

Humanitarian Policy Group

HPG Background Paper

HIV/AIDS and humanitarian action

Insights from US and Kenya- based agencies

Dedicated to improving humanitarian policy and practice

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A background paper for HPG Research 16



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HIV/AIDS and humanitarian action: insights from US and Kenya-based agencies

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Report summary

This report highlights key themes that emerged in discussions with dozens of key informants from humanitarian agencies in the US and Eastern Africa about the implications of HIV/AIDS for humanitarian action. While specific attention was paid to the Southern Africa food crisis response of 2002/3, experience of integrating HIV/AIDS concerns into relief programming in East Africa, the Horn of Africa and the Great Lakes was also pertinent. Useful insights and experiences also come from those working in emergency relief and long-term development everywhere that the HIV/AIDS has become a generalised epidemic.

The findings of this research indicate that the implications of HIV and AIDS are not limited to the practical concerns of providing relief aid to high HIV-prevalence communities in Southern Africa; the ramifications for agency policies and approaches to relief and development are broader and longer-term. Interviews with agencies based in East Africa also provide additional perspectives on the framing of the Southern African food crisis as a crisis exacerbated and even driven by high HIV prevalence. Concerns arose about rhetoric emphasising HIV/AIDS and its role in the Southern Africa crisis for relief programmes and policies in Sub-Saharan Africa.

Most informants viewed HIV/AIDS as a long-term crisis: in some cases a fully-fledged emergency, and in others an aggravating factor affecting vulnerability. HIV/AIDS brings multi-faceted challenges. These demand that the humanitarian community think harder about the nature of relief and of long-term development, and about how they are related at all stages, from early warning to assessments. Incorporating a deeper, more informed understanding of HIV and AIDS into contemporary humanitarian action – ‘mainstreaming’ HIV/AIDS – has many ramifications. These range from policies to handle HIV/AIDS in the relief agency workplace to demands for greater flexibility from donors in spending and accountability. Internally, agency mainstreaming policies tend to emphasise a broad cross-cutting or multi-sectoral approach. The implications also span the spectrum from the practical field logistics of delivering aid to increasingly labour-scarce communities, to conceptual debates about the fundamental nature of the kind of aid that should be provided to these communities, and how it should be deployed. The lack of practical, workable guidelines – as well as new demands for skills and staffing – to accommodate HIV/AIDS during field interventions emerged as a concern. Stigma concerns everyone, but no one is sure how to work around it, avoid it or minimise it. Targeting aid emerges as a major concern, since it is linked to the stigma associated with HIV/AIDS. The use of proxy measures (in assessments)

and of community-level mechanisms (for identifying vulnerable people and providing aid) are two techniques mentioned frequently, but both have flaws.

Clearly, HIV/AIDS introduces enormous practical, financial, institutional, technical and ethical challenges to meeting the goal of providing appropriate relief during a long-term crisis. Many experiences are emerging, and many new questions arise in the face of this relatively new and certainly unprecedented pandemic. The concerns and experiences of agencies are shared here through the comments and insights of humanitarian agencies involved in this study.

The organisation of information in this report is by theme or issue raised, rather than by agency. The goal of the study is to generate understanding of experiences and trends within the humanitarian community, rather than to assess the work of any single agency. It is hoped that the findings will facilitate fruitful discussion and debate at all levels within and across agencies, from field work to headquarters policy-making and donor funding. Research is also needed to advance our understanding of how HIV/AIDS actually intersects with people's livelihoods, responses and food security status in different settings.

Background to the study

The purpose of this background report is to document lessons, policy implications and questions arising from the experiences of agencies dealing with HIV/AIDS and humanitarian action in Sub-Saharan Africa particularly Southern Africa. It is one outcome of a larger study of the implications of HIV/AIDS for humanitarian action led by Humanitarian Policy Group (HPG) Research Fellow Paul Harvey. The primary audience for this report includes fieldworkers, practitioners, policy-makers and researchers involved in emergency relief, development and HIV/AIDS mitigation in Sub-Saharan Africa.

Field and desk research focused on issues raised during the humanitarian response to the 2003 Southern African food crisis, focusing on Zambia, Zimbabwe and Malawi. The findings are reported HPG Report 16, *HIV/AIDS and Humanitarian Action* (Harvey, 2004). As a complement to this study, researchers affiliated with Tulane University's Department of International Health and Development talked with officials, technicians and policy-makers in the headquarter offices of major US humanitarian agencies, in order to draw out broader perspectives and lessons arising from the mainstreaming of HIV/AIDS within humanitarian agencies and their responses. Since HIV and AIDS will continue to extend its geographic and social reach over coming decades, the experiences of agencies working in the Great Lakes, the Horn of Africa and East Africa were deemed relevant to understanding the implications of HIV/AIDS for different types of humanitarian actions.

This report summarises the most prominent observations and themes emerging from discussions with over 40 informants from August to December 2003. People from a range of governmental, UN and non-governmental relief and development agencies – ActionAid, CARE, Concern Worldwide, CRS, ECHO, InterAction, Oxfam, Save the Children (UK), USAID, WFP, UN OCHA, World Vision – kindly shared their time and experiences. (A full list of informants is in Annex 1.) A short semi-structured questionnaire (Annex 2) was developed to facilitate and systematise discussion around key themes; not all informants had time to address all the issues equally, nor were all issues pertinent to all respondents. Dozens of internal agency reports, policy statements, baseline studies and presentations also inform this report, enhancing statements made in interviews and providing additional evidence of trends in policies and programmes. Unfortunately, time and resources did not allow for more in-depth interviews or visits to distribution centres or other field programmes. Even so, it is hoped that this background report and the parent study will stimulate discussion about how HIV/AIDS should be handled by the humanitarian and development communities. The aim is to aid the many people living with, and responding to, HIV and AIDS.

Chapter 1

Conceptualising HIV/AIDS, emergencies and the 2002/3 Southern African food crisis

The conventional wisdom of many agencies working in countries in Africa hardest hit by HIV and AIDS is captured by this statement by a UN official (working in eastern and Southern Africa):

HIV is everywhere and it has changed the lives of people in many different ways. It is now part of all emergency and development problems. We are going beyond health and development – we need to integrate it at every level.

Most informants are familiar with the potentially profound, wide-ranging and long-lasting impacts of HIV/AIDS. These affect rural individuals, families, households and communities. The impacts on agriculture are visible to many, not just those working in Southern Africa, where the most famous crisis occurred. An agricultural expert working in disaster relief observes: ‘parents are dying ... kids don’t know how to grow things’. Relief commodities officers working in high HIV-prevalence districts in Kenya note that ‘fields are not being planted’.

The high costs of care and the loss of productive-age labour eat into financial, human, social and other capital, undermining farming systems, reducing production and income and aggravating the vulnerability of households. This model is supported by a growing body of anecdotal evidence, agency studies and official statements, and a small but growing number of rigorous scientific studies (see Box 1). Permeating policy and advocacy statements, and, increasingly, programme and research agendas, is the sense that HIV/AIDS is an exceptional shock and a particular kind of threat to food security.

Several informants from a variety of technical and institutional backgrounds raised serious concerns about the inflated rhetoric of emergency appeals, which often draws on the ‘new variant famine’ or related models. The rhetoric seems to extend too far beyond the original intent of the hypotheses. Policies are being made which lack sound empirical backing; they might simply be wrong. These respondents do not intend to diminish the suffering of people living with HIV/AIDS (PLHA) nor the large social impacts at all levels. They do, however, worry that agencies may not be basing social policies on solid evidence and a clear understanding of inter-relationships. This section summarises responses on the topic of the food security crisis in relation to HIV/AIDS: how HIV/AIDS and the crisis are related, whether HIV/AIDS is itself an ‘emergency’, and how HIV/AIDS complicates thinking about the relief–development continuum.

Box 1: Is HIV/AIDS driving the food crisis in Southern Africa?

This question concerns academics, fieldworkers, policymakers and donors, since the answers have huge implications for social policies. One leading answer takes the form of a hypothesis quickly adopted by many UN agencies to explain the recent food crisis in Southern Africa. First introduced in 2002 (de Waal and Whiteside, 2002) and later revised and published (2003), the *new variant famine* model postulates that, in the absence of relevant policies and programmes, a 'new kind of acute food crisis' will emerge in Sub-Saharan Africa because of the wide-ranging and cumulative impact of HIV/AIDS on agrarian households and food production and livelihoods. HIV/AIDS makes rural communities more susceptible to external shocks, such as drought, and less resilient when these shocks occur. So far, despite the popularity of this model in official rhetoric and the abundance of anecdote and field observation of the severity of impacts apparently due to HIV and AIDS (evidence by many quotes in this study), actual empirical support for an HIV/AIDS-driven food crisis remains skimpy.

Empirical evidence of the role of HIV/AIDS in the food crisis comes from a few studies spread across a wide region, of which the following are representative. In Zambia, the loss of adult labour forced families to withdraw older children from school to help maintain levels of food production (Nampaya-Serpell, 2000). In Zimbabwe, the loss of an adult female was likely to lead to increased poverty and food insecurity for a household (Mutangadura, 2001). Analysis of SADC vulnerability data for Zambia, Zimbabwe and Malawi indicate that households affected by adult morbidity and mortality, and with a high dependency ratio due to orphans and the elderly, are significantly more vulnerable to food security shocks than are other households, and showed reductions in agricultural production and income generation (SADC FANR, 2003). In Kenya, premature adult death, one indicator of the HIV/AIDS-affected, erodes household livelihoods, particularly for the relatively poor (Yamano and Jayne, 2003). World Bank studies of Kagera, Tanzania, indicate that poor households are more vulnerable to the impact of an AIDS-related death. The loss of an adult household member depresses the per capita food consumption of the poorest by 15% (World Bank, 1998), while a recent adult death was associated with increased morbidity and reduced height-for-age of children under five (Ainsworth and Semali, 2000).

Other studies, however, do not support the hypothesis of a significant role for HIV/AIDS in food insecurity. Analysis of 2003 Zambia VAC household survey data found that drought, food pricing policies, lack of agricultural extension services, environmental degradation and poverty played a larger role in inadequate harvests than HIV/AIDS (Zambia VAC, 2003). A USAID-commissioned study in relief zones in Zambia (Scott and Harland, 2003) also found 'no evidence ... to support the new variant famine, where HIV infection directly or indirectly overwhelms the majority of rural families, having community level effects that throw rural life into unsustainable decline'. A World Food Program baseline study in western Kenya found weak if any association between indicators of HIV/AIDS affectedness and household food security (WFP, 2003).

Relationships seem to vary by population density, agro-ecological setting, stage of epidemic and political context. Clearly, much more research is needed to illuminate and assess the complex and long-term relationships between HIV infection, AIDS impacts, and food insecurity in many settings.

Is HIV/AIDS an ‘emergency’?

Informants varied about the value of viewing HIV/AIDS as itself ‘an emergency’. To one HIV/AIDS expert, it seemed obvious: ‘HIV/AIDS is an emergency ... With thousands of people dying each week!’. The scale, duration and accumulated impacts of this global pandemic place it squarely in the realm of national, even global, emergencies, calling for special funds, special attention and even the diversion of resources for non-emergency concerns.

Semantics – is HIV/AIDS a ‘crisis’? Is it ‘an emergency’? Is it an ‘added vulnerability’? – have specific programming implications, and are rightly debated at the personal, ethical, programmatic and agency policy level.

One experienced nutritionist working in emergency relief traces the implications of language and perception in the context of her agency response:

the question of what is an emergency has really come up over the past several years. People in Southern Africa say they are still in an emergency. But agencies use the term ‘emergency’ in another way, like natural disaster. If we accept ‘HIV/AIDS’ is an emergency, then we will focus on high prevalence populations all of the time. That doesn’t fit into our little box ... In ‘emergencies’ we just rush in, do our thing, and rush out.

Another NGO participant touches upon wider debates about the relief-development transition:

HIV in some contexts is the emergency itself... in prevention, HIV is the disaster, but the response should be a developmental one.

The ‘emergency’ label is seen as useful for completely different reasons, both humanitarian reasons (as noted above: the pandemic is killing thousands of people a week) as well as strategic and/or practical reasons. USAID Food for Peace (FFP) officials highlight the emergency nature of immediate food shortages, tending to under-value concerns about assets and human development. One respondent dismissed the concerns around dependency on food aid often raised by European NGOs as irrelevant ‘when people are starving’. This long-standing debate about dependency does not, of course, start with HIV/AIDS. For some, the humanitarian argument alone is flawed conceptually, since it disregards many

other common maladies and social ills, such as malaria, which also kill thousands of poor people every week.

An alternative argument for using an emergency designation is more systematic and strategic. One respondent emphasised the value of using existing supply chains. Building on an emergency response framework (spanning preparedness, relief, recovery, transition and long-term mitigation) provides a useful and comprehensible structure for intervening in different ways. Furthermore, emergency funds can come with fewer conditions, and with less emphasis on long-term expectations around financial and institutional sustainability such as attach to long-term development projects. In relation to addressing HIV/AIDS, one NGO programme manager asked whether ‘donors are going to have to give us a break on the issue of sustainability’.

For many people, and for different reasons, HIV/AIDS should be considered a continent-wide disaster meriting extraordinary measures, attention and resources not just for the short term, but for years, perhaps decades. Agencies know that this cross-cutting approach has a tendency to result in many bureaucratic obstacles when working with the major international donors:

The problem for USAID relates to the divisions of short term relief, food and non-food, with 18 month horizon, and long-term development. We are not sure how to integrate HIV/AIDS into this ... AIDS is an emergency, a continuing long-term problem, but there are long term resource deficits and strategic issues.

At the same time, similar reasons justify *not* using the emergency label for the HIV/AIDS pandemic. For example, several emergency relief specialists within international NGO considered that HIV/AIDS programming is better when it is not seen as an emergency *per se*, since in their mind that actually narrows the nature of support, the types of aid and the approach to short-term relief interventions. Furthermore, it confuses long-term chronic problems with immediate, acute short-term emergencies. HIV/AIDS has many long-term and wide-ranging ramifications and needs, and there is no return to ‘normality’, nor an easy exit plan:

if we accept that HIV/AIDS is an emergency, then we will focus on high prevalence populations all of the time... [the threshold crude mortality rate/CMR] may exceed 1/10,000/day in a ‘normal’ population with HIV/AIDS! – (NGO nutrition expert)

Similarly:

food resources can be targeted to PLHA, but that is not an emergency issue, it's a developmental issue. An emergency is a quick-fix 'band-aid' response, and AIDS does not require that type of response. We're going to be dealing with this for the next 20 years. So if you have a complex humanitarian emergency in a population with a high prevalence, then adjust the rations, but don't call the AIDS crisis in Southern Africa an emergency strictly speaking.

In fact:

populations that are more AIDS-affected will decompensate in a crisis faster than populations that are less affected. Thus in high prevalence populations, we need to act as quickly as possible, or stockpile food locally (in country or in the region). That is how AIDS should factor into the emergency. The tricky part is to avoid the dependency mentality.

Another argument is to do with institutional structure: some agencies can only respond to an official 'emergency'. OFDA respondents mentioned the constraints on acting on officially defined 'emergencies', rather than long-term development, though occasionally they can use funds creatively when there is no mission presence, as with a 2003 HIV/AIDS project in South Sudan (USAID/DCHA, 2003). Mostly, however, they are constrained to emergency, non-food aid.

Many countries, including Kenya (since 1999), identify HIV/AIDS as a 'national emergency'. It is not clear what this label really means for a country or populations facing a generalised food crisis. The expectation is that a national emergency will garner public commitment to addressing the pandemic, and to possible sacrifices, but in the absence of clear leadership, the label alone can possibly undermine public support if it means sacrifices in other areas, or if lack of action undermines faith in the government.

The concept of 'emergency' thus means many things to many people in the context of HIV/AIDS, and humanitarian action in Sub-Saharan Africa. The term is varied in its use and potential implications, and can become unusable without more precise definition. Whatever the semantics, the landscape of international relief work (not just in Southern Africa) has fundamentally shifted. As one Nairobi-based UN official notes:

The Southern African crisis served as a wake up call for the international community; they were finally able to see a food crisis as part of other problems – not just a food crisis.

The backlash against ‘HIV/AIDS exceptionalism’

The view that HIV/AIDS played an ‘exceptional’ role as a major causal factor in the 2002/3 food crisis has been reflected in many official policies and in the rhetoric of appeals, and is visible in the policy statements of UN agencies involved in food aid and relief (WFP, FAO). Several informants expressed scepticism about this, and voiced concern that programmes and policies are being made without adequate data. As one experienced nutritionist noted:

the advocacy and mobilisation got ahead of our knowledge and empirical evidence of the reality. This was a problem ... The vast generalisations made by James Morris and Stephen Lewis were driving programmes, instead of evidence driving programmes.

Another notes:

it was larger, higher profile people going out who ‘found people affected by AIDS’ and drew conclusions ... early assessments led to more donor involvement and trips to the field. The awareness is good, but the jump to causal linkage is bad. It is not data driven, not based on data. The consequences are that people start looking at climate patterns and jump to HIV, instead of looking at agricultural policies, as in Zimbabwe. They are too quick, risk shifting focus; they are not scratching the surface.

Essentially, the hypothesis of a new variant famine (see Box 1) of what *might* happen in the region in the future due to HIV/AIDS was being used to attribute causality for the recent (and ongoing) crisis. Several informants were concerned that HIV/AIDS, being a novel (even ‘sexy’) new issue, was used to attract attention to the crisis, but at a cost to other places and concerns. For example, a nutrition expert observes:

I did not see the famine. Perhaps it was a case of the Emperor has no clothes, but it did not seem that bad, especially in Zambia ... I thought we had gotten over the grandiose statements of doom and gloom.

The HIV lens, an apparently benign approach to mainstreaming awareness, also appears inadequate to some. One HIV/AIDS and food security expert with many years' experience in Sub-Saharan Africa asks:

Why see everything through just one lens? We need to look through many lenses. Furthermore ... We need to be more balanced, not just think 'HIV is driving this.' Even with 15% prevalence, 85% of the population is HIV negative! Let's not have HIV become a crutch.

A technical programme officer from a major US NGO shares the concern:

we're paying too much attention to AIDS, because there may not be big differences between households affected by AIDS, malaria and violence; but we often target only households with AIDS. We need to look at this as another poverty/shock issue. In some areas, more people are dying of malaria. It makes people poor. How do we address that? It makes poverty worse. What can we do about poverty

Not only is the direct role of HIV/AIDS in the 'food crisis' probably overstated, it might simply be a convenient way to depoliticise the issue and divert attention from other causes of chronic food insecurity and poverty. One regional NGO officer commented that:

Malawi food stocks were sold to Kenya ... the IMF mandated it! The money was pocketed... Malawi has always been nonviable and had food problems before ... then came HIV.

Inflated rhetoric can also divert resources from other regions that are equally or perhaps harder hit by chronic hunger, poverty and recurrent food crises, but which lack the documented high HIV/AIDS prevalence rates, such as in East Africa and the Horn. One informant made specific reference to shortages of aid to address the Ethiopia food crisis, as well as the apparently inequitable handling of north-eastern Kenya's refugee camps. HIV/AIDS-related issues helped attract attention to the food crisis in Malawi, which was characterised by global acute malnutrition rates of 5% or 6% at the *start* of food distribution. In contrast, rates of 12% are commonly seen in feeding centres that are being *closed* in Eastern Africa. This difference is seen by some observers as a terrible injustice, and might be owed in part to HIV/AIDS exceptionalism. Interpretation of the same statistics to yield distinctly different

programme responses feeds a perception that the Southern African ‘crisis’ is not one of real food shortages according to standard indicators. Observing the Southern African situation directly, one nutrition expert expressed concern that:

many [studies] were not scientifically sound, not comparable ... There were questions of leadership, of mandates. The data were contradictory, not helpful.

To the extent that the crisis was exacerbated by HIV/AIDS, other indicators were needed to back the anecdotal evidence and attribute impacts to HIV and the impacts of AIDS, and not to drought and many other long-standing concerns.

From relief to development: how does HIV/AIDS change R2D?

One question being explored in this study is how new issues and problems raised by HIV and AIDS intersect with longstanding debates about the relationship between short-term emergency relief and long-term, sustainable development. It seems that two related questions must be tackled separately, then addressed jointly:

- How does the HIV/AIDS pandemic challenge the way we should handle relief interventions?
- How does HIV/AIDS change the way long-term development should be undertaken?

Some agencies have the answers: essentially, linking short-term relief and long-term development efforts is easier if these activities are not separated in the first place. An emergency relief specialist with a US NGO suggests that:

we must ask what the long-term plan is: people may recover from short-term food shortages, but people will not recover from HIV infection or its longer-term effect on families and communities. It raises all sorts of questions about how one determines the criteria for ending the short-term emergency response and the criteria for continuing the longer-term emergency response. My gut feeling about the relief/development distinction is that it is not entirely useful, that you must focus on development throughout the emergency response.

Agencies with this approach are generally developmental NGOs with a focus on community development, child rights or rights-based development. They bring HIV/AIDS into their prior vision and mission. Action

Aid, Concern, CARE, Oxfam, Save the Children and World Vision typify NGO viewpoints as they grapple with what HIV and AIDS mean for their programming for both emergency relief and development. Major principles include:

- keeping a geographic focus on a specific *region*, and committing to staying there for the long term, responding to emergencies through local institutions;
- focusing always on the *poorest*, most vulnerable and insecure, rather than those considered likely to succeed in a specific project. These include orphans and vulnerable children (OVCs), the elderly and women;
- in an acute or chronic ‘emergency’, not forgetting about people and their *livelihoods* in the heat of large-scale, population-based, top-down commodity distribution; and thus
- trying to provide short-term ‘relief’ in a way that does not undermine *assets*, i.e. thinking carefully about the food aid distribution, rations and sources of other aid, for the local context, not just generically; and
- ‘*community-managed*’ or at least *community-based* targeting and distribution aiming to build capacity, local commitment, long-run development, preserve assets, etc.

While none of these principles directly responds to HIV/AIDS *per se*, they accommodate it at a household and community level. In effect, through their approaches, many NGOs ponder and address these questions:

- How does HIV/AIDS differ from other *acute shocks* such as natural disasters and economic change, that also affect efforts to provide relief and promote long-term development in Africa?
- How does HIV/AIDS differ from *chronic problems*, such as widespread poverty and endemic malaria, that also affect relief and development in Africa?

Answers reflect development strategies and values, but the general principles take different form because agencies’ missions, funding sources and other characteristics vary. For example, for World Vision, one emergent approach to addressing HIV/AIDS and crises is ‘relief *within* development’ (Lorey, 2003). In this approach, building capacity to respond to (and define) emergencies is integrated into community-development work within specific institutions and programmes. Elsewhere, ‘developmental relief’ is given a new lease of life in the context of HIV/AIDS through C-SAFE (the Consortium for Southern African Food Security, led by WV, CARE, and CRS in Zambia, Zimbabwe, Malawi) and the lead agency’s partners in each country (C-SAFE, 2003).

These community-based approaches have shortcomings as approaches to widespread acute emergency relief, and emergency and disaster relief agencies have a different stance on relief–development. Even so, all these agencies function at some point as implementing partners for large relief donors, such as USAID, who in turn are responding to NGOs’ innovations and experimentation by adjusting their policies, partnerships and financing mechanisms (see Box 2, below).

The classic large humanitarian donors are more constrained than NGOs in rethinking ‘relief–development’ because of their official mission, even while staff are trying to adapt to the new reality brought on by HIV/AIDS. Thus, they lack consistency, and informants’ comments tend towards the critical. WFP in particular has a mixed record: the agency is producing remarkable policy papers and technical standards which emphasise HIV/AIDS as an added vulnerability that can justify emergency relief intervention. Several NGO informants in this study, however, expressed strong displeasure at the perceived heavy-handed role of WFP in the field, especially in Malawi during the food crisis. Informants voiced concern that, while WFP attempts to be efficient and humanitarian in the short run (so the argument goes), this top-down intervention is bad for long-term development, so a fundamental conflict arises between the goal of achieving short-term technical efficiency in the mass provision of relief, and the long-term aims of sustainable human development. These concerns are exacerbated by constraints of resources and the complications raised by HIV and AIDS.

A technical expert with UN and USAID experience best expressed a shared opinion about the constraints of food relief:

The institutional architecture leads to a food-heavy response: if you have food, that is what you use. As much as food was needed by some or many, was it appropriate? How can we use it – if it is the commodity we have?

USAID Food for Peace (FFP) has borne the brunt of similar complaints, but as with other donor agencies, officials address humanitarian and developmental concerns within existing constraints, while new thinking is emerging (see Box 2). USAID’s OFDA officials were able to channel emergency funds in South Sudan for HIV/AIDS surveillance, communication and prevention (USAID/DCHA, 2003), while the USAID/FFP concept paper and other agency efforts emphasise multisectoral approaches to HIV/AIDS and holistic, livelihoods approaches to emergencies.

Box 2: USAID Food for Peace: linking HIV/AIDS, risk and food insecurity

The initial vision of the USAID office of Food for Peace (FFP), established by Public Law (PL) 480 in 1954, was ‘to create a world free of hunger and poverty, where people live in dignity, peace and security’. This vision remains, but the implementation has evolved within the broader USAID agency and national policy context. A hint as to how agency policy is evolving in response to the external social, environmental and political context is found in the *2004-2008 Concept Paper (USAID/FFP 2003)*. HIV/AIDS, not previously mainstreamed into FFP policy, is highlighted among other aspects of a challenging ‘operating environment’, such as corruption, conflict, IDPs and the US ‘war on terrorism’. In light of the many disasters of the 1990s, *risk* has been acknowledged as a key factor which can accentuate food *insecurity*, calling for more direct attention to underlying poverty and lack of entitlements, rather than simply aiming to enhance ‘food security’ through providing food aid.

The USAID ‘Food Aid and Food Security Policy’ of 1995 aimed to bring Title II programming more in line with the 1990 Farm Bill, leading to a refocus on the poorest countries and the underlying causes of food insecurity. A recent assessment of this policy (Bonnard et al., 2002) highlighted progress and shortcomings, and many of the recommendations emerge in the new strategy concept paper.

Recently, FFP was incorporated, along with the OFDA, into USAID’s Bureau for Democracy, Conflict and Humanitarian Action (DCHA), which provides institutional manoeuvring room for integrating relief and development within a broader framework. Specifically, the Bureau’s new organising principle of ‘fragile, failing and failed states’ surpasses the conventional division of emergency versus development.

By 2003, the FFP Strategy was undergoing review, and a new Concept Paper was circulated for comment. The final draft concept paper states that FFP should ‘focus its efforts on the reduction of food insecurity in vulnerable populations’. Also being discussed within USAID and conferences and workshops with partners is the need for *multisectoral* approaches to address HIV/AIDS (AED, 2002; USAID/DCHA/OFDA, 2002). Multisectoral programming to address HIV/AIDS is the emphasis of the agency’s new draft HIV/AIDS policy. This reflects increased recognition of HIV/AIDS as not just a health issue, but a development and emergency programming challenge. Expertise from many sectors is needed, and all sectors must apply an HIV lens to their programmes.

Conceptual debates about whether HIV/AIDS is an emergency, a crisis or an aggravating factor, and how these affect the ‘relief–development’ transition or continuum, are not just academic questions. They

raise policy and practical concerns about how to integrate the issues raised by HIV/AIDS into ongoing relief and development work in Africa in such a way that mass relief efforts function effectively and rapidly, while process-oriented long-term development is not undermined. Ideally both types of effort work to reduce the potential for future crises, while at the same time mitigating the increasingly severe impacts of HIV/AIDS on societies in Sub-Saharan Africa. This is a huge demand, but agencies seem to be rising to the challenge. Emblematic of the level of rethinking needed about both relief and development in the context of HIV/AIDS is a statement by a thoughtful NGO nutrition specialist:

We have not done enough soul-searching. Instead it was 'let's attach and an HIV/AIDS response' to the food aid. AIDS will be around for 10-15 years, food will be a major response, but there are other needs too. How can we manage it all more systematically?

Chapter 2

Integrating HIV/AIDS concerns into food security, development and relief programming

This section covers a range of new thinking about ‘mainstreaming HIV/AIDS’ into humanitarian agencies. ‘Mainstreaming’ is being discussed and implemented at levels ranging from internal policies to external partnerships, and across sectors from health programming to agriculture to education. This section also covers thinking about the integration – across a wide spectrum of relief programming – of new concerns for enhanced prevention of transmission, treatment and care for the afflicted; awareness and knowledge within the community; and impact mitigation at all levels. Ramifications range from including information, education and communication programmes (IEC) into food distribution, to integrating community-based early-warning systems within long-term community development efforts. Multisectoral and cross-cutting programmes are discussed as part of the solution to tackling HIV/AIDS as a multidimensional development issue facing all agencies and actors, not ‘just a health problem’ for health professionals.

Mainstreaming HIV/AIDS into agency programmes and policies

New policies dealing with HIV/AIDS within and between agencies and partners are being hammered out and revised. These deal with internal human resources, personnel and health insurance, as well as guiding field operations. They are a source of angst for some informants; many NGOs struggle with appropriate and enforceable internal policies and their practical implications, such as financing for health care and pensions. Ethical dilemmas arise by having insufficient resources and having to limit coverage for anti-retroviral (ARV) therapy to immediate staff only, and not their families. Policies for handling HIV/AIDS within emergencies range from minimalist to comprehensive, reflecting the different types of emergency situations that agencies face, and the specificity of policies or guidelines. Among NGOs, some well-developed workplace policies exist and are under discussion by agencies including Oxfam, Concern Worldwide and others. Action Aid has a comprehensive strategic approach which spans agency workplace issues such as staff training and awareness to programmatic priorities such as advocacy and lobbying. In contrast, one major international disaster relief agency (the USAID/OFDA) lacks an official HIV/AIDS policy: the term HIV/AIDS hardly emerged in the OFDA 2001–2003 Strategic Plan for East Africa, for example. InterAction, the US-based network of relief and development NGOs, has an HIV/AIDS taskforce; while not specific to Sub-Saharan Africa, it aims to facilitate discussion and learning by agencies on these topics and concerns.

More typically, the European Commission Humanitarian Aid Office (ECHO) is working on minimum guidelines for its implementing partners that effectively mainstream standard priority actions in field programmes, focusing on preventing transmission. The policy identifies four levels of activity: first are 'compulsory' actions, including universal precautions, protecting the blood supply, and preventing transmission. Second are actions to undertake 'where possible', such as targeting of orphans and vulnerable children (OVCs) and PLHA. Third are actions that are 'desirable', such as preventing the exploitation of vulnerable people during relief operations. Finally, there are actions considered 'not feasible' and not expected in an acute emergency response, such as provision of ARV therapy. This policy minimises attention to voluntary counselling and therapy (VCT) or ARV treatment, recognising that providing these health services requires skills and resources that are not consistent with the acute emergency settings in which the agency operates.

The Interagency Standing Committee for HIV/AIDS (IASC) distributed its revised guidelines at the ICASA Conference in Nairobi in September 2003. These outline a wide range of potential interventions to address HIV/AIDS within emergency settings. This framework (and the effort it implies) generated criticism from some quarters: as one HIV/AIDS specialist remarks: 'We don't need any more guidelines! We already know what to do; we just need to go do it!'. Other informants found the IASC guidelines useful if insufficient. In fact, they do at least provide a common broad framework for action among emergency personnel, allowing for common terminology and thus better planning and training.

A common response was to criticise narrow sectoral approaches, or 'stove-piping' in USAID terminology, and to argue for multisectorality and more integrated programmes within and among agencies, and with their partners. For example, one US NGO that collaborates with USAID

is looking at an integrated holistic development framework on how to address AIDS in all of our programs. That is in line with Food for Peace's outlook in terms of trying not to categorize emergencies and development into separate boxes. There is so much grey and there is so much overlap. It is not a linear progression, obviously. I see the agency looking into transitional activities with food aid and in general addressing HIV/AIDS, because it is a cross cutting issue across sectors. I'm not saying we have a lot of answers, but it's at the forefront of our thinking right now.

Senior USAID officials in a wide range of sectors – health, agriculture, relief and sustainable development – asked for more dialogue between different divisions. One health officer emphasised the need for more

dynamic mission leaders in the field, who can implement the multisectoral programmes that are discussed at headquarters. The HIV/AIDS policy under development emphasises multisectoral programming, and will also encourage non-HIV-specific programmes to be more responsive to, and aware of, HIV/AIDS concerns. Many workshops and new proposals emphasise multisectoral thinking.

One obvious outcome of this new mainstreaming is the need for training, hiring and capacity-building. As mentioned by informants, these range from prevention awareness for drivers and fieldworkers up to awareness-creation and stigma-reduction among national government policy-makers. Skills training is needed on specific topics such as food rations for PLHA. General HIV/AIDS sensitisation is needed for new staff to work during acute emergencies in Southern Africa (or in high HIV-prevalence settings). Emergency response specialists might need greater knowledge of the developmental and livelihood impacts of HIV/AIDS to appreciate new facets of emergency programmes (such as new rations and distribution centre considerations). Meanwhile, health and development programme staff need greater awareness of the emergency programming concerns that relate to HIV and AIDS. At another level, a senior USAID officer argued for more training of African government officials in multisectoral thinking to help coordinate programmes better, to develop solutions across and not just within ministries and disciplines, and to accommodate donor demands for multisectoral programmes and the use of an ‘HIV lens’ in all sectors.

Some informants raised practical concerns about the implications of mainstreaming and integration: How responsive will staff be to new demands? Is this an acceptable burden – in terms of time and staff and agency resources? For one USAID official, the issue of mainstreaming HIV and AIDS is reminiscent of debates around the training of ‘women in development’ in the 1980s. The demand then for new awareness programmes around women’s roles/gender met with resistance among donors and NGOs alike. Based on that experience, resistance can be expected now among staff in specialised areas, who see the new training in HIV/AIDS and new accountability standards not simply as an additional burden – which it admittedly is – but also as an important issue in its own right, one best left to specialists with more experience and skills.

Institutional partnerships

We are not experts in HIV/AIDS and we won't be, but we must look at our programs and collaborate with HIV support programs – create complimentary partnerships.

New interagency partnerships are emerging among humanitarian and development actors. These partnerships, as the above quote by a Kenya-based international NGO programme officer suggests, are proof that many humanitarian agencies lack the technical skills and knowledge they feel they need to properly address the interactions of HIV/AIDS and food insecurity. HIV/AIDS introduces a huge range of new issues. These relate to the risk of transmission of the virus, home-based and clinical care, nutritional interactions, ARV and other medical treatments, impact mitigation and development, stigma and psychosocial issues, national advocacy, access to drugs and legislation to ensure women's rights to land. Clearly, integrating HIV/AIDS into humanitarian relief and development work requires specialised knowledge, which in turn demands collaborative work. Since it was not an aim of this study, this report cannot provide a systematic review of such collaboration, but this section classifies the types of partnerships mentioned during discussions or visible in the agency literature. In 2002/3, for example, partnerships existed among community groups, NGOs, donors and UN agencies to:

- target and deliver food aid more effectively and in a way conducive to long-term capacity-building and addressing issues of HIV/AIDS. Existing home-based care programmes are used by World Vision to carry out food distributions. The use of food aid to better meet the needs of PLHA and HIV/AIDS awareness in refugee settings and other emergencies is being jointly researched in the field, endorsed by an interagency partnership (UNICEF, UNHCR and WFP: personal communication with Ellen Mathys);
- address the increasingly complex, multiple needs of HIV/AIDS-affected people in an emergency. Numerous examples exist of efforts to increase nutrition and care for PLHA using emergency food aid, to accommodate reduced labour availability, to care for dependants and to address the specific concerns of children and orphans (OVCs);
- better address the long-term and multidimensional nature of the crisis and underlying vulnerability. Research into farming systems and rural livelihoods in the age of HIV/AIDS is supported by the IFPRI/ISNAR Renewal initiative (RENEWAL, 2001). C-SAFE was formed specifically to tackle long-term, chronic food insecurity in the context of HIV/AIDS in Malawi, Zambia and Zimbabwe. Three lead agencies (WV, CRS and CARE), with funding from a major donor (USAID/DCHA/FFP), partner many local agencies in each country (C-SAFE, 2003a, b, c);
- tackle stigma, discrimination and silence: for example, SC-UK works with a women's legal rights organisation to assist Basotho women to retain access to land/livelihood; advocacy campaigns by MSF and Action Aid increase access to ARVs for the poor. In Kenya, ActionAid allied with First Lady Kibaki to raise public awareness of HIV/AIDS, and try to overcome massive, institutionalised denial;

- improve accountability and prevent abuse or misuse of resources, aid and power. Examples include SC-UK's 'community complaint centres' in partnership with local beneficiary communities in Zimbabwe; WFP's avoiding working with or through local governments by partnering with international aid agencies in Malawi (the JEFAP consortia) and in Zimbabwe to bypass government authorities;
- train people and aid institutions about these new demands and concerns. Examples include training of trainers to reach field staff and prevent transmission (SC-UK in Southern Africa). Also, many programmes involve training for beneficiary populations in an attempt to avoid worsening the spread of the epidemic, and related stigma and denial, and the larger social and economic impacts (awareness and sensitisation campaigns attached to relief distribution); and
- finance activities in novel ways: OFDA used 'emergency' funds to finance HIV/AIDS surveillance, VCT and outreach in South Sudan (USAID/DCHA/OFDA 2003); the monetisation of FFP food resources supports long-term HIV/AIDS programming, agricultural development, water and sanitation work with partner NGOs.

Some useful partnerships can be envisioned, but have not yet materialised properly, while others need improving. In Southern Africa, inter-governmental partnerships played a larger role than in other regions of the continent in addressing the food crisis. Specific partnerships emerged (RIACSO) while advocacy, research and discussion were facilitated by pre-existing arenas, networks and institutions (namely SADC, but also SARPN and SAHIMS). An important question was raised by a US official:

Are these alliances possibly aiding the large international UN and non-governmental response to effectively displace national government accountability to respond to the food crisis and to HIV/AIDS broadly as a long-term crisis?

One UN official asked, in response to the need for a broader response to food insecurity and vulnerability in the context of HIV and AIDS: 'Where is UNAIDS? ... we need them to come to the emergency side'. ECHO is trying to improve coordination through its 'Partnership Agreements', and is developing an HIV/AIDS policy that would set clear priorities for partner agencies during emergencies.

A clearer division of responsibility and coordination of tasks among partners is needed, especially in the context of a large relief operation that can affect long-term development programmes. One NGO relief official observed:

The way that WFP divides up the country, geographically, with each area being served by one NGO results in specific areas getting a limited number of services from one agency ... multiple agencies can work in the same geographic areas, each providing specific services ... based upon the agency's capacity and expertise ... the population receives a comprehensive package of services ... [but] ... this requires more coordination than seen at present.

Funding mechanisms need careful thought. The conventional wisdom is summarised by a UN relief official, who states that 'donors tend to be simple-minded ... either they will support emergency relief, or development'. This has been true in the past of food aid agencies (WFP, USAID-FFP) and non-food agencies (OFDA, ECHO). While it might well be changing now, donors apparently have a long way to go to overcome the institutional and internal barriers to responses to the pandemic and its wide-ranging impacts in Sub-Saharan Africa.

Referring to the emergency versus development programming distinction, one NGO respondent complained 'USAID expects people to graduate out of these [food security] programs, but it's not realistic. There is no exit strategy for long-term safety nets'. Furthermore, while multisectoral approaches are often mentioned, not only are emergency and developmental aid still distinguished, but attention to HIV/AIDS often just means adding on information campaigns to food distribution, or separate HIV/AIDS programming. An NGO programme officer active in field service during the 2002/3 Southern African Food Crisis notes:

'AIDS-programming' doesn't mean anything! You can't just program for AIDS. For example, if you are not educating your girls, the AIDS rates won't go down.

It is difficult to get around congressional restrictions on donor funding separating out family planning, HIV/AIDS, child health, maternal health, agriculture and education, into distinct programming areas. During an emergency, the temptation to cut corners can lead to awkwardness among partner agencies. Reflecting on disappointing experiences during the Southern African response, one US NGO relief expert suggests:

[Why not have] multiple agencies in the same geographic areas, each providing specific service, divided by service, not by agency, based upon the agency's capacity and expertise. In this way, the population receives a comprehensive package of services ...

This requires more coordination between agencies than one sees at present. This is very tough, especially in a resource-constrained environment.

WFP received considerable criticism. A major complaint centred on the fundamental fact that the resource it offers is food, and food is not enough, especially with HIV and AIDS. Furthermore, observed an informant about the Malawi response, 'They do not respond quickly to emergencies. It's like turning a 28-ton battleship'. Many informants mentioned the need to work on ways to use food aid to mitigate HIV/AIDS, asking: 'If food is the resource available, then what can be done with it?'. Generally, their work reflects widespread recognition of research by FANTA and other researchers. Others argue that, for many reasons, especially with HIV and AIDS, cash is better and would be more flexible and appropriate. Monetisation of commodities alone is not the answer to dependency, and has the potential to upset local markets. These criticisms tap into long-standing practical complaints and ideological divides about the role of Western food aid in development and relief.

Finally, one partner that was rarely mentioned is the national government. Within Sub-Saharan Africa, obviously, they vary widely in their perception and public response to the HIV/AIDS epidemic(s) and in their capacity and preparedness to respond to food emergencies. Despite labelling HIV/AIDS as a national emergency, across the board national government response is hindered by institutionalised stigma and discrimination around HIV/AIDS. In Kenya, for example, HIV/AIDS was declared a national emergency in 1999. An official of Kenya's national food security programme – well-regarded for its effective and rapid response to the 1999–2000 drought in East Africa – emphasised how 'open' Kenyan officials and society are to HIV/AIDS, 'in contrast to' Southern Africa. In fact, according to an NGO participant on the national food security planning board, HIV/AIDS is not yet talked about in the Kenya national food security committee. Thus, while official rhetoric often reflects both the popular image of HIV/AIDS as a cause of food insecurity, and an eagerness to appear forward thinking, at the same time the official reality is one of stigma and denial. This hinders governmental responses to HIV and AIDS at all levels.

Sectoral issues

This section summarises findings that emerged on topics relating to specific sectors of action, including preventing transmission of HIV, broader health and nutrition programming, and agricultural relief and recovery.

Prevention of transmission

Prevention of transmission of HIV has been a longstanding concern for actors in complex emergencies and food distributions which involve mobilising staff – often new to the region – rapidly across a large area (Smith, 2002). This concern with reducing the risk of transmission, while important, is not a major focus of this study, which focuses on US and East Africa agency policy directions in light of the larger generalised impacts of AIDS. Two new themes, however, were brought up by informants in their thinking about how to integrate HIV/AIDS throughout emergency relief. The first is the uncertainty about the value of adding information, education and communication programs (IEC) and other prevention and awareness programmes into emergency relief, especially food distribution. The second concerns the lessons learned from Southern Africa about transmission reduction and programme integration within a ‘normal’ food emergency. This may be relevant to more common complex emergencies found elsewhere in Africa.

A fairly common response about how HIV/AIDS issues would be handled is to simply build in ‘IEC’ into relief distribution. In part, this is in recognition of the clear additional risk of HIV transmission that programmes bring to targeted communities, which is ideally handled through a range of programmes and policies. For example, a Kenya-based NGO program officer noted:

We found that the prevalence of HIV was highest in urban areas ... it seems linked to where there are major aid programs. Aid programs bring increased police presence, more prostitutes, more truck drivers and refugees. We are now examining this link between higher rates and presence of aid programs ... We are also looking at ways that we may be contributing to transmission. We now have a strict code of conduct for all our employees to help reduce HIV transmission because of our presence. This applies to all of our truck drivers, local staff, etc. For instance: no sleeping with beneficiary populations. This is all with the aim to stop transmission associated with aid programs coming into the community.

To some, however, HIV/AIDS translates not into agency policies, training and programming, but into a simpler model, analogous to the ‘add women and stir’ approaches to the early mainstreaming of women’s issues in development. Thus, addressing the implications of HIV/AIDS for food distribution or refugee camp relief programming takes a parallel form: ‘add IEC and stir’. Others challenge this approach, asking whether it is always a good idea to try to add on some awareness-creation or information campaigns if programmes do not accommodate specific population needs, agency resources

and long-term implications. Bad or ill-designed campaigns might be worse than none, and IEC needs to be tailored to the audience. Add-on IEC programmes might distract from the main goal of saving lives and alleviating suffering.

Accepting that it is basically desirable to integrate IEC programming and/or broader prevention programmes into a relief effort, many practical issues arise around logistics and resources. Ongoing field-based research supported by UNHCR, UNICEF and WFP to develop guidelines for the use of food aid to mitigate HIV/AIDS in refugee settings identifies specific details of distribution sites, such as noise levels and crowding, that should be considered and addressed in designing complementary awareness, prevention or educational programs (pers. comm. E. Mathys). Furthermore, in providing condoms along with food in mass distribution, one must know a great deal about demand, supply, maintenance and stocking (IASC, 2003). Ill-equipped and over-burdened emergency response personnel might underestimate what is involved and make mistakes; ideally, specific skilled new staff are hired, adding to the cost and complexity of field operations.

In Eastern Africa, many emergency relief agencies deal with conflict and refugee settings as a matter of course, so the increased risk of transmission is often uppermost in their minds when the subject of HIV is raised. The generalised livelihood impacts of AIDS on food security, and how this affects mass distribution programmes, have not yet emerged as a major concern. Broader perspectives on HIV/AIDS and impacts on food production and livelihoods are beginning to be discussed throughout East Africa and pilot programmes are being tested. Furthermore, looking at the continent as a whole, the majority of countries are in conflict, which is not the case in much of Southern Africa. One informant thus challenged this assumption, asking in essence: is it realistic to try to single out 'normal' crises and the additional implications of HIV/AIDS in non-conflict settings? What can we take away from the Southern African experiences that can be realistically applied elsewhere where civil war, unrest, genocide and other politically complex emergencies are the norm? The challenge pertains to all attempts to generalise lessons from one specific setting to another. Lessons can also be learned from the experiences of NGOs dealing with the aftermath of genocide in Rwanda and its legacy of orphans and other vulnerable populations; some agency approaches and programmes can probably be applied to HIV/AIDS orphans and AIDS-affected children. For example, lessons on how to reduce the risk of transmission of STDs in chaotic refugee camp settings can perhaps be applied to an ongoing food emergency faced by a generalised rural population.

Health and nutrition

The purpose of US- and Kenya-based interviews was to provide a sense of policy and institutional trends emerging from experiences in dealing with HIV/AIDS during the Southern African food crisis as well as other emergencies; the broader topic of health, by intent, was raised and touched on only peripherally. In part, this is due to the broad aims of this study, but also because emergency relief agencies obviously have much less experience in dealing with HIV/AIDS as a multisectoral health and development issue. This section also does not address the long-standing HIV/AIDS programmes of many agencies. Even so, a few discussion points and areas for further research emerged.

ARVs were recognised by a few informants as a possible complement to other aid during a non-acute emergency setting. MSF began ARV treatment to urban slum dwellers in Nairobi in 2003. Action Aid campaigns alongside MSF to increase access to ARVs as a human right. For most emergency actors, however, this was considered a remote ideal to be handled by others at some time in the future. ECHO, for example, explicitly relegates ARV treatment to a lower priority in its HIV/AIDS policy, recognising that adequate attention to provision of ARV treatment is not possible in an acute emergency setting. In terms of the difficulties ARVs pose to emergency programmes, one HIV/AIDS officer in a regional office commented: ‘ARVs are a moral imperative, but not suitable for emergency clinics. Nobody is giving “food and drugs”’.

Within USAID, it is recognised that ARVs will be extending lives, but without the support structure they need. An experienced USAID health officer noted:

Another problem is tremendous down the road ... people will be living longer, 8–10 years. How will they be provided for? There is no game plan for the many employed who face discrimination. What about the many unemployed, and the youth ... What livelihoods are there for people who survive?

The landscape of ARV availability and treatment is changing rapidly, however, with new programmes being designed, including the World Health Organization ‘3 x 5’ (i.e., 3 million on ARV by 2005), the US President’s Fund, and the South African government plan. Many issues arise in integrating ARV treatment into humanitarian action: these span the need for staple foods to more enhanced nutrition to provision of non-food items, such as clean and accessible water, shelter that supports caring for ill and psychosocial support. This does not include the complex logistical demands arising from providing ARV treatment on a large scale: specific drug supply lines and monitoring, for example. These also must be

addressed, and bring additional challenges for acute emergencies, recovery and long-term development. In the near future, refugees, supplemental feeding programme participants and food aid beneficiaries will include a growing number who have been on ARV treatment and who ought to continue, for reasons of their own health as well as to minimise drug resistance.

Revised and enhanced technical specifications for rations for PLHA (i.e. from WFP, USAID/FANTA, such as Piwoz and Preble, 2000) are evidently widely known among emergency response and food security offices. Unfortunately, practice in the field remains far from the theory and ideal. Informants with field experience remarked on how difficult it is to procure and provide enhanced rations because of logistics and the simple lack of resources. Stigma is also a barrier to directly targeting PLHA with specific rations when they are not reached through a community-care or clinic programme, so targeting to improve health care for PLHA in practice is difficult. Lacking seroprevalence data and in the context of stigma, reaching PLHA with the adequate enhanced nutrition they need can only happen through pre-existing home-care or other programmes. It is probably not feasible to reach PLHA with enhanced rations through mass general distribution programmes, since food supplies are insufficient to reach everyone with the increased rations.

Surprisingly little was said about the need for broader ‘health’ care or health system support in interviews with emergency response personnel, although the topic arises in literature and agency documents. No unsolicited mention was made of primary health care needs during emergencies and how they relate to HIV/AIDS; from a review of agency literature (such as IASC, 2003) these might include clean and accessible water, sanitation and housing (or camp layout) designed to prevent transmission and protect health. On probing, several informants acknowledged the value of these non-food interventions. This is an area that will need further, focused attention and discussion, especially in the light of new programmes for ARV treatment.

Agriculture

Informants generally were aware and concerned about the predicted labour shortages and other direct and indirect impacts of AIDS on rural farming systems and livelihood assets. The need to adapt rehabilitation and developmental programming to fit the needs of workers is apparent. Concrete experiences in adapting agricultural interventions for relief and development in the context of HIV/AIDS are emerging. Comments here are related to relief and recovery (rethinking ‘seeds and tools’) and long-term development (in training and agricultural extension), and increasingly encompass not just farming communities but also pastoral, fishing and urban settings. ‘We will need to adapt “seeds and tools”

assistance to provide more labor-saving crops and tools' remarks one disaster response official. 'Seeds might not be what affected people want [so we are] experimenting with cassava plantings' noted an agricultural officer working with a disaster relief agency.

A health officer noted more broadly a need to:

Look at the perspective of development: We need small kitchen gardens, drip irrigation, etc. That was what was needed – agricultural development, both short term and long-term. We need to look at those together. We know so much, we should not just 'dole out food'. In fact most want cash!

A 2003 study of poverty and environment in Kenya reached high HIV-prevalence fishing communities in Lake Victoria region, where it found child fishermen (often orphans) using the wrong size nets and fishing improperly, as a result of the inadequate transmission of knowledge of fishing (ELCI, 2003). In new proposals for developmental relief in Zambia, Zimbabwe and Malawi, conservation farming techniques will be needed to address labour shortages (C-SAFE 2003a, b, c). Even though 'conservation farming requires more labor to start, it is less labor-intensive later ... people are interested'. A school-based programme in Lesotho (reported by SC-UK) invites adults to grow staples and other foods for children, combining new systems of food production with adult mentoring to share and transmit knowledge.

In reference to pastoral communities, another neglected population for HIV/AIDS research, an NGO program coordinator in East Africa commented:

We continue to be looking at these pastoralist communities wondering how we can stop the food insecurity to prevent migration to urban areas to avoid families selling their livestock and losing their livelihoods ... but now we're looking at it in terms of preventing HIV as well.

These comments, study findings and proposals reflect a growing body of evidence from grass-roots and NGO-based research on farming systems, agricultural technology and other adaptations in the context of HIV/AIDS. These are reflected in the writings and reports of FAO- and NGO-sponsored studies, such as SafAids, 1999, and more recently Bishop-Sambook 2003, Gari 2002, Gari 2003 and WARDA 2001.

Chapter 3

Issues in the targeting and delivery of aid

This section summarises comments, queries and concerns surrounding the targeting of aid in the context of HIV and AIDS. This topic generates the most concern and uncertainty; in the words of one high-level relief official: ‘we are not reaching people ... not even the tip of the iceberg. Stigma and suffering are widespread. We are targeting too many people, while AIDS is swept under the carpet’. Comments here are organised around three sub-sections: assessments and information systems; types of aid; and stigma.

Early warning and assessments

Given the wide-ranging impacts of HIV/AIDS on societies over the long term, the possible ramifications for improving information systems to use in early warning, planning and assessment of relief efforts are large. Information systems encompass the quantitative and qualitative data gathered and analysed for the purposes of early warning, needs assessments, baseline studies, follow-up monitoring and impact evaluation. Even without considering HIV/AIDS, much needs to be done to improve humanitarian information systems (Maxwell and Watkins, 2002). In the context of HIV/AIDS, more research and planning is needed to enhance systems (with new criteria and multiple indicators to triangulate) as well as to simplify procedures (to contain the costs of data collection, analysis and interpretation). Questions arising from discussions with informants, and worth examining in further discussion and research, include:

- Which indicators are useful, and for what aims?
- What level of analysis is best, and for what purposes?
- How well do existing HIV/AIDS data mesh with (or not) the needs of other systems for famine early warning, assessment and monitoring of vulnerability?

These sorts of questions are the focus of some articles (i.e. de Waal, 2003) and are reflected in many informants’ comments. This section merely summarises lessons or ideas mentioned by informants and which arise from related agency literature.

Informants consistently mentioned a few proxy measures of households affected by HIV/AIDS. These include having a ‘chronically ill’ person in the household; the presence of orphans; a child- or elderly-headed household; or experiencing a recent adult death. These indicators have become standard

approximations of HIV/AIDS ‘affectedness’. Such proxy indicators seem to be generally accepted as necessary owing to the stigma of HIV/AIDS and the undesirability of asking more direct questions. (Issues in using indicators for targeting are addressed below.)

Given the lack of biomarker data to capture actual seroprevalence for a population, estimates based on ante-natal clinic data are used as a backdrop to identify geographic regions of high HIV infection. But this level of integration of HIV/AIDS data can lead to other problems, as noted by a nutrition expert:

We faced an operational dilemma ... mass distribution of food based on antenatal data on women ... but the sick people could not get to the queues.

All measures proposed, however, have problems in capturing vulnerability and targeting at the household level. As one nutritionist observed:

The expectation is that the population would self-report that food is an issue that we can overlay HIV prevalence – but we don’t know seroprevalence! Which proxies to use? Chronic illness? PLWA groups? Are all people within a region equally vulnerable? Are the food rations even appropriate?

Furthermore, the household unit often used is at best a convenience, and can miss the vulnerable people. All proxies capture the effects not of HIV/AIDS alone but other diseases, so are inadequate for capturing HIV/AIDS *per se*. Upon reflection on experiences in Southern Africa, some NGO fieldworkers and program managers conclude that several indicators should be used in targeting, to triangulate (World Vision, 2003). Others question whether it is useful and worth the trouble to address HIV/AIDS through proxies. If the goal is to identify and reach ‘vulnerable’ and food-insecure individuals, then wealth and livelihood measures at the household level may well be sufficient, if not perfect. However, if the goal is to understand how HIV and AIDS are affecting livelihoods and food security, information which would be useful for guiding broad health and development policies, then the proxies are not adequate anyway, so other information is needed.

In terms of the best unit of analysis, several concerns were noted by informants, including convenience of existing data sources, cost of new data collection and validity of measures. The problem of ecological fallacy arises when using different levels of data. The general problem is that HIV prevalence data are gathered in the aggregate for a region, whereas (in)security is best measured at the household or, better,

the individual level. In Kenya, WFP targeted an area of high HIV prevalence (>20%) for special food aid considering this to indicate a vulnerable population justifying the intervention, but baseline data using the proxy measures did not yet show a strong correlation between measures of ‘HIV affectedness’ and food insecurity.

The standard early warning (EWS) systems at the national level do not incorporate HIV/AIDS yet, although FEWSNET, a USAID-funded global program to support national systems of early warning, would like to encourage more discussion on HIV and AIDS as it affects early warning. Livelihood-based models (FEG, HEA) that look specifically at households and communities can better capture HIV/AIDS-induced vulnerabilities at the level of individuals, households and communities where HIV and AIDS have the largest impacts. The areas selected for such studies, however, are not usually representative of the larger setting.

Furthermore, informants point out that the interpretation of indicators is evidently not consistent across different famines and emergency settings. One food security officer with a range of African experience contrasts the ‘food crisis’ situation in Malawi, characterised by global acute malnutrition rates of 6% at the start of food distribution, as compared with the commonly seen rate of 12% in camp-based feeding centres that are being closed down in East Africa. This apparent inequity in interpretation of the same statistics feeds a perception that the Southern African crisis was not one of food shortage or even food access, at least not based on standard indicators. To the extent that a food crisis was exacerbated by HIV and AIDS, other indicators and additional research are needed to back the anecdotal evidence.

During evaluation stages, new indicators and threshold points will probably be needed, especially given broader uses of food aid for PLHA and for long-term development. A CRS expert noted:

We don't know what percentage of kids in supplementary feeding programs is HIV positive. In therapeutic feeding programs, are we running hospices? That may not be a bad thing, but we may need to adjust our thresholds for interpreting success because of high seroprevalence – you may have a high death rate even when it's a good program.

Government agencies were involved in the response principally through national early-warning and assessment committees. There is room for partnership for training, sensitisation and better integration of HIV/AIDS-related indicators into food security and other disaster warning systems. Despite much rhetoric

about the need to include indicators of HIV/AIDS in early warning and assessments, few real changes in government programming are evident. This may be due to high-level denial due to stigma, lack of clear direction from the national leadership, or institutional inertia.

Other data and research needs arise from agency literature:

- *Urban and peri-urban assessments:* HIV/AIDS is rapidly spreading to the general urban and peri-urban population, such that new forms of relief and new ways of thinking about relief-to-development are needed for the general urban and peri-urban poor (as opposed to 'at risk' urban populations like sex workers and truck drivers). Increased vulnerability and negative impacts on livelihoods will be seen in urban areas as in poor rural settings. Urban vulnerable people also need to be identified, their needs assessed and any aid monitored and evaluated. New indicators, and perhaps survey and sampling methods, will be needed to identify those in need of aid and to monitor progress.
- *Age structure:* With HIV and AIDS, the age structure of the vulnerable population is changing faster than the age structure of the national population; indicators, programming, monitoring and integration with long-term relief should take into account the particular needs, aspirations and capabilities of elderly and young people.

Several broad conclusions arise from this background study, even recognising that this was not intended to be a systematic survey of early-warning systems or monitoring and evaluation systems. Several proxy indicators are almost taken for granted by many, such as the presence of 'chronically ill' people in the household. One indicator is probably not enough, so indicators should be chosen carefully, and used in multiple ways so as to be redundant and triangulate information. They should be sex- and age-disaggregated. Sampling, especially for rapid surveys, should avoid and acknowledge potential bias due to issues such as 'missing' households. Biases exist in both directions: sampling approaches can lead to both under- and over-stating relationships between HIV/AIDS and household food insecurity and other livelihood outcomes. Many of these issues and others relating to scales and a mismatch of data units are beginning to be addressed (de Waal, 2003, Mdladla, 2003 and other RIACSO Vulnerability workshop papers).

In sum, no standard exists for integrating HIV/AIDS vulnerabilities into any stage of information systems for humanitarian action, but progress is being made. It is likely that no single, ideal monitoring and evaluation (M/E) system will arise, but only many different ones that are hopefully adequate to different

needs. These range from accountability in short-term relief distribution to PLHA for a few commodities, to comprehensive assessment of long-term, multisectoral programmes which deal with HIV prevention and AIDS mitigation. These would pay less or more attention to specific associations with HIV/ AIDS, and use indicators and data sources as appropriate to the task and setting. Indicators are also important during targeting, discussed in the next section.

Targeting of aid

The main issues that arose in discussions concern the indicators used in targeting and the need for community-level mechanisms in the context of HIV and AIDS to avoid stigma and to reach those considered vulnerable by local definition. Community-based targeting and delivery of aid is also seen to be more consistent with long-term development goals.

Many respondents viewed targeting relief aid in the context of HIV/AIDS as a major problem. One USAID officer observed:

Targeting refers to reaching vulnerable households, and the difficulty because of stigma. We need to broaden it to households with someone 'ill'.

For the recent Southern African Food Crisis, reports an NGO officer, the 'WFP issued criteria that included chronic illness as a selection criterion ... our agency works with community groups to identify those households affected by HIV/AIDS'. At the same time, however, noted a relief official with a US NGO involved in the Southern African food crisis, targeting is not working:

The biggest issue that arose was in terms of targeting ... headquarters had lobbied that the rationale for large-scale food distribution was the presence of a large, highly vulnerable HIV/AIDS affected population. However, no one knew in practical terms how to specifically target food to those individuals or households. So the agency targeted at a community-level, which really meant they weren't targeting PLHA.

In general, there is a consensus that 'the HIV/AIDS epidemic definitely complicates targeting':

Our home-based care (HBC) programs weren't in the geographic areas where we distributed relief food. The epidemic gave us and our partners an excuse to advocate

strongly for food distribution in specific geographic areas, without investing in the actual identification of vulnerable (HIV-affected) households.

And:

within the C-SAFE program, HIV/AIDS was integrated into all activities. We developed indicators for each activity ... during the emergency response, we target the malnourished kids, pregnant and lactating women, and now HIV/AIDS-affected households (the latter being the recent change in programming).

For many, the solution to the problems of adequate indicators, lack of data, stigma and the relief-development transition lies with community-level mechanisms for the targeting and distribution of aid. These would be located within specified geographic areas determined as 'vulnerable' or food insecure by other indicators, such as declining food production, rising prices, drought and, in some cases, HIV prevalence. This approach builds on community-based institutions which already exist, but which are threatened by HIV/AIDS as it erodes the social capital which sustains these informal safety nets. This approach might involve NGO-managed programmes for building capacity among local community agencies. Community warning systems, as mentioned by World Vision, can even help to alert agencies to upcoming crisis, rather than waiting for national systems to kick in.

NGO field officers working in the same region reported that local communities know who is affected, who has PLHA, and that they include them in registration lists. This means that HIV prevalence and affectedness are being taken into account in local distributions to some degree, although we do not know who is being left out. We know only that at least some PLHA and more broadly HIV-affected households are included.

However, donor informants raised concerns about delegating to the community, rather than through more impartial implementing agencies, as they view the NGO implementing partners. Community-level mechanisms encompass many institutions and process which do not always favour the most vulnerable, nor do they always promote human development. Committees can exclude needy people for political, ethnic, personal (or simple technical) reasons. Indeed, according to several informants, exclusion from relief lists through stigma and discrimination does occur.

One CARE official noted some concerns with indicators and the increasing reliance on community-based systems to identify aid recipients:

I think that an interesting facet of this is that, given that NGOs have often been criticized for not engaging community groups in planning emergency interventions, you must work closely with community groups to identify PLHA. This strategy [of working through community groups to identify PLHA] was chosen because it is a generally accepted strategy, but I do not know how effectively it works.

Furthermore:

HIV/AIDS does have an effect on all food and non-food activities. It highlights the issue of gender, as women are more affected (as survivors and as the afflicted). It has also influenced the non-food activities such that HIV/AIDS-affected households are specific targets of the programs. HIV/AIDS is woven throughout all programming now. There is also more emphasis on community-based surveillance because of the involvement of community groups.

Process matters too, and some distinguish between community-managed and community-based targeting and distribution (Jaspars and Shoham, 2000; Mathys, 2003). The former is fully in the hands of the community (not just a nominal community committee), which fully manages the relief effort; they determine needs, set criteria for vulnerability, assess needs, distribute aid and account for it. It is thus a process of capacity-building and development which also serves to distribute relief aid. In contrast, community-based distribution can be counter-productive in terms of developmental goals. It can, for example, entail handing over distribution tasks to a local food relief committee which follows orders from the implementing agency. A few NGO informants mentioned *community-based* when they probably meant *community-managed* efforts. More clarity is desirable in discussions of community-level mechanisms for relief work. There are advantages and disadvantages to each in terms of efficiency and speed of response, and the role in long-term development.

Generally, however, some type of community-level targeting and distribution is a common direction noted by many, with clear benefits as well as additional challenges for both relief efforts and long-term development. A CRS nutritionist noted:

the good thing is that we are targeting communities as a whole (moving away from targeting households), making sure that kids are going to school, developing mechanisms to pass on agricultural knowledge, working with mothers on psychosocial issues (writing books and memories to pass on to their kids), and there are a lot of different areas and new activities that we can do.

Finally, new demands arise stimulated by expanding the use of food aid to specifically mitigate HIV and AIDS (rather than simply reducing the potential risk of transmission during distribution). For example, one NGO respondent mentioned that:

families that are caring for orphans should be targeted. Also we should target adults who are HIV positive and still healthy with food aid, since the increasing evidence that proper nutrition can slow down the progression to full-blown AIDS, it's important to help them stay healthy as long as possible.

An internal evaluation of its Southern African response by World Vision identified a targeting concern due to the dynamic and long-term 'crisis': a household not initially registered as vulnerable can become so during the course of the crisis and distribution as AIDS runs its course. Meanwhile, the change in vulnerability status over time is not necessarily accounted for in registration lists (World Vision, 2003). This means that targeting strategies might have to be continually updated in the field, especially over a longer-term crisis.

Types of aid

The main issues arising in the interviews addressed the appropriateness of food aid itself as a commodity, and as food. Many viewed food aid as not appropriate, regardless of HIV/AIDS, and more problematic with it. Despite predictions that it would be irrelevant given labour shortages, in fact food for work (FFW) is still common in programmes throughout East and Southern Africa. Agencies are adapting criteria to meet the new labour and other constraints and needs of communities. Recommendations for increased food rations (including additional protein and micronutrients to meet the needs of the immuno-compromised) are fine in theory, but are rarely implemented in practice. Non-food aid is needed.

Food aid

Some see food aid as generally a bad idea: this notion predates HIV/AIDS, of course. Others are more balanced about the role of food commodities; food is fine, but not necessarily sufficient, nor what is needed over the long term. Some view food aid programmes as ‘dumping’ surplus Western commodities into local economies, thereby disrupting local markets, farming systems and livelihoods. This debate does not arise with HIV/AIDS, but might become more of a concern. Furthermore, the overemphasis on food is also inappropriate. In the context of HIV/AIDS, since the real needs are for health, clean water and care, farming technologies and support for education and governance may be more appropriate.

The well-known contrasting argument is that food aid is useful, valuable and life-saving. It might not be sufficient by itself – we need health, water, and other support – but there is definitely a place for the use of food ‘as food’ for the starving, and ‘as commodity’ to support other activities, especially for recovery and development. Even so, it is not necessarily appropriate for addressing HIV/AIDS, as one NGO nutritionist believed:

I don't think that emergency food aid should be used for HIV/AIDS programming. I do think that food resources can be targeted to PLHA, but that is not an emergency issue, it's a developmental issue.

Many are now asking: since we have food aid anyway, then what can we do with it to better address HIV and AIDS? Potential uses of food aid to this end – mentioned by many informants and in agency literature – include supplemental feeding for children or PLHA, school feeding programmes, support for training and sensitisation programmes, support for new food-for-work activities to aid PLHA, and many other innovations. While it might be unfeasible to directly reach PLHA through general mass feeding, they can be reached through supplementary feeding programmes at a clinic, or through home-based care programmes, and many agencies are going in this direction in rethinking uses of food aid.

Food for work

This classic self-targeting tool (along with using low-value/less desirable foods) is alive and well in relief and recovery and ‘developmental relief’ programming in many agency initiatives. This is true despite predictions that illness and labour shortages would make the strategy unfeasible, and despite strong ethical arguments against food for work in general. One UN relief official reminded us that we cannot necessarily decide for PLHA and their families or communities that they should not work for cash or food. Instead, we should give them a choice:

CFW [cash for work] and FFW are very good ... They give people dignity. This counts even more for HIV/AIDS sufferers ... CFW makes them active participants.

Food for work is also still used and adapted by many agencies in Southern and Eastern Africa, including WFP, WV and CRS. In Kenya, FFW is being adapted by World Vision to combine free food distribution for the most vulnerable (which includes HIV/AIDS-affected) households, while others are expected to contribute labour for projects. C-SAFE proposals (2003a, b, c) mention several ways in which food for work will be accommodated to the new reality of labour shortages and of women- and child-headed households. The nature of the 'work' is changing. It is not enough in these settings to build (sometimes unnecessary) community assets like roads and dams; instead, work can include caring for affected households or PLHA within the community. Food for work programmes can assign individual participants to work on behalf of AIDS-affected households to plough, weed, plant or harvest, for example.

Rations

Food rations should increase, according to recent research, but many practical, logistical difficulties exist to operationalising the new technical recommendations and scientific knowledge about the need for enhanced nutrition for PLHA (i.e., coming from USAID/FANTA and WFP). Some agencies find it difficult to distribute the bare minimum (1,500kcal) to populations – as is the case in Ethiopia – much less the larger rations and better-quality foods that are recommended.

Opposition arises also from within emergency response teams, reflecting different mentalities or principles. Some emergency personnel argue that '1,800 is enough to survive!', and want to see the available food aid stocks go further and faster to more individuals. The inequity in response at the continent level in Africa has not been ignored by observers of famine relief: the HIV/AIDS crisis in Southern Africa seems to have been used to depoliticise the issue of food crisis and chronic poverty. Its effect is arguably to exacerbate shortages of resources to East Africa and the Horn, areas not yet visibly affected by HIV and AIDS.

Non-food aid

Food aid is probably not going to be sufficient in HIV/AIDS-affected communities. It is increasingly clear that needs are great for people facing HIV and AIDS – staving off infection, caring for the ill, and mitigating the impacts of care and loss. This requires attention to primary health care, psychosocial

support, schooling, and developmental efforts, as well as emergency relief. A UN official expresses it like this:

HIV/AIDS victims need food but they need other things as well. What does a family need who has HIV-infected parents? They need money to sustain the family. Beyond food, beyond jerry cans or kitchen sets. They need clothes, money for books for school and hygiene. We need to have a holistic approach for individuals.

Stigma

Humanitarian officials and development professionals and health researchers alike are not clear how to manoeuvre through this minefield. It is the subject of a growing body of research (Nyblade et al., 2003), was a topic at many ICASA sessions, and receives attention on the listserv of the USAID-funded initiative CORE (Communities Responding to HIV/AIDS: www.coreinitiative.org). Stigma and its impacts – denial, discrimination and silence – clearly demand attention and create concern among relief workers and donors, and for PLHA and their communities.

Almost every informant was aware that stigma is a thorny issue complicating the delivery of aid, but the answer seems to lie in using proxy measures and/or community-based targeting. Informants accept that stigma exists, it is harmful and we must avoid stigmatising people by singling out HIV prevalence or AIDS status. We must use ‘chronically ill’ and other proxy indicators, not provide special ‘AIDS foods’, for example. Communities are said to ‘know who is vulnerable’ (i.e. who has AIDS) and to be able to include them (as well as other vulnerable people) in registration lists. Does this mean that stigma is not as significant at the local level? To what extent are PLWA being stigmatised and excluded? Knowledge is lacking here.

At the same time, a small but increasing minority response says, in essence: ‘We – the NGOs, the international community – are creating and perpetuating stigma by handling it with kid gloves. Instead, we should be more straightforward. We should deal with it like other sexually transmitted infections (STIs)’. Simply asking this question opens the door to questioning the attention to proxy measures and the need for indirect targeting to get around stigma.

Meanwhile, there is hope, mentioned by several informants in particular, that providing treatment will reduce stigma. Specifically, it is hoped that stigma, or at least the outward discrimination resulting from it, will be diminished by targeting PWLA with treatment and care. This might occur with high-profile

medical programmes such as the WHO '3 x 5' initiative, or with smaller-scale ARV programmes (such as MSF's). The increasing availability of affordable public ARV treatment will itself probably help reduce the paralysing shame, silence and denial associated with the disease and its ramifications. This might be true even if the drug treatments are effectively highly rationed (for now) because of scarce resources and uncertainty about how to proceed with specific regimens. Reducing denial, shame and silence at all levels of society will increase openness to discussion about how to change behaviour, care for PLHA and mitigate societal impacts. Through this reasoning, providing long-term ARVs becomes part of the package of essential medications, and part of an emergency relief intervention.

Conclusions and final thoughts

These interviews and conversations, as well as agency documents and conference presentations, suggest a growing convergence of opinion about how to integrate the challenges of HIV/AIDS within humanitarian action in Sub-Saharan Africa. In some cases, responses were as expected, such as concerns about stigma, and reliance on community-level mechanisms and multisectoral programme approaches. In other ways, responses were surprising: namely, the rising backlash against HIV/AIDS exceptionalism, or the extension of the ‘new variant famine’ hypotheses, to explain recent crises and justify policies. The convergence of lessons and widening debate is heartening, as it indicates rapid learning and exchange among international agencies. These agencies are increasingly informed and aware of the enormity of the long-term crisis of HIV/AIDS. The debates reflect a growing humanitarian problem which demands more attention, rigorous research and open discussion.

Conceptualising HIV/AIDS, emergencies and the food crisis

There are different, overlapping conceptions of the nature of the crisis and the role of HIV and AIDS. Many agree that it is a major cross-cutting, multisectoral issue that affects all relief and development work, and demands much more attention. At the same time, many recognise that it is only one among many chronic, severe and intractable problems facing people in Sub-Saharan Africa. Communities are ‘living with AIDS’ and many other urgent problems. It is important to devote attention and resources to HIV/AIDS-affected regions, but also to avoid AIDS exceptionalism, which could distract attention from other policies and services in response to threats that are not novel, such as malaria, poverty and debt. Evidence for the role of HIV/AIDS as a cause of the food crisis in Southern Africa is ambiguous, but the tone and content of the 2002/3 appeals and responses have fundamentally changed the landscape of humanitarian action. HIV/AIDS is accepted as a valid and huge long-term crisis (and by some an emergency), it requires the mobilisation of resources as if it were a relief effort – rapid, concentrated, without strings. Others suggest that emergency food aid is not suitable as it is itself restrictive, with a limited time frame, requires special monitoring and is physically hard to move around. Whether it is an emergency or crisis; whether or not HIV/AIDS has played a major role in recent food crises; the epidemic is still not being addressed properly. It is being used to make a chronic problem (famine in Africa) more novel and exciting to donors, without necessarily tackling HIV or AIDS *per se*.

Informants’ perspectives on how to link relief and development efforts varied shared much common ground despite the different weights placed on acute emergency relief versus long-term development. Discussion is under way to better integrate relief principles and programming into development in ways

that accommodate the particular challenges of HIV and AIDS, such as through community-based warning systems and 'relief within development'. Integration of long-term development principles, approaches and programming into emergency relief is also happening in ways that accommodate HIV and AIDS, whether through 'developmental relief' or community-managed targeting and distribution. The potential for sustaining human development after a crisis through preserving local assets, institutions and capacity should be emphasised. Relief responses can more effectively use the mechanisms, resources and processes of emergency relief to build capacity, empower individuals and institutions, strengthen social capital and safety nets, and other goals usually relegated to the post-recovery phase.

For the long term, continued support is needed for social welfare systems, such as community-based safety nets, schooling, health systems and other activities that span emergency and development. In the absence of sufficient governmental capacity, the international community probably has an obligation to current and future generations to try to prevent further livelihood erosion and food insecurity.

Integrating HIV/AIDS into food security, development and relief programming

While the conceptual and political landscape has changed, it is not clear what should be done on the ground to adequately account for HIV and AIDS. Many field practitioners grapple with how and when to help people with limited resources, time and energy, especially where underlying political, environmental and social realities exacerbate chronic livelihood insecurity and also need long-term attention. Mainstreaming the cross-cutting issue of HIV/AIDS now seems standard in major NGOs and UN agencies through workplace and food aid and relief programming. Most NGOs have an HIV/AIDS policy, however well- (or ill-) developed at present. Several UN and donor agencies have placed great emphasis on mainstreaming HIV/AIDS into food security programming, in part in reaction to the Southern African food crisis. These efforts seem to influence other agencies and donors. Practical, operational aspects of mainstreaming need much fine-tuning and human and financial resources to fulfil their mainstreaming goals. Multisectoral and cross-cutting programming, in which attention to HIV/AIDS is inserted into a wide range of programmes for relief and development, is an established part of mainstreaming.

Partnerships Partnerships range in nature and duration from flexible and shorter-term projects in a small community, to long-term, formal, multi-country consortia with billion-dollar budgets. They help address problems, but also raise new questions/issues for the nature of relief and the integration with development. More partnerships will probably be seen among governmental, international, NGO and local community institutions, whether secular, religious, educational or financial. *Financing* humanitarian action and development in the context of HIV and AIDS is still restricted by emergency versus

development distinctions, and remains a major constraint on operations. The emergency distinction places fewer demands on recipients for the sustainability of local institutions and programme impacts, but is often shorter-term and with expectations of a clear 'entrance' and 'exit'. Informants recognised both the urgency, and the emergency nature of the new demands of HIV/AIDS, but also that long-term efforts are needed. More sophisticated programmes, monitoring and longer project time frames are needed to meet a much larger set of aims. Donors seem to be starting to respond to the need for greater flexibility and more holistic responses to this long-term crisis.

Progress is being made within specialised areas where relief efforts are responding to HIV/AIDS: sectors mentioned here include health and nutrition, HIV prevention and agricultural recovery and rehabilitation. Informants raise practical questions about integrating prevention into emergency aid programmes, and are thinking about the implications for relief programmes of the extension of ARV treatment throughout Sub-Saharan Africa. Agricultural programmes such as 'seeds and tools' are beginning to accommodate themselves to changes in local farming systems and livelihoods, such as reduced labour supply.

Issues in targeting aid

Early warning and assessments

No clear standard exists for integrating HIV/AIDS vulnerabilities into *any* stage of information systems for humanitarian action, although several proxy indicators are regularly mentioned and even taken for granted, such as the presence of a 'chronically ill' person in a household. Individual proxy measures each have weaknesses, so informants' experiences suggest that indicators should be chosen more carefully and used jointly. Sampling needs more attention to account for many sources of potential bias, such as 'missing' households. Agencies are developing monitoring and evaluation (M&E) systems to accommodate HIV/AIDS programmes and concerns, and these need more attention. No single M&E system will be adequate for all the different needs, ranging from the accountability of short-term relief distribution to comprehensive impact assessment for integrated and long-term programmes. Early warning systems integrate HIV/AIDS at different levels: HIV prevalence mapped onto food insecurity measures at large geographic scale at one end, and community-based measures of vulnerability at another.

Targeting aid

This is a problem for everyone, in large part because of the fear of exacerbating stigma through identifying those who are vulnerable due to HIV and AIDS. Community-level mechanisms for vulnerability assessment, registration, needs assessment, targeting, delivery, distribution and accountability offer a

solution to many dilemmas. This approach is seen to help avoid stigmatising persons due to HIV/AIDS-affectedness. Local communities are believed to know who is vulnerable (and what vulnerable means), leading to better-targeted emergency relief. Proxy indicators of HIV/AIDS affectedness also seem to be a standard solution to the issue of stigma and how to identify and reach the vulnerable. Still, many concerns remain: which proxy measures work best for what types of vulnerability? Which measures capture HIV and AIDS at different levels? What forms of community-based relief work best, where, why and how? Does the exclusion of PLHA still occur with community-managed programming? If so, how can programmes get around it? Do community-level mechanisms for targeting always contribute to local capacity, or only some types of programmes? Or do they bolster privileged groups within the community and contribute to exclusion? How can community-level mechanisms mesh with national programmes? The issue of targeting in the age of HIV and AIDS clearly demands (and is receiving) much more attention and research.

Type of aid

Although debates persist about its relevance for other reasons, food for work is evident across a spectrum of UN and NGO programmes. Programmes are being redesigned to respond to the perceived new labour constraints of vulnerable households and communities. Informants tended to agree that food aid is insufficient, especially with HIV/AIDS: a broader range of non-food aid is needed during emergency settings. Similarly, food aid, it was generally agreed, can be fruitfully used for developmental goals in the context of HIV/AIDS, to support social programmes such as schools, safety nets and care for PLHA. So far, few concrete experiences exist for such programmes, but these are emerging.

Final thoughts

The intent of this background report is simply to take stock of what humanitarian agencies are thinking about and experimenting with in Africa to better address the humanitarian imperative: to save lives and alleviate suffering, but in a new context: the widespread generalised impacts of the HIV/AIDS pandemic, that now challenge all efforts to promote human development. Comments summarised in this report suggest that awareness of the extent of the challenge to humanitarian action is widespread. Many pressing questions remain, and these need to be addressed through appropriate research, training, and discussion:

- What is the actual role of HIV and AIDS in driving food crisis, at different levels? The available studies indicate that different agro-ecological settings, political crises and population densities can converge in a context of high HIV prevalence to generate serious food crises. However, areas

with high HIV prevalence are not necessarily food insecure. More research is needed on these complex relationships and the generalisability of our models. More applied research is needed to identify workable local innovations and test out models of intervention by external agencies.

- What types of community-level mechanisms sustain positive relief and development efforts, without further excluding community members? How can community-level and developmental approaches be integrated with national-level emergency warning to provide comprehensive coverage?
- If food aid is not sufficient, what mechanisms exist to support non-food aid during emergencies?
- What can be done about stigma? Are humanitarian agencies dealing with it well by handling it with kid gloves? More discussion is needed between health and psychosocial professionals skilled in understanding stigma and discrimination, and relief and development workers need to confront the barriers of stigma at all levels.
- Several approaches to spanning the relief–development continuum are emerging that pay particular attention to HIV and AIDS. How are these ideas working out in practice? What factors facilitate successful transition from an emergency to recovery and development in the context of HIV and AIDS?

HIV/AIDS is not an emergency like any other; it is a major epidemiological event. We must address the implications of HIV and AIDS within the actual, present and complicated setting in which we undertake humanitarian action and long-term development efforts. The disease particularly affects a part of the world already hard-hit by environmental, political and economic shocks and long-term decline. Sub-Saharan African societies, and particular categories of people within them, were already subject to stress and vulnerability when the disease emerged. Its impacts vary within the region, and not all communities suffer equally. The worst-case scenarios of child-headed households, untended fields and widows caring for a multitude of dependants are fortunately not widely representative, but neither are they merely illusions or rhetorical devices. Challenging the misguided use of images to develop possibly inappropriate policies for long-term food security does not diminish the real suffering and the range of action and attention needed to make up for enormous hardship. Informed action, creative thinking, rational planning, open debate and foresight are required to deal with the implications of HIV/AIDS in humanitarian action and development over coming decades as the pandemic runs its course.

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Annex 1

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Watkins, Ben (WFP, Kenya)
Whelan, Will (USAID FEWSNET)

Annex 2

Interview guidelines for NGO headquarters and donors, August 2003

[1] During 2002/3, what, if any, specific issues arose during field operations concerning the impact of HIV/AIDS for relief work and long-term development?

(probe if necessary i.e., during assessments, targeting, relations between expatriate and local staff; regular development programs displaced by emergency efforts)

[2] Given your experiences in 2002, 2003: Has your own thinking about **emergency relief aid** been affected in light of the HIV/AIDS epidemic(s) and impacts? If yes, how so?

(Probe: for example, on the appropriateness of food aid, FFW/CFW or other specific interventions for famine relief aid given reduced labor availability in HIV/AIDS affected populations.)

[3] Specifically, how has your thinking about **FOOD AID** been influenced if at all in light of HIV/AIDS and its impacts on the local populations (and perhaps in light of impacts on employees, staffing and agency capacity). (probe if necessary, i.e., was food aid sufficient, inadequate? What non-food aid is needed?)

[4] Has your thinking about **long term development efforts** been affected by experiences in relief during the recent food crisis? If so, how? If not, why not?

[4b] For example, can emergency food aid be used to support **longer-term social safety nets** for HIV/AIDS-affected communities? How? What about other forms of aid?

[5] In the context of HIV/AIDS, How do you think emergency relief SHOULD, in the future, interact with long-term development programming?

... internally, within the organisation?

... externally, in relationships between agencies, donors, partners?

[6] Is your agency now considering any immediate changes in **future** emergency programming to reflect your experiences in dealing with the impacts of HIV/AIDS in the recent crisis, or with the risk of HIV transmission associated with emergency interventions? (*Specify*)

[7] Looking back at the Southern Africa 'food crisis' of 2002/3, can you identify any other major lessons earned (i.e. not mentioned so far)?

[8] What would you like the agency to do differently in the future to respond to an emergency, in an area hard hit by HIV/AIDS?

[9] Additional questions or themes:
