Interagency Coalition on AIDS and Development
Coalition interagence sida et développement

HIV, Nutrition, Food Security and Gender

Exploring the Intersections

INTRODUCTION

There are multiple and complex intersections between nutrition, food security, HIV and gender. Examining these intersections is critical to the development of effective programmatic and policy responses, and aligns with the approach of the Sustainable Development Goals, which address global challenges from an integrated perspective. In sub-Saharan Africa, as in many geographies of the world, increasing levels of malnutrition and food insecurity threaten to undo progress made in access to antiretroviral treatment (ART) and reductions in HIV prevalence. Compounding and contributing to these overlapping challenges, are the extreme and increasingly unpredictable weather patterns that result from climate change and are jeopardizing food security in sub-Saharan Africa. The emergence of the global COVID-19 pandemic stands to further exacerbate the impact of inequities and derail progress made on malnutrition, food insecurity, HIV and gender inequality, particularly amongst the world's most marginalized groups. This fact-sheet presents an overview of the manifold intersections between nutrition, HIV and gender, with the aim of promoting an integrated programmatic and policy approach to addressing these global challenges, which have been exacerbated by the advent of the COVID-19 pandemic.

ABOUT THE SANI TWINNING PROJECT

care
Southern African Nutrition Initiative
Malawi • Mozambique • Zambia
Project undertaken with the financial support of the Government of Canada

As part of CARE Canada's Southern African Nutrition Initiative (SANI) funded by the Government of Canada, the Interagency Coalition on AIDS and Development (ICAD) is leading a capacity-building initiative to improve the health outcomes of women living with HIV and children living with and/or affected by HIV in targeted regions of Malawi and Zambia. ICAD's partners in Zambia, Malawi and Canada have been implementing projects that target the nexus of HIV, nutrition and gender, delivering community-based interventions from an integrated perspective.

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NUTRITION, HIV AND GENDER: AN OVERVIEW

In 2018, there were more than 820 million people globally who were hungry. Over 230 million of these people were in sub-Saharan Africa, where the prevalence of undernourishment has reached 22.8 percent. Gender inequality is a significant determinant of women's nutritional status and one of the key barriers to women exercising their right to food. In every continent, the prevalence of food insecurity is slightly higher in women than in men.

In 2018, there were 20.6 million [18.2 million– 23.2 million] people living with HIV in Eastern and Southern Africa. Globally, women constitute more than half of all people living with HIV, and AIDS-related illnesses remain the leading cause of death for women aged between 15 and 49.

In some hospitals in Southern African countries, more than half of the children admitted for treatment of severe acute malnutrition test positive for HIV, and in some HIV/AIDS treatment services, more than half of the patients – adults and children - are found to be in need of food and nutrition support.

FOOD SECURITY VS. NUTRITION SECURITY

Food Security

Adequate access to food in both quantity and quality

- People experiencing **moderate food insecurity** face uncertainties about their ability to obtain food and have been forced to reduce, at times during the year, the quality and/or quantity of food they consume due to lack of money or other resources, which can have negative consequences for nutrition, health and well-being.
- People facing **severe food insecurity**, on the other hand, have likely run out of food, experienced hunger and, at the most extreme, gone for days without eating, putting their health and well-being at grave risk.

Nutrition Security

The intake of a wide range of foods which provide the essential needed nutrients

- **Acute malnutrition/Wasting:** Low weight for height, generally the result of weight loss associated with a recent period of starvation
- **Chronic malnutrition/Stunting:** Low Height for Age, reflecting a sustained past episode or episodes of undernutrition

Nutrition security relies on food security, but malnourishment can exit in a food secure context.

HOW DOES HIV IMPACT NUTRITION AND FOOD SECURITY?

HIV and AIDS negatively impact on a person's nutritional status in different ways: insufficient dietary intake, mal-absorption and diarrhoea, and impaired storage and altered metabolism. In regions such as sub-Saharan Africa, these factors often result in nutrient deficiencies, compromised immunity, increased risk of acquiring infectious disease, and, in a vicious circle, progression of HIV-disease. Opportunistic infections like diarrhoea and tuberculosis lead to weight loss, and as little as 3-5% weight loss has been associated with mortality. People living with HIV may also experience compromised nutrition due to dysphagia (i.e. difficulty swallowing), a symptom of esophageal candidiasis, despite the fact that ART has significantly reduced the prevalence of this opportunistic infection. In areas of the Global North, people living with HIV experience similar nutritional challenges, particularly poor dietary intake and foodborne illness, impacting HIV progression and overall health. People who use drugs, have mental health challenges, low socio-economic status and unstable housing face increased food insecurity.

Compounding these impacts is the fact that nutritional needs of people living with HIV and AIDS are increased because the body has to fight the virus and opportunistic infections. An adult living with HIV has 10-30 percent higher energy requirements than an HIV-negative, healthy adult; children living with HIV have 50-100 percent higher needs than those who are HIV-negative. The energy needs increase by 10 percent even when HIV infection is asymptomatic, and increase further when an opportunistic infection is present. This increase can be as much as 25-30% with tuberculosis, chronic lung disease and persistent diarrhoea to as high as 50 to 100% with AIDS progression in children.

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Studies have also shown that HIV contributes to food insecurity through the debilitation of the most productive household members, decreased household economic capacity, decreased household agricultural output, and increased caregiver burden, all of which risk being exacerbated by COVID-19 and associated lockdown and quarantine measures.

HOW DO NUTRITION AND FOOD INSECURITY IMPACT HIV?

Poor nutrition exacerbates HIV and can hasten AIDS-related illnesses in people living with HIV. Low body mass index at the initiation of ART is associated with increased mortality in HIV-infected adults. Evidence shows that people living with HIV who are undernourished when they initiate into ART are 2-6 times more likely to die in the first six months of treatment than those who have a normal body mass index.

The most common form of adult malnutrition in the sub-Saharan Africa is protein-calorie malnutrition (lack of both dietary protein and sufficient calories), which compounds the immunosuppressive effects of HIV. Advanced nutrition deficiency is an independent predictor of early mortality after antiretroviral therapy, likely due in part to malnutrition-induced dysfunction of the immune system and metabolism and a higher incidence of infections.

Nutrition and food insecurity have negative implications for treatment adherence, individual health outcomes and immediate and long-term downstream health system costs. Delays in uptake of ART and interruptions of treatment can result from food insecurity and poor nutrition. Many ARVs need to be taken with food in order to prevent side-effects, and the experience of or fear of these side-effects may lead PLHIV to delay or pause ART in times of food scarcity, even when they have access to them. In Malawi where about 79% of the 1 million people with HIV were on ART in 2018, many are choosing to stop treatment rather than take ART without food and experience the side-effects. In one district alone, up to 6400 of 14 200 people on ART are reported to have stopped therapy.

Among individuals with low income in many parts of the world, accessing health care services must be balanced against competing demands for food and other household resources. Not only do interruptions to ARVs result in individual illness, they impact health systems when failures of first-line treatments lead to the need to move to a more costly second-line regimen.

ADDING IN THE GENDER DIMENSION

Gender inequality remains a key driver of the HIV epidemic and a leading factor contributing to food insecurity. Food insecurity occurs as a result of power imbalances and poverty as much as inadequate food supplies .Existing gender inequalities put women and girls at heightened risk for transmission. Women often have less social and economic power within relationships making protecting themselves extremely difficult. Food insecurity has been shown to increase the risk of HIV exposure and infection, particularly as food insecurity increases the likelihood of women engaging in transactional or intergenerational sex.

Women bear an inequitable burden of food insecurity due to lack of control over resources and over household food allocation decision-making. HIV and traditional gender roles have a disproportionate impact on the lives of women and girls. Women and girls traditionally bear an unequal responsibility for the work of caregiving for those who are sick and orphaned children due to AIDS effectively removing their labour from formal employment markets and the education sector.

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Unequal intra-household decision making power (including income and food distribution), divisions of labour, resource and services access, and control (e.g., property/inheritance rights, access to water and land, credit, information and education) have deep implications for women's and girl's health, food, nutrition and livelihood security. When food is scarce, women typically eat less and eat last, meaning that their nutritional needs are more likely to go unmet.

Pregnant and lactating women living with HIV have additional nutritional requirements that may make them particularly vulnerable, and food insecurity has been associated with an increased risk of mother-to-child transmission of HIV among pregnant women living with HIV.

CANADIAN CONTEXT

While the challenges in sub-Saharan Africa and other regions in the global South are of a different magnitude, the intersecting challenges discussed here exist in Canada (and other countries known as the "Global North"), with marginalized groups including Indigenous Peoples and African, Caribbean and Black people being disproportionately impacted. In a national study of people living with HIV, sixty-seven percent were food insecure. HIV-infected adults receiving anti-retroviral therapy have a high prevalence of food insecurity in both high- and low-income settings, with women having higher odds of experiencing food insecurity than men. Among a sample of HIV-infected individuals in British Columbia, 33% of women were categorized as hungry, compared with 20% of men. In an Ontario study, the OHTN found that people who were food-secure reported 30% fewer symptoms of HIV, and were 11% more likely to take their medications as prescribed. Women and people from racialized communities were twice as likely to be food-insecure.

COVID-19

The COVD-19 pandemic will have dire consequences across each of these cross-cutting issues, particularly on those already experiencing marginalization. The World Food Program projects a doubling of the number of people facing food crisis as a result of COVID-19. A combination of economic slow-down and recession, disrupted markets, lack of international trade, lower travel, increased food prices, and mobility restrictions are going to impact people's ability to grow, buy, sell, or prepare the food they need to stay healthy, all of which have gendered impacts, including increased rates of gender based violence.

The number of deaths from AIDS-related illnesses in sub-Saharan Africa could double if the provision of healthcare to people living with HIV is disrupted during the COVID-19 crisis.

CONCLUSION

Programs and policies that account for the multiple intersections are critical to an effective and integrated response that advances holistic approaches to any one of these global challenges. HIV programs must take into account the food security and nutrition needs of people living with HIV, and women living with HIV in particular. Conversely, food security and nutrition programs must account for the specific needs and realities of people living with HIV, and women in particular. Without addressing these intersections, crucial gains in one area will not translate into gains in another, and those experiencing marginalization will bear the brunt of these failings. Responses to crises, including climate change and the COVID-19 pandemic, must similarly take into account the intersections between HIV, nutrition, food security and gender.

ABOUT ICAD

*The **Interagency Coalition on AIDS and Development (ICAD)** is a registered Canadian charity based in Ottawa, Ontario representing a large coalition of over 100 Canadian HIV and AIDS organizations, international development non-governmental organizations, academic institutions, labour unions, and individuals. ICAD was founded in 1989 as a working group of the Canadian Council for International Cooperation (CCIC) with the mandate to bring together AIDS service organizations and international development organizations to address the HIV crisis at home and abroad.*

ICAD helps Canadians contribute to international HIV work and encourages Canadian organizations to use the lessons learned from the global response that ICAD makes available, to improve prevention, care, treatment and support services across diverse settings in Canada. ICAD provides leadership in reducing the global and domestic impact of the HIV and AIDS epidemic through improving public policy, providing information and analysis, and sharing lessons learned.

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