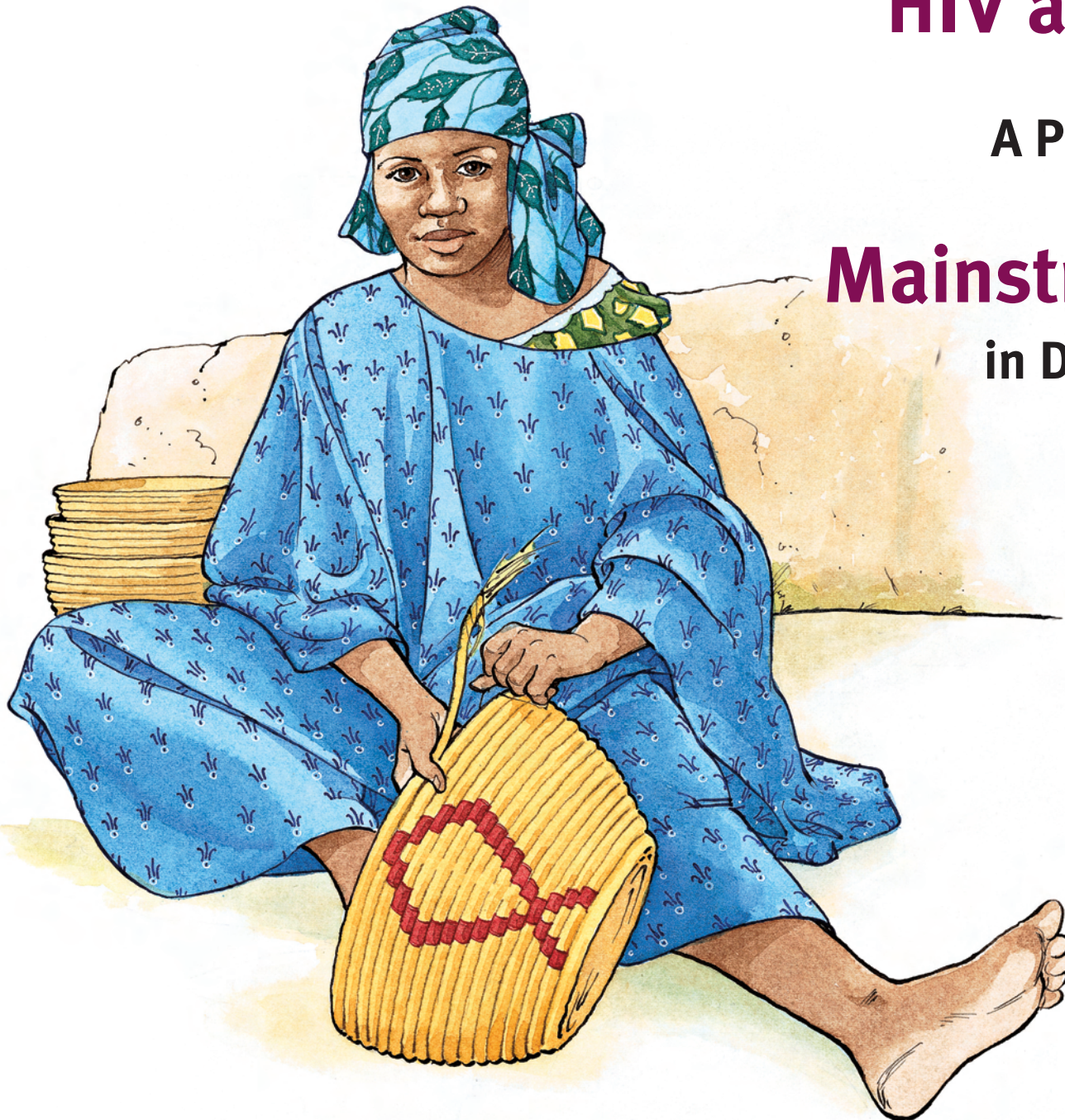


Revised Version

Responding to HIV and AIDS

A Practitioner's Guide to **Mainstreaming** in Development Projects



MISEREOR
IHR HILFSWERK

Impressum

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in Development Projects**

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“Christians send clear signals of hope and redemption when they help the sick and their families by providing practical assistance. Those who are HIV positive or suffer from AIDS need people who will stand by them and support and help them in their need.”

Position paper published in German by the Secretariat / the Pastoral Commission of the German Bishops' Conference (1997).

Foreword

Every country in the world is facing a more or less severe threat of HIV and AIDS. Individuals, families, communities and societies are affected in various ways. HIV and AIDS reduce development achievements of the past, diminish opportunities for future development, and make people poorer. A major pillar of Misereor's work, and that of its partners, is to reduce poverty and assist the poor and marginalized in Africa, Asia and Latin America.

HIV and AIDS cannot be tackled by the health sector alone. “Mainstreaming” – mobilizing actors across every development sector according to their specific professional expertise and comparative advantage – is an important strategy in the response to HIV and AIDS of Misereor, its partners and other development organizations. Mainstreaming aims to reduce the vulnerability of an organization's target groups to HIV infection, as well as mitigating the effects of HIV and AIDS. It also ensures that the organization's staff and structure are able to respond appropriately to HIV and AIDS.

Because HIV and AIDS have devastating effects on development, it is vital that Misereor and its partners take them into account in their work. Misereor hopes that this guide will assist its partner organizations and others to address HIV and AIDS as an integral part of their development work.

This book is a revised version of the first Misereor HIV/AIDS mainstreaming guide. Misereor partners from Africa and Asia were actively involved in developing the content of this guide.



Dr. Martin Bröckelmann-Simon
(Managing Director of Misereor)

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Many thanks to all those who contributed by providing literature, sharing information and giving permission to copy their documents on the accompanying CD-ROM.

Last but not least, our thanks go to Paul Mundy for his editing and assistance in formulating the text into a language that is easy to understand for readers who are not familiar with medical and sociological terms, to Annegret Schroif for managing the layout and printing, Rolf Bunse for his creative inputs as illustrator, N&N Design-Studio for the design and layout, and MVG Medienproduktion for the printing.

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Nina Urwanzoff and Rolf Goldstein (editorial team)

Introduction: A worldwide concern

More than 30 million people around the world were infected by HIV in 2009, the virus that causes AIDS. Some parts of the world are harder hit than others: Southern Africa is home to about 35% of all people who are living with the virus (→ Figure 1). The epidemics in sub-Saharan Africa vary significantly from country to country in both scale and scope. Strategies to combat the epidemic seem to be working in several African countries, and the prevalence of HIV there is declining; in others the epidemic has stabilized. But it is still rising in other regions, mainly in Central Asia and Eastern Europe (UNAIDS 2010). There is also a lot of variation within countries too: a country with low overall prevalence may have areas where prevalence is higher.

HIV and AIDS are a complex issue with medical, social, economic, political, cultural and human-rights dimensions. And they are a fundamental development issue, so concern everyone working in development.

About half of all people living with HIV worldwide are women; in sub-Saharan Africa nearly 60% are women (UNAIDS 2008). In general, women are disproportionately affected: they also carry the burden to care for family members, all this leads to the expression “feminization of the epidemic”.

Children and elderly people are also greatly affected. Children take care for their sick parents and a large number of children have become orphans due to AIDS. Many have become household heads at a very young age. Elderly people frequently have to take care of their sick children and are guardians of their grandchildren. The psychosocial and economical needs of orphans and their guardians will remain a huge challenge over the coming years.

Antiretroviral therapy is a combination of at least three different antiretroviral drugs that can suppress the multiplication of the virus in the body, but not get rid of it (→ Glossary). Such therapy is now easier to obtain in many developing countries. As a result, people with HIV can live longer, and fewer are dying of AIDS – though not everyone who needs therapy is covered.

While treatment gets a great deal of emphasis, prevention must remain a priority, as there is still no vaccination or cure. Universal Access to HIV prevention, treatment, care and support by 2010 was not

achieved and much still has to be done to achieve Millenium Development Goal 6 (target 7), to “have halted by 2015 and begun to reverse the spread of HIV/AIDS” (→ Box 1). In particular we need to:

- Develop and broaden successful and context-adapted strategies to HIV prevention
- Strengthen weak health systems to scale up treatment, medical care and monitoring
- Make available more affordable and accessible antiretroviral therapies for adults, including second- and third-line therapies
- Make prevention of mother-to-child transmission more accessible
- Make treatments for children more available
- Develop more successful strategies to promote voluntary counselling and testing (UNAIDS 2008).

Many development projects funded by Misereor are confronted with HIV and AIDS. Misereor and many of its partners are continuously searching for the most effective responses to HIV and AIDS.

The HIV/AIDS mainstreaming approach described in this book gives development agencies an “HIV/AIDS lens” they can use to view projects in a sensitive and considerate way, and that will guide them to develop an appropriate response.

Mainstreaming is not simply a matter of adding HIV and AIDS components to the project, but of searching for appropriate and effective contributions while focusing on the project’s comparative advantages and professional competence.

For example, one project might offer a life-skill-training for young women tailoring apprentices, which changes their perception of risks and considerably reduces their chances of becoming infected by HIV. Another project might promote farming practices that need less labour, so helping households headed by single parents (or by children or elderly people) to grow enough food.

HIV/AIDS mainstreaming cannot replace HIV/AIDS-specific work, but the mainstreaming approach is a very important contribution in the response to HIV and AIDS.

Box 1. HIV and AIDS

HIV, or **Human Immunodeficiency Virus**, is a virus that weakens the body's immune system, opening the way for other, "opportunistic" infections, other HIV-related conditions, and leads to AIDS after an imprecise period of time. HIV destroys the body's ability to fight off infections and diseases, which can ultimately lead to death.

AIDS, or **Acquired Immunodeficiency Syndrome**, is a collection of symptoms and infections associated with an acquired deficiency of the immune system caused by HIV.

In this book, we distinguish between HIV and AIDS. We use "HIV" to refer to the virus, and "AIDS" to mean the disease (see left). For approaches or strategies, we use HIV/AIDS (as in "HIV/AIDS mainstreaming").

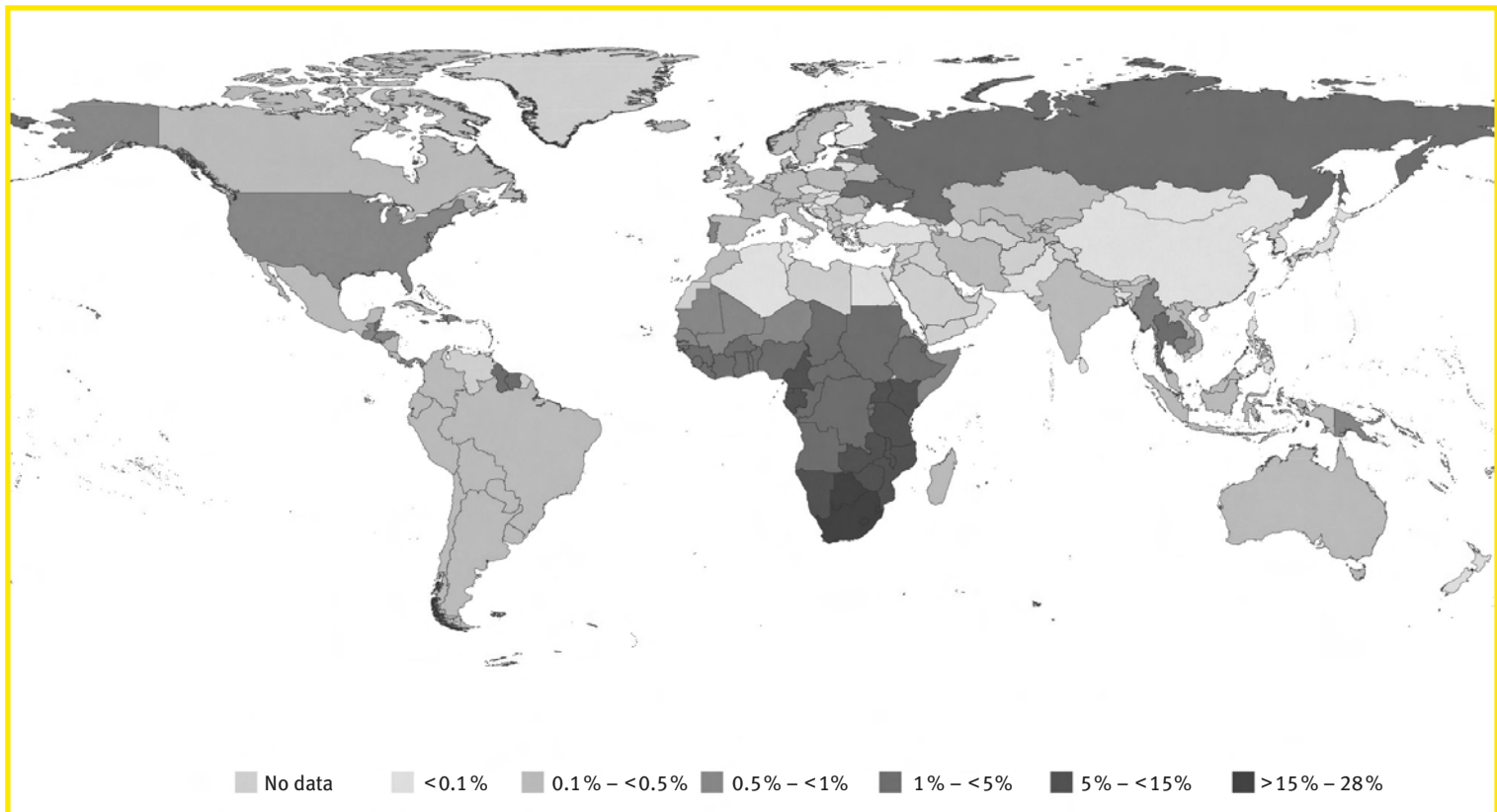
For **current facts and figures** regarding HIV and AIDS → www.unaids.org and www.who.int

For the **Millennium Development Goals** → www.undp.org/mdg/ and www.un.org/millenniumgoals/

For more information → Glossary

Figure 1. A global view of HIV prevalence in 2009: 33 million people living with HIV

Source: UNAIDS (2010)



Purpose

This guide is intended for managers and field staff of development projects supported by Misereor. It also addresses other development agencies and a wider public interested in HIV/AIDS mainstreaming.

This guide helps you find ways to mainstream HIV and AIDS in your work. You can use the methodology described here without outside assistance. You can apply all the methods directly, without major modification. You should, of course, adjust them if necessary to the specific circumstances of your project.

History of this guide

The need to focus more closely on HIV and AIDS in development projects has been a recurring theme in the dialogue between Misereor and its partners.

The first edition of this guide was published in 2004, and some of the methods described were developed in conjunction with three of Misereor's partners in South Africa. Four years later, it became apparent that the guide needed to be updated and simplified, and new experiences included. This new edition was developed in a process and is based on the results of a questionnaire sent to Misereor partners and other development agencies that have used the guide. A desk study on 'Promising responses to HIV and AIDS in agriculture, rural development, self-help and social protection' (published in 2010) was realised to search for further findings to complete the guide. It presents a simplified mainstreaming methodology and experiences of practitioners on mainstreaming HIV/AIDS.

The new edition is intended for development projects in all parts of the world. Nevertheless, the illustrations and many of the examples still relate to Africa. If you are in another part of the world you may need to adjust the materials and examples to your own context.

Content and structure

The guide provides comprehensive information on HIV/AIDS mainstreaming and shows how to translate the mainstreaming approach into practice. Many of the examples and explanations refer to Africa; nevertheless the guide is designed to be used also in Asian and Latin American countries. Thus, you will also find references to non-African countries in this guide.

The guide is structured as follows:

- **Chapter 1: Responding to HIV and AIDS.** Background to the HIV/AIDS mainstreaming concept.
- **Chapter 2: Root causes of HIV infection and effects of HIV and AIDS.** Overview of root causes contributing to HIV infection and the effects of HIV and AIDS, and examples of (unintended) negative implications of project activities.
- **Chapter 3: Mainstreaming: A practical guide.** Step-by-step approach to identifying suitable areas for HIV/AIDS mainstreaming, planning of HIV/AIDS mainstreaming, monitoring and evaluation.
- **Chapter 4: Good practice examples of HIV/AIDS mainstreaming.** Practical examples from 12 areas of development activities.
- **Chapter 5: Seeking pathways within and beyond your organization.** Networking, lobbying and advocacy in the HIV/AIDS mainstreaming process; the rights-based approach, universal access, traditional medicine, the church, and social protection schemes with regard to HIV and AIDS.
- **Appendix 1: Glossary.** Helps you understand the jargon surrounding HIV and AIDS and the terms used in this book.
- **Appendix 2: Basic knowledge on HIV and AIDS.** The technical details you need to know about HIV and AIDS.

Focus of this guide

This guide assists project staff to identify ways to effectively address the root causes of HIV infection and to mitigate the effects of HIV and AIDS within their core activities (→ especially Chapters 3 and 4). This is called “external mainstreaming” because it takes place as part of project work. You may also want to address HIV and AIDS issues concerning staff within your organization (we call this “internal mainstreaming”). Chapter 1 has more on this.

Generally, it is advisable to start with staff awareness on HIV and AIDS and carry out both internal and external mainstreaming.

How to use this guide

If you are already familiar with HIV and AIDS, you may want to focus your attention on particular individual chapters. Each chapter is designed as a stand-alone unit and can be read on its own. But if you intend to launch a complete HIV/AIDS mainstreaming process, you should proceed through the guide step by step.

The CD-ROM that accompanies this guide contains the full text of the guide and the illustrations to be used for workshops, as well as various documents on mainstreaming HIV/AIDS and related issues.

You can use the attached postcard to order more copies of the guide, to send us feedback, or to tell us about your own experience of mainstreaming. Your comments are very welcome!

We wish you every success in developing and implementing sustainable and effective responses to HIV and AIDS in your daily work.

1. Responding to HIV and AIDS

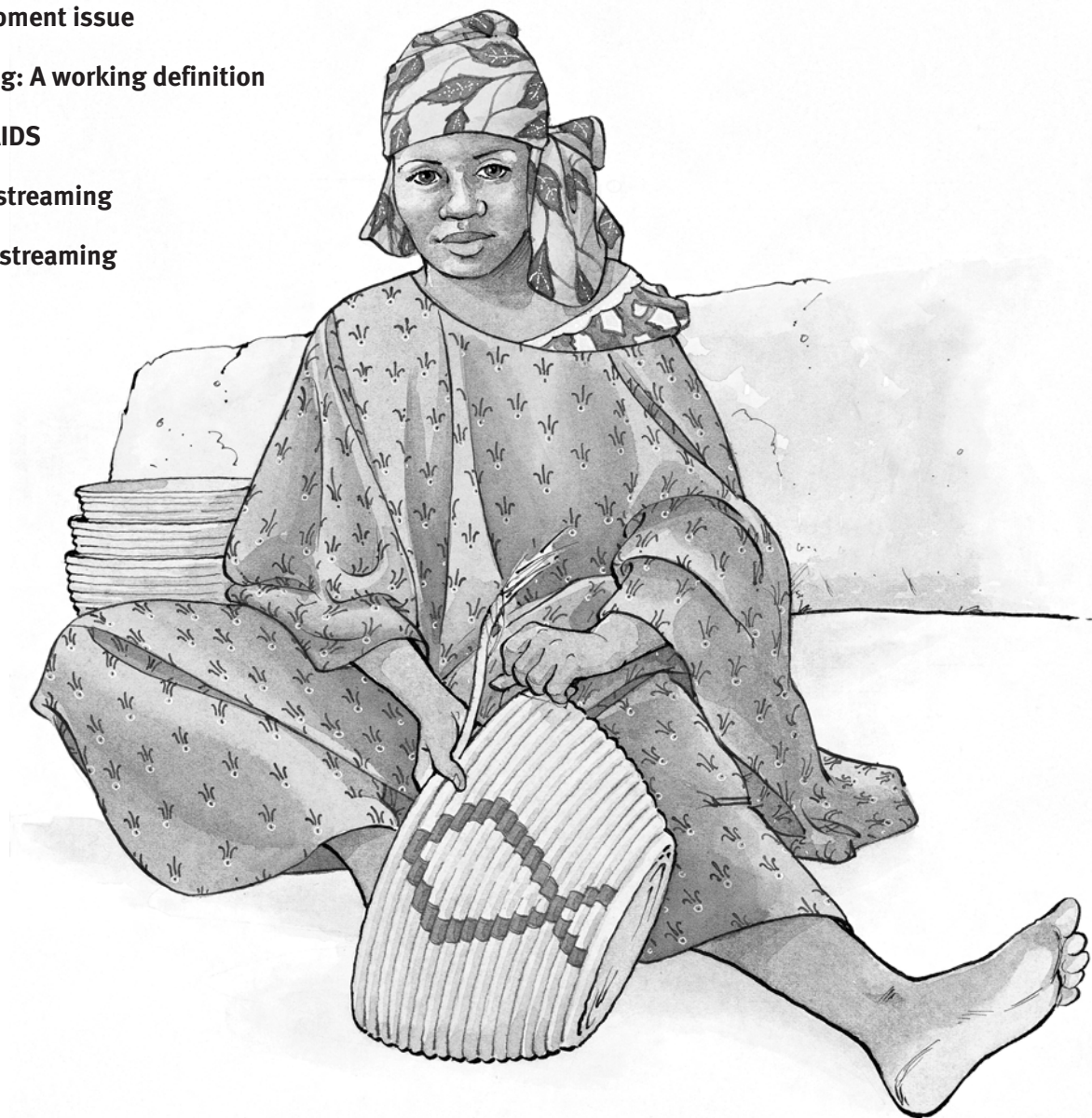
HIV and AIDS: A development issue

HIV/AIDS mainstreaming: A working definition

Responses to HIV and AIDS

Internal HIV/AIDS mainstreaming

External HIV/AIDS mainstreaming

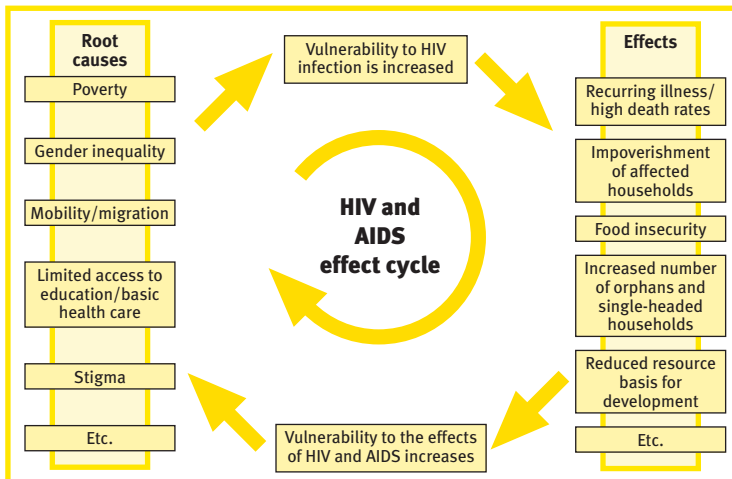


1.1 HIV and AIDS: A development issue

The sheer size of the HIV pandemic makes it one of the most urgent and threatening development and security problems in the world today. In many countries, particularly in southern and eastern Africa, the epidemic has reached such critical levels that it affects the whole of the economy and society. HIV and AIDS can no longer be considered a “mere” health issue but a complex medical, social, economic, political, cultural and human-rights issue. The root causes of HIV infection are closely linked to development constraints, and the effects of HIV and AIDS hamper, or even reverse, development progress already achieved (Holden 2003). Apart from individual risky sexual behaviour, the spread of the virus is linked to many underlying factors, such as gender inequality, poverty, migration and mobility, social disadvantages, conflict and war, drug consumption, limited access to education, lack of information and awareness, poor health care system, inadequate access to health care services, and changes in lifestyle, norms and values.

On one hand, these factors make individuals more vulnerable to HIV infection (→ Box 2). On the other hand, HIV and AIDS have a negative effect on development and make households and communities poor by depriving them of their assets. This increases their vulnerability. The HIV and AIDS effect cycle (→ Figure 2) shows how HIV and AIDS and development constraints may reinforce each other.

Figure 2. Example of an HIV and AIDS effect cycle



Box 2. What do we mean by risk and by vulnerability?

“**Risk** is defined as the probability or likelihood that a person may become infected with HIV. Certain behaviours create, increase, and perpetuate risk. Examples include unprotected sex with a partner whose HIV status is unknown, multiple sexual partnerships involving unprotected sex, and injecting drug use with contaminated needles and syringes.”

Vulnerability results from a range of factors outside the control of the individual in the sense of the psychosocial, cultural and economic conditions experienced by individuals, households or communities that hinder their capability to react adequately to the root causes and risks associated with HIV infection and to develop a response to the effects of HIV and AIDS.

These conditions may include:

- Lack of knowledge and skills required to protect oneself and others
- Factors pertaining to the quality and coverage of services (e.g., inaccessibility of health service due to distance, cost or other factors)
- Societal factors such as human rights violations, or social and cultural norms that disadvantage certain groups such as women, children or injecting drug users.

These factors can limit the ability to access or use HIV prevention, treatment, care, and support services and commodities. These factors, alone or in combination, may create or exacerbate individual and collective vulnerability to HIV.

Adapted from UNAIDS (2007a), UNAIDS (2008)

Example – Vulnerability to HIV infection. Poverty may make sex a key economic factor in the lives of people, especially women and girls. The only way they can earn cash or get food and shelter may be through sex. That makes it hard for them to insist on safer sex practices, and more likely to be infected by HIV. Women who are financially and socially dependent also find it difficult to refuse sex with their husbands. This may be also true for women who are not poor.

Example – Vulnerability to the effects of HIV and AIDS. Frequent and recurring illness harms people infected by HIV and their families. In many cases it is the breadwinner who is sick. The person cannot work, and the household faces higher health-related costs and has to care for the sick person, so loses additional income. A household that is better-

1. Responding to HIV and AIDS

off in terms of labour, savings and other assets will feel the implication, but may be able to cope. A household that is already resource-poor and has weak social ties will have far more difficulty.

1.2 HIV/AIDS mainstreaming: A working definition

“Mainstreaming AIDS is a process that enables development actors to address the causes and effects of AIDS in an effective and sustained manner, through both their usual work and within their workplace.”

UNAIDS, World Bank and UNDP (2005)

HIV/AIDS mainstreaming means that an organization should address the **root causes** of HIV infection and the **effects** of HIV and AIDS in areas that fall into its competence and mandate. Within these areas, it should focus on its **comparative advantages** to:

- Adapt its core activities to changing needs
- Avoid unintended negative side-effects
- Improve the performance of its core activities
- Adapt its workplace practices
- Create **complementary partnerships** between health and development actors (→ Box 3).

Adapted from UNAIDS, World Bank and UNDP (2005), Misereor (2005), CAFOD (2008)

Box 3. Comparative advantage and complementary partnerships

Here is an example of comparative advantage and complementary partnerships.

Imagine you are an agricultural extension officer. It's not your job to teach people about HIV and AIDS, but you see that many people in the community are affected by the disease. What can you do?

You can contact an HIV/AIDS organization (one that specializes on providing support, training, prevention measures, etc.) and work with it:

- You can identify affected households and ask the HIV/AIDS organization to give them economic, financial or psychosocial support.

Antiretroviral treatment helps people living with HIV to lead a reasonably normal life, provided they take their medication regularly. They may need support to do this.

- You can train infected people to start home gardens using labour-saving methods.
- You can arrange meetings for the HIV/AIDS organization to inform farmers about HIV and AIDS.

In this example, you and the HIV/AIDS organization are building on your **comparative advantages**. You know the community well, and local people trust you. You have a lot of practical farming information useful for people living with HIV and affected household members. The HIV/AIDS organization has specific skills and information on how to prevent and deal with HIV infection.

A **complementary partnership** means that you work together. Each contributes what you can do best.

1.3 Responses to HIV and AIDS

In the very beginning, dealing with HIV and AIDS used to be solely a health concern. Since the mid-1980s, it has shifted to a multisectoral and a “mainstreamed” approach with broader medical, developmental and human-rights-based aspects.

Health approach. This was the initial approach. HIV and AIDS were seen as merely medical problems, and responses focused on preventing HIV and treating opportunistic infections (infections that occur because HIV weakens the immune system).

Education and social sector. Later, the HIV and AIDS response became broader, and the social and education sector became involved. The aim was to provide information and to fight against stigma and discrimination of people living with HIV.

Multisectoral responses. As the far-reaching effects of the epidemic on various sectors and the two-way relationship of HIV and AIDS and development became clearer, multisectoral approaches emerged in many countries. HIV and AIDS became a concern for many actors in different sectors, and they began to get involved. But most responses still focused on medical and behavioural aspects.

1. Responding to HIV and AIDS

Mainstreamed responses. These have emerged in recent years to further strengthen and deepen multisectoral approaches and to address developmental aspects of HIV and AIDS more effectively. Mainstreaming implies that all sectors and actors adapt their core work to the new situation caused by HIV and AIDS. To be more effective, they build partnerships based on their comparative advantages.

HIV/AIDS mainstreaming complements HIV/AIDS-specific work by addressing the root causes of HIV infection and the effects of HIV and AIDS.

Human-rights-based approaches. Empowering people to fight for and to protect their rights is an essential part of responding effectively to HIV and AIDS. These approaches have several goals:

- To fight stigma and discrimination of people living with HIV.
- To ensure access to prevention, treatment, care and support.
- To address social and economic disempowerment in order to reduce vulnerability to HIV infection.
- To empower people who are vulnerable to HIV or living with HIV by reforming laws, providing legal aid, and education in human rights.
- To achieve human rights standards e.g., to protect people (in particular women and children) from sexual violence and gender inequality.
- To involve people living with HIV in designing, implementing, monitoring, and evaluating HIV-related programmes.
- To increase the accountability of governments and to enhance international cooperation in the response to HIV and AIDS.

Box 4 illustrates some achievements of human-rights-based approaches.

Box 4. Some achievements of human-rights-based campaigns

The Treatment Action Campaign in South Africa won a court ruling that forced the government to provide antiretroviral therapy to HIV-positive pregnant women at public health care centres.

People in several countries in Latin America, such as Brazil and El Salvador, have claimed their rights to HIV prevention and treatment services.

Adapted from UNAIDS (2004 and 2008).

Box 5. The comprehensive response to HIV and AIDS

The main pillars of a HIV/AIDS-specific response are **prevention, treatment, care and support**.

Prevention. Tries to prevent new infections. It includes:

- HIV and AIDS education and awareness
- Behaviour change programmes
- Life skills education
- Community based programmes
- Tailor-made programmes for specific vulnerable groups
- Voluntary counselling and testing
- Prevention of mother-to-child transmission.

Treatment. Aims to ensure that everyone infected by HIV can get treatment. It includes:

- Provision of treatment of opportunistic infections
- Provision of prophylactic medication
- Provision of antiretroviral therapy
- Treatment of sexually transmitted infections.

Care. Medical and non-medical care for people who are infected. It includes:

- Treatment and psychosocial support to people living with HIV
- Help in making sure that people continue to take their medicine regularly (this is called “adherence support”)
- Home-based care
- Palliative care (to relieve a person’s suffering).

Support. This helps people living with HIV and their family members. It includes:

- Emotional and psychosocial support
- Self-help support
- Financial support
- Home-based care
- Improved nutrition.

Besides medical, behavioural and social aspects, a comprehensive response should also include HIV/AIDS mainstreaming.

1. Responding to HIV and AIDS

Table 1. Difference between HIV/AIDS-specific responses, add-on HIV/AIDS activities and HIV/AIDS mainstreaming

Term	Meaning	Focus	Examples
HIV/AIDS-specific responses	The organization's core business is HIV prevention, treatment, care and support of people living with HIV	Prevention, treatment, care and support	Behavioural change programmes HIV prevention programmes Voluntary counselling and testing Prevention of mother-to-child transmission Provision of antiretroviral therapy Treatment of infections and other HIV-related conditions Home-based care
Add-on HIV/AIDS activities	The organization adds HIV and AIDS-specific activities to its core business	Prevention, treatment, care and support	Adding HIV and AIDS-specific activities to the tasks of development workers Development workers outside the field of HIV and AIDS carry out HIV/AIDS awareness campaigns
External HIV/AIDS mainstreaming	The organization adapts its core business to address the root causes and effects of HIV and AIDS	Adapting core business to address root causes and effects and to avoid unintended side effects	HIV and AIDS as integrated part of an existing life skills programme for young people Information on healthy nutrition for people with HIV as part of existing nutrition training Labour-saving methods for affected households as part of a sustainable agriculture programme Changing existing activities to be relevant to the situation with HIV and AIDS
Internal HIV/AIDS mainstreaming	The organization changes its policies and practices to reduce the vulnerability of staff to HIV infection and to mitigate the effects of HIV and AIDS on staff and the organization itself	Adapting organization's functions	HIV and AIDS awareness sessions for staff and their relatives Voluntary counselling and testing provided to staff Fighting stigma and discrimination in the workplace Implementing an HIV/AIDS workplace policy as part of human resource regulations

Adapted from Holden (2004) and CAFOD (2008).

1.4 Internal HIV/AIDS mainstreaming

HIV/AIDS mainstreaming differentiates between **internal** (organizational level) and **external** mainstreaming (project work). This section deals with internal mainstreaming: adapting the organization's in-house structures and functions to providing staff information and create awareness, and preparing for and dealing with the effects of HIV and AIDS.

How HIV and AIDS can affect your organization

Employees working for the organization may be infected by HIV. Or they may be affected by the illness and deaths of relatives, friends and colleagues. That may affect their ability to do their jobs. It may also affect the organization as a whole, through:

- High rates of absenteeism
- Reduced physical capacity of sick employees
- High staff turnover and loss of relevant experience
- Lack of properly trained and qualified personnel
- Increased recruitment and training costs
- Extra workload for others
- Emotional stress
- Increased health and welfare costs.

If it cannot work efficiently, your organization may fail to achieve its goals (Mullin 2002). WHO recommends keeping HIV-infected employees in the workplace while assisting them with treatment and training: "treat, train and retain" (WHO 2006).

What does internal mainstreaming imply?

The key action for internal mainstreaming is developing and implementing a policy that manages HIV and AIDS at the workplace. This can be a stand-alone policy or can be an integral part of the organization's human resource policy.

The policy may cover these elements (adapted from Mullin 2002):

- **Staff awareness.** This means ensuring that staff understand the basics of HIV transmission, risky situations, risky behaviour, the progression from HIV to AIDS, living positively, overcoming stigma and discrimination, as well as related topics such as gender and HIV, over-

coming stress, and coping strategies. The organization may hold periodic awareness sessions for staff and family members on these topics, establish HIV and AIDS information corners. These aspects fall within the broader context of changing the overall organization's culture, partly through attention to individual attitudes and skills.

- **Staff health policies.** This means promoting HIV education, prevention and management of ill health, confidential HIV counselling and testing in line with national legal framework and good practice guides. It may include measures to care for and support infected or affected staff, and providing health insurance covering HIV infection (perhaps extended to family members).
- **Performance management.** Job applicants should be made aware of organizational commitment to HIV and AIDS issues, and assessed on their understanding of the issues. Job objectives and reporting should reflect HIV and AIDS-related aspects of the job.
- **Budgeting.** This ensures that the possible effects of HIV and AIDS are considered in the budget. For example, the budget may project the cost implications of staff illness, health and life insurance, temporary cover for absent employees, and additional recruitment over a period of 5–10 years. A special budget may be made available for HIV and AIDS-related activities.
- **Human resource planning.** This means projecting human resource implications in the long run. It may mean working out how to deal with absenteeism, illness and death, demands on employee benefits, staff turnover, recruitment time and costs. The organization may make HIV and AIDS-related tasks part of the main responsibilities of all employees. It will be necessary to make arrangements for staff members infected or affected by HIV and AIDS, for example through:
 - Flexible working hours to enable them to access medical care and attend support groups
 - Flexible working hours for staff caring for sick family members
 - Part-time work
 - Opportunities for rest breaks
 - More office work, less field work.

Any HIV/AIDS workplace policy has to comply with the laws of the country and should be aligned to international codes of good practice, such as the ILO code of practice on HIV/AIDS and the world of work (ILO 2001).

1. Responding to HIV and AIDS

Table 2. ILO key principles of an HIV/AIDS workplace policy

Recognition of HIV and AIDS as a workplace issue	HIV and AIDS are workplace issues, and should be treated like any other serious illness/condition in the workplace. This is necessary not only because HIV and AIDS affect the workforce, but also because the workplace, being part of the local community, has a role to play in the wider struggle to limit the spread of the infection and its effects.
Non-discrimination	In the spirit of decent work and respect for the human rights and dignity of persons infected or affected by HIV and AIDS, there should be no discrimination against workers on the basis of real or perceived HIV status. Discrimination and stigmatization of people living with HIV inhibits efforts aimed at promoting HIV prevention and assisting people living with HIV.
Gender equality	The gender dimensions of HIV and AIDS should be recognized. Women are more likely to become infected and are more often adversely affected by HIV and AIDS than men due to biological, socio-cultural and economic reasons. The greater the gender discrimination in societies and the lower the social position of women, the more negatively they are affected by HIV. Therefore, more equal gender relations and the empowerment of women are vital to successfully prevent the spread of HIV infection and enable women to cope with HIV and AIDS.
Healthy work environment	The work environment should be healthy and safe, so far as is practicable, for all concerned parties, in order to prevent transmission of HIV, in accordance with the provisions of the Occupational Safety and Health Convention, 1981 (No. 155). A healthy work environment facilitates optimal physical and mental health in relation to work and adaptation of work to the capabilities of workers in light of their state of physical and mental health.
Social dialogue	The successful implementation of an HIV/AIDS policy and programme requires cooperation and trust between employers, workers and their representatives and government, where appropriate, with the active involvement of workers infected and affected by HIV and AIDS.
Screening for purposes of employment	HIV screening should not be required of job applicants or persons in employment.
Confidentiality	HIV-related information of staff members has to be kept strictly confidential. The information may only be disclosed if legally required or with the consent, preferably signed, of the person concerned.
Continuation of employment relationship	HIV infection is not a cause for termination of employment. As with many other conditions, persons with HIV-related illnesses should be able to work for as long as medically fit in appropriate conditions.
Prevention	HIV infection is preventable. Prevention of all means of transmission can be achieved through a variety of strategies which are appropriately targeted to national conditions and which are culturally sensitive. Prevention can be furthered through changes in behaviour, knowledge, treatment and the creation of a non-discriminatory environment. The social partners are in a unique position to promote prevention efforts particularly in relation to changing attitudes and behaviours through the provision of information and education, and in addressing socio-economic factors.
Care and support	Solidarity, care and support should guide the response to HIV and AIDS in the world of work. All workers, including workers with HIV, are entitled to affordable health services. There should be no discrimination against them and their dependants in access to and receipt of benefits from statutory social security programmes and occupational schemes.

Adapted from ILO (2001)

Steps to develop and implement a workplace policy on HIV/AIDS

1. Establish an HIV/AIDS Committee with representatives of top management, unit heads, office-based staff, staff members of the human resource department, field workers, including people living with HIV, etc.
2. Define the responsibilities and decision-making mandate of the HIV/AIDS Committee.
3. Conduct a simple confidential assessment of HIV and AIDS-related knowledge among staff to find out the effect of HIV and AIDS on the workplace and the needs of infected and affected staff members.
4. Decide on important topics for the workplace policy. Consider the national laws and workplace policies of other organizations.
5. Formulate a draft policy, possibly with the assistance of a consultant.
6. Circulate the draft within the organization for comments and changes. Revise and adopt the draft accordingly.
7. Establish a plan of action, with a timeframe, indicators, responsibilities and a budget to implement the policy.
8. Seek funds from inside and outside the organization, if necessary.
9. Disseminate the policy and plan of action to a wide audience, e.g., through notice boards, mailings, pay slip inserts, staff and unit meetings, special meetings, training sessions.
10. Monitor the outcome of the policy and programme.
11. Regularly review of the policy and programme.

The HIV/AIDS committee can be responsible for the realization and regular up-date of the policy. It is not enough to have policies on paper. It is also necessary to implement and follow them up.

Box 6. More information on workplace policy

ILO. 2001. The ILO Code of Practice on HIV/AIDS and the world of work. <http://tinyurl.com/2wn2mvg>

ILO. 2002. Implementing the ILO code of practice on HIV/AIDS and the world of work. An education and training manual. <http://tinyurl.com/349jrhh>

WHO. 2006. AIDS and health workforce plan "Treat, Train and Retain", <http://tinyurl.com/36svnen>

World Council of Churches. 2006. Towards a policy on HIV/AIDS in the workplace. <http://tinyurl.com/36jgsm2>

DED/InWEnt. 2007. Checklist of requirements for a workplace policy developed by AIDS Workplace Programs in Southern Africa. AwISA workshop protocol. (See the accompanying CD.)

1.5 External HIV/AIDS mainstreaming

External mainstreaming focuses on the organization's external project work serving its target groups. Any development project, regardless of the nature of its project activities, has target groups who are potentially at risk, or whose members are already infected or affected by HIV and AIDS.

Effects of HIV and AIDS on target groups and project activities

The effects of HIV and AIDS on communities and, in particular, on target groups, reduce the project's ability to do its work and achieve its goals. HIV and AIDS affect this work in various ways:

- Members of target groups miss meetings and do not take part in activities due to HIV-related illness and death.
- Key contact persons or trainees who fall ill or die no longer put knowledge into practice, and do not pass on their knowledge to others.
- The composition of households within the community may shift: more households may be headed by single women, children and the elderly.

These changes make the project's work less effective and hinder development efforts.

(→ Table 3)

Unintended negative side-effects

A project may have side-effects that may make the HIV and AIDS situation worse. Here are some examples:

- People living with HIV and affected household members are excluded from project activities.
- The target groups become more mobile (for example, they may visit the market more often). Mobility may increase the risk of HIV infection.
- Meetings close late and female participants have to go home in the dark.
- Women may become more financially dependent on men.
- Alcohol production as income generating activity.
- Target groups may get wrong or outdated information on HIV-related issues.
- Information given on HIV and AIDS may lead to fears and worries.

These negative side-effects may exclude target groups, put them at greater risk of infection, or may hinder them from seeking information and health care. (For more details → Section 2.5)

1. Responding to HIV and AIDS

Table 3. Examples of how HIV and AIDS may affect project work

	Rural areas	Urban areas	Rural and urban areas
Households	<p>Lack of farm inputs Labour shortages Inability to attend project activities and social events Lack of money for transport Target groups seek paid labour Temporary migration</p>	<p>Loss of job High costs and inability to pay for rent, food and running expenses Lack of wide family support to pay costs of recurring illnesses Food insecurity and precarious living conditions in high-density areas Dependence on informal sector to make a living</p>	<p>Time constraints Reduced ability to earn money High costs for medical check-ups, treatment and transport to health centres Reduction in expenditure e.g., for education Loss of knowledge and skills Social safety net is challenged</p>
Communities	<p>Elderly people get less support from younger generation Sale of assets such as farm land, equipment and animals Less labour-intensive crops grown (e.g., tuber crops) Fewer skilled community members</p>	<p>Impoverishment of community members Lower participation in community development Weak social safety net means affected households depend on NGO and government assistance</p>	<p>Reduced self-help ability within communities Changes in demographic structure Many children drop out of school Loss of knowledge and skills More food insecurity More poverty</p>
Project	<p>Goals and expected results cannot be achieved due to changes in age structure and resources, labour scarcity, etc.</p>	<p>Goals and expected results cannot be achieved because target groups move to cheaper parts of town Ill people return to their home area</p>	<p>Poor participation of target groups Loss of trained members Groups dissolve People on antiretroviral treatment may also be weaker</p>

Sources: Holden (2004), Sida (2007)

What does external mainstreaming imply?

The main goal of external mainstreaming is to strengthen and adapt the project's core activities to respond in a systematic way to HIV and AIDS at the individual, household and community level. The project may modify its overall strategy and its detailed planning and implementation of project components (Mullin 2002). Staff become aware of unintended negative side-effects of the project and can then adapt their work accordingly.

Mainstreaming does not entail shifting the focus to HIV/AIDS-specific work. Projects respond within their core activities using their pro-

fessional expertise. They should build complementary partnerships with players from different sectors (e.g., with projects carrying out specific HIV/AIDS work) to enhance the effectiveness of their HIV and AIDS response, while remaining focused on their core activities.

Table 4 shows whether an activity is HIV/AIDS-focused or mainstreamed.

Table 4. Examples of HIV/AIDS-specific and mainstreamed activities

Activity	Specific HIV/AIDS-focused activities	Mainstreamed activities
Agriculture		
An agricultural project promoting labour- and time-saving methods for vulnerable households		✓
Extension officers referring their clients to HIV and AIDS support organizations, encouraging voluntary counselling and testing		✓
An agricultural project adapting its extension messages to target orphans		✓
Education		
Including HIV and AIDS awareness sessions in adult literacy classes		✓
Health		
Introducing antiretroviral treatment in the health care system	✓	
Addressing nutritional aspects of antiretroviral treatment as part of a cooking and nutrition course		✓
Infrastructure		
Community mobilization around HIV and AIDS in a road project		✓
A transport project analysing the effect of increased mobility on risky behaviour		✓
A project building wells close to central places in the village in order to minimize risky situations for women		✓
A water project evaluating the impact of introducing user fees for water on HIV and AIDS-affected households		✓
Livelihoods		
A rural livelihood project starting a home-based care programme	✓	
A project altering its income-generating component, because it increases the dependency of women on men		✓
Youth		
Conducting an ad-hoc HIV and AIDS awareness campaign for young people	✓	
Introducing HIV and AIDS prevention into a life skill programme for young people		✓

Key questions for external mainstreaming

Here are some key questions to help you do external mainstreaming in your project:

- How does your project curb the spread of HIV?
- How does your project possibly contribute to the spread of HIV?
- How are HIV and AIDS likely to affect your project goals, objectives and measures?
- What effects do the changing needs and capacities of the target groups have on your project goals, objectives and measures?
- How are the effects of HIV and AIDS mitigated?
- What effects of HIV and AIDS are possibly aggravated by your project activities?
- Based on your professional competence and comparative advantage, how can your project be planned and implemented so as to:
 - curb the spread of HIV?
 - mitigate the effects of HIV and AIDS?
 - avoid unintended negative side-effects?
 - remain effective?
 - adapt to the changing needs and capacity of the target groups?

2. Root causes of HIV infection and effects of HIV and AIDS

Key areas of mainstreaming

Ways of transmission

Root causes of HIV infection

Effects of HIV and AIDS

Unintended negative side-effects of project activities



2.1 Key areas of mainstreaming

Mainstreaming HIV/AIDS in development projects aims primarily to make people less vulnerable to HIV infection and to reduce the effects of HIV and AIDS. In the process of mainstreaming, projects do three things within their core activities:

- They address the **root causes** of HIV infection by:
 - Promoting changes in social attitudes and behaviours.
 - Dealing with the social, cultural and economic factors that make people vulnerable to HIV infection.
- They address the **effects** of HIV and AIDS by:
 - Focusing on the social, cultural, economic and other aspects that make individuals, households and communities vulnerable to the effects of HIV and AIDS.
 - Dealing with changes in social structures at household and community level and in society as a whole.

- Handling the psychosocial, medical, economical and financial needs of affected individuals and households while collaborating with necessary structures (such as counselling, health and support services).

- They avoid **unintended negative side-effects**. This means:
 - Anticipating such negative side-effects and finding ways to avoid them.

This chapter provides a short overview on various root causes that foster the spread of HIV, and describes the effects of HIV and AIDS on individuals, households, communities, wider society and the national economy. The details may differ from place to place, so we describe general trends and linkages.

It is important to distinguish between the root causes and the effects of HIV and AIDS. If project staff know about the root causes and effects, they can respond to HIV and AIDS more effectively.

Box 7. Using the right language

It is important to be both accurate and sensitive when talking or writing about HIV and AIDS. The wrong choice of words may **mislead people**. For example:

Don't use	Why	Use instead
AIDS test	This is inaccurate: there is no such thing as a test for AIDS. Rather, there are several tests for HIV, the virus that causes AIDS.	HIV test or HIV antibody test
AIDS virus	There is no "AIDS virus". AIDS is caused by HIV.	HIV or HI-virus
Catch HIV	It is not possible to "catch" AIDS or HIV. People can become infected with HIV.	Contract HIV or become HIV-positive

The wrong words may also **insult or stigmatize people**. For example:

Don't use	Why	Use instead
AIDS (or HIV) sufferer, AIDS victim, HIV carrier	These are disempowering. Many people with HIV can enjoy relatively good health for years, and lead happy lives.	Person (or people) living with HIV, people living with HIV and AIDS
High risk group	There are no high-risk groups, only high-risk behaviours.	High-risk behaviour

Using the right words is also important because it helps you think in a constructive, non-judgmental way.

Unfortunately, the field of HIV and AIDS can be very technical. You should avoid using technical language that your audience does not understand. → Appendix 1 (the Glossary) and → Appendix 2 (Basic knowledge on HIV and AIDS) explain some of the technical terms you may come across in this book and in other reading.

The following sources have more advice on using the right language: → EU-India Media Initiative on HIV/AIDS (2007), UNAIDS (2008)

2.2 How HIV is transmitted

People become infected by HIV:

- **Through sex** (anal, vaginal and oral sex). HIV can be transmitted through heterosexual and homosexual intercourse. Worldwide, heterosexual transmission (between a man and a woman) is the most important form of transmission.
- **From mother to child.** A child can become infected during pregnancy, at birth, or through breastfeeding. This is the main reason for HIV infection in children. It is called “mother-to-child transmission”. Some prefer to speak of “parent-to-child transmission” referring to the father’s and husband’s part and responsibility to support the prevention of HIV transmission as well as his wider responsibility to care for the mother and the child.
- People can also be infected through **contaminated blood transfusions** or **needles and syringes** (e.g., while injecting drugs) or **other contaminated sharp instruments**. Worldwide, such transmissions account for fewer cases than transmission through sex or from mother to child.

Remember that each country has its specific pattern of the epidemic. That means that different ways of transmission may be more or less important in different places.

2.3 Root causes of HIV infection

The previous section lists how someone can become infected with HIV. Those are the **immediate causes**. But what causes certain individuals to have a higher vulnerability of becoming infected? To answer these questions we must look deeper, at the **root causes** of HIV infection.

Here are some root causes:

- Poverty and poor health
- Vulnerability related to social and cultural roles
- Mobility and migration
- Conflict and war
- Stigma, discrimination and denial
- Misconceptions and beliefs
- Harmful traditional practices.

We will discuss each of these in turn.

Poverty and poor health

Poor people may be vulnerable to HIV infection in many ways. They probably cannot afford good, continuous health care. They are likely to have limited access to education and information about health and related issues. That makes them more likely to fall ill, and less likely to get the right treatment.

If people already have a sexually transmitted disease (such as syphilis or gonorrhoea) and have unprotected sex with someone who is HIV-positive, they are more likely to become infected by HIV. And if they are already HIV-positive and have a sexually transmitted infection as well, they are more likely to pass on HIV to their sex partner.

It is difficult for poor people to plan for the long term. Just surviving from day to day is hard enough. They may have to sell sex to earn money, and may find it difficult to insist that their sex partner uses a condom. They may have to migrate away from their home and family in search of work – and find themselves in a situation where they are more likely to be infected. They may not be able to afford condoms to protect themselves from HIV or other sexually transmitted infections (Holden 2004, Bie 2008).

Nevertheless, HIV and AIDS have no socioeconomic boundaries. Wealthier and better educated people may be more mobile and have greater sexual autonomy, have more sex partners and be more likely to live in cities (where HIV is usually more common). But they may also have a better chance to access treatment in general and HIV prevention information, and may be more likely to change a behaviour that puts them at risk of infection.

Vulnerability related to social and cultural roles

“Sex” and “gender” are not the same thing. “Sex” means the biological and physiological differences between men and women, while “gender” refers to social and cultural differences (Table 5).

2. Root causes of HIV infection and effects of HIV and AIDS

Table 5. What is the difference between "sex" and "gender"?

	"Sex"	"Gender"
What does it mean?	Sex = the biological and physiological characteristics that are different between men and women	Gender = the social and cultural roles, behaviours, tasks and attributes that a society considers appropriate for men and women
Related words	Male and female	Masculine and feminine
Examples	<ul style="list-style-type: none"> • Women have breasts and a vagina • Men have testicles and a penis • Only women can give birth • Men have usually bigger bones than women 	In a given society: <ul style="list-style-type: none"> • Women may grow crops but are not allowed to sell them • Women do most of the work, but men make the important decisions • Women are not allowed to inherit land • Men may want or need to show their masculinity by having many sex partners
Does it vary from place to place?	No Aspects of sex do not vary much around the world	Yes The roles of men and women may differ from place to place. They may also change over time. For example: <ul style="list-style-type: none"> • Women and men can have equal rights • Both women and men can take care of children and of sick people
Aspects of analysis		Pay attention to: <ul style="list-style-type: none"> • Different rights of women and men • Access to and control over resources (land, property etc.) • Participation in making decisions (use of income, type of crop for cultivation, sale of land and property etc.) • Power relations between women and men (domination, subordination) • Socially determined categories of "masculinity" and "femininity". For example, a man may be considered a "real man" if he has multiple sex partners. Health-seeking behaviour is sometimes regarded as "unmanly"

Sources: WHO (2009), InWEnt (2007)

Gender inequality is an important root cause of HIV infection. Women are far more vulnerable than men to HIV infection for various reasons.

Biological reasons

From a biological perspective, women are at greater risk of contracting HIV during sexual intercourse. The labia and vagina have sensitive tissue, and the latter stays in contact with semen for some time after intercourse. That is one reason that makes women more likely to be infected by men than vice-versa. Young women whose reproductive organs are not yet fully mature have an even higher risk of becoming infected. Sexual intercourse while the vagina is dry (during forced sex/rape, or induced by natural or chemical remedies) increases the risk of lesions facilitating the penetration of viruses.

Social reasons

In many societies, the social status of a woman largely depends on men – her father, husband, etc. It is important for women in such societies to be married and have children. Women are often expected to comply with men's sexual wishes. They find it hard to negotiate safer sex practices (such as insisting on using a condom), and in some societies a married woman cannot refuse sexual intercourse with her husband even if he is unfaithful. It is often accepted for men to be sexually experienced, which increases the infection risk for women even in marriage. Where "intergenerational sex" (sex between older men and young women or girls) is common, the young women and girls are particularly vulnerable because older men are more likely to be infected than younger men. Older men often with a long sexual history frequently marry young women, further reinforcing the unequal power relations between men and women.

2. Root causes of HIV infection and effects of HIV and AIDS

Economic reasons

Women often depend on men economically. They may have access to land, property and equipment only through their husbands. In this case, they may fear to separate from or divorce their husbands because they would lose all their assets. Marriage is often not only an issue for the two partners, but a bond between two families. Where high bride price is paid, the possibility of the woman to negotiate with or separate from the husband becomes difficult, as her family of origin may not be able to pay back the bride price. She may be seen as her husband's family "property".

Single women, single mothers and widows may find themselves in a critical economic and social situation. In addition, girls and young women are often lured into risky sexual relationships with older men in exchange for cash or presents. Desperate economic situations of the family may also result in girls being forced to marry while they are still young.

Passing exams, and getting or keeping a job may depend on having sex with someone with the power to make decisions. Women who work as cross-border traders or run small businesses may engage in sex to get better prices or to bring their goods cheaper and more easily across the border.

Sexual violence

Women and girls are more vulnerable to sexual violence and rape than men. They may be subject to sexual violence and rape even in their homes by their partners or by male relatives. A male stereotype that men dominate women and have the right to punish them underpins violence against women and girls. Drinking alcohol may make men more likely to engage in such violence. Forced intercourse and rape lead to lesions of the tissue and increases the risk of HIV infection if the perpetrator is HIV-positive. In some societies, girls from impoverished families are sent to earn money through sex work. Sexual harassment in the workplace can also be recognized as a sort of sexual violence.

Access to education

Education influences a person's empowerment and self-esteem. It helps people get a job or start a business, so making them economically independent. In many societies, women have a lower level of education than men, so have fewer job options or must work in

exploitative conditions. A low level of education frequently means economic dependency as well as limited access to information and health care. All these make women and girls further vulnerable to HIV. But nevertheless sometimes higher HIV prevalence can be found in higher educated girls as well.

In societies where parents and children do not discuss sex openly, young people depend on information from their peers. That information may be incomplete or wrong.

Male stereotypes

Gender with regard to HIV does not mean that women are the only ones who are vulnerable to HIV infection. Men may be vulnerable too. A society expects men to behave in a certain way: for instance they have to be strong, independent and risk-taking. They may not be very interested in a healthy lifestyle or in seeking medical help, as these are not seen as "masculine" things to do. Such perceptions can lead them to be less consistent in taking preventive measures, or to seek HIV testing or medical care later rather than earlier. Economic pressure may also make men vulnerable to HIV infection: they may migrate and be separated from their families for long periods, so enter extramarital affairs. In many societies it is OK for men to have several sex partners and diverse sexual experience, but not for women.

A desperate economic situation or the lifestyle can also lead boys and men to engage in risky sexual behaviour.

To address gender-related vulnerability to HIV infection, it is important to target both men and women.

More information on gender, HIV and AIDS: → Holden (2004), HSRC (2005), Hope (2007), Schmitt (2005), UNAIDS (1999), UNAIDS (2004), UNAIDS (2008).

Mobility and migration

In many developing countries, thousands or millions of rural people migrate seasonally or for longer periods of time to cities, commercial farms and mines in search of work. Many other people have mobile lifestyles. Moving, especially without one's family, is stressful: people need to cope with new circumstances and the lack of a network of friends and relatives. It may lead to a changed lifestyle. All this favours risky behaviour.

2. Root causes of HIV infection and effects of HIV and AIDS

Some jobs – such as trading, long-distance driving and extension work – also involve high mobility and family separation. Such workers are similarly vulnerable to HIV infection.

Migration and informal sexual services

Many men and women migrate seasonally in search of work. This, and transactional sex, increase the risk of HIV infection. “Transactional sex” means occasional sexual services in return for food, cash or shelter. Recent research in eastern and southern Africa shows that such transactional sex by rural women aged 15–25 years may be the main reason for HIV infection.

Source: Bie (2008)

Conflict and war

In times of civil unrest and war, people may flee to other countries or to other parts of their country. In these situations, women (and men) are highly vulnerable to sexual harassment, abuse and rape by male refugees, militias and bandits, soldiers, police and rebels – while on the move, in refugee camps or at home. Sexual abuse and rape is often used as a weapon. The military and other combatants may exploit civilians, including children, to give them money, food, “protection” or shelter in exchange for sex. Forced sexual intercourse and rape may damage sensitive parts of the genitals and increase the risk of transmitting HIV (if the perpetrator is HIV-positive) and other sexually transmitted infections. Rape of girls and women demonstrates the absolute defencelessness of the one group and the ultimate power and control of the other. UNAIDS estimates that men in armies have a 2–5 times higher HIV infection rate than their civilian counterparts. Returning home HIV-positive, they put their partners at risk, too.

Conflicts disrupt information and communication flows (radio, information and educational materials), interrupt schooling, mean that children are not taught about life skills and HIV, and worsen the already-weak health services (UNICEF 2003).

Box 8. Conflicts, rape and vulnerability to HIV

- **Rwanda:** Eighty percent of 2,000 women who went for HIV testing within 5 years after the 1994 genocide were found to be HIV-positive. Many of them had been raped, and rape was the first sexual experience for many of these women.
- **Democratic Republic of Congo:** In Kalemie, in Katanga province in the east of the country, the HIV prevalence among pregnant women rose from 2.8% in 1991 to 24.2% in 2001. This area has experienced violent conflict and widespread sexual violence.
- **Kenya/Somalia:** A large number of assaults and rape cases of female refugees from Somalia were reported from isolated camps in Kenya in 1992 and later. Several hundred women were raped during night attacks and when fetching firewood.
- **Darfur:** Darfuri women suffered sexual violence and rape during attacks of their villages in Darfur and in refugee camps in Chad. They experience stigma because of being raped.

Sources: Mwangi Kagwanja (2000), Physicians for Human Rights (2009), UNICEF (1993, 2003)

Stigma, discrimination and denial

People may fear becoming infected by HIV (e.g., through casual contact), and are afraid of other people’s negative attitudes and prejudices towards people who are infected. But stigma, discrimination and denial hinder effective HIV prevention and access to treatment, care and support. People are afraid to get tested for HIV for many reasons: they are afraid of discrimination, even within their own family; they fear conflict with their partner, separation and divorce; they have wrong or fragmentary information on HIV and AIDS; they are afraid their family, friends or health personnel will not keep their test results confidential. Stigma and discrimination also hinder people from finding out how to protect themselves or from seeking early and adequate treatment (UNAIDS 2008).

Misconceptions and beliefs

People may have the wrong information, or only partial information, on how HIV is transmitted, what it does, and how to treat it. They may not understand the difference between HIV and AIDS. They may not know how to avoid infection or how to use a condom properly. They may believe that witchcraft is the cause of AIDS. They may think that

prayer or herbal remedies cure HIV infection or AIDS, so stop taking their antiretroviral treatment. Such misconceptions and harmful beliefs, and the circulation of wrong and partial information, have a negative effect on HIV transmission and treatment.

Harmful traditional practices

Various traditional practices may encourage the spread of HIV. They include:

- **Female genital mutilation** (“female circumcision”), cutting a girl’s or woman’s genitals for religious or cultural reasons.
- **Traditional scarification or tattoos** using contaminated sharp instruments (razor blades, knives) or needles.
- **Sexual cleansing**, where a newly widowed woman must have sex with a man (who may be relative of her husband) to free the husband’s spirit.
- **Widow inheritance**, where the dead husband’s brother or another relative marries a widow. This is a traditional practice to ensure social and economic security of the woman (and her children) left behind. If she is HIV-positive, she may infect her new husband, who in turn may infect his other wife or wives.

Such harmful traditional practices may combine with other social and legal factors to increase the risk of someone becoming infected (Box 9). Traditional practices that encourage the spread of HIV in a society should be identified and changed.

Box 9. Property rights and harmful traditional practices

A combination of insecure property rights and harmful traditional practices makes women vulnerable to HIV infection.

- A woman who knows her husband has other sex partners and is aware of her risk of HIV infection may not be able to get a divorce because she is afraid losing her children and her home.
- A widow may have to be “sexually cleansed” by a man – perhaps one of her husband’s relatives. Or she may be “inherited” by one of them. If she refuses, she may lose her husband’s property.

Source: Human Rights Watch (2003)

2.4 Effects of HIV and AIDS

HIV and AIDS do not just affect the infected individuals. They can also have devastating effects on their families, their livelihoods, the social structure, the social safety net, the population structure, and the national economy.

Effects on families

People who are infected with HIV go through a range of emotions and experience various social and economic problems. So do their families. These emotions and problems change over time – when the person is first diagnosed as HIV-positive, when symptoms appear, and when he or she is taking antiretroviral treatment.

Psychological reactions

Someone who tests positive for HIV may react in different ways. So too may the person’s family, if they are told the test result. Reactions include fear, loss, grief, guilt, denial, anger, anxiety, low self-esteem, depression, suicidal behaviour and thinking, and fears about income and social status. Family members may insult or attack each other, and accuse each other of bringing the virus into the house. Family ties may be strained or break. Some people do not tell their partners and family members they are HIV-positive because they are afraid of being rejected. The emotions depend on the personality of the person infected, as well as the reactions they expect and the support they receive from the family and society. In the long run, a positive test result will bring about many changes in how the household functions. At best, people living with HIV and their family members receive the support they need to cope with the situation (Bezuidenhoudt et al. 2006).

Effects on children

It may be very difficult for children to see their parents becoming sick and to care for them and some even for their younger siblings. The children experience many, often traumatic, changes. Their parents may be unable to do routine tasks. The family may go short of food and be unable to buy clothing. Because of lack of money and labour, the children may drop out of school. Children start to worry that they may lose their parents. They may become angry and fearful, feel isolated, and be unable to concentrate.

Orphans are vulnerable to economic and social hardship: poverty, malnutrition, child labour, limited access to education and health care,

2. Root causes of HIV infection and effects of HIV and AIDS

and so on. They do not learn from their parents, and may be abused and exploited by relatives, their foster family or neighbours. Protecting orphans from such abuse is crucial (Nabcoa 2004, Bezuidenhoudt et al. 2006).

Effects on livelihoods

HIV and AIDS aggravate the vicious cycle of poverty, food insecurity and ill health.

Labour shortages and reduced income

Someone who is infected with HIV may be weak and unable to work. If he or she is the main breadwinner, the household may lose much of its income. Other household members have to care for the sick person, which limits the other work they can do. Their overall economic activity declines. For farming households, the loss of adults and their labour may harm agricultural production. Planting, weeding and harvesting may be delayed, and the household may cultivate less land. Other household members may have to work longer hours, and children, especially girls, may have to leave school to save money and so they can help at home. The shortage of income may force people to sell land.

Figure 3 shows how the loss of family members and labour may affect a smallholder farming household.

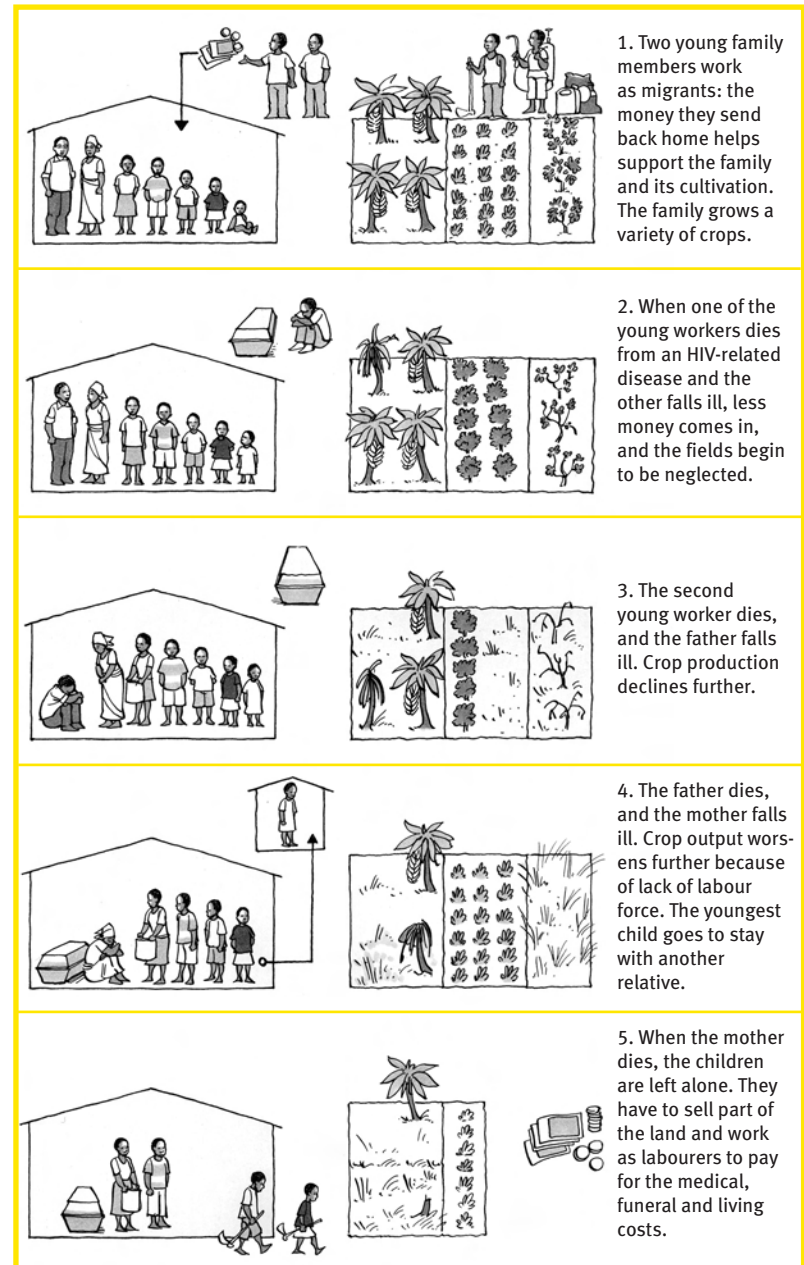
Box 10. Traditional factors that worsen labour shortages

In many societies, women and men are traditionally responsible for different things. For example, men do the ploughing while women do the weeding and harvesting. If the man dies, the woman is not permitted to do the ploughing. She may have to wait for someone else to do it for her – and may have to pay for the work. That costs money, and delays planting and may reduce the yield.

Mourning customs also curtail the labour available in individual households and the community as a whole.

In hard-hit communities, because of people dying due to HIV-related sicknesses, burials can be a frequent occurrence, exacerbating labour shortages and the effects of long mourning customs.

Figure 3. The effects of illness and death on cropping patterns in rural Uganda
Adapted from Quinlan et al. (2002)



2. Root causes of HIV infection and effects of HIV and AIDS

Rising expenditures erode household assets and increase indebtedness

HIV and AIDS-affected households are in a double bind: they have less income on the one hand, but have extra costs for medical care, treatment and transport on the other. They may need expensive drugs. They may make repeated visits to health centres, doctors or traditional healers. If they have to stay in hospital, they need to pay the costs.

Even though antiretroviral drugs are free in many countries and the costs of treating other infections have fallen, treatment is still inadequate in many places, especially in remote areas. A household may have to pay not only for medical treatment, but also for transport to the health facility and for food. They may have to sell their livestock, land or other goods, or go into debt to cover these costs. And if the infected person eventually dies, they may have to cover the funeral expenses, which can be high and will further increase their debts. In some societies, long mourning periods are practised. They can have negative economic effects as relatives are not supposed to work during this time.

Box 11. The high cost of funerals

Local custom may make funerals very expensive. They can take a household to the verge of financial ruin.

Many farm households use up their savings and sell what they can: such as cattle, other livestock, plantations of perennial crops, farm tools and equipment, bicycles, furniture and radios.

They may borrow money from relatives, friends or neighbours, or take loans from saving clubs, local traders or moneylenders. The latter, in particular, charge very high interest rates.

Source: Mutangadura et al. (1999)

Box 12. Poverty, malnutrition and HIV infection

Poor people often consume unbalanced and inadequate diets.

Poor-quality staple foods are often contaminated by aflatoxins and other fungi. Poor people cannot afford to buy foods richer in proteins and vitamins. Their drinking water may be unsafe. These problems may cause gastrointestinal infections and weaken the immune system. That in turn makes people who are infected with HIV more vulnerable to diseases, and they tend to develop HIV-related symptoms more quickly.

Source: Bie (2008)

Overcoming the effects of HIV and AIDS

How can households deal psychologically, economically and socially with HIV and AIDS, and with the death of the infected person? How can they recover afterwards?

It helps if kinship ties are strong and the extended family and the community help out. So do social protection schemes run by the government, NGOs and faith-based organizations.

Some responses may be helpful in the short term but cause problems in the longer term. For example, selling equipment or taking out a loan raises money to pay for immediate expenses but makes it harder for the household to recover in the future.

Box 13. Secure land rights and inheritance laws for women and children

In some societies, a man's widow and children cannot inherit land, equipment and other family property. The deceased man's relatives take over the land and property, even if the woman has used her income to buy it and needs it to support herself and her children. Such "property grabbing" makes life harder for widows and orphans.

In several countries, grassroots organizations have started to create awareness, advocate and press for changes in such inheritance laws and customs, and to push local authorities to support the affected women and children.

Zambia is one country that has responded. Its government has established "victim support units" to address land and property grabbing and other abuses of women and children. Encouraging people to write a will can also ensure a measure of economic security to bereaved women and children.

Sources: Izumi (2006), UNAIDS (2004a, 2008), Varga (2006)

Effects on the social structure

At the community level, HIV and AIDS may cause changes in the social structures and the numbers of people of different ages. In some countries, there are more single-parent households (mostly headed by a woman) and households headed by a child. Grandparents need to take care of their grandchildren when the children's parents fall ill or die. The number of street-children has risen.

These effects influence various aspects of the community: social safety nets within the extended family, the degree to which people help others in the community, people's willingness and ability to care for sick household members, and the education of children.

2. Root causes of HIV infection and effects of HIV and AIDS

Social safety nets

People often care for their relatives and help them out in times of need. An extended family may provide an entire social safety net: middle-aged adults take care of their elderly parents and their own children. They may do the same for their friends and neighbours. These social safety nets can mitigate the effects of HIV and AIDS. The amount of such assistance depends on local traditions and cultural norms.

But such safety nets have limits: they can break down if too many people need help. With HIV, middle-aged people are disproportionately infected. In countries where HIV is more common, several members of an extended family may be infected. This will lead to a shift in the family's social safety net as the ability to take care of others declines and the number of family members in need rises.

Generally, social safety nets are more likely to be effective in rural areas than in towns and cities, where fewer people are related to or have social ties to their neighbours.

Women and elderly people bearing the burden

Many societies see women and female children as the caregivers in the family. That gives them a heavy burden when responding to HIV and AIDS. In Zambia, a study found that female-headed households are more involved in caring for orphans: 67% of households headed by women cared for orphans, compared to only 26% of those headed by men (FAO, 2003). But households headed by females tend to be poor anyway, and get poorer if they bear a disproportionately large share of the costs of HIV and AIDS.

Where both parents are sick or have died, grandparents often take care of their sick children, and look after their grandchildren too. Instead of having their children look after them in their old age, the grandparents (often the grandmothers) have more work to do.

Orphans

Many children have become orphans due to HIV and AIDS. In sub-Saharan Africa, nearly 12 million children below the age of 18 have lost one or both parents (UNICEF et al. 2008). This huge number of orphans affects the potential of the households, communities and countries. It is a big challenge to care for these children, ensure they have adequate emotional and financial support, provide them with education and health services, protect them from abuse, and ensure they do not fall deeper into poverty.

Box 14. Children: The future generation

How to care for the high number of orphans and vulnerable children? Here are some possibilities.

Supporting, strengthening and monitoring include:

- **Informal arrangements** for the children to stay within their own (possibly extended) family and in their community.
- **Formal arrangements** for the children to live in safe and caring foster families or high-quality institutional care.

Family-like settings in communities should always be preferred to institutional care.

Social protection schemes to benefit orphans and vulnerable children include:

- **Cash transfers**, such as allowances for books, school fees and transport.
- **Transfers in kind**, such as food, clothing, exemptions of school and medical fees.
- **Supportive grants**, such as child-support grants, orphan's allowances, foster-care allowances, and basic pensions for the elderly.

Sources: UNAIDS (2006), Slater (2004)

Loss of skills and knowledge

The loss of parents and other adults in the community means that indigenous knowledge and skills are lost: they are not passed on to the children in a family or to young people in the community. Traditional practices may be forgotten, for example in farming, care for the environment and traditional medicine.

HIV and AIDS may also lead to fewer children attending school and a decline in the already low level of education (Gari 2004).

2. Root causes of HIV infection and effects of HIV and AIDS

Box 15. Traditional self-help mechanisms

Mutual support groups are common in rural Africa. They play an important role in the response to HIV and AIDS. Here are some of the things they do:

- **Production:** groups for farming, gardening, fishponds, poultry
- **Household:** assistance in water supply, sanitation, nutrition, hygiene
- **Labour:** groups supporting each other in harvesting, weeding, handling draft power, tool sharing
- **Health:** mutual aid societies, assistance in times of sickness
- **Financial issues:** savings clubs, rotating “merry-go-round” lending associations, credit cooperatives
- **Food security:** community seed banks, grain banks, community fields, market women’s groups

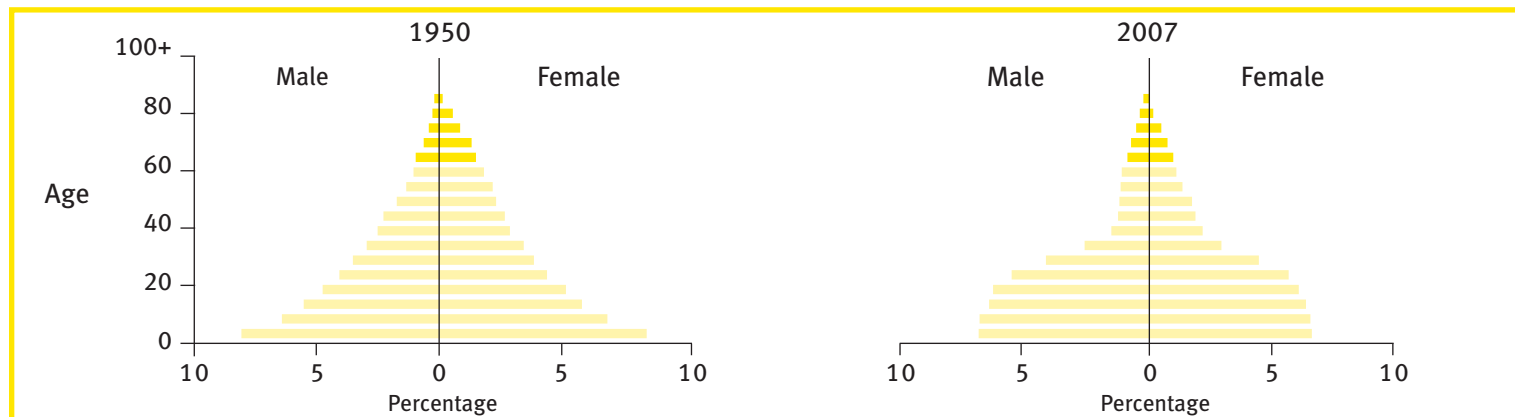
Sources: Mutangadura et al. (1999), ECA (2006), Bishop-Sambrook (2003)

Population structure

HIV and AIDS can change the population structure. Many young adults die, and HIV-positive women tend to have fewer children. For example, Lesotho faces a high prevalence of HIV, and the effects can be seen by comparing two population pyramids, for 1950 and 2007 (Figure 4). In the 2007 pyramid, there are fewer young children and people in the 30–50 age group than might be expected.

Figure 4. Changes in population structure in Lesotho due to HIV and AIDS

Source: UNAIDS (2008)



Impact on national economies and social services

National economy

HIV and AIDS affect the most productive age groups: people from 15 to 49 years of age (UNAIDS 2004b). The loss of so many young adults hits the economies of countries where HIV and AIDS are widespread. It is difficult to estimate the economic impact accurately as economic growth rates are influenced by many other factors. But evidence clearly shows that HIV and AIDS are deepening poverty levels, even in less-affected countries (UNAIDS 2008).

Impact on individual sectors

Several studies show the effects of HIV and AIDS on various sectors, industries and the government.

- In countries where HIV prevalence is high, many **industries** face increased production costs (up to 10%) due to HIV-related absenteeism and death (Piot et al. 2007).
- The **health** and **education** sectors are highly affected by the loss of skilled labour. For example, a study in two public hospitals in South Africa found that 11.5% of the health-care workers were HIV-positive (Connelly et al. 2007). Tanzania needs about 45,000 additional teachers to replace those who have died or left due to HIV-related sicknesses (UNAIDS 2006).
- **Agriculture** is the backbone of many developing countries. Agrarian economies based on labour-intensive small-scale agriculture are particularly hard-hit by HIV and AIDS (Waal et al. 2003).

2. Root causes of HIV infection and effects of HIV and AIDS

- Frequent deaths of parliament members reduces the capacity of **parliaments** and considerably increases government expenses, a study in seven African countries showed (UNAIDS 2008).

Box 16. Making antiretroviral treatment more accessible

Increased access to antiretroviral treatment can significantly prolong life, improve the quality of life, reduce absenteeism and increase the productivity of people living with HIV.

Universal access to HIV treatment would prevent up to 5 million children from becoming orphans.

Source: UNAIDS (2008)

2.5 Unintended negative side-effects of project activities

A project may unintentionally reinforce the root causes of HIV infection, increasing the vulnerability of its target groups and the project's own staff.

Here are some examples of how this may happen.

- **Mobility.** The project may increase the target groups' mobility. This may be desirable (for example, if people visit the market more often), or it may be impossible to avoid (for example, if group members come to meetings). But the project can find ways to reduce the risk, for example by increasing their awareness of risks, and avoiding people having to travel home late.
- **Income-generating activities.** The project may promote income-generating activities. But an increase in income may encourage men to have girlfriends, marry another wife, or spend the money on alcohol. The project may help people earn money by making and selling beer. But it may not help them think about the consequences: drunkenness increases the probability of violence (including sexual violence), and drinking alcohol may make people forget all the HIV-prevention messages they have learned – and would normally follow while they are sober.
- **Inaccurate information.** Project staff may inadvertently spread the wrong information about HIV and AIDS and prevention measures.
- **Unintended results of information.** Showing pictures of people who have disease symptoms may lead to judgements and rumours, or

may inspire fears of getting tested or having contact with someone living with HIV and his or her family.

- **Negative staff attitudes.** Staff may have negative attitudes towards people living with HIV and their relatives (stigmatizing, discriminating against them, etc.).
- **Damage to relationships.** Asking intimate questions about sexual behaviour may harm the relationship between project staff and the target group.

The project may inadvertently make its own staff more vulnerable to HIV (CAFOD 2008):

- **Project design.** Staff such as extension workers and construction workers may have to stay away from their families for long periods. That makes it more likely for them to have a sexual relationship with someone while they are away from home.
- **Living and working location.** Travelling alone, working in violent areas, and living in insecure accommodation increase the female staff's vulnerability to sexual violence, rape or sexual coercion.
- **Work situation.** Stress, exhaustion, lack of free time, emotional traumatic situations and lack of support in difficult circumstances may lead staff to resort to alcohol, drugs or casual sex to relieve stress.
- **Exposure to blood.** The staff may be put into situations where they risk exposure to blood – which may be infected with HIV. Such risks include poor first-aid practices and unsafe vehicles with an increased risk of accidents.

Box 17. Negative implications: A question of power

Project staff may hold power in a number of ways.

- They may have power over project target groups or workers.
- They may have power over other staff based on their gender, age, experience, ethnicity or nationality.

Such power can be misused. For example, managers may demand sexual favours from their staff, and field staff may misuse their position to seek favours from the people they are supposed to serve.

Source: CAFOD (2008)

3. Mainstreaming: A practical guide

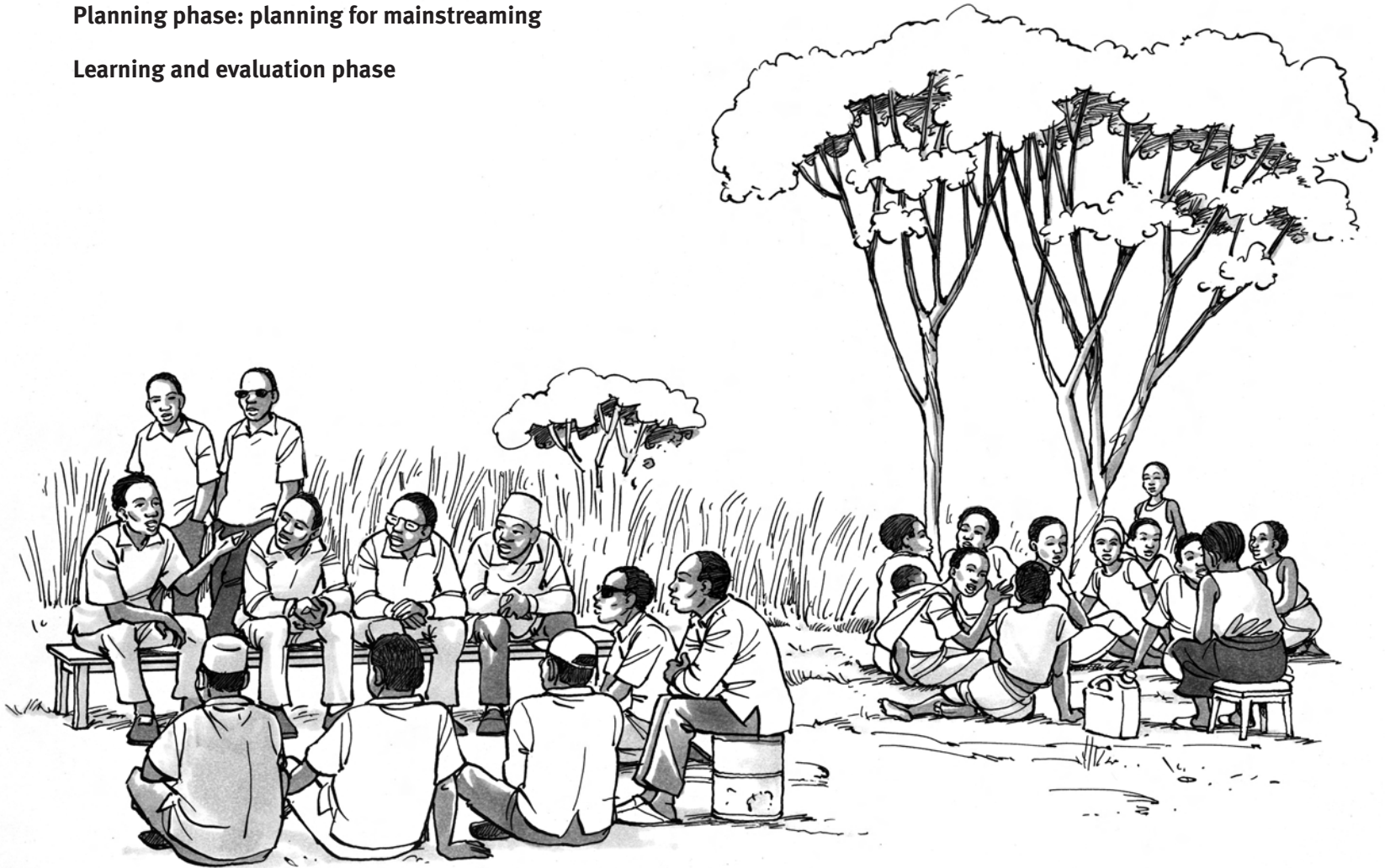
Step by step approach

Awareness phase: project staff

Analysis phase: project staff and target group perspective

Planning phase: planning for mainstreaming

Learning and evaluation phase



3.1 Step by step approach: An overview

This chapter describes how project management and staff can initiate an external mainstreaming process. This method is based on practical experience. We advise you to follow all phases, but depending on the time available and the project management and staff's experience with HIV and AIDS, you may conduct some of the phases more or less intensively.

For each phase, we provide background information, define the expected results, and offer a variety of tools. For each tool we explain the purpose and procedure, and outline the preparation, material and time requirements. For some tools, we present model results. You may be able to use some of the tools in sessions with project target groups.

The process comprises four phases (Figure 5).

- Phase I Awareness
- Phase II Analysis
- Phase III Planning
- Phase IV Learning, monitoring and evaluation

Figure 5. The four phases in the HIV/AIDS mainstreaming process

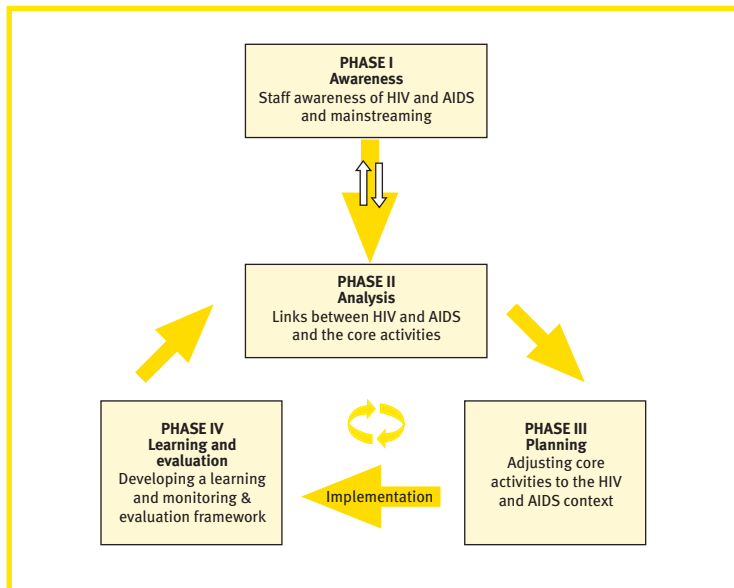


Table 6 provides an overview of the different phases of the mainstreaming process, with a brief description of each phase, the expected results and the time requirements. It also indicates who should be involved in carrying out the different phases.

This chapter uses these symbols:

-  • Expected results
-  • Overview
-  • Materials
-  • Purpose
-  • Time
-  • Preparation
-  • Facilitation/ How to use/ Process
-  • Participants

Initial mainstreaming process

Starting the mainstreaming process does not require a lot of time. You will need about 5–7 days for the initial process, depending on the situation in your country and your organization. You can spread these initial activities over a period of time (though it is better not to leave too long between them). You should be able to fit the schedule in with existing activities and commitments.

This book describes how to do various exercises as part of the mainstreaming process. It is not necessary to do all of the exercises, or to do them in the precise order given here. You can pick and choose those that are relevant to your situation. Feel free to adapt them as required, or to develop new exercises to suit your needs.

After the initial awareness phase (Phase I), HIV/AIDS mainstreaming should become an ongoing process.

Some key factors for success

The success of a mainstreaming process depends on the dedication and motivation of all staff, and most importantly on the commitment and supportive role of management, which plays a key role in initiating and bringing the mainstreaming process forward. Staff members should know basic facts and figures on HIV and AIDS and understand HIV and AIDS as a development issue. They should see the link between HIV and AIDS and their work; they must be convinced they can address HIV and AIDS using their own professional expertise.

There is no single approach to mainstreaming; it is important to adapt the different phases to the core activities of the project.

3. Mainstreaming: A practical guide

Table 6. Overview of phases in mainstreaming process

Description	Expected results	Persons involved	Expected time requirements, observations
Phase I: Awareness			1–1.5 days
<p>Introduction to mainstreaming</p> <p>Staff awareness of basic facts and figures and of linkages between HIV and AIDS and development issues</p>	<p>Participants:</p> <ul style="list-style-type: none"> • Are aware of HIV and AIDS as a development issue which affects them and their work. • Understand the concept of HIV/AIDS mainstreaming – internal and external. • Are acquainted with the medical facts: transmission and progression of HIV, difference between HIV and AIDS, opportunistic infections, options for prevention and medical treatment, etc. • Discuss issues related to HIV and AIDS and sexuality more openly. • Link HIV and AIDS to their own work and are motivated to address them in their work. • Understand the difference between internal and external mainstreaming. 	<p>All staff</p> <p>It is recommended to invite a local resource person, preferably a person living with HIV, to provide profound information and to share personal experiences</p>	<p>Although week-long breaks are possible between the phases, they are not recommended; instead, try to set aside one week to initiate the entire mainstreaming process</p> <p>Staff members are encouraged to share personal experiences</p>
Phase II: Analysis			2–3 days
<p>II-1: Analysis from the management and staff perspective</p>	<p>Participants:</p> <ul style="list-style-type: none"> • Are sensitive to the root causes of HIV infection and effects of HIV and AIDS. • Are aware of the factors that determine the vulnerability of the different target groups. • Have identified gender-related vulnerability factors. • Are aware of the effects of HIV and AIDS on the various components and results of the core activities. • Are aware of positive and unintended negative side-effects of their project components on HIV and AIDS. • Have understood that networking with other stakeholders is crucial to ensure the effectiveness of the HIV/AIDS mainstreaming process. • Have identified possible networking partners in the surrounding area. • Have identified key areas for mainstreaming. 	<p>All staff members</p> <p>If this is not possible, certain staff members conduct the analysis and present the results in a plenary session to those unable to participate</p>	<p>0.5–1 day</p> <p>A break between Phase II-1 and II-2 can be useful to allow arrangements to be made for the situation analysis with target groups in the field</p>
<p>II-2: Analysis from the target group's perspective</p>	<p>Staff members:</p> <ul style="list-style-type: none"> • Have a better understanding of how far their target groups are aware of HIV and AIDS. • Are aware of myths and misconceptions about HIV and AIDS among the target groups. 	<p>Target group members</p> <p>All staff members</p> <p>If this is not possible, certain staff members conduct the</p>	<p>1–2 days, including planning and documentation of results</p> <p>Staff members work with selected community or target group, who are</p>

3. Mainstreaming: A practical guide

	<ul style="list-style-type: none"> • Gain insights into specific factors (including gender-related factors) that make the target group vulnerable to HIV infection and to the effects of HIV and AIDS. • Gain insight into the extent of HIV and AIDS in the communities. <p>Selected target group members:</p> <ul style="list-style-type: none"> • Are sensitized to the root causes of HIV infection and effects of HIV and AIDS (including gender-related issues). • Are aware of family dynamics, role of social customs and HIV- and AIDS-related stigma and discrimination. • Are motivated to address HIV and AIDS-related issues. 	analysis and present the results in a plenary session to those unable to participate	already familiar with each other
Phase III: Planning			1 day
III-1: Developing an appropriate HIV/AIDS mainstreaming response: collating the results of Phase II	<ul style="list-style-type: none"> • The results of Phase II are compiled, analysed and prioritized. • Key areas for mainstreaming are identified. 	<p>All staff members</p> <p>Target group members who participated in the situation analysis (Phase II-2)</p>	0.5 day
III-2 Adjusting planning for mainstreaming HIV/AIDS	<ul style="list-style-type: none"> • Key areas of mainstreaming are identified. • Project components to be strengthened or modified are identified. • Project components to be made accessible for households affected by HIV and AIDS are identified. • Activities where complementary partnerships are necessary are identified. • Additional activities or project components needed in mainstreaming are identified. • Planning of HIV/AIDS mainstreaming measures is developed: this may be a mainstreaming action plan, a new operational plan that includes mainstreaming, or an existing operational plan is adjusted. • Mainstreaming measures to include in the overall project strategy, when this is revised. 	<p>All staff members</p> <p>Target group members who participated in situation analysis (Phase II-2)</p>	<p>0.5 day</p> <p>A break of several weeks between Phases III-1 and III-2 is possible but not recommended, because they are linked</p>
Phase IV: Learning and monitoring & evaluation			1 day
Developing a learning and monitoring & evaluation system for mainstreaming	<ul style="list-style-type: none"> • A framework is developed for the systematic exchange of experience and know-how on HIV/AIDS mainstreaming. • An appropriate system is created for monitoring, evaluating and assessing the outcome of HIV/AIDS mainstreaming with clear responsibilities and time frame. • The learning framework as well as monitoring, evaluation and outcome assessment are linked to existing project practices. 	<p>All staff members</p> <p>Possibly target group members who participated in situation analysis (Phase II-2)</p>	
	Recap session after each day of workshop	All staff members	

3.2 Phase I: Awareness

It is important that project staff understand the concept of HIV/AIDS mainstreaming (internal and external), possess basic knowledge of HIV and AIDS, and understand the relevance of HIV and AIDS to other development issues and to their own work. The awareness phase can be handled in a 1- or 1.5-day workshop, depending on the extent to which the project has previously considered HIV and AIDS issues. Choose those tools described in this section that fulfil your needs. You will need to prepare guiding questions for facilitation for all the workshop sessions. In general, you will need facilitation skills and to know how to handle group dynamics.



Expected results

Participants:

- Are aware of HIV and AIDS as a development issue which affects them and their work.
- Understand the concept of HIV/AIDS mainstreaming – internal and external.
- Are acquainted with the medical facts: transmission and progression of HIV, difference between HIV and AIDS, opportunistic infections, options for prevention and medical treatment, etc.
- Discuss issues related to HIV and AIDS and sexuality more openly.
- Link HIV and AIDS to their own work and are motivated to address them in their work.
- Understand the difference between internal and external mainstreaming.



Overview

- Exercise 1. Introducing the concept of mainstreaming
- Exercise 2. Quiz on existing knowledge on HIV and AIDS
- Exercise 3. Existing knowledge on HIV and AIDS: Sorting information
- Exercise 4. Basic facts and figures and personal experiences of HIV and AIDS
- Exercise 5. Role play on stigma, discrimination and local customs
- Exercise 6. How easy is it to talk about sexuality?
- Exercise 7. Breaking shame: Talking about sexual terms
- Exercise 8. Wildfire simulation: Sexual networks and HIV transmission

- Exercise 9. Internal mainstreaming: HIV and AIDS and my workplace
- Exercise 10. Key considerations for a workplace policy on HIV/AIDS
- Exercise 11. External mainstreaming: HIV and AIDS as a development issue
- Exercise 12. Wrap-up of Phase I



Estimated time needed

- 1–1.5 days



Participants

- All staff



Materials

- Flipchart and paper
- A4 paper
- Pens, coloured markers
- Small cards (three different colours).

Exercise 1.

Introducing the concept of mainstreaming

This session introduces the concept of mainstreaming and stimulates a discussion on what mainstreaming could mean for the different components of a project.



Purpose

- To introduce the concept of internal and external mainstreaming HIV/AIDS to staff members.



Preparation

- Write the definition of mainstreaming (→ Section 1.2) and key questions (→ Box 18) on a flipchart.

Box 18. Key questions for external mainstreaming

- How does your project curb the spread of HIV?
- How does your project possibly contribute to the spread of HIV?
- How are HIV and AIDS likely to affect your project goals, objectives and measures?
- What effects do the changing needs and capacities of the target groups have on your project goals, objectives and measures?
- How are the effects of HIV and AIDS mitigated?
- What effects of HIV and AIDS are possibly aggravated by your project activities?
- Based on your professional competence and comparative advantage, how can your project be planned and implemented so as to:
 - curb the spread of HIV?
 - mitigate the effects of HIV and AIDS?
 - avoid unintended negative side effects?
 - remain effective?
 - adapt to the changing needs and capacity of the target groups?

- Prepare ideas to introduce and explain the concept of mainstreaming HIV/AIDS. Make sure you include the following:
 - Why mainstreaming? Explain that mainstreaming is necessary in development work as HIV and AIDS affects staff, target groups, communities, and development as a whole.
 - The definition of mainstreaming (→ Section 1.2).
 - The difference between internal (→ Section 1.4) and external mainstreaming (→ Section 1.5).
 - Practical examples of mainstreaming related to your project's core activities.



Time

- 30 minutes



Facilitation

- Facilitate a discussion where participants talk about what mainstreaming HIV/AIDS (internal and external) means to them.
- Introduce the definition, key questions and examples of mainstreaming relevant to the project's core activities.
- Invite participants to ask questions and make comments.

Exercise 2.

Quiz on existing knowledge on HIV and AIDS

A quiz is a good way to find out what people already know about HIV and AIDS. It also reinforces accurate knowledge and enables you to correct faulty ideas. It can be a good basis for a discussion where misunderstandings can be clarified.



Purpose

- To ascertain existing knowledge, knowledge gaps and other HIV and AIDS-relevant issues among staff members.



Preparation

- Develop a quiz with questions to ascertain the participants' existing knowledge, knowledge gaps and other HIV and AIDS-relevant issues. See an example of such a quiz on the attached CD-Rom. Adapt this to suit your own needs.
- You should have very good knowledge on HIV and AIDS to give the correct answers and to explain more details if needed. You may need to bring in an HIV/AIDS specialist to help you with this.



Time

- 1 hour



Facilitation

- Distribute the quiz to participants to answer.
- When everyone has completed the quiz, ask the participants to give their answers to each question.
- Based on the answers given by the participants, reinforce the right answers and correct the wrong ones. Make sure to do this in a respectful way.
- Use the opportunity to discuss interesting topics in more detail.

Exercise 3.

Existing knowledge on HIV and AIDS: Sorting information

In this exercise, participants brainstorm HIV-related risk situations and decide the level of risk of HIV transmission under various circumstances.



Purpose

- To ascertain participants' knowledge on HIV and AIDS.
- To break barriers among participants to talk about HIV and AIDS-related issues.

3. Mainstreaming: A practical guide



Preparation

- Draw two large circles on separate flipchart papers. In one, write “No risk of HIV transmission”. In the other circle, write “Risk of HIV transmission”.
- On cards, write eight statements on sexual behaviour and about living and caring for people living with HIV (one on each card). These statements should cover blood and blood products, sexual intercourse (anal sex, vaginal sex, oral sex), and mother-to-child transmission (during pregnancy, during delivery, during breastfeeding).

See → Box 19 for some examples.

Box 19. Some possible items for the information sorting exercise

Assuming that the other person is HIV-positive	Risk of HIV transmission	No risk of HIV transmission
• Having anal sex with him or her	X	
• Having vaginal sex with him or her	X	
• Having oral sex with him or her	X	
• Kissing him or her		X
• Touching the person’s skin		X
• Pricking yourself on a used injection needle	X	
• Being bitten by a mosquito		X
• Using the same plate and spoon as the person		X
• Sleeping in the same room as him or her		X
• Travelling on a bus with him or her		X
• From mother to the unborn child when the mother is pregnant	X	
• From mother to child during birth	X	
• From mother to child by breastfeeding	X	
• Using the same toothbrush	X	
• Using the same razor blades	X	



Time

- 30 minutes



Facilitation

- Fix the two large circles on boards, or lay them on the floor.
- Divide the participants into two groups. Give each group four statements. Ask each group to decide whether the behaviour carries ‘no risk’ or ‘risk’ of transmitting HIV.
- Bring the groups back to the plenary.
- Group 1 reads out loud one of its statements and says in which circle they think it belongs, and explains why. Group 2 may agree or disagree. Statements are placed and may be moved to a different circle. If necessary, advise on the correct answer.
- Repeat the previous step, with Group 2 reading out one of its statements and saying which circle it belongs in and why. Repeat for all eight statements, alternating between groups.
- At the end of the activity, set aside the cards that require further investigation and information.

Exercise 4.

Basic facts and figures and personal experiences of HIV and AIDS

A resource person is invited to share basic facts and figures about HIV and AIDS with the participants. If the resource person is living with HIV, he or she can share personal experiences.



Purpose

- To acquaint participants with basic facts and figures related to HIV and AIDS.
- To encourage participants to share their personal experiences related to HIV and AIDS.



Preparation

- Invite a knowledgeable resource person to share information about HIV and AIDS, and local HIV/AIDS support organizations and other stakeholders. The resource person should preferably be someone who is living with HIV.
- If the resource person is not HIV-positive, consider also inviting someone who is living with HIV to share his or her personal experience.

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Time

- 1.5 hours



Facilitation

- Ask the resource person to present basic facts and figures about HIV and AIDS: modes of transmission, measures of prevention including prevention of mother-to-child transmission, counselling and testing, difference between HIV and AIDS, progression of HIV infection, and measures of treatment. Facilitate a discussion with the participants.
- Invite the person living with HIV to share personal experiences with the participants. Encourage questions and discussion.
- Encourage participants to share their own personal experiences related to HIV and AIDS.

Exercise 5.

Role play on stigma, discrimination and local customs

In this exercise, participants compose and perform short role plays on HIV and AIDS-related stigma and discrimination and local customs.



Purpose

- To sensitize participants on HIV- and AIDS-related stigma and discrimination and the linkages between local customs and HIV and AIDS.



Preparation

- None



Time

- 1.5 hours



Facilitation

- Introduce the idea that stigma and discrimination related to HIV and AIDS are root causes that encourage the spread of the virus. Some local traditions may also result in the spread of HIV. Tell participants it is important to reflect on these issues and share their personal experiences.
- Divide participants into groups of at most five people.
- Invite each group to choose a topic related to stigma and discrimination or local customs relevant to HIV and AIDS. Ask them to design

a small role play to last a maximum of 5 minutes. Give them time to prepare their role play.

- Each group presents the role play in the plenary.
- After each role play, facilitate a discussion on the subject presented.

Exercise 6.

How easy is it to talk about sexuality?

This exercise animates participants to reflect why it might be difficult to talk about sexuality and related matters, and to discuss how they can overcome this barrier.



Purpose

- To enable participants to become aware of own reluctance to talk about sexuality, and to overcome barriers to talk about this subject with target groups.
- To sensitize participants about the importance to freely talk about sexual matters regarding HIV and AIDS.



Preparation

- Write “How easy is it for you to talk about sexuality?” on a flipchart.
- Write cards saying “Easy”, “Sometimes easy/sometimes difficult” and “Not possible”. Place these cards in different corners of the room.



Time

- 30 minutes



Facilitation

- Open the session by saying that the topic of HIV and AIDS is closely related to sexuality. But often it is difficult for people to discuss such issues.
- Introduce the guiding question, “How easy is it for you to talk about sexuality?”
- Ask participants to stand by the card saying “Easy”, “Sometimes easy/sometimes difficult” or “Not possible” that best reflects their answer to the question.
- Ask participants in the “Not possible” group to explain why they have chosen this answer. The other participants listen carefully. At the end of the explanations summarize the responses.

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- Ask the “Sometimes easy/sometimes difficult” group to explain their reasons for choosing this answer. Summarize the explanations.
- Ask the “Easy” group to explain their answer. Again, summarize their responses.
- Highlight ways to overcome attitudes hindering openness.
- Discuss why it is important to feel free to talk about sexuality with project target groups:
 - If staff members feel free to talk about sexuality, the target groups will also be more open.
 - If it is not possible to talk about sexuality it will be difficult to talk about HIV and AIDS because both are closely related.
 - Not talking openly about sexuality, especially with young people, means that they may depend on inaccurate information from their peers, which may put them into risk.

Exercise 7.

Breaking shame: Talking about sexual terms

This game is an amusing way to help participants learn to talk openly and neutrally about sexual organs and relations. It trains participants not to feel ashamed and strengthens their ability to talk about these body parts and sexuality in a serious way.



Purpose

- To help participants break barriers to talking about sex organs and sexual relations closely connected with HIV and AIDS, and to prepare them to discuss these matters openly, neutrally and without shame.



Preparation

- Write the words “Breast”, “Penis”, “Vagina” and “Sexual relations” separately on four flipchart sheets.



Time

- 30 minutes



Facilitation

- Explain the exercise to the participants.
- Divide the participants into four small groups (possibly according to gender) and give each group a marker pen and one of the flipchart papers with a word written on it.

- Invite the participants to brainstorm local terms for their word, and to write these terms on the paper.
- After 5 minutes, the groups exchange their papers with another group.
- Each group brainstorms local equivalents for their new word and writes these on the paper. After 5 minutes, they again swap papers, until each group has seen all four papers.
- Bring the groups back to the plenary and invite volunteers from each group to read out the terms written on their paper. They should read out the local terms seriously!

Exercise 8.

Wildfire simulation: Sexual networks and HIV transmission

This exercise simulates the spread of HIV in a hands-on manner. Participants experience emotions related to being HIV-positive. Although this is a simulation, not reality, the facilitator should be sensitive to participants’ reactions and fears of being HIV-positive.



Purpose

- To enable participants to experience some of the emotions associated with HIV transmission, and to reflect on their perceptions of risk taking.
- To enable participants to experience some of the emotions associated with HIV infection.
- To illustrate that someone may be HIV-positive without showing any symptoms.



Preparation

- None



Time

- 30 minutes



Facilitation

- Ask all participants to stand in a circle facing inwards.
- Shake someone’s hand and explain this handshake is equivalent to having unprotected sexual intercourse.
- Ask everyone to close their eyes. Explain that you will touch 3–5 people on the shoulder. For the purpose of this activity, this means these people will be HIV-positive. Those who are HIV-positive must not tell others about their status.

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- Touch 3–5 people on the shoulder (everybody must keep their eyes closed!).
- Ask everyone to open their eyes. Ask if anybody can see who may possibly be HIV-positive. (This makes the point that HIV infection does not change someone’s physical appearance.)
- After the discussion, invite the participants to walk around and shake hands with 2–4 other participants. The participants should remember whom they shook hands with.
- Ask everybody to sit down in a circle facing inwards.
- Invite the first HIV-positive participants (whom you touched on the shoulder) to stand up.
- Then ask all the participants who shook hands with these individuals to stand up. Explain that these people are possibly infected.
- Then ask all those who shook hands with these individuals to stand up. Then all those who in turn shook hands with the new group.
- Explain that everyone who has stood up is either infected or at risk of infection. Ask them to move inside the circle.
- Ask participants how they felt when they were waiting to be touched on the shoulder.
- Ask the participants inside the circle: “How do you feel knowing that you might be infected?” “Would you change your sexual behaviour?”
- Ask the ones outside: “How do you feel knowing that you are not at risk of being infected?” “Would you change your sexual behaviour?”
- Finally, start a discussion on sexual networking. Emphasize that the 3–5 people who were first infected may have infected everyone they had sexual contact with, and that these potentially newly infected persons may have passed on the infection to their partners. Highlight the fact that the virus does not change the infected person’s physical appearance. Discuss the idea of voluntary counselling and testing. Encourage participants to ask questions about HIV transmission, prevention, counselling and testing, etc.

Exercise 9.

Internal mainstreaming: HIV and AIDS and my workplace

This exercise puts the participants in the shoes of someone who is HIV-positive. It asks them to think what they would fear in their workplace, and what they would wish for at work.



Purpose

- To start the process of internal mainstreaming with the involvement of all staff members.
- To reflect on which options for internal mainstreaming should receive attention, and to highlight favourable options.



Preparation

- Write the following question on flipchart paper: “Imagine you are tested positive for HIV. What would your wishes and fears in your workplace be?”



Time

- 1 hour



Facilitation

- Explain that in this exercise, participants should assume they are HIV-positive. They should express their wishes and fears concerning the workplace.
- Introduce the question you have written on the flipchart.
- Give each participant six cards: three of one colour (for “wishes”) and three of another colour (for “fears”).
- Ask the participants to write their three biggest wishes on one set of cards (one wish per card) and their three biggest fears on the other cards.
- After 10 minutes, collect the cards and pin them on the wall (or spread them on the floor), clustering together cards with similar answers.
- Lead a discussion about the wishes and fears participants have expressed.
- Summarize the session (See → Table 7 for an example).

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Table 7. Example of the results of brainstorming on fears and wishes concerning HIV infection and the workplace

My fears if I were HIV-positive	My wishes if I were HIV-positive
<ul style="list-style-type: none"> • I would fear to lose my job because they would think I will become incapacitated with HIV and AIDS. If not sacked I would fear stigmatization. • To be discriminated against as a worker. To be terminated. • To be pointed at by fellow staff members. Inability to execute my normal official duties. Losing my job. • Symptomatic looks would indicate my predicament. Fear I may lose the job, if the organization comes to know about it. • Who will look after my children? Who will provide basic needs for them? Failure to realize my dreams. The daily intake of ARVs if I get them. Looking unhealthy. • Losing my job. My colleagues' reactions towards me. How to deal with my responsibilities? • Expelled from work. Neglected by my fellow workmates. • Fear to be replaced before I resign. Not to see the benefits of my sweat (pension). • What will the other officers and my boss think about me? Who will take over my responsibilities? 	<ul style="list-style-type: none"> • Support from the organization in terms of treatment and my family. To get a decent burial. • My workplace should help me to create a sustainable income-generating activity for the good of my family. • To hand over to someone else. To tell my boss to get me a good counsellor. To see a priest for prayers. • To be “contagious” (in talking openly about HIV and AIDS). To accept my situation. • To continue at workplace to sustain my family to the end. That the deadly virus would be limited to me, excluding my spouse. • Organization to help my family mostly my children via education. • To be taken or treated like any other patient of any other disease – say malaria. To be left to continue working so that I can get money to support my family and myself. • To die when I have finished a house for my family. To subscribe to health insurance. To get a genuine caretaker for my children. Have a genuine property manager for my children’s estate. • I am accepted by my workmates. They open up to me about HIV and AIDS and related diseases. Make me an ambassador of HIV and AIDS.

Modified from a workshop on HIV/AIDS mainstreaming, Uganda, March 2008.

Exercise 10.

Key considerations for a workplace policy on HIV/AIDS

In this kick-off exercise, small groups of participants brainstorm key considerations for developing a workplace policy on HIV/AIDS and its content. After this session, work groups or an HIV/AIDS committee should be formed to carry forward the internal mainstreaming process. See → Section 1.4 for more.



Purpose

- To stimulate all staff members to consider the process and key issues of internal mainstreaming.



Preparation

- Write the following questions on separate flipchart sheets:
 - “What needs to be considered before developing a workplace policy on HIV/AIDS?”
 - “Which aspects should a workplace policy on HIV/AIDS address?”



Time

- 1 hour



Facilitation

- Explain that the participants will reflect on key considerations for developing a workplace policy on HIV and AIDS

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(such as human resource regulations and procedures of the organization, other local, national and international regulations or existing workplace policies).

- Stress that internal mainstreaming concerns all staff in the organization. Explain that it addresses the information on HIV and AIDS, the prevention of HIV and the mitigation of its effects on infected and affected staff members and on the organization.
- Divide the participants into small groups, and give one of the questions to each group. If there are more than two groups, have several groups discuss each of the questions. If more than 60 minutes are available, the groups can discuss both questions.
- The groups discuss their question for 30 minutes and write their responses on flipchart paper (see → Table 8 for an example of responses).
- Invite the groups to present their results to the plenary. Invite everyone to raise questions and concerns or give ideas.
- Provide comments and inputs if needed, and summarize the results of the discussion.
- Invite the participants to discuss what should happen next. Record the necessary steps and who should be responsible.
- If the management has agreed in advance, elect an HIV/AIDS workplace committee to use the results of this exercise to bring the process of internal mainstreaming forward.

Table 8. Example of key considerations for a workplace policy on HIV/AIDS

What needs to be considered before designing a workplace policy on HIV/AIDS?	Which aspects should a workplace policy on HIV/AIDS address?
<ul style="list-style-type: none"> • Awareness and scope of HIV and AIDS problem for the workplace and the individual • Gather information in a sensitive way on how staff are affected by HIV and AIDS • Examine existing policies and the organizational culture (maternity leave, sick leave, compassionate leave, etc.) • Examine the existing national policy • Identify aspects for referral • Take into consideration staff participation and needs • Information from other organizations like TASO* and networking • Commitment of the employer 	<ul style="list-style-type: none"> • No discrimination, no stigmatization • Access to treatment • Financial support (sick staff, orphans, widows and widowers – scheme with policy guidance) • Clearly spelled-out rules and regulations regarding sickness, loss of a person, burials, caring for the sick (immediate family members) • Clear terms and conditions of employment vis-à-vis spouse and children • Visitations and follow-ups of the sick • Staff empowerment and education on HIV and AIDS (capacity building) • Respect for people’s rights (confidentiality, voluntary testing, secrecy, and control reactions) • Job security and pension • Insurance for those affected while working for an organization • No judgmental attitude

Modified from a workshop on HIV/AIDS mainstreaming, Mbarara, Uganda, March 2008.

* TASO (The AIDS Support Organisation) is a local AIDS organization in Uganda.

Exercise 11.

External mainstreaming: HIV and AIDS as a development issue

This exercise shifts the focus to external mainstreaming. Groups of participants who work in the same project component or with the same target groups discuss how HIV and AIDS are linked with their work.



Purpose

- To sensitize staff on the linkages between HIV and AIDS and their work with target groups.
- To initiate the process of external mainstreaming with the involvement of all staff members.



Preparation

- Write the following questions on a flipchart:
 - “How am I affected by HIV and AIDS in my daily work with project target groups?”
 - “What are the specific linkages between HIV and AIDS and my core activities?”



Time

- 1 hour



Facilitation

- Introduce the topic of external mainstreaming and explain that it is concerned with the project’s target groups. Therefore it is important to reflect on linkages between HIV and AIDS and the project’s activities.
- Introduce the guiding questions to the participants.
- Divide participants into groups according to their project components (or target groups) and ask them to respond to the guiding questions.
- Individual participants think of their own responses, then discuss them in their groups. They write their responses on flipchart paper.
- After 20 minutes, bring the groups together and ask them to present the results of their discussions. Invite the other participants to comment on each group’s presentation.

Exercise 12.

Wrap-up of Phase I



Purpose

- To summarize Phase I and prepare participants for Phase II of the mainstreaming process.



Preparation

- Agree with management on activities and dates for Phase II.



Time

- 30 minutes–1 hour



Facilitation

- Invite participants to recap and evaluate Phase I.
- Summarize the discussions and conclusions. Add those missed during the recap and evaluation.
- Remind the participants that they will analyse the linkages between HIV and AIDS and project activities in depth during the next phase, which covers the external mainstreaming process.
- Briefly outline what participants can expect in the next phase, and inform them where and when it will take place.

Possible additional activities in Phase I

These ideas refer mainly to the internal mainstreaming process.

- Set up tables to display pamphlets and further reading on HIV and AIDS, useful addresses for support, counselling and testing, and a box for anonymous suggestions. Display posters on the wall and show films on HIV/AIDS after the session.
- Arrange for participants to elect HIV/AIDS focal-point representatives.
- Arrange to have HIV and AIDS included on the organization’s agenda on a regular basis.

3.3 Phase II: Analysis

Both project management and staff need to be sensitive and perceptive in order to develop a strategy to put HIV and AIDS into the mainstream of development work.

They have to be aware of factors that make various target groups vulnerable to HIV infection and to the effects of HIV and AIDS. They have to understand the linkages between HIV and AIDS and the project's core activities. They should analyse how HIV and AIDS affect the project's objectives and results. Conversely, they should know how the project and its various components impact on HIV and AIDS, and whether the project mitigates or aggravates the HIV and AIDS situation.

We can analyse the relationship between HIV and AIDS and the project's core activities from two angles:

- **Management and staff perspective:** the project management and staff examine the linkages based on their own experiences. We discuss this in Phase II-1.
- **Target group's perspective:** staff members analyse the situation in the field to elicit the target group's views. We discuss this in Phase II-2.

These analyses will enable projects to identify entry points for mainstreaming.

3.4 Phase II-1: Analysis from the management and the staff perspective



Expected results

Staff members:

- Are sensitive to the root causes of HIV infection and the effects of HIV and AIDS.
- Are aware of the factors that determine the vulnerability of the different target groups.
- Have identified gender-related vulnerability factors.
- Are aware of the effects of HIV and AIDS on the various project components.
- Are aware of positive and unintended negative side-effects of their project components on HIV and AIDS.
- Have understood that networking with other stakeholders is crucial to ensure the effectiveness of HIV/AIDS mainstreaming.

- Have identified possible networking partners in the surrounding area.
- Have identified key areas for mainstreaming.



Overview

- Exercise 13. Root causes of HIV infection and effects of HIV and AIDS on a specific target group
- Exercise 14. Effects of HIV and AIDS on project work
- Exercise 15. Effects of project work on HIV and AIDS
- Exercise 16. Gender perceptions
- Exercise 17. Service provider list
- Exercise 18. Wrap-up of Phase II-1



Estimated time needed

- 0.5–1 day



Participants

- All staff



Materials

- Flipchart and paper
- A4 paper
- Board or tables
- Coloured markers
- Coloured cards
- Glue or sticky tape
- Coloured stickers.

Exercise 13.

Root causes of HIV infection and effects of HIV and AIDS on a specific target group

In this exercise, the participants use a problem tree to map out the root causes of HIV infection and the effects of HIV and AIDS for a specific target group. The problem “HIV and AIDS”, written on the trunk of tree, is visible for everyone. The roots of the tree symbolize the problem's causes. These are often hard to understand, so lie deep “under the soil” and may be invisible. The effects of a problem are usually more visible and easier to understand, and are symbolized by the branches and top of the tree (→ Figure 6).

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Purpose

- To analyse the root causes of HIV infection among a specific target group.
- To analyse the effects of HIV and AIDS on a specific target group.



Preparation

- Draw a large tree on a flipchart.



Time

- 1 hour



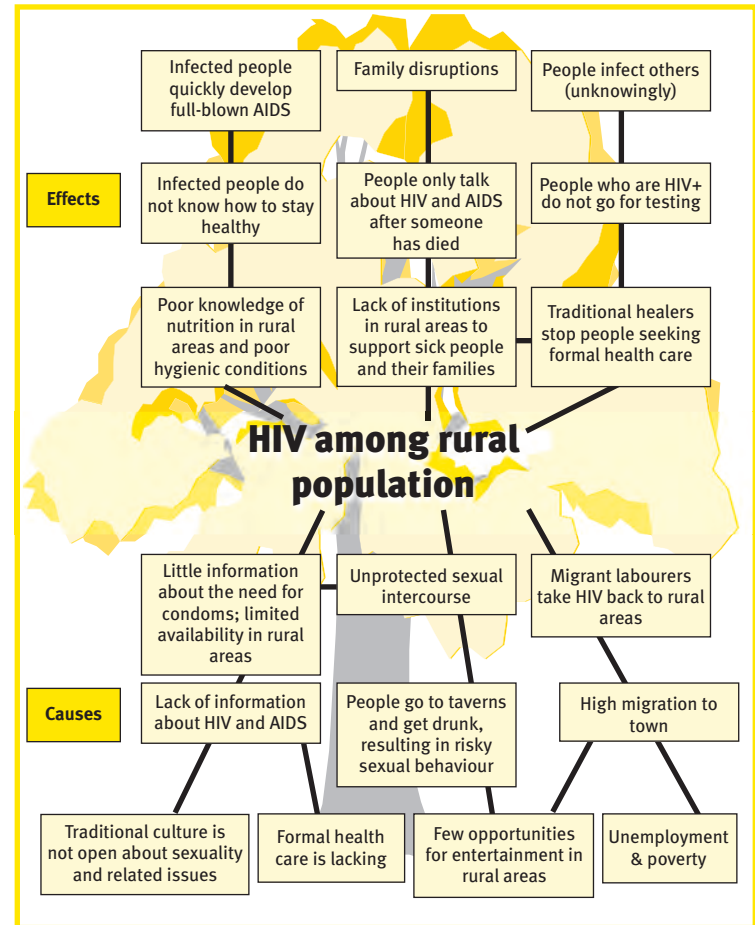
Facilitation

- Show the participants the drawing of the tree. Explain what it means, and explain the idea of logical connections between causes and effects.
- Ask the participants to name their specific target group or their field of project work: for example, farmers, traders, young people, women, people attending literacy classes, people in region X; or microfinance project, rural development project, project on justice and peace, or on women and development.
- Tell the participants that they will draw problem trees related to HIV and AIDS for these target groups or field of project work. Invite the participants to divide into groups, with one group for each specific target group or project type.
- Give each group a piece of flipchart paper and ask them to draw a tree on the paper. Each group writes its specific problem on the trunk of the tree, e.g., “HIV and AIDS among farmers”.
- Ask the groups to identify the root causes that contribute to HIV infection among their target group. They should write these root causes on the tree roots. They should draw lines showing how the causes are related to each other.
- Ask the groups how HIV and AIDS affect their target group. They should emphasize conditions that make the target group vulnerable to the effects of HIV and AIDS. For instance, paying for treatment may mean that people can spend less on food and other items; children may drop out of school so they can earn money. Or a lack of labour for farming may reduce yields, leading to food insecurity and to less seed for the next planting season. The participants write these effects in the tree branches. They draw lines to show how the problem on the trunk leads to the effects, and how the effects are related to each other.
- To make this easier, the participants can write ideas on cards and

- sort them before placing them in the appropriate place on the tree.
- Each group then discusses which of the root causes and effects are already being addressed in their project component. They mark these in green.
- The groups discuss which other causes and effects they can approach without changing their core activities. They mark these in red.
- After 25 minutes, the groups present their problem trees to the plenary.
- Facilitate a discussion on which of the root causes and effects will be addressed within the mainstreaming process.

Figure 6. Example of a problem tree

Source: Modified from diagram from Umthathi mainstreaming HIV/AIDS workshop, Grahamstown, South Africa, June 2004.



Exercise 14. Effects of HIV and AIDS on project work

In this exercise, participants draw an “effect diagram” showing how HIV and AIDS influence the core activities of their project component (→ Figure 7).



Purpose

- To analyse the effects of HIV and AIDS on the core activities of the project.

- To identify key areas for mainstreaming.



Preparation

- Prepare questions.



Time

- 1 hour



Facilitation

- Introduce the idea of an effect diagram and describe how it allows an analysis of the effects of HIV and AIDS on the project’s objectives and results.

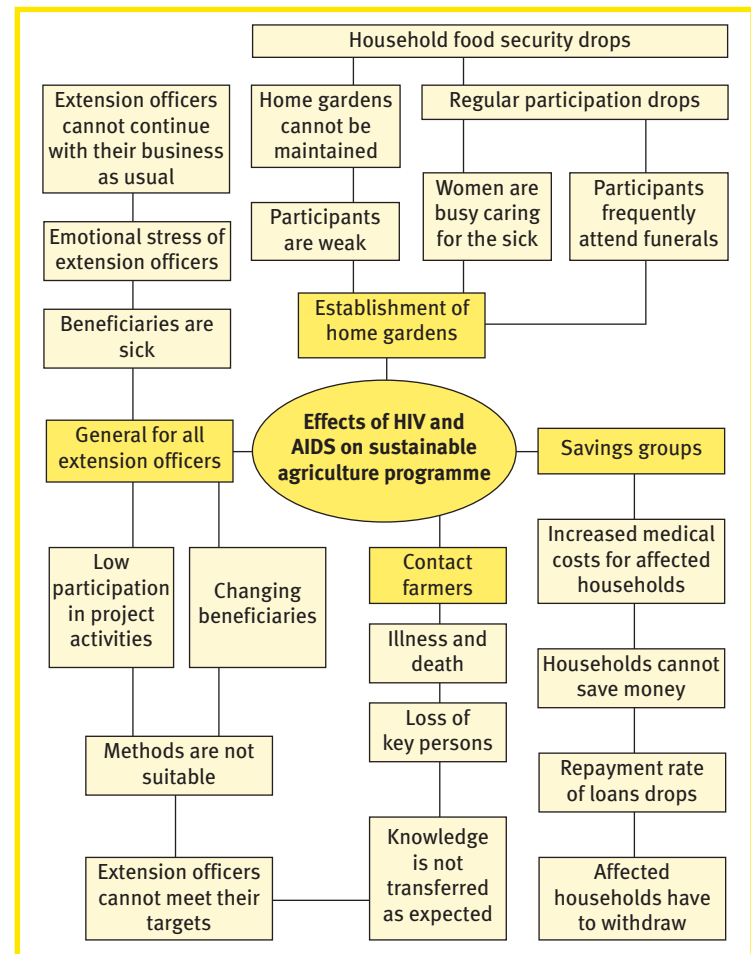
- Demonstrate how to create an effect diagram. Write a question in the centre of a flipchart, for example, “How do HIV and AIDS influence food security?”, or “How do HIV and AIDS affect the gender and development project?”
- Invite participants to suggest responses to this question.
- Write their answers on cards and put them in a logical order to form an effect diagram. Explain that it helps to identify logical chains and inter-linkages. Stress the importance of an in-depth approach and considering all aspects of the project’s core activities. Make sure that everybody has understood how the effect diagram works.
- Divide the participants into groups according to the project component they work on. Invite each group to create an effect diagram to answer the question, “How do HIV and AIDS influence project component X?” (e.g., rural development). → Box 20 has some suggestions for more detailed questions to stimulate ideas.
- The groups write their question in the centre of a flipchart paper.
- Individual group members think of how HIV and AIDS influence on their project component, and write their ideas on cards.
- The group collates their ideas and place the cards in a logical order around the central question, as in → Figure 9. They should discuss the

effects and the logic in detail so as to agree on the final effect diagram.

- After the diagram has been drawn, the group marks with stickers some key areas of concern, such as “Agricultural methods are not appropriate” or “Loan repayment rate drops”.
- After the following session (→ Exercise 15), invite the groups to present their effect diagrams to the plenary.

Figure 7. Effect diagram developed in answer to the question: “How do HIV and AIDS affect a core activity of your project component?” (the project component was sustainable agriculture)

Based on diagram from the ACAT (Africa Co-Operative Action Trust) mainstreaming HIV/AIDS workshop in Howick, KwaZulu-Natal, South Africa, May 2004.



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Box 20. Some key questions on the effects of HIV and AIDS on the project

- How do HIV and AIDS influence the different components of the core activities?
- How far are the project's objectives still achievable?
- To what extent are the target groups affected by HIV and AIDS?
- To what extent are the original project objectives compatible with the changed situation resulting from HIV and AIDS?
- How do HIV and AIDS affect the work of extension officers?
- What kind of modifications and adaptations to the core activities are necessary because of HIV and AIDS?

Exercise 15. Effects of project work on HIV and AIDS

This exercise uses an effect diagram to analyse how the project's core activities influence HIV and AIDS. → Figure 8 shows an example of such an effect diagram.



Purpose

- To analyse how the project's core activities influence HIV and AIDS, both positively and in an unintended negative way.

- To identify key areas for mainstreaming.



Preparation

- None



Time

- 1 hour



Facilitation

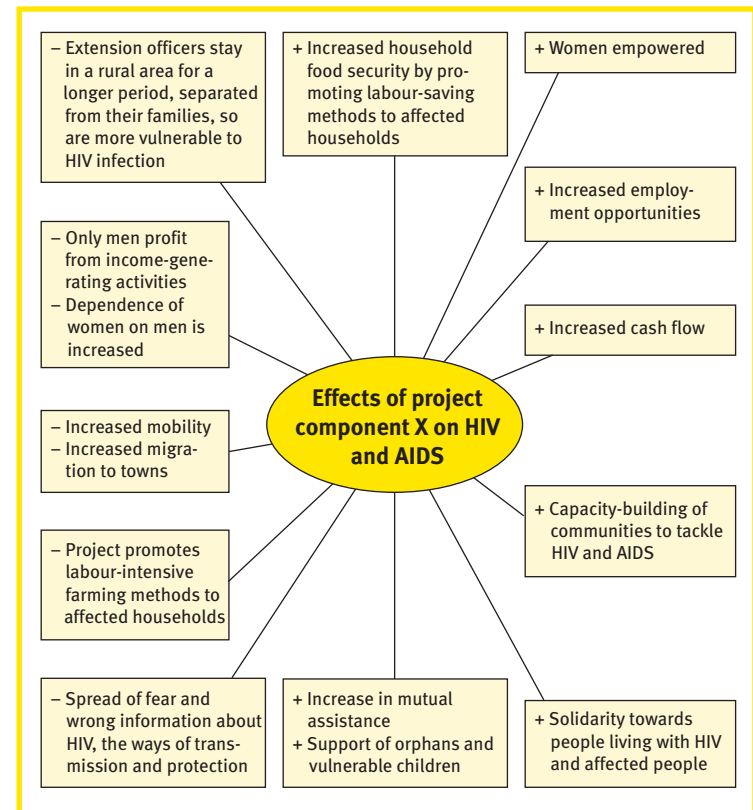
- Explain that the participants will draw a second effect diagram, this time to analyse the effects of the project of HIV and AIDS.

- Stress that the project's effects may be:
 - **Positive:** reducing the spread of HIV or reducing the effects of HIV and AIDS on target groups.
 - **Negative:** unintended consequences that increase the spread of HIV or make life more difficult for people who are affected.

- **Neutral:** effect is neither positive nor negative in terms of HIV and AIDS.

- Invite the same groups as in → Exercise 14 to construct a diagram showing the effects of their project component on HIV and AIDS. They write the name of their component in the centre of the diagram, then write the effects around this, as in → Figure 8. They should take an in-depth approach and consider all working areas of the component. → Box 21 has some suggested questions to stimulate their ideas.
- After they have completed their effect diagram, the group marks some possible key areas for mainstreaming.

Figure 8. Positive (+) and negative (-) effects of a project on HIV and AIDS. Example of an effect diagram with the central question: "How do the core activities of a project component influence HIV and AIDS"?



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Box 21. Some key questions on the effects of project work on HIV and AIDS

- How does your project component help curb the spread of HIV?
 - How does your component empower communities to tackle the causes and effects of HIV and AIDS?
 - How does your component directly address the needs of the affected households?
 - How does your component empower communities to tackle the causes and effects of HIV and AIDS?
 - How do the project activities influence the power structure within the community?
 - How does your component empower women?
 - How do the project activities influence gender relations? In how far do the activities aggravate gender inequality?
 - To what extent do the project activities result in increased mobility and migration of target groups and project staff, now and in the future?
 - What are the unintended negative side-effects of project activities that make target groups more vulnerable to HIV infection and to the effects of HIV and AIDS?
-
- Invite the groups to present the two diagrams (from Exercise 14 and this exercise) to the plenary. The groups should highlight possible key areas for mainstreaming, and indicate unresolved questions.
 - Encourage the participants to comment on the analyses, focusing on the similarities and differences between project components and the implications for mainstreaming.
 - Record the potential mainstreaming areas in each project component on the flipchart.

Exercise 16. Gender perceptions

This activity stimulates discussions on gender roles in a given society, gender-related vulnerability to HIV infection, and the effects of HIV and AIDS.



Purpose

- To make participants aware of their own views about the specific roles, perceptions and tasks of women and men in the society.
- To make participants aware of the linkages between HIV and AIDS and gender.



Preparation

- Prepare 10 statements concerning “typical” role perceptions and tasks of men and women in a society. See → Box 22 for some possible statements. Adapt these to suit your needs.
- Write the numbers 1 to 10 on cards (one number on each card). On the card with the number 1, write “I totally agree”. On the number-10 card, write “I totally disagree”.

Box 22. “Typical” role perceptions of men and women

- A real man does not show emotions.
- Boys should have a better education than girls.
- Children belong to the women.
- Property such as house and land belongs to the man and his family.
- Childcare is a real women’s job.
- A wife should never contradict her husband in public; a daughter should not contradict her father.
- The mother is the most important person for a child.
- A man should have several girlfriends to prove that he is a real man.
- The man should have a larger income than the woman.
- Women are not good in decision making.
- The husband is the head of the family.
- A wife has to be submissive.
- A married woman cannot say no to her husband if he asks for sex.
- Women take care of the sick.

You can also change the statements to the opposite: for example:

- A woman should have several boyfriends.
- The father is the most important person for a child.
- Men take care of the sick.

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Time

- 30 minutes



Facilitation

- Explain that the exercise aims to assess opinions about the roles, perceptions and tasks of men and women in the society in order to identify gender-related vulnerability factors to HIV and AIDS.
- Point out that there is no wrong or right answer in this exercise. Different opinions are subject to discussion.
- Lay out the cards in a line on the floor, to make a scale from 1 to 10. Explain that the number 1 on the scale means “I totally agree” and number 10 means “I totally disagree”. Tell the participants that you will read out different statements and ask them to position themselves somewhere on the scale.
- Read out the statements. After each statement, ask some of the participants who agreed and who disagreed with the statement to explain their position. Allow a short discussion about the reasoning behind the majority and the minority opinions.
- Lead a discussion related to gender and HIV and AIDS. Some questions to guide this discussion:
 - How do gender roles increase vulnerability to HIV infection and to the effects of HIV and AIDS?
 - What is the difference between sex and gender regarding HIV and AIDS? (→ Chapter 2).
 - What does it mean for individuals in different social groups (women, men, young women, young men, etc.) in the society to be **infected** with HIV?
 - What does it mean for different social groups in the society to be **affected** by HIV and AIDS (for example, if family members are HIV-positive)?

Adapted from InWEnt (2007)

Exercise 17. Service provider list

In this exercise, participants compile a list of local service providers relevant to HIV and AIDS and other development fields.



Purpose

- To compile information among staff members on existing regional and local service providers related to HIV and AIDS and other development fields in order to facilitate inter-sectoral cooperation.



Preparation

- Write headings for different categories of service providers on flipchart sheets. For example, “Local clinics”, “Hospitals”, “Home-based care organizations”, “Development projects”, etc. If necessary, subdivide the categories further (e.g., “Income-generating projects”, “Nutrition projects”, “Water and sanitation projects”, etc.).
- On each sheet, draw columns for Organization, Activities, Resource person and Intervention area (→ Table 9).
- Put the sheets up on the walls around the room.



Time

- 30 minutes



Facilitation

- Explain that creating a list of local service providers lets the organization know who is doing what on HIV and AIDS, and who might be a potential partner for collaboration or networking.
- Introduce the categories and column headings. Encourage participants to suggest more categories of organizations.
- Invite participants to walk around the room and fill in the lists.
- Read out all the information on the lists so that participants can cross-check the information (delete double entries, correct spellings and numbers, etc.).

Table 9. Example of a service provider list

Organization	Activities	Resource person	Intervention area
Positive Living	Voluntary counselling and testing	Mrs Bola	Ayedun village
...
...

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Exercise 18. Wrap-up of Phase II-1

The next stage of the mainstreaming process – Phase II-2 – is where the views of target groups are incorporated into the process. This session wraps up the current phase and tells participants what to expect for the next phase.



Purpose

- To recap and allow participants to evaluate the sessions in Phase II-1.
- To conclude and remind participants what they have covered during this phase.
- To prepare participants for the next phase in the mainstreaming process, and inform them about other planned follow-up activities.



Preparation

- Discuss with management the dates and procedures for → Phase II-2 and other follow-up activities.



Time

- 30 minutes – 1 hour



Facilitation

- Inform the participants about the next phase of the mainstreaming process, where the views of the target groups are incorporated into the process.
- Discuss with the participants when this next phase will take place and summarize what it will consist of.
- Discuss with participants about other follow-up activities, such as staff training.

Follow-up to Phase II-1

The mainstreaming activities so far may have identified the need for other follow-up activities. For example, perhaps additional staff training on HIV and AIDS is needed. You should discuss such needs and activities with the participants and the management and they should plan them as appropriate.

→ Box 23 gives an example of planning for such activities.

Box 23. Training of personnel of DERN (Développement Rural du Nord), Rwanda, on HIV/AIDS mainstreaming

An initial mainstreaming workshop with DERN's coordination and supervision team identified a need to train all staff members about HIV and AIDS. The organization planned a series of training courses for its staff and contracted resource persons to conduct this.

Problem: Lack of staff knowledge on HIV and AIDS
Objective: Strengthen the capacity of field personnel in HIV and AIDS

Activities	Period	Source of verification	Responsible persons	Budget (Rwandan francs)
Identify resource persons	Apr 2008	List of identified resource persons	Coordinators and supervisors of extension workers (management)	0
Contact resource persons	May 2008	List of contacted resource persons	Coordinators and supervisors of extension workers (management)	150,000
Select partners	Jun–Jul 2008	Contract of partnership	Coordinators and supervisors of extension workers (management)	0
Train coordinators and supervisors	Sep 2008	Number of persons trained	Resource persons	805,000
Train extension workers	Oct 2008	Number of extension workers trained	Management	1,440,000
Total				2,395,000

Source: Modified from operational plan developed during the DERN mainstreaming HIV/AIDS workshop, Musanze, Rwanda, March 2008. DERN works with farmer groups to increase their agricultural and animal production and supports them in their technical and organizational capacities and self-help potentials.

3.5 Phase II-2: Analysis from the target group's perspective

Basing the mainstreaming solely on the project staff's perspective would not produce the best results. So the staff should carry out a situation analysis together with representatives of the project target group to learn their opinions and to gather first-hand information on location-specific root causes of HIV infection (economic, social, cultural etc.) and the effects of HIV and AIDS on individuals, households and communities. The results will be used to adjust project activities to better address the root causes of HIV infection and the effects of HIV and AIDS on the target group. This phase may lead also to community action.

Other issues that project staff cannot tackle may need the involvement of specialized resource persons. You should make this clear to avoid raising expectations among participants that cannot be fulfilled.

The situation analysis in this phase covers three themes:

- The target groups' general knowledge on HIV and AIDS
- The root causes of vulnerability to HIV infection
- The effects of HIV and AIDS.

The situation analysis can be done in two ways:

- You can invite representatives of target groups from various communities to a single workshop at a central venue. This provides insights into the situation in several places and allows comparison among them, but may take more organization and mean incurring higher costs.
- You can conduct workshops in different communities. This approach is likely to stimulate more intense discussions because the participants know each other. This option is the one referred to in this guide.

Allow enough time to prepare the tools needed for the situation analysis. For example, it is important to formulate appropriate questions to stimulate the discussions. Depending on the circumstances, it may not be advisable to ask for certain types of information directly. Consider instead posing questions on child-headed households, single- or elderly-headed households, and people being sick. These questions do not refer to HIV and AIDS directly, so create fewer suspicions. It is also

important to translate key words into the local language. If a straightforward discussion is not possible, you may have to use other means, such as questions or pictures as entry points.



Expected results

Staff members:

- Have a better understanding of how far their target groups are aware HIV and AIDS.
- Are aware of myths and misconceptions about HIV and AIDS among the target groups.
- Gain insights into specific factors (including gender-related factors) that make the target groups vulnerable to HIV infection and to the effects of HIV and AIDS.
- Gain insight into the extent of HIV and AIDS in the communities.

Selected target group members:

- Are sensitized to the causes of HIV infection and effects of HIV and AIDS (including gender-related issues).
- Are aware of HIV and AIDS-related stigma and discrimination.
- Are motivated to address HIV and AIDS-related issues.



Overview

Day 1

- Exercise 19. Workshop opening
- Exercise 20. Voting with the feet
- Exercise 21. Assessing knowledge
- Exercise 22. Presentation on HIV and AIDS
- Exercise 23. Root causes of vulnerability to HIV infection: Hotspot map
- Exercise 24. Gender roles, HIV and AIDS

Day 2

- Exercise 25. Root causes of HIV infection and effects of HIV and AIDS
- Exercise 26. Social customs and HIV and AIDS
- Exercise 27. Family dynamics
- Exercise 28. Way forward: Pocket voting and community planning
- Exercise 29. Close

Estimated time needed



- 1–2 days

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Participants

- All staff
- Members of the respective target group



General preparations

The awareness phase will have sensitized the staff on the root causes of HIV and the effects of HIV and AIDS concerning the target group. This phase requires the staff involved to act as facilitators in a workshop with representatives of the target group.

If the staff cannot answer questions adequately, they should make the limits of their knowledge clear and refer to individuals who are familiar with HIV/AIDS. Consider organizing a separate session after the workshop to answer these questions.



Preparation for staff

- Hold a planning session with the staff who will participate in the situation analysis.
- Present the objectives and methods to use. If the staff members are familiar with other methods to achieve the same objectives as presented below, they may choose to use these.
- Invite the staff members to form small teams of individuals who usually work together. Each team will facilitate sessions with different groups of participants drawn from the target group. Working in teams has several advantages: several sites can be covered, the staff will not outnumber the target group members, and all team members can play an active role. The team members should be familiar with the target groups they will work with.
- Clarify the individual responsibilities within each team (facilitation and co-facilitation of various tools, documentation during the workshop, final documentation, logistics, informing target groups, etc.).
- Each team visualizes the methods it will use, prepares guidelines to introduce the methods, formulates questions to stimulate discussions, etc. These guiding questions should relate to general knowledge on HIV and AIDS, root causes and effects.
- Prepare a list of key terms covering HIV and AIDS, health, sexuality, and so on. Some of these terms may not exist in the local language, so staff will need to find equivalent terms or use pictures to get their message across to the target groups.
- Prepare the logistics for the situational analysis (→ Box 24).

Box 24. Logistics for the situational analysis

- **Location:** One central place.
- **Venue:** The choice of venue is important for the atmosphere at the workshop. It should be large enough to accommodate all participants and be suitable for conducting plenary and group activities.
- **Catering:** Ensure that refreshments are provided.
- **Materials:** Ensure that sufficient flipcharts, pinboards, paper, coloured markers, stickers and other useful items are available.
- **Transport:** Arrange transport to bring staff and target group members to the venue.
- **Budget:** Ensure that funds to cover transport, materials, etc. are provided.
- **Information:** The target groups have to be informed well in advance.



Materials

- Flipcharts and paper
- Boards or tables
- A4 paper
- Coloured cards
- Coloured markers
- Glue or tape
- Scissors
- Other materials or visual aids (the participants may not be able to read or write).



Day 1

Expected results from Day 1

- The target groups' level of knowledge about HIV and AIDS is identified.
- Factors that make various target groups vulnerable to HIV infection (including factors that are gender-related) are identified.
- Linkages between gender roles and HIV and AIDS are analysed.

Exercise 19.

Workshop opening

This session introduces the aims of the workshop to the participants. The facilitator's opening speech is important – it should enable participants to understand the purpose of the workshop and feel comfort-

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able with the topic. The approach should depend on the project's work with the participants. One way is to pose questions that relate to the project's purpose. For a project on sustainable agriculture, for example, such opening questions might be:

- “How is it possible to increase agricultural production?”
- “Which factors may decrease agricultural production?”

Other possibilities:

- “Which factors keep people poor?”
- “Which factors hinder development?”

Even if participants do not mention HIV and AIDS in their response, they may still name other diseases, and the facilitator can use these as a bridge to introduce the topic of HIV and AIDS. That will make it clear why a project that does not normally deal with health issues has decided to work on HIV and AIDS.



Purpose

- To welcome the participants and introduce the main aims of the workshop.



Preparation

- Prepare an introductory presentation outlining the workshop aims and programme.
- Prepare visual aids, including a flipchart listing the workshop objectives, and another with the workshop programme.



Time

- 30 minutes



Facilitation

- Welcome the participants and introduce the participants, facilitators and project team.
- Present the workshop aims and programme. Outline some basic principles:
 - The project staff would like to learn about the topic of HIV and AIDS from the target group members so they can improve their work.
 - The workshop also aims to raise the participants' awareness on HIV and AIDS.
- Assure the participants that the information gathered is confidential and will be used solely to improve the project's work and the community's response to HIV and AIDS.

- Say that everybody is free to ask questions, and if someone feels uncomfortable, he or she should raise the concern openly or talk privately to one of the facilitators.
- Emphasize that the workshop's success depends on everyone's active participation. A common understanding of ground rules assures the workshop will run smoothly.
- Hold a brief evaluation after each session.

Exercise 20. Voting with the feet

This exercise makes participants to move around and acts as a humorous lead-in to the HIV and AIDS topic.



Purpose

- To put participants at their ease so they are free to talk about HIV and AIDS and to ask questions for clarification.



Preparation

- Formulate a set of questions about HIV or AIDS that can be answered with “yes” or “no”. Examples of possible questions:

- Can HIV be transmitted by sharing a spoon with a person living with HIV?
- Can HIV be transmitted:
 - During sexual intercourse?
 - By touching someone who is HIV-positive?
 - From a mother to her child?
 - By sharing the sharp instruments (razor blades, etc.)?
 - By kissing?
 - By blood transfusion?
- Can a grandfather be infected by HIV?
- Is there a cure for HIV infection?
- Is it visible that a person is HIV-positive?
- Do you think HIV and AIDS are a problem in your community?



Time

- 30 minutes



Facilitation

- Inform participants that this exercise will not give in-depth information about HIV and AIDS.

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- Tell participants that one corner of the room is the “Yes” corner, and the opposite corners is the “No” corner.
- Ask the first question related to HIV and AIDS. Invite the participants to vote by walking to the “Yes” or “No” corner.
- Ask some of the voters to explain why they have chosen their corner. Start a discussion about the issue in question.
- If voters change their opinion during the discussion, they can go to the other corner.
- Repeat this procedure with the remaining questions.

Exercise 21. **Assessing knowledge**

This exercise encourages participants to share their knowledge and experiences about HIV and AIDS. Separating the participants into age and gender groups makes it more likely that individuals will express their opinions and makes it easier to assess the knowledge of each group.



Purpose

- To find out more about the participants’ general knowledge of HIV and AIDS.
- To identify information gaps and misconceptions.
- To provide the participants with up-to-date information on HIV and AIDS.



Preparation

- Write a series of questions on HIV and AIDS on flipchart papers. Make several copies of this list – one for each group.

Possible questions:

- When did you first hear about HIV and AIDS?
- How did you come to hear about HIV and AIDS?
- How is HIV transmitted?
- How can HIV infection be prevented?
- What is the difference between HIV and AIDS?
- How do you find out if someone is HIV-positive or has AIDS?
- Which kind of treatment is available?

If HIV and AIDS are a taboo in the society, select questions that are sensitive.



Time

- 30 minutes



Facilitation

- Explain that participants are encouraged to share what they know about HIV and AIDS.
- Divide the participants into groups (if needed). Form groups to represent different social groups, e.g., women, men, young people. Ask the participants what the most appropriate groups are.
- Assign a facilitator to guide each group.
- Invite the groups to read and discuss the questions, and to record their answers on the flipchart.
- In the plenary, ask the groups to present and compare their answers.
- Tactfully correct any wrong or partially correct answers and clarify misunderstandings and misconceptions.

Exercise 22. **Presentation on HIV and AIDS**

This is a short, up-to-date presentation of basic facts and figures on HIV and AIDS. The presenter – preferably an HIV resource person – should have a good knowledge of HIV and AIDS so he or she can give correct explanations and answers.



Purpose

- To provide participants with information about HIV and AIDS.
- To correct misconceptions they may have about HIV and AIDS.



Preparation

- Prepare a presentation (perhaps using a flipchart) on:
 - The difference between HIV and AIDS.
 - The national and local prevalence of HIV.
 - How HIV can be transmitted.
 - How HIV progresses once someone is infected.
 - Options for prevention and treatment.



Time

- 1 hour



Facilitation

- Present the information in a clear and interesting way to the participants.
- During or after the presentation, encourage participants to ask questions and highlight what they have learned from the presentation.

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- Start a discussion about the participants' needs concerning HIV and AIDS and what the next steps should be. Make notes of the discussion to use in planning these steps. Clarify which of the needs can be tackled by the project staff, and which will need outside help.
- After the session, plan the next steps and make suitable arrangements to implement them.

Exercise 23.

Root causes of vulnerability to HIV infection: Hotspot map

Participants draw a rough map of their community and indicate “hotspots” where people are more likely to be at risk of contracting HIV. This can be an eye-opener for participants that not only obvious places such as “bars” can imply high risk.



Purpose

- To identify places, so-called “hotspots”, in the community where people are more likely to be at risk of contracting HIV.



Preparation

- Prepare guiding questions. For instance: “If you take a close look at places and infrastructure in your community, where do you think there is a risk of someone being infected by HIV? Please explain why.”



Time

- 1 hour

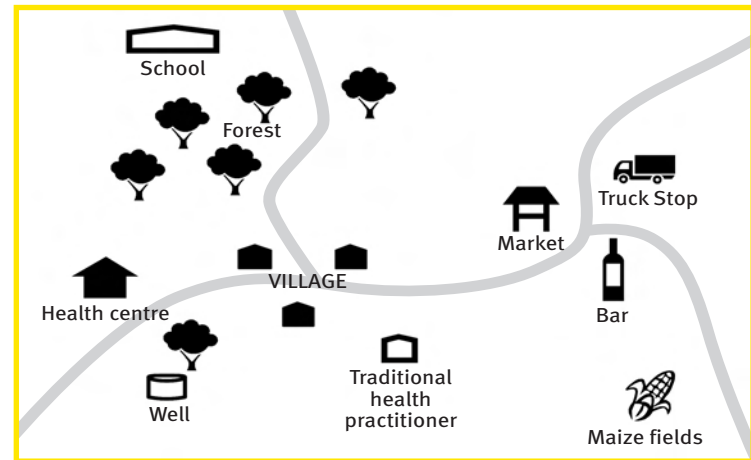


Facilitation

- Explain that the “hotspot map” will show places in the community where people are more likely to be at risk of contracting HIV (including sexual harassment).
- Tell participants how to draw a rough map of their community on a flipchart (or on the ground using sticks and leaves), highlighting places where people are more likely to be at risk of contracting HIV.
- Divide participants into several groups according to gender and age. Each group may be guided by a facilitator.
- Each group draws a general map of the area, showing towns, villages, rivers etc., then marks the hotspots on the map (→ Figure 9).
- The group discusses who is particularly at risk at each hotspot, and marks this on the map.
- Each group discusses how to minimize the risk situations.

- In the plenary, the groups present and compare their maps.
- Stimulate a discussion of the hotspots and the differences between the maps drawn by men and women and people of different ages. Point out that risky behaviour and sexual harassment are not confined to obvious places such as bars; they are also found at other everyday meeting points, such as markets and schools, as well as at hospitals and health centres (where people risk coming into contact with contaminated blood). Stress that everybody can be at risk at one hotspot or another.

Figure 9. Example of a map with hotspots in the community



Exercise 24.

Gender roles, HIV and AIDS

This exercise helps participants to become aware about the complex interlinkages between gender and HIV and AIDS. See also Sections → 2.3 and → 2.4.



Purpose

- To analyse the linkages between gender roles, expectations and perceptions towards women and men and their vulnerability to HIV and AIDS.



Preparation

- Write on a flipchart paper:
 - “What comes to your mind when you hear the words ‘man’ and ‘woman’?”

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- “What specific factors make women or men vulnerable to HIV infection?”
- “What makes women or men vulnerable to the effects of HIV and AIDS?”



Time

- 1 hour



Facilitation

- Explain that:

- People in a society look on women and men differently. They expect them to play different roles, do different things, and behave in different ways. This is what we mean by “gender roles”.

- That means that men and women are vulnerable to HIV infection in different ways, and they are affected in different ways.
- This exercise helps us understand the linkages between these gender roles and HIV and AIDS.
- Run through the questions on the flipchart. Check if anyone needs clarification.
- Divide the participants into groups of men and women, young and old. Each group may be guided by a facilitator.
- The groups discuss the questions and summarize their responses on a flipchart.
- Each group presents its results in the plenary.
- After all the presentations, facilitate a discussion covering these questions:
 - What does this mean for our community?
 - How can we reduce the vulnerability of men and women to HIV infection?
 - How can we reduce their vulnerability to the effects of HIV and AIDS?
 - How can the project assist us do this?
- Summarize the responses and discussion on a flipchart (→ Table 10 and → Table 11).

Table 10. Summary of groups' perceptions of women and men

Women's group	Men's group
<p>Women are:</p> <ul style="list-style-type: none"> • Housewives • Working women, breadwinners <p>Women's tasks:</p> <ul style="list-style-type: none"> • Child bearing • Nursing the family and children • Manager (of the house) • Caregiver of the family <p>Perceptions of society about women:</p> <ul style="list-style-type: none"> • If the wife is earning, her income is secondary • Girls are seldom sent to school • Women are emotional • If women are talking/discussing it is seen as gossip; discussions among men are seen as important <p>Perceptions of society about men:</p> <ul style="list-style-type: none"> • The father is the head of the household • The man/husband should be the breadwinner • If men are unfaithful, it is okay, but for women it is not good; people look down on them 	<p>Men are:</p> <ul style="list-style-type: none"> • Providers (if they have no income, they feel little) • Strong (do not cry, hide tears and emotions) • Macho type • Dominant character • Leaders • Achievers • Direct, to the point

Modified from a workshop on HIV/AIDS mainstreaming, Cagayan de Oro, Philippines, July 2008.

Table 11. Example of gender roles in relation to vulnerability to HIV infection and the effects of HIV and AIDS

Vulnerability to HIV infection	
<p>Women</p> <ul style="list-style-type: none"> • Economic dependency on men • Women often have to tolerate that their husbands have multiple partners • Women cannot negotiate safer sex 	<p>Men</p> <ul style="list-style-type: none"> • Peer-group pressure leading to multiple partnerships • Men have to prove they are “real men” • Separation of family because of work
Vulnerability to the effects of HIV and AIDS	
<p>Women</p> <ul style="list-style-type: none"> • Caregiver for the sick • Economic crises after death of husband might lead to “survival sex” • Women have little time to care for children because of loss of husband's income • In some societies, women are at risk not to inherit their husband's land and property (even though it is partly theirs) 	<p>Men</p> <ul style="list-style-type: none"> • Cannot be the breadwinner of the family any longer • Loss of respect in the society • Crisis in the family • Has to take care of children after death of wife • This new role might not be accepted in the society

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Day 2

Expected results from Day 2

- The root causes of HIV infection are identified.
- The effects of HIV and AIDS on individuals, families and community life are identified.
- The linkages between HIV and AIDS and local customs are identified.
- The way forward is planned.

Exercise 25.

Root causes of HIV infection and effects of HIV and AIDS

This exercise uses a problem tree to analyse the root causes of vulnerability to HIV infection and the effects of HIV and AIDS. For details of the problem-tree technique, see → Exercise 13.



Purpose

- To analyse the root causes of HIV infection in the community.
- To analyse the effects of HIV and AIDS on individuals, households and the community.



Preparation

- Draw a large tree on several flipchart sheets (one tree per sheet).
- Prepare cards with different headings to be placed in the branches: “Effects of HIV and AIDS on...”
 - Women, men, young people, children
 - Family life
 - Community life
 - Small businesses
 - Agriculture
 - Social customs
 - Others as appropriate.
- Prepare questions that can stimulate discussions of the causes of HIV infection and the effects of HIV and AIDS.



Time

- 1.5 hours



Facilitation

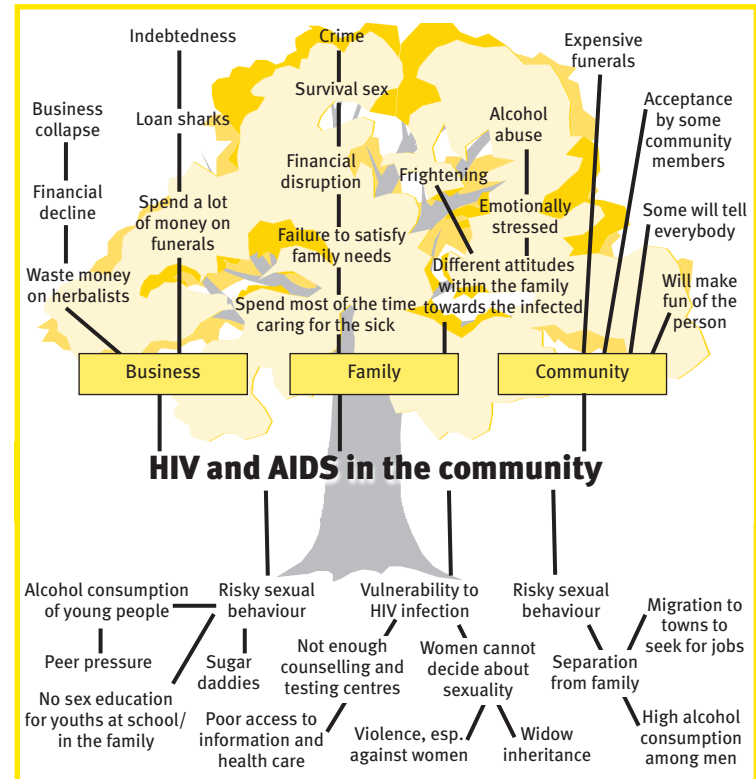
- Explain that participants will analyse the root causes of vulnerability to HIV infection and the effects of HIV and AIDS concerning them.
- Discuss possible problems with regard to project work, such as “HIV and AIDS among small-scale farmers”, “HIV and AIDS in the

community”, “HIV and AIDS among women”, or “HIV and AIDS among men”. Invite participants to suggest other problems to analyse.

- Write each problem on the trunk of one of the trees you have drawn on the flipcharts.
- Divide the participants into at most four groups, perhaps according to gender and age or interests. Assign a different problem to each group. Each group may be guided by a facilitator.
- Ask each group to analyse the root causes and effects of their problem, and to develop a problem tree. The groups can use cards to help organize the linkages between the causes and between the effects. See → Figure 10 for an example.
- Invite the groups to present their completed problem trees to the plenary. Facilitate a discussion on how to address some of the issues identified.

Figure 10. Example of a problem tree – HIV and AIDS in the community

Modified from a diagram produced at the village workshop in Sweet Waters with the Africa Co-Operative Action Trust, Howick, KwaZulu Natal, South Africa, September 2004.



Exercise 26. Social customs and HIV and AIDS

In this exercise, small groups of participants discuss local customs and how they relate to HIV and AIDS.



Purpose

- To sensitize the participants to the relationship between HIV and AIDS and social customs.
- To identify social customs that help prevent HIV and mitigate its consequences, as well as customs that contribute to the spread of HIV and worsen its effects.



Preparation

- Prepare questions on myths, misconceptions and traditional harmful practices.



Time

- 1 hour



Facilitation

- Introduce the topic: social customs and HIV and AIDS. Highlight the importance of customs in preventing new infections and in dealing with the effects of HIV and AIDS – for example, the mutual support provided by the members of the extended family and community. Mention that some traditions that used to be helpful may now increase the risk of HIV infection or exacerbate the effects of HIV and AIDS. Give an example (such as widow inheritance, where a woman whose husband has died of AIDS may infect her new husband with HIV).
- Explain that this exercise will identify traditions which are helpful in tackling HIV and AIDS, and some which are not.
- Divide the participants into groups according to gender and age. The groups may be guided by a facilitator.
- Encourage the groups to identify and discuss local customs that have a positive effect – that help to prevent new infections or strengthen the capacity of individuals, families and the community to cope with the effects.
- Then invite the groups to identify and discuss customs that have negative effects.
- Ask each group to write the customs on a flipchart or cards. They should mark the positive and negative customs with different sym-

bols. They may add explanations of why a particular custom mitigates or aggravates HIV transmission or the effects of HIV and AIDS.

- Invite the groups to discuss their results in the plenary.
- If the results from the groups differ, point out the diverging perceptions and opinions.
- Summarize the discussion.
- Facilitate a discussion of how the community could strengthen positive and modify negative customs.

Exercise 27. Family dynamics

This exercise uses pictures to enable participants to imagine how family life changes if a family member becomes HIV-positive, and how other community members could assist the affected household.



Purpose

- To sensitize participants on the effects of HIV and AIDS on individuals, families, and community life.



Preparation

- Prepare several sets of cut-out figures or photographs, each representing a different family, for example:
 - A father and mother with four young children of different ages and sexes
 - A single mother with infants and young children
 - A grandfather with his two grandchildren
 - A young girl with her younger siblings
 - A man with his two wives and three children
- On the reverse of each picture, draw a star against one person.



Time

- 1 hour



Facilitation

- Divide the participants into small groups. The groups may be guided by a facilitator.
- Give each group a set of cut-out figures or photograph.
- Invite the groups to “breathe life” into the family by discussing the following questions one after another:
 - What is the role of each person in the household?
 - What are the relations between the family members?

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- How does the family make a living?
- What are the dreams and goals of the family?
- What are the dreams and goals of each family member?
- What are the links between the family and the community?
- Participants look at the reverse side of the cut-out figures or photo. Tell them that a star shows a person is now HIV-positive.
- The participants discuss the effects on family life:
 - What has changed within the family?
 - How does the family make a living now?
 - What happens if the person dies?
 - How have the dreams and goals of the family changed?
 - How have the dreams and goals of the different family members changed?
 - How have the links to the community changed?
- The participants meet in the plenary and report on the two family scenarios (before and after HIV).
- Facilitate a discussion on how HIV and AIDS impact on households and on community life:
 - What has changed within the family due to HIV and AIDS?
 - What has changed within the community due to HIV and AIDS?
 - What about HIV and AIDS-related isolation, stigma and discrimination?
 - What about the future?
- Ask each of the participants to play the role of one of the family members. For example: one participant can act as the mother in the picture. She can ask other family members and the community for assistance. The next participant will be in the role of the young girl in the picture, and so on. Each of these family members has a different situation to cope with, and has different needs. They should ask other family members and the community for assistance, or offer assistance to others. The other participants who are not acting as family members will play the role of the community. (As the participants are playing a role, harmful statements such as blaming should be avoided.)
- On a flipchart, summarize the possible outcomes and solutions (for example, the how affected households receive assistance from other households and the community, how they fight against stigma and discrimination).

Exercise 28.

Way forward: Pocket voting and community planning

This exercise allows participants to vote confidentially on which of the workshop outcomes could be addressed by the community. Although the voting is confidential, the opinions of different social groups can be easily identified. This exercise aims to plan a community-based response to address the root causes of vulnerability to HIV infection and the effects of HIV and AIDS in the community.



Purpose

- To review the workshop results and to identify issues that could be addressed by the community.



Preparation

- Make two sets of pockets out of paper. Make one set for each of the major causes of HIV infection identified in → Exercise 25. Use a marker pen to write one of the causes on each pocket. Attach these pockets to a board.
- Make a second set of pockets for the effects of HIV and AIDS identified in → Exercise 25. Using a different coloured marker pen, write one of the effects on each of these pockets. Attach these pockets to a second board.
- Prepare several sets of counters with different shapes or colours. You can use beans, small stones, large seeds, or pieces of coloured paper.



Time

- 1–2 hours, or more if you include the community action planning step.



Facilitation

- Briefly remind participants of each of the causes and effects.
 - Give each participant a counter, representing a vote. Give members of each social group (women, men, young people, elderly people) counters of a different type so it is clear which group voted for what.
- Turn the boards away from the participants so they cannot see how someone votes.
- Invite the participants to vote on which of the causes should be addressed as a priority. They do so one by one, by putting their counters into the appropriate pockets.

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- Then give the participants a second counter and ask them to vote for the effect they think should be addressed as a priority.
- When everyone has voted, count the number of counters in each pocket. Reorder the pockets so that the ones with the most votes are at the top of the boards.
- If it emerges that the different social groups have set different priorities, discuss this openly.

Optional: Community action planning

- Consider developing a community action plan with the target group at a later stage after the workshop. Write the highest-priority causes of HIV infection on the left side of a flip chart sheet.
- Ask participants to identify and agree on possible solutions to the problem, action steps to take, resources or partners to work with, individuals or groups to be responsible, and the time period for the initiative.
- For each cause, note these items on the flip chart (→ Table 12).
- Repeat this procedure for the effects of HIV and AIDS (→ Table 13).

Table 12. Example of a community action plan: Root causes

Root cause of HIV infection	Possible solution	Action steps	Resources/networking partners	Who is responsible?	Time period
High incidence of sexual harassment of women	Give women a voice in community meetings Take cases of sexual harassment seriously	Sensitize local leaders Invite women to the next community meeting ...	NGOs Neighbouring villages Department of Justice Local courts	Members of the existing committee Traditional leaders	Start at the next community meeting
Widow inheritance	In the village, widows are no longer inherited Enforce widows' right to inherit land and property Punish property grabbing	Community meeting to discuss new law ...	Local authorities Church leaders NGOs	NGO staff members All participants ...	As soon as new regulations have been agreed
...

Table 13. Example of a community action plan: Effects

Effect of HIV and AIDS	Possible solution	Action steps	Resources/networking partners	Who is responsible?	Time period
Large number of orphans	Foster care within the village Families transfer local knowledge to orphans	Identify foster parents at community meetings and church services	Department of Social Welfare Local authorities Local churches	NGO staff members All participants ...	Lobbying as soon as possible
Increased food insecurity due to sickness and deaths	Labour and tool sharing Labour-saving methods	Project staff train farmers on concepts for labour/tool sharing ...	Department of Agriculture Local land authority NGOs ...	Project staff Key farmers Village heads	Next meeting with NGO
...

Exercise 29. Close

This final session wraps up the workshop and informs participants what will happen next.



Purpose

- To remind participants of the key outcomes of the workshop.
- To inform participants what happens next.



Preparation

- None



Time

- 30 minutes



Facilitation

- Highlight the key findings of the workshop and assure the participants they will receive a documentation of the workshop results.
- Explain that the results of the workshop will be used to adjust project activities to better address root causes of vulnerability to HIV infection and the effects of HIV and AIDS among the target groups that fall in the mandate and competence of project staff.
- Explain that other issues which cannot be tackled by project staff may need to involve specialized resource persons.
- Assure the participants that some of them will be invited to the planning session of the project staff.
- Thank all present for their participation and openness.



Women and men analysing issues related to HIV and AIDS in their daily lives

3.6 Phase III: Planning

Phase II focused on gathering information – from the perspectives of the staff and the target groups – about what makes target groups vulnerable to HIV infection and the effects of HIV and AIDS, as well as on how the project core activities are affected.

In Phase III, all these results will be collated and further analysed to develop an appropriate, practical and realistic HIV and AIDS response. It will prioritize the major issues and identify key areas of action within the project's core activities. These will either be included in the current operation plans or will be considered in the next operational planning and the strategic planning sessions. In the latter case, an action plan for mainstreaming can be developed in the meantime and put into action immediately.

This phase is divided into two steps:

- Phase III-1: Collating and prioritizing the results of Phase II.
- Phase III-2: Planning the steps in HIV/AIDS mainstreaming.

Both activities should be carried out by all management and staff, along with selected members of the target group who took part in the situation analysis.

3.7 Phase III-1: Collating the results of Phase II



Expected results

- The results of Phase II are compiled, analysed and prioritized.
- Key areas for mainstreaming are identified.



Overview

- Exercise 30. Tag voting to collate the results of Phase II
- Follow-up to Phase III-1



Estimated time needed

- 2 hours



Participants

- All staff members
- Selected target group members who participated in Phase II-2.



Materials

- Flipchart and paper
- Coloured markers

Exercise 30.

Tag voting to collate the results of Phase II

Tag voting is a fast ranking exercise that identifies key issues to be addressed in the mainstreaming process.



Purpose

- To compile and structure the information gathered in Phase II and to identify key issues for mainstreaming.



Preparation

• Compile all information obtained in Phase II on flipchart sheets and put them up on the walls of the room. Prepare separate sheets on the following six areas:

- **Root causes** of vulnerability to HIV infection. → Exercise 13, Exercise 16, Exercise 23–Exercise 26, Exercise 28.
- **Effects of HIV and AIDS** on individuals, households and communities. → Exercise 13, Exercise 24–Exercise 28.
- **Effects of HIV and AIDS** on project activities. → Exercise 14

- **Positive effects** (intended and unintended) of project activities on HIV and AIDS. → Exercise 15
- Unintended **negative side-effects** of project activities on HIV and AIDS. → Exercise 15
- Potential **networking partners**. → Exercise 17.



Time

- 2 hours



Facilitation

- Explain the purpose of the meeting: much information has been collected on the relationship between the project and HIV and AIDS. Staff members are now in a position to use this information to identify key areas of action for the mainstreaming process.
- Draw the participants' attention to the sheets on the walls. Invite them to walk around for 10 minutes and to further reflect on and compare the results.
- Give each participant a marker and ask them to tag or mark the three most important issues to address on each sheet.
- After the voting, count the marks.
- Within each area, read out the issues with the highest number of marks, and write them on a separate flipchart.

Follow-up to Phase III-1

The key areas identified during this phase will be used in Phase III-2 when developing and planning an appropriate mainstreaming response.

Decide with the staff members on a date for planning. This should happen as soon as possible, so that the results of Phase II are still fresh in their minds.

If the project already has an operational planning or strategic planning meeting arranged in the immediate future, make sure mainstreaming is included on the agenda.

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Box 25 shows an example of an operational plan for HIV/AIDS mainstreaming. The next step, Phase III-2, shows how to develop such a plan based on an existing logical framework.

Box 25. Example of an initial operational plan for HIV/AIDS mainstreaming for the target group

Problem: Insufficient information of farmer groups on HIV and AIDS

Objective: Implementation of an efficient information system for farmer groups to improve the knowledge of farmers on HIV and AIDS

Activities	Period	Source of verification	Responsible person(s)	Cost (Rwandan francs)
Analyse initial situation	3 months (May–Jul 2008)	Report	Organization’s coordination team	855,000
Develop strategy to incorporate HIV/AIDS mainstreaming	1 month (Jul 2008)	Action plan	Coordination team	
Identify or develop information sheets and other materials for extension workers and target group	3 months (Jul–Sep 2008)	Number of information sheets developed and distributed Number of information and education materials distributed	Coordination team	
Organize information sessions: basic facts of HIV and AIDS, project activities (e.g., gardening, crop cultivation) in relation to HIV and AIDS	Continuous (from Oct 2008 onwards)	Number of sessions by extension workers Participation of farmers’ associations	Extension workers, presidents of farmers’ associations	Included in existing activities
Encourage exchange between farmers’ associations and associations of people living with HIV	Continuous (from Oct 2008 onwards)	Participation of farmers’ associations Frequency of participants by topics of exchange	Extension workers, presidents of farmers’ associations	–
Internal evaluation	Every 6 months	Reports of extension workers and farmers’ associations Supervision by supervisors and coordination team	Coordination team, extension workers, farmers’ associations	

Modified from workshop with coordination and supervision team of DERN (Développement Rural du Nord), Sustainable Agriculture and Rural Development Programme, Rwanda, April 2008. (information about DERN → Box 23).

3.8 Phase III-2: Planning for mainstreaming

Based on the outcomes of the previous phase, Phase III-2 develops a planning for mainstreaming. It decides if project components have to be modified, strengthened or realigned.

The mainstreaming measures can be incorporated in the project's next operational plan and its strategic plan. Until this happens, a separate action plan for mainstreaming can be developed and put into effect. See → Box 26 to Box 28 for a summary of terminology on project planning, monitoring and evaluation.



Expected results

- Project components to be strengthened or modified are identified.
- Project components to be made accessible for households affected by HIV and AIDS are identified.
- Activities where complementary partnerships are necessary are identified.
- Additional activities or project components needed in mainstreaming are identified.
- Plans for HIV/AIDS mainstreaming measures are developed: they may be a new operational plan that includes mainstreaming, or an adjustment to an existing operational plan, or an action plan for mainstreaming for immediate realization.
- Record of mainstreaming measures to include in the overall project strategy, when this is revised.



Overview

- Exercise 31. Planning mainstreaming



Estimated time needed

- 0.5 day



Participants

- All staff members
- Possibly, selected target group members who participated in situation analysis (Phase II-2)



Materials

- Flipchart and paper
- Coloured markers

Exercise 31. Planning mainstreaming

In this exercise, participants use the results of Phase III-1 to revise the operational plans for their project component. Alternatively, they develop a separate action plan for HIV/AIDS mainstreaming to implement in the meantime before the operational plan is revised.



Purpose

- To revise the project's operational plans to mainstream HIV and AIDS.



Preparation

- For each project component, construct an empty planning matrix on a flipchart sheet. The matrix format and headings should correspond to the component's operational plan.
- Prepare a series of questions to help participants think of how to revise their operational plan. For example:
 - What can we do to assure that our project activities also target marginalized and disempowered groups in the community?
 - What can we do within our core activities to curb the spread of HIV?
 - How can we address the needs of people living with HIV and AIDS, and affected families who have little or no income and limited skills and labour?
 - How can we make our services or technologies more accessible to these people?
 - How can we help empower communities to deal with the causes and effects of HIV and AIDS?
 - How can we improve gender relations, reduce gender inequality and empower women?
 - How can we ensure that the project does not create unintended negative side-effects (for instance, greatly increase mobility)?
- Prepare a flipchart showing the symbols and their meanings in → Table 14.
- Prepare multiple copies of the key areas for mainstreaming prepared in Phase III-1 (→ Exercise 30), one for each project component.
- Have available the current operational plan and other planning documents (e.g., the project's logical framework).
- See → Table 15 and Table 16 for examples of the outputs from this exercise.

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Estimated time needed

- 4 hours








Facilitation

- Explain the procedure to be followed in this exercise.
 - Tell the participants they will identify suitable responses to HIV and AIDS, based on the key areas for mainstreaming identified in Phase III-1, which can be undertaken within their core activities.
- Remind the participants they should not develop a separate action plan for mainstreaming, but should revise the current operational (or action) plans to the context of HIV and AIDS. However, if it is not possible to revise the current operational plan immediately, they should detail the revisions and develop a separate action plan for mainstreaming until the operational plan can be adapted.
- Present the results of Phase III-1 to the plenary.
- Discuss the guiding questions with the participants.
- Introduce the symbols to be used for the planning (→ Table 14).
- Divide the participants into groups according to their project component. Give each group a copy of the key areas for mainstreaming from Phase III-1, a copy of the current operational plan (or action plan), and an empty planning matrix where they can indicate the revisions.
- Each group studies its project component in the operational plan and compares the current activities with the key areas for mainstreaming identified in Phase III-1.
- They insert symbols into the plan to indicate revisions that need to be made. → Table 15 shows an example of part of a logical framework with symbols inserted.
- The groups detail the revisions (and any new measures required) in form of a revised operational plan (for example, as a revised logical framework). → Table 16 shows the same logical framework revised so as to mainstream HIV and AIDS. → Table 17 and Table 18 present the same operational plan after the first and second phase of implementation the mainstreaming. The groups take a critical look at the timeframe and discuss the urgency of the revisions, i.e. whether they are short-term (to be initiated as soon as possible), medium-term or long-term (can be addressed at a later stage).

- Each group presents its revised operational plan (or mainstreaming action plan) for its component.
- Encourage critical feedback on the plans from the other groups, and ask participants to identify important linkages and useful synergies.










Table 14. Symbols to structure the mainstreaming planning

Symbol	Core activities that have to be...
	Strengthened
	Modified
	Realigned to serve a different target group
	Supported through networking with organizations which work outside the project's core activities
	Considered as new key areas in the mainstreaming response

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Table 15. Example: Part of a logical framework of a rural development project with key actions for mainstreaming indicated by symbols
Project logical framework: Rural development project in province X
Project phase: January 2007 to December 2009

The example below refers to the component “**Sustainable agriculture**” (part of a larger rural development project)

	Indicators (objectively verifiable indicators)	Means of verification	Hypotheses, critical assumptions and risks
Development goal The project has contributed to the improved livelihood of small-scale farmers and their families in province X	At the end of the project in Dec 2009, at least 50% of the project farmers' families  have improved their ability to meet their needs (in terms of nutrition, health, school education, etc.)	<ul style="list-style-type: none"> - Summary of household analysis (including comparison of the situation before and at the end of project implementation) - Participatory learning and action reports (semi-structured interviews) 	
Project objective The income of small-scale farmers and their families (owning 5 or less acres) has improved through increased agricultural production while using sustainable agriculture methods	At the end of the project in Dec 2009, the farm income of at least 150 out of 300 trained small-scale farmers and their families  has improved by 10–20% through practising sustainable agriculture  methods in 25 selected villages in province X	<ul style="list-style-type: none"> - Summary of household surveys compared to baseline data - Semi-structured group interviews/ discussions - Monitoring reports and end of project evaluation report - Farmer records - Field surveys' reports 	Functioning social infrastructure (education, health, etc.)
Intermediate objectives 1. By the end of the second year, farmers practise soil conservation methods and receive better yields	By the end of 2008, 200 of the 300 trained farmers  practise regularly at least two soil conservation methods. Stable and increased yields by 20–30% are observed by the end of the project (Dec 2009)	<ul style="list-style-type: none"> - Project progress reports - Farmer group records - Yield records of individual farmers - Direct observation - Photographs - Summary of household surveys - Interviews 	<ul style="list-style-type: none"> - Absence of serious environmental events (drought leading to food shortage, flooding) and crop shocks (pests and diseases) in project areas - Functioning market infrastructure - Economic and political stability
2. By the end of the third year, food security of the farmers and their families has been improved	By the end of the project in Dec 2009, at least 75% of the 200 farmers  that regularly practise soil conservation methods and cultivate a variety of  crops are able to afford a balanced diet three times daily for their family		
3.  New key area see table 16			

3. Mainstreaming: A practical guide

<p>Planned measures / activities</p> <p>1.1 Carry out 10 training sessions and follow-up on soil conservation methods (crossbars ≈, cut-off drainage ≈, contour lines, mulching ≈, ploughing across the slope) with various farmer groups </p>	<p>300 interested farmers  have been trained on soil conservation methods by end of 2007 20 follow-up visits have been carried out by June 2008 ≈</p>	<ul style="list-style-type: none"> - Reports of training workshops - Monthly and biannual progress reports - Pictures of field visits - Farmer records 	<ul style="list-style-type: none"> - Training and service delivering by the project in time - Natural factors remain stable - Economic and political stability prevails
<p>1.2 Carry out 3 training sessions for the 25 farmers' groups in group dynamics, team building and group management  ≈</p>	<p>3 training sessions on group dynamic, team building and group management have been carried out for all 25 farmers' groups by the end 2007 ≈</p>		

For meaning of symbols → Table 14.

Table 16. Example: The logical framework extract revised to mainstream HIV and AIDS

Italics indicate changes made to mainstream HIV/AIDS (see → Table 15)

	Indicators (objectively verifiable indicators)	Means of verification	Hypotheses, critical assumptions and risks
<p>Development goal</p> <p>The project has contributed to the improved livelihood of small-scale farmers and their families in Province X</p>	<p>At the end of the project in Dec 2009, at least 50% of the project farmers' families (<i>among them farmers' households with people living with HIV, households headed by grandparents, widows or orphans</i>) have improved their ability to meet their needs (in terms of nutrition, health, school education, etc.)</p>	<ul style="list-style-type: none"> - Summary of household analysis (including comparison of the situation before and at the end of project implementation) - Participatory learning and action reports (semi-structured interviews) 	
<p>Project objective</p> <p>The income of small-scale farmers and their families (owning 5 or less acres) has improved through increased agricultural production while using sustainable agriculture methods</p>	<p>At the end of the project in Dec 2009, the farm income of at least 150 out of 300 trained small-scale farmers and their families (<i>including people living with HIV and affected households headed by grandparents, widows or orphans</i>) has improved by 10–20%</p>	<ul style="list-style-type: none"> - Summary of household surveys compared to baseline data - Semi-structured group interviews/ discussions - Monitoring reports and end of project evaluation report - Farmer records 	<ul style="list-style-type: none"> - Functioning social infrastructure (education, health, etc.)

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	Indicators (objectively verifiable indicators)	Means of verification	Hypotheses, critical assumptions and risks
	through practising sustainable agriculture (<i>labour-saving</i>) methods in 25 selected villages in Province X	- Field surveys' reports	
Intermediate objectives 1. By the end of the second year, farmers practise soil conservation methods and receive better yields	By the end of 2008, 200 of the 300 trained farmers (<i>among them at least 50 households with people living with HIV, households headed by grand-parents, widows or orphans</i>) practise regularly at least two soil conservation methods Stable and increased yields by 20–30% are observed by the end of the project (Dec 2009)	- Project progress reports - Farmer group records - Yield records of individual farmers - Direct observation - Photographs - Summary of household surveys - Interviews	- Absence of serious environmental events (drought leading to food shortage, flooding) and crop shocks (pests and diseases) in project areas - Functioning market infrastructure - Economic and political stability
2. By the end of the third year, food security of the farmers and their families has been improved	By the end of the project in Dec 2009, at least 75% of the 200 farmers (<i>among them at least 50 households with people living with HIV, households headed by grandparents, widows or orphans</i>) that regularly practise soil conservation methods and cultivate a variety of nutritious crops are able to afford a balanced diet three times daily for their family		
3. Mutual assistance is strengthened and stigma of people living with HIV and affected family members is reduced	At the end of the project, at least 60% of the affected families indicate a positive change concerning mutual assistance and reduction of stigma	- Semi-structured group interviews - Individual interviews (people living with HIV, affected family members/youth) - Direct observation	

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	Indicators (objectively verifiable indicators)	Means of verification	Hypotheses, critical assumptions and risks
<p>Planned measures / activities</p> <p>1.1 Carry out 10 training sessions and follow-up on soil conservation methods (crossbars, cut-off drainage, contour lines, mulching, ploughing across the slope) with various farmer groups</p>	<p>300 interested farmers (<i>including at least 50 households with people living with HIV, households headed by grandparents, widows or orphans</i>) have been trained on soil conservation methods by end of 2007</p>	<ul style="list-style-type: none"> - Reports of training workshops - Monthly and biannual progress reports - Pictures of field visits - Farmer records 	<ul style="list-style-type: none"> - Training and service delivering by the project in time - Natural factors remain stable - Economic and political stability prevails
<p>Changes in addressing people living with HIV, elderly-, single- and youth-headed households:*</p> <ul style="list-style-type: none"> - Promote raised seed beds for vegetable production - Promote conservation agriculture wherever possible - Promote permaculture methods for homegardens - Train on nutrition including nutrition and HIV and AIDS, integrated in the homegardening training - Link affected households and orphans to support groups and specific organizations 	<p>20 follow-up visits have been carried out by June 2008 <i>considering agricultural labour-saving methods and techniques appropriate for people living with HIV, women, elderly and youth</i></p>		
<p>1.2 Carry out 3 training sessions for the 25 farmers' groups in group dynamics, team building and group management</p>	<p>3 training sessions on group dynamic, team building and group management have been carried out for all 25 farmers' groups by the end 2007</p>		
<p>Changes for the benefit of households lacking labour force (households of people living with HIV, households headed by single-, elderly- and orphans): Form farmers' work groups ("operational groups")</p> <p>...</p>	<p><i>36 operational groups have been formed</i></p> <p><i>36 operational groups have been sensitized on solidarity and mutual assistance by June 2008</i></p>		

* Crossbars, cut-off drainages are not promoted for households lacking labour force (households of people living with HIV or headed by grandparents, widows or orphans). Project continues to seek labour-saving sustainable agricultural methods.

3.9 Phase IV: Learning and evaluation

Once started, mainstreaming takes on a momentum of its own. The mainstreaming process must be regularly monitored and its outcome has to be assessed so the project can constantly adapt to changing needs.

This phase focuses on methods that can be used for learning, monitoring and evaluation as well as for outcome and impact assessment for mainstreaming.

Box 26. Monitoring, evaluation, outcome and impact assessment

Monitoring

Monitoring is a routine assessment. It gathers information (promptly and with little effort) that is needed to control and manage a project or organization.

The monitoring (observation, analysis, drawing conclusions) is performed relatively often – in contrast to evaluation – and adheres closely to the planned measures. Deeper investigations are made only if serious difficulties are observed.

You should include HIV/AIDS mainstreaming in the regular project monitoring.

Evaluation

Evaluation is a comprehensive, systematic analysis of an ongoing or completed project, or of policy aspects of the organization.

In evaluation, two questions are usually asked: “Are we doing the right things?” and “Are we doing things right?”

Evaluations support the individual and institutional learning, deliver information for the control and management of a project, and are used for accountability to the funding agency and the public. In contrast to monitoring, evaluation is a more strategic activity.

You should evaluate HIV/AIDS mainstreaming as part of the project evaluation.

Outcome and impact assessment

Outcome and impact assessment determines the outcomes and impacts of the project work.

This is done as a midterm review, at the end of the project cycle, or later. It checks what kind of changes have been achieved through mainstreaming: positive or negative, intended or unintended, caused by the project or other factors, concerning the target groups and the wider social environment.

Box 27. SMART indicators

- **S – Specific:** Does the indicator measure what it is supposed to measure (the intended changes to achieve the objective)?
- **M – Measurable:** Can the indicator be measured easily? Does it produce figures that can be compared over time and from place to place?
- **A – Accessible/achievable:** Does the indicator reflect whether the objective has been achieved? Is regular monitoring possible? Are the measurements cost-effective?
- **R – Relevant:** Is the information given by the indicator relevant for decision making?
- **T – Time-bound:** Does the indicator show when a change takes place?

Box 28. Terminology for planning and implementation

The following terminology is used for the planning and implementation stages of projects.

Planning stage		Implementation stage
Intended effects (or ‘intended outcomes and impacts’)	→	Effects (or ‘outcomes and impacts’)
<ul style="list-style-type: none"> • Goal (or development goal) • Project objective(s) • Intermediate objective(s) 	<ul style="list-style-type: none"> → → → 	<ul style="list-style-type: none"> • Impact(s) • Outcome(s) • Use of outputs that the project makes available
Planned outputs	→	Outputs
Planned measures or activities	→	Implemented measures or activities

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The monitoring, evaluation, outcome and impact assessment should focus on three aspects:

- Addressing the root causes of vulnerability to HIV infection
- Tackling the effects of HIV and AIDS
- Avoiding unintended negative side-effects of the project on HIV and AIDS.

These aspects should be an integral part of the project's monitoring, evaluation, outcome and impact assessment framework. HIV and AIDS must be considered in all phases of the project cycle, and staff members should share experiences on a regular basis.



Expected results

- A framework is developed for the systematic exchange of experience and know-how on HIV/AIDS mainstreaming.
- The monitoring, evaluation and assessment of the outcome of HIV/AIDS mainstreaming with clear responsibilities and time frame are considered.
- The learning framework as well as the monitoring, evaluation, outcome and impact assessment of HIV/AIDS mainstreaming are linked to existing project practices.



Overview

- Exercise 32. Learning framework
- Exercise 33. Measuring progress of external mainstreaming at the organizational level: The spider web
- Exercise 34. Measuring progress of external mainstreaming at the target group level: SMART indicators
- Exercise 35. External mainstreaming: SWOT analysis to measure achievements



Estimated time needed

- 0.5–1 day



Participants

- All staff members
- Target group members who participated in the situation analysis (Phase II-2) for measuring progress and achievements at the target group level.



Materials

- Flipchart and paper
- Coloured markers

Exercise 32. Learning framework

This exercise involves staff in developing a “learning framework” to serve as an exchange platform. This framework should be developed shortly after the mainstreaming process has started. Its effectiveness can be assessed regularly, for example by using the “spider web” (→ Exercise 33).



Purpose

- To establish a framework for on-going exchange of experience regarding mainstreaming HIV and AIDS.



Preparation

- Prepare some guiding questions. Some possibilities (adapt as appropriate):

- What has changed as a result of the mainstreaming process on the level of the organization? On the level of the project work?
- How far does the project address the root causes of HIV infection?
- How far does the project address the effects of HIV and AIDS on the target groups?
- To what extent are the project components accessible for affected target groups?
- How far has the mainstreaming process enabled the project to avoid unintended negative side-effects?
- Which are the successes of mainstreaming?
- What are the challenges in realizing mainstreaming?
- How can future challenges be overcome?



Time

- 1 hour



Facilitation

- Stress the importance of a framework that allows a regular exchange of experience regarding HIV/AIDS mainstreaming.

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- Invite participants to list opportunities for sharing experience on HIV/AIDS mainstreaming. Possibilities include staff meetings, unit meetings, regular area meetings organized by extension officers, monthly reports, project reports, and so on. → Box 29 gives an example of how project staff planned to monitor HIV/AIDS mainstreaming through a “champion team”.
- Ask who is responsible for ensuring that experience is shared on a regular basis.

Box 29. Example of a learning framework guided by an “HIV/AIDS champion team”

Responsibilities of an HIV/AIDS champion team to monitor the mainstreaming of HIV/AIDS:

- At each meeting, we will report on mainstreaming HIV/AIDS
- Mainstreaming HIV/AIDS is a major focus (standing item) at all unit/staff meetings
- Activities and experiences related to HIV/AIDS mainstreaming should be included in monthly reports.

Source: Umthathi mainstreaming HIV/AIDS workshop, Grahamstown, South Africa, June 2004.

Exercise 33.

Measuring progress of external mainstreaming at the organizational level: The spider web

The “spider web” is a participatory evaluation tool that allows participants to determine the areas that need to be evaluated for the external and internal (organizational) progress of mainstreaming HIV/AIDS at the target group level. In this example, the “spider web” will be used to assess the progress of external mainstreaming.



Purpose

- To evaluate and assess the progress of the mainstreaming process – the organizational setup that favours or hinders the progress of external mainstreaming.



Preparation

- Prepare guiding questions. For example: “Concerning external mainstreaming, where do you place in a range of 1 (lowest) and 5 (highest):

- Management support?
- Importance of mainstreaming on the organization’s agenda?
- Dedication of all staff members to external mainstreaming?
- The level of staff capacity in (a) analysis, (b) planning and (c) implementation of mainstreaming?
- The progress of networking and strategic partnership?



Time

- 1.5 hours



Facilitation

- Introduce the purpose of this tool:
 - To identify key factors which are important for a successful mainstreaming process.
 - To develop performance indicators for these factors.
 - To assess performance with regard to the key factors.
 - To plan for improvement.
- Ask the group “What does a spider do? How does a spider spin its web? Why does a spider spin a web?” Guide the discussion to show that the connecting strands are important for the stability and functionality of the web as a whole. If one radius is weak, it weakens the whole web.
- Suggest that the web is a metaphor for organizations that are mainstreaming HIV/AIDS.
- Invite the participants to brainstorm the important factors of a successful mainstreaming process.
- Ask them to cluster the answers into categories such as management support, dedication of staff members, basic knowledge on HIV and AIDS, staff capacity for analysis, planning and implementing mainstreaming, networking/strategic partnerships etc.
- Separate the elements into those that are important for the whole organization (e.g., management support) and those important for specific departments in the organization (e.g., specific staff capacity measures, specific strategic partnerships).
- Invite the participants to focus first on elements that are important for the whole organization. Guide them to reflect on each of the elements and develop a five-level performance rating, each level with its own indicator(s). → Box 30 gives an example of a monitoring indicator.

3. Mainstreaming: A practical guide

Box 30. Example of monitoring indicator for spider web

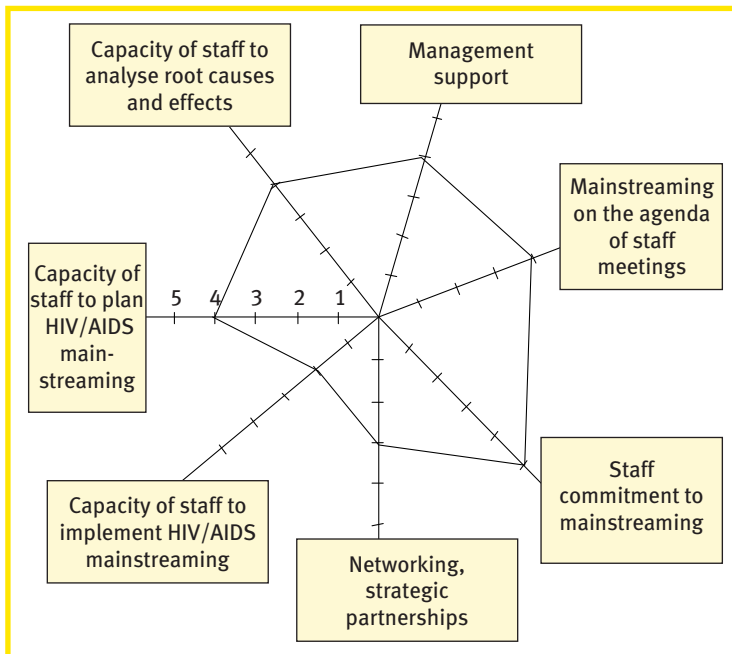
Element: Mainstreaming on the agenda of the organization

- **1 (lowest rating):** Experience with mainstreaming is not discussed at staff or unit meetings.
- **5 (highest rating):** Mainstreaming is regularly on the agenda at staff and unit meetings.

- The participants agree on the indicators and assess their own performance with respect to each of the elements.
- Construct a spider-web diagram to show the assessments. See → Figure 11 for an example.

Figure 11. Example of a spider's web for monitoring elements in a mainstreaming process

Ranking: 1 – lowest achievement; 5 – highest achievement



- Lead a discussion of the spider web:
 - What are the implications for the mainstreaming process?
 - Where are our strengths?
 - What must we improve?
 - Where do we want to be in 6 or 12 months?

- Divide the participants into groups by project component, and invite them to work on the component-specific elements. Each group elaborates performance indicators, evaluates itself against the indicators, develops a spider web for its component, and discusses how the situation can be improved.
- Invite the groups to present to the plenary their spider webs and possible means for future improvements.
- Invite the participants to identify ways to achieve synergy among the project components, the organization's departments or with stakeholders outside the own organization.

Follow-up

This exercise may be repeated on a regular basis to monitor the key elements in advancing the mainstreaming process:

- After a fixed period, develop a second spider web on key issues of mainstreaming.
- Compare the first and second spider webs and draw conclusions about the mainstreaming progress.

Exercise 34.

Measuring progress of external mainstreaming at the target group level: SMART indicators

This exercise develops a practical monitoring system for mainstreaming HIV/AIDS at the project's target group level. This system has to be linked to ongoing monitoring and evaluation practices, preferably based on outcome and impact.



Purpose

- To monitor, evaluate and assess the changes initiated through mainstreaming HIV/AIDS on the target group level.



Preparation

- Write the characteristics of SMART indicators on a flipchart sheet (→ Box 26).
- Write the definitions of monitoring, evaluation, outcome and impact assessment on a flipchart sheet (→ Box 26).
- Prepare a diagram on a flipchart showing the links between inputs, planned activities, planned outputs, intended outcomes and intended impacts (→ Figure 12).

3. Mainstreaming: A practical guide

- Prepare handouts for each participant with guiding questions (see → Box 31 for examples; adapt these as appropriate).
- Make the revised operational plans available as handouts for participants (→ Exercise 31).



Time

- 2 hours



Facilitation

- Stress the importance of regularly monitoring, evaluating and assessing the outcome(s) and impact of changes initiated through external mainstreaming. Also mention the importance of linking these to existing monitoring and evaluation practices.
- Clarify if necessary the differences between inputs, activities, outputs, outcomes and impacts (→ Figure 12). Give examples of HIV/AIDS mainstreaming at each level. Remind the participants that a chain of causality like in Figure 12 is a simplification: in a project context, different causes may exist and various influences, apart from the project measures, come into play.
- Describe how the revised operational plans allow:
 - Monitoring the progress of implementation
 - Critical evaluation of whether the modifications initiated through the mainstreaming process go into the right direction
 - Assessment of whether the project is achieving its intended outcome or impact in terms of mainstreaming HIV/AIDS.
- Describe the characteristics of SMART indicators (→ Box 26).
- Divide participants into groups according to project components.
- Request each group to cross-check the revised operational plans and indicators and agree upon a means of verification for each indicator and the monitoring tools to use. They should if possible select tools already being used in the existing monitoring and evaluation system. See → Table 17 and Table 18 for examples of planned activities and indicators of mainstreaming in different project phases.
- For each indicator, the groups clarify who is responsible for measurement: staff member(s), or member(s) of the target group.
- Invite each group to present its revised operational plan to the plenary, and encourage critical feedback and suggestions for improvements from other participants.

See → Figure 12 for an example of a causality chain.

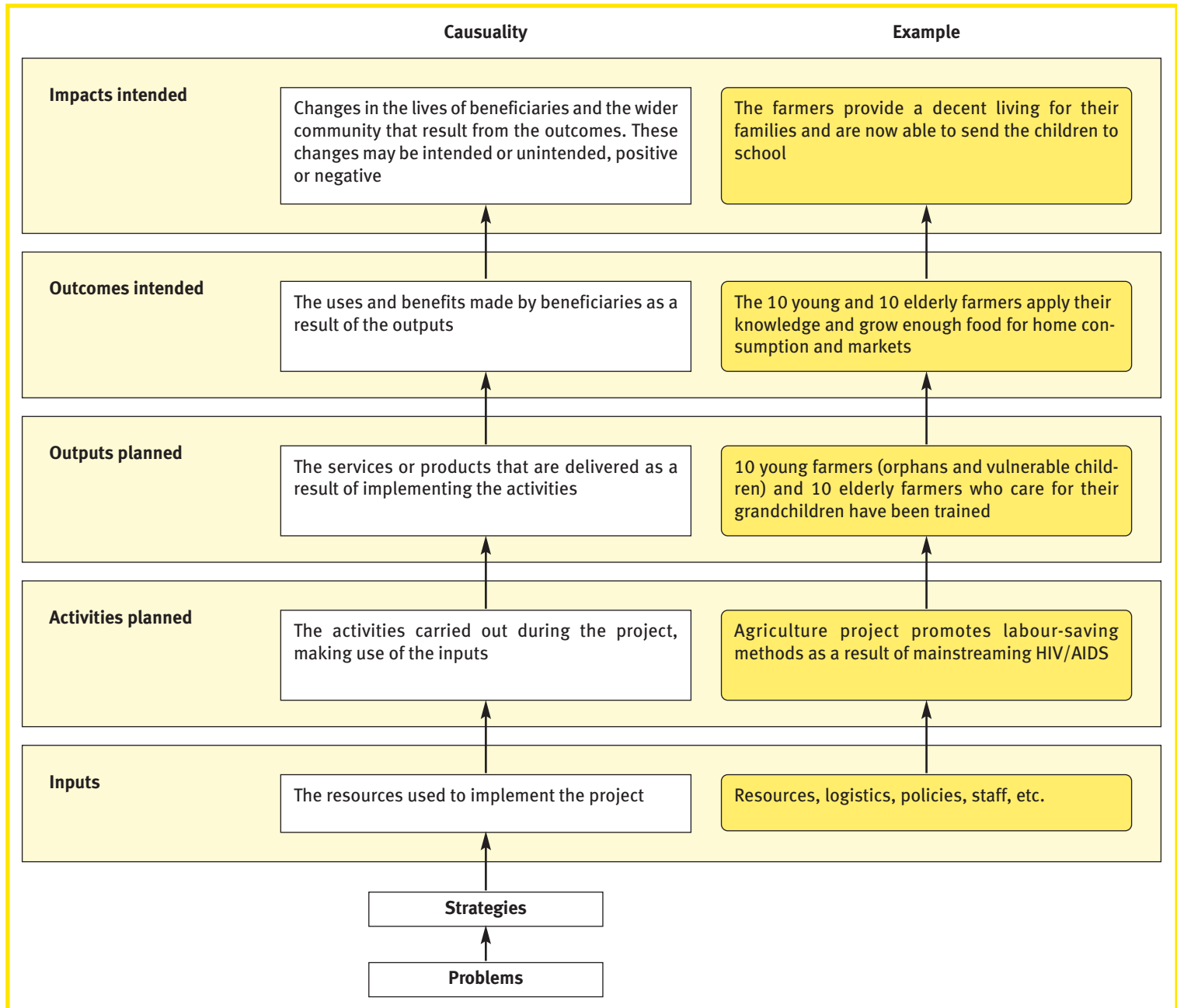
Box 31. Guide questions on measuring the progress of external mainstreaming

- To what extent have we achieved the objectives stated in the revised operational plans? How did we do so?
- How far are the objectives realistic? Do they respond to the problem?
- How far do the changes initiated address the causes of HIV infection and the effects of HIV and AIDS?
- Which positive (intended and unintended) effects are achieved by mainstreaming HIV/AIDS with the target groups and the wider social environment?
- How far do the changes ensure that the project avoids unintended negative side-effects concerning HIV and AIDS?
- How far are the project components accessible for affected households (for example, in enabling the participation of people living with HIV, affected people, single- and child-headed households)?
- To what extent have stigma and discrimination on the part of target groups against people living with HIV been reduced?
- To what extent have awareness of and openness to HIV and AIDS-related themes increased among target groups?
- Which changes can be observed concerning the power structures, access to resources and decision-making processes of men, women and young people?
- How far have we established strategic partnerships that can benefit the affected target groups?
- How far have the target groups benefited from the activities? Are there positive changes in their lives?

Follow-up

The fully revised operational plans will be used as a basis for monitoring, evaluation, outcome and impact assessment of the mainstreaming process.

Figure 12. Example of a causality chain related to mainstreaming HIV/AIDS



3. Mainstreaming: A practical guide

Table 18. Example: Part of an operational plan after second phase of mainstreaming (Jan–Dec 2008)*

Activity	Action steps	Indicators	Source of verification	Time frame	Responsible persons	Budget, resources
First objective: To improve the income of 150 out of 300 trained subsistence farmers and their families (including people living with HIV, affected households also headed by orphans) through the promotion of sustainable agriculture methods in Province X (Jan–Dec 2008)						
<ul style="list-style-type: none"> Follow-up visits concerning establishment of home-gardens using labour-saving methods 	<ul style="list-style-type: none"> Regular visits of farmer groups to discuss issues related to the establishment of homegardens Visiting individual farmers on request to discuss problems on the spot with involvement of other group members Gathering of data of how far group members benefit from homegardens (e.g. increased yields) 	<ul style="list-style-type: none"> Bi-monthly visits of farmer groups have been carried out A maximum of 50 farmers have been visited on individual basis By end of 2008, 50% of the trained farmers (150) have established homegardens, regularly practise at least two soil conservation methods, and have changed their preparation and food habits The practising farmers benefit from stable yields 	<ul style="list-style-type: none"> Reports of visits Monthly and biannual progress reports Pictures of field visits Farmer records 	<ul style="list-style-type: none"> Group visits start Jan 2008 Individual visits start after planting season (Apr 2008) Data on yields are collected and recorded (Jun and Sep 2008) 	<ul style="list-style-type: none"> Group visits: Ms Ifetayo Individual visits: Mr Femi and Ms Jide Monitoring: Mr Damolabayo 	<ul style="list-style-type: none"> Regular visits: 18,000 Naira Monitoring: 8,000 Naira
Secondary objective: To strengthen mutual assistance and reduce stigma of people living with HIV and members of affected households						
<ul style="list-style-type: none"> Supervision of operational groups (5–10 members each) 	<ul style="list-style-type: none"> Meetings and exchange with operational group members as part of the visits of subsistence farmers' groups Follow-up visits once per month as part of the visits of small-scale farmers' groups 	<ul style="list-style-type: none"> Mutual assistance of operational group members Increase in yields for affected households Stigma has reduced 	<ul style="list-style-type: none"> Reports of semi-structured group interviews Reports of individual interviews (people living with HIV, affected family members/youth) Direct observation 	<ul style="list-style-type: none"> Meetings: Mar-Jun 2008 Follow-up visits: Jul-Nov 2008 	<ul style="list-style-type: none"> Meetings: Ms Yewande and Ms Stife Monitoring and supervision: Ms Damson and Mr Jidedamilari 	<ul style="list-style-type: none"> Meetings: 18,000 Naira Monitoring: 8,000 Naira

* Based on the revised logical framework (→ Table 16) with outcome monitoring.

Exercise 35.

External mainstreaming: SWOT analysis to measure achievements

A SWOT (Strengths, Weaknesses, Opportunities, Threats) analysis is useful to assess progress made with external HIV/AIDS mainstreaming. The SWOT analysis can also be used to assess the progress of internal mainstreaming, (such as the effectiveness of implementing a work-place policy on HIV/AIDS).



Purpose

- To assess progress and identify problems and opportunities in mainstreaming.



Preparation

- Prepare a flipchart with an empty SWOT matrix (→ Table 19).



Time

- 2 hours



Facilitation

- Briefly describe the SWOT analysis, perhaps using a simple example.
- Divide participants into groups according to their project components.
- Invite each group to assess the strengths and weaknesses of the activities planned in the mainstreaming process. Ask them to draw a SWOT matrix and note the strengths and weaknesses in the appropriate cells.
- Invite the groups to consider the opportunities for each activity and identify any threats that may hinder implementation.
- Request the groups to summarize the lessons and identify the way forward for their component.
- Invite the groups to present their findings to the plenary.
- Facilitate a discussion to identify common strengths, weaknesses, opportunities and threats, and to decide how to use this knowledge to advance the mainstreaming process.

Table 19. Example of a SWOT analysis: Monitoring the implementation of mainstreaming activities

Activity 1: Introduce labour-saving methods		
Inside the project	Strengths ...	Weaknesses ...
Outside the project	Opportunities ...	Threats ...

4. Good practice examples of HIV/AIDS mainstreaming

Women's empowerment and gender

Local customs

Community responses

Mobility and migration

Water and sanitation

Food security

Knowledge transfer to orphans and vulnerable children

Nutrition

Land rights

Social protection schemes

Microfinance and savings and credit schemes

Justice and peace



Introduction

The ideal project tackles both the root causes of HIV infection and the effects of HIV and AIDS in its specific context.

This chapter gives examples of HIV/AIDS mainstreaming from various development fields, as well as add-on HIV/AIDS activities (see also Chapter 1). We present both because, depending on the circumstances, both are important. A few of the examples are not genuine mainstreaming examples, but nevertheless they may encourage other projects to tackle certain of these issues through mainstreaming. At the end of each example, we present some lessons for mainstreaming. Most of the examples are from partner organizations of Misereor.

This chapter covers the following topics and development fields:

- 4.1 Women's empowerment and gender
- 4.2 Local customs
- 4.3 Community responses with regard to HIV and AIDS
- 4.4 Mobility and migration
- 4.5 Water and sanitation and HIV and AIDS
- 4.6 Food security
- 4.7 Knowledge transfer to orphans and vulnerable children
- 4.8 Nutrition
- 4.9 Land rights
- 4.10 Social protection schemes
- 4.11 Microfinance and savings and credit schemes
- 4.12 Justice and peace

4.1 Women's empowerment and gender

It is widely acknowledged that gender and HIV and AIDS are closely interlinked. Women are more vulnerable to HIV infection due to biological, economic, social, cultural and other factors. For example, gender-related roles and expectations reduce the ability of women to discuss sexual matters with their partners. Unequal property rights bring women in a position to lose land and property after the death of their husband and put them under pressure to earn a living. But socially constructed roles, expectations and perceptions can make men vulnerable to HIV infection, too.

The following examples show how projects promoting gender equity respond to HIV and AIDS conceptually and in the related activities, so

as to reduce vulnerability to HIV infection and to the effects of HIV and AIDS. Some of the projects presented also carry out add-on HIV/AIDS activities.

Promoting gender equality through economic empowerment

Women in Development Programme of Iringa Diocese, Tanzania

The Women in Development Programme of Iringa Diocese in Tanzania aims at improving women's welfare. The programme works with 616 women from small-scale farming households, organized in groups in fifteen target villages in Iringa Rural, Kilolo, Mufindi and Mbarali districts. Women are trained in various income-generating activities, human rights issues, savings and credit skills, and HIV and AIDS. As they have become more aware of HIV and AIDS, the women have realized the effects of HIV and AIDS on their communities and how they can counteract stigma and discrimination and assist affected individuals and households.

Mainstreaming HIV/AIDS

The process of mainstreaming HIV/AIDS resulted in the following changes:

- **Savings and credit.** The women's groups started to provide low-interest loans to enable individual members to start small income-generating activities and businesses to meet their basic family needs.
- **Income generation.** The women's groups make sure that the members keep pigs and chicken for food and income. If a group member is chronically sick and unable to run the enterprise, the groups encourage other household members to continue it. The women have started to help each other not only in economic activities, but also in times of sickness and death, and during mourning periods.
- **Gender and development.** Married group members have convinced their husbands of the importance of income-generating activities for women to improve their families' living conditions. Women also have convinced their husbands to stay at home to work together on their farm, rather than migrating elsewhere in search of work as casual labourers. The women insist on marital fidelity. The women advocate for abandoning outdated customs such as widow inheritance.

4. Good practice examples of HIV/AIDS mainstreaming

- **Breaking stigma.** Group members help affected households by supporting them with water, firewood, maize flour, beans, vegetables, etc.
The groups are encouraged to fully accept people living with HIV, also if they become chronically sick.
- **Risk reduction.** Many young girls in the region attend only primary school. Afterwards, some move to the cities (especially Dar es Salaam and Zanzibar) to work as maids in private households, where they risk abuse. The women's group members realize that work migration makes the girls vulnerable to HIV infection. The groups have therefore committed themselves to send all their children, including the girls, to secondary school. They have also alerted other families to the dangers of young girls migrating to cities.

New activities and project modifications

New activities related to HIV/AIDS mainstreaming include training on nutrition, small-scale animal production, and backyard production of fruits and vegetables.

The project tries to avoid unintended negative side-effects by not negatively influencing power relations between men and women. It organizes awareness sessions on human rights and women's rights also with regard to HIV and AIDS, involving political leaders, NGOs and other stakeholders.

Effects

Various positive changes in the women's lives have resulted from the mainstreaming process:

- The women's groups accept people living with HIV; they are fully incorporated in group activities.
- Group members have changed behaviour to avoid situations where they risk contracting HIV. They are aware about the relation between work migration and increased vulnerability to HIV infection which has led them to action. They also create awareness on HIV and AIDS and behaviour change among their partners and other community members.
- The women's groups inform people about support programmes, which now reach affected individuals and households, including orphans and widows.
- Women have gained influence in decision making and access to resources: men have become more open to discuss family matters

such as trust, faithfulness and family welfare. Men also allow women to become involved in savings and credit and income-generation activities.

- Local government leaders have become aware of the women's activities and attend HIV and AIDS-related training together with other community members.

Lessons for mainstreaming

The project combines economic and social aspects of development. Empowerment measures convince women to talk to their husbands and the wider community. The women's groups address gender-based inequality and harmful traditions. They assist their members who are living with HIV as well as orphans and members who are affected by HIV in one way or another.

The Iringa region is known as a source of cheap female labour, especially for Dar es Salaam and Zanzibar. To reduce vulnerability to infection and the effects of HIV, it is important to raise awareness of HIV and AIDS, of the importance of girls' education, and of social and economic empowerment of girls, women and households.

Promoting gender equity through awareness raising and economic empowerment

Women in Development/Gender and Development Programme, Mbulu Diocese, Tanzania

The Women in Development/Gender and Development (WID/GAD) Programme of the Mbulu Diocese in Tanzania focuses on gender imbalance, which is seen as an obstacle for community development in the area. The main components of the programme are awareness raising, savings and credit schemes, and networking. The programme targets marginalized groups, such as women, young people, people with disabilities and orphans, as well as men (who are important to change the situation of the women).

HIV and AIDS affect all the programme activities and the organization itself. Therefore, the WID/GAD Programme considers HIV and AIDS as a cross-cutting issue in all components of the programme.

4. Good practice examples of HIV/AIDS mainstreaming

Mainstreaming HIV/AIDS

The WID/GAD programme has started to mainstream HIV/AIDS to reduce the vulnerability of target groups and the effects of HIV and AIDS on programme activities.

- The programme, with the support of about 100 trained animators, raises awareness among the community through songs, role plays, etc., on various concerns, including HIV and AIDS. It encourages women and men, including local leaders, to discuss these issues in order to reach a mutual understanding.
- Groups formed by the programme further sensitize women and men on HIV and AIDS, gender and other family issues. The programme promotes skills training and revolving loans to build their capacity.
- Promoting savings and credit schemes among group members has increased the solidarity, group power and economic capacity of the members. In particular women are economically empowered; traditionally, they do not own assets and resources.
- People living with HIV are members of the groups and benefit as other members. Depending on their health situation, some receive special conditions for repaying loans, such as more time to repay and low interest terms.

Effects

- Many of the women are now aware of HIV and AIDS and are motivated to go for voluntary counselling and testing.
- HIV-infected women disclose their status and can join economic groups without fear of being excluded by stigma. More openness is seen, and cases of stigma have decreased.
- Women, men and young people who join the groups are economically empowered. This reduces the chances of men manipulating women through economic power.
- Women and young people are confident to express their views in their families and in public meetings.
- Women are more respected due to their financial contribution and participation in decision making at family and community levels.
- It is not known how many infected people the sensitization efforts have reached. But 15 people have disclosed that they are living with HIV and have joined savings and credit groups. All of these are women. Many others are not open about their status to the wider public, but group members know their HIV-positive status.
- Group members have formed drama groups to sensitize people in various villages about HIV and AIDS.

Lessons for mainstreaming

The programme successfully mainstreamed HIV/AIDS without changing its focus. It purposely targets women and men to bring a change in gender roles in the society. Further, empowering women motivates them to act as change agents in their communities to break stigma and to sensitize people about HIV and AIDS.

Prevention of family violence: Reproductive health for men

Western Samar Development Foundation, Philippines

The Philippines has still a low HIV prevalence. A total of 3,061 people are known to be living with HIV in 1984 to 2007 (of a population of nearly 88 million). Of these, 52% were registered in the last seven years, and the numbers seem to be increasing significantly.

The Philippines presents a range of factors which drive the HIV epidemic: poverty, high levels of migration for work, trafficking of women and children, prostitution, gender inequality, a poor health system, and so on. Other aspects to observe are abuse and high incidence of domestic violence against women and children.

The Western Samar Development Foundation (WESADEF) aims to ameliorate the socioeconomic and environmental conditions of impoverished people in Samar. In 2001, it started the Prevention and Management of Family Violence Project to address violence against women and children, targeting underprivileged women in Samar with special consideration of women and children as victims of domestic violence.

The project has three basic approaches:

- Preventing domestic violence through advocacy and awareness creation among target groups, community members and other stakeholders such as local leaders and government.
- Providing prevention and rehabilitation services for abused women and children in communities and shelters.
- Institutionalizing sustainability mechanisms; strengthening and mobilizing networks.

At the beginning, WESADEF focused only on domestic violence. Later, it integrated reproductive health, family planning, maternal and child health care, nutrition and male involvement in its advocacy efforts and training activities. This covered the topic of sexually transmitted infections, including HIV and AIDS.

Mainstreaming HIV/AIDS

Since August 2008, WESADEF started to mainstream HIV and AIDS systematically into its programme activities. Its approach includes encouraging equal participation of men and women in all areas of family concerns and responsibilities, promoting responsible sexual behaviour (including sexual abstinence, faithfulness and condom use), and enabling women to continue their parenting responsibilities while participating in the work force.

Effects

Since the mainstreaming process is still young, it is difficult to report on outcomes. Nevertheless, the following changes have been observed:

- Increased awareness among communities of HIV and AIDS, including the possible effects on their lives, confidentiality issues, and the avoidance of stigma.
- A referral system has been put in place for people who disclose that they are HIV-positive.

Challenges

- Staff members need in-depth understanding of HIV and AIDS and related issues.
- Access to HIV and AIDS-related services is lacking.
- Unequal gender roles influence sexuality: men decide when, where and how sex takes place, whether a couple practises family planning, and how many children they have.

Lessons for mainstreaming

This example shows mainstreaming HIV/AIDS in a place where prevalence is low. WESADEF uses its existing programme activities as entry points and addresses HIV prevention and the fight against stigma towards people living with HIV. It is important to target men in order to reduce family violence, strengthen family structures and change men's behaviour towards women and children. The approach of targeting men on issues related to reproductive health and sexual responsibility might also be useful elsewhere.

4.2 Local customs

HIV and AIDS deprive many households and communities of the human or material capacity to follow traditions such as expensive funerals, long mourning periods and lavish weddings. Adjustments in such customs are needed. While some traditions have been beneficial in the past, in a time of HIV and AIDS they may actually contribute to HIV infection and worsen its effects. It is important to analyse such practices in the light of HIV and AIDS and to identify which are good and which are harmful. The following case studies show how projects have successfully modified local customs in this way.

Widow inheritance, land and property rights

Women Fighting AIDS in Kenya, Kenya

In some regions of Kenya and elsewhere in sub-Saharan Africa, it is still common for a widow to be inherited by her husband's brother or another male family member. This custom has a long tradition. It used to function (among others) as a social and economic support mechanism for widows and their children, giving them access to their deceased husband's land and other belongings. Until now, this custom has often been the only way for widows to protect themselves and their children, and to have access to their property and land.

But now the custom exacerbates the spread of HIV. Widows whose husbands have died from HIV-related diseases, often undiagnosed or denied, are likely to be infected as well, and may pass on the virus to their new husbands.

Note that this is not a "real" mainstreaming example as the core business of WOFAK has to do with HIV and AIDS. Nevertheless it shows the vulnerability of these women and the importance to assist them, which may also be possible for other projects realizing the mainstreaming approach.

Responses to HIV and AIDS

Working with the Luo ethnic group in western Kenya, Women Fighting AIDS in Kenya (WOFAK) provides HIV and AIDS education and basic counselling to women who are either infected with HIV or vulnerable to infection. It also promotes financial empowerment and facilitates support within the community, so assisting women who do not wish to follow the custom of inheritance.

4. Good practice examples of HIV/AIDS mainstreaming

WOFAK has initiated an income-generating project to mobilize the skills of women who produce *ciondos*, a type of basket made from sisal and yarn, two readily available local materials. The baskets are very popular among tourists. Basket weaving does not necessarily mean that the women have less time for other tasks, as it can be done parallel to other work. It is important that it gives women additional income which they themselves control.

Effects

This financial independence enables women to secure a living for themselves and their children. It is crucial if they do not wish to be inherited by a relative, and thus risk losing their deceased husband's property and the basis of their livelihood. Widows are thus able to make their own decisions without the threat of total impoverishment for themselves and their children.

Lessons

Financial independence and security are important for widows and their children if they are to break with the custom of widow inheritance – a decision which might result in losing all their property. Nevertheless, the example does not address the fundamental problem, namely that customary inheritance laws hinder widows from inheriting the land and property of their deceased husbands. In the long run, the ownership of land and related assets provides more security and prospects for developing sustainable livelihood strategies. Therefore, in addition to supporting widows to develop sustainable incomes, projects can assist women to lobby community and other decision-makers for a

change in the customary inheritance laws. Where statutory inheritance laws are already in place, they need to be known by the public and there may be the need to press for their enforcement. This could also mean that projects encourage husbands to write a will to ensure their wives and children inherit their property. Further, projects can advocate including issues related to inheritance laws in school curricula and marriage preparation classes.

More information → Buckley (1997), Mason (2002)

Lobbying for a reduction in funeral costs

Africa Co-operative Action Trust, South Africa

In many areas of KwaZulu Natal, as elsewhere in Africa, expensive funerals are common. Much money is spent on catering, coffins and customary rituals. In the Nquthu area of KwaZulu Natal, a funeral complete with the customary “after-tears party” can cost over R 28,000 (over € 3,500). HIV and AIDS have considerably increased the mortality rate locally, and the extra funeral expenses exacerbate the poverty levels in the community. When someone with HIV dies, the family may already be financially and physically exhausted, especially if more than one family member is infected. An expensive funeral may push them (further) into debt, and the family often has to borrow money from moneylenders. A family that is totally insolvent is particularly vulnerable to the effects of HIV and AIDS, and it may take a long time for them to get back on their feet. Recognizing the link between funeral costs and increasing poverty, particularly in conjunction with HIV and AIDS, the Africa Co-operative Action Trust (ACAT) started to address the issue of high funeral costs within its core activities.

Mainstreaming HIV/AIDS

The causes of poverty were constantly on the agenda at meetings of savings groups and farmers' groups, and the discussions led to action. The groups approached representatives of local authorities (for example local ministers or community leaders) to discuss the issue of high funeral costs and to press for a reduction. The spirit of *ubuntu*, which means “helping one another in times of difficulty”, was restored.

Effects

- Local ministers and leaders work towards reducing the cost of funerals, for example by promoting the principle of “bring and share”. Here, the family and neighbours contribute food.



Widow rejecting the custom of widow inheritance

4. Good practice examples of HIV/AIDS mainstreaming

- Group members campaign against competitive funerals, where the funeral expenses reflect the wealth and status of the bereaved family.
- Some savings groups start their own funeral schemes to provide mutual support for their members, for example by helping with catering.
- More funerals are now held during the week; this reduces the number of people attending.
- In some cases, food and drink is provided for the immediate family only.
- In other communities, lunch is no longer offered and the number of sacrifices has been reduced.
- Funerals can be held at or near home, reducing the cost of hiring tents and chairs.
- The number of mourning days has been reduced in some communities.
- In some areas, target groups are reverting to the tradition of wrapping the dead in grass mats (the former traditional practice) instead of buying coffins.

Reducing the expense and the duration of funeral ceremonies has several benefits:

- The family returns to its normal daily routine sooner and continue its productive activities.
- Family savings are not depleted so severely; the family is less likely to need a loan, and the business is financially more secure.
- More money is available for other purposes, such as education.
- Typical reductions in funeral costs (R 8 = € 1):
 - Okhahlamba: from R 15,000 to R 5,000
 - Highflats: from R 10,000 to R 1,500
 - Ladysmith: from R 10,000 to R 2,000.

Lessons for mainstreaming

This example may be useful for organizations working in areas with high death rates due to HIV and AIDS. ACAT helped reduce funeral costs by raising awareness among its target groups and mobilizing them to approach local authorities. As high funeral costs are a major cause of impoverishment, reducing them has big benefits for the affected households. The influence of the extended family on funerals has to be considered, as funerals implicate the whole family, and the extended family (not an individual) is the decision-making entity.



Funeral expenses exacerbate the poverty levels in families and communities

Lobbying for shorter mourning periods

Africa Co-operative Action Trust, South Africa

Long mourning periods are a common practice in KwaZulu Natal and in many other African societies. In the project area served by the Africa Co-operative Action Trust (ACAT), mourning customs had various negative effects on community members.

- Everybody was expected to stop working in the fields during the mourning period, widows even for a whole year. Community members were not allowed to exchange seed.
- The whole community mourned for up to one year after the death of the chief.
- Ploughing and planting were delayed. This often resulted in poor yields.
- In some communities, fields were not cultivated at all. People had to buy food, and this used up their assets.
- Long periods of mourning thus exacerbate the effects of HIV and AIDS. Affected families cannot rapidly resume their normal productive activities.

Mainstreaming HIV/AIDS

The Sustainable Agricultural Programme of ACAT tackles the issue of long mourning periods by including discussion of the causes of poverty at meetings and in project activities. Farmers begin to realize that a long period of mourning is not necessary, and gradually overcome fears that derive from their traditional beliefs and worship of ancestors. A few examples of such beliefs:

- If people work during the mourning period, bad hailstorms will destroy crops.
- Non-observance of the custom could bring a curse upon the area.
- Neighbours or relatives will die if people break with the tradition.

4. Good practice examples of HIV/AIDS mainstreaming

ACAT also tackles the topic in continuous discussions with its target groups and local authorities to change the unfavourable mourning practices. The programme builds on community activities that are already in progress:

- Some tribal authorities have chosen specific days of the week for mourning, or have reduced the number of mourning days.
- Mourning starts after the funeral, not while the body is in the mortuary.

Effects

The main reason for the long mourning periods has been addressed: the fear of negative interference by ancestors. Communities and leaders are made aware of the negative implications of long mourning periods. Mourning periods become shorter, and are determined according to the needs and circumstances of each family. The time saved can be used for other purposes, such as farming or other livelihood activities.

Lessons for mainstreaming

The ACAT example may be useful for organizations working in areas with high death rates due to HIV and AIDS. This example shows that taboos are best tackled by addressing the root causes, in this case traditional beliefs and fears. It is important to win the support of traditional leaders and local authorities, particularly in areas where such customs are still widely practised, by proving that long mourning practices hinder peoples' efforts to survive. Modifying traditions takes time, and a respect for traditions is essential if they are to be modified in an appropriate manner.

4.3 Community responses with regard to HIV and AIDS

Community self-help efforts are of key importance for grassroots development; this is also true when dealing with HIV and AIDS. Communities have developed a variety of complex responses to cope with the overwhelming effects of HIV and AIDS. Mobilizing and strengthening self-help potential within communities helps counteract labour and capital constraints through e.g., labour-sharing arrangements, savings and credit schemes, and mutual assistance. The following examples show how projects can support community-based responses to HIV and AIDS.

Strengthening community-based responses to HIV and AIDS

Caritas and Development, Sumbawanga, Tanzania

In 2007, three community organizations focusing on the needs of orphans, widows and people living with HIV asked the Caritas and Development Office of Sumbawanga to build their capacity on HIV and AIDS and income-generating skills. Caritas gave them training on how to prevent HIV, mitigate the effects of HIV and AIDS, and use participatory approaches in planning, implementation, monitoring and evaluation. The initiative described below was the result of a community organization requesting for assistance, rather than from Caritas's own mainstreaming efforts.

Responses to HIV and AIDS

One of the three community organizations, based in Mkima village, is the Farmers' Groups Network. This consists of four groups with a total of 45 members. Caritas and Development helped this organization improve the quality of its services by training it in HIV prevention and HIV and AIDS mitigation services.

Effects

The Farmers' Groups Network itself developed the mechanism to help vulnerable people. It persuaded every household in the village that was able to produce surplus food to contribute 10 kg of maize or beans to vulnerable households in the community. The community organization distributes this food to orphans, widows, people living with HIV, and other vulnerable groups. The organization also persuaded the village community to contribute 300 kg of maize for distribution to the disadvantaged groups.

The organization provides counselling services to disadvantaged groups. It has counselled twenty orphans, fifteen widows, and six people living with HIV with these services. It has provided pigs to five families (of whom four have increased their incomes and living standards). Twenty orphans and vulnerable children can now go to school.

Sustainability of community organizations

The community organizations have participated in every step of planning, implementation, monitoring and evaluation of their activities, so have gained a sense of ownership. They work hard to identify and solve their problems in the groups, families and the community.

4. Good practice examples of HIV/AIDS mainstreaming

The community organizations together with Caritas and Development have identified the need for mobile services on voluntary counselling and testing, further income-generating activities for affected people and for others with low income as well as vocational training for the youth in order to address the vulnerability to HIV infection in their community.

Lessons

This example demonstrates community-based activities to cope with HIV and AIDS. The community organizations originated the initiative and feel they own it, so are very likely to continue it. Community organizations know best what kind of assistance vulnerable individuals and households need. They know how to mobilize other community members, but they may lack skills. Providing technical and planning skills and supervisory services to strengthen the activities of such organizations is of key importance. Helping communities help themselves is crucial.

HIV/AIDS mainstreaming in the Support of Peasant Initiatives Development Programme

Diocesan Development Office Nyundo, Rwanda

The Support of Peasant Initiatives of Development Programme is a rural development programme initiated by the Diocesan Office for Development (BDD) under the Caritas of the Diocese of Nyundo/Gisenyi in Rwanda. This programme operates in a part of the Nyundo Diocese, which comprises 11 parishes and coincides with the former province of Gisenyi. The target groups for this programme are 55 farmers' groups or agro-oriented cooperatives with a total of 2,052 members.

The programme's main objectives are to promote sustainable agriculture and good management of agricultural production, strengthen farmers' groups and cooperatives, and enhance the capabilities of BDD-Nyundo.

The development programme has a range of activities, including combating erosion (agroforestry, cultivation of the soil-stabilizing vegetation, anti-erosion ditches, terraces), fruit farming (passion fruit, avocado, pineapples, plums, etc.), gardening (amaranth, spinach, carrots, etc.), small livestock raising (goats, chickens, rabbits), the production of organic manure, crop production, biological pest manage-

ment, food storage by families and groups, supporting farmers' groups to form cooperatives, promoting the self-help activities, and capacity building of target groups and staff.

Mainstreaming HIV/AIDS

Before starting the HIV/AIDS mainstreaming activities among the target groups, meetings were held with all staff of Caritas Nyundo/Gisenyi to increase their knowledge on the issue and to plan joint actions on HIV and AIDS between BDD and the AB Project (Abstinence, Be faithful), a project implemented by the Caritas health department.

Then BDD-Nyundo conducted HIV/AIDS mainstreaming activities with all the target groups it supervised. In the first phase, it sensitized the groups on HIV and AIDS and linked HIV/AIDS issues to agricultural productivity. Each extension worker conducted sessions, sometimes assisted by staff of the AB Project. After these sessions, some of the group members went for HIV testing.

One of the programme's target groups, with 40 widows as members, has been sensitized to HIV and AIDS. As one result, everyone in the group has had voluntary screening; 18 of the 40 members turned out to be HIV-positive. Stigma occurred in the beginning, but the battle against it has been successful: the infected members are now very well integrated into the group and are not marginalized. Those who are not yet ill take part in activities that do not require too much labour: for example, they engage in livestock breeding, gardening and fruit farming. The sick members are helped by several other members; for example, the group president has long been sick and the group has helped her cultivate her fields.

In the second phase, BDD-Nyundo plans to continue its work on HIV and AIDS as part of its regular activities, for example by promoting labour-saving activities, crop varieties and nutritious crops. Because of the genocide in 1994 and afterwards, Rwanda already has a large number of orphans, widows and single mothers. The project makes no distinction between these and the people affected by HIV and AIDS. Rather, the mainstreaming approach is also of benefit for those groups.

Effects

- The Caritas staff have realized the importance of knowing their own HIV status. All staff members have gone for HIV counselling and testing.

4. Good practice examples of HIV/AIDS mainstreaming

- Discussions among the staff have led to honest and sincere collaboration between BDD and the AB Project on HIV and AIDS.
- Collaboration between BDD and the AB Project has led to considerable synergies. For example, AB Project field staff, who work normally with young people, were able to use their subject-matter expertise to discuss the issue with BDD's adult farmers.
- A large number of people were reached with messages on HIV and AIDS, and some decided to go for testing. Those who know they are HIV-positive can seek medical assistance.
- Success in the fight against stigma towards group members living with HIV.

Lessons for mainstreaming

Through the mainstreaming process, Caritas staff members have gained personally by discussing HIV and AIDS. The target groups have much better access to information through the collaboration with the AB Project HIV/AIDS specialists. They have started helping each other more in times of sickness, fighting against stigma, and openly discussing HIV and AIDS within their groups.



Agricultural extension is especially important to improve food security of affected households, to create solidarity and mutual assistance

4.4 Mobility and migration

Mobility and migration are key factors in the spread of HIV by increased vulnerability to infection. Families are separated for longer periods, and partners are more likely to engage in extramarital affairs. Unfortunately, development projects may increase mobility among their staff and target groups. The examples in this section show how projects can reduce the need for migration and how they can avoid unintended negative side-effects of project activities related to mobility and migration.

Reducing the vulnerability of overseas Filipino workers and their families

Episcopal Commission for the Pastoral Care of Migrants and Itinerant People, Philippines

The Philippines is one of the world's largest labour exporters. According to the Department of Health in June 2006, there were 2,566 people living with HIV in the Philippines. Of these, 891 (31%) were former work migrants. Not many migrant workers know about the situation they will expose themselves when working overseas. The key objectives of the Episcopal Commission for the Pastoral Care of Migrants and Itinerant People (ECMI) are to create awareness about the risks associated with overseas migration and to strengthen family ties while people are separated. ECMI works with overseas Filipino workers on their return to the Philippines, as well as with their families, students and potential migrants in parishes, schools and other institutions.

Mainstreaming HIV/AIDS

Along with other religious and pastoral agencies in the Philippines, ECMI was involved in developing the *Training manual on HIV and AIDS for Catholic Church pastoral workers* with UNAIDS assistance, for use in a seminar on HIV and AIDS among pastoral workers for migrants. ECMI has incorporated HIV and AIDS in its activities on the realities of overseas migration addressing potential, actual and former work migrants and their family members.

Effects

- ECMI has started giving seminars on potential risks related to overseas work that include sensitization on HIV and AIDS, which is discussed as a "social cost of migration". Potential migrants are concerned about the consequences of living overseas, including the risk of HIV infection.

4. Good practice examples of HIV/AIDS mainstreaming

- ECMI has established a livelihood programme to help families left behind by the migrants to spend remittances from the overseas workers wisely. This programme trains family members on income-generating activities and savings. ECMI thus tackles the vicious cycle of poverty and the dependency on migration and remittances, and helps overseas migrant workers find a means of livelihood when they return home. ECMI also addresses vulnerability to HIV infection by strengthening family relationships across the distance.
- Further plans include enhancing networking on HIV and AIDS, especially for referring overseas workers who have contracted HIV, and holding in-depth seminars on HIV and AIDS for pastoral workers who deal with actual and potential migrants.

Lessons for mainstreaming

Work migration contributes considerably to the spread of HIV. Besides creating awareness on HIV and AIDS, it is important to stop the vicious cycle of poverty and migration in order to successfully address this vulnerability factor. Other projects, also in a high HIV prevalence context, can learn from this example: it is important to provide economic alternatives to reduce mobility and migration as one root cause of HIV infection.

Conversely, projects also need to avoid increasing the mobility and long family separations of target groups and staff.

Minimizing mobility and migration

Swiss Development Cooperation, Nepal

Some projects enhance mobility, especially those in transport and construction. In the SDC-funded District Road Support Programme (DRSP) in Nepal, a social assessment in 2000 led to a comprehensive strategy for HIV/AIDS mainstreaming. DRSP focuses on building district roads. It has a strong social mobilization component, which is allocated 5% of the construction budget.

Mainstreaming HIV/AIDS

- In every DRSP road project, major social issues are identified and prioritized in a participatory rural appraisal.
- The potential HIV and AIDS-related side-effects of the project are discussed. As a preventive measure, only local workers are employed and no female workers are allowed to sleep in the construction camp.

- Several activities with a social focus accompany the planning and implementation phases: savings and credit programmes, literacy and English teaching campaigns, livestock rearing, non-timber plantations, and services on hygiene, basic health, reproductive health, family planning and HIV and AIDS.

Effects

Through the programmes external mainstreaming efforts, local people are increasingly willing to participate in sensitive discussions on reproductive health as well as HIV and AIDS. The acceptance of condoms and family planning among workers and target groups has increased. Internal mainstreaming has included creating an emergency fund for local workers, built and managed by the workers themselves with programme support.

Lessons for mainstreaming

Construction projects risk evoking unintended negative side-effects if they recruit workers from other areas, so increasing their mobility. This example shows that projects can minimize such unintended effects. Social issues, and therefore also HIV and AIDS, were considered during planning, and a tailor-made response was planned. Measures to reduce negative side-effects in construction projects include employing local workers, avoiding women staying in the construction camp overnight, conducting HIV and AIDS awareness sessions, promoting income-generating activities and promoting savings so workers use their earnings wisely (for instance, by investing in sustainable enterprises that will bring in income after the construction project has ended). Power relations should also be taken into account, for instance between foremen and female workers, and clear behaviour codes stipulated in a “code of conduct” will improve protection for women against sexual harassment.

More information → SDC (2004)

4.5 Water and sanitation and HIV and AIDS

Access to safe drinking water and sanitation is very important in the response to HIV and AIDS. For example, drinking safe water helps people avoid water-borne diseases, and hygienic sanitation facilities near the home are crucial for people living with HIV and family members who care for a sick person. Good hygiene is essential to avoid certain infections and diseases. The following example illustrates mainstreaming HIV/AIDS in the water sector.

Water and sanitation: Addressing behaviour and special needs for vulnerable people

Ukamba Christian Community Services, Kenya

Ukamba Christian Community Services (UCCS) works in the Eastern Province of Kenya. Its vision is to have “empowered communities in Ukamba who enjoy sustainable livelihoods free from food insecurity, unstable incomes, and inadequate water supply”.

Seeing the effects of HIV and AIDS on the community and on its own organization, the idea of mainstreaming HIV/AIDS at both organizational and community level started in October 2004 when Bread for the World organized a workshop for its partner organizations on mainstreaming HIV/AIDS and gender.

Mainstreaming HIV/AIDS

After developing a workplace policy on HIV to address the prevention aspect and the effects of HIV and AIDS on the staff and the organization, UCCS started to look at the effects of HIV and AIDS on the communities.

UCCS modified its interaction with the community in various ways. It developed codes of conduct for workers employed by UCCS and for community members. These codes of conduct attempt to minimize the risk of HIV infection. They were prepared by the communities and validated in a public community gathering, facilitated by UCCS. The management of the community organization oversees the implementation of the codes, while UCCS monitors their application.

The code of conduct stipulates how staff should interact with the communities. It includes issues such as when to finish a community

gathering (so people can get home before dark), appropriate dress, the use of responsible language, avoiding sexual harassment, etc. Before anyone is sub-contracted by UCCS, he or she has to read, understand and sign the code of conduct.

UCCS considers HIV/AIDS mainstreaming at all levels of its programme implementation. For example, it now installs water infrastructure up with HIV and AIDS in mind. A water point is not located somewhere where it might encourage sexual violence and rape, but in a central place (such as a market) frequented by a lot of people. The sick and people living with HIV are granted special conditions in contributing to the project. The location of demonstration sites are chosen to give priority to people with special needs.

Effects

The HIV/AIDS mainstreaming efforts have reduced stigma and increased community participation in project work.

Lessons for mainstreaming

UCCS addresses HIV and AIDS through both internal and external mainstreaming.

The external mainstreaming effort focuses on risk reduction. For example, the programme develops codes of conduct that regulate the relation between staff and the community, with the aim of minimizing risk situations. Project sites are chosen carefully to avoid risk – for example, water points are built near public places.

Further, people with special needs like people living with HIV are benefiting from projects realized near their houses. Other benefits in the field of water and sanitation would be promoting water harvesting from roofs for affected households, further improving access to water for drinking, washing and cooking (vital to keep people living with HIV healthy), and building latrines nearby for weak persons. Like in all other projects, the active involvement of people living with HIV in planning and implementing water and sanitation projects would make it easier to respond appropriately and avoid their being excluded from project activities.

Lobbying for improved living conditions on commercial farms

Eastern Cape Agricultural Research Project (ECARP), South Africa

Tenure conditions for farm workers and dwellers have not changed much since the end of the apartheid in 1994. Farm workers and dwellers continue to live under poor conditions with no access to basic services such as health, clean drinking water, sanitation, electricity and adequate housing. All these issues need to be addressed properly in order to reduce also the vulnerability of farm workers to HIV infection and to the effects of HIV and AIDS.

Mainstreaming HIV/AIDS

Since 2005, ECARP has established farm committees on 48 commercial farms. The committee members have gone through training on legislation, health issues including HIV and AIDS and rights to access health care and other basic services, clean water and sanitation. They have devised ways to address these issues to farm owners and identified those that need to be referred to the government. As a result, it has been possible to lobby for improved living standards for farm workers and other residents.

Effects

The farm committees have identified issues that could be hazardous to the well being of farm workers and dwellers: lack of sanitation, contaminated water, poor housing conditions, etc. Seven farm committees have successfully lobbied for toilets on their farms. This has benefited 271 farm workers and residents in 62 households. Thirteen more farms have improved the quality of water, benefiting 498 people in 115 households. Nine farms have successfully negotiated with farmers for land to grow vegetables; this has provided 239 people and 55 households with a chance to improve their food security and nutrition. At least two areas have compelled the district municipality to reinstate a mobile clinic service cut off in mid-2008.

Lessons for mainstreaming

ECARP uses mainstreaming HIV/AIDS strategically to strengthen its existing approaches to achieve its goals – improving the living conditions of farm workers and their families. Access to safe drinking water, sufficient water for household use, toilets close to the house, balanced nutrition, and access to health care services are particularly important for people living with HIV. Improved food security reduces the need for income gained through sex.

4.6 Food security

The most immediate effect of HIV and AIDS in agriculture is the loss of labour due to chronic illness and death. This may lead to cultivation being delayed, land being left fallow, production systems changing, and farmers becoming dependent on hired labour. All these reduce agricultural production and harm livelihoods. Agriculture extension projects are challenged to modify their approach, for example by promoting labour-saving methods, and adjusting their messages to cater for elderly, female and child-headed households. The following examples show how agricultural projects can be modified to deal with HIV and AIDS.

Promotion of sustainable agricultural practices in an HIV and AIDS context

Sustainable Agriculture Programme of Caritas Iringa, Tanzania

The Sustainable Agriculture Programme of Caritas Iringa promotes the sustainable use of natural resources to improve the livelihood of small-scale farmers in the Diocese of Iringa, in southwestern Tanzania. It works with various groups in 15 villages, providing training in sustainable, integrated crop and animal production, storage and processing, and group management skills. The programme targets vulnerable households. About 52% of group members are women, and around half of them are members of households headed by women.

Mainstreaming HIV/AIDS

The latest phase of the programme has been planned with an “HIV and AIDS lens”. Vulnerable and affected households mainly benefit from the following activities.

- The programme improves nutrition and household income by promoting the growing of vegetables and fruit trees in backyards. Seedlings from backyard fruit-tree nurseries can fetch high prices; the business is very suitable for affected households because it does not require heavy labour.
- Small-scale animal production, mainly chickens, pigs and milking goats, is promoted. Affected households in particular benefit from improved chicken production, which has a quick turnover and improves household food security.

4. Good practice examples of HIV/AIDS mainstreaming

- Improved beekeeping methods are also beneficial for vulnerable households; beekeeping requires limited amounts of labour and investment, while honey can produce extra income and is nutritious.
- The programme promotes fruit and vegetable processing so households can store these items when they are in surplus.
- Introducing light equipment saves energy and time for affected households. For example, ploughs and pedal pumps ease farm operations, while ox carts, bicycles and wheelbarrows help with transportation.
- The programme has entered complementary partnerships with the Caritas AIDS programme and other organizations to carry out awareness sessions on HIV and AIDS among its target groups.

Effects

The process of mainstreaming started 1.5 years ago, so is still new. However, all Caritas staff members understand and practise HIV/AIDS mainstreaming, and their knowledge is steadily increasing. Target groups are also becoming more aware of the root causes and effects of HIV and AIDS, and group members now show more tolerance for people living with HIV.

Box 32. Reducing seasonal migration through improved income in Mtambula village

The HIV prevalence among labourers on tea plantations in Tanzania is high. As one result of the gender approach, couples who are members of groups affiliated with Caritas Iringa have started to work more together in their fields. As a result of programme interventions, they earn more from farm work such as growing potatoes and vegetables, and from raising chickens and pigs.

Many of the men have stopped migrate to the tea plantations, 60 km away, where they work as casual labourers and are exposed to a way of life that favours multiple sex partners. The women also prefer that their husbands are around.

Lessons for mainstreaming

This programme promoted various agricultural activities that are beneficial for affected households because they bring in money, save labour and enhance food security. These activities include labour-saving cultivation methods, small-scale animal production, tree nurseries and honey production. Generally, income-generating activities for

affected households should require few inputs and little labour. They should assure quick turnover and returns throughout the year. To minimize risk, a multipurpose product with high local demand may be preferred. It is also beneficial if the business can be run close to the homestead. The example of Mtambula village (→ Box 32) reinforces the importance of local economic empowerment to reduce seasonal migration, a key factor for HIV infection.

Reducing risk situations in an agricultural extension project

Agency for Integrated Rural Development, Uganda

The intervention area of the Agency for Integrated Rural Development (AFIRD) is near Kampala, Uganda. The project works with 38 farmer groups with an average membership of 20. About 60% of its target groups are women.

Mainstreaming HIV/AIDS

One of AFIRD's staff is a trained HIV/AIDS counsellor, and for some years the agency has facilitated sensitization sessions on HIV and AIDS. AFIRD gives consideration to avoiding unintended negative side-effects of programme activities. For example, farmers are now trained near their villages, and trainings end by 4:00 pm so the participants have time to get back home before dark.

AFIRD has various other mainstreaming activities. It trains farmers on soil and water conservation methods, and if labour is a constraint, it offers alternative methods, such as working in groups, zero tillage and roof-water harvesting for domestic use. It emphasizes the importance of vegetables and fruits for health. Partnerships are formed with organizations specialized on HIV and AIDS. AFIRD provides information materials on HIV and AIDS to the communities, sensitizes them about the linkage between agriculture and HIV and AIDS, and encourages people to get tested so they know their HIV status. People who have disclosed their status are referred to HIV/AIDS support organizations.

Effects

At the organizational level, the staff members are actively involved in issues concerning HIV. AFIRD was elected chair for the coalition on HIV and AIDS in Wakiso District.

4. Good practice examples of HIV/AIDS mainstreaming

At the target group level, some farmers have willingly disclosed their status to project staff and have adopted an attitude of “living positively” with the infection. The target groups help each other more as a result of AFIRD’s work. Various challenges remain:

- Some sustainable agricultural practices are too strenuous for people living with HIV, and more alternatives have to be found.
- People who are infected still face stigma and discrimination.
- More networking and funds are needed in the area of HIV and AIDS.
- Regular capacity building of staff is needed on HIV and AIDS, as well as a clear monitoring and evaluation system for mainstreaming.

Lessons for mainstreaming

For AFIRD, mainstreaming HIV/AIDS means revising the content of its extension messages (e.g., promoting labour-saving methods), and adjusting its mode of operation to avoid risk situations (e.g., closing project activities well before dark and training farmers near their villages). The project wants to develop an outcome monitoring system for HIV/AIDS mainstreaming that is linked to its existing planning and monitoring efforts.

Home gardening and labour-saving methods

The Valley Trust, South Africa

The Valley Trust, a partner organization of Bread for the World, aims to improve people’s health status in rural KwaZulu-Natal, South Africa. For a number of years it promoted community gardens to improve people’s food security. Since nutrition is of paramount importance for households affected by HIV and AIDS, the programme seemed very relevant. But due to the worsening situation of HIV and AIDS in the community, fewer and fewer people were interested in working in the community gardens.

Mainstreaming HIV/AIDS

The Valley Trust discussed this issue with the target groups. It found that the community gardens were some distance from the homesteads, so people affected by HIV and AIDS could not get to them easily. Those who had to look after sick relatives could not spend long hours away from home. Infected people found the walk to the garden too exhausting and the gardening itself too much work, given their other roles as caregivers, particularly for young children.

The Valley Trust and the target groups sought a solution together. The

Valley Trust changed its approach and started promoting gardens in the homestead making it possible for people to work in their garden and still look after the sick and children.

The Valley Trust also modified its technical interventions to suit household food production. It now promotes the interplanting of crops; small, highly productive, diverse vegetable production; water harvesting; seed saving; bed composting; and the cultivation of medicinal plants to treat certain opportunistic infections.

The Valley Trust’s approach contains a strong element of nutrition security, which includes produce preparation, cooking and storage. It advocates growing fruit trees, which require little labour and produce nutritious, vitamin-rich fruit, and the rearing of chickens for meat and for sale.

By working with the households’ real situation and needs, The Valley Trust staff greatly developed their capacity to deal with HIV and AIDS-related issues.

Effects

Adapting both the general project approach (a shift from community to homestead gardens) as well as the farming techniques (from single crops to intercropping, and adding fruit trees, poultry and medicinal plants), enabled households affected by HIV and AIDS to continue to benefit from the programme and to improve their health. The shift also helped strengthen the social relationships between households, so nurturing a caring environment for people infected and affected.

Lessons for mainstreaming

Other studies have also shown the benefits of homestead gardening for affected households. Gardening can be combined with household’s tasks (including caring for a sick person). Homestead gardens usually have many crops (including medicinal plants), so improve the intake of micronutrients and boost the immune system. Garden produce can be sold to earn money. One caution: some medicinal plants cause negative effects if combined with other medicines such as antiretroviral drugs.

Responding to weakness and low participation among target groups

The Umthathi Community and Home Food Garden Unit, South Africa

Food security is important in the response to HIV and AIDS. Many affected individuals and households are not able to maintain a home garden because they are short of labour and face other constraints. They have to divert money for food to cover other expenses, and food security often decreases. For the most vulnerable groups, the Umthathi Community and Home Food Garden Unit aims to improve access to healthy food by promoting home gardens based on permaculture principles.

Training facilitators from Umthathi realized first-hand the effects of HIV and AIDS on their target groups. Some training participants were weak and unable to do all the physical work needed. Drop-out rates from the courses rose markedly. The facilitators therefore changed their techniques and training approach.

Mainstreaming HIV/AIDS

Umthathi added nutrition courses including how to prepare food in the right manner (not overcooking it so as to preserve as many nutrients as possible) to help people directly or indirectly affected by HIV and AIDS live healthier lives and boost their immune systems. The facilitators organize special lessons for absentees.

The organization promotes labour-saving methods. Instead of “trench digging”, it now promotes “double digging” because this method takes less work. It also advocates a technique called sheet mulching as being energy-efficient and enhancing soil fertility. Other techniques include intercropping (which reduces weeding time), making liquid manure, and growing vegetables and herbs in bottle gardens, old baths or tyres.

Umthathi has entered strategic partnerships to provide training on home gardens for clinics, hospices, child welfare and HIV/AIDS support centres, with a special focus on labour- and time-saving methods.

Effects

Intercropping allows a large variety of vegetables to be grown on a small area of land. This variety helps people eat a balanced diet. Intercropping also reduces pest attacks and weeds and increases the nutritional value of the soil. Mulching further reduces the time spent on weeding and conserves water. When a plant is harvested or removed, another seedling is put in its place. This saves energy.

Cultivating indigenous crops, such as wild garlic, is encouraged. Such indigenous crops are often highly nutritious and intercropping with them reduces pest infestation.

People living with HIV benefit from home gardens in many ways: a balanced diet strengthens their immune system; and the money saved on food can be used for other purposes (for example, to pay the transport costs for medical check-ups or to buy medicine). Participants are trained in nursery practices, so they no longer have to buy seeds and can support themselves. Through Umthathi’s partnerships with HIV/AIDS organizations, many people living with HIV can continue to benefit from Umthathi’s programme.

Lessons for mainstreaming

At the Umthathi Community and Home Food Garden Unit, mainstreaming HIV/AIDS means promoting energy-, labour- and time-saving methods, and using local resources. The unit has established partnerships with organizations specialized in HIV and AIDS. By working with these organizations, Umthathi gains expertise on HIV and AIDS and related issues, and frequently refers target group members to them for assistance.

4.7 Knowledge transfer to orphans and vulnerable children

Children are particularly hard hit by HIV and AIDS. Many children are distressed by the sickness and death of their parents. They do not learn traditional skills and livelihood strategies from their parents, or from relatives if they are not nearby. They often have to drop out of school early due to financial and time constraints. The following two examples deal with knowledge transfer to and support of orphans and vulnerable children.

Securing knowledge transfer to vulnerable children and orphans

Kitovu Mobile Farm Schools, Uganda

The Kitovu Mobile Farm Schools Project targets teenage school drop-outs, providing them with skills in sustainable crop production, animal husbandry and farm management. Priority is given to the most vulnerable and needy children. In most cases these are children from very poor families, or orphans whose parents have died of HIV-related diseases or have lost them for other reasons. In addition to training vulnerable children in modern sustainable organic farming, the project aims to strengthen the capacity of target communities to address the psychological and economic effects of HIV and AIDS within the community.

4. Good practice examples of HIV/AIDS mainstreaming

Note that this is not a “real” mainstreaming example as the Kitovu project already addresses vulnerable children and orphans, many of whom have been affected by HIV and AIDS. But it shows how to ensure knowledge transfer and may encourage other projects realizing mainstreaming to assist these children and youth.

Responses to HIV and AIDS

The project is open to teenagers who have had to leave school and are not able to continue formal education. Recruitment is highly selective in order to minimize dropout rates. After the children have been selected, the head of their household must sign a binding memorandum of understanding. The trainees learn skills in sustainable agricultural production, post-harvest storage, animal production, farm management, etc. Orphans attend classes in literacy, basic mathematics and HIV and AIDS awareness. The training lasts for 2 years and combines residential with on-farm training. The courses are supervised by qualified agriculturalists in collaboration with district government extension staff. Local schools and communities provide land for farming and demonstrations. The trainees practise their new skills in their home communities on land provided by families, guardians or neighbours.

Effects

Over 400 young people were trained in the first phase (across five districts) from 1998 to 2000. The ratio of girls to boys was 3 to 5. The second phase began with 550 trainees lasting from 2000 to 2002. Some 15% of the initial graduates raised enough funds to buy land for themselves. Over 70% graduates continue to farm in their local areas.

Many of the young trainees came to consider farming as a proper business. This reveals a considerable change in attitude, as many young people used to regard farming as an activity more suited to the elderly. The young trainees now act as advisers on agricultural practices within their communities, and have gained higher status.

Communities have been mobilized to contribute to development activities, and people are encouraged to participate, for example by providing land. The programme makes a great contribution to the empowerment of orphans and vulnerable children, and thus to HIV prevention and HIV and AIDS mitigation.

Lessons

The project employs strict recruitment procedures as a means assuring

project success. In addition to promoting the transfer of knowledge to orphans, the project also mobilized rural community support for them. A high percentage of the project graduates continue to farm; this has manifold positive effects on the rural communities and HIV and AIDS. Fewer young people migrate to town, and this helps stimulate the local economy, enhances food security and reduces the vulnerability to HIV.

More information → White (2002)

Agricultural knowledge transfer and school meals for the most vulnerable children

Umthathi School Garden Programme, South Africa

In the townships around Grahamstown, in the Eastern Cape province of South Africa, unemployment and poverty levels are very high. Young people are often disillusioned about their future. Umthathi runs its School Garden Programme in a number of primary and secondary schools in the townships around Grahamstown and in rural areas. A facilitator supports one school for a period of 3 years. After this time, the school has completed the programme and is expected to run the garden without external support. The programme trains the students in sustainable agricultural methods, business skills and life skills, which includes HIV and AIDS. The garden produce is used to feed the school children.

Mainstreaming HIV/AIDS

Classes at each school are selected by the principal for training in sustainable agriculture methods, with emphasis on soil fertility, environmental education and development skills. The students are encouraged to farm at their homesteads as well, and to pass on their knowledge to their parents and caregivers. At some schools, the vegetables produced in the garden are used to provide meals for the most vulnerable children. Surplus products are sold to the community at reasonable prices. In some cases, drama groups raise awareness on HIV and AIDS, the importance of gardens and healthy food.

Effects

Pupils become aware of the importance of agriculture and learn how to apply sustainable agricultural practices from a young age. They often establish their own home gardens and transfer the knowledge acquired to their families, friends and neighbours. The most vulnerable

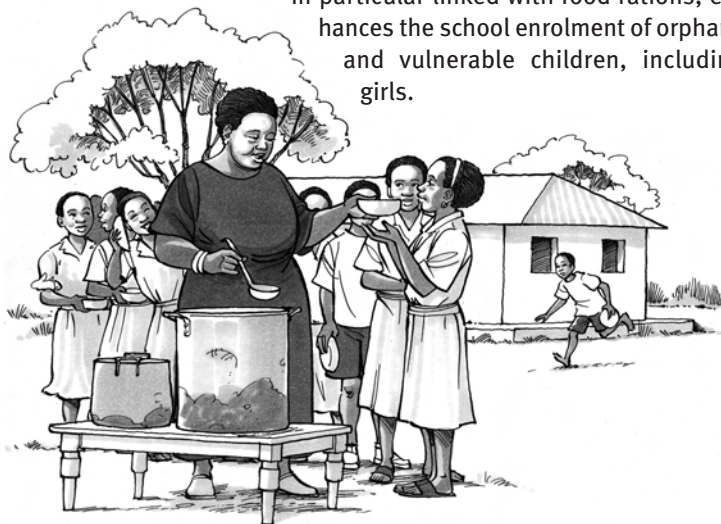
4. Good practice examples of HIV/AIDS mainstreaming

children profit from their new knowledge and the food grown, and their health improves.

The School Garden Programme imparts life skills, including HIV and AIDS awareness. Generally, the self-esteem of students is enhanced. Through the increased availability of vegetables within the community, the programme has a positive impact on food security.

Lessons for mainstreaming

The School Garden Programme is a good example of how to transfer agricultural knowledge and general life skills to children (especially orphans and vulnerable children), and how to improve their health status. It is very important to provide one nutritious warm meal per day to the most vulnerable children. Experience shows that school feeding, in particular linked with food rations, enhances the school enrolment of orphans and vulnerable children, including girls.



School meals and nutrition education

4.8 Nutrition

A balanced diet is very important for strengthening the immune system of people living with HIV. For people who are on antiretroviral treatment, a rich, balanced diet is of paramount importance. The next example deals with the link between HIV and AIDS, nutrition and herbal remedies.

Training on nutrition with regard to HIV and AIDS: Establishing family support groups

The Umthathi Health, Hygiene and Nutrition Unit, South Africa

The Umthathi Health, Hygiene and Nutrition Unit supports family health by providing information on nutrition and disease awareness and prevention. HIV and AIDS affect the work of the Unit in various ways; for instance, participants may have to go to hospital, attend funerals or travel to town to pick up social grants. HIV and AIDS have transformed the role of the trainers, who increasingly function as informal HIV and AIDS counsellors. The facilitators in the Unit have mainstreamed HIV/AIDS in several ways.

Mainstreaming HIV/AIDS

The Unit links HIV and AIDS to its core work; training now includes sessions on HIV and AIDS, nutrition, first aid, and how to make herbal remedies for people living with HIV. The facilitators use their close links to the target groups to stimulate discussion on HIV and AIDS and related topics, such as gender violence. The facilitators hold sessions on HIV and AIDS awareness (including condom demonstrations) and refer the target groups to relevant support organizations with voluntary counselling and testing facilities. The facilitators distribute the “Umthathi HIV and AIDS referral list” (a list of all organizations working on HIV and AIDS within the zone). Condoms are also made available.

The facilitators encourage the establishment of family support groups. From each training course, one participant is nominated to form a family support group. During the last week of training, a meeting is organized for all nominated persons where they can get to know each other and share experiences. The facilitators refer the volunteers to local clinics, where they meet the persons in charge of HIV/AIDS support programmes in order to gain information and continue training. The project has engaged a social worker to provide emotional support to facilitators if necessary.

Effects

The course participants are aware of the relationship between a balanced diet and a strong immune system, and that people living with HIV are prone to other diseases (opportunistic infections). They have learned how to care for people living with HIV and how to prepare herbal remedies. One caution: Some herbal remedies cause negative effects if combined with other medicines such as antiretroviral drugs.

The facilitators are role models for their target groups. They promote the ABC approach: “Abstinence before marriage, Be faithful within marriage/to your partner, Condom use”. Many participants are encouraged to go for voluntary counselling and testing.

The family support groups have been successful in several ways. The groups are introduced at community meetings, and the course participants help to draw attention to their existence. Support group members often become volunteers at clinics. During the monitoring phase, facilitators receive information on the progress of the support groups. Facilitators keep in touch by telephone.

Lessons for mainstreaming

The holistic mainstreaming strategy focuses on root causes of vulnerability to HIV infection and mitigation of the effects of HIV and AIDS. The establishment of family support groups assures a wider impact on the community. It might be beneficial to establish a mutual support system between affected households and to further strengthen community efforts with regard to HIV prevention and HIV and AIDS mitigation in order to reduce stigma and discrimination. The high frequency of gender-based violence and rape in South Africa mean it is crucial to fight them.



Cooking demonstration of a balanced meal

4.9 Land rights

In many patrilineal societies, widows and (female) orphans cannot inherit property or land. This makes them very vulnerable after the death of the husband, father or parents. Relatives often grab the land and other property of widows and orphans. HIV and AIDS worsen the situation of women and children. That is one more reason it is important for projects to address the issue of insecure land rights. The next example describes the land redistribution process in South Africa.

Secured land titles for farm workers and dwellers and secured heritage regulations for widows under communal property associations

Eastern Cape Agricultural Research Project (ECARP), South Africa

South Africa still has a land ownership pattern skewed in favour of its white population. Through the Land Redistribution for Agricultural Development Act (LRAD), formerly disadvantaged people can now purchase land through the willing-buyer willing-seller principle. With the aim of securing land tenure rights and establishing the conditions necessary for sustainable livelihoods, ECARP facilitates the process of land redistribution, in particular to farm workers and dwellers on commercial farms who were formerly denied access to land.

One of ECARP's major activities is to secure land titles. With this it indirectly influences positively also on the target group's root causes of vulnerability to HIV infection and on the effects of HIV and AIDS.

Activities

ECARP assisted former farm workers and dwellers at Trentham Park Farm to buy the farm and to form four communal property associations (CPAs), which are legal entities under LRAD. The aim was to secure full ownership of the land, and to develop separate businesses for each CPA. ECARP also lobbied the Department of Agriculture to provide infrastructural support to the CPAs.

Effects

Buying the farm secured the farm workers' tenure. They can settle on the farm without threat of eviction.

4. Good practice examples of HIV/AIDS mainstreaming

Land ownership provides a basis for diversified sustainable livelihoods. The new farm owners are in a position to break the cycle of poverty and dependency afflicting many farm workers and dwellers. As they can earn their livelihood from their own farm work, the pressure to migrate in search of work (and so engage in casual sexual relations) is minimized.

Food security is improved through opportunities for livestock husbandry and crop cultivation. Surplus products can be sold at the market. This food security has improved the workers' health status, and reduces their vulnerability to the effects of HIV and AIDS.

The CPAs offer assistance when family members fall ill. The CPA constitution ensures that the immediate family members inherit the CPA membership and all assets on the death of a member.

Lessons for mainstreaming

In general, secure land titles are important to assure the means of livelihood. In the context of HIV and AIDS, secure land titles are of strategic importance as widows and orphans frequently are subject to land and property grabbing. The CPA constitution recognizes the right of family members, including children, to inherit land, and so contributes to HIV and AIDS mitigation. This example can encourage other projects to lobby for secured land rights for women and children.

4.10 Social protection schemes

HIV and AIDS can have devastating effects that many households are unable to overcome – such as the death of their main breadwinner. The household becomes more and more dependent on help from outside – from the extended family, other community members, organizations and the government. Social protection schemes from the government may include health insurance, contributory (or non-contributory) old-age pension schemes, and child and disability grants. The following example shows the importance of government social protection schemes in the HIV and AIDS context. It shows how projects can help affected households to benefit from such schemes.

Helping farm labourers to access unemployment funds

Eastern Cape Agricultural Research Project (ECARP), South Africa

In South Africa, all workers on commercial farms must be registered with the Unemployment Insurance Fund (UIF). A UIF benefits claim can be made when a worker loses employment, during illness or maternity leave, or when adopting a child. A worker's dependants can also claim benefits in case the worker dies. Many farm workers and farmers also contribute to provident funds. The benefits from such funds can be used to cover funeral costs and as a source of income if the breadwinner dies. In case of sickness, unemployment, incapacity or death, UIF and provident fund benefits are often a household's only source of income. However, in reality not all farm workers, especially women, are registered. And when farm workers want to claim their benefits, they often face difficulties because of restricted access to information, illiteracy, and the farm owners' indifference to labour legislation. In the case of provident funds for example, the policy files are often kept by the farm owners, and the farm workers have no information about the fund other than seeing the deductions on their pay slips.

ECARP does not deal with HIV and AIDS directly, but its work to access funds also helps people living with HIV and affected families.

Activities

ECARP started holding awareness-raising workshops on labour legislation. It encouraged farm workers to familiarize themselves with the laws and to challenge or report any violations. It also conducted a survey to assess how many farm workers were registered with UIF. With regard to provident funds, ECARP held meetings to identify the problems and urged farm workers to seek clarity. They demonstrated the importance of keeping copies of the provident fund documents, which makes a claim easier. ECARP contacted a number of insurance companies to obtain clear information about the provident funds and the registered farms. It also contacted AgriEC (an organization representing commercial farm owners in the Eastern Cape) about the issue. AgriEC is now prepared to meet the workers' representatives.

Effects

Farm workers approached the farm owners to point out that not all workers (especially women) were registered for the UIF funds. As a result, an increasing number of women are now being registered. The number of women workers registered for UIF has increased from 212 to

4. Good practice examples of HIV/AIDS mainstreaming

262 out of 267 women working on 48 commercial farms. Helping farm workers to access these employment benefits mitigates the effects of HIV and AIDS on families. The money obtained pays for medicine and food, both for the affected and infected household members. It also guards against increasing indebtedness should the breadwinner be unable to provide for the family, due to either illness or death.

Lessons for mainstreaming

This case shows just how crucial access to information is, if farm workers and marginalized groups are to fight for their rights. The money received through the unemployment and provident funds can make all the difference in times of crisis, when chronic sicknesses strike. If such social security mechanisms exist, people need to be well informed about their access and conditions, and how and when a claim makes sense.

4.11 Microfinance and savings and credit schemes

Microfinance provides small loans and saving services to clients who do not have access to the formal financial sector. Informal savings and credit schemes also support families with financial assistance. These arrangements can play an important role to assist families to overcome the effects of HIV and AIDS. Nevertheless, the schemes are also affected by illness and death among their members. The following examples show how microfinance and savings and credit schemes can be adjusted to benefit households affected by HIV and AIDS.

Savings groups as support groups

Entrepreneurial Development Unit, Africa Co-operative Action Trust, South Africa

Families need access to financial resources if they are to escape the effects of poverty and remain independent. Households affected by HIV and AIDS usually face rising expenditures. They are at risk of indebtedness, and it becomes increasingly difficult for them to obtain loans. The Entrepreneurial Development Programme (EDP) offers loans to the poorest of the poor and provides training in business skills.

EDP is confronted with the effects of HIV and AIDS. Target group members or their relatives are affected by HIV and AIDS, and they cannot take part in meetings and project activities. Due to HIV-related sickness, productivity and income fall, making loan repayments difficult. Loans are often used to pay health bills instead of for promoting productive activity. If the borrower dies, his or her family uses all the available money for the funeral; the loan is either not repaid or repayment is delayed. Sick people are often taken advantage of by others; their assets may be stolen.

Mainstreaming HIV/AIDS

EDP had already established its basic concept: working with savings groups of five persons, the “G5s”. Under the effects of HIV and AIDS, these groups became support groups. The group members are jointly responsible for paying back the loan; if one member defaults the others are liable. In times of crisis, G5 members support each other wherever possible.

In each G5, EDP initially identified volunteers, known as “Timothies” (“faithful men who will be able to teach others also” – from the Bible, 2 Timothy 2:2). They receive special training according to their individual abilities and interests, for example in basic business skills, spiritual development, gardening, health and HIV and AIDS. The Timothies have a wide influence on community development, also in terms of HIV prevention and HIV and AIDS mitigation.

Through the group support mechanism, members help each other; they encourage good business management practices and even help the sick run their businesses when they are incapacitated.

G5 members are encouraged to save money. Before receiving their first loan, they have to open a bank account and all members together contribute an initial deposit of R 50. EDP is flexible in its dealings with affected members and assists in rescheduling loans, for example by arranging the payment of smaller amounts. There is an incentive to repay and keep proper records: upon repayment, borrowers can take out new loans.

Members are encouraged to set up home gardens in order to reduce food costs and to ensure a healthy diet for their families. Surpluses can be sold on the market. Families are advised on business opportunities which may yield better profit margins and that are less arduous

4. Good practice examples of HIV/AIDS mainstreaming

and less time consuming. EDP encourages people to save in order to be prepared for times of crisis.

Effects

The loan repayment rate has improved, due to shared rather than individual responsibility. There is a greater level of mutual support within the groups; infected members receive help from other members, for example by running errands and relaying messages.

If a G5 member dies, families are motivated to continue the business after the period of mourning. This helps families to escape the worst consequences of HIV and AIDS and to face the future. If the surviving family members do not wish to operate the business in future but repay their loans and thus reduce the debt burden, other families might take the opportunity to continue the business.

The Timothies use their skills to assist affected families, in some cases as home-based caregivers. They are well-respected within the community; they help reduce stigma and discrimination and strengthen community support.

Finally, target groups have developed trust in EDP.

Lessons for mainstreaming

EDP successfully modified its core work to respond to the effects of HIV and AIDS on its target groups and project components, thereby helping affected households to escape the worst consequences of HIV and AIDS. The G5 savings and support groups and the intensive training of community volunteers strengthen mutual support within the groups and the communities and enable the whole community to benefit from the EDP's services.

Savings and credit organizations, and groups that face the difficulty of members not being able to pay back the loans or with low financial capacity, can use various other measures. These include paying back loans without interest (or at reduced interest rates), prolonging the repayment period, and reducing the amount of financial saving capital. The group constitution may specify mutual support and acceptance of all members (including people living with HIV), avoidance of stigma and exclusion, transparency and participation in decision making.

Microfinance in an HIV and AIDS context

Foundation for International Community Assistance (FINCA), Uganda

Founded in 1992, FINCA Uganda provides financial services to low-income entrepreneurs through "village banks". It operates in regions with high HIV prevalence, so it has modified its financial services in response. It has developed several products to cater to its clients' health needs.

Mainstreaming HIV/AIDS

- **Health insurance.** In October 1999, FINCA started a pilot programme in partnership with the Nsambya Hospital Healthcare Scheme by introducing a health insurance product for its clients (and their spouses and children) that covers treatment of opportunistic infections. A co-financing strategy is used to avoid overburdening the service: apart from their payment for the insurance, clients have to pay a small fee when seeking medical help.
- **Savings plan.** In 1992 FINCA initiated a savings plan to encourage clients to save above the required amount for collateral purposes. These savings can be very useful for FINCA clients who face (or might face) high medical costs and a reduction in household income.
- **Life insurance.** In partnership with a large multinational insurance company, FINCA offers life insurance to clients, which (among other things) covers any loans outstanding when the client dies by accident. That protects family members or co-borrowers from having to pay the loans, and protects FINCA as well. The policy only covers accidental death: it does not cover death caused by illness or AIDS.
- **Service delivery.** FINCA's existing products were adjusted, for example to increase flexibility in loan amounts and repayment times, allow greater flexibility in group meetings, and enable easy access to savings and top-up loans.
- **HIV and AIDS awareness.** FINCA provides HIV and AIDS education to clients and their family members in a strategic partnership with the Church of Uganda Doctors. The seminars are linked to village bank meetings; they are held upon the request of clients, who pay for the costs.

Effects

- **Health insurance.** In January 2000, 235 individuals were already covered under the pilot scheme. While coverage is optional, at least 60% of FINCA clients in a given village bank are obliged to join to assure coverage.
- **Savings plan.** This product brings out the importance of flexible savings that are available to clients as needed.
- **Life insurance.** In January 2000, more than 123,000 individuals were either fully or partly covered by the life insurance.
- **Service delivery.** The flexibility in service delivery is a great advantage for affected households, who may face problems to pay back loans.

Lessons for mainstreaming

FINCA has successfully modified its mode of operation to adapt to the effects of HIV and AIDS of its clients. The example shows that microfinance is a business and aims at remaining profitable, also in an HIV and AIDS context. Nevertheless, the modifications, such as the introduction of insurance, are beneficial for both clients and company. Access to microfinance can be very beneficial for affected households, though the scope of microfinance remains limited. Only a small portion of households in need of financial assistance are reached. In the HIV and AIDS context, with the existence of many child-headed households, it is important to open up microfinance and training in entrepreneurship for younger people. It may also be important for microfinance institutions to provide legal services to clients (e.g., on inheritance laws) in strategic partnership with specialized organizations. For people living with HIV and their relatives, life insurance covering also death caused by illness such as AIDS would be of benefit.

More information → Parker et al. (2000), Achola (2006)

4.12 Justice and peace

HIV and AIDS are linked to human rights issues. Access to prevention, treatment, care and support are such human rights. Depending on the society people infected and affected may face different sorts of exclusion and violation. An environment where they are accepted and part of the community supports self-help capacities. The legal rights and the support of women, orphans and vulnerable children are important to tackle as well as harmful traditional practices, sexual violence and rape.

The following example shows how to address human rights issues with regard to HIV and AIDS in 'Justice and Peace'.

Human rights and "harmful" traditional practices with regard to HIV and AIDS

The Catholic Commission for Justice and Peace of Caritas Solwezi, Zambia

The Catholic Commission for Justice and Peace (CCJP) of Caritas Solwezi works in 13 parishes in the North-Western Province of Zambia. Its main objective is to alleviate poverty by promoting holistic human development. It tackles injustice in communities, deals with violations of gender and human rights, and advocates for good governance. It trains and works with volunteers. It also addresses HIV and AIDS from a human-rights-based perspective.

Mainstreaming HIV/AIDS

CCJP has started internal and external mainstreaming of HIV/AIDS. In terms of internal mainstreaming, staff members were trained on basic facts and figures on HIV and AIDS and on HIV/AIDS mainstreaming, and sensitizes new employees on these topics.

In external mainstreaming, CCJP has aligned its core activities with HIV and AIDS. Much of this has involved advocacy together with other civil society groups: for access to free antiretroviral therapy for everybody in need, for the rights of people living with HIV, for informing them about their rights to therapy, for better health services, and for mobile clinics. Such mobile clinics provide voluntary counselling and treatment in some areas, but do not prescribe or distribute antiretrovirals,

4. Good practice examples of HIV/AIDS mainstreaming

meaning that infected individuals cannot avoid long distance travel to get such treatment.

CCJP also assists people living with HIV in the fight against stigma and advocating for the rights of widows, orphans and vulnerable children, and sensitizing them to safeguard their own interests. It advises on how to write a will to ensure the inheritance rights for widows and orphans (by law, children receive 50% of the inheritance, but cases of property misuse by relatives are still reported). It supports child-headed households by providing information about assistance available and refers them to social welfare and other support institutions. It addresses the harmful traditional practices of widow inheritance and sexual cleansing. Rape is rampant, and the programme informs people about recent reforms in the penal code concerning rape.

CCJP works closely with other organizations involved in HIV and AIDS: it collaborates with the diocese's home-based care programme and refers infected people to this programme. It also provides information about free antiretrovirals. The home-based care programme informs the Justice and Peace staff if it discovers cases of stigma and discrimination.

Effects

More people now attend voluntary counselling and treatment, receive free antiretrovirals, and more people have voluntarily declared their HIV status. The amount of stigma has been reduced. Although men and women have equal access to voluntary counselling and testing and antiretroviral treatment, more women make use of these opportunities.

There is an observable positive change in behaviour through the support groups, farm production has increased at both household and community levels. Levels of sexual cleansing and property grabbing have fallen. Networking on HIV and AIDS has increased tremendously. Paralegal services (legal advice or interventions given to poor people on matters related to violation of their rights) were provided to 30 people in need in 2008.

Lessons for mainstreaming

CCJP has mainstreamed HIV/AIDS both internally and externally. It addresses HIV and AIDS from a rights-based perspective, advocating

the rights of people living with HIV in various areas: access to voluntary counselling and testing, treatment, care and support, fighting stigma and discrimination. The rights of orphans and widows are addressed in its advocacy work and in concrete actions (such as sensitization on will writing and property grabbing). Because HIV and AIDS are closely linked to the topic of gender, and because gender is also a human rights issue, CCJP plans to focus more strongly on gender in its mainstreaming strategy, addressing gender relations and sexual violence among others.

5. Seeking pathways within and beyond your organization

Networking in the mainstreaming process

Lobbying and advocacy in the HIV and AIDS context

Traditional medicine and HIV and AIDS

HIV and AIDS with regard to the church

Social protection schemes



5.1 Networking in the mainstreaming process

Projects cannot respond to all the needs of their target groups that result from HIV and AIDS. Particularly in the area of treatment and care, development projects may not be able to respond to these particular requests and needs of people living with or affected by HIV. In the area of HIV prevention and awareness, lobbying, advocacy or human rights they may lack expertise.

Projects should therefore form partnerships on various levels with different stakeholders. They should exploit their comparative advantages (→ Box 3) and individual professional expertise to build complementary relationships and achieve synergies. Concerted action on the part of all stakeholders is key to maximizing impact in the response to HIV and AIDS.

Establishing partnerships based on comparative advantage

When building partnerships, make sure you select the appropriate partners. In the analysis phase of mainstreaming (→ Section 3.3), project staff identify potential networking partners and establish initial contacts.

It is important to intensify links with these contacts and to continue searching for other suitable partners. Projects' existing networking structures and partners may be a springboard for developing partnerships (→ Box 3).

Key principles for effective networking

In the response to HIV and AIDS, networking involves interaction between stakeholders at different levels (community organizations, local and international NGOs, government institutions, international organizations, etc.). Partners who join a network or enter a strategic partnership should clarify their goals and responsibilities, coordinate their actions through joint planning, and discuss resource allocation. HIV/AIDS mainstreaming is not costly: it is a concept that is incorporated in an ongoing development project, and is not a separate project.

Box 33. Benefits and principles of networking

Benefits

- **Synergy:** collaboration has a greater effect than the sum of individual activities
- **Reduced duplication** and waste of resources

Principles

- Partners **plan and coordinate** activities jointly
- Partners commit to **shared objectives**, responsibility and action
- Partners regularly **communicate**, exchange information and learn from each other

Adapted from Smart (2001)

Besides agreements and implementation of joint rules, effective networking depends on the availability of adequate human and financial resources and the communication and coordination skills of the partners involved.

Equally important are the internal communication structures in the various organizations for disseminating and using the information gained through networking.

Limitations to complementary partnerships

In particular in remote areas, HIV/AIDS programmes are often insufficient or absent. Development projects may therefore find it necessary to carry out add-on HIV/AIDS activities in collaboration with specialized service providers to address their target groups' needs. But this might be insufficient. In such cases, projects should draw the attention of specialist HIV/AIDS organizations and the government to the unacceptable conditions and urge them to provide services. Projects can also support their target groups' local responses and lobbying activities. It is not possible to respond directly to all important HIV/AIDS-related issues (such as providing treatment) through the project's core activities.

Wider networks and global players

Besides building complementary partnerships on local and regional level, it might be useful to join local, national and international networks to share experiences, receive the latest information, and carry out lobbying and advocacy work. Projects should seek information on relevant networks locally, nationally and internationally. → Box 43 in section 5.4 lists a few important international church-related networks.

5.2 Lobbying and advocacy in the HIV and AIDS context

Advocacy

“Advocacy is indispensable in placing AIDS on the political agenda. It can encourage governments to tackle taboo subjects such as sex and drug use and can galvanize broad-based political commitment and mobilize financial support for effectively responding to AIDS...

“Advocacy efforts vary widely, but in the AIDS context the goal is to exert influence on governments and other stakeholders to either take action or to change a course of action. Advocacy can involve working with community leaders, parliamentarians or other decision-makers to build political and popular support for resources and policies to ensure an effective AIDS response. Or advocacy can entail working with labour, faith-based or business communities to bring about change. Fundamentally, advocacy must be directed towards people with decision-making power and to those who influence them, such as the media. Finally, it is critical that advocacy be underpinned by a solid factual base.” (UNAIDS 2005b)

One way for projects to advocate for greater attention to HIV and AIDS is to join the World AIDS Campaign (→ Box 34).

Box 34. The World AIDS Campaign

The World AIDS Campaign is a global coalition of national, regional and international civil society groups with the joint objective of putting pressures on governments to keep to their commitments regarding HIV and AIDS under the slogan “Stop AIDS. Keep the Promise.”

The campaign connects a large number of networks and groups worldwide dedicated to HIV and AIDS. It aims to achieve synergetic effects and address gaps in services and activities. It builds the campaigning capacity of HIV/AIDS-related organizations to ensure strong civil society advocacy. The campaign is ruled by a steering committee of global constituency-based networks and assisted by a team of support staff.

Key advocacy messages of the 2005–2010 World AIDS Campaign

- Political leaders must be made accountable for their promises regarding the response to HIV and AIDS.

- The public can play a vital role in encouraging political will, and in securing financial resources needed to slow and eventually end the global crises.
- Good health status for people living with HIV means good health for the community.
- Civil society must be involved as full partners in an expanded response to HIV and AIDS.
- Civil society needs to be united in its advocacy work in order to maximize the impact of AIDS campaigning efforts.
- An effective AIDS response is more easily achieved if skills are shared, lessons learned made available to everybody, and if good practice is pooled and easily accessible.

Sources: → www.worldaidscampaign.org, UNAIDS (2005b)

Rights-based approach to HIV and AIDS

In their daily work, but also at a wider level, projects are encouraged to lobby for rights of people living with HIV using a rights-based approach:

“A human rights approach can encourage and enable non-governmental development actors to no longer confront governments and international donors as petitioners, but to adopt the role and attitude of people that have rights, and to demand from governments that internationally guaranteed rights are respected, protected and fulfilled.” (Misereor 2004)

See also → Box 35, Box 36 and Section 1.3 for information on a rights-based approach to HIV and AIDS.

5. Seeking pathways within and beyond your organization

Box 35. Articles of the UN Declaration of Human Rights of 1948 that directly apply to HIV and AIDS

Article 2

“Everyone is entitled to all the rights and freedoms set forth in this Declaration, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status. [...]”

Article 25 (1)

“Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.”

United Nations (1948)

Box 36. Health as a human right: The Alma-Ata Declaration

Here is an excerpt from the declaration of the 1978 International Conference on Primary Health Care at Alma-Ata:

(1) “...health, which is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector.”

Declaration of Alma-Ata (1978)

Protecting the human rights, both of those vulnerable to infection and those already infected, is necessary to improve public health interventions with regard to HIV. National and local responses will not work without the full engagement and participation of those affected by HIV, particularly people living with HIV. The human rights of women, young people and children must be protected if they are to avoid HIV infection and withstand the effects of HIV and AIDS. The human rights of marginalized groups (sex workers, people who use drugs, men who have sex with men, prisoners) must also be respected and fulfilled for the

response to HIV to be effective. Supportive frameworks of policy and law are essential to effective HIV responses.

UNAIDS (→ www.unaids.org) has a strong human rights emphasis. It helps states meet their human rights obligations and empowers individuals and communities to claim their rights in the context of HIV and AIDS. Governments have made a range of commitments on human rights and universal access (→ Box 37).

Box 37. Human rights and universal access: What have governments committed themselves to?

- To ensure the full enjoyment of all human rights and fundamental freedoms by people living with HIV and members of vulnerable groups
- To promote access to HIV education and information
- To ensure full protection of confidentiality and informed consent
- To intensify efforts to ensure a wide range of prevention programmes, including information, education and communication, aimed at reducing risk-taking behaviours and encouraging responsible sexual behaviour, including abstinence and fidelity
- To expand access to essential commodities, including male and female condoms and sterile injecting equipment
- To expand harm-reduction efforts related to drug use
- To expand access to voluntary and confidential counselling and testing
- To ensure safe blood supplies
- To ensure early and effective treatment of sexually transmitted infections
- To develop strategies to combat stigma and social exclusion connected with HIV
- To make antiretroviral treatment accessible for all those who are in need and for the prevention of mother-to-child transmission.

Adapted from UNAIDS (2009a)

Projects that adopt a human rights approach to HIV and AIDS can lobby for improved access to prevention programmes, improved access to antiretroviral treatment and health care, gender equality and non-discrimination of people living with HIV. Staff members, in particular those in management, may participate in networks, lobbying and advocacy campaigns at local, national and international levels.

5. Seeking pathways within and beyond your organization

In addition, staff can actively motivate communities and target groups to advance human rights for people living with HIV by:

- Acting as role models in reducing the stigma attached to HIV and AIDS and counteracting discrimination against people living with HIV and those who are affected.
- Encouraging target groups to volunteer as home-based carers and peer educators etc., and linking them to HIV/AIDS support organizations and local groups.
- Urging target groups to lobby at the local level for the protection and observance of human rights, especially with regard to HIV and AIDS.

The human rights approach should be internalized in all organizations so that employees are not discriminated or lose their job on the basis of their known or presumed HIV status.

Lobbying and advocacy for access to treatment

Universal access is a global commitment to scale up access to HIV treatment, prevention, care and support (→ Box 37) and is based on the UN Political Declaration of 2006 (United Nations 2006). Countries have set up their commitment to universal access through comprehensive national targets, but the range of the achievements varies.

Here, we take a closer look at access to antiretroviral treatment. Access to antiretroviral treatment and the prevention of mother-to-child transmission are important human rights. Although antiretroviral treatment has become more accessible in low- and middle-income countries in recent years, coverage is still far below what is needed, especially in rural areas. On average, the coverage of antiretroviral therapy rose from 7% in 2003 to 42% in 2008 (coverage of 48% was achieved in eastern and southern Africa). Conversely, this means also that nearly 60% of people who need antiretrovirals still lack access to them (UNAIDS/WHO 2009). This figure is even higher in regard to the WHO recommendations of 2010 whereby people should start treatment earlier than it was recommended before (UNAIDS 2010).

The cost of antiretrovirals is still high in many developing countries, in particular for second and third-line therapies – treatments that are given when the initial treatment (the first-line therapy) does not work (UNAIDS 2008).

For babies and children living with HIV, access to antiretroviral treatment is still very inadequate. Research on HIV in children is lacking,

and early HIV diagnosis is scarce. There is a shortage of affordable, improved combinations of antiretrovirals, packaged in doses and applications suitable for infants and children. Many health workers are unaware of children's HIV status, and infants are not sufficiently referred for testing. A lack of local laboratories and equipment to detect the virus directly in the first months after birth is one reason infants often do not get antiretroviral treatment.

Starting antiretroviral treatment early can save the lives of infants with HIV. At least one-third of HIV-infected babies without access to antiretroviral treatment die by the age of one, and about half of HIV-infected infants die before their second birthday. (UNICEF, UNAIDS, WHO and UNFPA 2008)

There is a strong need to campaign for universal access to antiretrovirals for all people living with HIV (→ Box 38).

Box 38. Advocacy messages on HIV and AIDS

Production and sale of antiretrovirals

Messages. Organizations can lobby at different government levels to issue compulsory licences for the production of affordable, generic, first-, second- and third-line antiretroviral drugs for adults and children and for the prevention of mother-to-child transmission within their country.

If the country does not have the capacity to produce drugs of high quality locally, organizations may lobby that the government initiates a procedure established by the World Trade Organization (WTO) in 2003, whereby generic-low cost drugs are produced in other countries under compulsory licenses and imported.

Background. Under the TRIPS Agreement (Trade-Related Aspects of Intellectual Property Rights) of the WTO, all WTO members must grant patents for a minimum of 20 years covering all new inventions and manufacturing processes. This includes medicines such as antiretrovirals.

Nevertheless, governments can issue compulsory licences. These licences allow the production and sale of inexpensive versions of drugs (“generic drugs”) still under patent within the country. In case of national emergency, other circumstances of extreme urgency or in cases of public non-commercial use, governments can apply this safeguard immediately i.e., without the obligation of previous authorization from the patent holder (voluntary licence).

Challenge. Many developing countries do not have the capacity to produce antiretroviral drugs of quality and therefore depend on imports. Most generic drugs used in developing countries are imported from India. In 2005 India was obliged to implement the TRIPS Agreement in its national legislation. In case newer generations of antiretrovirals are patented in the country, the Indian government would have to issue a compulsory license each time a local company is asked to export generic versions of these drugs to countries in need.

Imports of antiretroviral drugs

Messages. Lobby at different government levels for the importation of inexpensive antiretrovirals for adults, children and for the prevention of mother-to-child transmission.

Organizations may join international or national campaigns, such as Action Against AIDS Germany → www.aids-kampagne.de. This German network of faith-based organizations, NGOs and grassroots organizations engaged in development and AIDS work advocates for Universal Access and puts pressure on pharmaceutical companies that insist on getting patents on generic drugs produced in India.

Background. Pharmaceutical companies sell the same drugs in different countries at different prices. Governments may decide to buy a certain drug not from the original pharmaceutical company, but from a wholesaler who bought the medicine more cheaply in another country. This is called parallel importing, and is not regulated by the TRIPS Agreement. The Declaration on the TRIPS Agreement and Public Health adopted in 2001 explicitly gives every member country the freedom to establish its own legal regime in order to allow this measure.

Challenge. Not all developing countries have made the legal provisions to be able to make use of this safeguard, even though this is consistent with WTO rules.

Strengthening health systems

Message. Lobby for strengthening health care systems, including improvement in health care infrastructure – based on health as a fundamental human right – at various government levels (→ Box 36).

Background. Treatment with antiretroviral drugs relies on efficient and effective public health services and infrastructure: facilities for HIV testing and other medical services, personnel who are well-trained in testing, diagnosing, treating, counselling, caring, and supporting people living with HIV to take their antiretrovirals continuously (“adherence support”), etc.

Research

Message. Lobby to increase funding for research in the field of HIV and AIDS at international levels.

Background. Research is still needed in preventing and treating HIV, for instance to continue developing life-saving drugs.

Sources: Aids Law Project (2003), Oh (2006), Obijiofor (2008), UNAIDS (2008)

5. Seeking pathways within and beyond your organization

Box 39 lists some sources of funding for programmes for HIV prevention, treatment, care and support.

Box 39. Sources of funds for programmes for HIV prevention, treatment, care and support

Funds for antiretroviral treatment on a big scale have been made available by the following international, national and private donor organizations in recent years. These organizations also support programmes on HIV prevention, care and support:

- Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), www.theglobalfund.org
- U.S. President's Emergency Plan For AIDS Relief (PEPFAR), www.pepfar.gov
- World Bank Multi-Country AIDS Programme, <http://tinyurl.com/yzcxum5>
- William J. Clinton Foundation, www.clintonfoundation.org
- Bill and Melinda Gates Foundation, www.gatesfoundation.org

5.3 Traditional medicine and HIV and AIDS

Traditional medicine makes a remarkable contribution to the delivery of health services. In many countries, there are as many as 100 traditional health practitioners for every health worker trained in “Western” medicine (including nurses and doctors).

Traditional practitioners are well recognized and trusted within their locality; they are important in influencing decision making on health and social issues. They are often easier to reach than Western medical services, so people use them more often. Their approach is holistic: it considers the whole person (physical, mental, spiritual), as well as his or her family and socio-cultural background. Trust and respect within the community, combined with their holistic approach to healing, are of particular importance in handling sensitive matters such as sexually transmitted infections and HIV.

Since the early 1990s, the World Health Organization has advocated involving traditional practitioners in national responses to HIV and AIDS. In many countries, joint initiatives between traditional practitioners and Western health workers for HIV prevention, treatment, care and

support have emerged. Nevertheless, few of these interventions have had wide effects or major results, and much of the potential remains untapped. Many collaborative efforts are focused on the research and the use of herbal medicines to treat HIV-related diseases.

The effects of medicinal plants can differ depending on dosage, on different parts of the plant used (e.g. leaves, bark or roots), or if taken together with other medicines. Some medicinal plants cause negative effects if combined with antiretroviral drugs. Therefore, it is recommended to seek the advice of qualified persons to verify if different types of medicines may be taken together in order to avoid negative side-effects.

Generally, traditional and Western-trained practitioners have to respect and accept each others' expertise if they are to cooperate. Both should rely on facts, based on medical evidence. Recognizing traditional medicine and practitioners as complementary health service providers is an important step to make them part of the overall response.

Some projects may wish to establish links with traditional health practitioners for HIV/AIDS mainstreaming, for example to learn about the cultivation and health benefit of medicinal plants.

More information → UNAIDS (2000, 2006b, 2007), Urwanzoff (2005)

Box 40 lists some ways traditional health practitioners can contribute to the response to HIV and AIDS.

Box 40. Potential roles of traditional health practitioners

Traditional practitioners can play various roles in the response to HIV and AIDS.

- They can provide affordable medicinal plants and herbal remedies to strengthen the immune system and to treat certain HIV-related diseases; preferably in collaboration with health workers trained in Western medicine.
- They can exchange medicinal plants, knowledge and experience on HIV and AIDS through networking via associations of traditional practitioners.
- They can conserve medicinal plant diversity and transmit indigenous healthcare knowledge.
- They can improve traditional health care practices through joint research with scientists and Western-style health workers.

5. Seeking pathways within and beyond your organization

- They can promote open dialogue and consideration of HIV and AIDS issues in the community by:
 - Supporting community awareness on HIV and AIDS
 - Providing advice on sexually transmitted infections
 - Assisting with community-based responses and actions
 - Counselling people living with HIV (including giving psychosocial support and nutrition advice)
 - Combating stigmatization and discrimination of people living with HIV and affected persons as well as misconceptions and beliefs around HIV and AIDS
 - Raising awareness on harmful traditional practices and their change appropriate to the cultural context (e.g., initiation rites for girls without female genital mutilation; rejection of widow inheritance and sexual cleansing).

Adapted from Gari (2003)

5.4 HIV and AIDS with regard to the church

Churches and faith-based organizations play an important role in the response to HIV and AIDS. Faith-based organizations have long been leaders in delivering social, educational and health services in many countries – in some countries they even provide up to 40% of the health services. In the response to HIV and AIDS, they are particularly important in the area of treatment, care and support (health care, home-based care, local support initiatives, spiritual support, etc.), as well as in the area of prevention.

Box 41. Importance of churches and faith-based organizations

UNAIDS stresses the role of faith-based organizations in the response to HIV and AIDS

“Faith-based organizations play a crucial role in the fight against HIV/AIDS. The involvement of faith-based organizations is multifaceted and includes organizations, spiritual, emotional, psychological and value-related issues. Faith leadership plays an important role in motivating people to become involved in HIV/AIDS-related work... Faith underpins and propels the response of the Church as an institution to the HIV/AIDS epidemic. The

morality of care and compassion obliges individuals and organizations to become involved in the prevention of spread of HIV and to care for the sick or those whose lives are affected by the sickness or death of family members.”

Source: Waal (2005) in UNAIDS (2006a)

Reasons for engagement of churches and FBOs and the necessity to change

“The churches have strengths, they have credibility, and they are grounded in communities. This offers them the opportunity to make a real difference in combating HIV/AIDS. To respond to this challenge, the churches must be transformed in the face of the HIV/AIDS crisis, in order that they may become a force for transformation – bringing healing, hope, and accompaniment to all affected by HIV/AIDS.”

Source: World Council of Churches (2001)

Religious leaders and institutions have several comparative advantages in the response to HIV and AIDS:

- They enjoy respect and trust in the communities where they operate.
- They shape religious values related to personal behaviour, morality and family life, congruent with social values of a given society.
- They are in close contact with the communities, while they do pastoral work and guide key events in life such as birth, marriage, death.
- They are important for the spiritual well-being of the faithful, providing strengths, support and hope for them, for instance in times of sickness (Parker and Birdsall 2005).

The following section highlights the potential of the churches in the response to HIV and AIDS.

Promoting a non-judgemental attitude

In many societies, a culture of silence surrounds HIV and AIDS. This is often because people associate HIV and AIDS with sexual practices and behaviour that are perceived as “immoral”. People living with HIV feel (or may be actually) stigmatized and therefore do not seek support. Religious leaders can play a decisive role in breaking this silence and isolation; they have the influence to diminish guilt, denial, stigma and discrimination. Religious leaders can be good examples and can take

5. Seeking pathways within and beyond your organization

an inclusive approach to people living with HIV, reaching out with love and compassion, encouraging people living with HIV to open up with their status and to live positively.

HIV and AIDS awareness

By stimulating discussions on HIV and AIDS at church and other places of worship, church leaders can stress the importance of solidarity for people living with HIV and affected members, and the need to be non-judgemental. People living with HIV can be actively involved in the discussions and awareness-raising sessions. HIV and AIDS should be an integral part of church work on all levels; it should also be mainstreamed in the training of priests, pastors, sisters, nuns and pastoral workers.

HIV prevention and behaviour change

Religious leaders provide value and moral guidance to the community. Sexual abstinence before marriage and mutual fidelity within marriage are cornerstones of HIV prevention (assumed both partners are HIV-negative). Religious leaders can promote open discussions on sexuality within their congregation and communities, and provide evidence-based information and materials on HIV prevention. There are a number of reasons (→ Chapter 2) that some people are unable (or unwilling) to act in accordance with these religious teachings. Full, correct and non-judgmental information on prevention measures (also on correct and consistent condom use) should be given so that the person can take an informed decision. If the latter is not possible in the church setting, the person should be referred to somewhere where he or she can get full information. The overall goal has to be to avoid HIV infection.

Parents and sex education for their children

The delay in the onset of sexual experience is an important prevention measure. There is evidence that young people who are well-informed about sexuality and sexual behaviour delay having sexual relations or are more likely to protect themselves if they do engage in sexual activity. It is therefore crucial that young people receive sex education before they become sexually active. Sexuality, sexual abstinence before marriage, and mutual fidelity are often part of life-skills education programmes implemented by many religious institutions. Church leaders may inform parents about the importance of sex education to avoid wrong information (for instance from peers or the media) being young people's sources of information, or to prevent their ignorance being

misused by others. Orphans and vulnerable children need protection from physical and sexual abuse. Sex education can be dealt with in specific sessions for children (appropriate to their age), in youth groups, youth clubs and other gatherings, but it needs specific expertise.

Gender with respect to HIV and AIDS

Referring to the proclamation of Jesus and his exemplified attitudes, every human being is equal. Religious leaders can address gender inequality in their work with communities and promote equal rights for women and men at all levels – for example, in access to resources and in decision making. Topics such as rape and violence against women and girls, gender roles in relation to the vulnerability to HIV infection and the caring for sick persons and orphans can be addressed in religious teachings and during church activities. For example, special classes can be offered for married couples to endorse mutual respect and to encourage them to discuss sexual matters openly. Marriage-preparation classes are well placed to include the topic of gender roles, the equality of every human being and responsibility towards oneself and others. Pressurizing girls and women to “respect tradition, culture or religion” with regard to potential risk of HIV infection (e.g., obliging wives to accept sex with the husband even though he is unfaithful) has to be avoided.

Spiritual support

In their pastoral and spiritual work, religious leaders can emphasize the importance of love, compassion and support for people living with HIV and affected family members. They may be able to help people living with HIV to accept their status and to live positive, meaningful and dignified lives. When people are terminally ill, religious leaders accompany them during their last phase of life and provide comfort and support to bereaved family members and friends.

Mobilizing volunteers

Many community-based self-help efforts in the response to HIV and AIDS are carried out by church members: raising awareness on HIV and AIDS, support for orphans and widows, provision of home-based care, and provision of food for vulnerable community members, among others. It is a key strength of religious leaders to mobilize volunteers in their communities to respond to HIV and AIDS.

5. Seeking pathways within and beyond your organization

Mobilizing resources for HIV and AIDS responses

It may be possible for religious leaders to set aside financial and personnel resources to support community-based initiatives, such as community gardens for the benefit of infected and affected community members, soup kitchens, home-based care, HIV and AIDS awareness and prevention activities, and spiritual and social counselling. Overall, the active participation of people living with HIV is very useful and should be encouraged.

More information → UNICEF (2003), Tearfund (2009), UNAIDS (2006a), Foster (2008)

Challenges

Faith-based organizations also face challenges in their response to HIV and AIDS. These include the lack of personnel with adequate skills to expand their activities, and a lack of funding. Sometimes their activities are isolated and not well connected with other initiatives; even linkages with other faith-based organizations are often weak (Foster 2008).

Some faith-based organizations still lack strategies to overcome some past weaknesses in the response to HIV and AIDS, such as linking HIV infection to “immoral, sinful” behaviour – which increase stigma and discrimination. Other weaknesses are providing inadequate training on HIV transmission, silence about human sexuality and gender roles, and the denial of religious leaders who are living with HIV (Parker and Birdsall 2005).

The stand-alone promotion of ABC – Abstinence, Be faithful, Condom use (→ Glossary) – in HIV prevention does not sufficiently take into account the circumstances in which people live and their possibilities to decide. Comprehensive approaches are needed addressing economic, social and cultural conditions, including gender relations. But consistent and correct condom use should be considered as one option in the prevention of HIV transmission.

In the context of HIV transmission, condom use can be considered rather as a measure of “saving lives” than as “avoiding lives”.

Box 42. Catholic voices on HIV prevention

The **German Bishop Emeritus Franz Kamphaus** claims that “today, Catholic institutions usually provide information on all paths of infection and possible ways of protection. It is up to individuals to decide whether they use condoms or not. Not referring to condoms would be withholding information.”

Source: Kamphaus (2005)

In an interview about HIV prevention, the **South African Bishop Kevin Dowling** said that abstinence and faithfulness in marriage “are the only way to be sure you won’t get infected.” In his diocese of Rustenburg, where many male migrants work in mines, poor women have few options beyond prostitution to feed their children. In such circumstances, the use of condoms seems to him “a pro-life option in the widest sense.” In his opinion, in much of AIDS-afflicted Africa the primary effect of using condoms would not be contraception but “to stop transmission of a death-dealing virus”. Under Church doctrine, that is “not only allowable, it’s a moral imperative”, he said. “The principle is to protect life. I’m fighting for the principle here.” Influenced by this sad experience of people suffering he would like to see a “humble attitude” from the Vatican and a recognition that “we have to develop a theology for the HIV-AIDS pandemic that [recognizes] the poor and the suffering and the marginalized and the vulnerable” and is based on an ethic of “human dignity and justice and human rights instead of just on an ethic of sexuality.”

Source: Chicago Tribune (2005)

In another interview Bishop Dowling said, “Abstinence before marriage and faithfulness in a marriage is beyond the realm of possibility here. The issue is to protect life. That must be our fundamental goal.” Considering the especially difficult plight of women of his diocese he continued, “My passion is for the women. I’m in that corner.”

Source: Grand Rapid Press (Michigan) (2007)

Cardinal Carlo Maria Martini, former Archbishop of Milan, said “that in couples where one had HIV/AIDS, which could pass to the partner, the use of condoms was ‘a lesser evil’.”

Source: BBC (2006)

5. Seeking pathways within and beyond your organization

Projects in the mainstreaming process may seek to establish contacts and cooperation with religious leaders at a high level and enlist their commitment to contribute in preventing new infections and reducing the effects of HIV and AIDS on individuals, families and communities.

Box 43 lists some Church-related networks in their response to HIV and AIDS.

Box 43. Church-related networks on HIV and AIDS

The Ecumenical Advocacy Alliance

A global ecumenical network seeking the active participation of churches and faith-based organizations – representing 40% of the health services in developing countries – to carry out advocacy-related activities on HIV and AIDS. Some key activities include sharing of resource materials, providing information on national and international advocacy efforts, joint campaigns on local, regional and global levels, and coordinating efforts at major international conferences. → www.e-alliance.ch

African Jesuit AIDS Network (AJAN)

AJAN was set up in 2002 to encourage and assist Jesuits in Africa to respond effectively to HIV and AIDS, and in particular, to bring national actions together in a continental network and to develop relations with other groups and associations and the wider Church. The relationships and activities are based on sharing of information, expertise, financial and other resources. → www.jesuitaids.net

Catholic HIV and AIDS Network (CHAN)

Created in 1992, CHAN consists of Catholic development, humanitarian and pastoral agencies that support projects in developing countries. CHAN members exchange ideas and experiences, update their knowledge, discuss thematic issues and cooperate with each other. The network is represented at high-level events, including meetings and conferences of UNAIDS and the World Health Organization. The role of the Catholic Church at these meetings is vital given the extent of the Church's work on HIV and AIDS throughout the world. CHAN was one of the first Catholic networks to draw up guidelines for HIV and AIDS project proposals. These are still valid and used by many member organizations.

Contact: CHAN, Caritas Internationalis, Rue de Varembe 1, CH-1202 Geneva, Switzerland

5.5 Social protection schemes

“Social protection refers to the public actions taken in response to levels of vulnerability, risk and deprivation which are deemed socially unacceptable within a given polity or society.” (Norton et al. 2002)

Social protection mechanisms may be:

- protective (providing relief),
- preventive (avoiding deprivation),
- promotional (enhancing real incomes and skills), or
- transformative (addressing social inequality) (Adato 2007).

Government-funded social protection schemes include child-support and disability grants, pensions and school feeding programmes. Some interventions, such as non-contributory old-age pensions, have proven highly effective to bring affected households out of total impoverishment (→ Devereux 2006).

In many countries, government social protection schemes are hard to access or do not exist at all. But communities have a lot of local social safety nets which are of crucial importance; they include labour-sharing arrangements, traditional savings groups and mutual-assistance associations. Mobilizing and strengthening such self-help potentials are highly important in the response to HIV and AIDS (→ Waal and Tumushabe 2003).

As part of their mainstreaming process, projects may provide information to vulnerable target groups on existing social protection schemes at community, regional and national levels, and help these individuals to get access to such schemes. The effects of HIV and AIDS and some responses are further explored in → Section 2.4.

Appendix 1: Glossary

This Glossary explains the meanings of technical terms used in this book, as well as words and phrases you may come across in other books about HIV and AIDS. Cross-references to other terms in the Glossary are shown as **SMALL CAPITALS**.

ABC – HIV prevention strategies:

A – Abstinence from penetrative sexual intercourse (also used to indicate delay of sexual debut)

B – Be faithful (have sexual relations with only one partner or reduce the number of partners)

C – Condom use (use male or female condoms consistently and correctly).

Acquired Immunodeficiency Syndrome → AIDS.

Adherence support – Supporting people living with HIV to take medications as prescribed (regularly, in time, correct dosage). Good quality adherence support delivered by trained community nurses, trained counsellors who are lay people, people living with HIV or home-based care volunteers, can potentially improve outcomes and minimize the complications of antiretroviral therapy associated with treatment failure, side-effects induced by the medication, irregular intake, or a pause in taking the drugs.

Affected individuals/households – Individuals/households with family member(s) infected by HIV or who died because of AIDS. Their lives have changed due to the multi-dimensional effects of HIV and AIDS.

AIDS, Acquired Immunodeficiency Syndrome – The collection of symptoms and infections associated with an acquired deficiency of the immune system caused by HIV infection (human immunodeficiency virus). HIV destroys the body’s ability to fight off infections and diseases, which can ultimately lead to death. Currently, **ANTIRETROVIRALS** slow down replication of the virus and can greatly enhance quality of life, but they do not eliminate HIV infection – they are not a cure.

Acquired – Something which one gets which is not his or her own. The virus that causes AIDS is “acquired” because it is transmitted from HIV infected blood or body fluids and causes HIV infection.

Immuno from “immune” – Capacity of the body to fight infections and diseases.

Deficiency – Something that is lacking. AIDS is called an immunodeficiency because the immune system of HIV-infected persons is deteriorating over time.

Syndrome – A set of symptoms which together indicate a particular condition diagnosed as AIDS. **OPPORTUNISTIC INFECTIONS** include tuberculosis, *Pneumocystis carinii* pneumonia, cryptosporidiosis, histoplasmosis, other parasitic, viral and fungal infections, and some types of cancers.

Antiretrovirals (ARVs) → **ANTIRETROVIRAL TREATMENT**.

Antiretroviral Treatment or Therapy (ART) – Standard antiretroviral therapy consists of the use of at least three antiretroviral drugs to maximally suppress the replication of HIV and stop the progression of HIV infection. HIV is a type of virus called a **RETROVIRUS**, so this treatment is called “antiretroviral” treatment.

The decision to start antiretroviral therapy is based on the combination of clinical findings (appearance of symptoms/diseases) and laboratory findings (such as CD4 count, viral load). The ultimate aim of ART is to restore physical health through restoring the immune system. The drugs have to be taken regularly and for the rest of the person’s life. Treatment with antiretroviral drugs is **not** a cure. However, people living with HIV who take antiretroviral drugs as prescribed can stay healthy, well and productive. There are international guidelines made by WHO, and many countries have adopted these into national guidelines for treatment.

There are three main reasons for applying ART:

- To treat people living with HIV and to prolong their lifespan.
- To prevent mother-to-child transmission.
- To reduce the risk of people getting infected with HIV if there is a risk of exposure to the virus, for instance through occupational injury or rape (→ **POST-EXPOSURE-PROPHYLAXIS**, or PEP).

Behavioural aspects – Promoting change in regard to (risky) behaviour is part of a comprehensive HIV/AIDS response. Prevention campaigns promote behaviour change by providing risk-reduction strategies and offering (participatory) methods and materials for HIV prevention.

Care – Treatment, physical care and psychosocial support to PEOPLE LIVING WITH HIV (e.g. ADHERENCE SUPPORT, HOME-BASED CARE, PALLIATIVE CARE).

Changes in the social structure – A high death rate among the adult population due to HIV and AIDS causes long-term changes in the population and social structure in high-prevalence countries. HIV and AIDS reduce the amount of productive labour, and many children become orphans and vulnerable children. As a result, the number of households headed by single parents, grandparents and children increases.

Comparative advantage – The way a sector or project can best contribute to HIV PREVENTION, TREATMENT, CARE and MITIGATION of the effects of HIV and AIDS within its CORE ACTIVITIES and professional expertise. → Box 3.

Complementary partnership – Partnerships in the response to HIV and AIDS, whereby each partner uses its COMPARATIVE ADVANTAGE or professional expertise to achieve synergies and become most effective. → Box 3.

Comprehensive HIV/AIDS response – The main pillars of an HIV/AIDS-specific response are PREVENTION, TREATMENT, CARE, SUPPORT and MITIGATION. Besides medical, behavioural and social aspects, a comprehensive response should also include HIV/AIDS MAINSTREAMING, focusing on developmental aspects, ROOT CAUSES of HIV infection and EFFECTS OF HIV AND AIDS within development work. → Box 5.

Core activities – The core mandate or goals of a project or sector.

Developmental aspects – The two-way relationship between HIV and AIDS and development is addressed: The spread of HIV is closely linked to other development constraints (economic, social, cultural), such as poverty, mobility and migration, gender inequality, limited access to basic health care, and education. The effects of HIV

and AIDS hamper or even reverse current development progress. → Chapter 2.

Discrimination – Discrimination in regard to HIV and AIDS means that a person is discriminated based on his or her real or perceived HIV status. For example, he or she may be shunned by family members, friends and neighbours, may not be able to get a job or a loan, may be fired from his or her job, or may be refused access to school.

Effects of HIV and AIDS – HIV and AIDS cause long-term changes to individuals, families, the community and the society as a whole. The changes comprise various aspects, such as an individual's physical, mental health and social well-being, a person's or family's social networks, social customs, social structures, and the local and national economy. HIV and AIDS may affect negatively on all household's resources: labour, natural resources (such as land), physical inputs and assets, financial resources and social networks.

Epidemic – A disease or condition that appears as condition in a given human population during a given period, at a rate that greatly exceeds what is expected based on recent experience. An epidemic may be restricted to one locality (an outbreak), more general (an epidemic) or global (a pandemic). The term "HIV epidemic" refers to the situation in a particular country or region. Because HIV infection is found everywhere in the world, it is called a "pandemic" in this case. → PREVALENCE.

Faith-based organization (FBO) – Non-governmental and non-profit organization related to a religious body and which is religiously motivated.

External mainstreaming → MAINSTREAMING.

Gender – There are both biological and social differences between men and women. The term SEX refers to the biologically determined differences. The term "gender" refers to the different social roles, perceptions, expectations of and relations between men and women. Gender roles are adopted through socialization and vary greatly within and between societies. Gender roles are shaped by age, class, ethnicity, religion and by the geographical, economic and political environment. → Table 5, Exercise 16 and Exercise 24.

Good practice – An approach, method, etc., used by a project that has proven successful and which other projects may adopt for the same purpose, considering the local conditions including financial, human, natural resources, social customs, etc.

HBC → HOME-BASED CARE.

HIV, Human Immunodeficiency Virus – HIV is a type of virus called a “retrovirus”. It weakens the IMMUNE SYSTEM, leading to OPPORTUNISTIC INFECTIONS, other HIV-related conditions (such as certain cancers) and AIDS after an imprecise period of time. → AIDS.

HIV-PEP → POST-EXPOSURE PROPHYLAXIS.

Home-based care (HBC) – A set of activities responding to medical, nursing, psychological and social needs of people infected and families in the home environment. “Home care services can be classified into preventive, promotive, therapeutic, rehabilitative, long-term maintenance and palliative care categories.” Department of Health, South Africa (2001).

People who are ill on and off (i.e., they are in the “symptomatic stage” → Appendix 2) or have developed AIDS, need adequate care and support. Home-based care initiatives offer support to infected individuals and their families. Sick adults are taken care of at home by home-based care professionals, volunteers and family members. Volunteers and family members receive practical training to care for the sick family member, they receive emotional support, and are prepared to cope with the death of the sick family member and its effect on the whole family.

An important element in the quality of home-based care is the capacity of caregivers; this can be enhanced by social recognition, training, counselling, and appropriate support (respite services, assistance, material support, etc.).

With ANTIRETROVIRAL TREATMENT the needs change. The need for home-based care normally falls as antiretroviral treatment becomes more accessible.

Hotspots – Places that are associated with high risk of HIV infection, such as truck stops, harbours and bars.

Human Immunodeficiency Virus → HIV.

Human-rights-based approach – An approach to HIV and AIDS that is based on the UN Declaration on Human Rights and similar agreements. → Section 5.2.

Immune system – An immune system is a system of biological structures and processes within an organism that protects and defends against infection and disease by identifying and killing pathogens and tumour cells.

Incidence – The number of new cases of HIV infection in a population during a certain time period, usually given as a rate. Determining the HIV incidence in a population is important to monitor the epidemic, improve the targeting of populations for interventions, and evaluate the effectiveness of HIV prevention and treatment programmes.

Measuring HIV incidence is a major challenge. Many countries must rely on PREVALENCE instead. → WHO (2009).

Internal mainstreaming → MAINSTREAMING.

Mainstreaming – The systematic and effective anchoring of a major issue or problem (for example HIV and AIDS) in the “mainstream” of an organization. For HIV and AIDS, this means enabling development actors to address the causes of vulnerability to HIV infection and effects of HIV and AIDS in an effective and sustained manner, through both their usual work and within their workplace. Mainstreaming HIV/AIDS is not a one-off event; it consists of a series of phases, and after the awareness phase becomes an ongoing process. → Figure 5.

Internal HIV/AIDS mainstreaming – The main goal of internal mainstreaming is to assist an organization and its staff in preventing HIV infection, preparing for and dealing with the effects of HIV and AIDS at the workplace. → Section 1.4.

External HIV/AIDS mainstreaming – A project that mainstreams HIV/AIDS externally responds to the root causes of HIV infection and the effects of HIV and AIDS on its target groups and project components. → Section 1.5.

Misconceptions – Wrong ideas or understanding of something. Some actions or behaviours based on wrong understandings contribute to the spread of HIV.

Mitigation – Actions taken to reduce the effects of HIV and AIDS on individuals, households, communities or society, for instance in health, agriculture, the economy, etc.

Mother-to-child-transmission (MTCT) – An HIV-positive pregnant woman may transmit the virus to her baby during pregnancy, during delivery or through breast-feeding.

Myths – Beliefs that are not scientifically proven. Some myths contribute to the spread of HIV, for instance the myth that having sexual intercourse with a virgin cures AIDS.

Opportunistic infections – Infections caused by micro-organisms, which usually do not cause disease in persons with healthy immune systems.

Orphans and vulnerable children (OVC) – Orphans are children that have lost one or both parents. Vulnerable children are children that are made vulnerable by HIV, e.g., children whose parents are HIV infected. A vulnerable child is not necessarily an orphan and an orphan is not necessarily vulnerable.

Orphans and vulnerable children need a supportive environment (national strategies to build and strengthen governmental, family, and community capacities), including provision of appropriate counselling and psychosocial support; ensuring their enrolment in school and access to shelter, good nutrition and health and social services on an equal basis with other children; protection from all forms of abuse, violence, exploitation, discrimination, trafficking and loss of inheritance; guarantee of non-discrimination and full and equal enjoyment of all human rights. → United Nations (2001).

Palliative care – Palliative care aims to provide the best quality of life for individuals living with an incurable illness, many of whom will be approaching death, and to offer comfort and support to their families and carers as well. It is a holistic approach to care that takes account of emotional, psychological and spiritual needs as well as those of a physical nature. Pain control is a central focus of palliative care. Palliative care requires specialist training.

PEP → POST-EXPOSURE PROPHYLAXIS.

People living with HIV (PLHIV), people living with HIV and AIDS (PLWHA) – Individuals who are infected with HIV. This book uses “people living with HIV”.

Post-exposure prophylaxis (PEP) – The immediate use of antiretroviral drugs for someone who has come into contact with blood or body fluids that may be HIV-infected. It aims to prevent the person from becoming infected with HIV. To be effective, the treatment has to start as early as possible after contact (not later than 72 hours) and has to be taken for a specific period of time. This treatment is prescribed in certain situations related to local directives: occupational injury for health staff, rape survivors, sex workers, people who use injection drugs. It is not always effective. → UNAIDS (2009a).

Prevalence – The proportion of individuals in a population who are infected with HIV at a specific point in time. It is usually given as a percentage. HIV prevalence is reported for adults aged 15–49, or for specific groups (such as for particular age groups, locations, sexes, and population groups for instance migrant workers, sex workers or injecting drug users).

WHO and UNAIDS (2007) differentiate the HIV epidemic as follows:

Low-level HIV epidemics.

Although HIV may have existed for many years, it has never spread to substantial levels in any sub-population. Recorded infection is largely confined to individuals with higher risk behaviour: e.g., sex workers, injecting drug users, men having sex with other men. HIV prevalence has not consistently exceeded 5% in any defined sub-population.

Concentrated HIV epidemics.

HIV has spread rapidly in a defined sub-population, but is not well-established in the general population. This epidemic state suggests active networks of risk within the sub-population. The future course of the epidemic is determined by the frequency and nature of links between highly infected sub-populations and the general population. HIV prevalence is consistently over 5% in at least one sub-population, but is less than 1% in pregnant women in urban areas.

Generalized HIV epidemics.

HIV is firmly established in the general population. Although sub-populations at high risk may contribute disproportionately to the

spread of HIV, sexual networking in the general population is sufficient to sustain an epidemic independent of sub-populations at higher risk of infection. HIV prevalence is consistently over 1% in pregnant women.

Prevention – Measures to reduce or avoid the risk of HIV infection. Key elements in comprehensive HIV prevention include (among others):

- Education and awareness on HIV and AIDS
- Behaviour change programmes to reduce risky practices
- Promoting abstinence, fidelity and reducing the number of sexual partners, along with promoting male and female condoms as a protective option
- Voluntary counselling and testing
- Preventing and treating sexually transmitted infections early and effectively
- Primary prevention among pregnant women and prevention of mother-to-child transmission
- Harm-reduction programmes for injecting drug users
- Male circumcision in high HIV prevalence settings
- Measures to protect blood supply safety
- Infection control and prevention of HIV transmission in health-care settings
- Community education and changes in laws and policies to counter stigma and discrimination
- Vulnerability reduction through social, legal and economic change.

Prevention is comprehensive if it involves a variety of interventions (see above), since no single element is enough. The reduction of vulnerability has to be accompanied by a social, legal and economic environment in which prevention is possible. This includes access to education, empowerment of women and prevention of human trafficking for sexual exploitation (probably with international cooperation). → UNAIDS (2004).

Primary prevention means measures to avoid HIV infection and to reduce the risk of HIV infection.

Secondary prevention is understood as measures for preventing aggravation of current stage of infection.

Tertiary prevention aims to reduce the negative effect of an already existing disease by restoring bodily functions and reducing disease-related complications.

Retrovirus – A type of virus. HIV is one type of retrovirus.

Risk – Individual behaviour and factors or situations which may place people at risk of exposure to HIV.

Root causes – Economic, social, cultural, individual and other factors driving HIV infection, including gender inequality, illiteracy, poverty, migration, mobility, etc., which may lead to risky situations or sexual behaviour.

Second- and third-line therapies – Treatments that are given when the initial ANTIRETROVIRAL TREATMENT (the first-line therapy) does not work, or no longer works. Antiretroviral treatment may not achieve the desired results if the virus is resistant against one or more of the drugs, or if the adherence to treatment is insufficient. If there is a resistant virus, a second- or possibly third-line therapy is indicated. If the reason is lack of adherence, it is necessary to find out why before identifying a solution.

Concerning **virus resistance**: HIV can change rapidly and can quickly adapt to whatever medicines are being taken. This makes it “clever” at developing resistance so that certain drugs no longer work. That allows the virus to reproduce as before (but now as a resistant type). To reduce this ability, people living with HIV are generally prescribed a combination of different antiretroviral drugs that stop or interfere with the reproduction of virus in the body. Nevertheless, drug resistance may occur and makes it necessary to change the drugs. The first combination of drugs taken by a patient is usually called the **first-line regimen**. When this no longer works, another regimen made up of new medicines is needed, and is called the **second-line regimen**. This is usually not needed for many years. If this also eventually fails, a **third-line regimen** of medicines is usually recommended. Antiretroviral drugs should only be taken under medical supervision.

Sex – The biologically determined differences between males and females. → GENDER.

Side-effects of a project – A project may have both positive and negative (probably unintended) side-effects with regard to HIV and AIDS. For example, it may result in the target group becoming more mobile and earning more income through trading activities (a positive side-effect) but at the same time may make it likely to develop/increase risky behaviour (a negative side-effect).

Social customs – Customs that are widely practised in a certain culture and geographical area. Some customs may help prevent HIV or mitigate its effects (for instance mutual faithfulness in sexual relations, strong social networks and assistance); others may add to the problem (such as widow inheritance, long mourning periods).

Sexually transmitted infections (STI) – Infections that are transmitted through sexual contact (vaginal, oral, anal), which include syphilis, chancroid, chlamydia and gonorrhoea. If someone (who may not see or feel any early symptoms) has one of these infections, he or she is more likely to be infected by HIV by having sex with a person living with HIV. If a person has both an HIV infection and a sexually transmitted infection, the risk of infecting someone with HIV is higher than if the person has only an HIV infection.

Support – Support for people living with HIV and their family members may include emotional and psychosocial support, self-help support, financial support, HOME-BASED CARE, improved nutrition, etc.

Survival sex – The use of sex by (poor) people, mainly women and girls, as a way to earn vital cash, food, protection or favours.

Target group – Individuals, groups or organizations that benefit directly from a project.

Testing

Voluntary counselling and testing (VCT) – The HIV test is voluntary and the client asks for it (client-initiated testing and counselling). An HIV test (HIV antibody test) involves thorough counselling before and after the test. After the pre-test counselling, the person is asked whether or not a test should be done. Post-test counselling

is a process that can continue for a period of time to help persons living with HIV to cope with the situation and to receive updated information, for example about treatment.

Provider-initiated HIV testing and counselling – According to the recommendation of WHO/UNAIDS: “In countries with generalized epidemic where an enabling environment is in place and adequate resources are available, including a recommended package of HIV prevention, treatment and care, health care providers should recommend HIV testing and counselling to all adults and adolescents seen in all health facilities.”

It is emphasized that, as in the case of client-initiated HIV testing and counselling, provider-initiated HIV testing and counselling is voluntary and the “three Cs” are fulfilled – that the test is conducted with the person’s informed consent, is confidential and accompanied by counselling. → WHO and UNAIDS (2007).

Traditional medicine – Traditional medicine is provided by traditional health practitioners through client-centred, personalized health care that is culturally appropriate, holistic, and tailored to the needs of patients. Traditional practitioners provide psychosocial support for people living with HIV and their families. Symptomatic treatment of some of the opportunistic infections is possible. There is a need for collaborative research to validate traditional or alternative remedies and to understand how they may affect treatment with modern medicines.

In contrast, some traditional healers claim to have a cure for HIV and AIDS (which is not true). It is important that traditional health practitioners refer PEOPLE LIVING WITH HIV to health services for ANTIRETROVIRAL TREATMENT. → UNAIDS (2009b).

Treatment → see also ANTIRETROVIRAL TREATMENT.

If an HIV-infected person does not yet require antiretroviral treatment, a doctor may prescribe a specific antibiotic to prevent certain OPPORTUNISTIC INFECTIONS. Opportunistic infections, other HIV-related diseases as well as diseases which have no relation to HIV infection have to be treated as recommended. Pre-antiretroviral therapy, as well as treatment of opportunistic infections, must be prescribed by medical professionals.

Vulnerability – The psychosocial, cultural and economic conditions that hinder the capability of individuals, households or communities to react adequately to the root causes and risks associated with HIV infection and to develop a response to the effects of HIV and AIDS. → Box 2.

Vulnerable children → ORPHANS AND VULNERABLE CHILDREN.

Workplace policy – A policy or programme that assists organizations to contribute to the prevention of HIV infection and to manage the effects of HIV and AIDS concerning the personnel of an organization. It is a central action for INTERNAL MAINSTREAMING. A workplace policy may consider various aspects, such as HIV prevention and staff awareness, non-discrimination of people infected or affected, gender equality, confidentiality, continuation of employment, care and support, and human resource planning. → Table 2 and Exercise 10.

Appendix 2: Basic knowledge on HIV and AIDS

HIV and AIDS and the immune system

What is HIV and what is AIDS?

The abbreviation **HIV** stands for **H**uman **I**mmunodeficiency **V**irus.

There are two types of HIV: HIV-1 and HIV-2.

- HIV-1 is the most common type.
- Different subtypes of HIV-1 exist. The subtypes A, C, D and E are mainly found in sub-Saharan Africa and Asia. Subtype B is the main subtype in the Americas, Australia, Japan, Caribbean and Western Europe. Recombinant strains (different combinations of subtypes) are relatively common.
- HIV-2 is mostly found in West Africa.
HIV-2 is less virulent and evokes a slower progression from HIV infection to AIDS than HIV-1.

A person can be infected with both types of HIV (WHO 2010a, 2010b).

The abbreviation **AIDS** stands for **A**cquired **I**mmunodeficiency **S**ndrome.

HIV harms the body by attacking the immune system, the body's defence against infections and diseases. Amongst the cells that make up the immune system, one kind of cell is called **CD4+ T-cell** or **helper T-cell**. CD4 cells can be seen as the "managers" of the immune system. HIV is able to attach to the surface of the CD4 cells, to enter them and eventually to destroy and replace the usual function of the CD4 cells. These CD4 cells are mainly used by HIV for its multiplication. Over time, many CD4 cells are destroyed and this leads to a profound damage of

the immune system while at the same time the amount of HIV steadily increases. As a result, the person becomes susceptible to all kind of infections and diseases. The likelihood of progression from HIV infection to AIDS or death without antiretroviral treatment rises with increasing immunodeficiency (decreasing CD4 cells), opportunistic infections and other HIV-related conditions and is increasingly likely with CD4 counts below 200 cells/mm³ in adolescents and adults.

Without HIV, the normal absolute CD4 count in adolescents and adults ranges from 500 to 1,500 cells/mm³ of blood.

Adults

In adults, the typical course of an HIV infection to AIDS is as follows.

Some people will have a flu-like period shortly after the infection with HIV. This lasts just a few days. This is called **acute HIV syndrome**. In the first 6 to 12 weeks the body starts reacting to the infection and antibodies are formed. During the first period the amount of HIV found in the blood is extremely high and the person is much more infectious than in later stages. Once antibodies are formed, the HIV antibody test becomes positive.

A long period without any signs or symptoms will follow. It varies from individual to individual how long this symptom-free period will last. The progression of HIV infection appears to be genetically determined. So-called **rapid progressors** develop the first signs and symptoms within months, as their CD4 cell count drops quickly, while **slow progres-**

sors remain symptom-free for many years. The symptom-free period is called the **latent period**.

Over time the CD4 cells decline and unspecific signs and symptoms are seen, such as a mild loss of weight, mild skin infections, bacterial upper respiratory chest infections, diarrhoea, etc. People can suffer from these minor conditions for many years. Slowly the type and seriousness of the conditions increase, and when the immune system is severely compromised, opportunistic infections can occur. These infections are caused by micro-organisms that can be found in many healthy people, but that will only cause an infection when the immune system is down, i.e., when the micro-organism is given the opportunity. At the time opportunistic infections are found, HIV-related malignancies like Kaposi's sarcoma can also appear.

The immune system is further weakened and at one point or another, opportunistic infections or HIV-related malignancies cause the patient to die. The amount of HIV found in the blood increases when the immune system becomes weaker and weaker and the person becomes more infectious.

Antiretroviral therapy (ART), when given in time, can prevent the development of HIV-related signs and symptoms. The "right" time to start is still discussed, but when ART is started at a level of above 350 CD4 cells/mm³, and when the medication is taken in time and at the correct dose, over 90 to 95% of the people react very well and regain good physical health within a few months. Every country has treatment guidelines. These guidelines indicate the drugs to be given and when to start with treatment. Usually these national guidelines are based on WHO recommendations (→ WHO 2010c, 2010d, 2010e). Although in many people on ART HIV cannot be found in the blood any more, the treatment is not a cure. People receiving ART who respond well to the treatment have very low infectiousness, especially when HIV is undetectable. Nevertheless, people on ART are advised to take all possible precautions to prevent the transmission of HIV to others.

Children

In **children** the typical course from HIV infections to AIDS is as follows:

- Progress in children is normally faster than in adults, but when a child reaches the age of 5 (about 20% will do so without treatment) they will have relatively few problems. Children respond very well to ART, even better than adults.

- The majority of HIV-infected infants develop opportunistic infections during the first years of life, and there is a high mortality rate. One third of HIV-infected babies without access to antiretroviral treatment die by the age of one year, and half of HIV-infected infants die before their second birthday.
- Probable symptoms are: increased frequency of common childhood infections, fever, diarrhoea and dermatitis, which tend to be more persistent and severe and do not respond well to treatment. The length of time before infected children develop AIDS can vary.

HIV transmission

Although HIV is present in all body fluids, it has to be in a sufficient concentration to cause HIV infection. This applies to the following body fluids:

- Blood
- Semen
- Vaginal fluids
- Breast milk.

HIV can be transmitted only by the following routes:

- **Unprotected sexual intercourse** (vaginal, anal or oral) with an infected person. This is the most frequent mode of transmission worldwide.
- **From an infected mother to her baby** – during **pregnancy, birth** or from **breast-feeding**. This is called vertical transmission.
- Transfusion of **contaminated blood** or **blood products, use of contaminated needles, syringes** and other **sharp instruments**.

There is **no risk of HIV transmission** from everyday contact with an infected person either at work or socially (hugging, using the same glasses, food plates, toilets etc.).

Everybody who has **unprotected sex** is at risk, regardless of religion or sexual orientation.

Persons with untreated sexually transmitted infections (especially those with sores) are more likely to get infected with HIV during sexual intercourse with an infected person. The risk of becoming infected by HIV is increased by having unprotected sexual intercourse with someone who has got both a sexually transmitted infection and HIV. The risk of transmission is also increased when the sexual contact is forced.

Testing for HIV

Two types of tests are currently often used, i.e. antibody tests that search for the HIV antibodies (the immune system's response to the virus), and special tests that will test for the presence of the virus directly ("PCR test"). Normally the antibody test is used, and the special tests only in cases of doubt or for research purposes. The rapid tests (antibody tests) are relatively cheap and the direct tests are very expensive and complicated.

UNAIDS and WHO recommend the use of two or three rapid antibody tests. The first test will be used as screening test and the second as the confirmation test. In areas with a low HIV prevalence (below 1%) a third test will have to be done.

Babies born to mothers who are living with HIV are usually carrying the HIV antibodies of the mother, irrespective of the babies' own actual status. These antibodies of the mother disappear over a period of time. In order to be sure of the babies' HIV status, an HIV antibody test is not considered accurate for the first 18 months after birth. The PCR test that checks directly for the virus gives a more reliable result and will be positive within a few days after infection. A problem is that about one-third of the infections from the mother to the child occur after birth by breastfeeding. → WHO (2004).

Voluntary counselling and testing

Voluntary counselling and testing (VCT) comprises voluntary pre-test counselling, (usually) antibody testing for HIV, and post-test counselling conducted by specialized personnel. Pre-test counselling will give information on HIV infection with the aim of assessing the risk of infection and reducing the person's fear in case of a positive test result. If the result is HIV-negative, a dialogue on risk-reduction measures to remain negative should be part of post-test counselling. If the test result is HIV-positive, post-test counselling will assist the person cope with the situation and as this will take time, counselling will most probably take more than one session and sometimes even family members or friends are involved. People are also given information and advice on options for prophylactic treatment of opportunistic infections and antiretroviral therapy, and are advised to take precautions to avoid infecting others and become re-infected. They are encouraged to live positively and may be referred to an HIV/AIDS support group for sharing of experiences and mutual assistance.

Living positively may include:

- Accepting the HIV infection
- Eating a healthy, balanced diet
- Staying as active as possible
- Having sufficient rest and sleep
- Reducing stress as far as possible
- Staying occupied with meaningful activities
- Supportive social environment by family and friends
- Seeking medical attention for any health problems
- Avoiding contracting infections and diseases through prevention measures.

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MISEREOR – The German Catholic Bishops’ Organization for Development Cooperation

Misereor was founded by the German Catholic Bishops’ Conference in 1958 as an overseas development agency “against hunger and disease in the world”. It cooperates with partner organizations in Africa, Asia and Latin America, whose work it supports. Since its foundation, more than 98,000 projects have been funded and carried out.

Misereor’s mandate is:

- to fight the causes of hunger and disease,
- to support the poor in their efforts to lead a life of human dignity,
- to promote justice, freedom, reconciliation and peace in the world.

The three pillars of Misereor’s work

1. Support for partner organizations in the South

Misereor supports self-help among the poor in order to help improve their living conditions in a sustainable way and to enable the underprivileged to claim their civil, social, cultural and economic rights. Misereor’s partners are organizations working with people in distress, irrespective of ethnic background, gender, creed or nationality.

2. Spiritual renewal

Misereor calls upon Catholics, and everyone else in Germany, to open their eyes to poverty and injustice in this world, to see the world as the poorest of the poor and the oppressed see it, and to empathise with them as Jesus did: “Misereor super turbam“ – “I suffer with the people“ (Mk 8:2). The annual Lenten Campaign organized by Misereor invites Catholic communities and other interested people to help, share with the poor, and undergo a process of spiritual renewal through solidarity and community with the poor. It also calls for a commitment to ensure the responsible development of our own society in order to create “One World” which is more just and where people can live in peace.

3. Lobbying, advocacy and campaigning

Hunger, poverty and injustice cannot be overcome by development cooperation alone. The underlying root causes also have to be addressed. That is why Misereor’s activities include lobbying and advocacy work and campaigning in Germany and at the international level on various topics such as climate change, world trade, debt relief, HIV/AIDS, intellectual property rights, “fair play” in the toy industry, etc.

Funding

Misereor’s financial resources are threefold:

- donations from German Catholics, in particular through the annual Misereor Lenten Campaign, and other private donations,
- funds allocated from German diocesan budgets through the Association of German Dioceses, and
- public funds provided by the Federal Republic of Germany and the European Union.

For further information, please visit our website www.misereor.org.

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