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Food, Nutrition and HIV: What next?

UNGASS 2006 Article 28 provides the high-profile international endorsement needed to secure vigorous action if used effectively.

Access to adequate food and nutrition significantly mitigates the impacts of HIV and AIDS. This is well established and increasingly recognised. To date, however, limited progress has been made in integrating nutrition interventions into HIV/AIDS programmes and policies. A key reason for this is the lack of inter-sectoral collaboration. Typically, the food and agriculture sector interacts little with the health sector. On the other hand, a major step forward was taken in June 2006, with the inclusion of Article 28 in the Declaration of Commitment by the United Nations General Assembly Special Session dedicated to HIV/AIDS (UNGASS). The Article highlights the essential role of food and nutrition in a comprehensive response to HIV/AIDS. It provides, at long last, the high-profile international endorsement needed by campaigns to secure vigorous action by donors and national policy makers on food and HIV/AIDS.

This briefing paper outlines the various ways in which food and nutritional security is essential in the HIV/AIDS response. It provides some information on Article 28 and what it implies.

Box 1: Article 28

Article 28 recognises the need to integrate food support as a part of a comprehensive response to HIV and AIDS. It states that '... all people at all times, will have access to sufficient, safe, and nutritious food to meet their dietary needs and food preferences for an active and healthy life, as part of a comprehensive response to HIV/AIDS'.

Woman demonstrating how to produce and use nutritious food for positive living, Lesotho.

It ends by examining some possible actions, at both programme and policy levels, for integrating food and nutrition into the response to HIV/AIDS. The paper does not discuss possible nutritional interventions in detail, or such issues as whether cash transfers may be more appropriate than food aid. These are critical topics. However, it is important first to establish the role that food and nutritional security could play in the HIV response, why there has been limited action so far and why Article 28 represents a key milestone which needs to be capitalised on.

Why food and nutrition matter in HIV/AIDS policy

That HIV/AIDS causes food and nutritional insecurity is obvious – people are sick and unable to work and this threatens their livelihoods.

Key points

- Food and nutritional security significantly mitigates the impacts of HIV and AIDS.
- Limited progress has been made in integrating nutrition interventions into HIV/AIDS programmes and policies.
- Lack of action is due to limited inter-sectoral collaboration and lack of powerful levers of civil society pressure.

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Less understood is that food and nutritional insecurity can also precipitate HIV/AIDS, prevent effective treatment and undermine efforts to provide care and support. A number of scholarly reviews have been carried out. For example, Box 2 outlines some of the ways in which, according to research, food and nutritional insecurity contributes to the spread of HIV.

Box 2: How food and nutritional insecurity can contribute to HIV

- Food and nutritional insecurity increases short-term mobility and migration – 'looking for food' places people in risky situations away from home.
- Food and nutritional insecurity exacerbates gender inequality – when there is limited food in the household, women often are the ones who suffer most, leading them to seek food elsewhere.
- In order to survive, hungry people may be forced into high risk situations, e.g. transactional or commercial sex.
- In food-insecure households, HIV/AIDS becomes a domestic hazard with intra-household clustering of infection and the possibility of parasitic infestation when collecting water.
- Generally poor and food-insecure households are likely to face reduced access to, and ability to use, information around HIV prevention.
- Food insecurity increases risk of malnutrition, which may increase risk of infection.

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Policy approaches for dealing with HIV/AIDS have been conceptualised as a continuum, from prevention; to treatment; to care and support. Policies for each part of the continuum together provide a comprehensive response to HIV/AIDS. The stages of the continuum are also appropriate for understanding the critical role that food and nutrition play.

The role of food and nutrition in prevention

Prevention must not be neglected in the HIV/AIDS response. With the furore that the arrival of Anti-Retrovirals drugs (ARVs) created in the HIV/AIDS world, there has been a tendency to place prevention on the back burner. This relative neglect came as something of a relief to the many HIV/AIDS prevention programmes around the world that seemed to have been having little effect on the pandemic.[1] However, more recently, increasing knowledge about the effects and behaviour associated with Anti-Retroviral Therapy had led many donors (e.g. USAID), civil society organisations (e.g. the International HIV/AIDS Alliances), UNAIDS and others to renew their emphasis on prevention.

Food and nutritional security is critical to successful prevention programmes. As Box 2 suggests, people who do not have access to adequate food (and income), especially women and girls, are more likely to be vulnerable to exposure to HIV infection by being forced into high risk situations. Those include engaging in transactional and/or commercial sex, staying in high risk and abusive sexual relationships because of economic and social dependency, and having to migrate or having a mobile lifestyle in order to make a living (e.g. miners, fishermen). Migrant and mobile communities often have poor(er) access to health care than settled populations, and thus face a double challenge.

We know that food shortage and malnutrition weaken the immune system and generally make a person more susceptible to infections, including HIV.[2] We also know that a balanced and nutritional diet can strengthen a person's immune system, making him/her less likely to acquire opportunistic infections which then allow the easier transmission of HIV/AIDS. Lack of proper nutrition also compromises the health status of pregnant and lactating mothers, thereby increasing the chance of mother-to-child transmission of the virus during birth and during breastfeeding. Finally, ongoing studies are showing that a good diet for an HIV-infected person can delay the onset of AIDS-related illness slow down the progression of the illness.[3]

The role of food and nutrition in treatment

Anti-Retroviral Therapy (ART) is now becoming increasingly available to poor people in developing countries. Costs are going down, in some cases drugs are being provided free (though other costs such as transport and user fees still represent insurmountable barriers for many people) and there is increased political will and commitment on the widening of access.

We now know that adherence to ART and its efficacy are significantly influenced by access to adequate food and nutrition. Medicines are strong and many need to be taken 'on a full stomach', which is difficult for people in resource-poor settings ('meds don't matter if you have nothing to eat!'). Evidence is emerging that people on ART receiving food supplementation recover much faster.[4] A stronger, healthier body can also increase resistance to opportunistic infections, which are dangerous to people living with HIV, especially in resource-poor settings where preventive health care is unavailable. Better food and nutrition, by making ART more effective, has a cost-saving effect, not only for households and dependants, but also for the national economy.

The role of food and nutrition in care and support

While ART is being scaled up to reach those most in need, a survival period of positive living is necessary for large numbers of other people living with HIV. Adequate and nutritious food plays a central role in the care and support of people with HIV. In fact, we

know that an HIV-positive person has higher energy requirements than a healthy non-infected person of the same age, sex and physical activity level. These energy requirements can range from 10-30% higher depending on whether the person exhibits AIDS symptoms.[5] Adequate food is thus essential for prolonging the period of positive living and delaying the moment when ART needs to be started. This is an additional source of cost saving for households and programmes.

Integrating food security with universal access to HIV/AIDS care would not only mean a longer life for many individuals, but could have important spill-over effects by enabling more HIV positive people to continue active and productive lives. Those people could be expected to continue contributing to household income, caring for families and adding to the general well-being of their communities.

Food processing extends availability of nutritious food and provides income generating opportunities, Lesotho.

Why no action?

There is now widespread awareness of the facts outlined above. However, this awareness has not been translated into action.

Reasons for inaction include the limited and ineffective interface that exists in many resource-poor settings between the authorities and agencies responsible for health and those responsible for agriculture and food/nutrition. Both see the other as having the main obligation to take the lead in integrating nutrition and food into HIV programming. There is also, more surprisingly, limited commitment on the part of donors and national policy makers to supporting the initiatives that would be necessary to achieve integration.

Even more surprisingly, pressure from civil society is lacking in these debates. Partnerships between government and civil society are increasingly recognised as a key aspect in programming and policy interventions for HIV/AIDS. This is particularly relevant to bridging the divide between the public-health aspects of HIV/AIDS and the livelihoods and food- and income-security aspects. Although regrettable, the lack of civil society pressure on this issue is understandable. It has been partly due to the lack of powerful levers and influencing tools with which to exert pressure on governments and official agencies to take heed of these critical linkages. With Article 28 of the 2006 UNGASS Declaration, a suitable tool has been made available.

United Nations General Assembly Special Session and Article 28

At the earlier UNGASS held in June 2001, participating Heads of State and Representatives of Governments issued a first Declaration of Commitment on HIV/AIDS. The Declaration described the extent of the epidemic, the effects it has had and ways to combat it. It then stated what governments have pledged to do – themselves and with others in international and regional partnerships, with the support of civil society – to roll back the epidemic. Although not a legally binding document, the Declaration proved a powerful tool with which to guide and secure action by all those fighting the epidemic, both within and outside government.

Rather than address the obstacles that arose in meeting the commitments in the original Declaration, the 2006 UNGASS focused on agreeing a political declaration to 'scale up to' universal access to prevention, treatment care and support. Discussions of food and income security were missing from the debate until very late in the day. That HIV/AIDS is a poverty issue was generally accepted, but the impacts of food insecurity were not prioritised. Nonetheless, the final Declaration did contain one breakthrough. Article 28 recognises the need to integrate food support as a part of a comprehensive

Box 3: Other relevant articles from the UNGASS Declaration of Commitment on HIV/AIDS

Article 49.
Commit ourselves to setting, in 2006, through inclusive, transparent processes, ambitious national targets, including interim targets for 2008 in accordance with the core indicators recommended by the Joint United Nations Programme on HIV/AIDS, that reflect the commitment of the present Declaration and the urgent need to scale up significantly towards the goal of universal access to comprehensive prevention programmes, treatment, care and support by 2010, and to setting up and maintaining sound and rigorous monitoring and evaluation frameworks within their HIV/AIDS strategies.

Article 51.
Call upon Governments, national parliaments, donors, regional and subregional organizations, organizations of the United Nations system, the Global Fund to Fight AIDS, Tuberculosis and Malaria, civil society, people living with HIV, vulnerable groups, the private sector, communities most affected by HIV/AIDS and other stakeholders to work closely together to achieve the targets set out above, and to ensure accountability and transparency at all levels through participatory reviews of responses to HIV/AIDS.

response to HIV and AIDS. It states that '... all people at all times, will have access to sufficient, safe, and nutritious food to meet their dietary needs and food preferences for an active and healthy life, as part of a comprehensive response to HIV/AIDS'.

This is an important milestone for HIV/AIDS policy. This is not to belittle the efforts made by many to put the food/HIV agenda onto the table. Those efforts include two recent international forums, both of which made concrete recommendations calling for action – the WHO-led Durban forum in April 2005 on nutrition and HIV/AIDS and the Project Concern International-led forum in Lusaka in May 2006 on food security, nutrition and HIV. However, neither of these initiatives carries the international weight that a UN Declaration does.

As the most representative international body, the UN expresses the consensus views of the world. Civil society can use this fact as a powerful source of persuasion in advocating for national governments to adopt articles included in the Declaration. In theory, governments have already agreed to its contents (by adopting the Declaration unanimously). They are therefore under an obligation to incorporate key articles in their own national policies. If they do not, they can be called to account.

What next?

The evidence is clear, and an effective campaigning tool is now available. Nevertheless, challenges remain. Work needs to be done first to raise awareness of the existence of Article 28, and then to explore the potential for using it to secure action.

The following are some actions donors and policy makers could to be taking, and civil society could be pressing for in the field of food/nutrition and HIV/AIDS:[6]

- Programming needs to be holistic and comprehensive. Responses must not be limited to the health sector.
- Programming and policy that open up opportunities for less risky, less susceptible livelihoods are an essential part of prevention, treatment and care and support. HIV is a disease driven by inequality and poverty. It needs to be addressed and funded with this in mind.
- It should be recognised that where Anti-Retroviral Therapy is necessary, food is a key element in strategies to promote adherence to it and its efficacy.
- Donors and governments need to make better use of available mechanisms to strengthen the links among sectoral policies. This means using poverty reduction strategies and sector plans in new ways. All sectors should be expected to work to minimise risk of HIV transmission and strengthen resilience to AIDS.
- A harmonised approach is needed in strategic planning, in line with the 'Three Ones' Principles (One agreed AIDS action framework, One national AIDS coordinating authority, One agreed country-level monitoring and evaluation system). Having one national plan that takes into account synergies among sectors supports a holistic response. Decentralisation can also be used to support the facilitation of synergies, with local and district plans used to make links between HIV and food and income security.
- Appropriate nutrition and impact indicators should be included in clinical and community surveillance, and in national, regional and international progress reporting.
- Governments should work in partnership with civil society and other relevant actors to ensure the incorporation of and attention to Article 28 as they set national targets for scaling up to universal access this year.

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Endnotes

1. Catherine Campbell (2003), 'Letting them die' Why HIV/AIDS Prevention Programmes Fail.

2. R.K Chandra, Nutrition and the immune system: an introduction, American Journal of Clinical Nutrition, 1997 Aug, 66(2): 460S-463S; Suneetha Kadiyala and Stuart Gillespie, FCND Discussion Paper Briefs, Discussion Paper 159, Rethinking Food Aid to Fight HIV/AIDS, International Food Policy Research Institute (IFPRI) - Food Consumption and Nutrition Division.

3. Overseas Development Institute, 'HIV/AIDS, food security and humanitarian action: a resource guide' www.odi.org.uk/hpg/aidsresources.html#nutrition. see also www.wfp.org/food_aid/food_for_hiv/index.asp?section=12&sub_section=2 and IFPRI (2006), AIDS, Poverty and Hunger: Challenges and Responses.

4. Kate Sadler, 'Nutrition and HIV/AIDS', Valid International, Conference on Food Security, Nutrition, HIV/AIDS, PCI, June 2006.

5. HIV/AIDS: A guide for Nutritional Care and Support 2004, FANTA, p.15. These guidelines also point out that 'HIV-infected persons do not require more protein than the level recommended for healthy non-HIV-infected persons of the same age, sex and physical activity level.' This revision to the 2001 guidelines, cited in the earlier version of this paper, was based on the results of a technical review by the WHO in 2003 which concluded 'Data are insufficient to support an increase in protein requirements due to HIV infection.'

6. Several policy recommendations come from CARE briefing papers for UNGASS 2006, with special thanks to Dan Mullins and Karen Tibbo.

Photos credit: Amilcar Lucas, VIDA programme, Mozambique.

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