

Food Security , Livelihood and HIV: Challenges and Responses

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**XVII International AIDS Conference
Food Security, Livelihoods and HIV: Challenges and
Responses
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STEPHEN LEWIS: —attempting to find panels that I can moderate simply because it is my vocation, and therefore, I will leave that as a sufficient introduction of myself.

We have a very distinguished panel, in fact, and I have had the opportunity in advance to see some of the material and presentations. I can assure you that the substance and the content is unusually apt and forceful and filled with insight in a way that I have not often seen at some of the sessions at International AIDS Conferences.

The whole question of food security and livelihoods and HIV is, of course, is growing in import year after year as people understand both the decline in agricultural productivity for individual households, the ravaging of income that occurs when one or more of the people are stricken with the virus and the objective international difficulties, which obviously exist around food security.

You have got food prices rising and oil prices rising and droughts taking hold of large parts of the continent of Africa, in particular and you have climate change looming as a possible sabotaging ingredient of life on the southern part of the continent.

The Intergovernmental Panel on Climate Change that received the Nobel Prize with Al Gore identified Southern Africa as the place in the world that would feel the impact of climate change more forcefully more than any other part, at

least initially. On top of everything else we have had the breakdown in the Doha Trade Negotiations, not a surprise to anyone but clearly with great implications for agricultural security.

When we talk about food security, livelihoods and HIV we are talking about increasingly compelling issues which suffuse the debate around the pandemic. As I said you have got five really excellent Panelists with fascinating contributions to make.

We anticipated the lead contribution to be that of Stuart Gillespi who is with IFPREY and RENEWAL and whom I knew well from previous sessions that were held by WFP and FAO at previous AIDS conferences. Stuart's plane did not get here on time. This is a conspiracy which is visited on many I notice in coming to Mexico City.

We will take the perpetrators before the International Criminal Court but for the moment we are without Stuart, we are however with a wonderful colleague of Stuart whose name is Sunneetha, is it Kadiyala, who is also directly associated with RENEWAL which is the regional program on food security and livelihoods.

She is a Post Doctoral Fellow at the International Food Policy Research Institute better known as IFPRI and at IFPRI she was with the Regional Network on AIDS Livelihoods and Food Security which is RENEWAL. When Stuart sent me the Email saying that Sunita would step-in in his absence he admitted somewhat

forlornly that she would give a presentation vastly superior to his own. Sunneetha?

SUNNEETHA KADIYALA: Thank you Stephen Lewis for the kind introduction. It is difficult to follow right after you with your eloquence and even more difficult to fill Stuart's shoes but I will try my best.

Ordinarily I would thank the Conference organizers for inviting me to present but in this case I will just thank United Airlines for having me here.

Let me first introduce briefly what RE is. As Stephen said, it is the Regional Network On AIDS Livelihoods and Food Security and when I look around there are many of you in the audience that have been associated with RE since its inception in 2002. For the past five years I have been working with RE and we are active in five countries. I think it is Zambia, South Africa, Malawi, Kenya and Uganda and many of the regional national coordinators are among the audience if you wish to know what is happening more in these countries.

What I am now going to talk about is the three coexisting and interacting crisis of AIDS, malnutrition, livelihood and food insecurity. I am just going to give an overview of the interactions but also walk you through some of the latest evidence especially since the last AIDS Conference and leave you with some of the implications, what are some of the policy and program options that are in our arsenal.

Many of you have seen the slide before which is RE Logo slide, pretty much that HIV and AIDS and food insecurity and malnutrition are viciously interlocked in a vicious cycle. On one hand food insecurity can increase susceptibility to HIV transmission through various routes and on the other side of the downstream, impacts HIV and AIDS can exacerbate the already existing food insecurity and malnutrition situations in Sub-Saharan and Africa.

I am first going to talk about the up-streams. What is the evidence, what do we know about the role of food insecurity often seen through the lens of poverty and its relationship with HIV susceptibility.

So the question is, does poverty or wealth drive HIV transmission? VENUE along with UNAIDS in 2007 posed this question and we investigated or examined the issues on what exactly we know given the current evidence thus far. That has resulted in an AIDS supplement in 2007 and I am just going to give you two slides on what the synthesis says.

When you look at the micro level there seems to be a direct relationship between income and equality at the country level and HIV prevalence. Here in this slide you can see HIV prevalence on the Y Axis and [inaudible] coefficient, which is a measure of inequality. What this scatter plot, a correlation matrix shows is that as inequality within countries increases then there is a higher HIV prevalence in that country.

As most of you also know there is an association and we need scratch under that surface. When you look at large panel data sets that look ahead and track people then what the evidence show is that economic status is not a strong predictor of HIV status in Africa. Perhaps this is because the epidemic now in its mid 2000 to now is much more generalized than we expected it to across economic groups. But what the evidence continues to show is that equivocally that the impacts of AIDS are most severe among the poor.

So we should move away from seeking magic bullet us and simple explanations and accept that this is a complex relationship and the relationship between economic status and poverty is often mediated by many factors.

Poverty and food insecurity especially of women of course continue to be a crucial part of the whole story. Then there are other mediating factors such as mobility, fragile livelihoods, access and ability to use information and we know that peopled that are oppressed and people who are marginalized and those include people with HIV have compromised ability to access and even if they are able to access information ability to use that information.

There are occupational related notes of risk, such as occupations which can increase the high risk of behaviors.

So these various factors, this is not an exhaustive list but clearly these are some of the important mediating factors that we found to be quite important. The news is also

in of focal unequivocal in terms of the evidence that we have reviewed in the relationship between education and HIV status and women's economic impendence and HIV status. Both are protected against HIV.

So we need to continue to invest in education and improving economic empowerment of women and continue to ramp up the AIDS sensitive agriculture and livelihood development programs.

Once there is HIV in the body and once there is HIV in the household or the community what happens to the nutrition status of a person and what happens to the food and nutrition security. I am going to talk briefly about this. Malnutrition is associated with immune function decline and the degree of malnutrition, proteinal malnutrition is clearly linked with mortality risk.

The recent studies, especially from observation studies show that malnutrition compromises effectives and increases ARV toxicity and it increases ARV side effects, compromises adherence. We also know from observational studies in Uganda and Molivi that people who initiate ARTs Antirecteralviral Therapies when they are more malnourished are three to six times more likely to die in the first three months, than people who are not malnourished. So clearly, nutrition status is important before someone starts ART and as people starts ARTs as well.

There is substantial evidence to show that many micro nutrients slow the progression from HIV to AIDS, although the role of Vitamin A and zinc is not consistent.

What is the latest evidence on the impact of an on food insecurity? The latest evidence basically confirms what was presented in Toronto many other publications by many esteemed colleagues and stakeholders in this arena. What the evidence basically shows that impacts are determined by the degree and type of vulnerability.

And this is often revealed in response of what we tend to call as coping or impasse or effects, the vulnerability and the ability to change a person or an institution plus the inability to change in response to a particular situation. But vulnerability is not something constant; the vulnerabilities that people face today are not the same as vulnerabilities that people face two years down the line.

And I think the global food crisis that our next speaker is going to talk about is a good example of that which is clearly going to interact with the existing vulnerabilities and play out probably in not very desirable ways.

So what are these vulnerabilities that have often been studied? These vulnerabilities depend on household demographics and here is a list of various conditions and contexts in which the vulnerabilities get played out. So clearly given the evidence of the role of food security and

nutrition there is scope for various sectors to come together to scale up the response to AIDS.

The last three slides I am going to present are in relation to the role of what food and nutrition research and programming do along the continuum of prevention care and treatment and along the continuum of HIV timeline.

So if you look at prevention, which is classic and one of the core pillars of an AIDS response, studies from Botswana and Swaziland, show that women who are food insecure are more likely to engage in high risk behaviors.

So clearly, strengthening women's food security should be a top priority. We need to explore alternatives to migrations or the possibility of making migration a safer venture. There is convincing evidence to show that maternal malnutrition increases mother to child transmission of HIV and improving malnutrition is fundamental to preventing future infections of children.

If you look at care and treatment, nutrition interventions have a pretty important role to play in terms of improving immune function before an individual is put on ARTs and also to ensure optimal ART outcomes once they are on ARTs.

On the final aspect of the timeline which is the mitigation, work by a Michigan State University for example, in various countries in Sub-Saharan and Africa show that the real constraints to adequate food production and food security depend on multiple context which relate to the vulnerabilities.

I was just alluding to and this includes cash, labor, land and we really need to investigate in various context what these are and address those real constraints. Work with the actual World Food Program and VENUE and many other colleagues have shown that formation of children's human capital is under threat.

Children who have experienced parental death or AIDS in their households are much more likely to falter in growth and much more likely to have compromised education outcomes. It is imperative that we all act and continuing and scaling up investing in children's human capital formation for a better future of our children.

As far as what VENUE is doing is that we know that clearly that although there is this neat timeline displayed there, that within a household these things do not exist in that framework of horizontal timelines. Many of this prevention, mitigation care and treatment along the timeline coexist within a household therefore along with VENUE, IFPREY and concern worldwide, WFB in Uganda and the AIDS Support Organization, we are trying to investigate the role of food supplementation in adequately addressing the prevention, care and treatment and mitigation aspects.

So thank you very much with that and I hope that I adhered to the time limit.

STEPHEN LEWIS: Thank you, it is quite remarkable how you were committed to speaking within the time line suggested

and that so rarely happens that I want to acknowledge it as being worthy of Nobel Prize.

I was particularly taken, if I may be so presumptuous, with the emphasis on nutrition and nutritious foods and malnutrition and their links because increasingly this is becoming a center piece. I remember Paul Farmer saying publicly at the Partners in Health Project in rural Rwanda, he is now spending 28-percent of budget on food in order to bring a nutrition component into the lives of those who are struggling with the pandemic and the relationship of food is everywhere being more fully understood.

Food prices, however, are intensely complex and Byzantine in their application and I am very glad, therefore, that we have Martin Bloem here to give us a sense of what the consequences and implications are. He is the Chief of Nutrition and HIV/AIDS in the policy department of the World Food Program. I am a World Food Program groupie.

I love the Agency it is one those UN Agencies that does remarkable work in the field. I once back just a few years ago did a tour of Southern Africa with James Morris when he was the Executive Director of World Food Program. And I remember his response both to child headed households and to women who are living with the virus and clearly improvised and vulnerable and his determination spontaneously and intuitively to begin to redirect the work of the World Food Program to vulnerable communities.

And that indeed happened and it has give WFP a central role in what has emerged certainly on that continent. Martin holds positions at the John Hopkins Blumberg School of Public Health and at Tufts University and he has worked for some 20 years in the field of development. Martin.

MARTIN BLOEM, M.D., PH.D.: Okay, what I would like to do in the next 10 to 15 minutes is a discussion on what the impact is of high prices in the field of nutrition. I think Sunneetha already explained that food security has of course much more implication and only looking at nutrition because it looks at life-lode but I will not focus on that. I will only focus on nutrition.

It is always very difficult when you start to discuss this as someone who works with the World Food Program because people will say, you always are biased because you would like to get food because that is your business. A lot of the data which I will show you is actually coming from my previous job when I was working for Helen Keller International. So it is a little bit unbiased in the sense of what two programs perspective.

I will start with an Email that was sent out last Friday, I think, it was an Email from one of my colleagues and there is a lot of confusion in the field saying what does it mean, these high food prices, what is the impact on HIV/AIDS? What is the impact on nutrition.

It is very understandable, of course, because there is this huge information over the past couple of months that it will have of course a lot of impact but people do not know how we measure that and who are more vulnerable? These are very valid questions. One of the things we have tried to do within WFP is working with UNICEF and thinking what is the evidence of high prices on the impact of nutrition.

There are not many studies in fact. There are only eight studies in the latest year that have really looked carefully at this impact. So what I tried to do with you is to look a little bit at my own experience, it is about three papers of the eight papers.

The first experience we had was actually in 1994 when I was working in Bangladesh, we had set up a surveying system and we looked over that first period and you can actually see it here until 1994 but in the beginning we looked at seasonable impact and we saw that there was a very interesting correlation between the rice prices and the differences in malnutrition.

But, of course, it was only a very short period, so in 2003 we did a paper and we looked over a period of 10 years. What you can see here is that there is a decline in the rates of malnutrition and we used under-weight as the primary indicator. There was an incredible correlation between the expenditure on rice which is the main commodity in Bangladesh. You can see that here.

The next slide shows you that in fact it was during this whole period when there was a decline in malnutrition, there was not an increase of rice intake. In fact it was a decrease in the rice intake. What we see over time when a country becomes more rich then in fact intake of commodities actually is declining.

So what is happening actually among poor people? Well, Amit Desenovi [misspelled?] said, okay poverty is a matter a choices. If you are poor you have hardly any choice and you are rich you have a lot of choices. And of course, if you translate that in what it means in food, so when you are very, very poor you only eat staple and in this case, in Bangladesh, it was rice.

When your are very poor you eat rice and vegetables and the more you become affluent you then in fact you include meat and eggs and the more expensive products of course are animal products which are very rich in micronutrients.

If you follow this and this is coming from Peter Timmer, one of his books on food policy and what is happening is when a country becomes more rich, in fact it increases their energy intake but at the same time of course it also increases the intake of micronutrient rich foods. Bangladesh was about at this level so it moved from more energy deficient to less energy deficient.

If you look at this slide it shows very clearly that a decline in malnutrition was very much determined by in fact the

increase in the expenditure on more nutritious food which we call the non-grey food component of the food expenditure. And of course is determined by micronutrient and the right fatty acids and these kinds of very nutritious products for actually increasing the growth of children.

This experience helped us to understand it in fact but we need of course during a certain time period that if we talk about food we just cannot talk about food in general. We have to be very specific. We have to talk about nutritious food. In 1998 when the economic crisis broke out in Asia we were by accident working in Indonesia at that time and we said, oh, this will have impact of course on the nutritional status.

But Indonesia was not country like Bangladesh which was energy deficient in fact Indonesia was more at this particular level. So it went from about here to here. So we could not expect an impact on malnutrition but what we could expect is an impact on in fact on micronutrient rich food because they could not afford that food and then you could actually expect micronutrient deficiencies.

We looked at many different of the aspects but because of the time frames I can only show you one indicator which is vitamin deficiency. We look particularly at maternal night blindness. And maternal night blindness is a symptom of a disease which happens quite often among pregnant mothers but also it happens on women of reproductive age in general.

It is a disease which has been studied extensively in Bangladesh as well as Nepal and also in India. Women with maternal night blindness have about three to four times higher risk of dying than women who have none of these symptoms.

We looked at that in Indonesia and we knew that before in fact the crisis broke out there was no prevalence of maternal night blindness at all. But what happened after the crisis is it immediately went to a level, which was similar as with what we have seen in Bangladesh at the same time.

Then we did a logical regression analysis and this data shows you a little bit about one of the main indicators which is in fact the weekly food expenditure on animal products and you can see there is a dose response relationship, we take in fact the lowest intake as one and you can see it goes from the arch ratio which would explain to you a little bit about the importance of that indicator for the outcome and maternal night-blindness it goes from .68 to .66, .72 to .47 and it explains in a way that in fact the intake of these highly nutritious food was the main determinant of the increase of maternal night blindness.

When we looked over time, what you can see here is that at the beginning the level was suddenly at 2.5-percent which is what I said before a similar level of prevalence as what we saw in Bangladesh. Before the crisis we could not see it at all, there was not prevalence of maternal night blindness.

So you can imagine how a shock which is not even the same shock which you are seeing now during the high food prices at this particular moment had an increase in this disease. But what happened over the period of about three years time that symptoms diminished and now we cannot see anymore prevalence of maternal night blindness and it was correlated with in fact the increase of the food expenditure on animal products.

So you can see what is happening now as a result of this is that the increased food prices but now they are in fact stabilized, the high food prices will not go away for the next five years. That is the prediction of the private sector as well as the World Bank and even some people say it will be longer than six years.

This is not what happened in fact in Indonesia where you have a very short shock only for a couple of months in fact where you had the food prices. You can already see that you had three years time to recover from that shock. You can imagine what the impact will be on nutrition over the next five years. I think we underestimate the impact on nutrition. What will happen will be major for many, many people living in Africa, Latin American but also in Asia.

So, if you do the translation to what it means for HIV/AIDS or tuberculosis, I think Sunneetha already explained quite well what the relationship is between malnutrition and HIV and AIDS, although there are still some discussions about whether an extra amount of micronutrients will be beneficial,

it is quite clear that when you have a deficient population, you will have an increase incidence for example tuberculosis and increase risk of mortality.

But in fact we have three phenomenons in the world now. We have malnutrition both in children as well as in adults, we have HIV and AIDS of course caused by the virus and the tuberculosis caused by bacteria. So in fact there are three different ideologies but of course they coincide with each other.

So when you think about HIV and AIDS the current advice and I take a very conservative view on this although I believe there is a much more role for nutrition in this but the current WB recommendation is an increase energy intake and we need at least one RDA of micronutrients. At this particular moment as a result of the increased food prices you will see an enormous increase of micronutrient deficiencies and nobody is covering in fact one RDA of my micronutrients during treatment or prevention.

So even though you are conservative you are not doing that work. Increased energy will definitely have a big impact and we do not do any of that either. So, I think the impact will be we may hasten the disease progression and may see maybe an increased mortality and it is also possible that our PFCs programs less effective.

When we talk about tuberculosis and I think this conference will discuss a lot about the interaction between

tuberculosis and HIV and about joint programming, in the evidence for the impact of nutrition and tuberculosis is much stronger. We know that in fact that the incidence of tuberculosis is related to malnutrition but definitely even there is more evidence for that micronutrient treatment will have an impact on in fact the treatment effectiveness of the tuberculosis.

So just a few seconds about of course it is much complex, it has already been discussed before and I only highlighted one small component of the high food prices on nutrition but we know that it has a major impact on other behavior issues as well as life-long vulnerabilities. So, one issue is for example, an increase in risk sexual behavior as a result of more poverty and lack of food availability and we know this will also have additional effects.

This slide shows you what we did a couple of months ago. WFP hired a consultant and they went to two different places to Swaziland and Malawi and they just looked for a qualitative perspective at what, in fact the impact was according to the people who are interviewed.

The main issue is in fact that it was much more dramatic than we had expected. And this of course are very qualitative data very preliminary we need more hard data to this although I think we need to act more than we should have collecting data.

But is quite clear that people are vulnerable who cannot act in a similar way as they could a year ago. I think a lot of our treatment programs as well as our HIV/AIDS programs will be much less effective as a result of high food prices. Thank you very much.

STEPHEN LEWIS: Thank you, Martin, that was fascinating and the emphasis on the graph of the graduation of degradation really of poverty and its application and the emphasis on micronutrient deficiency is most interesting.

And that reference to the study of Botswana and Swaziland and risky sexual behavior, I have been reading the UNAIDS Report and actually I was so struck by the quote that I jotted it down and I found it and I want to read it to the audience.

It said, "According to a recent study in Botswana and Swaziland, women who lack sufficient food are 70-percent less likely to perceive control in sexual relationships, 50-percent more likely to engage in intergenerational sex, 80-percent more likely to engage in survival sex, 70-percent more likely have unprotected sex."

That is an extraordinary degree of implication in this study around the absence of food.

Our next speaker is going to take us into the practical application on the grounds in what are called hyper endemic areas. Hyper endemic areas are defined as countries where you have a prevalence rate of 15-percent or higher in the 15 to 49

year old category so they would include obviously South Africa and Botswana and Namibia, Mozambique, Lesotho, Swaziland, and Zambia. Those are the hyper endemic areas.

Fadzai Mukonoweshuro is an HIV and Livelihood, she says, Officer, Specialist really, with FAO in emergency and related application. She holds a Masters in Development Studies and is studying toward a Doctorate in Livelihood and Antiretroviral Treatment. Fadzai provides backstopping for FAO, I like the term, in seven countries in Southern Africa on HIV and rural livelihoods. Fadzai, the microphone is yours.

FADZAI MUKONOWESHURO: Okay, thank your very much, Stephen. Morning, as you have just heard, I am in the South of Africa where we are have been trying quite a number of interventions in the Food and Agricultural Organization of the United Nations but today, my presentation is going to look very much at what has been tried, some of the interventions so this presentation will really go down and be more operational in terms of what really can be done to improve livelihoods and food security in these hyper endemic countries.

I would like to discuss more the strengths in terms of these interventions, to also look at the challenges and then the lessons learned and also recommendations for programming because I know a number of you have been trying some of these some of these interventions and it may be interesting to know what community perceptions have been on some of some these interventions.

As you have been told, I will focus mostly on Southern Africa which as you know, is more than 60-percent of people living with HIV and AIDS. Most of the livelihoods are very dependent on agriculture and as well we have had protracted food insecurity since 2002 as well as nutrition insecurity.

You might say most of these interventions we are very aware of them. I would like to go a bit more in detail in terms of some of the studies that have been undertaken and some of the community perceptions. How do they perceive some these interventions in the context of HIV and AIDS?

The first one of course being Fudate, this definitely been appreciated communities it is an intervention that we cannot really do away with and I think the previous speakers have spoken about the food prices, et cetera, so at least with this first intervention I will not go much into it.

In community and household gardens we have seen and there is a study that has been done recently in Zimbabwe has shown that communities have really perceived this as one of the most important interventions. Why? Because it has been providing quite a diverse number of food stuffs that families can consume at household level and also really has improved household nutrition security through this dietary diversification. It has also improved the eating behavioral patterns of families.

We have seen that this intervention really works if it is in conjunction with nutrition education not just the

provision of nutrition guidance but with nutrition education. This package normally comes along things like food hygiene, how to preserve food and issues of how to incorporate other kinds of foods stuffs in garden such as agriforestry.

We also looked at small livestock which seems to be quite promising and an example is really from LeSoto where they have reported that small livestock for HIV affected households is really been instrumental in the increasing of household assets as well as also providing things like animal protein. And then on food production, this diversified food production, we have seen also interventions that have worked such as those that promoted orange fleshed sweet potato. There is a very good example Mozambique, where communities have been growing this orange fleshed sweet potato.

In Zimbabwe they are starting to grow casaba, which has not been grown that much in Zimbabwe but because these families would like to diversify the kinds of foods that they are eating this seems to be coming up well as well as also the traditional foods. We have seen with the advent of HIV and AIDS that communities are really going for the traditional foods that they had done away with before the advent of HIV and AIDS.

The next one is quite interesting, I think one of the previous speakers spoke about the issue of labor that labor is really a challenge for affected households. Communities has really gone out to organize themselves in Zimbabwe, we call it Zundamemabo [misspelled?] which is an initiative which has been

taken up by the chiefs that they provide labor to actually grow food for affected households.

The same can be said in Swaziland where they have taken more or less the same model and built up on the traditional system of assisting each other in terms of social capital and this seems quite promising.

I know Michelle will dwell more on social protection especially on the cash transfers but in a recent study that has just been done in Swaziland, this study looked at households that have received cash and have received food and as well and it has been shown that those households that receive cash and food actually even use the cash to actually buy more food. So despite them receiving food they also go and buy food with the cash that they receive. So it looks like people are not really irresponsible with the cash that they receive.

The next intervention is on life skills. As you know, FAO has been quite instrumental in what we have called the Junior Farmer Field and Life Schools. Which has been operational in a number of countries in Southern Africa and which we actually say try to catch them young.

Because when we look at nutrition habits, when we look at food production, it has been quite successful in bring life skills for producing food to these young children that are still growing. The same can be said with school guidance as well.

These interventions of producing food have been introduced in the schools and what has made this intervention quite successful is that it is not just the Ministry's of Education that have been working on the school guidance or on the life skills but they have now incorporated Ministry's of Health as well as Ministry's of Agriculture to provide these life skills.

The next three interventions that I have put in blue are more the institutional responses which we have seen to be working in Southern Africa. The first one being the nutrition care and support for people living with HIV and AIDS, which brings in the whole scenario from production to actual consumption and brings in aspects of nutrition education and this has been building up the capacity of mostly agriculture sector workers as well as health workers in trying to bring the link between health and agriculture as well as also social welfare.

The Extension and Advisory Services, I will not say much but these are actual interventions that promote things like small scale irrigation, good farming practices and these have also been provided through various forms, NGOs but links with Ministry's of Agriculture.

Another way that we have seen that can actually be used to institutionalize some of these responses, is where we have seen countries developing HIV and AIDS strategies for the agriculture sector, where some of these responses are actually

incorporated and actually become institutionalized as people carry these interventions.

So I will just put a few pictures which are where you find people at a livestock fair. They are all brimming with the sweet fleshed potato that I talked about and then as well as somebody working in their garden there.

What have been the strengths of these interventions within the context of HIV and AIDS because some of you might ask what the difference between normal gardening programs is. We are going to put this a bit under the microscope and see that most of these interventions that I have just discussed provide immediate support for these HIV affected households.

They also improve household nutrition through the dietary diversity that I referred to. They also improve behavior in eating patterns because this is one of the most difficult things to change especially for grown up people in terms of what they should now start to eat. And then in terms of asset promotion and generating income because with some of these interventions people are able to sell off the surplus.

They also provide stateless that are less labor intensive and increase the knowledge and skills for OVC and the youth. We would like to think in terms that in terms of the food pillars they are providing availability access and utilization.

I would like to just borrow from one of the programs that we have working on in Southern Africa which is often the

vulnerable alliance which looks at promoting interventions get its stateless that alleviate the impacts of HIV and AIDS on offices.

I think this is also part of what Stephen Devereux has tried to look at in terms of if we are looking the effectiveness and appropriateness of interventions they should really be able to protect, prevent, promote livelihoods of targeted household and they should be accessible, predictable, affordable, guaranteed and unconditional.

We can re-look at some of those interventions and see how they meet some of these criteria that I have just presented and how they are meeting some of these criteria by at least targeting the food insecure and nutritionally at risk. It is quite important when we look at targeting we are not looking at the HIV affected, especially for food insecurity and livelihood insecurity but to target those that are food insecure and nutritionally at risk.

And I am sure in high endemic countries we are targeting the people that we would like to target in the end. And then to integrate these interventions because some of these interventions were are talking of in Southern Africa drought prone so if we are going to provide for guidance for instance without really providing the nutrition that started the water and sanitation support then we have not done justice.

If they are supported by institutional frameworks as I have discussed with the HIV/AIDS strategies that are in some of

the countries like Malawi, Zimbabwe and Tanzania and the fact that they should be gender sensitive. If we look at the caring practice of women and how maybe some of these levels of strategies that we are talking about actually increasing the burden of women.

Also to build on community responses this was really, really critical when we looked at the last study that was done by Scott Drimean [misspelled?] in studies of Gondura [misspelled?] in Zimbabwe where we actually found out that community perceptions were really important in terms of what they themselves considered to be important interventions for them.

Okay, just to dwell a bit on bit the challenges, in the countries that I have taken examples from we will see that food and nutrition insecurities are highly political and therefore the decisions on the kinds of interventions may be quite political. Some of the targeting criteria increases stigma that is why maybe we also try to move away from HIV affected but to nutritionally at risk and food insecure.

Then there are always a lack of clear exit strategies as I have said before, we have been in an emergency for 2002 in terms of food insecurity and most of the programs have really been emergency programs so there has not been really a clear distinction in terms of exit strategies. What came out of some of the studies with that, the quantities were just too small and they did not make any impact. If it is a livestock

program, if it is a garden program the quantities were almost negligible.

Food aid and agricultural inputs have really dominated the response without providing the extension support that should go along with it. And then the cash transfer only work in stable communities. It is an unfortunate account from Zimbabwe but this will not be time to give cash transfers in Zimbabwe at this moment in time.

Designing implementation methods that will translate into reduction in hunger in Southern African is still really a big challenge and of course the issue of water I have discussed.

Lessons learned. Well to understand the livelihood of people and their needs is really key. I think that it cannot be underscored more. Interventions have to be based on specific contextual environments according to assets and opportunities and aspirations of target. We found that in one of the studies that was undertaken, definitely there were very big differences of terms of what type of interventions to give to give to communities because of the geographical context., because of the livelihoods that these people have always had.

The quality of implementation is important for success that cannot be underscored, short team agency have little or no impact and then to really stress this partnership between agriculture, health and social welfare, which we have been trying on this nutrition, care and support program which we

have done in seven countries in Southern Africa and which a partnership between WHO, FAOWFP and the local partners and local government ministry's.

Strong policy frameworks are required to support these interventions and then the cost effective challenges solutions are solutions are still a challenge and the issue of inheritance. I hope somebody will touch more about it, is still an issue regarding this protecting assets which we hope people use to carry out their livelihoods.

This is my last slide on the recommendations. To support and build on existing livelihood strategies, to target attitudes and knowledge regarding food and nutrition security options, for better targeting to target food insecure and nutritionally at risk and linking emergency relief with development.

And then also creating the right policies in agriculture to help farmers to grow a diversity of food and to grow more food I think that Saadark and Commisa are trying very hard to see how this can be possible. How instead of providing food aid coming from outside we can actually ask the farmers to actually grow this food and then buy off the food from them and then also to document and apply lessons learned.

I know with PCI Project Concern International, they have been trying to build up the observatories from Zambia Conference about two years ago in terms of what is really working.

A RENEWAL, RVP is in regards to Southern Africa they have also been trying document those lesson learned and sharing those. Then the rolling out of joint FAOWHO training, this is one that is on nutrition care and support which really brings out issues from production right up to consumption and the nutrition part. And then life skills catching them young. These projects need to be expanded.

I would like to thank you but I would like to say we do have those studies that have I have been referring to should anyone have an interest I will just put my Email for you to take. Thank you very much.

STEPHEN LEWIS: Thank you Fadzai that was quite an omnibus review of the various interventions, household gardens, livestock, collective labor active. It makes you wonder sometimes why we are unable to bring these things to scale in countries in a way that would alleviate the desperate hunger that is so often felt. I have never fully understood the impasses myself.

I was concerned only with your reference of the expansion of sweet potatoes in Mozambique because I fear that it will catch to attention of Minister of Health in South Africa and she will migrate and destroy the policies in yet another country.

We are now in for a treat. A shift in emphasis, to the livelihood and clinical support in mobile and transient fishing communities. I say a treat because I had the privilege of

looking through Janet Seeley's slides in advance and I was quite struck and fascinated by the content. I suspect you will be too.

Janet Seeley is a lecturer at the School of Development Studies, University of East Anglia. She has worked on HIV and AIDS and livelihoods issues since the late 1980s. She with Eddie Allenson, the World Fish Center has been involved in research and advocacy on HIV/AIDS and fisher folk since 2003. It is worth it to come to a Conference to hear the word fisher folk used. Janet.

JANET SEELEY, PH.D.: Good afternoon. It is a pleasure to be here. As Stephen has said, I am not sure I can live up to the build up but it is a shift now to think about the group that I believe are significantly neglected and it one of the tragedies that UNAIDS are still not mentioning. The epidemic fisher folk throughout the world in the global AIDS reports that we get and we are trying very hard to change that.

This is a rather out of date slide but it gives you some idea of the scale of the epidemic amongst some selected fishing communities in four countries. Very quickly, the red line, the fisher folk down at the bottom you can see the number of likely to be affected in those groups compared with other traditionally high risk groups. Truck drivers, military prisoners and injecting drug users.

In a sample of 10 countries that we looked at the prevalence rates are between 4 to 14 times higher than the

national average in nine out of 10 of those countries. Among fisher folk and we use that term because it embraces everybody involved in fishing not just fishermen but also fish traders, fish processors and etc., men as well as women.

This is a rather stereotypical view of fishing lifestyles but if you look throughout the world a number of these elements that hemorrhage into who I have just mentioned hold true. Vulnerability in them because of high mobility, long absences from home, cash incomes that are erratic but you get cash in your pocket you want to spend it. Casual sex availability, alcohol et cetera.

It is not just fishermen, this quote is about fishermen but get women fish traders who in order to secure their particular livelihood may have to engage in either taking very low prices therefore increasing their financial vulnerability or in some places so called sex for fish deals whereby they exchange sex for fish in order to secure the sale. Transactional sex is something that is quite widespread in a number of different places, not just in fishing.

Poverty vulnerability marginalization. As I said, the fisher folk not always are the poorest of the poor so the money in the pocket is erratic. It comes you want to spend it and it is unlikely to be save. It is political social marginalization, poor access to services and vulnerability due to insecure rights uncertain productions and high physical economic and regulatory institutional risks.

We have heard many fishing people say, if we are going to die on the lake or we are going to die in a fishing accident at sea why worry about HIV. This is a stylized schemer of the potential impact of HIV and AIDS on fishery sector from the individual, where you have got declining ability to work and stigmatization out to the whole sector where you have got issues around reduced management capacity.

And it is a sad fact we have heard some people say, well if there are less fisher folk than that is good for the fish. They will not be so over fished. That is not only a rather sad thing to say but it is also inaccurate because people who hard pressed often engage in illegal or inefficient methods which are greater risk to the fish. So there are a number of different impacts at different levels.

So what are we doing about it? Well actually, not very much. I have some few examples of some of the things that are happening around the world. AMREF have a project in Homer Bay in Kenya. They are working with 200 orphans and 240 widows in that area mainly related to fishing and then working to protect their rights and look at different ways to offset the economic impact of HIV and AIDS.

Papua New Guinea. The Coastal Fisheries Management and Development Project, now BNG and other areas in that region you get a lot of women who are fishing. Women who are fishing and coming into contact with large strollers and so forth which are populated by men, they may have relationships with those men in

order to secure their own catches. Some of the literature that this particular project are using highlights those relationships which are putting women as well as men at risk.

In the Malawi Populations Project in the Greater Nikon Sub-Region it is not just about fisher folk but targeting them in issues around preventing HIV and AIDS, again awareness raising.

Now the Sustainable Fisheries and Livelihood Program in West Africa was an initiative between FAO and DVID in 25 countries. It ended last year. This was again around the number of different things to do about livelihoods but included a lot of work on HIV. Awareness rising again actually trying to create awareness through diagnosing the extent of the epidemic or the extent of knowledge of the epidemic and then theater for development. Raising awareness through plays and so forth as you see in many other scenarios.

Also working to establish cross sectional linkages and mechanisms for implementing community action plans. The alternative livelihoods, trying to help people who can no longer make a living out of fishing.

Addressing the social conditions of fisher folk I found one project which I think really sort hits the mark on it is the Population Equity AIDS and Coastal Project, so called PEACE in Tanzania funded by USAID. This really has a twofold part. One is trying to help coastal communities in there livelihoods but also trying address issues around resource degradation of

the coastal resources and introducing alternative livelihoods again. Paprika farming and milk fish agriculture which is a particular type of fish which is evidently quite popular there.

Another project that has just started and it implemented by FAO and the World Fish Center and is funded by the Swedish CEDA. Fisheries and HIV/AIDS in Africa and each of these dots represents a group of local researches or implementers doing small scale project under this umbrella and they are looking at some particular areas. It has just started, it started last year.

Looking at mobility and migration trying to identify target groups of mobile populations, looking at fish market chain. Now this is also involved in what I mentioned before the sex for fish deals but also looking at the vulnerability of female fish traders who are scraping a living from the work they're doing looking at business innovations for them.

Then nutrition impact. Martin has mentioned this already. I think we should not have the idea that fish are very well fed because of they have a good diet of fish. The tragedy is many cannot afford to eat the fish that they catch and so looking at what could be done to nutrition contribution of fish in target areas, the health impact of fish consumption. Trying to raise awareness over the value of fish in the local areas and looking for ways to ensure that some of the fish is affordable.

Institutional change integrating fisheries into food security monitoring for example there you will see and raising awareness amongst other related sectors.

The final project I want to mention one that has just started that I am involved which is funded by the EDCTP Program. Is implemented by a group of partners in Uganda and Malawi. Led by the Uganda Virus Research Institute. The title is rather scary and is talking about preparing fishing communities for future HIV vaccine trials.

Actually what we are trying to do is work with fishing communities on any interventions on prevention as well as treatment and care. Because in building up so called cohorts for vaccine trials one has a duty of care and ethical obligations towards supporting those communities for better access to what is available now.

So the two initiatives, one in Malawi and one in Uganda have slightly different titles but they have the same fundamental aim. Trying to prove that one can work mobile populations and these particular mobile populations for the long-term because so many of the interventions have been very short term one off projects. What can we do to really as Stephen said to scale up?

So, many of the efforts are small scale they are often short-term and few as yet really address the social conditions of fisher folk which affect the susceptibility to HIV infection

and mitigate against provision of adequate care and support services.

The fishing industry throughout the world supports hundreds of thousands of livelihoods and is a source of food and employment for many, many people. Yet the spread of HIV among fisher folk remains a major threat to their survival and existence because very few of them are as yet being reached by treatment and care.

Much more needs to be done to ensure this woman fish trader in Uganda who I have pictured here as well as other woman men and children and there are many children who are fisher folk too can enjoy and I use enjoy advisedly because we want them to have productive and dignified lives. Thank you.

STEPHEN LEWIS: You will agree I think that this is a remarkably disciplined and interesting Panel. One of the pieces of material I saw said that there were 250 million fisheries dependent to people and the extent of the fisher folk and vulnerability I was most interested in Papua New Guinea, because it begins to explain why Pa New Guinea, has such a high prevalence rate in the South Pacific some of the other countries.

I thought too if I may be so bold, Janet, that that was a stunning graph on the comparative prevalence rates amongst high risk groups. I mean who would have thought that the prevalence rates amongst the fisher folk of Indonesia significantly exceeded injecting drug users. I mean that

simply has never entered the sort HIV/AIDS parlance and therefore think you are quite right to say that it should have place in the reports that are issued because it is of great significance.

We turn now to our final speaker who is Michelle Adato who is going to speak to us on social protection challenges and responses. Michelle, I was at a Conference over the last two days held in conjunction with the International AIDS Conference on Children and AIDS and it was quite interesting how the focus flowed to cash transfers and social security as the answer to the difficulties which children were facing. So your presentation is certainly germane.

Michelle is Senior Research Fellow with IFPREY who leads IFPREY's global program on large scale human capital interventions and she is involved with RENEWAL theme on AIDS community's resilience and social protection. Michelle.

MICHELLE ADATO, PH.D., M.P.A.: I am going to start out talking out social protection is so important and urgent at this time. We have heard this morning the many ways in which HIV and AIDS destabilizes people's livelihoods but what it also does it simultaneously destabilizes those communities and family safety nets that in the past have supported people in time of shock.

Now we know that those communities and family safety nets are till there they are still playing a very important role in many ways, but they do not have the sort of economic

and other resources that they had when they are effected when many pep and families and communities are affected at the same time by AIDS.

And what social protection does it provides various forms of social assistance, social insurance and social services to those who are very poor vulnerability and excluded from society in a range of ways that do not otherwise have access to that sort of assistance.

Without social protection what we will see is an acceleration of that of that vicious circle between poverty, food security and AIDS that Sunita laid out in initial presentation, but we will also see a of human capital of children, losses of human capital in future generations which have irreversible consequences.

There are not at least over 100 studies that show the interactions between early child nutrition, health and education and we know that poor and malnourished children will start school late or not start school at all, they will achieve lower school achievement and there is many studies showing how childhood nutrition and years of schooling affect people wages later in life and so we see how failure to stem the loss the human capital will have affects that are going to be passing poverty on through generations.

This is a conceptual framework for showing what social protection is and what it can achieve. What we have at the bottom is a range on interventions that normally fall within

the group of social protection and up above we show the various different effects that it can have from securing basic consumption to reducing fluctuations and adverting people off of assets as well as enabling investment in assets and increasing their productivity as well as transforming a range of relationships.

The point of this graph is one, all of those different interventions can be designed in different ways to achieve all those different objectives. However, they are going to have tendencies more of being more effective of achieving certain objections in others.

Certain ones that are on the left side have shown to require lower capacities on the part of beneficiaries as well as on the implementing institutions. They are faster to scale up and they requiem lower inputs where as you move to the right hand side it requires higher capacities and higher inputs and are going to be slower to scale.

So there are good arguments for all these interventions but there is going to be tradeoffs between them. I am going to focus first on some impacts of cash transfers and food transfers because those have some of the best impact evaluations and then I am going to present a range of other social protection options that can be designed in ways to make them AIDS appropriate or appropriate to populations that are highly affected by AIDS.

The purpose of this slide here is to show that cash transfers and large scale social protection more generally is not just pipe dream on the part idealists that actually these large scale programs exist and other ones are in planning stages with governments having serious plans to scale them up.

Now those questions as to what extent that scale up will take place but currently we have got programs in South Africa that have reached over 8 million people at `Ethiopia as well which is not on here because it is a slightly different design but that reaches over 8 million people it is a cash transfer and food transfer for work activities.

We have got tens of thousands of people covered by old age pensions in Southern Africa and now in some of the countries that are normally associated as poorer where we would expect to social protection to be more difficult to scale up, Kenya, Zambia and Malawi and Uganda are all they have pilots and they are in the process of scaling up to tens of thousands and they have got plans to go up to the hundreds of thousands now on Kenya, and Malawi appear to be largely on track.

Zambia and Uganda have run into some problems and so there are questions around political will, political commitment and capacities that I can come back to if there is time but nevertheless this shows what is possible.

We did a review in conjunction with RENEWAL and Joint Learning Initiatives on children and AIDS looking at impacts on human capital from cash transfer programs in particular and I

am just going to show a small sample of impacts on school enrollment, South Africa National data a 25-percent increase on enrollment. Ethiopia has shown an increase for not impact on girls or I want to say something about general impacts in a minute.

Zambia and South Africa have both showed the highest impacts of the five to six year olds showing an increasing school readiness possibly as a result of increased nutrition but you see a very sharp drop here in Zambia once you get beyond the first couple of years and see you see still a good impact on boys but very little actually negative on girls.

I think the point of this is to say that while cash transfers have showed effectiveness they are still big gender gaps and it is important to pay attention to gender in design.

Health impacts have shown the new results from the scaling up cash transfers program in Malawi has showed in terms of reported health improvements in increase of 55-percent of people reporting health improvements. Acedias and Zambia showed a reduction in 12-percentage points in the incidence of illness.

In South Africa a study showed that the children support grant if received within the first year of life and two thirds of that period will increase child height. In South Africa the old age pension was also shown to have a significant increase in child height but there are also some gender effects as well.

I think what is interesting about this particular slide which looks at seven different cash transfers programs in Sub-Saharan and Africa, what it does is it shows that people spend the cash transfers on food so concerns about people maybe making bad spending choices and so on are largely unfounded between 40 and 70-percent of the cash transfers are normally spent on food.

The other category is other and some of the items that go under other are transportation and that is important when you think about the people need for transportation to look for work to reach the clinics to pick up their ARVs also clothing and blankets. So cash provides for people other additional household needs.

I am going to report some selective impacts on food transfer and nutrition programs. The first two results are from generalized the ones that are not AIDS affected populations in particular about 16 out of 18 evaluations showed that maternal and child health and nutrition programs were reducing stunting. Early results comparing different types of food supplementation for highly malnourished children in Kenya found 80 to 90-percent recovery rates.

I am going to skip now because do not want to take up too much time but basically some of the ones that worked with HIV affected populations in particular found in Tanzania that women who received daily a multi-vitamin supplementation were significantly less likely to progress to the higher stages of

terms of the WHO disease progression and die of AIDS related causes and some new research by Matt Moran and Sunita and others in Uganda have shown that ART plus food and food alone have positive impacts on weight gain and slowed health status decline.

I am going to present some other types of approaches to social protection they do not have the same kind of impact evaluations that have done but nevertheless show promise in terms of reaching AIDS affected people populations especially when they are designed in a particular way and not in a conventional way to be appropriate to particular set of circumstance.

In South Africa in Qwazoon Naton [misspelled?] particular household contracts have been designed for families that have flexible hours that allow families to substitute labor, different family members can all participate in that showed a reduction in families that reported having to reduce children meals from 34-percent down to 1-percent and a substantial increase in school attendance rates.

In Zimbabwe, public works programs have designed very light work activities as well as more restricted tasks to families that are weaker as well as providing child care. Very interesting innovations going on in the area of home based care and early childhood development in a number of countries in South Africa.

In Zimbabwe and Mozambique they are doing work with home based care. Zimbabwe has monitoring and referral and particular work around ART. South Africa has some very interesting work going on in its Department of Education and Department of Health and Department of Public Works to scale up hundreds of thousands of learners in the area of home based care and the ECD and to provide work opportunities.

So those are not necessarily work opportunities for people who are directly affected or severely affected by AIDS but it provides the care services and it shows how public works can be made to relevant in a AIDS affected context.

Public works are also joining up with information education and communication activities that center around AIDS education and a number of other health and nutrition education issues. There is limits on those in terms of how when you get into these complicated designs, how many people you can reach as opposed to the large scale cash transfers that can reach more people more quickly.

And also when you are talking about ECD and home based care there some serious questions raised about the quality of the services you cannot scale up very quickly and not worry about making that those services care for children and old ill people are not very well done and implemented.

On micro credit and livelihoods Fadzai gave a very comprehensive review of livelihoods and so I am not including this in presentation I want to say a few things about micro

credit because it generally tends to not be the best approach for families that are not suffering some of the more severe consequences of HIV and AIDS nevertheless there are ways in which micro credit has been designed to be responsive.

Having groups that include having affected and non-affected household using them to promote education and preventive services having rest terms between loans, having offering financial packages that require everybody to purchase certain kinds of health and burial and life insurance.

Also targeting each of those members who are HIV positive but still productive. A study in Zimbabwe of a program that implemented some those particular aspects of design showed that clients actually savings and school enrolment compared to the non-affected clients.

Other approaches involve linking transfers food or cash transfers with the different types of education activities in Kenya the net cash transfers program there links with lectures on maternal and child health and prevention and treatment of illness and nutrition. Using paydays to promote information and behavioral messages and giving people information about health services as well as information on psychosocial support and the possibility as well of income generation programs.

Now there is going to be hard to reach children which require a whole different type and set of interventions in terms of street children abandoned institutionalized as well as child headed households and so there are smaller scale work

doing on creative approaches to trying to reach those others who would not necessarily be captioned by a cash transfers program in particular.

I want to talk about what I think are some of the key policy debates within social protection currently. One is around food or cash transfers. A lot of work has been done on food or cash outside an HIV affected context and found that there are relative advantages in disadvantages that have to do with markets and prices, capacities politics and gender relations. For very severely malnourished and the ART patients these people that need food now.

So food transfers and nutrition programs might be more appropriate on the other hand cash assists with both food as well as transportation and other household needs. I do not think this is an either or and we can come back to this but these are issues are being currently debated. And certainly all issues take on whole new dimensions in the context of rising food prices.

Other important questions around targeting. Who should be targeted and how. There was a lot of momentum for many building up around orphans. A consensus at this point is that it seems to be reached about not targeting on AIDS in particular and on orphans but rather on multiple poverty and vulnerability criteria for example labor constraint or high dependency ratios.

However, some papers that were presented the last couple of days at the Conference Symposium on children and AIDS were also pointing to the fact that we still need to be attentive to the situation of orphans.

In Malawi and Zambia a program that targeted specifically on multiple vulnerability criteria were found that 70-percent of the participants were actually directly AIDS affected we might want to make an exception for ART patients in terms of doing AIDS specific targeting there.

There is a big question now around the e question of child support grant or pensions in six Southern African and Eastern African countries over 50-percent of orphans are living with the elderly and so reaching AIDS affected through old age pension have been shown to be effective on the other hand there is going to be some children that are going to be missed.

And so that is a debate happening in a number of countries right now. Also when you use conventional means tests for communities based methods and there are some communities based methods have been shown to be effective in a number of the new programs in Africa but there are some problems and complications in trying to scale them up.

There will be debates around direct transfers versus livelihoods support and I think that maybe can come back to that but there certainly a case for some people that direct transfers now versus some of the kinds of livelihoods support

options that are presented but again it is not an either or there is ways to combine these.

Another debate going combining transfers with services one is a debate about conditionality. Do you require people to participate in health nutrition and education services as they do in Latin American and parts of Asia which have shown to have very high impacts. There are very good impact assessments on the other hand there are some very good questions being about whether or not in the African context the supply of services is adequately available to be able to make conditioning appropriate currently.

There are a number of ways of combining social transfers with services without making them mandatory and social welfare services, a big debate going on about that right now. Child protection psychosocial support, very good arguments for why these types of services not just cash or a food transfer. On the other hand the transfer programs are difficult to implement and are you going to over burden them if try to load all of these different dimensions on to a cash transfers program.

Questions surround durations of coverage how long do people stay in the program how do you bring them out of the program. There are life cycle approaches if you have the resources to cover people at all these crucial stages of the life cycle on the other hand for many countries that are just

starting out with social protection programs you might need to start small and then scale up as is possible

And then some questions around capacity and affordability which are I should say costs because I think affordability is really a political economic question but costing that needs to be done.

I am just going to make some final comments up here on what I perceive are the gaps in knowledge and in action. We need to compare impacts not only within particular program but cost across different programs today. Really some costs and benefits across program types. We know certain kinds of programs are very effective but effective as compared to what?

The dilemma is that action is needed now if you do not provide the social protection to children between 0 and 2 they are never going to recover from the effects that they are currently experience and so how o you balance that need for cost analysis, for comparing across programs to the need to say this is a good strategy we need to scale this up now.

We need typologies of different types of programs across different regions, different context within those regions and for different groups. What kinds of programs are most relevant to particular areas and particular people within those areas.

There are very strong gender effects of all these different programs. Who gets the benefit, who benefits in terms of the outcomes and those need more attention to program

design and there are some interesting attention to that in Latin American. I think that as these programs now into Sub-Saharan and Africa there needs to be more and more attention to gender.

Capacity audits. What exists currently that can be scaled up providing services, providing transfers and implementing these different types of interventions. And what sort of modalities exist for technical support. There has been some experience with mobile task teams. Do we need something like that for social protection?

Then finally the last point I want to make is about political commitment because I think there is sufficient evidence now that social protection programs are feasible and they are affordable but the largest gap seems to be in terms of political commitment.

There has been a huge amount of progress I was at the African Regional Meeting in social protection for Eastern and Southern African in May and 17 countries presented very ambitious plans for social protection. I think there is a lot of commitment now in this area but what you find that in the implementation phase a lot of road blocks, a lot of stumbling points.

And so thinking back to that slide I presented on going from a few thousand pilots of hundreds of thousands are we going to get there and what is needed in terms of work on that part of champions in government as well as international

communities and actors in civil society to try to achieve those goals. [Applause]

STEPHEN LEWIS: I would think it is pretty exciting to be on the cutting edge of the cash transfer debate. Another expert who I am sure Michelle with and knows well Dr. Linda Richter was saying that one of fascinating things about the cash transfers is how inexpensive they are.

That they can consume something like 0.5-percent up to 1.5 of GNP, which is very, very small percentage of a country's wealth if in fact the social transfer is rolled out across the country to say 10 to 20-percent of the poorest families will make an astonishing difference in the fight against the pandemic.

That ends, I think, the formal interventions because we started late and because there are people in the audience who might well wish to ask questions, if the panel does not mind I am going to turn it over to the audience because only have about 20 minutes remaining.

There are two microphones in the center of the room I judge that they are controlled by the [inaudible] in this corner. If anyone wants to ask a question please go ahead.

KATE GREENWAY: Hi, I'm not shy, is this on?

STEPHEN LEWIS: Yes, if you would introduce yourself and your organization if you are affiliated.

KATE GREENWAY: Sure, my name is Kate Greenway

[misspelled?]. I am currently unaffiliated. I am a consultant
kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

I work with a number of NGOs. I want to congratulate the panel on a really focused, really punchy presentation, it was fabulous. I need to make a quick pitch and then I have a quick comment. I hope you can bear with me to take two spaces.

I am working with PCI, with Project Concern International on the Forum, The Africa Forum 2009, which is the follow-on from that forum that Fadzai mentioned, African Forum 2006. It is specifically on food security and nutrition and HIV. It is four practitioners on the ground. It is not a big, big plush conference it is very much for the ground, who is right in the field, it is their conference, that is your conference if that is who you are.

There are save the date and get in touch with us cards on the back table or you can grab from me. I will stay around until the bitter end and catch you as you leave.

A comment that I wanted to make really just that it strikes me that I am seeing more and more that there is urban hunger. We used to think that hunger was something we found more in rural areas and we needed to work on food security and growing crops and that kind of approach.

I know that the cash transfers piece is really going to help with urban hunger in emergent or urgent phases but I guess I am really just asking us all to pay attention livelihoods in its purest form for urban communities who are experiencing such extreme hunger and poverty related HIV impacts. I am jut throwing it out there as a thought, I am not sure if anybody

would like to respond but please can we keep it on our radar?

Thanks.

STEPHEN LEWIS: Thank you Kate. Thoughts are always welcome. If you are going to ask a specific could you direct to the Panelist of choice. Yes, go ahead next.

CARLY NIGES: Hi, my name is Curly Niges [misspelled?] and I am from the Netherlands. I work for ETC Crystal as a consultant. I just came back from Indonesia on an assignment and what struck me from Mrs. Seeley's presentation was the statistics on the fisher folk, because I talked with a number of key players, the National AIDS Commission, UNH, FHI, Australian Aid and nobody mentioned this.

I came across one NGO working in the southern part Pucko who is targeting the fisher folk. I would like to get some more background on the data itself. How was it discovered, why is it not being paid attention to? What is the opinion of Mrs. Seeley? Thanks.

STEPHEN LEWIS: Please, Janet, go ahead.

MARGARET: Hi, good afternoon, my name is Margaret —

STEPHEN LEWIS: Could you wait one moment, Margaret? I would like Janet to respond if I may. Thank you.

JANET SEELEY, PH.D.: Yes, that is what provoked us look into this more closely. The graph came from a paper published in AIDS in 2005, where we reviewed all the available

literature that we could find on HIV in fisher folk and the statistics comes drawing that together from across the world.

I think it is, perhaps some people have said and told us that fisher folk cannot have a focus because it is a fussy area. There are fish farmers there are some people who do it as a very minor part of their livelihoods. Where do you draw the line?

It is not a livelihood that is so easily defined but I think the striking thing from an increasing body of literature because there are a large number of researches engaged in looking at this more closely are that the prevalence levels are high in different places in the world.

There is some recent data from Uganda from Lake Victoria, the lakeshore communities where you have got prevalence rates of 20 to 27-percent and you go inland and it is 6, 7-percent which is still high but it is horrendous in some of these coastal communities. I think it is an emergency that we have really been quite blind to.

STEPHEN LEWIS: Thank you for that. Martin wants to say a word to Kate about urban hunger.

MARTIN BLOEM, M.D., PH.D.: One of the impacts of high food prices will be particularly on the urban areas. We have seen for example in Indonesia. It is actually has shifted to effect the high food prices.

The whole discussion among the UN Agencies as well as the NGOs that we have to focus a lot on quality food and what

kind of form and particularly in urban areas. When you think about sustainable issues, you cannot ignore for example the private sector and that is why groups like GAIN for example are very much in force in looking into sustainable approach so that you can actually do a good cash transfers program.

Because if there is no product available so that they can buy good product which is highly nutrition it does not help very much particularly when focus on young children or when you focus on people living with HIV for example who demands are much for tuberculosis.

What we see in WFP is that the last couple of months we have an enormous trend into looking very careful how we can actually improve the food basket with much more high quality products but as an agency you cannot do that alone and that is why I think the nutritional communities specifically is very serious about looking in all different ways to improve the quality and focusing particularly on the urban areas.

STEPHEN LEWIS: Go ahead of Michelle.

MICHELLE ADATO, PH.D., M.P.A: Again, in quick response to Kate. This is not specific to the urban context but I think your question about not forgetting about livelihoods your point is a broader one. There is different ways to look at it.

One is that the straight cash transfers for the very labor constraint for those who have such high dependency ratios could work but they practically cannot. However cash admitted

again is not an either/or working together can be very effective. Cash can be used for investments.

Research in Mexico on the cash transfers progress has shown productive improvements and investments using the cash transfers there. Recent results from a study by Efpere [misspelled?] in Ethiopia showed— their productive safety nets program showed a cash transfers plus agricultural technology support and agricultural services was more effective than a straight cash transfers in terms of certain food security indicators and investment indicators.

However, in both of those studies you have a more productive populations people are not necessarily on the whole as affected and again it depends on you are trying to reach and what kind of program that you would want.

STEPHEN LEWIS: Margaret, thank you for being so patient. The microphone is yours.

MARGARET: Thank you, thank you so much. My first question goes to Martin on the issue of high food prices. The reason why I am asking this is because hyper endemic communities we are now faced with a situation where the high food price is complicating and if anything might even undermine some of the gains that are beginning to be felt and the impact on HIV and AIDS particularly among the poor who already have problems with accessing food, who are already having those kinds of problems is going to be very, very devastating.

So I do not know what you have or can to tell us according to the WFP's policy responses that you see that can be put in place to cushion those that are in critical need and are being impacted negatively by high food price. So that is my first question.

The second question goes to Michelle and Fadzai. Again, my observation here is that you did tell us about targeting the food insecure and nutrition at risk. I am working on a project with WFB and we are trying to develop a guideline on targeting people living with HIV/AIDS who are food insecure and nutrition at risk.

Our experience is that targeting these populations is very complex because the assumption is not all households or communities who are HIV/AIDS are food insecure. And not all food insecure households are HIV/AIDS positive.

So when you want to target for food assistance how do you do it in order not to have as your beneficiaries in order that you not end up with populations that you do not need. To eliminate the inclusion and exclusion areas. How do you target effectively? And the same will come to cash transfers how do you target that you only end up with actual populations that are at risk? Thank you.

STEPHEN LEWIS: Thank you. Those are very reasonable questions, well designed. Martin, do you want to take the first?

MARTIN BLOEM, M.D., PH.D.: Absolutely, very important question, very difficult to answer in the sense that WFB works in close cooperation with UNICEF for example have designed various safety net programs. What we are trying to do at headquarters level, especially under the leadership of our new executive director, is being more innovative looking at what I said before, the issue of quality food is extremely important.

Now for WFP, however to implement that is of course is much more complicated because we actually do not even have some of the products are not even available. There is a lot of research ongoing furthermore there is of course an enormous lack of funding even despite the fact that we got billion dollars to actually at the ground.

If you look at the problems which are currently going on in Ethiopia and in Somalia as well as Sudan, a lot of the cost already go to those countries. What I would say on theoretical basis we try to work as much as possible with a lot of other partners to come up with good safety nets, which have a sustainable aspect but include in fact very much the shift at the same time that we cannot just give food for food anymore but that we have to give high quality food as part of the food basket particularly for vulnerability groups as well as the mechanism of how are we going to do it is again is not only food alone but we are very much into mechanisms.

Like for example the cash transfers conditional cash transfers all the different possibilities. But again of course

the country offices are also changing and they are under pressure at the same time so this is a major obstacle so we have a lot of country offices coming to Rome and have discussions about what the new programs should.

We do not know all the answers and the world does not know all the answers and that is why in fact we need to be very very keen on doing monitoring evaluation as work for example a group like IFPREY who does a lot more research on what works and what does not work.

At the same time you have act now and I think this is what is going on and I think we need a lot more funding in fact to support whether it is in the form of food or whether in the form of cash transfers. I really think it is a problem that is underestimated. I think the impacts will be much bigger now at this particular moment really realized.

STEPHEN LEWIS: I thank you for saying Martin because persuaded as well that that is true. Fadzai, do you want to take the first crack at the second quest in that asked?

FADZAI MUKONOWESHURO: Thank you. Thank you very much. I think I will insist on the targeting of food insecure and nutrition at risk but still go back to the point in terms of what kind of intervention are we talking about. Because with some of the interventions be it food aid may be in most instances you do reach the target right in terms of maybe these are people that are assisting antiviral treatment but for the food insecure and nutrition insecure especially in high endemic

countries in most instances you will be able to hit the right target that you would like to target. Thanks.

STEPHEN LEWIS: Michelle?

MICHELLE ADATO, PH.D., M.P.A: I will preview some of the work that was done in Zambia and Malawi targeting on the cash transfers programs there. I can give you some of those reports because they did a very interesting process of work shopping this and working with a number of communities on how to develop system for targeting the cash transfers and [inaudible].

STEPHEN LEWIS: Sorry, we have a problem with the audio.

MICHELLE ADATO, PH.D., M.P.A: And what they came to they communities based processes that involve local area committees and district committees and they came up with across a number of communities a set of criteria that, as I mentioned before it has to do with labor constraint of dependency ratios of about three to one and what was considered extreme poverty.

That was often locally defined although there was a fair amount of commonality across the definitions and what happens is a communities committee comes together and decides who that pool of people that meet this criteria.

And then there is a district level committee from there that reviews it so there are some checks and balances to the system. Now there are going people that are missed through that and that is one of the things that some of people working

on the cash transfers programs are looking into but largely it has worked well.

And as I mentioned some research that was done on that tried to look at who was targeted in comparison to data that was collected according to a number of criteria as AIDS affected that had to do with deaths from illness and orphans and certain other indicators found that 70-percent of the people in that program what they called severely AIDS affected.

So the program managed to catch those people but at the same time they were catching the people who are poor and food insecure. And so targeting based on food insecurity and extreme poverty might be a better way than trying to get directly AIDS affected populations because of stigma issues and for equity issues because the evidence of whether if orphans are more disadvantaged than non-orphans is very mixed.

But again there are going to be some populations like on ART that you might be able to work with programs directly through the clinics whether it is food or cash.

STEPHEN LEWIS: We have a looming problem because we have more people wanting to ask questions than the time available but if you can ask fairly quickly and I will prevail on the Panelists who reply briefly maybe we can get through two or three or you, maybe all. Go ahead, sir.

GAVIN SILVER: My question is primarily to Michelle, my name is Gavin Silver [misspelled?] I am from the Treatment Action Campaign. In South Africa you mentioned how children

and OAPs have the means to supplement healthy living through United VEV.

The old age pension drawers and child drawing respectively but that effectively leaves everyone from the age of 18 and 65 at the moment only have access through the disability grant to access that you need to be so sick that you are unable to work.

My question reward staying healthy rather rewarding getting sick and how do you end this cycle of, especially people with chronic illnesses becoming so sick that they are unable to work and going onto a grant for year, getting better and then getting off the grant and having the whole cycle repeat itself? How do you change or how do you suggest that policy changes around the social welfare in SOUTH AFRICA to better target this massive segment of the populations?

MICHELLE ADATO, PH.D., M.P.A: I think it is a difficult question especially because there is a time limitation. I think there are problems around the criteria for the disability grant which is very restrictive and then have people falling ill again as you point out and it is a serious problem.

And right now the child support grant largely goes for the family as a whole. So it is not that those people between 18 and 65 are completely uncovered the grant is distributed but there is arguments for making the grant higher and certainly it is not sufficient as a poverty alleviation strategy but it is

what they have go going so far and again the old age pension also supports many people as well. So they are both dependent on that but the idea of the disability grant is a whole other debate in a sense.

STEPHEN LEWIS: Maybe the two of you can have a chat immediately afterwards. Yes sir?

PETER: Thank you my name is Peter and my question goes to Martin, I am the National Coordinator for a Newer Uganda and that the start of the increasing food prices there was this line of argument that the increase in food prices is actually beneficial to the farmer from which you get income to meet food and nutritional requirements apart from gaining more income.

My question is, have you come across any evidence across any of the countries or from recent history that supports this line of argument? Thank you.

MARTIN BLOEM, M.D., Ph.D : I think it is a very good question because it always comes up as an argument. If you remember the first slides I showed were from rural Bangladesh and it was clear that in fact that the rural populations in Bangladesh was actually benefiting from low rice prices.

And you would say it is all rural they produce rice but in fact only 5-percent of that populations were actually net producers of rice and most were net consumers of food. I think that is happening in many, many places in the world you have to make the analysis first where in fact people are really actually producing so that they can sell.

This is one of the reasons why I said that the high food prices in first instance will have an impact on urban populations who are completely dependent on a market economy. I am not saying because we didn't talk Peter, a lot of discussions about small how they may still benefit from the high food prices.

That is maybe possible but also the inputs for the farmers are increasing for example the fuel prices, fertilizer, there are other issues like transport like going to the market if farmers do not have access to big markets that is not a problem.

I am not an economist I am a medical doctor so I am not the right person to talk on this subject but I know that it is much complicated. And I personally think the reality a lot more people will actually have problems with the high food prices then in fact people will benefit from.

But it does not mean that of course for example we do what we call P for P that we actually support farmers to produce locally and sort of eventually they can actually use those products also for the fundamental groups so there are different ways to different ways to tackle that but I think in general more people will actually have negative impact of high food prices.

STEPHEN LEWIS: In the interests of equity, let us see if we can get the last two questions in and we will do it as quickly as possible. Go ahead.

MARY ENGEROGA: Thank you. My name is Mary Engeroga [misspelled?] I am from WFP. And my is just a comment to support what Martin said and also on the programming side regarding urban programming Kate and Margaret asked about urban programming and Margaret was very specific high food prices and their impact.

Just to share with you a little bit WFP has been doing assessments in most of the countries that have been affected and we can talk about it more after I realize you do not have time and also we have in theses assessments we have a component of HIV so once the analysis is done will be able to capture households are affected by HIV and AIDS are coping.

The second thing is that in the whole debate of high food prices if you look at the June declaration you find the high level meeting which was held in Rome you find that social protection has been the immediate response more or less give the money to [inaudible] and in that there is a focus on the immediate needs and the focus also on vulnerability groups and within these vulnerability groups we have HIV and AIDS.

I think that is a big, big step for us and we just need to make sure that there is real impact. Then lastly I will just mention that at this stage of [inaudible] we are not able to share with any of these assessment reports. Martin mentioned about qualitative study, which is ongoing now in Swaziland and in Malawi but we are hoping that from this that

we will be able to caption key trends and issues and will be able to share with you in the coming weeks. Thank you.

STEPHEN LEWIS: When will the assessment reports be available?

MARY ENGEROGA: It is divided into countries, there are some which are complete actually we can have a small discussion after that. There are some which are ongoing but I think what is important is when you look at the impact of high food prices and HIV prevalence this is where we have to pick between the countries which are relevant in our case but I am willing to have a small discussion after the session. Thank you.

STEPHEN LEWIS: Thank you. The last question or comment.

ICOZE AHEAU: Yes, Icoze Aheau [misspelled?]. The causes of the higher prices are different opinions and activities and speculation et cetera et cetera part extent are different causes impacted.

The conference in June it was discussed and was one of the key issues but there was a disagreement among member countries between those who are producing and those who are not producing. I will try to get to this point that the American countries made this point and [inaudible] the final [inaudible] from the conference that they are saying that [inaudible] to pinpoint.

The key issues, the fundamental issues, which is that the current increase in food prices is the consequence of

failure of capitalism, so I think that this is not a fair view but it think there are two key procedures could be taken immediately. One is a moratorium on biofuel production and the second is to take special measures on speciation.

STEPHEN LEWIS: A moratorium on what?

ICOZE AHEAU: Biofuel productions.

STEPHEN LEWIS: Biofuel.

ICOZE AHEAU: Yes, because land is disappearing taking away from communities by investors. And the UN should make more decisive role in this debate. And so what we need is a really more fundamental political and economic solutions to current crises otherwise HIV/AIDS infected people would be the first one to suffer.

And just to mention a comment on the farmers benefit from high food prices. As far as I am aware from different studies the key finding is that poor farmers are consumers so they are equally negatively affected by increasing food prices. Thank you.

STEPHEN LEWIS: I make only the slightly acerbic comment that if you want the UN to take a lead there is something called the Food and Agricultural Organization that might begin to do more actively in public terms then it have thus far done. I very, very much appreciate the participation of the Panelists.

I must say that I regret that Panel precedes the formal conference because in terms of the presentations it has been

one of the most interesting panels I have attended and I thank you all on behalf of all of us here assembled. It is a small but passionate attentive and committed audience. Thanks everyone we are adjourned.

[END RECORDING]