WFP food distribution programme. Churches are also often heavily involved in home-based care, and have been used as partners by international faith-based organisations such as CAFOD, Christian Aid and Tear Fund.

The relief response to the southern Africa crisis in 2002 and 2003 relied heavily on international aid agencies, notably WFP, the Red Cross movement and a relatively small number of large international NGOs. National governments were much less involved than in the 1991/92 crisis. In Zimbabwe, there were concerns about the possible manipulation of aid for political advantage. In Malawi, donors were concerned about government corruption, especially as it related to the sale of the strategic grain reserve. In general throughout the region, government capacity is seen to have declined in the past decade. Clearly, however, governments are the appropriate providers of long-term safety nets. Given that, a key issue is the extent to which there should be greater government involvement in relief response, and whether international aid agencies should be trying to devolve responsibility for ongoing welfare support back to governments. However, the extent to which this is possible or practical in the context of weak and neo-patrimonial governance in many parts of Africa is unclear.

It is important to guard against an uncritical enthusiasm for greater involvement of local organisations in relief programming in the context of HIV/AIDS. There are important questions about the capacity of relatively small organisations to manage large-scale relief programmes. The 2002 response required food to be provided to over 14 million people across six countries with very little planning and preparation time. Given this, some marginalisation of small local organisations was probably inevitable. Greater involvement of local organisations has costs in terms of the time and resources that need to be devoted to capacity-building. Often, local organisations also have other activities that risk being neglected during a relief response. Oxfam (2002) raises the point that assumptions underpinning partnerships may need rethinking, given the impact of HIV/AIDS on institutional capacity, through sickness, absenteeism, death and the loss of institutional learning, for example.

4.2.8 Monitoring and evaluation

As humanitarian aid programmes increasingly recognise HIV/AIDS issues in their programming, monitoring and evaluation systems will also need to adapt. This study has noted several areas where explicit and active monitoring by aid agencies is likely to be needed. These include:

- Whether people are being excluded from assistance because of stigma relating to HIV/AIDS, or because of the type of intervention (chronically ill people unable to participate in public works projects, for example).
- The risks faced by aid agency staff and the people they work with, for instance through dangerous sexual behaviour and exploitation.
- The assumptions underpinning agricultural interventions and the extent to which they hold true in different contexts.
- The success and appropriateness of HIV prevention and awareness activities linked to relief programmes.

There are obviously many more, and this list merely highlights some of the more pressing unanswered questions facing aid agencies in southern Africa. A particular point is that, given the sensitivities around HIV/AIDS and sexual behaviour and the stigma that still prevents open discussion, monitoring systems will have to investigate more deeply than is normally the case if they are to be able to adequately address some of the key questions surrounding the interface between HIV/AIDS, food security and emergencies.

4.3 HIV/AIDS and sectoral issues

4.3.1 Food programming

The response to the southern Africa crisis was overwhelmingly focused on food aid. This section examines issues relating to rations, distribution modalities, food for work and longer-term food aid programming in the context of an HIV/AIDS epidemic.

WFP outlines a set of key principles for food aid programming for HIV/AIDS (see Box 7). In southern Africa, WFP is developing what it calls Protracted Relief and Recovery Operations (PRROs), a funding modality previously used in long-running conflicts, and sees food aid as an important part of the long-term response to HIV/AIDS. The long-term nature of vulnerabilities relating to HIV/AIDS raises particular difficulties about when food is appropriate and whether, once food aid is provided, it will be possible to stop assistance. For example, food aid linked to treatment for HIV/AIDS is potentially a lifelong commitment.

Ration types

The new WHO guidelines on the nutritional needs of people living with HIV/AIDS make it clear that there are additional energy requirements for people with HIV and those with AIDS (WHO, 2003c). In practice, however, providing people living with AIDS with different and additional foods is likely to be very difficult, given that most people do not know their HIV status, there is stigma surrounding AIDS and there are difficulties around targeting. The question then becomes whether general ration sizes should be increased for all people in areas of particularly high HIV prevalence – a policy that would have huge resource implications.

Box 7: Principles for WFP programming relating to HIV/AIDS

1 The entry point for WFP involvement will always be situated in nutrition and food security. WFP's interventions will target beneficiaries based on their food security status, not their HIV status.
2 When and where appropriate, WFP will take HIV/AIDS into account in all of its programming categories and in all assessments of needs.
3 WFP's HIV/AIDS response in specific countries will depend on the national strategy and will always fit within the government's framework for action.
4 In order to minimise the debilitating stigma and discrimination often associated with HIV/AIDS, WFP will support local non-government organisations and community-based organisations, including associations of people living with HIV/AIDS. WFP will use food aid to complement and scale up existing government, UN and NGO partner activities in prevention, mitigation and care for HIV-affected individuals and families.
5 WFP food assistance will place special emphasis on women and vulnerable children, in particular orphans, and will support the broader national and international response to HIV/AIDS to ensure that food aid is part of a larger package provided to HIV affected households and communities.

Source: WFP, 2003a: 11

In southern Africa during 2002–2003, there was much discussion of whether AIDS-related vulnerabilities meant that food aid rations should be adjusted. For Save the Children and Oxfam 'food rations must be adapted to the specific needs of people living with HIV/AIDS. Donors need to supply non-maize food with high nutritional values, such as oils, beans, pulses, Corn Soya Blend [CSB] for infants etc' (Save the Children and Oxfam, 2002: 5). WFP, in its first regional emergency appeal for southern Africa, made a strong case for adjusted ration sizes and compositions, and advocated strongly to donors on the role of non-cereal commodities (pulses, oil and particularly CSB) in the general ration. The approach used by WFP was to revise ration standards across the board, which resulted in an increase in the reference ration from 2,100 to 2,200 kcal. Actual rations were designed keeping in mind the higher reference, but also locally available coping mechanisms and food sources. What is not yet clear is at what prevalence rate of HIV/AIDS it is justified and effective to adjust rations for all beneficiaries, rather than trying to apply targeted support (WFP, 2003c).

Despite WFP's revision of the planned ration scales, in effect rations in 2002–2003 were largely determined by pipeline constraints, with little flexibility for adjusting or increasing them. As the WFP real-time evaluation found, 'in no country was the optimal daily food ration met consistently over time' (2003c: 12). The controversy over genetically-modified foods meant that GM maize had to be milled before distribution, and this enabled WFP to fortify the maize at relatively low additional cost. The possible additional nutritional needs of people living with HIV/AIDS provided an extra reason for fortifying milled maize. HIV/AIDS also provided an additional justification for attempting to deliver as full a food basket as possible when the pipeline allowed, and at some points for the inclusion of CSB in general rations.

During 2003–2004, aid agencies started to move from general food aid distributions to more targeted food aid programmes, some of which specifically focused on HIV/AIDS-related groups, such as providing food aid to participants in home-based care programmes. This raises different questions about the appropriate composition of rations, with the possibility of tailoring them more specifically to the needs of people living with HIV/AIDS. There is also growing interest in the food and nutrition needs of people receiving anti-retroviral therapies in resource-limited settings (Castleman et al., 2003). However, to date rations have tended to remain fairly standardised, and there is a perceived need for additional technical guidance on the nutritional needs of people living with HIV/AIDS (FANTA, 2002; WHO and FAO, 2002).

Distribution issues

HIV/AIDS has clear implications for the ways in which food aid, and indeed other relief commodities, are delivered. The labour constraints and burden of illness in high HIV/AIDS-

prevalence areas raises a question about how far people should have to travel to distributions, how long they should wait and how much they should be expected to carry. In Malawi, Ntata (2003) highlights the long distances that some beneficiaries had to walk to distribution points, and recommends reducing the weight of commodities that have to be transported, either by more frequent distributions of smaller amounts, or through village-level storage. The impact of HIV/AIDS may impel children or the elderly to take responsibility for collecting food aid from distribution sites, and these groups may not fare well in such 'first come, first served' situations. Lack of representation, especially for children or the chronically ill, may mean that they are not registered for food aid (Zimbabwe VAC, 2003).

The SADC vulnerability assessment committee report on the impact of HIV/AIDS (2003: 17) argued that:

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

Of course, having more distribution points and distributing smaller amounts of food more often would significantly raise costs. Many of the respondents for this study found that, in a large-scale food aid operation, it was often not practical to increase the number of distribution points, as capacity was already fully stretched. As ever, at food distributions there was a thriving local market of people willing to transport food aid for people who were not able to get it themselves. Aid agencies allowed food aid rations to be collected by a relative or nominated representative if the person named on the beneficiary list was too sick to collect their rations.

Food for work

Food for work (FFW) has traditionally been used as a way of phasing out free food distributions and as an instrument for 'recovery and rehabilitation' (Harvey, 1998; Barrett et al., 2001). The HIV/AIDS epidemic raises important issues with regard to the design of food for work programmes, due to the labour constraints of affected households. FFW programmes are often designed to target the poorest by setting wage rates low enough that only the poorest will want to participate. However, as Kadiyala and Gillespie (2003: 20) argue, 'Self targeting may leave out a large proportion of the needy population who are too weak or busy with intra-household caretaking to participate. Households headed by children and the elderly will also be excluded'. Certainly, given the multiple negative impacts of HIV/AIDS on household labour capacity, there is a strong theoretical case that communities with high levels of HIV prevalence should not have their access to transfers rationed by labour capacity.

Food for work continues to be used in southern Africa and, in practice, the tendency has been to adjust the design and implementation of FFW programming, which is still seen as a useful tool. The SADC (2003) report, for example, argues that the type of work should be within the capacity of the elderly and adults that are not at their peak health. Agencies in southern Africa have started to develop food for work programmes focused on activities that can provide benefits to the most labour-constrained households. Examples include programmes involving working the land of labour-constrained households, and the development of 'community gardens', where some of the produce goes to vulnerable households. Another option has been to continue free food distributions for those unable to take part in food for work activities. Some respondents questioned the extent to which labour constraints were really affecting participation in FFW projects. It was found that, even in households where a member was sick, the household could still find someone to take part in FFW projects.

Non-emergency food aid programming

The question of whether and how food aid should be used in development programming is a thorny issue that has long been debated outside the context of HIV/AIDS. Some commentators have called for food aid to be more tightly focused on emergency relief; others maintain that food aid has a role in development (Pillai, 2000; Clay and Stokke, 1991). HIV/AIDS can be seen as providing a new justification for the continuation of food aid programming in countries moving out of immediate crisis and for long-term development food aid. This has been the case in southern Africa. In his report 'Next Steps for Southern Africa', the UN Special Envoy, James Morris, argued for food-based safety nets to support the most vulnerable:

> *These programmes should include where possible value added activities such as school gardens, nutrition education, de-worming and prevention education and HIV/AIDS awareness raising, including condom distribution. Sustained support for school feeding and take home rations should be a key element of all safety net programmes in the region* (Morris, 2003d: 4)

C-SAFE, a consortium of NGOs led by CRS, World Vision and Care, aims to address both short-term and long-term vulnerability to food insecurity through continuing food aid programmes in Zimbabwe, Zambia and Malawi (C-SAFE, 2003; Murphy, 2004). WFP (2003 and 2001) suggests the following programming options for food aid, related to HIV/AIDS mitigation:

- school feeding, with take-home rations for families caring for orphans;
- food support for orphans and their families;
- food for training in livelihood diversification;
- food for home-based care services;
- food assistance to TB patients;
- food for vocational training for street children and orphans;
- food for work and food for training; and
- food assistance for ill people and their families.

These different food aid modalities are discussed in more detail by Kadiyala and Gillespie (2003). Guidelines are also

being developed at a country level. WFP Malawi has guidelines for food aid as part of tuberculosis treatment, prevention of mother-to-child transmission, and orphan and home-based care for people living with HIV/AIDS (WFP Malawi, 2003a–e).

Perhaps the most fundamental issue is around the appropriateness of food aid as a resource over the long term. There appears to be a common assumption that, because HIV/AIDS exacerbates food insecurity, and because people with HIV/AIDS have additional nutritional requirements, food aid is needed. Few of the agencies interviewed in southern Africa had explicitly considered the ongoing appropriateness of food aid, or alternatives to it, in countries such as Malawi and Zambia, where there were no longer national-level shortages in 2003. WFP in southern Africa sees food aid as a catalyst for non-food activities, and is emphasising regional purchases of food where possible. In the first emergency appeal, WFP bought nearly 400,000 tons of food in southern Africa (WFP, 2003b). The WFP's second regional emergency appeal makes reference to food as a component in wider service delivery programmes that aim to 'deploy food, technical advice and advocacy measures to encourage and support government efforts to create or strengthen safety nets that provide minimum protection to populations facing food insecurity and the risks of living in an HIV/AIDS affected environment' (WFP, 2003b: 8).

The costs and benefits of food aid over the medium to long term need to be compared to other ways of providing long-term welfare and safety nets. It should not be assumed that, even where people with HIV/AIDS are hungry and have inadequate diets, food aid is the only or best way of addressing their needs.

Nutrition

As discussed in Section 2.2.4 above, HIV/AIDS has important impacts on nutrition, and nutrition has an impact on the progression of HIV/AIDS. Understanding of these interactions is still at an early stage. This section focuses on the implications of HIV/AIDS for the traditional 'humanitarian' nutrition interventions of therapeutic and supplementary feeding. It does not examine broader nutrition questions, such as the quality of diet or breastfeeding (Leyenaar (2004) looks at the question of infant feeding in emergencies).

In areas where HIV prevalence rates are very high, significant numbers of children may have HIV/AIDS through mother-to-child transmission. These children are likely to be disproportionately represented in therapeutic feeding centres because of the links between AIDS and malnutrition. Mason et al. (2003: 12) estimates that about 10% of children below 36 months may have AIDS, and may be failing to grow as a result. After the age of three, most of these children die: 'Thus the age distribution of growth failure may be changing; prevalence of children 6–36 months may measure a mix of AIDS and deprivation, whereas in the 36–60 months age group is the more familiar underweight due to malnutrition'. Case fatality rates in therapeutic feeding programmes based in government-run health facilities during 2002–2003 in southern Africa were much higher than accepted standards. It is thought that this is probably related more to issues around the quality of care in such centres, where levels of supervision and resources are lower than in centres run by NGOs, particularly as case fatality rates were also high prior to the crisis. Nevertheless, HIV/AIDS will clearly make some contribution to fatality rates, and may require adjustments to key indicators, minimum standards and protocols for therapeutic care.

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

In some therapeutic feeding programmes, aid agency staff had anecdotal evidence that the majority (up to 80%) of the children could be HIV-positive. This has implications for the causality of acute malnutrition and for the timeframe of therapeutic care. In the context of HIV/AIDS, there is a need to consider both acute and chronic factors, and not simply to assume short-term causes for acute malnutrition. During crisis situations, therapeutic care is traditionally expanded to cover larger numbers of patients as prevalence rates rise. Care can then be scaled down when prevalence rates recover to normal levels. However, experience in southern Africa suggests that severe acute malnutrition is likely to be high as a proportion of global acute malnutrition, and that even when GAM is relatively low, levels of severe acute malnutrition will remain significant. This implies a possible need for the long-term provision of therapeutic care, and for thought as to how this can be integrated into long-term health care systems. In southern Africa, particular efforts have been made by aid agencies to integrate therapeutic care into existing health care systems. For example, in Malawi national treatment protocols were strengthened and training programmes conducted to support existing systems for the treatment of malnutrition.

One problem with therapeutic feeding centres has always been the risks of the cross-transmission of opportunistic infections that arise when a large number of sick children are gathered together in one place. The weakened immune system of people living with AIDS may mean that these risks are increased. Community-based forms of therapeutic care use take-home food rations such as plumpinut (Collins and Sadler, 2002). This may have added value in the context of an HIV/AIDS epidemic by reducing cross-infection risks and lowering the labour demands on the main carer of acutely malnourished children, who will not have to stay as long in a therapeutic centre.

HIV/AIDS may increase the prevalence of acute adult malnutrition, suggesting the need for nutrition programmes to further develop protocols for evaluating, admitting and treating adults. Hudspeth (2003) suggests that aid agencies should start gathering information on adult malnutrition

using the Body Mass Index (BMI) in addition to the regular anthropometric data gathered on under-fives.

4.3.2 Health

Support to health systems in southern Africa during 2002 and 2003 was comparatively neglected, and so there was little practical experience to review in interviews carried out for this study. This section, therefore, focuses on examining the reasons for this neglect. There are, of course, important technical issues relating to HIV/AIDS and health, which are not dealt with here. These are covered in the IASC (2003a) guidelines, and include the need to ensure a safe blood supply, provide condoms, ensure safe deliveries, manage the consequences of sexual violence, establish syndromic STI treatment and ensure IDU-appropriate care. Nor can this section go into detail regarding the long-term humanitarian challenge of expanding access to treatment for HIV/AIDS. HIV/AIDS prevention activities are also not covered, although they can be seen as a public health intervention and must be a critical part of any response to HIV/AIDS, both in the short and long term.

The relative neglect of health systems in southern Africa during 2002 and 2003 seems to stem from the view that such systems present a long-term and complex development problem, and are not amenable to a short-term humanitarian response (Griekspoor et al., forthcoming 2004). As Darcy et al. (2003) argue, it is harder to understand the health sector in terms of deficits below a certain norm. Assessments of the health situation during the southern Africa crisis were patchy; they identified significant problems, but no worse than in previous years (MOH and WHO, 2002; MOHP and WHO, 2002).

Humanitarian health responses tend to be triggered by short-term increases in the disease burden, for example from cholera outbreaks, or when population movements create a clear risk of additional disease and clear need for additional services. However, it could be argued that the humanitarian system has a responsibility to highlight unmet needs, as well as responding to short-term increases in the disease burden. In Malawi, less than 50% of the population had access to basic health care before the current crisis, and the health system was already struggling to cope with the increasing burden of disease related to HIV/AIDS (UNDP, 2002). Another option would be for humanitarian aid agencies to refuse to accept the status quo and aim for supporting expanded access to basic health care even if only on a short-term basis, partly in the hope that this might provide a catalyst for improved access in the long term.

There were some limited examples of attempts to include health aspects within the overall response. For example, in Zimbabwe WHO managed to secure funding for the provision of essential drugs to health centres, and WHO in Malawi conducted a cholera programme that succeeded in reducing the number of cholera cases, deaths and case fatality rates in 2003 compared to the previous year (Griekspoor et al., forthcoming 2004). MSF is implementing programmes in southern Africa focused on the long-term response to HIV/AIDS. For example, in Zimbabwe MSF Spain ran a pilot project to support the Ministry of Health in Bulawayo to provide ART treatment, and in Malawi MSF worked with the Ministry of Health to develop national protocols on ARTs. This is part of a global campaign to make ARTs affordable in developing countries, and to show that they can be successfully provided in resource-poor settings (MSF, WHO and UNAIDS, 2003: WHO and MSF, 2003). MSF has treated more than 10,000 people in 42 projects in 19 countries (MSF, 2004).

The appropriate health system response to emergencies in the context of HIV/AIDS brings us squarely back to the difficult debates about development and relief, the interactions between them and the implications of HIV/AIDS for these debates. There is clearly a minimum level of required action relating to HIV/AIDS, health care and emergencies, and these are covered in existing guidelines (IASC, 2003). There is also clearly a long-term humanitarian challenge in expanding the health response to the huge levels of mortality and morbidity relating to HIV/AIDS. However, the role of humanitarian aid in supporting health care systems in situations such as southern Africa in 2002 and 2003 is much less clear. Tackling this difficult interface will be critical if the right of access to basic health care is to be recognised in both crises and longer-term development.

4.3.3 Water and sanitation

Water and sanitation was another relatively neglected issue in the southern Africa response. This section, therefore, is only able to highlight a number of generic issues from the existing literature. The IASC (2003) guidelines include a checklist of key actions for including HIV considerations in water and sanitation planning.

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

- Consider the out-of-sight needs of chronically ill bedridden people. They need a lot of water for washing due to the fevers, vomiting and diarrhoea that they suffer from.
- Carers may be unable to look after sick people and collect adequate amounts of water. Consider closer tap stands, assistance in gathering water, or special deliveries of water to bedridden people.
- Place latrines, water points and washing facilities in locations decided by the women in the community, in places believed to be safer.
- Install lighting to improve the security of latrines and washing facilities.
- People who are chronically sick may have difficulty in using latrines – consider the provision of bedpans for these groups.

In southern Africa, the Red Cross is aiming to integrate its water and sanitation activities more closely with its home-

based care programme. The Zimbabwe Red Cross (ZRCS) has argued that 'using referrals from home based care projects to identify areas in need of water and sanitation inputs will add value to an entire community and may reduce stigma associated with the programme' (Zimbabwe Red Cross, 2003: 3). ZRCS was also planning to build stronger links between home-based care and water and sanitation programmes by promoting community nutrition gardens managed by support groups using run-off from new or rehabilitated boreholes.

4.3.4 Livelihood support

Support to livelihoods is used here as a broad term for a wide range of possible responses, from seed distributions to cash grants. Given the array of possible areas covered under the term, this section cannot hope to be comprehensive, but highlights some of the main issues arising from experience in southern Africa. Issues around micro-finance and HIV/AIDS are not covered here, but have a substantial literature in their own right (Donahue, 1999 and 2000; McDonagh, 2001; Parker, 2000; Anderson et al., 2002; Horizons, 2001).

In southern Africa, non-food interventions in 2002 and 2003 focused mainly on support to agricultural production, primarily through seed distributions. HIV/AIDS raises a number of issues in this area. First, there is the question of what types of seed are most appropriate. If, as has been suggested, there is a need to promote low-input, low-labour cropping systems, then standard packages may not be suitable. Equally, if tools are provided there may be a need for adaptations. Examples of AIDS-related innovation cited in the literature include tools that are light enough for children and the elderly to use. Of course, developments in seed programming suggest that distributing seed may be less effective than alternative interventions such as vouchers and fairs, leaving the choice of seed in the hands of individual farmers and stimulating local seed markets (Longley and Sperling, 2002).

In 2002, distributions in southern Africa were mostly large-scale and planned late. This meant that the main focus was on distributing the seeds in time for the main planting season, and accessing sufficient high-quality seeds from inside the region. There was, therefore, little time or capacity to consider specific issues around HIV/AIDS. Seed packages tended to be standardised, and it was assumed that even the most vulnerable households would be able to find sufficient land and labour to plant, maintain and harvest the seeds provided. In 2003, greater consideration was given to whether programmes needed to be adapted to reflect specific vulnerabilities relating to HIV/AIDS. One of the central issues in agricultural input programmes is the availability of labour within the household. The impact of HIV/AIDS on food security suggests that households may suffer serious labour constraints. If this is the case, some households affected by HIV/AIDS might be unable to participate effectively in agricultural input programmes.

The extent to which labour constraints were affecting participation in agricultural programmes in southern Africa remained unclear. Some agencies felt that, even for households where people were frequently sick, access to land was maintained, and they were able to find sufficient labour to plant and maintain crops. In Zambia, an FAO programme specifically targeted what it called 'vulnerable but viable' households. It was accepted that this might exclude the poorest and most labour-constrained, which would be better supported through welfare or relief programmes rather than agricultural inputs.

The Zimbabwe Red Cross provided seeds to clients of its home-based care programmes in both rural and urban areas. The experience of this programme suggests that beneficiaries value the inputs provided. If it is assumed that people with HIV/AIDS are unable to benefit from input programmes without careful assessment, there is a clear risk that they could be further stigmatised. Even if households affected by HIV/AIDS are less productive than normal households, the provision of agricultural inputs may still be more cost-effective than continuing food aid distribution. The Red Cross expected that some home-based care clients would not be able to plant the seeds themselves, but that they would be used by friends and relatives, helping to strengthen social capital and community-based safety nets. There is an urgent need for better and more explicit monitoring and evaluation of the labour constraints relating to HIV/AIDS to see whether they really are restricting effective participation in agricultural input programmes.

There was little experience in southern Africa with alternative interventions, such as cash grants. This may be an important avenue for exploration given that many of the most immediate impacts of HIV/AIDS are financial, and given the resource and logistical implications of the kind of long-term and open-ended food aid programme implied by, for instance, provision to home-based care clients.

Examples of how aid agencies in southern Africa adapted agriculture and livelihood programmes to address vulnerabilities relating to HIV/AIDS include:

- Provision of vegetables as part of seed packages, on the assumption that these can be cultivated in home gardens even in households with labour constraints, and may provide both a nutritional supplement useful to people with HIV/AIDS and/or an additional source of income.
- Provision of crops felt to require less labour, such as cassava and sweet potatoes, as part of seed packages, on the assumption that these may be particularly valued by households facing labour constraints.
- Promotion of agricultural practices or technologies felt to be labour-saving. Examples include draught power and conservation farming, which spreads labour more evenly throughout the year.
- Providing seeds for community gardens, where labour is provided based on community participation, and at least some of the benefits go to the weakest and most vulnerable members of the community.

There has been little evaluation of these approaches, or the extent to which households affected by HIV/AIDS were able to participate and benefit from them. Evaluation of existing initiatives and further research is urgently needed into

precisely how 'livelihood support' should be adapted in areas of high HIV/AIDS prevalence. Some research was under way in 2003, such as that through the RENEWAL initiative, a regional network on HIV/AIDS, rural livelihoods and food security (Loevinsohn and Gillespie, 2003).

4.4 Conclusion

This chapter has examined lessons from the response to the crisis in southern Africa for how humanitarian programmes may need to be adapted in the context of an HIV/AIDS epidemic. It has argued that HIV/AIDS issues need to be 'mainstreamed' by aid agencies both internally, in terms of training and policies, and externally, in terms of how humanitarian aid programmes are structured and delivered. For many over-burdened humanitarian practitioners the response to this is likely to be a weary sigh at the prospect of yet another issue that they must take into account, along with, for example, the need to mainstream gender considerations, to demonstrate greater downwards accountability and undertake more sophisticated analysis of the political economies in which aid is delivered. In practice, however, many of these issues overlap and are integral to good programming.

The need to mainstream consideration of HIV/AIDS cuts across all of the different sectors involved in relief response and across the programme cycle, and many of the issues raised are highly technical and context-specific. However, some of the key general findings in terms of the implications of HIV/AIDS for humanitarian programming are:

- Early-warning systems and assessments need to incorporate analysis of HIV/AIDS and its impact on livelihoods.
- The emergence of new types and areas of vulnerability due to HIV/AIDS should be considered in assessment and targeting. Groups such as widows, the elderly and orphans may be particularly vulnerable, and urban and peri-urban areas may need to be assessed.
- Targeting and the delivery of aid must be sensitive to the possibility of AIDS-related stigma and discrimination.
- The HIV/AIDS epidemic reinforces the existing need for humanitarian programmes to be gender-sensitive.
- Emergency interventions must aim to ensure that they do not increase people's susceptibility to infection with HIV/AIDS.
- Food aid in the context of HIV/AIDS should review ration sizes and types of food and assess delivery and distribution mechanisms in the light of HIV/AIDS-related vulnerabilities, such as illness, reduced labour and increased caring burdens.
- Labour-intensive public works programmes should consider the needs of labour-constrained households, the elderly and the chronically ill.
- HIV/AIDS reinforces the need for health issues to be considered as part of a humanitarian response.
- Support to agricultural production (including seed distributions) should recognise the adaptations that people are making in response to HIV/AIDS.

This chapter has provided as many questions as answers in examining the practical details of how humanitarian aid programmes may need to be adapted. For example, there are unresolved debates about when and where HIV/AIDS prevention activities should be part of relief distributions, and whether food for work is appropriate in the light of HIV/AIDS-related labour constraints. There is, therefore, a clear need for greater monitoring, evaluation and research to address these questions. It is, however, possible to suggest that aid agencies should at least be asking the right questions, and this chapter has aimed to highlight some of the key ones in the context of southern Africa.

Chapter 5
Conclusion

HIV/AIDS clearly has profound humanitarian consequences, both in terms of directly causing illness and death and in terms of the wider impact it is having on societies, and these will inevitably deepen as the impact of the epidemic grows. These consequences will develop over a period of decades, meaning that existing models of humanitarian aid, which remain constructed around the idea of a short-term response to acute need, may not be an appropriate instrument for responding to the long-term crisis of HIV/AIDS. Equally, existing models of development assistance are likely to prove inadequate to cope with the consequences of HIV/AIDS. The pandemic, therefore, raises profound challenges for the system of international assistance, and these are only beginning to be fully appreciated.

The starting point for analysis of these issues should be a clearer understanding of how HIV/AIDS impacts on livelihoods, and how food insecurity increases susceptibility to HIV/AIDS. This study's review of the existing literature highlights the diversity of ways in which HIV/AIDS affects livelihoods, and the dynamic ways in which households, communities and societies are responding to the epidemic. This leads us to caution against a narrow range of responses to the effects of HIV/AIDS on food security, whether these are developmental or humanitarian.

The impact of HIV/AIDS on livelihoods reinforces the need for some form of social protection or welfare safety net for the poorest. By increasing underlying vulnerability, HIV/AIDS may also mean that crises are triggered more easily, reinforcing the need for development actors to invest more in disaster preparedness and mitigation. These are not new challenges, and there is a danger, in considering the broader impacts of HIV/AIDS on livelihoods, of 'AIDS exceptionalism', whereby AIDS is privileged over other diseases within health systems, or where there is undue focus on the impact of AIDS in food security programmes.

When turning to the contribution of HIV/AIDS to emergencies, in the sense of acute short-term crises, this report argues that it acts at many different levels:

- HIV/AIDS is one of many factors contributing to underlying vulnerability, both through its impact on food security at a household level and through its impact on economic, social and political trends at a macro level.
- HIV/AIDS may increase levels of mortality in acute crises, due to the way in which it undermines conventional coping strategies and interacts with nutrition.
- Issues associated with crisis may exacerbate the risks of transmission, contribute to the spread of the epidemic and accelerate health deterioration among people with HIV/AIDS.

Humanitarian actors, therefore, have a responsibility to understand the ways in which HIV/AIDS is impacting upon livelihoods, and to address these issues in their response to crises. The southern Africa crisis in 2002 and 2003 raised a series of practical questions around the programming of humanitarian aid in the context of an HIV/AIDS epidemic which aid agencies grappled with in their relief response. For practitioners, there is therefore an urgent need to inform practice and reflect on what applying an HIV/AIDS lens to humanitarian programming means in practical terms.

This report has mapped some of the attempts by humanitarian agencies to address the fundamental questions raised by the HIV/AIDS epidemic, based on grey literature and interviews with aid agencies. A commitment to mainstreaming the cross-cutting issue of HIV/AIDS is now standard in the major NGO and UN agencies involved in relief programming. Most agencies have HIV/AIDS policies and strategies, and most are attempting to address issues raised by HIV/AIDS in their programming. This ranges from adapting seed distribution programmes to conducting HIV/AIDS awareness activities at distribution sites and developing new partnerships and programme approaches. However, many of the key questions relating to the provision of assistance in the context of an AIDS epidemic remain unanswered, and practical programming experience is at an early stage.

Responding to HIV/AIDS will need to encompass action in response to all three of the challenges outlined in this report: the prevention, treatment and mitigation of HIV/AIDS; taking HIV/AIDS into account in humanitarian relief; and HIV/AIDS as a contributory factor to poverty over the long term. Some of the key implications for humanitarian action and its role in this wider response to HIV/AIDS are:

- HIV/AIDS is a long-term crisis. Humanitarian aid has a role to play, but agencies should recognise that it is only part of a wider response, and should be clear about what it can and cannot achieve.
- Humanitarian agencies need to mainstream HIV/AIDS issues internally, in organisational policies, and externally, throughout the programme cycle and across the different sectors of response.
- HIV/AIDS may increase the likelihood and severity of acute crises. This reinforces the need for greater investment in disaster preparedness and mitigation.
- HIV/AIDS will increasingly add to the burden of chronic poverty and destitution in Africa. This reinforces the need for greater investment in social protection and long-term welfare. Given the limited capacity and resources of many African governments, this implies a long-term commitment by donor governments.
- There is a need for greater understanding of the complex ways in which HIV/AIDS is affecting people's livelihoods, and the impacts of livelihood insecurity on HIV/AIDS, particularly in relation to non-agricultural livelihoods.
- Aid agencies should endeavour to link humanitarian aid programming where possible to the development of local capacity for long-term welfare provision.

Annex 1
List of interviewees

William Aldis, WHO Representative, Malawi
Rachel Baggaley, Head of HIV/AIDS Unit, Christian Aid, UK
Irene Banda, Gender and HIV/AIDS Focal Person, Oxfam, Zimbabwe
Clare Barkworth, Relief and Recovery Adviser, DFID, Zambia
Gareth Barrett, MSF Spain, Zimbabwe
Tom Barrett, DFID, Zimbabwe
Francis Battal, Relief Manager, World Vision Malawi
Sergi Benedito, Logistics Coordinator, MSF Spain, Zimbabwe
Vera Boerger, Agriculture Extension, Education and Communication Officer, FAO, Zimbabwe
Antione Brion, CARE, Zambia
Simon Cammelbeeck, WFP Emergency Coordinator, Zimbabwe
Lola Castro, Head of Programmes, WFP Malawi
Kennedy Chibeta Nkwemu, World Vision Monitoring, Evaluation and Research specialist, Zambia
Emmanuel Chigogora, Programmes Director, ADRA, Zambia
Joy Chigogora, ADRA, Zambia
Lucius Chikuni, Relief and Rehabilitation Commissioner, Department of Disaster Preparedness, Malawi
Grace Chirewa, Gender and HIV/AIDS Officer, Oxfam, Zimbabwe
Doras Chirwa, Sector Coordinator HIV/AIDS, CARE, Zambia
Fiona Clark, HelpAge Policy Officer, UK
Mary Conville, Christian Aid, Zimbabwe
Brenda Cupper, Country Director, CARE, Zambia
Hanna Dagnachew, Director Of Program Quality, CRS, Malawi
James Davey, Concern Malawi
Panganai Dhliwayo, TB Programme and Disease Prevention and Control Officer, WHO, Zimbabwe
Jill Donahue, Senior Technical Adviser, CRS, Zimbabwe
Mike Drinkwater, CARE, South Africa
Dr Sean Drysdale, Epidemiologist, WHO, Zimbabwe
Gerry Dyer, Head of Office, UNICEF Liaison and Support Office, South Africa
Francesca Erdelmann, WFP Regional Programme Officer, South Africa
Kevin Farrell, WFP Country Representative, Zimbabwe
Ana Fernandez, Emergency Operations Coordinator, WFP, Zambia
Cyril Ferrard, FAO Malawi
Bertand Ficini, Country Representative, AAH, Malawi
Michelle Foust Broemmelsiek, CRS Country Representative, Zambia
Priscilla Gavi, Executive Director, HelpAge Zimbabwe
Sarah Godfree, HIV Technical Adviser and Programme Support Officer, CAFOD, Zimbabwe
Jim Goodman, Food Security Manager, Concern, Malawi
Steve Goudswaard, RPU Manager C-Safe, South Africa
Anthony Grange, Programme Officer, Dan Church Aid, Malawi
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The background study, *HIV/AIDS and Humanitarian Action: Insights from US and Kenya-based Agencies* by Laura Murphy, is available on the HPG website at www.odi.org.uk/hpg/papers/tulane_hiv.pdf.

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