

The purpose of these *Key Sheets* is to provide decision-makers with an easy and up-to-date point of reference on issues relating to the provision of support for sustainable livelihoods.

The sheets are designed for those who are managing change and who are concerned to make well-informed implementation decisions. They aim to distil theoretical debate and field experience so that it becomes easily accessible and useful across a range of situations. Their purpose is to assist in the process of decision-making rather than to provide definitive answers.

The sheets address three broad sets of issues:

- Service Delivery
- Resource Management
- Policy Planning and Implementation

A list of contact details for organisations is provided for each sub-series.

Overview of the debate

The HIV/AIDS epidemic is unprecedented in its scale and impact on the most productive age categories, especially on those in whom society has invested most. The epidemic permeates all key sectors in heavily affected countries, and threatens the development gains made in recent decades. Its spread is mainly linked to sexual behaviour, which is both sensitive and resistant to change. A range of social and economic factors determine the degree of susceptibility to infection and vulnerability to impact.

Over the past 5 years, the debate has focused on:

- How to increase the commitment of governments to reverse the spread of the epidemic not only by increased funding, but also by fully implementing agreed policies.
- The need to mainstream responses to HIV/AIDS within government and in society as a whole.
- Implications of HIV/AIDS for the development agenda (Millennium Development Goals) and the main donor-supported instruments (e.g., Poverty Reduction Strategy Papers, direct budgetary support, sector-wide approaches).
- The move to multisectoral response strategies, and the involvement of government, civil society and the private sector.
- Methods to increase the capacity of health systems to provide prevention, treatment, care and impact mitigation in complementary ways.
- Efforts to move beyond the dominant public health approach to ones that integrate HIV/AIDS and its impacts within existing governance and development frameworks.
- Ways to increase (equitable) access to care and treatment, including anti-retroviral drugs.
- Ways of addressing the continuing stigma that undermines prevention, care, treatment and impact mitigation efforts, but also discourages political and community mobilisation around HIV/AIDS.

Key issues in decision making

Basic facts and phases of the epidemic Over 20 million people have died and 42 million more are infected with HIV. Most of these are likely to be unaware of their status, and so, perhaps unwittingly, pass on the infection or re-infect others. Historically, more men were infected globally, but now the proportions of men and women are equal, though in Sub-Saharan Africa more women are infected. Some progress is being made in vaccine development, but there is little chance that vaccination against HIV will be available on a large scale before the end of the decade.

The epidemic develops in phases, each with its own impact on livelihoods, and each requiring different prevention and impact-mitigation strategies. In the initial phases, the impact is mainly at the household level and within specific populations. In a further phase (prevalence >5% in antenatal clinics) the health care system becomes overwhelmed, and community social cohesion is affected. When antenatal clinic levels exceed 20%, coping problems at community level become severe, social and economic impacts are felt in all sectors at all levels, and national stability may be threatened. The full impact has yet to be seen (and understood) in most countries: orphan numbers may peak even after infection rates have fallen. The phase of the epidemic, its spatial distribution, and the financial resources available will guide governments in setting priorities for intervention.

Prevention Prevention can focus on bio-medical issues (blood safety, vaccine and microbicide development, anti-retroviral drugs, treatment of sexually transmitted infections...), enhancing sexual and reproductive health services, or changing behaviour (behaviour change communication, condom promotion and marketing, voluntary counselling and testing...). Prevention interventions must be targeted at people/communities with increased vulnerability (e.g., injecting drug users, sex workers and their clients, men having sex with men, prisoners, migrant workers, and adolescents) but also at the general population (e.g., mass awareness; prevention of mother-to-child transmission and prevention of transmission in health care settings).

Effective targeted prevention strategies aim at behaviour change instead of simply awareness. They typically include behaviour change communication, STD services, condom programming and contextual interventions addressing socio-economic factors associated with vulnerability. For injected drug-related HIV epidemics, a comprehensive 'harm reduction' approach includes: drug-dependency treatment and rehabilitation, HIV/AIDS education, access to clean needles, syringes and condoms, legal and social services, and social support. Reaching all these groups requires interventions, developed with them, that are specifically tailored to their realities and needs. Laws and police practices should facilitate rather than hinder outreach work and service provision.

Prevention and care are linked in voluntary counselling and testing services, where people are tested and counselled on how to remain negative or how to avoid spreading the infection and live healthily. They are also directed to relevant care, treatment and support services. These services require complete confidentiality, non-judgemental attitudes among staff, and skilled counsellors.

Care and treatment Comprehensive care for people living with or affected by HIV/AIDS includes: voluntary counselling and testing services, prevention and treatment of opportunistic infections, palliative care, psychological support to patients and their families, and community activities that mitigate the impact of HIV and AIDS. This 'continuum of care' has to be delivered by a weakened, overwhelmed and understaffed health system. Private (often informal) care by less than fully qualified practitioners is often vital. Massive increases in training and investment are essential to support the health system.

HIV/AIDS and Development *continued*

DGIS experience

Global International Aids Vaccine Initiative; International Partnership on Microbicides; Global Network of People Living with HIV/AIDS; Population Services Intl
Southern Africa Safaids; Soul City; Red Cross
Asia CARAM; Asian Harm Reduction Network

DFID experience

Global UNAIDS, WHO, Unicef, UNFPA, International AIDS Vaccine Initiative, Global Fund to Fight AIDS, Tuberculosis and Malaria
Countries Ethiopia, Kenya, Nigeria, Southern Africa, China, India

Expertise

- ACI, Senegal
- Aids Fonds, Amsterdam
- Centre for the Study of AIDS, Univ. of Pretoria
- ETC Crystal, Netherlands
- HEARD, South Africa
- HIV/AIDS Alliance, UK
- IDS, Sussex University
- JSI-UK
- KIT, Amsterdam
- ODG, Univ. of E Anglia
- PharmAccess
- Share-net, Netherlands
- Stop AIDS Now
- UK Network on Sexual and Reproductive Health & Rights

Websites

- BRIDGE, www.ids.ac.uk/bridge/reports_gend_CEP.html
- International AIDS Economics Network, www.iaen.org/papers/
- Justice Africa, www.justiceafrica.org
- UNAIDS, www.unaids.org
- UNDP, www.undp.org/hiv
- UNICEF, www.unicef.org/aids
- World Bank, www1.worldbank.org/hiv_aids

Relief of symptoms through anti-retroviral treatment has become standard in richer countries. Increased access in developing countries is a priority, along with lower drug prices and facilities to monitor treatment efficacy and potential drug toxicity. In view of the enormous tasks and funding requirements, innovative partnerships have developed involving donors (e.g., through the Global Fund to Fight AIDS, Tuberculosis and Malaria), the public sector, the private sector (mining companies, multinationals such as Heineken, Coca-Cola, pharmaceutical firms), faith-based organisations, NGOs and communities.

Socio-economic impact and implications for wider development efforts At the *household and community levels*, HIV/AIDS induces and deepens poverty, while poverty increases susceptibility and vulnerability to HIV/AIDS. The disease affects both men and women, but women are more vulnerable for biological, epidemiological and social reasons. Important questions are:

- How can gender inequities be reduced? These inequities include unequal power relations, women's inability to negotiate safe sexual practices, and women's (especially widows') social and economic insecurity forcing them to sell sex services.
- How can the plight of orphans and vulnerable children, whose number will rise dramatically over the next 10–20 years, be addressed to avoid creating a 'lost generation' of marginalised youth?
- How can communities be strengthened to diminish threats to social cohesion and to provide care for orphans and others, through extended family networks, foster families or adoption?
- How can food and livelihood security best be addressed?

At the *community and district levels*, strategies need to combine (a) the empowerment of communities, women and orphans to develop prevention and impact-mitigation strategies with (b) access to basic services such as health care, education, water, agricultural extension and income generation. The involvement of people living with HIV/AIDS is crucial. These services must be provided in partnership with the private sector, NGOs and faith-based organisations. However, the epidemic has seriously affected the public sector's capacity to provide these services. Demands for services also change (more safe water is needed for home-based care; school enrolment falls), and the type of services required may change (life skills and HIV education programmes in schools; less labour-intensive technologies in agriculture). How can multi-sectoral responses best be organised to respond at district and community levels according to their respective comparative advantages?

At the *national level*, lower economic growth resulting from declining productivity, declining profits and a declining tax base may undermine the ability to fund such services.

Integration of HIV/AIDS in development instruments PRSPs will have to include an analysis of HIV/AIDS as a cause of poverty. The main strategies for addressing HIV/AIDS must also feature in the PRSP, and provide appropriate medium-term goals and monitoring indicators. The PRSP process needs to be used as an instrument to build national and local political commitment and action in the fight against HIV/AIDS.

How can specific action be taken to mainstream HIV/AIDS? All sectors will have to analyse how HIV/AIDS impacts on their own organisation, and develop strategies to protect and support their staff and to plan for future depletion rates. The impact of HIV/AIDS on sectoral programmes has to be anticipated in terms of types of services needed, strategies for sustainability, and cost-recovery mechanisms. Activities must mitigate impact rather than increase vulnerability. Mainstreaming is not to be seen as an 'add-on' to awareness raising, but has to be done in keeping with the core business. All plans, budgets and indicators should reflect inter-linkages with HIV/AIDS to avoid a mechanical 'box-ticking' process.

Key literature

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- Cohen, D. (2002) 'Human capital and the HIV epidemic in sub-Saharan Africa'. *ILO Programme on HIV/AIDS and the World of Work, Working Paper 2*. Geneva: International Labour Organization. www.gtz.de/wbf/dokumente/AIDS-Cohen-Human-Capital-and-HIV.pdf
- Tallis, V. (2002) *Gender and HIV/AIDS overview report*. BRIDGE, Institute of Development Studies, University of Sussex, United Kingdom. www.ids.ac.uk/bridge/reports/CEP-HIV-report.pdf
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Key Sheets are available on the Internet at www.keysheets.org



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