THE RIGHT TO FOOD

The Right to Food in the context of HIV/AIDS

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Right to Food Studies

The Right to Food in the context of HIV/AIDS

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FOOD AND AGRICULTURE ORGANIZATION
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Right to Food Studies

Right to Food Studies is a series of articles and reports on right to food related issues of contemporary interest in the areas of policy, legislation, agriculture, rural development, biodiversity, environment and natural resource management.

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List of Acronyms

AIDS	auto-immune deficiency syndrome
AMPATH	Academic Model for the Prevention and Treatment of HIV/AIDS
CESCR	Committee on Economic, Social and Cultural Rights
CRC	Committee on the Rights of the Child
FAO	Food and Agriculture Organization of the United Nations
HIV	human immuno-deficiency virus
ICESCR	International Covenant on Economic, Social and Cultural Rights
IFPRI	International Food Policy Research Institute
UNAIDS	Joint United Nations Programme on HIV/AIDS
WHO	World Health Organization

Photo by P. K Mahanand

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LIST OF ACRONYMS

INTRODUCTION

1. THE RIGHT TO FOOD

2. HIV/AIDS AND THE IMPORTANCE OF ADEQUATE FOOD

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CONCLUSIONS

Introduction

The annual reports of the Joint United Nations Programme on HIV/AIDS (UNAIDS) indicate little progress in the struggle against the epidemic: the numbers continue to increase – the latest report states that 38.6 million people are living with HIV/AIDS.[1,2] And the worst seems yet to come: the epidemic occurs in waves, and many people who are still asymptomatic will be affected in the future.

We have known for a long time what causes HIV infection, but we are only now starting to understand what fuels the HIV/AIDS epidemic.[3] The most characteristic change in addressing the HIV/AIDS crisis was the view that to achieve positive results and address the root causes, a human rights based approach was needed.[4] The United Nations *Declaration of Commitment on HIV/AIDS* declares:

> *Recognizing that the full realization of human rights and fundamental freedoms for all is an essential element in a global response to the HIV/AIDS epidemic, including in the areas of prevention, care, support and treatment,*

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[1] UNAIDS. 2006. *Report on the Global AIDS Epidemic*, , Geneva, p. 8.

[2] *Paris Declaration on Women, Children and AIDS*, 30 March 1989; *Vienna Declaration and Programme of Action*, World Conference on Human Rights Vienna, 14–25 June 1993 (A/CONF.157/23); *Rights and Humanity Declaration and Charter on HIV/AIDS*, United Nations Commission on Human Rights, 1992; *Paris Declaration*, World AIDS Summit, Paris, 1 December 1994; *Women and HIV/AIDS: The Barcelona Bill of Rights*, July 2002; United Nations General Assembly, *Political Declaration on HIV/AIDS* (A/RES/60/262); United Nations General Assembly Special Session on HIV/AIDS, *Declaration of Commitment on HIV/AIDS*, (A/RES/S-26/2); United Nations International Guidelines, consolidated version, 2006; *United Nations HIV/AIDS and Human Rights: International Guidelines*, 1996; *United Nations HIV/AIDS and Human Rights: International Guidelines - Revised Guideline 6* (HR/PUB/2002/1); *Programme of Action of the United Nations International Conference on Population and Development* (A/CONF.171/13), 18 October 1994; *Beijing Declaration and the Platform for Action*, Fourth World Conference on Women (A/CONF.177/20 and A/CONF.177/20/Add.1,1995); *United Nations Millennium Declaration, Resolution to the General Assembly* (55/2), 8 September 2000; *Declaration of the Tenth Ibero-American Summit of Heads of State*, 18 November 2000; *Pan-Caribbean Partnership against HIV/AIDS*, 14 February 2001; European Union Programme for Action, *Accelerated action on HIV/AIDS, malaria and tuberculosis in the context of poverty reduction*, 14 May 2001; *Baltic Sea Declaration on HIV/AIDS Prevention*, 4 May 2000; *Central Asian Declaration on HIV/AIDS*, 18 May 2001; *Regional Call for Action to Fight HIV/AIDS in Asia and the Pacific*, 25 April 2001; *Abuja Declaration and Framework for Action for the fight against HIV/AIDS, tuberculosis and other related infectious diseases in Africa*, 27 April 2001. Also: Hodgson, I. and France, T. 2005. *Promises, Promises… Statements, Commitments and Declarations on HIV/AIDS since 2001*, World AIDS Campaign.

[3] Gillespie, S. and Kadiyala, S. 2005. HIV/AIDS and Food and Nutrition Security. *In* Evidence to Action, *Food Policy Review* (7) p. 11.

[4] Gruskin, S., Mann, J.M. and Grodin, M.A. 1999. *Health and Human Rights: a Reader*. New York, Routledge.

and that it reduces vulnerability to HIV/AIDS and prevents stigma and related discrimination against people living with or at risk of HIV/AIDS.[5]

There has been a parallel debate about the hunger problem. In relation to this paper, it is useful to highlight the changes in the Food and Agriculture Organization of the United Nations (FAO). The recent adoption by the FAO Council of the *Voluntary Guidelines to Support the Progressive Realization of the Right to Adequate Food in the Context of National Food Security* (hereinafter Right to Food Guidelines or Guidelines),[6] and the subsequent establishment of an FAO Right to Food Unit reflect the growing importance given by FAO to a rights-based approach and illustrate the policy shift in many United Nations agencies following publication of the *Common Understanding on the Human Rights Based Approach to Development Cooperation.*[7]

The 2005 World Health Organization (WHO) conference on HIV/AIDS, food and nutrition security in Durban, South Africa, reviewed the evidence for the link between food security and HIV/AIDS and called for the integration of nutrition into the package of care, treatment and support for people living with HIV/AIDS.[8] Other events acknowledging the impact of the epidemic on food security were (i) the 2003 WHO Technical Consultation on Nutrient Requirements for People Living with HIV/AIDS in Geneva, (ii) the May 2006 forum on food security, nutrition and HIV led by Project Concern International in Lusaka, (iii) the World Food Summit: *five years later* in 2002, (iv) the 2001 and 2003 sessions of the FAO Committee on Food Security[9] and (v) the 2002 and 2004 African Regional Conferences.[10,11] Increasing acceptance of the link is reflected in the June 2006 United Nations *Political Declaration on HIV/AIDS*, in which paragraph 28 highlights rights to food such as availability, accessibility and adequacy:

The United Nations Member States resolve to integrate food and nutritional support, with the goal that all people at all times will have access to sufficient, safe and nutritious food to meet their dietary needs and food preferences, for an active and healthy life, as part of a comprehensive response to HIV/AIDS.[12]

This move towards international recognition of the importance of food and nutrition in mitigating the impacts of the HIV/AIDS epidemic is an important step towards

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5 United Nations. 2001. *Declaration of Commitment on HIV/AIDS* (A/RES/S-26/2). New York.

6 *Voluntary Guidelines to Support the Progressive Realization of the Right to Adequate Food in the Context of National Food Security*, adopted by the 127th session of the FAO Council, November 2004. Avilable at: www.fao.org/righttofood

7 United Nations. 2003. *The Human Rights Based Approach to Development Cooperation: Towards a Common Understanding Amongst UN Agencies' Report of the Second Inter-Agency Workshop on Implementing a Human Rights Based Approach in the Context of UN Reform*. Stanford, USA.

8 WHO. 2004. WHO Consultation on Nutrition and HIV/AIDS in Africa. Durban, South Africa; also Resolution WHA57.14 of the 57th World Health Assembly, 22 May 2004.

9 FAO. 2001. *The Impact of HIV/AIDS on Food Security*. Paper for 27th Session of the Committee on World Food Security. Rome; FAO. 2003. *Food Security and HIV/AIDS: an Update*. Paper for 29th Session of the Committee on World Food Security. Rome.

10 FAO. 2002. HIV/AIDS, Agriculture and Food Security in Mainland and Small Island Countries of Africa. Paper for the 22nd Regional Conference for Africa in Cairo. Rome.

11 FAO. 2004. *HIV/AIDS and the Food Crisis in Sub-Saharan Africa*. 23rd Regional Conference for Africa, Johannesburg.

12 Political Declaration on HIV/AIDS, (A/RES/60/262, para. 28).

a genuinely comprehensive approach. The Right to Food Guidelines also assert that the right to food has a significant role in fighting the disease and needs to be taken into account.

Research on the vicious circle of HIV/AIDS and food and nutrition security has changed the focus of HIV/AIDS and food-security programmes: food-security aspects are now included in treatment programmes and vice versa. But there has been little attention to prevention and treatment through the right to food, though it is now acknowledged that a rights-based approach to the epidemic is fundamental. This paper aims to clarify the relevance of the right to food in combating HIV/AIDS.

Photo by S. Wren

1. The Right to Food

1.1 Definition of the Right to Food

Several human rights treaties and declarations recognize the right to food.[13] The main legal basis of the right to food is the International Covenant on Economic, Social and Cultural Rights (ICESCR),[14] which has been ratified by 157 States.[15] In article 11.1, States Parties recognize "...the right of everyone to an adequate standard of living for himself and his family, including adequate food…"; article 11.2 concerns "the fundamental right of everyone to be free from hunger". The right to adequate food goes beyond freedom from hunger: there is also an "adequacy" standard that requires food to be in "a quantity and quality sufficient to satisfy the dietary needs of individuals, free from adverse substances, and acceptable within a given culture."[16] The adequacy requirement is vital for people living with HIV/AIDS (see section 2) because food needs to be "the most appropriate under given circumstances".[17]

A further distinction concerns the nature of States' obligations: the right to freedom from hunger requires "more immediate and urgent steps" (see section 1.2).[18]

General Comment 12 of the Committee on Economic, Social and Cultural Rights (CESCR), an authoritative interpretation of Article 11, provides that "The right to adequate food is realized when every man, woman, child, alone or in community with others, [has] physical and economic access at all times to adequate food or means for its procurement."[19]

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[13] *Universal Declaration of Human Rights*, article 25; *Convention on the Rights of the Child*, 21(1), 24(2c) and 27(3); *Convention on the Elimination of all Forms of Discrimination Against Women*, article 14(2h); *Additional Protocol to the American Convention of Human Rights in the Area of Economic, Social and Cultural Rights 'Protocol of San Salvador'* (OAS, Treaty A-52, Series 69, 1988, article 12).

[14] *International Covenant on Economic, Social and Cultural Rights*, Art.11, General Assembly resolution 2200A (XXI), 21 U.N. GAOR Supp. (No. 16) at 49, U.N. Doc. A/6316 (1966), 993 U.N.T.S. 3, entered into force Jan. 3, 1976.

[15] As of March 2008. For the status of ratification, http://www2.ohchr.org/english/bodies/ratification/3.htm General Comment 12, para. 8 presents "adequacy" as a third pillar of the right to food, together with availability and accessibility.

[16] Committee on Economic, Social and Cultural Rights, General Comment 12,1999, UN doc.E/C.12/1999/5, para 8.

[17] CESR General Comment 12 (E/C.12/1999/5).

[18] Ibid, para 1.

[19] Ibid, para. 6

The definition distinguishes between the following core elements of the right to food:

- availability: the possibilities for feeding oneself directly from productive land or other natural resources, or from effective distribution, processing and market systems that can move food in accordance with demand;
- adequacy: the available food must to be in quantity and quality sufficient to satisfy the dietary needs of individuals, free from adverse substances and acceptable in a given culture; and
- accessibility: access must be sustainable and must not interfere with the enjoyment of other human rights.

The paper demonstrates that the HIV/AIDS epidemic primarily creates difficulties in economic and physical access to food or the means of procuring it. Economic access implies that the financial costs of food procurement do not threaten the attainment of other basic rights such as the right to health. This is particularly relevant in the context of HIV/AIDS, because people become involved in high-risk responses and may trade their rights to health and food. Accessibility encompasses economic and physical accessibility for all, including "[…] physically disabled, the terminally ill and persons with persistent medical problems […]."[20] HIV/AIDS victims are "vulnerable individuals", which has important implications for the obligations of a State and will be discussed in this paper.

1.2 State Obligations

The right to adequate food does not mean that everyone is entitled to receive food. It denotes people's right to feed themselves in dignity through economic and other activities. Individuals and groups are responsible for undertaking activities that give them access to food. States are required to support these efforts.

1.2.1 Progressive Realization

ICESCR Article 2(1) provides that States must "...take steps [...] to the maximum of [their] available resources, with a view to achieving progressively the full realisation of the [right to food] by all appropriate means". CESCR clarifies this concept: "The concept of progressive realization constitutes recognition of the fact that full realization of all economic, social and cultural rights will generally not be able to be achieved in a short period of time. […] Nevertheless, the fact that realization over time, or in other words progressively, is foreseen under ICESCR should not be misinterpreted as depriving the obligation of all meaningful content." ICESCR "...imposes an obligation to move as expeditiously and effectively as possible towards that goal. Moreover, any deliberately retrogressive measures in that regard would require the most careful consideration and would need to be fully justified by reference to the totality of the rights provided for in ICESCR and in the context of the full use of the maximum available resources".[21] The obligation to take such steps entails restrictions on measures that would reduce enjoyment of the right to food and the duty to take measures that improve enjoyment of that right.

[20] Ibid, para. 13.

[21] CESCR General Comment 3, para. 9.

1.2.2 Three Dimensions of State Obligations

The right to adequate food imposes three dimensions of obligations on States: (i) to respect, (ii) to protect and (iii) to fulfil, which incorporates obligations to facilitate and to provide.

The obligation to respect means that a State can not take any action that impedes people's access to adequate food and requires States to ensure that every individual has access at all times to adequate food. It has been stated that:

> *States should, at the primary level, respect the resources owned by the individual and the individual's freedom to find a job of preference, to make optimal use of her or his own knowledge and to take the necessary actions and use the necessary resources – alone or in association with others – to satisfy his or her own needs.*[22]

The obligation to protect requires a State to protect people's access to food by preventing non-state actors such as individuals or the private sector from depriving people of permanent access to adequate food; this includes protection against assertive or aggressive interests, particularly economic interests.[23] State authorities are therefore required to intervene when private parties violate the right to food.

The *Maastricht Guidelines on Violations of Economic, Social and Cultural Rights* asserts that it is not longer to be assumed that the realization of economic, social and cultural rights depends solely on the State.[24] The private sector has an important influence on the availability and accessibility of food and medicines, which are both important in the treatment of HIV/AIDS.

The obligation to fulfil contains (i) the obligation to facilitate, which implies that the State has to engage in activities that enhance people's access to resources and their ability to use them, and (ii) the obligation to provide, which requires: "… whenever an individual or group is unable, for reasons beyond their control, to enjoy the right to adequate food by the means at their disposal, […] to fulfil (provide) [the Right to Food] directly".[25] This means providing food for HIV/AIDS infected persons when "no other possibility exists", for the elderly when they can no longer be employed and for the sick, through food subsidies or resources to procure food.

1.3 The Value of a Human Rights Approach to Food Security

Compliance with the right to food involves applying the human rights based approach to food security, but there are few actual examples of this approach in HIV/AIDS

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[22] Eide, A. *Human Right to Adequate Food and Freedom from Hunger*. Available at: www.fao.org/docrep/W9990E/w9990e03.htm

[23] Ibid.

[24] Commission of Jurists the Faculty of Law of the University of Limburg, Urban Morgan Institute for Human Rights, University of Cincinnati 1997. *Maastricht Guidelines on Violations of Economic, Social and Cultural Rights*, p. 1. Maastricht, United Nations.

[25] CESCR General Comment 12, para.15.

programming. The value-added of the right to food in such programmes is related to food security and to the right to food, which goes beyond the concept of food security. Food security is needs-based, consisting of food availability, access, stability and utilization.[26] The right to food shares these concepts and asserts rights and obligations. Given that human rights are interrelated, the right to food should be implemented using principles such as participation, accountability, non-discrimination, transparency, human dignity, empowerment and the rule of law. Food security has been distinguished from the right to food in that the right to food is a form of access that respects human dignity.[27]

The challenge posed by HIV/AIDS is so great that States are obliged to intervene when people's right to food is not realized; failure to intervene violates human rights. The application of accountability and the rule of law makes the shift from needs-based food security to rights that empower people. Empowerment is linked to accountability because it enables people to be agents of change through (i) the ability to seek legal enforcement of rights and (ii) capacity empowerment, which gives people the right to seek their own solutions to problems. The right to food creates an enabling environment for individuals: instead of being forced into decisions or high-risk actions, people can make the decisions or proposals that are appropriate to them. Empowerment strengthens HIV/AIDS and food-security programmes by giving them a legal basis, which makes them more effective.

A third element is the notion of non-discrimination, which is a fundamental right in international law: discrimination on the grounds of religion, gender, race or national or social origin is illegal. The right to non-discrimination requires special measures to protect people who are discriminated against. Non-discrimination is an immediate obligation: it is not constrained by the provision for progressive realization applied to the other obligations in ICESCR.[28] This is important in the context of the HIV/AIDS epidemic: individuals who are HIV-positive face stigmatization, social exclusion and denial of access to productive resources. Access to land, food and credit is problematic for people affected by HIV/AIDS: without it they cannot realize their right to food. The Right to Food Guideline 8.3 demands specific attention for HIV-positive people and States that governments "...should take measures to protect all people affected by HIV/AIDS from losing their access to resources and assets" (see chapter 6).

Participation and transparency are two other human rights principles that reinforce people's capacity and empowerment. People should be involved in decision-making, especially with regard to their own future. This is an additional acknowledgement of people's inherent dignity and of the necessity to realize people's right to adequate food. The government in complying with its obligations needs to assure participation of the

[26] FAO. 2006. *Food Security*. Policy Brief, Issue 2, available at ftp://ftp.fao.org/es/ESA/policybriefs/pb_02.pdf

[27] Windfuhr, M. and Jonsén, J. 2005. *Food Sovereignty. Towards Democracy in Localized Food Systems*. Heidelberg, Germany, FIAN International. Also: Engh, I.-E. 2007 *Developing Capacity to Realize Socio-Economic Rights: the Example of the Right to Food in the Context of HIV/AIDS in South Africa and Uganda,* International Project on the Right to Food in Development, Norwegian Centre for Human Rights.

[28] *Report of the UN Special Rapporteur on the Right to Food* (A/58/330), para. 18.

people. In the context of HIV/AIDS it has been observed that when people are involved in the process of identifying viable dietary alternatives or help to find options to manage food-drug interactions the adherence to the drug regime is increased.[29] People get involved and hereby get ownership and interest in the continuation of the antiretroviral therapy.

There are examples of HIV/AIDS treatment programmes such as the Academic Model for the Prevention and Treatment of HIV/AIDS (AMPATH) in Kenya that integrate food-security elements, but they lack a right-to-food approach. Sustainability, accountability, participation and empowerment are weak areas: for example, patients are expected to provide for themselves after six months. A major challenge for AMPATH is reducing the dependency it creates.[30] The programme focuses on patients as a vulnerable group; it does not aim at enhancing the right to food of others affected by HIV/AIDS. Evidence that such programmes have resulted in capacity empowerment to deal with HIV/AIDS is anecdotal. One example is that the programmes educate people about gender equality and equal rights, but they do not advocate the realization of these rights, so patients are empowered with knowledge but may have no equal rights, making the programme ultimately ineffective. Realization of the right to food and subsequent focus on the human rights principles of accountability, participation, empowerment, non-discrimination, the rule of law, human dignity and transparency would create a legal environment for HIV/AIDS programmes.

1.4. The Right to Food Guidelines

In 2004, the FAO Council adopted the *Voluntary Guidelines to Support the Progressive Realization of the Right to Adequate Food in the Context of National Food Security*,[31] as a tool for implementing the right to adequate food at the national level. The Right to Food Guidelines, which are voluntary, do not create new obligations but draw on existing legal instruments. The document has increased momentum towards a rights-based approach to food security and HIV/AIDS.[32] Section III of the Guidelines asserts:

> *Developed and developing countries should act in partnership to support their efforts to achieve the progressive realization of the right to adequate food in the context of national food security through technical cooperation, including institutional capacity building, and transfer of technology on mutually agreed terms, as committed in the major international conferences, in all areas covered in these guidelines, with special focus on impediments to food security such as HIV/ AIDS.*[33]

[29] Castlemann, T., Seumo-Fosso, E. and Cogill, B. 2004. *Food and Nutrition Implications of Antiretroviral Therapy in Resource Limited Settings*, p. 14. Food and Nutrition Technical Assistance, Technical Note no. 7.

[30] Byron, E., Gillespie, S. and Nangami, M. 2006. *Integrating Nutrition Security with Treatment of People Living with HIV: Lessons Being Learned in Kenya*. Washington DC, IFPRI.

[31] Adopted by the 127th Session of the FAO Council, November 2004. Available at www.fao.org/righttofood

[32] Engh, I.-E. 2005. HIV/AIDS, Food Security and Human Rights: Concepts and Linkages. *In* Eide, W.B. and Kracht, U. (eds.) *Food and Human Rights in Development. Legal and Institutional Dimensions and Selected Topics*, vol.1. Antwerpen, Belgium and Oxford, UK, Intersentia.

[33] *Voluntary Guidelines to Support the Progressive Realization of the Right to Adequate Food in the Context of National Food Security*, section III, para. 5.

Some Guidelines are particularly relevant in the context of HIV/AIDS: guideline 10.4 stipulates that "States should address the specific food and nutritional needs of people living with HIV/AIDS or suffering from other epidemics".[34] This is noteworthy as the first explicit international recognition of the potential of the right food in fighting the epidemic. Other Guidelines deal indirectly with the needs of HIV/AIDS victims, but they are still relevant. Guideline 6, for example, deals with the participation of all the stakeholders in a society; Guideline 8 concerns access by vulnerable groups to resources and assets; guideline 11 provides for education and awareness training; and Guideline 14 addresses the need for safety nets for vulnerable groups. The Guidelines aim to help States to create an enabling environment for individuals to feed themselves in dignity.

1.5. The Right to Health

The right to health is another human right linked to the right to food; it is equally important for States dealing with HIV/AIDS. There is case law all over the world dealing with the right to health in terms of access to adequate treatment: an example is the Jorge Odir Miranda Córtez y Otros v. El Salvador case, in which the Inter-American Commission requested interim measures to be taken by the State of El Salvador in the provision of anti-retroviral medicines and hospital, pharmaceutical and nutritional care.[35] The claimant and 26 others argued successfully that in failing to provide adequate treatment the state was violating the right to life and the right to health.

ICESCR Article 12 on the right to health obliges States to take action on "...the prevention, treatment and control of epidemic, endemic, occupational and other diseases".[36] CESCR General Comment 14 states:

> *Formerly unknown diseases, such as Human Immunodeficiency Virus and Acquired Immunodeficiency Syndrome (HIV/AIDS), and others that have become more widespread, such as cancer, as well as the rapid growth of the world population, have created new obstacles for the realization of the right to health which need to be taken into account when interpreting article 12.*[37]

Hence, the right to health includes addressing HIV/AIDS, and it can only be achieved by implementation of the right to food. HIV/AIDS patients will not be healthy and cannot be treated if they are not adequately nourished. It follows that the right to health in the context of HIV/AIDS cannot be achieved without realizing the right to food. And, as stated earlier, healthy people are more likely to be able to eat adequate food and so maintain their immune systems. Realizing the right to health and the right to food requires an effective care package.

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[34] Ibid.

[35] Inter-American Commission. Jorge Odir Miranda Córtez y Otros (El Salvador). *Informe* No. 29/01, Case 12.249, 7 March 2001.

[36] ICESCR, Art.11. General Assembly res. 2200A (XXI).

[37] CESCR, General Comment 14 (E/C.12/2000/4), para. 10.

Photo by S. Wren

2. HIV/AIDS and the Importance of Adequate Food

When a person becomes infected with HIV, the immune system has to work harder to fight the infection. The disease has an increasing impact on nutritional needs, and the risk of malnutrition increases greatly during its development.[38] WHO and other organizations have documented the link between nutrition and HIV/AIDS and have produced nutritional guidelines for HIV-positive people.[39] In terms of macronutrients, an energy deficit is directly caused by the effects of HIV/AIDS: this results from a combination of factors such as reduced dietary intake, poor absorption, increased energy expenditure and an abnormal utilization of substrates. Poor absorption of food, for example, is a result of damage caused to the gut wall by the disease. In most cases, reduced food intake is the predominant factor in weight loss.[40]

The FAO and WHO *Manual on Nutritional Care* point out that reduced food intake is the result of a range of factors produced by the disease such as reduction of appetite, modification of the taste of food, nausea, vomiting and tiredness.[41] Malnutrition is an accelerator in the progressive development of the disease: the evidence shows that the disease progresses faster in malnourished people.[42] The frequency of opportunistic infections, of which tuberculosis is the most common, the subsequent reduced food intake and further weakening of the immune system significantly reduce the period before full AIDS develops. Reduced food intake also reduces the intake of vitamins or micronutrients: there is data suggesting that HIV infection diminishes the levels of a range of micronutrients and that HIV-positive individuals may have increased micronutrient requirements. This is a complex issue in that different micronutrients produce negative or positive effects; the available evidence shows that more research is needed

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38 Gillespie, S. and Haddad, L. *Food Security as a Response to HIV/ AIDS*. Washington D.C, IFPRI.

39 FAO and WHO. 2002. *Living Well with HIV/AIDS. A Manual on Nutritional Care and Support for People Living with HIV/AIDS*. Rome; also Academy for Educational Development. 2004. HIV/AIDS: *A Guide for Nutrition, Care and Support* (2nd edition). Food and Nutrition Technical Assistance Project. Washington DC.

40 Hsu, J. W.-C., Pencharz, P.B., Macallan, D. and Tomkins, A. 2005. *Macronutrients and HIV/AIDS: a Review of Current Evidence*. Consultation on Nutrition and HIV/AIDS in Africa, Durban, South Africa, 10-13 April 2005.

41 FAO and WHO. 2002. *Living Well with HIV/AIDS. A Manual on Nutritional Care and Support for People Living with HIV/AIDS*, p.19-20. Rome.

42 Piwoz, E. 2004. *Nutrition and HIV/AIDS: Evidence, Gaps, and Priority Actions*. Washington D.C., Support for Analysis and Research in Africa' (SARA) Project; Fawzi, W.W. , Msamanga, G.I., Spiegelman, D., Wei, R., Kapiga, S., Villamor, E., Mwakagile, D., Mugusi, F., Hertzmark, E., Essex, M., Hunter, D.J., 2004. A randomized trial of multivitamin supplements and HIV disease progression and mortality. *New England Journal of Medicine* 351(1): 23-32; Haddad, L. and Gillespie, S. 2001. *Effective Food and Nutrition Policy Responses to HIV/AIDS: What We Know and What We Need to Know*. Washington DC, IFPRI; United Nations Administrative Committee on Coordination/Subcommittee on Nutrition. 1998. *: Nutrition and HIV/AIDS,* Geneva SCN News.

on the effects of micronutrients on the disease,[43] particularly because the disease demands more energy just as it is reducing the body's ability to take in food. WHO points out that remaining physically active and maintaining body weight in asymptomatic HIV-infected adults and growth in asymptomatic children calls for a 10 percent increase in energy requirements. In the symptomatic phase of HIV and in the advanced stage of AIDS, maintaining adult body weight increases energy needs by up to 30 percent. For children who lose weight, energy needs rise by 50 percent to 100 percent above normal requirements.[44] Adequate and nutrition is thus vital in counteracting these effects and treating people. The disease cannot be cured by adequate nutrition, but an adequate diet can help significantly in maintaining the precarious nutritional status of HIV-infected people and delay the onset of AIDS.

It has been pointed out, however, that in resource-limited settings where malnutrition and HIV/AIDS coexist, people have difficulty in obtaining adequate food and nutrition during programmes to prevent or treat HIV/AIDS.[45] The right to adequate food addresses such issues, because it focuses on the right of people to have physical and economic access to adequate food.

Treatments focus on providing anti-retroviral drugs. Efforts are being made to increase access to antiretroviral therapy all over the world, but even when the therapy is available in resource-limited settings the need for adequate food remains because "...interactions between anti-retrovirals and food and nutrition can significantly influence the success of therapy by affecting drug efficacy, adherence to drug regimens and nutritional status".[46] Providing medicines is not enough – adequate food and nutrition are essential elements of treatment: recent reports show that in health programmes medicines are of little or no use without adequate food and nutrition. And because the reality is that there is still far from universal access to antiretroviral treatment, adequate food becomes even more important. In sub-Saharan Africa only one in four people needing treatment receive it, which does not usually start before the disease is well advanced, making the need for adequate food even more important.[47] And the number of people in need of treatment will rise faster than treatment services can be scaled up.[48] The focus should therefore be on good nutrition for HIV/AIDS patients; for unaffected individuals, good nutrition is often their only safeguard. As stated above, HIV-infected individuals have special nutritional needs whether or not they are receiving antiretroviral treatment.[49]

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[43] Friis, H. 2005. *Micronutrients and HIV Infection: A Review of Current Evidence*. Consultation on Nutrition and HIV/AIDS in Africa, Durban, 10-13 April 2005.

[44] WHO. 2003. *Nutrient Requirements for People living with HIV/AIDS: Report of a Technical Consultation*. Geneva.

[45] Raiten, D., Grinspoon, S. and Arpadi, S. 2005. *Nutritional Considerations in the Use of ART in Resource-Limited Settings*. Geneva, WHO.

[46] Castleman, C., Suemo-Fosso, E. and Cogill, B. 2004. *Food and Nutrition Implications of Anti-Retroviral Therapy in Resource Limited Settings*. Food and Nutrition Technical Assistance Project, Technical Note no. 7.FANTA: Washington DC.

[47] People with a CD4 count < 200/mm³ are generally recommended to start. See: WHO. 2003. *Scaling Up Antiretroviral Therapy in Resource-Limited Settings: Treatment Guidelines for a Public Health Approach*. Geneva.

[48] United Nations. 2007. *Millennium Development Goals Report 2007*, p. 19. New York.

[49] Castleman, C., Suemo-Fosso, E. and Cogill, B. 2004. *Food and Nutrition Implications of Anti-Retroviral Therapy in Resource Limited Settings*. Food and Nutrition Technical Assistance Project, Technical Note no. 7. FANTA: Washington DC.

This review of current evidence of the links between malnutrition and HIV/AIDS has not touched on the scientific evidence for the preventive effects of good nutrition. The relationship between malnutrition and infection was discovered decades ago and was known as the "nutritionally acquired immune-deficiency syndrome".[50] Decreasing calorie and protein consumption and increasing inequalities between people were found to have a strong correlation with HIV/AIDS prevalence.[51] A person's susceptibility to infection depends on the strength of the immune system and a diet sufficient to maintain it. The 2006 United Nations Political Declaration on HIV/AIDS is important in supporting the right to food: paragraph 28 asserts the need for all people to "...have access to sufficient, safe and nutritious food to meet their dietary needs and food preferences for an active and healthy life as part of a comprehensive response to HIV/AIDS".[52] This is not only a biological issue: people become empowered to make safe decisions and adopt healthy attitudes when their right to food is realized (see chapter 4).

Clearly, people living with HIV/AIDS must have adequate food to be able to follow the advice in nutritional guides and break the vicious circle of HIV/AIDS and malnutrition.[53] CESCR asserts that the right to food entails: "...the availability of food in a quantity and quality sufficient to satisfy the dietary needs of individuals, free from adverse substances, and acceptable within a given culture".[54] Right to Food Guideline 10.4 urges governments to attend to "...the specific food and nutritional needs of people living with HIV/AIDS or suffering from other epidemics".[55] CESCR General Comment 12 stresses the need for States to take measures that "...need to be taken to maintain, adapt or strengthen dietary diversity and appropriate consumption and feeding patterns".[56] CESCR affirms the principle of accountability, and reiterates that not only must a State provide food directly when people are unable for reasons beyond their control to provide for themselves, it must also maintain or protect access to adequate food. The right to adequate food obliges governments to provide adequate food for people infected with HIV and AIDS whether they are being treated or not.

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[50] Gillespie, S. and Kadiyala, S. 2005. *HIV/AIDS and Food and Nutrition Security. From Evidence to Action*, p. 24. Food Policy Review no. 7. Washington DC, IFPRI.

[51] Stillwagon, E. 2002. HIV/AIDS in Africa: Fertile Terrain. *Journal of Development Studies* 38(6): 1–22; also: Stillwagon, E. 2000. HIV Transmission in Latin America: Comparison with Africa and Policy Implications. *South African Journal of Economics*, 68(5): 985–1011.

[52] United Nations. 2006. Political Declaration on HIV/AIDS (A/RES/60/262).

[53] Gillespie, S. and Kadiyala, S. 2005. *HIV/AIDS and Food and Nutrition Security. From Evidence to Action*, p. 24. Food Policy Review no. 7. Washington DC, IFPRI.

[54] CESCR General Comment 12 (E/C.12/1999/5), para.8.

[55] *Voluntary Guidelines to Support the Progressive Realization of the Right to Adequate Food in the Context of National Food Security*, 10.4. Adopted by the 127th session of the FAO Council, November 2004.

[56] CESCR General Comment 12 (E/C.12/1999/5), para. 9.

Photo by S. Wren

3. Breastfeeding and HIV/AIDS

The discovery of possible HIV transmission through breast milk creates serious complications for infant feeding recommendations and the realization of an infant's right to food. There is firm evidence that breastfeeding is the best option for feeding infants and that it should be recommended in any situation. Even if breast milk contains viruses or toxins, it is still best for infants.[57] But in the context of HIV/AIDS, the question of breastfeeding becomes complex: it is no longer a question of what is best for mother and child, but of what is least harmful. The quest for consensus on recommending breastfeeding for infants by HIV/AIDS-infected mothers has become a debate as to the lesser evil: the core of the problem is that under some circumstances the dangers of using substitutes for breast milk – the risks of malnutrition and death – are greater than the risk of infecting infants with the virus through breastfeeding. It has been demonstrated that infants born of HIV-positive mothers are better off with exclusive breastfeeding than with mixed feeding. Infants fed by breastfeeding and solid foods or formula milk are at higher risk of HIV infection.[58] Breast milk is a potential transmitter of HIV but at the same time a type of immunization, which is particularly relevant in combating diseases such as HIV/AIDS that attack the immune system.[59] To prevent transmission, the mother's health and right to adequate food must be guaranteed. Women need additional food when breastfeeding: when an undernourished women breastfeeds, she makes significant demands on her already inadequate resources.[60] Even healthy women may lack the time to breastfeed because they carry out household tasks.[61] This can result in poor or partial breastfeeding, which increases the chance of child mortality by three times.[62] Mothers' enjoyment of the right to food is a prerequisite for them to be able to realize their children's right to food; keeping mothers in good physical health with access to adequate food is a priority as the cornerstone of an adequate response.[63]

[57] Kent, G. 2005. *Freedom from Want: The Human Right to Adequate Food*. Washington DC, Georgetown University Press.

[58] Coovadia, H.M. Rollins N.C., Bland, R.M., Little K., Coutsoudis A., Bennish, M.L., Newell, M.L.*l.* 2007. Mother-to-child transmission of HIV-1 infection during exclusive breastfeeding in the first 6 months of life: an intervention cohort study. *The Lancet* (369): 1107–1116.

[59] Kent, G. 2005. HIV/AIDS, Infant Feeding and Human Rights. *In* Eide, W.B. and Kracht, U. (eds.) *Food and Human Rights in Development. Legal and Institutional Dimensions and Selected Topics*, vol.1 p. 399. Antwerpen, Netherlands and Oxford, UK.

[60] Gupta, A. 2007. *International Obligations for the Right to Food*, p. 13. online publication, International Baby Food Action Network.

[61] Save the Children. 2008. *Saving Children's Lives. Why Equity Matters*, p. 8. London.

[62] Ibid, p.8.

[63] Research has shown that for example multivitamin supplementation during lactation may reduce the risk of mother-to-child transmission. See Gillespie, S. and Kadiyala, S. 2005. *HIV/AIDS and Food and Nutrition Security. From Evidence to Action*, p. 53. Washington DC, IFPRI.

In 1998, WHO published three manuals on preventing HIV infection through breastfeeding, followed by three publications in 2003 on the same subject by an inter-agency team[64,65] and a recent consultation on new evidence about HIV and infant feeding. The principal recommendations are that exclusive breastfeeding is recommended for HIV-infected women for the first 6 months unless replacement feeding is acceptable, feasible, affordable, sustainable and safe for the infant. If this is the case, avoidance of breastfeeding by HIV-infected women is recommended.[66]

The important point in this paper is its call for acceptable, feasible, affordable, sustainable and safe food for the infant. WHO reiterates it several times in its latest consensus statement: "All breastfeeding should stop once a nutritionally adequate and safe diet without breast milk can be provided" and "...governments and stakeholders should take measures to make replacement feeding safer for HIV-infected women".[67] For comparison, the core elements of the right to food, as described by CESCR, are:

> *...the availability of food in a quantity and quality sufficient to satisfy the dietary needs of individuals, free from adverse substances, and acceptable within a given culture; the accessibility of such food in ways that are sustainable and that do not interfere with the enjoyment of other human rights.*[68]

The WHO recommendation and these core elements overlap: WHO and other organizations stress the need for the right to adequate food; CESCR sees governments as responsible for making available food that is safe, accessible and adequate. The Right to Food Guidelines refer to the advice of WHO as a basis for policy development.[69] The right to adequate food fulfils the standards set by WHO: if, therefore, the right to food were to be realized in this context, the impasse about transmission through breastfeeding could be circumvented, because according to international law the government should provide adequate replacement feeding.

The problem is that (i) the right to food is realized progressively over time and (ii) that HIV/AIDS problems are predominantly in resource-limited settings. The overwhelming majority of mothers in developing countries are economically disadvantaged and unable to afford adequate replacement feeding. In response to this, attempts were made to formulate interim right-to-food recommendations for immediate action. This intermediate solution rests on the principle of informed choice.

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[64] WHO. 2000. *New Data on the Prevention of Mother-to-Child Transmission of HIV and their Policy Implications. Conclusion and Recommendations*. Technical consultation on behalf of UNFPA, UNICEF, WHO and UNAIDS. Geneva.

[65] WHO. 2003. *HIV and Infant Feeding: a Framework for Priority Action*. Geneva. Also: WHO. 2003. *HIV and Infant Feeding: Guidelines for Decision-Makers*. Geneva. Also: WHO. 2003. *HIV and Infant Feeding: a Guide for Health-Care Managers and Supervisors*. Geneva.

[66] WHO. 2006. *HIV and Infant Feeding Technical Consultation Held on Behalf of the Inter-Agency Task Team (IATT) on Prevention of HIV Infections in Pregnant Women, Mothers and their Infants*. Consensus Statement. Geneva.

[67] Ibid, p. 4.

[68] CESCR General Comment 12 (E/C.12/1999/5), para. 8.

[69] *Voluntary Guidelines to Support the Progressive Realization of the Right to Adequate Food in the Context of National Food Security*, guideline 10.6.

Given the scientific uncertainties about breastfeeding and the difficulties in realizing children's right to food, it is argued that the mother's participation should be a guiding principle. Mothers should be fully informed about the advantages and risks of breastfeeding or replacement feeding so that they can make an informed choice.[70] The right to informed choice is accepted by CESCR in General Comment 14 on the right to health[71] and General Comment 12 on the right to food. The principle of cultural or consumer acceptability in the right to adequate food means that people should be able to make informed decisions about food,[72] and that States have an obligation to facilitate access to relevant information. This empowerment enhances people's dignity. In line with Right to Food guideline 10.6, a State's obligation to facilitate the right to food could be satisfied if it disseminates information or invests in research. It has been pointed out that little research has been done on the impact of different methods of feeding and the differences in health outcomes; for example the risk of HIV infection is not equal to the risk of death, because HIV infection does not lead immediately to death. There is a focus on the need for more research on different health outcomes in the context of HIV/AIDS in order to make counselling more effective.[73]

Governments should give attention to providing sustainable access to adequate replacement feeding, because it entails hidden costs in access to education, clean water, fuel and sterilizing liquids. Replacement feeding may encourage mixed breastfeeding and have a spill-over effect into normal breastfeeding.[74] It has been observed that some women choose not to use formula milk because they are afraid of social exclusion and discrimination: such women face questions from family and neighbours and fear that there may be a connection between using infant formula and HIV infection.[75] There needs to be further discussion based on accurate information, and more openness at the community level to create a non-discriminatory environment where women can make safe choices about infant feeding (see chapter 6).

An important aspect of breastfeeding is that States have an obligation to fulfil and protect the right to food and to empower people to make informed choices. This is important in the context of replacement feeding, because situations where companies making formula milk have a commercial interest in promoting replacement feeding even when it is not recommendable, are violations of the right to food.[76]

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[70] The discussion of the legality of the suspension of informed choice is interesting.

[71] CESCR General Comment 14 (E/C.12/2000/4), para. 37. Apart from references in human rights conventions, the principle of informed choice is also protected in: WHO. 1981. *International Code of Marketing Breastmilk Substitutes*. Geneva.

[72] CESCR General Comment 12 (E/C.12/1999/5), para. 11.

[73] Kent, G. 2005. HIV/AIDS, Infant Feeding and Human Rights. *In* Wenche Barth Eide, W.B. and Kracht, U. (eds.) *Food and Human Rights in Development: Legal and Institutional Dimensions and Selected Topics*, vol.1 p. 402. Antwerpen, Netherlands and Oxford, UK, Intersentia.

[74] Coutsoudis, A., Goga, A.E., Rollins, N. and Coovadia, H.M. 2002. Free formula milk for infants of HIV-infected women: blessing or curse? *Health Policy Plan*, 17:154–160.

[75] Doherty, T., Chopra, M., Nkonki, L., Jackson, D. and Greiner, T. 2006. Effect of the HIV epidemic on infant feeding in South Africa: "When they see me coming with the tins they laugh at me". *Bulletin of the World Health Organization*, 84:95–96.

[76] For an illustration of the power of the private sector in overriding human rights see: Monbiot, G. 2007. Don't Listen to What the Rich Leaders Say – Look at What they Do. *The Guardian*, 5 June.

Photo by S. Wren

4. The Impact on Labour and Financial Capital

The main impact of HIV/AIDS is the illness or death of a household member and the subsequent loss of labour. This is the starting point for a set of high-risk responses. When a family member falls sick, the dependency ratio increases: households then seek human, financial and social alternatives to compensate for the loss. The following chapters demonstrate how HIV/AIDS affects people's enjoyment of their right to food.

HIV/ AIDS poses a unique threat because it affects the most productive people in a society.[77] It undermines or removes community and State labour resources, reduces the total number of people and changes the composition of a society because it affects mainly young, productive adults. This eventually leaves a country dominated by the elderly and without a workforce. The loss of labour is twofold: the household loses the labour of the HIV/AIDS-infected person and the labour of family members who care for the sick person.[78]

Loss of labour is followed by various high-risk responses, which make people even more vulnerable. They include (i) reduction in the acreage of land under cultivation, (ii) delays in farming operations, (iii) declines in crop yields and livestock production, (iv) a shift from labour-intensive crops to crops that are less nutritious and (v) declines in production.[79] The consequences of lost labour are numerous.[80] The impact of HIV/AIDS is different for every household, depending on the location and people's response.[81] But there appears to be agreement that the different impacts erode households' right to food: people's diet may deteriorate, for example, which makes them more vulnerable.[82]

[77] Engh, I.-E. 2005. HIV/AIDS, Food Security and Human Rights: Concepts and Linkages. *In* Eide, W.B. and Kracht, U. (eds.) *Food and Human Rights in Development. Legal and Institutional Dimensions and Selected Topics,* vol.1, p. 359. Antwerpen, Netherlands and Oxford, UK, Intersentia.

[78] Stokes, S. 2003. *Measuring Impacts of HIV/AIDS on Rural Livelihoods and Food Security*. Rome, FAO.

[79] Baier, E. 1997. *The Impact of HIV/AIDS on Rural Households/Communities and the Need for Multi-Sectoral Prevention and Mitigation Strategies to Combat the Epidemic in Rural Areas (with special emphasis on Africa)*. Rome, FAO.

[80] "It bears reminding that there is no single, 'African' epidemic', and that HIV prevalence varies significantly between and within sub-regions and countries. Such general trends in HIV prevalence therefore should not obscure the highly varied nature of the AIDS epidemics underway throughout this region". UNAIDS. 2006. *Report on the Global Epidemic 2006*, p 15. Geneva.

[81] Ibid.

[82] Gillespie, S. and Kadiyala, S. 2005. *HIV/AIDS and Food and Nutrition Security. From Evidence to Action*, p. 27. Food Policy Review no. 7. Washington DC, IFPRI.

Apart from loss of labour, household income may be drastically reduced when family members fall sick, since HIV/AIDS brings increased expenditures. This is a second characteristic of the disease: it lasts for a long period, putting households or individuals under severe financial strain, draining energy and household assets.

A normal family might be able to absorb the shock and cost of illness, but a poor and food-insecure family does not have the financial power to fight back. A review of cost-impact studies related to HIV/AIDS affirms this and reveals that HIV/AIDS is catastrophic for poor households because it can absorb 50 percent of annual income,[83] leaving less money to procure food and other vital assets. When the costs of caring for a sick family member surpass the daily or monthly budget, a chain of high-risk responses or trade offs begins. People liquidate saving accounts, sell assets such as jewellery or livestock, borrow money and begin to reduce food consumption or to substitute food items with cheaper goods or wild food.[84] The infected person and the relatives are thus impoverished; there is increased malnutrition among family members, and stunting and wasting begin to manifest themselves. Reducing the quantity or quality of food consumed can have catastrophic effects in that nutritional requirements increase after HIV infection and adequate food is needed to maintain the immune system.

It has been shown that families are not coping but struggling: because there is no reversible management strategy, the coping strategy may be costly; and if there is no homogeneity in the household or community, a long-term vision is not adopted. Coping implies:

> *... a degree of self-sufficiency, which may be a fallacy. It deflects from central authorities' responsibility to mobilize extra resources to fill local capacity gaps, and is thus diametrically opposed to a human rights approach wherein duty bearers, including governments, are held accountable for the respect, protection and facilitation of peoples rights to such essentials as food, health and care.*[85]

The trade-offs, or high-risk responses, thus affect people's right to economic access to food. The problem is that there can be no sustainable response, because households do not have sufficient means or rights.[86] This is what CESCR is addressing when it speaks about economic access to adequate food.

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[83] Russell, S. 2004. The Economic Burden of Illness for Households in Developing Countries: A Review of Studies Focusing on Malaria, Tuberculosis, and Human Immunodeficiency Virus/ Acquired Immunodeficiency Syndrome. *The American Society of tropical Medicine and Hygiene* 712:149. These findings occur in Africa and Asia. See: International Labour Organization. 2003, *Socio-economic impact of HIV/AIDS on people living with HIV/AIDS and their families, Delhi Network of Positive People, Manipur Network of People Living with HIV/AIDS, Network of Maharashtra People Living with HIV/AIDS, Positive Women's Network of Southern India.*

[84] White, J. and Robinson, E. 2000. *HIV/AIDS and Rural Livelihoods in Southern Africa*, p. 16. Chatham, UK, Policy Series 6, Natural Resource Institute.

[85] Loevinsohn, M. and Gillespie, S. 2003. HIV/AIDS, Food Security and Rural Livelihoods: Understanding and Responding. RENEWAL Working Paper no. 2, p.15. Washington DC. For more discussion on the illusion of coping see: Rugalema, G. 2000. *Coping or struggling? A journey into the impact of HIV/AIDS on rural livelihood in Southern Africa*. Rome, FAO.

[86] This has led to the hypothesis of the "new variant famine", which holds that HIV/AIDS has such far-reaching effects that it can be considered a major factor in creating famines. See: De Waal, A. and Whiteside, A. 2003. New Variant Famine: AIDS and Food Crisis in Southern Africa. *The Lancet* 362:234–237; De Waal, A. and Tumushabe, J. 2003. *HIV/AIDS and Food Security in Africa*. London, DFID.

The objective of the right to adequate food is that people can feed themselves in dignity, which implies a degree of self-sufficiency. To ensure this, governments have an obligation to ensure that people have economic and physical access to sufficient resources to ensure their food security. The UN Special Rapporteur on the Right to Food has stated that the obligation to facilitate is a positive obligation that requires a State to identify vulnerable groups and implement policies to increase their access to adequate food and their ability to feed themselves.[87]

Economic access under the right to food implies that "...personal or household costs associated with the acquisition of food for an adequate diet should be at a level such that the attainment and satisfaction of other basic needs are not threatened or compromised".[88] This is what is happens: people trade protecting themselves from the disease for having adequate food, or vice versa.

Right to Food Guideline 8.3 mentions the importance of having access to adequate food in the context of HIV/AIDS:[89]

> *States should pay particular attention to the specific access problems of women and of vulnerable, marginalized and traditionally disadvantaged groups, including all persons affected by HIV/AIDS. States should take measures to protect all people affected by HIV/AIDS from losing their access to resources and assets.*

Realizing the right to food in this context means that governments should facilitate sustainable, non-discriminatory and secure access to resources by adopting protective policies to prevent people from losing their access to resources as a consequence of such impacts as the loss of labour or the loss of financial capital.[90]

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[87] Commission on Human Rights. 2006. *Report of the Special Rapporteur Jean Ziegler on the Right to Food* (E/CN.4/2006/44).

[88] CESCR General Comment 12 (E/C.12/1999/5), para. 13.

[89] "States should take measures to protect all people affected by HIV/AIDS from losing their access to resources and assets". *Voluntary Guidelines to Support the Progressive Realization of the Right to Adequate Food in the Context of National Food Security*, 8.3.

[90] Ibid, 8.3.

Photo by S. Wren

5. The Right to Adequate Food of People Affected by HIV/AIDS

5.1 The Impact on Knowledge

Loss of knowledge is linked to the loss of labour. In this paper, loss of knowledge refers to the knowledge lost when a person dies of HIV/AIDS and to the reduced opportunities for learning if children cannot go to school because of HIV/AIDS.

Passing on farming knowledge and skills is of crucial importance for the right to food in agricultural societies or households. It has been asserted that "...planning a year-long strategy for a family to feed itself and protect the basis of its livelihood, requires much experience about income-earning opportunities...(and) without mature adults, these planning skills and networks may be absent".[91] An impact of HIV/AIDS is that it becomes difficult to pass on knowledge to others because of the burden of care placed on the household or because knowledge is lost when a person dies. The situation is particularly worrying in that much knowledge is gender-specific, and there is no transfer of this knowledge between the sexes.[92] This has implications for households headed by men and by women: in both situations, people are ill equipped to carry out new tasks, and because valuable knowledge is lost their ability to choose among adequate responses is increasingly constrained. FAO has pointed out that without development and where knowledge is constrained, people adopt high-risk behaviour or survival strategies.[93] Their ability to feed themselves is reduced and eventually lost. Right to Food Guideline 11 on education and awareness-raising urges governments to invest in education to preserve agricultural and environmental knowledge.[94]

The negative impact on children is particularly noted. Studies have reported the harmful effect of HIV/AIDS on children's education:[95] children drop out of school

[91] De Waal, A. and Whiteside, A. 2003. New Variant Famine: AIDS and Food Crisis in Southern Africa. *The Lancet*, 262:236.

[92] Stokes, S. 2003. *Measuring Impacts of HIV/AIDS on Rural Livelihoods and Food Security*. Rome, FAO.

[93] FAO. 2000. *Transferring and Passing Knowledge on to Future Generations*. Rome.

[94] *Voluntary Guidelines to Support the Progressive Realization of the Right to Adequate Food in the Context of National Food Security*, guideline 11.

[95] Nankhuni, F. 2005. *Household Deaths and Children's Schooling: Quantifying the Effect of HIV/AIDS on Adolescents*. Paper presented at the annual meeting of the Population Association of America, Philadelphia, USA; Case, C. and Paxson, J.A. 2004. *Orphans in Africa: Parental Death, Poverty and School Enrolment*. Princeton, NJ, Princeton University Centre For Health and Wellbeing; Gilborn, L., Nyonyintono, R,. Kambuli, R. and Jagge-Wadda, G. 2001. *Making a Difference for Children Affected by AIDS: Baseline Findings from Operation Research in Uganda*. New York, Population Council.

to care for invalids or to work. Because the dependency ratio rises when a person falls sick, households need all the help they can get, including help given by children. Again, people are forced to make counter-productive and unsustainable decisions. This situation increases the likelihood of malnutrition, HIV infection and exploitative child labour.[96] HIV/AIDS-positive children are often discriminated against and denied access to education, which increases their susceptibility to infection.[97] Predictions can only be pessimistic, because it is likely that even more children will be orphaned as the number of people living with HIV/AIDS increases.

Fewer than a third of young men and young women in sub-Saharan Africa have comprehensive knowledge about HIV/AIDS.[98] If a State has to tackle HIV/AIDS, it needs to realize the right of its citizens to education. "As an empowerment right, education is the primary vehicle by which economically and socially marginalized adults and children can lift themselves out of poverty and obtain the means to participate fully in their communities".[99] Education is essential in the HIV/AIDS crisis: it enables people to learn (i) how to prevent the disease, (ii) how to deal with it once infection has started, (iii) what to eat and (iv) what medicines to take. And it counteracts the loss of knowledge that is one of the impacts of HIV/AIDS on the right to food.[100]

The right to education is linked to the right to food in that there can be no learning without an adequate standard of living. Realizing the right to food is therefore essential to enable people to obtain education about preventing and coping with the disease and about its impacts on their right to food. By realizing the right to food, States empower people to deal with their problems themselves by creating an environment in which people can gain knowledge, put the knowledge into practice and make safe decisions.

5.2 The Impact on Social Capital

The impact of HIV/AIDS on people's social capital is immense: it affects the sick person and the whole community. Normally, households affected by HIV/AIDS[101] look for support in the family, among neighbours or in community institutions or informal organizations.[102] These relationships between households and communities are valuable in that they help affected families to respond to the effects of the disease, so much so that some studies have found no negative effects on economic productivity, and explained this by identifying social networks or collective coping mechanisms.[103]

[96] De Wagt, A. and Connolly, M. 2005. Orphans and the Impact of HIV/AIDS in Sub-Saharan Africa. *Food, Nutrition and Agriculture*, 34:24–29.

[97] Committee on the Rights of the Child, General Comment 3 (CRC/GC/2003/3).

[98] United Nations. 2007. *Millennium Development Goals Report 2007*, p. 21. New York.

[99] CESCR General Comment 13 (E/C.12/1999/10), para. 1.

[100] Programmes such as the FAO Junior Farmer Field Programme help orphans to acquire knowledge to survive and protect themselves from HIV/AIDS.

[101] It is suggested that disasters or afflictions put similar strains on traditional coping mechanisms.

[102] Stokes, S. 2003. *Measuring Impacts of HIV/AIDS on Rural Livelihoods and Food Security,* Rome, FAO.

[103] Mathambo Mitka, M. 2001. The AIDS epidemic in Malawi and its Threat to Household Food Security. *Human Organization* 60(2):185.

To some extent, communities can mitigate the impact of HIV/AIDS by sharing the burden of care. But what if the links between community or family and affected households are weak? What if communities are unable to help? It has been noted that HIV/AIDS ultimately erodes social networks and that the burden of caring may overpower the willingness or the ability of a community to help affected households.[104] Research in Malawi reveals a threshold level: once the epidemic reaches the level where people are overwhelmed and can no longer provide help, a downward spiral starts in which their ability to find help is eroded; this in turn erodes household food security. Hence, the threat of HIV/AIDS to household food security lies in weakening traditional coping mechanisms.[105] There have also been warnings of the threat posed by the epidemic to traditional coping mechanisms.[106] What has been described as a coping strategy is in fact an unsustainable and dangerous household response. And it does not stop after the death of a household member because the impact continues to be felt in the form of debts, medical costs or funeral expenses. These concerns demonstrate the immense burden placed on communities by the epidemic.

States must protect and facilitate people's access to adequate food (see chapter 4). One route to doing this, as described in the Right to Food Guidelines, is respecting and reinforcing people's traditional coping mechanisms and structures,[107] as mentioned previously.

A right to food approach means that a government will empower people to feed themselves in dignity in a transparent and participatory process of enhancing their capacity or existing coping mechanisms. There is, of course, a need to make governments accountable, but there is no need to abolish existing mechanisms or programmes. Best practice shows that reinforcing community or family structures is an effective way of supporting orphans and vulnerable children.[108] Increased participation at the local level in Swaziland, for example, has resulted in improved analysis and ownership of problems, enhanced the mobilization of resources and facilitated the development of sustainable and innovative solutions. Observers have warned, however, that these community responses would be hard to sustain without adequate food.[109] The Committee on the Rights of the Child has asserted that governments should facilitate "...the involvement of communities in the provision of comprehensive HIV/AIDS treatment, care and support, while at the same time complying with their own obligations under the Convention".[110] Empowering communities does not imply that a State should play a secondary role: as noted in chapter 1, States should create an environment in which communities can contribute to prevention, care and treatment of the disease.

[104] Gillespie, S. and Loevisohn, M. 2003. *HIV/AIDS, Food Security and Rural Livelihoods: Understanding and Responding*. RENEWAL Working Paper no. 2. Washington DC, IFPRI.

[105] Mathambo Mitka, M. 2001. The AIDS epidemic in Malawi and its Threat to Household Food Security. *Human Organization* 60(2):185.

[106] De Waal, A. and Tumushabe, J. 2003. *HIV/AIDS and Food Security in Africa*. London, DFID.

[107] *Voluntary Guidelines to Support the Progressive Realization of the Right to Adequate Food in the Context of National Food Security*, 10.9 and 10.10.

[108] See for example the CHIN project in Zambia, the work of village AIDS committee' in Malawi or Indlunkhulu in Swaziland.

[109] UNAIDS. 2006. *Helping Ourselves: Community Responses to AIDS in Swaziland*. Geneva.

[110] Committee on the Rights of the Child, General Comment 3 (CRC/GC/2003/3), para. 28.

List of Acronyms
Introduction
1. The Right to Food
2. HIV/AIDS and the Importance of Adequate Food
3. Breastfeeding and HIV/AIDS
4. The Impact on Labour and Financial Capital
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Conclusions

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6. Discrimination and The Right to Food

6.1 Discrimination Against HIV-positive People

Another distortion of the social fabric caused by HIV/AIDS is discrimination. Non-discrimination is a paramount principle in human rights law and is found in various international and regional human rights treaties. HIV/AIDS-related discrimination against men and women is widespread; it has been addressed in several legal cases, and courts have condemned violations.[111] CESCR General Comment 12 urges governments to develop national strategies to realize the right to food and to focus on "...the need to prevent discrimination in access to food or resources for food. This should include: guarantees of full and equal access to economic resources, particularly for women, including the right to inheritance and the ownership of land and other property, credit, natural resources and appropriate technology; measures to respect and protect self-employment and work which provides a remuneration ensuring a decent living for wage earners and their families".[112]

People are still denied treatment or discriminated against in various ways because of their HIV status:[113] stigma and the resulting discrimination and gender inequality are the greatest barriers in fighting the epidemic. Some of the impacts of stigma are "...abandonment by spouse and/or family, social ostracism, job and property loss,

[111] E.g. Canada (Attorney General) v. Thwaites, [1994] 3 FC 38 (Federal Court of Canada – Trial Division, 1994) 10; XX v. Gun Club Corporation *et al.*, Constitutional Court, Judgement No. SU-256/96 (1996) 13; MX v. ZY, AIR 1997 Bom 406 (High Court of Judicature, 1997) 18; Mr. X v. Hospital Z, (1998) 8 SCC 296, varied 2002 SCCL.COM 701 (Civil Appeal No. 4641 of 1998), Supreme Court of India (1998 and 2002) 21; A, C and Others v. Union of India and Others, High Court of Judicature at Bombay [Mumbai], Writ Petition No. 1322 of 1999 21; JRB *et al.* v. Ministry of Defence, Case No. 14000, Supreme Court of Justice of Venezuela (Political-Administrative Bench) (1998) 27; Haindongo Nghidipohamba Nanditume v. Minister of Defence, Case No. LC 24/98, Labour Court of Namibia (2000) 31; Hoffmann v. South African Airways, Constitutional Court of South Africa, Case CCT 17/00 (2000); 2001 (1) SA 1 (CC); 2000 (11) BCLR 1235 (CC) 35; XX v. Ministry of National Defence (General José María Córdova cadet school), Case No. T-707205, Third Appeal Bench of the Constitutional Court (2003) 39; Karen Perreira v. The Buccleuch Montessori Pre-School and Primary (Pty); Ltd *et al.*, High Court of South Africa, Case No. 4377/02 (2003) 42; Diau v. Botswana Building Society (BBS), Case No IC 50/2003, Industrial Court of Botswana (2003).

[112] CESCR General Comment 12 (E/C.12/1999/5), para.26.

[113] See for example: Human Rights Watch. 2006. *No Bright Future: Government Failures, Human Rights Abuses, and Squandered Progress in the Fight Against HIV/AIDS in Zimbabwe*. New York; Human Rights Watch. 2005. *Positively Abandoned: Stigma and Discrimination against HIV-Positive Mothers and their Children in Russia*. New York; Human Rights Watch. 2004. *Future Forsaken: Abuses Against HIV/AIDS Infected Children in India*. New York.

school expulsion, denial of medical services, lack of care and support, and violence".[114] These impacts affect people's enjoyment of the right to food and their ability to feed themselves and their families. Without the access to the means and entitlements to enjoy the right to food, a person becomes more vulnerable to the epidemic (see chapter 4).

6.2 Discrimination Against Women

Women are disproportionately affected by the epidemic: they face double discrimination because of their HIV/AIDS status and their social status. Women are more likely than men to face discrimination in the political, social and economic fields. They are severely and unequally affected by malnutrition, hunger and poverty, which make them more vulnerable to the disease as they engage in high-risk activities such as transactional sex. Lack of rights and lack of physical access to adequate food and productive resources increase women's vulnerability to HIV/AIDS.

In his third annual report to the Commission on Human Rights, the UN Special Rapporteur on the Right to Food highlighted issues such as household discrimination, workplace discrimination and the difficulties that women have in access to and control over land, credit and food.[115] The link between property, inheritance rights and HIV/AIDS is crucial in terms of the right to food; research and intervention strategies are only beginning to explore it. There is agreement that property rights for women are important in general, and that this importance increases significantly in the context of HIV/AIDS.[116]

The Special Rapporteur noted that women lack access to property and to productive resources such as labour, credit, training and technology;[117] violations of property and access rights have been reported in numerous countries. Women's lack of rights and access to productive resources increases household poverty and hence susceptibility to HIV/AIDS.[118] Women are less to cope with the economic consequences of HIV/AIDS, and without access to productive resources are less able to protect themselves from HIV/AIDS.[119] In general, women depend on men for access to productive resources,

[114] UNAIDS. 2007. Reducing HIV Stigma and Discrimination: a Critical Part of National AIDS Programmes. Geneva.

[115] Report of the Special Rapporteur of the Commission on Human Rights on the Right to Food (A/58/330).

[116] Global Coalition on Women and AIDS. 2004 . *AIDS and Female Property/Inheritance Rights*., Geneva.

[117] FAO. 2000. *Addressing Gender Inequalities* (AD/I/Y5573E/1/11.04/2000). Rome.

[118] The United Nations General Assembly has placed human rights and the fight against discrimination at the heart of the struggle against the epidemic since the Declaration of Commitment on HIV/AIDS in 2001 (A/RES/S-26/2), and reiterated in its 2008 Declaration on HIV/AIDS the need to empower women and decrease gender inequality to reduce the vulnerability of women. See United Nations. 2008. *Declaration of Commitment and Political Declaration on HIV/AIDS: Midway to the Millennium Development Goals* (A/62/780).

[119] See for example: Human Rights Watch. 2003. *Double Standards: Women's Property Rights Violations in Kenya*.New York; Global Coalition on Women and AIDS. 2004, *AIDS and Female Property/Inheritance Rights*. Geneva; UNAIDS, Securing Women's Property and Inheritance Rights. Geneva; The Centre on Housing Rights and Evictions. 2004. *Bringing Equality Home: Promoting and Protecting the Inheritance Rights of Women: A Survey of Law and Practice in Sub-Saharan Africa*. Geneva; FAO. 2004. *Protecting Women's Property and Land Rights to Protect Families in AIDS-Affected Communities*. Rome; Strickland, R. 2004. *To have and to hold: Women's Property and Inheritance Rights in the Context of HIV/AIDS in Sub-Saharan Africa.* Washington DC, International Centre for Research on Women.

so when the relationship ends on the death of the husband or other circumstances, women are left with no rights at all. Women are stripped of their assets, in many cases by their family. Many women submit to these abuses for fear of losing their homes. Consequently, women's low economic status inclines them to undertake high-risk responses that increase their susceptibility to HIV/AIDS. The high-risk actions women undertake when they are being discriminated against or forced into poverty have been described: their low socio-economic status increases the prospects of women engaging in transitional sex and decreases their chances of negotiating about sex, leading to increased risks of coerced sex and lower age at sexual debut.[120] All this increases women's susceptibility to HIV/AIDS and prevents them from acquiring economic access to adequate food (see chapter 4).

In its General Comment, CESCR acknowledges women's lack of the rights that would enable them to make an adequate living and urges States to provide:

> *...full and equal access to economic resources, particularly for women, including the right to inheritance and the ownership of land and other property, credit, natural resources and appropriate technology; measures to respect and protect self-employment and work which provides a remuneration ensuring a decent living for wage earners and their families.* [121]

The Convention on the Elimination of All Forms of Discrimination against Women contains no explicit reference to the right to food. It does, however, protect core elements of the right to food such as equal access to land (Art. 16), the right to enjoy adequate living conditions (Art. 14), the right to have access to adequate healthcare (Art. 12) and the right to social security or safety nets (Art.14).[122] CESCR affirms that any discrimination in access to food or means or entitlements for its procurement such as lack of property rights and lack of access to productive resources are violations of women's human right to adequate food in that they impede enjoyment of right to physical and economic access to adequate food.[123]

The Right to Food Guidelines stipulate that States should facilitate non-discriminatory, sustainable and secure access to resources for people, especially for women and disadvantaged groups such as people living with HIV/AIDS.[124] Guideline 8.6 urges States to implement gender-sensitive legislation on inheritance and property rights and to allow women to have access to and control over productive resources such as credit, land, water and technologies.[125]

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[120] Gillespie, S. and Kadiyala, S. 2005. *HIV/AIDS and Food and Nutrition Security. From Evidence to Action*. Food Policy Review no. 7. Washington DC, IFPRI.

[121] CESCR General Comment 12 (E/C.12/1999/5), para. 26.

[122] Convention on the Elimination of All Forms of Discrimination Against Women (General Assembly Resolution 34/180).

[123] CESCR General Comment 12 (E/C.12/1999/5), para.18.

[124] *Voluntary Guidelines to Support the Progressive Realization of the Right to Adequate Food in the Context of National Food Security,* guideline 8.

[125] Ibid, guideline 8.6.

The rights of women, especially the right to food, must be realized to enable women to cope and protect themselves from the impact of the epidemic. Their legal inferiority must be eliminated. By empowering women through a legal framework of accountability, non-discrimination and equal rights, States will enable them to enjoy the right to food and will reduce the incentives to engage in high-risk actions. Once they are considered as equals in dignity and rights, women will be able to adopt safer and more sustainable livelihoods and benefit from access to and control over productive resources.

Photo by S. Wren

Conclusion

In a complex multi-sectoral issue such as HIV/AIDS, there is no universally applicable analysis. The right to food is not the "silver bullet" that will solve the HIV/AIDS crisis. The call for a comprehensive rights-based approach to HIV/AIDS prevention requires identification of the rights that, when violated, make people vulnerable to HIV/AIDS.[126] The right to food is one such right. The human right to adequate food should be embodied in national laws to stand alongside other rights such as the rights to health, adequate housing and education. The realization of these rights does not guarantee the end of the epidemic; but it would help to create a safe, enabling environment in which people can adopt safe behaviour. Compliance with human rights is a starting point for further development: it is not a solution to the problem.

Adequate food is particularly important for people affected by HIV/AIDS, because malnutrition accelerates the development of AIDS. Adequate food delays the onset of AIDS and reinforces the immune system. It also improves the efficacy of drugs, so people must have an adequate diet during antiretroviral treatment. The right to adequate food aims to create an enabling environment in which people are healthy, can resist opportunistic infections and are able to consume adequate food.

In the context of HIV/AIDS and breastfeeding, realization of mothers' right to food enables them to breastfeed and care for their children. Governments should provide sustainable access to adequate replacement feeding to inhibit HIV transmission. Women have the right to a non-discriminatory environment in which they are fully informed about different feeding options and have economic access to adequate replacement feeding. Only then can they realize the right of their child to adequate food.

Loss of labour and financial capital erodes people's access to adequate food, because they undertake high-risk actions to compensate for the losses. The Right to Food Guidelines urge governments to give special attention to these access problems and emphasizes governments' obligation to facilitate sustainable, non-discriminatory and secure economic access to productive resources, which would empower people to make safe choices when confronted with the disease instead of having to resort to high-risk and impoverishing trade-offs.

[126] An idea mooted by the late Jonathan Mann. See: Mann, J. 1994. *Health and Human Rights*. New York, Routledge.

Other erosions of people's right to food are loss of knowledge and loss of social capital. These affect asymptomatic people, for example through sickness of a family member or the erosion of social networks. In dealing with the epidemic, governments need to invest in the protection of agricultural and environmental knowledge and empower, reinforce and support communities and their coping mechanisms.

With regard to discrimination against HIV-positive people in access to adequate food and the means for its procurement, women suffer disproportionately: lack of the right to food heightens their vulnerability to the disease. Governments should consider special protective measures to protect people infected by HIV/AIDS and fulfil their right to food.

This study demonstrates that there are good reasons for supporting the integration of the right to food into prevention and treatment programmes to make them truly effective. HIV/AIDS programmes and policies that were reinforced with the legally established right to food would have two impacts: HIV/AIDS prevalence would diminish, and strains on people's right to food would be reduced. The vicious circle of food insecurity and HIV/AIDS could be broken.

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