MAINSTREAMING HIV IN PRACTICE

A toolkit with a collection of resources, checklists and examples on CD Rom for SDC and its partners

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Swiss Agency for Development and Cooperation SDC
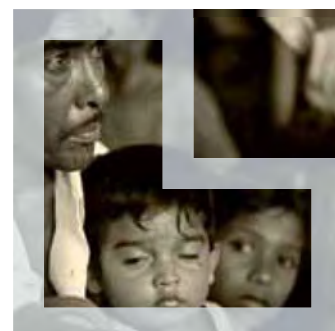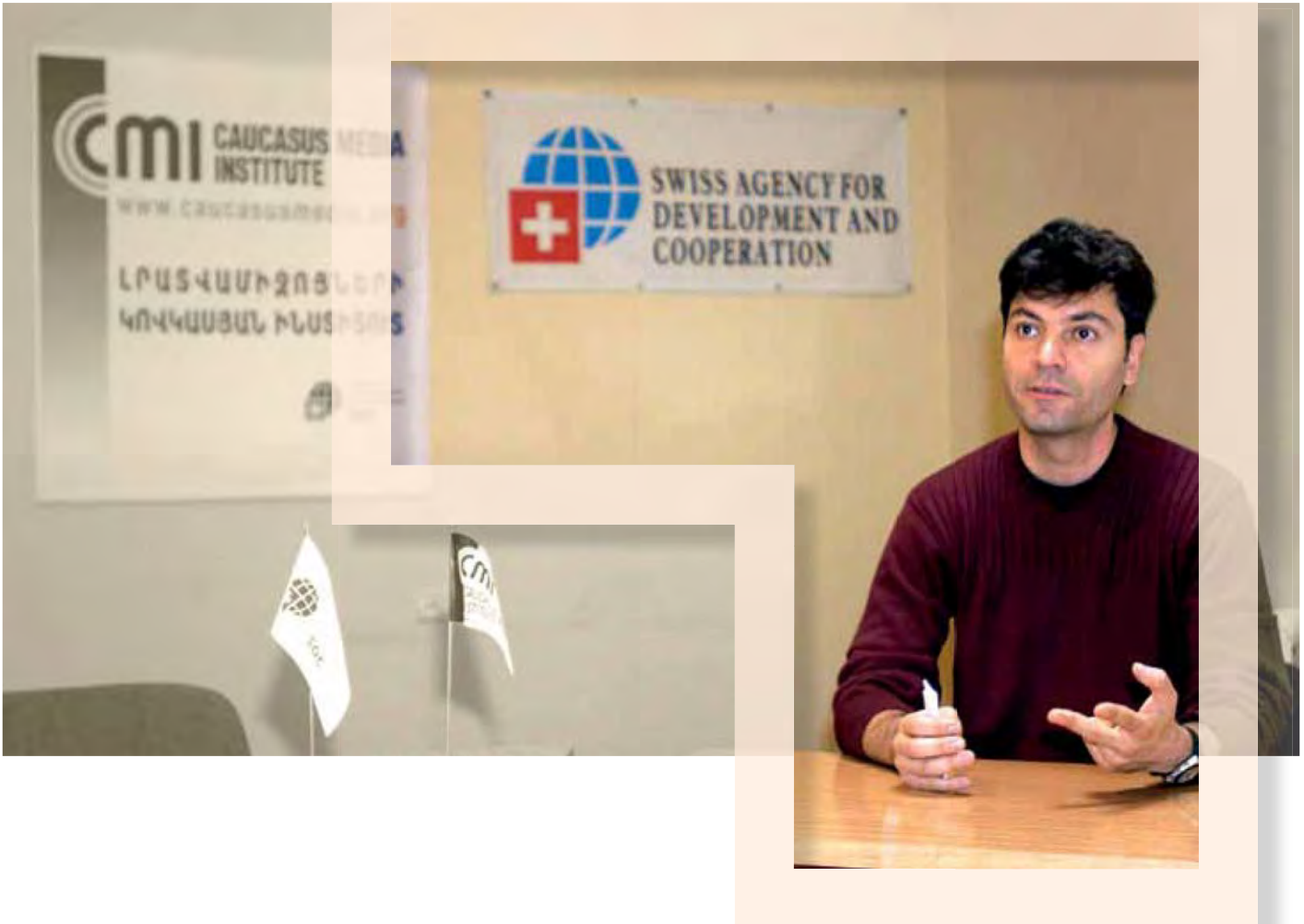
Contents

AIDS	Acquired Immunodeficiency Syndrom
ART	Anti Retroviral Treatment
BMZ	Bundesministerium für wirtschaftliche Zusammenarbeit und Entwicklung
CBO	Community Based Organisation
Coof	Cooperation Office (of SDC)
CoP	Community of Practice
DFID	Department for International Development, UK
DIC	Delegation of Intercooperation in Madagascar
DRSP	District Road Support Programme, Nepal
DSW	Deutsche Stiftung Weltbevölkerung
FAO	Food and Agriculture Organisation (of the United Nations)
FHI	Family Health International
FP	Focal Person
GHESKIO	Groupe Haïtien d'Etude du Sarcome de Kaposi et des Infections Opportunistes
GIPA	Greater Involvement of People Living with or affected by HIV/AIDS
GTZ	Gesellschaft fur Technische Zusammenarbeit (German Technical Cooperation)
GIZ (new)	Deutsche Gesellschaft für Internationale Zusammenarbeit
HEARD	Health Economics and HIV/AIDS Research Division, University of KwaZulu-Natal
HIPC	Heavily Indebted Poor Countries debt initiative
HIV	Human Immunodeficiency Virus
IASC	Inter-Agency Standing Committee
ICT	Information and Communication Technology
IDU	Injecting Drug Users
ILO	International Labour Organisation
InWent	Internationale Weiterbildung und Entwicklung GmbH
IPPF	International Planned Parenthood Federation
KAP	Knowledge, Attitude and Practice
KfW	Kreditanstalt für Wiederaufbau (German Bank for Reconstruction and Development)
LSTM	Liverpool School of Tropical Medicine
M+E	Monitoring and Evaluation
MSM	Men who have Sex with Men
MDG	Millennium Development Goals
NGO	Non Governmental Organisation
PADEM	SDC supported Programme in Support of Decentralisation and Local Government, Mozambique

PLHIV	People Living with HIV
PLWHA	People Living with HIV or AIDS
PMTCT	Prevention of Mother to Child Transmission
PRSP	Poverty Reduction Strategy Paper
REPSSI	Regional Psychosocial Support Initiative, a network for psychosocial support of HIV/AIDS affected children in Southern Africa
SAT	Southern African AIDS Trust
SCIH	Swiss Centre for International Health
SDC	Swiss Agency for Development and Cooperation
Sida	Swedish International Development Agency
OSA	East and Southern Africa Division of SDC
SRH	Sexual and Reproductive Health
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
Swiss TPH	Swiss Tropical and Public Health Institute
SWAp	Sector Wide Approach
ToR	Terms of Reference
ToT	Training of Trainers
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Fund for Population Affairs
UNICEF	United Nations Children's Fund
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation

Despite the impressive progress achieved in slowing the spread of the global AIDS epidemic over the last decade, HIV and AIDS are still amongst the most pressing development problems in today's world. The number of people living with the virus is on a steady increase, health systems in the most affected countries are not in a position to respond in a sustainable way to the enormous needs and the international commitment and funding for HIV is starting to fade. As the epidemic has begun stabilising, and the awareness is rising that other health and development problems must not be neglected at the expense of the AIDS response, the international response has moved from an emergency response, to one which aims at scaling up prevention and surveillance, as well as treatment and care services in a sustainable and more integrated way that strengthens systems rather than erodes them. As many of the drivers of the epidemic, and opportunities for mitigating the impact, lie outside of the sphere of influence of the health sector, a multisectoral response to HIV is considered more relevant than ever. Mainstreaming of HIV into international cooperation work remains one of the most important strategies for such a multisectoral response.

For the Swiss Agency for Development and Cooperation (SDC), contributing to the international AIDS response continues to be a priority and mainstreaming of HIV should be understood as a shared responsibility in all, or much, of cooperation work.

SDC promotes strategies and approaches that are adapted to the local context and epidemiological scenario. It is essential to use a culturally, and gender sensitive and appropriate approach when responding to the epidemic. Mainstreaming of HIV can take place in cooperation activities in various epidemiological contexts with various aid modalities – through bilateral cooperation, humanitarian aid and multilateral aid.

In order to effectively respond to HIV and AIDS, it is not enough to change individual behaviour. For a comprehensive approach, all three dimensions of risk (medical and behavioural factors), vulnerability/social resilience (developmental factors) and impact need to be addressed.

By «mainstreaming», we mean a process that enables development actors to address the causes and effects of HIV in an effective and sustained manner, both through their usual work and within their workplace. It means «wearing AIDS glasses» while working in all sectors and at all levels. Mainstreaming of HIV in the external sphere should not be imposed on all cooperation work, but the decision on which cooperation activities and actors to be involved should be grounded on strategic consideration of the needs, resources and response already existing, and the comparative advantages a specific cooperation activity offers. All cooperation activities should, however, consider setting up a workplace policy and programme in a participative way, in order to ensure that HIV related needs in the internal sphere of an organisation are being covered.

There is no standard approach to mainstreaming HIV. A gender sensitive approach, linking HIV to other sexual and reproductive health issues, involving people infected and affected by HIV and AIDS, and coordinating and aligning the response are essential principles that should guide mainstreaming efforts. In order to successfully mainstream HIV, a sector or an organization must be ready to allocate the necessary resources in terms of time, staff, material and financial resources. Leadership commitment, support by the teams, and capacity strengthening of the HIV focal persons and their collaborators are crucial factors for success and enhance commitment.

Mainstreaming HIV should happen in the internal sphere (related to the organisation/workplace) and in the external sphere (related to the cooperation work). Three key questions can guide mainstreaming efforts in both spheres:

1. How do HIV and AIDS affect your organisation and your cooperation work?
2. How to do no harm?
3. How can you contribute to the HIV response?

A three step approach to mainstreaming HIV is proposed. A context and organisational analysis allows you to assess the impact of HIV and AIDS on the organisation and the programmes and to answer the second key question – «How to do no harm?» The first two steps are linked as they are preparatory analytical steps that put you in a position to proceed to the response. The third step explores possible contributions to the HIV response at the workplace, and within the operational work. It is crucial that monitoring and evaluation instruments be developed from the very beginning and experience be capitalised and shared as described in the section dedicated to monitoring and knowledge sharing.

Key steps in mainstreaming HIV

INTERNAL SPHERE

EXTERNAL SPHERE

Step 1: Situational analysis

Organisational analysis:

How is the workplace (staff and their families, using a gender sensitive approach) affected?
What is the impact of HIV and AIDS on human resources (women and men) in the sector?
What institutional instruments are available to respond with?
What resources are available in the organisation to respond with?
How does HIV affect the work of your organisation?

Context analysis:

What is the general situation of the AIDS epidemic in the given context?
What is the outcome of the analysis of policies, the national response, stakeholders and resources?
What is the impact of HIV and AIDS on the sector?
How does HIV affect your programme and its beneficiaries (are men and women affected differently)?
How vulnerable is your cooperation activity to HIV?

Step 2: Do no harm

Discuss how far what you plan to do to mainstream HIV into the work place could have potential negative implications on HIV and worsen the situation.
Anticipate and plan corrective measures.

Discuss how far what you plan to do to mainstream HIV into the sector/into your programme could have potential negative implications on HIV and worsen the situation.
Anticipate and plan corrective measures.

Step 3: Contribute to the HIV response

HIV Workplace policy and programme

For more details, see the step 3 sheet «Develop a Comprehensive Workplace Policy and Programme»

Mainstreaming HIV into the programme

Plan and implement the contribution of your programme to the HIV response to act on:
  Reducing risk behaviour
  Reducing vulnerability and strengthening resilience
  Mitigating impact
(According to the comparative strengths and resources of your programme)

For both the internal and external sphere, a culture **of knowledge management and continuous learning** is crucial. Monitoring and Evaluation should be built into the planning and budget from the beginning. Share your experiences through networking and exchanging with others, and capitalise on these experiences by documenting them and making them publicly available. Further details are explained in the sheet «IX Monitoring and Knowledge Sharing». Use a **gender sensitive approach** to mainstreaming HIV as described in the fact sheet «VI Gender, HIV and AIDS»: Where it makes sense, try to **link HIV to sexual and reproductive health issues**, as described in the corresponding fact sheet.

This document is not a book that should be read from A to Z! The graph «Key Steps in Mainstreaming HIV» should help readers to situate themselves in the process and decide which step comes next for them. They can then jump to the relevant part of the document. For each step, the CD Rom contains a wealth of further checklists, resources and good practice examples. The content of the CD Rom and further links are listed in the last sheet of this document.

Overall goal to which this toolkit should contribute

The Swiss Agency for Development and Cooperation (SDC) has been committed for many years to contributing to the fight against the global AIDS epidemic in collaboration with its partner countries and international organisations. Mainstreaming – by addressing HIV and AIDS related issues at the policy and coordination level, at the workplace as well as in SDC projects and programmes – is thereby one of the major strategies they pursue.
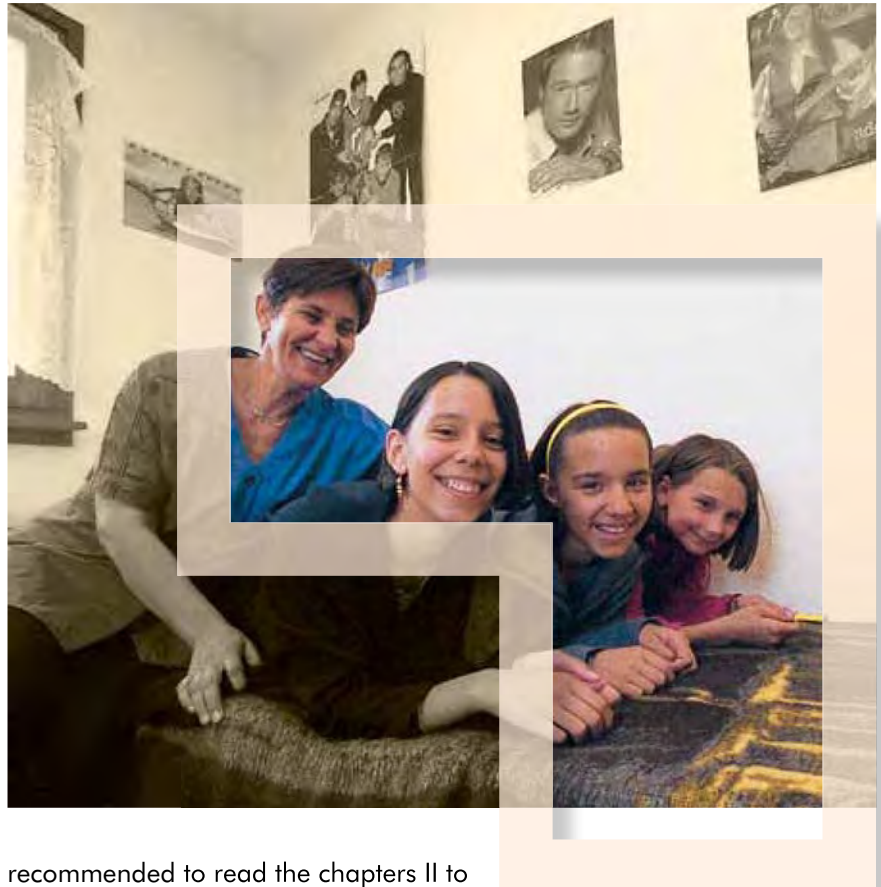
Objectives of the document
- Inform about approaches to mainstreaming HIV
- Provide practical information on «how to do it» for those who want to start mainstreaming HIV and help those who have already started to further strengthen their approach
- Provide relevant information useful to all continents, types of epidemics and aid modalities within SDC (Regional cooperation, cooperation with Eastern Europe and CIS, global cooperation and humanitarian aid) and for its partners
- Provide further resources for each of the essential mainstreaming HIV steps
- Share SDC's experience in mainstreaming HIV with interested partners and contribute to a shared understanding of the approach

Intended users
- SDC staff at the headquarters and Cooperation Offices
- Programme and project staff
- SDC's partners in Switzerland and partner countries

How to use this document

This is not a document to be read from beginning to end. For readers who would like to get an overview of the current AIDS epidemic, chapter I offers basic, but essential, information. All readers are recommended to read the chapters II to IV, as these chapters contain the basic concepts and guidance on mainstreaming HIV. The graph in chapter IV «Key Steps in Mainstreaming HIV» can help you to determine your current stage within a mainstreaming process. You can then jump directly to the relevant section describing the appropriate step. For more detailed information and practical examples each step is linked to further selected resources on the CD Rom. Special fact sheets look at mainstreaming of HIV in relation to gender, the linking to sexual and reproductive health and the specific questions when working in the field of humanitarian aid. Chapter IX contains information on monitoring and knowledge sharing – two critical, but often neglected elements. The glossary at the end of this document summarises important terminologies. The content of the CD Rom and further links are listed in the last section of this document.

An evolving concept

This document is based on experiences and lessons learned from within SDC, as well as from other development agencies and Non Governmental Organisations (NGOs). Other bilateral and multilateral organisations for which mainstreaming HIV has become an important issue, include the German Technical Cooperation (GTZ), the Department for International Development (DFID), the Swedish International Development Agency (Sida), The Food and Agriculture Organisation (FAO), the United Nations Development Programme (UNDP), the World Bank and the Joint United Nations Programme on HIV/AIDS (UNAIDS). SDC is aware that the concepts around mainstreaming HIV are evolving rapidly.

The first edition of this toolkit was published in 2004. Since then, much has changed. As a result, the decision was made to revise the first edition. New elements have been added, and other parts were only slightly adapted to currently used terminology and concepts.

What is new in the 2010 edition of the toolkit?

- A major revision of the essential steps of mainstreaming HIV as reflected in chapters IV and V
- A fact sheet on gender in HIV and AIDS
- A fact sheet on linking HIV with sexual and reproductive health
- A fact sheet on HIV in emergencies
- Updates of the chapters on the scope of the epidemic, and workplace policy and programmes
- Adaptation of the terminology and concepts used according to current UNAIDS guidance
- Many new resources on the CD Rom, including capitalisation products of mainstreaming HIV experiences supported by SDC

Your contributions, feedback and further case studies are welcome! Please contact SDC: health@deza.admin.ch (mention: toolkit mainstreaming HIV)

The Epidemiologic Situation Linked to Progress in the Response

Since this toolkit was first published in 2004, the global AIDS epidemic has changed considerably. The figures today look less alarming, reflecting real progress on the one hand, but also improvements and changes in surveillance of data and reporting on the other hand, which led to a correction and reduction in the estimated numbers of persons infected. Estimates of newly infected adults declined from 4.3 million in the year 2001 to 2.2 million in 2009. The estimated number of children newly infected in a year with HIV went down from 800'000 in 2001 to 370'000 in 2009. This reflects major progress in preventing vertical transmission. Coverage for services to prevent mother-to-child HIV transmission rose from 10% in 2004 to 45% in 2008 and to 53% in 2009. The most remarkable progress since 2003, however, is resulting from a much better access to antiretroviral treatment, particularly in resource poor countries. Within a time span of five years the number of people getting HIV treatment was increased more than fold, to a total number of people on treatment of 5 million in 2007. Today, fewer people are dying from AIDS related illnesses (1.8 million in 2009 as compared to 2.4 million in 2001).

Despite some encouraging trends, huge challenges remain. Across the globe, AIDS has claimed the lives of more than 25 million people. Although the global epidemic is stabilizing, this is happening on an unacceptably high level. Most concerning is that for every two people put on treatment, five others are newly infected. With this continuing high number of new infections and the deaths averted because of better access to antiretroviral treatment, the estimated number of people living with HIV reached 33.3 million in 2009.

Looking at HIV and AIDS data, geographic distribution plays a large role. Considerable differences exist both within, and between countries. The epicentre of the epidemic remains in Sub-Saharan Africa, where 67% of all HIV positive people live. However, some of the most alarming increases in new infections are occurring in countries such as the Russian Federation, Indonesia, Vietnam, Pakistan and various high income countries. In all regions outside of Sub-Saharan Africa, HIV disproportionately affects often marginalised key populations at higher risk, such as injecting drug users, men who have sex with men, sex workers and migrants. Today, members of these groups are still facing widespread stigmatisation and discrimination which manifests itself in many countries, in the lack of access to appropriate services that would meet their needs. Breaking taboos and combating stigma and discrimination against some of the groups most affected by HIV and AIDS must remain a priority, now, and in future.

Adults and children e
with HIV

North America
1.5 million
(1.2 - 2.0 million)

Caribbean
240 000
(220 000 - 270 000)

Central & South America
1.4 million
(1.2 - 1.6 million)

Wester
8
(720 00

Middl
Nor
46
(400 00

Su
22.
(20.9

Total: 33.3 million (31.4

UNAIDS

Source: UNAIDS and WHO, 2009

estimated to be living
V, 2009

Eastern Europe
and Central Asia
1.4 million
(1.3 - 1.6 million)

n and Central
Europe
20 000
00 - 910 000)

East Asia
770 000
(560 000 - 1.0 million)

e East and
th Africa
0 000
0 - 530 000)

South and
South-East Asia
4.1 million
(3.7 - 4.6 million)

b-Saharan
Africa
5 million
- 24.2 million)

Oceania
57 000
(50 000 – 64 000)

4 million – 35.3 million)
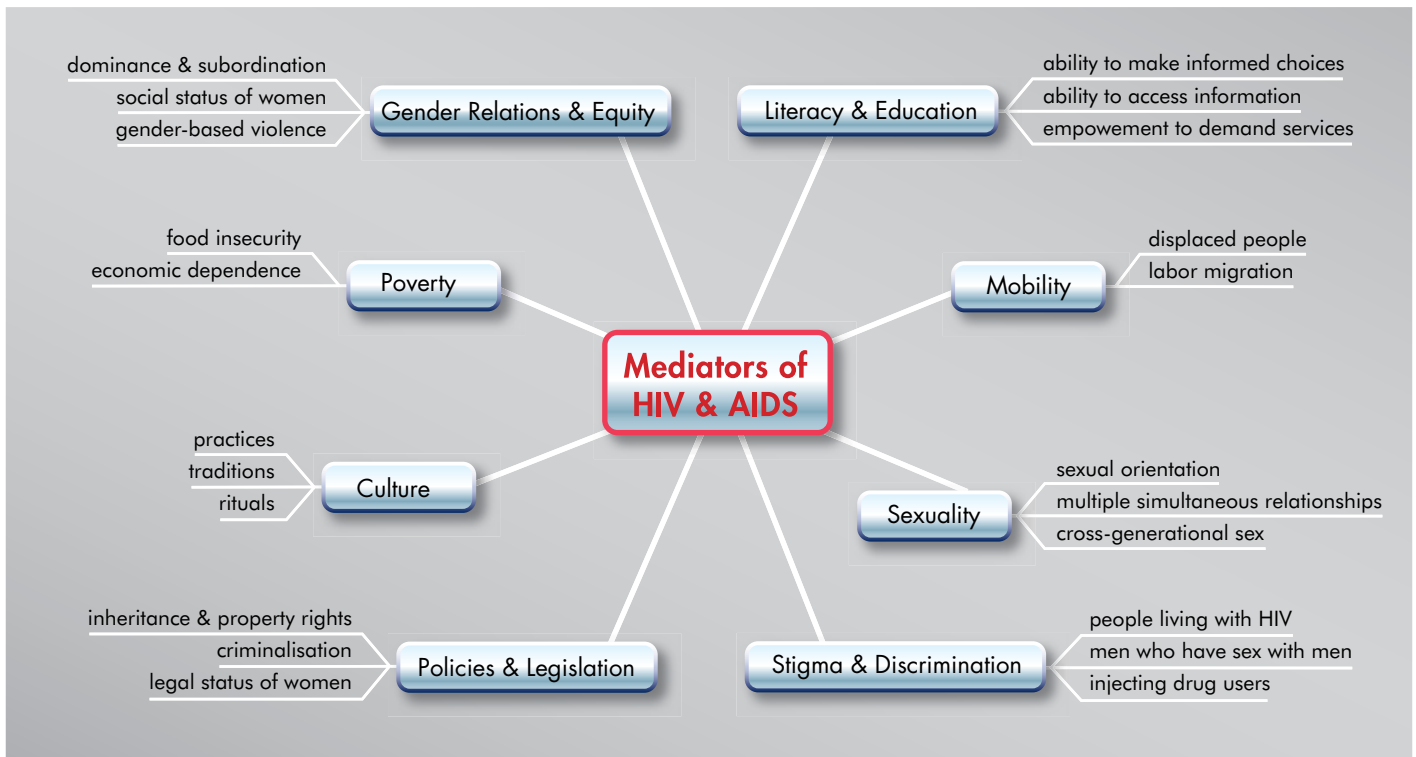
World Health
Organization

key populations at higher risk. Many Sub-Saharan African countries are faced with generalised or even hyper-endemic situations. In Asia and Europe, many countries are confronted with concentrated epidemics. Some of the Latin American countries have the opportunity to prevent a wider spread, as their epidemics are still at low level. Today, we also know that there is not necessarily a linear progression in terms of passing through the phases in a "natural evolution" from low level to hyper-endemic. Behavioural patterns greatly determine the nature of the scenario. The importance of large sexual networks with concurrent multiple sexual partners is today widely recognised as a prerequisite for epidemics to pass from a concentrated to a more generalised scenario. In any given country, one can also fit into different scenarios depending on the region or province one is looking at.

Knowing the epidemic is crucial for an efficient and effective response. The response needs to be tailored to the specific situation that a country or a programme is confronted with, taking into account the local epidemiological situation, behavioural risk patterns, vulnerability and resilience factors, as well as the political, economic and socio-cultural context. Improved monitoring of new infections, which contributes to a better understanding of the dynamics of HIV epidemics, is now being developed in many countries. Data from modes of transmission studies are essential for improving prevention programmes and targeting efforts to those most at risk.

For classifying the epidemic in a given country or region, UNAIDS today speaks of four epidemiological scenarios:

1. **Low level**
2. **Concentrated**
3. **Generalised**
4. **Hyper-endemic**

The definitions of these scenarios are explained in detail in the glossary of this toolkit. The scenarios refer to the question of how widely HIV infections spread, both in the general population, and in

Mediators of HIV & AIDS

Gender Relations & Equity
- dominance & subordination
- social status of women
- gender-based violence

Literacy & Education
- ability to make informed choices
- ability to access information
- empowement to demand services

Poverty
- food insecurity
- economic dependence

Mobility
- displaced people
- labor migration

Culture
- practices
- traditions
- rituals

Sexuality
- sexual orientation
- multiple simultaneous relationships
- cross-generational sex

Policies & Legislation
- inheritance & property rights
- criminalisation
- legal status of women

Stigma & Discrimination
- people living with HIV
- men who have sex with men
- injecting drug users

Political, socio-cultural and economic mediators[1] of HIV and AIDS

The dramatic spread of the global AIDS epidemic cannot merely be explained by individual risk behaviour. Individual risk of contracting HIV is influenced by a number of mediators as summarized in the chart below. Particularly in developing countries socio-cultural, political, and economic mediators, such as economic underdevelopment and poverty, population mobility (for work or due to political instability or war), gender inequalities, gender based violence and unfavourable policies and legislations all influence vulnerability and limit individuals› options to reduce their risk.

Vulnerability factors that drive the epidemic are at the same time exacerbated by the impact of AIDS. For people who live in poverty, food security and earning some money are first priority. As a result, they often make choices that increase the risk of getting infected with HIV. Young people and children are particularly vulnerable. Young people aged 15-24 account for about 45% of new infections worldwide. One in seven new HIV infections happens in children under 15 – the vast majority through mother-to-child transmission. Some 15 million children under age 18 have lost one or both parents to AIDS and lack basic rights, parental care, education and health care.
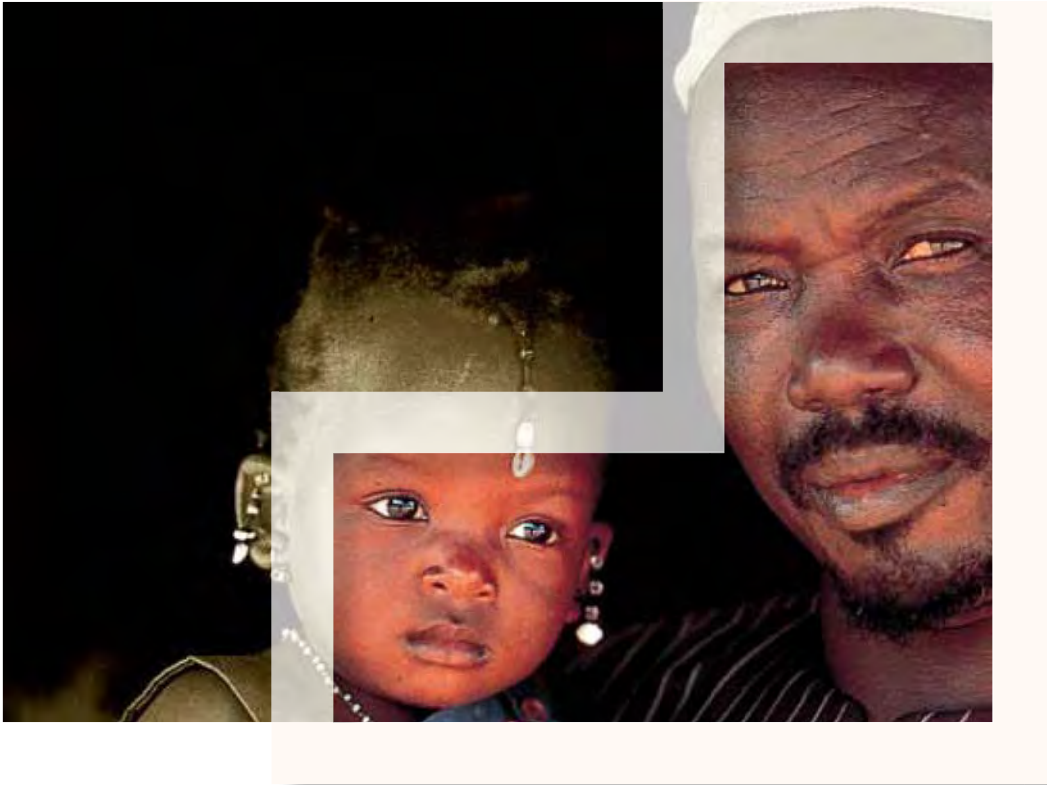
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[1] Using the term «mediator» puts the focus more on an indirect influence, interaction and involvement rather than seeing a direct causal relationship implied by the term «determinant».

However, a significant change in understanding the HIV epidemic is that we today know that the relationship between HIV and poverty is not as straight forward as we used to believe back in 2003. Many studies have shown that it is often also the well educated and economically better off who are much affected by HIV infections. HIV and AIDS is today understood less as a disease of poverty, but rather one of persisting inequalities, often in the context of rapid socio-economic changes.

One of the alarmingly persisting inequalities is that of gender. Between men and women there are important differences in the causes of contracting HIV and the level of vulnerability to HIV infection. Although men usually show significantly higher infection rates at the initial stages of the epidemic, women tend to outnumber men once the epidemic becomes generalised. When looking at the consequences of HIV and AIDS, women

and girls are again disproportionately
affected. Nonetheless, gender-based
vulnerability can also put men and boys at
a higher risk for HIV infection. Culturally
rooted peer pressure among men to
reflect a certain image of virility and
masculinity often leads to risky behaviours
such as having multiple partners or being
reluctant to have safer sex. In addition,
men having sex with men are one of the
most stigmatised and vulnerable groups
in relation to HIV. Gender inequalities and
their effect on HIV vulnerability for women
and men are further explained in factsheet
"VI. Gender, HIV and AIDS".

At the beginning of the epidemic in the early 1980s, HIV was considered a health problem to be addressed by interventions in the health sector. Since then, we have seen various conceptual shifts in the international response to the epidemic. Initially, a narrow biomedical paradigm focused on individual behaviour placing people at risk, and saw the solutions in a medical response to the epidemic. As time went on, the AIDS epidemic was considered a major threat to development, economic growth and security in the most affected countries and a multi-sectoral effort was deemed necessary to curb the epidemic. Following this recognition, financial resources were made available for the AIDS response at an unprecedented level. This was good news for many of the people infected and affected, but also for health workers and their governments, as resources to work with became more widely available. Because these resources had to translate into tangible results as quickly as possible, much of the funding during the emergency response was channelled through districts, programmes and services via parallel systems in an often uncoordinated and badly aligned manner. In this way, the situation was improved dramatically for many, as described in the first chapter of this toolkit. However, the price for these national systems was high – in terms of lack of ownership, uncoordinated duplication of efforts and inefficient use of human and financial resources,

to mention just a few. As the epidemic begins to stabilise, needs are increasingly being met, and the awareness that other health problems must not be neglected at the expense of the AIDS response is rising, the international response has moved from an emergency response to one which aims at scaling up prevention and surveillance, treatment and care services in a sustainable and more integrated way that strengthens the health system rather than erodes it.

HIV and AIDS today remain a major challenge for international cooperation. In highly affected countries it has a negative impact on many sectors in society and we observe the reversion of decades of progress made in development. While this understanding led to the so-called multi-sectoral response to HIV and AIDS, this was often (mis)understood as «omni-sectoral»- meaning that all sectors in all countries had to become active in preventing and responding to HIV and AIDS. We know today that the AIDS response needs a more

strategic approach. The decision on which other sectors to involve in that response should be based on the understanding of the epidemiological situation – the transmission patterns, thus by «knowing your epidemic»- one takes into account the resources already available. Depending on the context, various sectors should join forces, and can typically include sectors such as health, education, military and police, and finance, but also agriculture, transport or the corporate sector. Context specific and targeted mainstreaming in key sectors is highly recommended.

Mainstreaming HIV into development planning and management instruments, such as Poverty Reduction Strategy Papers or Medium Term Expenditure Frameworks, at the national level, as well as aligned district planning and monitoring is of particular relevance. In countries, where SDC and its partners have extensive experience and a strong voice in policy dialogue (e.g. through a Sector Wide Approach (SWAp), this allows informing the

macro level dialogue of experiences gained at the decentralised level, promoting a two-way flow of information.

Today, it is well recognized that prevention, treatment and care, and impact mitigation need to go hand in hand to effectively respond to the AIDS epidemic in the most affected countries by developing a continuum of mitigation. It is also widely recognised that within this continuum, HIV prevention should be receiving more attention and resources.

Mainstreaming of HIV, therefore, is still high on the agenda. However, the rational for mainstreaming should be repositioned in line with the more general international development objectives, such as the Millennium Development Goals, the

goal of Universal Access, the discussion around health system strengthening or the promotion of human rights – including sexual and reproductive rights.

The AIDS epidemic needs to be addressed as a crosscutting issue and should be understood as a shared responsibility in all or much of the cooperation work. For SDC, contributing to the international AIDS response continues to be a priority issue and mainstreaming of HIV remains an important strategy towards this aim. SDC promotes strategies and approaches that are adapted to the local context and epidemiological scenario. It is crucial to use a culturally appropriate and gender sensitive approach when responding to the epidemic.

Source: http://www.undp.org/mdg/basics.shtml

Box: Millennium Development Goals and targets regarding HIV/AIDS and Sexual and Reproductive Health

Millennium Development Goal 6: Combat HIV/AIDS, malaria and other diseases

Target 6a: Halt and begin to reverse the spread of HIV/AIDS (by 2015)
Indicators:
- HIV prevalence among population aged 15-24 years
- Condom use at last high-risk sex
- Proportion of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS
- Ratio of school attendance of orphans to school attendance of non-orphans aged 10-14 years

Target 6b: Achieve, by 2010, universal access to treatment for HIV/AIDS for all those who need it
Indicator:
- Proportion of population with advanced HIV infection with access to antiretroviral drugs

Millennium Development Goal 5: Improve maternal health

Target 5a: Reduce by three quarters the maternal mortality ratio
Indicators:
- Maternal mortality ratio
- Proportion of births attended by skilled health personnel

Target 5b: Achieve universal access to reproductive health
Indicators:
- Contraceptive prevalence rate
- Adolescent birth rate
- Antenatal care coverage (at least one visit and at least four visits)
- Unmet need for family planning

Mainstreaming of HIV can take place in cooperation activities in various epidemiological contexts with various aid modalities – through bilateral cooperation, humanitarian aid and multilateral aid. SDC also supports HIV and AIDS focused interventions such as, for example, REPSSI, a regional network for psychosocial support of AIDS affected children in Southern Africa (see fact sheet on REPSSI available on the CD Rom under Chapter V step 3- externally) and is committed to cooperation and coordination at the regional, international and multilateral level.

A Comprehensive response
In order to effectively address the AIDS epidemic, it is not enough to change individual behaviour. For effective prevention, the dimensions of risk (on a more individual level) as well as vulnerability (often strongly related to the social context) need to be addressed. At the same time, we need to identify and strengthen so-called «resilience factors» that help people to cope with a dangerous situation and avoid risks or mitigate the impact of risky behaviour. For a comprehensive approach, all three dimensions of risk (medical and behavioural factors), vulnerability/social resilience (developmental factors) and impact need to be addressed.

The four dimensions of risk, vulnerability, resilience and impact

Risk is determined by individual behaviour and situations such as: having multiple sexual partners, unprotected sex, sharing needles when injecting drugs, being under the influence of alcohol when having sex, having an untreated sexually transmitted infection.

Vulnerability refers to an individual's or community's inability to control their risk of infection due to factors that are beyond the individual's control. Such factors could be poverty, illiteracy, gender, living in a rural area, being a refugee, etc. Vulnerability factors are important mediators for HIV infections, as further explained in chapter one «The Scope of the AIDS Epidemic Today».

Resilience refers to the ability of an individual or a group to «thrive, mature, and increase competence in the face of adverse circumstances» (Gordon 1995). Using a resilience oriented approach therefore means looking at resources and coping mechanisms that people draw upon to avoid risk or deal with stress and adversities, and focusing on how these abilities can be strengthened.

Impact is about the long-term changes that HIV and AIDS cause at an individual, community or society level. An HIV infection, or being ill with AIDS, not only has an impact on the physical and mental health of individuals and populations, but a full blown epidemic also changes socio-cultural structures and traditions and impacts economies and many different sectors.

For a concrete example of an analysis of risk, vulnerability and impact in a given context, see the document «Elements of a Context Analysis, Intercooperation Madagascar» under Chapter V, Step 1 on the CD Rom.

A comprehensive response to a specific local HIV scenario will mean that – depending on the expertise and availability of actors and resources – a specific mix of interventions targeting these four dimensions will have to be designed. In a low level scenario the response will certainly have to focus on prevention (preventing risky behaviour, strengthening social resilience and reducing vulnerability), while preparing for screening, and comprehensive treatment and care services. In hyperendemic scenarios, detecting those infected and offering them early treatment is of course a priority and will contribute also to prevention. SDC and its partners have longstanding expertise in working in the field of psychosocial support to children and people affected or living with HIV and AIDS in highly affected regions. Supporting regional efforts has proved to be effective in rapidly scaling up much needed psychosocial support.

For more information on how to tailor a context specific approach, see the «Matrix: How to Match the HIV and AIDS Response to the Epidemic» in Chapter II on the CD Rom.

Each sector has particular comparative advantages in addressing one, or several of the four dimensions – risk, vulnerability, resilience and impact. In the matrix of influence below, selected examples from various sectors and from humanitarian aid are given to show how they could contribute to influencing these dimensions. The examples include specific AIDS-focused and mainstreamed activities.

Matrix of Influence

	Risk	Vulnerability/Resilience	Impact
Health	• Behaviour change campaigns • Information, education, communication • Promote Voluntary Counselling and Testing (VCT) and condom use and availability	• Promote access to services and information for both rural and urban populations • Strengthen health competence	• Provide testing and treatment services and care • Link with organisations that can support nutritional needs of people under antiretroviral treatment
Education/ Professional Skills Development	• Behaviour change campaigns for teachers and students • Information, education and communication campaigns • Life skills development • Promote condom use and availability	• Promote literacy and education • Change gender relations through education and literacy • Teacher posting policies that reduce mobility • Strengthen Information and Communication Technology (ICT) literacy	• Address the psycho-social needs of children, teachers, parents and school governing bodies affected by HIV and AIDS • Promote access to school for orphans
Agriculture	• Information campaigns and condom distribution through extension workers	• Poverty reduction by strengthening people's livelihoods • Strengthen skills and income of women and other vulnerable groups • Improve food security	• Develop labour saving technologies • Work with youth to fill knowledge gap left by AIDS
Infrastructure/ Mobility	• Information campaigns and condom distribution through extension workers	• Plan for strategies with reduced labour migration • Reduce isolation (information, economic, etc) of rural communities by road construction and improve access to social and health services	• Target towns with AIDS treatment centres for road construction • Give family contracts rather than individual contracts in areas heavily affected by HIV (e.g. in a road maintenance programme)
Governance	• Develop workplace policies for the sector ministries	• Develop policies that promote gender equality and human rights • Poverty reduction strategies • Build capacities of community based organisations	• Ensure that HIV is addressed in Poverty Reduction Strategy Papers (PRSPs), Heavily Indebted Poor Countries initiative (HIPC) and Sector Wide Approaches (SWAps) • Debt relief for heavily affected countries • Ensure donor coordination around impact mitigation
Humanitarian Aid	• Information campaigns and condom distribution, e.g., linked with food distribution	• Building latrines and water taps in a way that prevents sexual violence and rape • Strengthen social network building and group formation	• Make sure that key populations at higher risk, including People Living with HIV, are not excluded from food aid and other vital services

HIV-focused work AND mainstreaming is needed for a comprehensive approach

In addressing risk, vulnerability, resilience and impact, HIV-focused interventions go hand in hand with mainstreaming efforts. Cooperation Offices (Coof) and projects/programmes can respond to the AIDS epidemic by planning specific HIV-focused and/or mainstreamed interventions.

An overview with selected examples of SDC's AIDS response (both HIV-focused and mainstreaming) from the year 2008 is provided on the CD Rom. Experience has shown that for public sectors, as well as for programmes and portfolios supported by development partners, mainstreaming HIV can raise awareness of the actors in the problem of HIV where the epidemic is not yet widespread. Initial mainstreaming activities can thus provide an entry point for later involvement in specific HIV-focused activities of actors that would otherwise have never engaged in HIV-related work. Also, depending on which is perceived as a priority in a given context, HIV mainstreaming can serve as an entry point for more sensitive topics related to sexual and reproductive health (e.g. sex education in schools), or sexual and reproductive health interventions may serve as a conduit for HIV mainstreaming in countries with low HIV prevalence where recognition of the problem still needs to be built up. Further details are explained in the fact sheet «Linking HIV with Sexual and Reproductive Health» on the CD Rom.

Specific HIV-focused interventions

Specific HIV-focused interventions are those whose primary objective (core business) is to address HIV and AIDS. They can be introduced by the public or private sector, civil society or development partners. The health sector is well positioned to provide specific HIV-focused preventive, curative and care services, but specific HIV-focused interventions are not limited to the health sector.

Mainstreaming HIV

For a comprehensive response to HIV and AIDS, the potentials of many cooperation activities, also of those with a core business other than HIV (such as education, agriculture, water, small enterprises, women's empowerment, etc.), should be drawn upon. When used in an adequate and systematic way, the mainstreaming approach can make a significant contribution – by itself, or in addition to specific HIV-focused interventions. By many sectors joining forces and collaborating through mainstreaming activities, countries can address the context of vulnerabilities and mitigate key consequences and impacts of HIV and AIDS on specific population groups. Of course, all sectors should play a role in reducing risk and strengthening resilience, both amongst their personnel, and beneficiaries of their programmes. Mainstreaming activities can have an effect on the internal (organisation, workplace and its collaborators) and the external sphere (partners and beneficiaries, the field of activities).

The table below gives examples of mainstreamed activities as compared to specific HIV-focused activities.

Acknowledgement: We thank UNAIDS for their contributions to this chapter.

Examples of Activities	Specific HIV-Focused Intervention	Mainstreamed Intervention
A water project evaluating the impact of introducing user fees for water on AIDS affected families		✓
Introducing antiretroviral treatment (ART) into the health care system	✓	
A project with the main focus on HIV prevention in schools	✓	
Introducing HIV prevention into adult literacy classes or the school curriculum		✓
Setting up voluntary counselling and testing services (VCT)	✓	
A transport project analysing the effect of increased mobility on sex work		✓
A Ministry developing an HIV workplace policy		✓
Including issues related to HIV in the Terms of Reference (ToR) for the evaluation of an agriculture programme		✓
A social marketing campaign for condoms	✓	
A tuberculosis programme offering an entry point to VCT		✓
Community mobilization around HIV in the frame of a road programme		✓
Training relief workers on HIV and introducing a code of conduct to prevent sexual violence in refugee camps		✓
A Coof ensures that HIV is well taken care of in the PRSP		✓
A government developing an HIV policy	✓	
Awareness raising on HIV for project/Coof staff		✓
Addressing HIV in the country programme planning		✓

Working definition of mainstreaming

The growing understanding of the two-way relationship between AIDS and development has led to the insight that, in addition to developing programmes that specifically address AIDS, there is a need to strengthen the way in which existing development programmes address both the causes and effects of the epidemic in each country-specific setting. The process through which to achieve this is called «Mainstreaming HIV» (UNAIDS).

Mainstreaming means realising that we all work in a context more or less affected by the AIDS epidemic and analysing whether consequently we need to adapt our activities to this reality. It means thinking differently, wearing AIDS glasses.

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

It means «wearing AIDS glasses» while working in all sectors and at all levels.

It means all sectors determining[1]:

- whether and how they may contribute to the spread of HIV
- how the epidemic is likely to affect their sector´s goals, objectives and programmes
- where their sector has a comparative advantage to respond to and limit the spread of HIV and to mitigate the impact of the epidemic

Mainstreaming is about challenging the status quo by looking upstream to see the deep developmental causes, and downstream to appreciate the wide impacts of HIV and AIDS (UNAIDS, GTZ, Bangkok 2004).

Mainstreaming HIV does not mean:

- pushing HIV into programmes where it is not relevant
- changing core functions and responsibilities in order to turn all cooperation activities into HIV programmes
- simply introducing HIV awareness raising in all our activities
- that we all have to become AIDS specialists
- business as usual

Essential principles in mainstreaming HIV

- There is no standard approach or universal recipe to mainstreaming HIV. Approaches need to be designed according to the stage and nature of the AIDS epidemic in a particular country or community and adapted to the specific context, addressing the cultural context, challenges and opportunities in a given geographical area and sector. Using a cultural approach in mainstreaming is a key to success.
- Mainstreaming is a relevant approach in all stages of the epidemic – also in low prevalence countries – but becomes increasingly urgent as the epidemic evolves.

- Mainstreaming HIV should be done in an integrated way throughout the management cycle and not be limited to punctual efforts.
- A gender sensitive approach should be used when mainstreaming HIV (see also the fact sheet on Gender and HIV in this toolkit).
- Following the principle of Greater Involvement of People living with HIV and AIDS (GIPA), first enunciated in 1994, a participative approach to mainstreaming based on human rights implies involving People living with HIV (PLHIV). Combating stigma and discrimination linked to HIV should be a priority for all cooperation activities.

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[1] Source: Rose Smart in Elsey and Kutengule (2003).

■ Building relationships through coordination, networking and advocacy is crucial in international cooperation activities. While mainstreaming HIV, working in isolation should be avoided. Advocacy is especially important in low prevalence countries where awareness is still low. Advocacy is crucial both inside the own institution and outside when working with partners, beneficiaries and other agencies. As a rule, all mainstreaming activities should be in line with the national AIDS policy and international standards, such as those set by UNAIDS.

Key factors for success in mainstreaming HIV

Some factors should be considered essential when mainstreaming HIV. Obviously, not all these criteria have to be met before starting to get engaged in mainstreaming. They may be achieved as a result of the mainstreaming process.

■ **HIV and AIDS have to be understood as a development issue:** All stakeholders involved should be aware of the different dimensions of the global and local AIDS epidemic and understand it as an important development issue that concerns many sectors.

■ **Commitment and active support of decision-makers:** Mainstreaming needs to be of everybody´s concern. Decision makers within SDC and amongst partner institutions and organisations should take the lead to facilitate a joint commitment of all collaborators and strengthen the mandate of the Focal Person. The concept of Focal Person is explained on the last page of this sheet.

■ **Clearly defined objectives for mainstreaming of HIV:** Objectives should be clear and adapted to the context. Defining clear objectives for mainstreaming should ideally be part of a new project/programme, but can also be done if programmes are already running. Having clear objectives for mainstreaming will also help to monitor the approach and evaluate its effect.

■ **Knowledgeable, compassionate and skilled staff:** Everyone within the organisation must know how he/ she can contribute to the HIV response within the frame of the organisation´s policy and field of action and understand how the organisation itself is affected by HIV and AIDS. Teambuilding events and creating an emotional momentum (such as for example by watching and discussing a film together or paying a visit to a treatment and care centre for people living with HIV) are crucial to win support and enhance commitment. Capacity building on basic knowledge about HIV, on how to communicate about these issues and on how to mainstream it into development work is essential. The CD Rom contains an interesting Oxfam resource «Tools to support the mainstreaming of HIV/AIDS» that includes a training module with exercises for raising staff awareness and building capacity for HIV mainstreaming.

■ **Expertise and support is available and made use of:** In many countries local expertise is nowadays available, which can provide locally and culturally adapted support and advice. While it is often easy to identify support for questions related to HIV prevention, treatment and care, identifying competent support for mainstreaming strategies is often more challenging.

■ **Sufficient allocation of resources (financial, human and technical):** Mainstreaming HIV is not cost free and budgets and human resources need to be allocated accordingly. However, experience has shown that a mainstreaming approach needs relatively few financial and material resources. Cooperation Offices can provide funds to projects and programmes in order to stimulate the initial phase of mainstreaming. Nevertheless, projects and programmes should increasingly co-finance initiatives and consider budget allocation within the overall planning.

■ **Willingness to learn, reflect and share experiences:** There is a need for consistent documentation, monitoring and evaluation at various stages of policy formulation, project design and implementation and for sharing knowledge and expertise with partner organisations.

The role of Cooperation Offices and implementing agencies in mainstreaming HIV

Cooperation Offices (Coofs) and Implementing Agencies can play an essential role in making sure that a maximum of entry points are used for mainstreaming HIV. Together with programmes/projects and partners they can also define minimal standards for mainstreaming. Coofs and implementing agencies play an important role in raising awareness, as well as providing and organising support and financial resources for mainstreaming. Finally, one of their most important roles is to promote and ensure monitoring and capitalisation of mainstreaming experiences from all levels and to facilitate the exchange of lessons learned.

HIV Focal Person

Mainstreaming HIV is a work-intensive process that needs additional human resources. While the overall responsibility for mainstreaming remains with the country director and the programme/project heads, experience in SDC and other organisations shows that it is often very useful to delegate the practical coordination for the mainstreaming process to one person (the Focal Person) or a team.

The CD Rom presents a sample profile for an HIV Focal Person (FP) and a list of possible tasks at various levels. Based on their specific needs, an adapted task list should be developed by the FP together with the superior and colleagues. This can then be used to draw Terms of Reference for the FP.
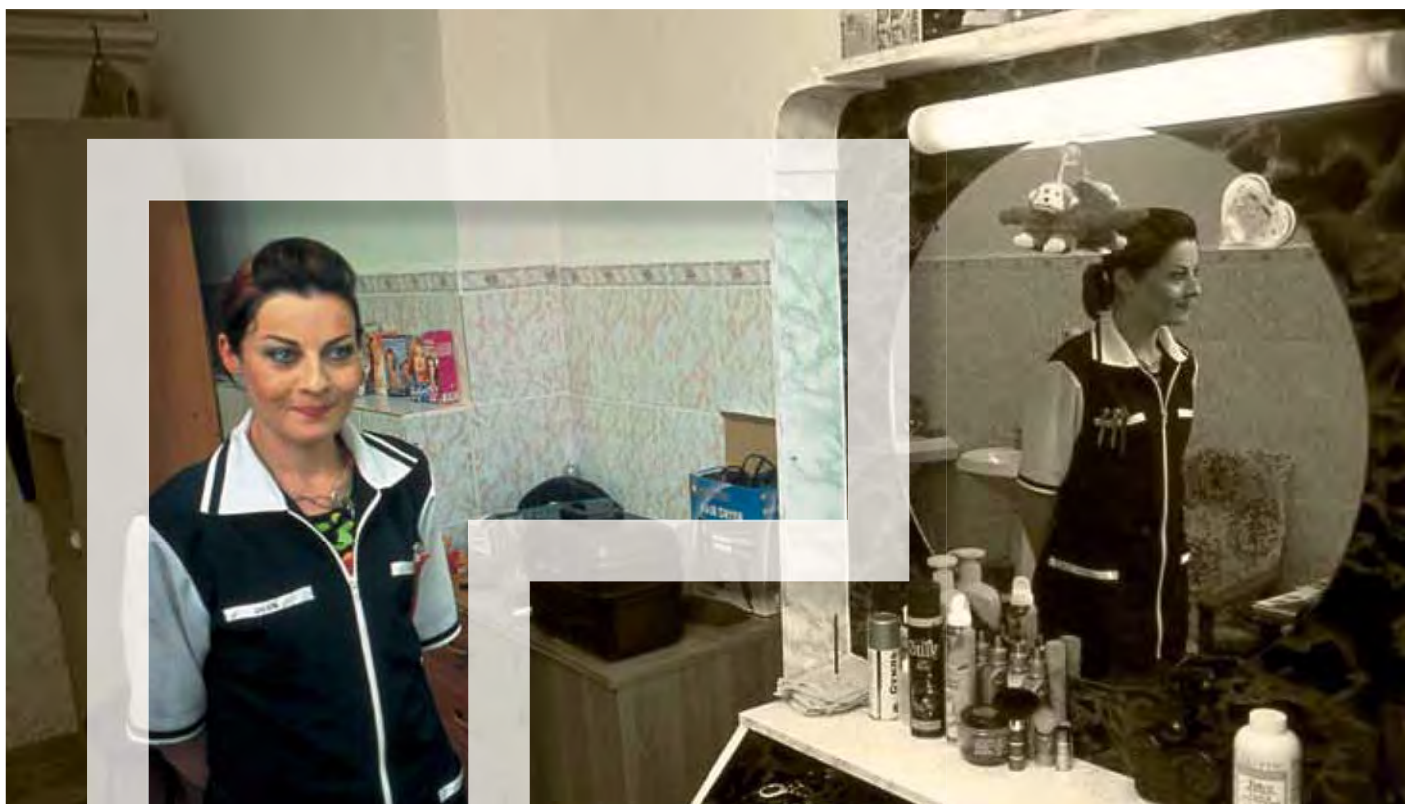
Since several years, SDC is supporting a moderated Community of Practice (CoP) to support the exchange of experience and mutual learning of the HIV Focal Persons. A «Starter Kit for New HIV Focal Persons» has been developed to help new FP with the introduction to their task. This starter kit can be found on the CD Rom.

Over the years, some essential lessons have been learned.

Lessons learned

- The Focal Person task should not be imposed – interest and commitment are prerequisites for being an effective FP.
- Sufficient working time should be allocated to this task, reflected by a change in the Terms of Reference and job description of the employee.
- Ideally, there is a FP at all levels – in the Coofs, the projects or programmes and in the various headquarter divisions. SDC can also play an important role in encouraging its implementing agencies and local partners to follow a similar approach.
- Even though the HIV FP will be leading the mainstreaming activities, this should not mean that all questions related to HIV are delegated to this person. HIV should remain everybody´s business! Without an effective team work towards the same goal and without the support of committed leadership and colleagues, the appointment of an HIV FP may even be counterproductive. Some organisations have created HIV working groups. The FP usually needs capacity building in order to be able to fulfil the role and may at times need expert support.
- For the FP to be able to fulfil the tasks, the necessary human, financial and material resources have to be made available.

There is no «gold standard» approach to mainstreaming HIV. In every country, and for every programme, the steps and their sequence will look different. However, existing experience shows that there are some common important elements that should be addressed at some stage when engaging in mainstreaming, regardless of whether one looks at mainstreaming into a sector, a development programme or humanitarian aid. The essential elements and steps are briefly presented in this overview. Further details can be found in the following chapter where all steps are elaborated in detail.

When describing the key steps to mainstreaming HIV it is helpful to distinguish between the two interacting spheres of mainstreaming:
- **the internal sphere** (related to your institution or organisation)
- **the external sphere** (related to your cooperation activities)

The internal sphere of mainstreaming HIV

Usually, it is recommended to start with the internal **workplace related aspects** of mainstreaming HIV. An organisational analysis can be applied to all institutional levels – be it an organisation, its decentralised structure (e.g. a Cooperation Office) or a project. Such an analysis assesses the implications of HIV and AIDS on the organisation's human resources and provides information on how programme design and delivery have to be adapted. An HIV workplace policy and programme should be developed based on this analysis. These steps are also relevant for low prevalence countries. In countries that are already heavily affected by the AIDS epidemic, it may also be necessary to develop a plan to anticipate, balance and mitigate the impact of HIV and AIDS on human resources and personnel.

The external sphere of mainstreaming HIV

In parallel, one should also address aspects related to the field of activities. A context analysis should precede the planning of mainstreaming activities. Such an analysis will allow assessment of the implications of the AIDS epidemic on beneficiaries, services and policies. It will also help to clarify how objectives and plans need to be adapted to adjust to consequences of the epidemic. Based on the context analysis and the assessment of implications, a programme can be re-designed to integrate relevant activities that **address risk, vulnerability and impact mitigation related to HIV**. In designing and implementing such activities, each programme will identify its comparative advantage and select activities that are related to its core business.

Three key questions[1] can guide mainstreaming HIV in both spheres.

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3 Key Questions in Mainstreaming HIV:

1. How do HIV and AIDS affect your organisation and your work? This concerns the beneficiaries, the sector, the workplace and the programme objectives and activities.

2. How to do no harm? Could the interventions have potential negative implications with regard to HIV? How could this be avoided?

3. How can you contribute to the HIV response? Where do you have a comparative advantage to limit the spread of HIV by reducing risk and vulnerability and how can you mitigate the impact of the epidemic?

The following graph highlights the essential steps that should be taken when mainstreaming HIV. It also shows how mainstreaming activities in the internal and the external sphere are interlinked.

1 The key questions have been inspired by similar questions used by GTZ.

Key steps in mainstreaming HIV

INTERNAL SPHERE   EXTERNAL SPHERE

Step 1: Situational analysis

Organisational analysis:

How is the workplace (staff and their families, using a gender sensitive approach) affected?
What is the impact of HIV and AIDS on human resources (women and men) in the sector?
What institutional instruments are available to respond with?
What resources are available in the organisation to respond with?
How does HIV affect the work of your organisation?

Context analysis:

What is the general situation of the AIDS epidemic in the given context?
What is the outcome of the analysis of policies, the national response, stakeholders and resources?
What is the impact of HIV and AIDS on the sector?
How does HIV affect your programme and its beneficiaries (are men and women affected differently)?
How vulnerable is your cooperation activity to HIV?

Step 2: Do no harm

Discuss how far what you plan to do to mainstream HIV into the work place could have potential negative implications on HIV and worsen the situation.
Anticipate and plan corrective measures.

Discuss how far what you plan to do to mainstream HIV into the sector/into your programme could have potential negative implications on HIV and worsen the situation.
Anticipate and plan corrective measures.

Step 3: Contribute to the HIV response

HIV Workplace policy and programme

For more details, see the step 3 sheet «Develop a Comprehensive Workplace Policy and Programme»

Mainstreaming HIV into the programme

Plan and implement the contribution of your programme to the HIV response to act on:
- Reducing risk behaviour
- Reducing vulnerability and strengthening resilience
- Mitigating impact

(According to the comparative strengths and resources of your programme)

For both the internal and external sphere, a culture **of knowledge management and continuous learning** is crucial. Monitoring and Evaluation should be built into the planning and budget from the beginning. Share your experiences through networking and exchanging with others, and capitalise on these experiences by documenting them and making them publicly available. Further details are explained in the sheet «IX Monitoring and Knowledge Sharing». Use a **gender sensitive approach** to mainstreaming HIV as described in the fact sheet «VI Gender, HIV and AIDS». Where it makes sense, try to **link HIV to sexual and reproductive health issues**, as described in the corresponding fact sheet.

How to use the graph «Key steps in mainstreaming HIV?

By positioning your cooperation activities within the framework reflected in the graph you can identify the steps that still need to be addressed. According to where in the process you find yourself, you can selectively use parts of this document and the resources on the CD Rom.

A context and organisational analysis allows you to assess the impact of HIV and AIDS on the organisation and the programmes and to answer the second key question – «How to do no harm?». Steps 1 and 2 are linked, as they are preparatory analytical steps that put you in a position to proceed to the response. Step 3 explores possible contributions to the HIV response at the workplace, and within the operational work. It is crucial that monitoring and evaluation instruments be developed from the very beginning and experience be capitalised and shared as described in the section dedicated to monitoring and knowledge sharing.

As further described in the fact sheet «XIII HIV in Emergencies», mainstreaming is also a relevant approach to be used in humanitarian aid. The same key questions and steps can guide the development of a mainstreaming approach that responds to the needs of a humanitarian aid setting.

The following sheets look at the 3 steps and essential elements of the mainstreaming process. The brief summaries are illustrated by further resources, checklists and examples on the CD Rom (see the overview in the list of resources on the CD Rom).

In order to answer the first key question «How do HIV and AIDS affect your organisation and your work?», a programme/Cooperation Office/ Ministry should conduct a situational analysis, including context and organisational issues. All mainstreaming strategies planned should be based on the findings of repeated analyses.

«Knowing your epidemic» is not only of key importance for countries, but for all who want to contribute to the AIDS response.

To strengthen national efforts countries are being encouraged to **«know your epidemic»** by identifying the behaviors and social conditions that are most associated with HIV transmission, that undermine the ability of those most vulnerable to HIV infection to access and use HIV information and services. Knowing your epidemic provides the basis for countries to «know their response», by recognizing the organizations and communities that are, or could be, contributing to the response, and by critically assessing the extent to which the existing response is meeting the needs of those most vulnerable to HIV infection. We must encourage countries to know their epidemic because we have learned over the last twenty-five years that the epidemic keeps evolving. It is important for countries to take stock of where, among whom and why new HIV infections are occurring. Understanding this enables countries to review, plan, match and prioritise their national responses to meet these needs[1]. (UNAIDS, Towards Universal Access, 2007)

Each analysis will be based on a different set of questions, depending on the geographic area, the sector(s) one works in and the specific interests of the Cooperation Office, project or programme. Ideally, both the context and organisational analyses should be an integrated part of the overall situational analysis which is done at the beginning of a programme. For the context analysis, one can usually draw on available information. It is not necessary, and in most cases it is not feasible either, to conduct specific surveys or studies. Good sources

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[1] http://www.unaidsrstesa.org/hiv-prevention/know-your-epidemic-modes-transmission

for local information on the AIDS epidemic are usually the National AIDS Programme and the various government ministries, NGOs as well as bilateral and multilateral organisations (e.g. WHO or UNAIDS). The compilation of a short report based on the information available and in function of one's needs, can also be contracted out.

The analyses should be as gender sensitive as possible. A gender perspective on mainstreaming HIV involves recognising and addressing the gender imbalances

that drive and characterise the epidemic (consult the fact sheet on Gender, HIV and AIDS in this toolkit).

An example from Oxfam of small scale, in-depth qualitative research in a high prevalence country

Oxfam conducted qualitative research in Mulanje district in Malawi. The aim of the research was to look at how HIV and AIDS affect different people, how it undermines organisations and how people and organisations respond. Much emphasis was on how HIV and AIDS change people's daily lives especially in productive activities such as agriculture, trading, household tasks and community involvement. Managers and staff from different organisations and representatives from local communities were interviewed using focus group discussions. The research helped to link theory with practical situations as well as developing relationships with those affected and infected who are mostly excluded from the development interventions. After the research Oxfam produced a report on the findings which was shared with several organisations and government departments. This formed a basis for Oxfam to modify their objectives, indicators and work plans so that they were more relevant to families affected.

Some of the key findings:

Impact on Communities
- Some families are more affected than others.
- The illness of a mother is a double blow in matrilineal societies.
- Badly affected people and households can become invisible to development interventions, as they do not participate in many activities.
- Poverty escalates as a result of death or illness of older, more skilled family members.
- Women and girls take on greater burdens as both parents fall ill.
- AIDS affected households have limited access to education, especially young girls who may be forced to drop out of school.
- Although those outside view the extended family and institutions as key sources of support, they often prove to be unreliable social networks.
- Poverty is the driving force of HIV transmission, as poor women and girls engage in occasional commercial sex.

Impact on Organisational Capacity
- Absenteeism, lower productivity, vacant posts, high cost and overloading of others
- The internal response on mainstreaming is predominantly specific AIDS work, not mainstreaming
- Challenge for improving internal policies which is not easy for most managers at district level

Source: Elsey and Kutengule (2003)

Analyse the impact of HIV and AIDS on what you do

As important as the collection of the data and resources is a participative analysis and discussion of the information obtained. The findings of the context analysis help to understand the impact of HIV and AIDS on beneficiaries, sectors and policies, while the findings of the organisational analysis provide information needed to understand the impact of the epidemic on human resources in the sector, personnel of the organisation and the workplace, as well as what this means for the programme design. The discussion on the impact of HIV and AIDS is an integral part of step 1.

As the impact of AIDS on cooperation activities will be less tangible in low prevalence countries, a short discussion regarding the implications will be sufficient in these contexts. For a concrete example of assessing impact/change in a low prevalence context, see the example from Madagascar on the CD Rom under Step 1, context analysis. Both the context and organisational analysis will help to answer the question:
«How vulnerable is the cooperation activity to HIV and AIDS?» (see box)

How vulnerable is the cooperation activity to HIV and AIDS?

- Are the objectives and plans of operations of the project/development activity still realistic and achievable under the given situation? How far need they be changed to take account of the HIV context?
- To what extent is the target population (beneficiaries) affected by the AIDS epidemic (changes in livelihoods, economic and social context of families and communities)? How are gender relations and inequities affected? How far does HIV and AIDS change the needs (demand) of the target population (men and women, girls and boys) with regard to the project's activities? How does the HIV situation change the ability of consumers/users to pay for services provided in the framework of the programme?
- To what extent can you still provide the planned outputs and outcomes given the impact of AIDS on human resources (men and women), staff and the workplace? Are there further workplace activities needed to protect your staff and families from getting infected and mitigate the impact of HIV and AIDS?

The following example shows an analysis on how HIV can affect a sector, in this case the agriculture sector. It is extracted from a resource developed by the Liverpool School of Tropical Medicine in collaboration with the Health Economics and HIV/AIDS Research Division (HEARD) at the University of KwaZulu-Natal and DFID Ghana.

9.2.2. What Impact is HIV and AIDS having on Agriculture?

How true are these in your context?

AIDS related illness and death affects labour available for agricultural production

Less produce

Lower inputs

AIDS related illness and death can lead to selling off of assets, i.e. animals which impacts on productivity and future livelihoods

What Impact is HIV and AIDS having an Agriculture?

Orphan households face particular problems in knowledge gap

Fisher folk are particularly hard hit due to their mobility to reduced capacity to fishing and for passing on fishing expertise to future generations

Source: Elsey and Kutengule (2003)

«Do no harm» is one of SDC's essential principles. It is crucial to answer this question and analyse how your sector or your work might aggravate the spread or impact of HIV. This means looking at whether the planned or ongoing activities increase vulnerability or risk behaviour of staff, partners and beneficiaries or whether the activities might aggravate the immediate and long-term consequences of the epidemic. This analysis is equally valid in low prevalence countries, as the primary aim is to prevent the epidemic from emerging further. This step is also relevant for humanitarian aid and particularly so in an acute emergency.

The following questions help to identify potential harmful effects

- Will programme activities result in increased mobility of specific groups such as staff, construction workers, tourists, traders or transport workers? Will the project result in increased mobility of the general population, e.g. for trade, construction work or pleasure? Will this be between high prevalence and low prevalence communities?
- Will the programme interventions create income which is likely to be spent on purchasing sexual services, particularly where income disparities or income generating opportunities aggravate gender inequalities?
- Will the programme activities lead to further inequality (e.g. by providing inequitable access to information or skills and resources for certain groups, such as women or people living with or affected by HIV)?

- Will the programme activities exclude people living with or affected by HIV (e.g. from services and benefits, such as job opportunities, credit schemes or water)?
- Could relief activities increase HIV vulnerability of refugee or displaced populations by creating risk situations for sexual violence and rape at water or food distribution points, badly illuminated paths to distant latrines or unprotected firewood collection? (Holden, 2004)

Doing harm should be avoided by anticipating potential negative consequences of programme activities and planning for corrective actions.

Here are two examples from SDC supported projects, where findings of such an analysis were used to adapt intervention strategies. The full case reports from Nepal, Mozambique and Madagascar can be found on the CD Rom (Chapter V, step 3 externally).

District Road Support Programme (DRSP), Nepal:
A social assessment was conducted in 2000. As a result of this a comprehensive strategy to integrate HIV was initiated, addressing awareness, behaviour, vulnerability and initiatives to avoid negative impacts, as outlined in the report «Beyond the Roads». Potential negative impacts (related to HIV) of programme activities were discussed and preventive measures were planned accordingly (for example to only employ local workers and not let female workers sleep on the construction sites).

SDC supported water sector in Mozambique:
At community level, a great concern was that the introduction of user fees for water could disproportionately affect persons and families affected by HIV or AIDS. Measures were then taken to ensure that these families would not be excluded from water services through encouraging traditional social mechanisms that enhance the use of pro-poor financing mechanisms or cross subsidies among community members.
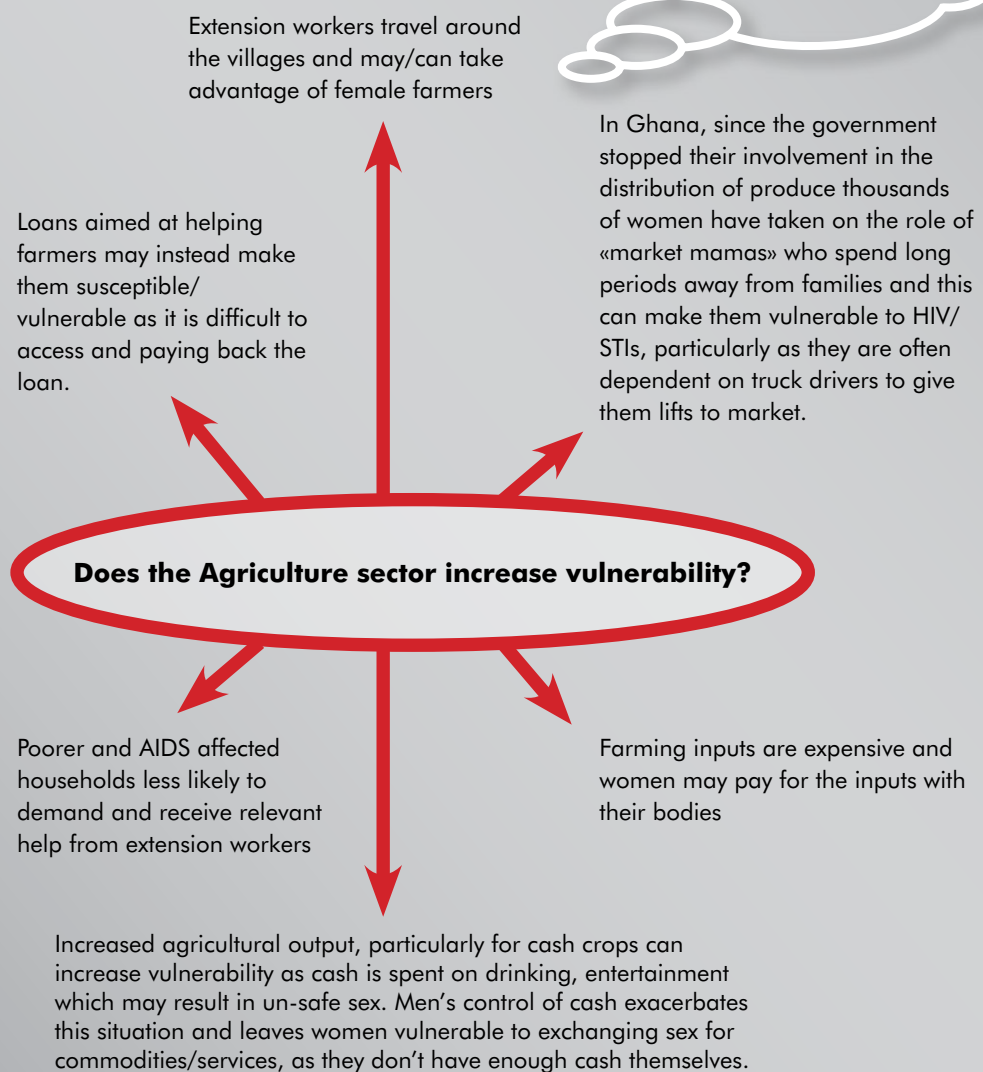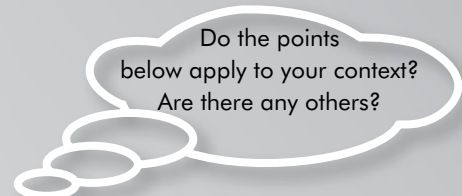
The following example of an analysis shows how a sector may have a negative impact on the HIV situation. A similar example for the education sector can be found on the CD Rom.

9.2.1. Does the Agriculture sector increase vulnerability?

Activities carried out by the sector that either increase susceptibility to HIV or reduce or fail to improve the capacity of households to respond to the impact of AIDS on their lives and livelihoods.

Do the points below apply to your context? Are there any others?

Extension workers travel around the villages and may/can take advantage of female farmers

Loans aimed at helping farmers may instead make them susceptible/vulnerable as it is difficult to access and paying back the loan.

In Ghana, since the government stopped their involvement in the distribution of produce thousands of women have taken on the role of «market mamas» who spend long periods away from families and this can make them vulnerable to HIV/STIs, particularly as they are often dependent on truck drivers to give them lifts to market.

Does the Agriculture sector increase vulnerability?

Poorer and AIDS affected households less likely to demand and receive relevant help from extension workers

Farming inputs are expensive and women may pay for the inputs with their bodies

Increased agricultural output, particularly for cash crops can increase vulnerability as cash is spent on drinking, entertainment which may result in un-safe sex. Men's control of cash exacerbates this situation and leaves women vulnerable to exchanging sex for commodities/services, as they don't have enough cash themselves.

Source: Elsey and Kutengule (2003)

Addressing the first two steps of the mainstreaming process will help you to create awareness and deepen the understanding for the relevance of HIV to the cooperation work. It is important to be sure that planned activities will not do harm and increase HIV vulnerability, risk taking or enforce its impact. Developing a workplace policy and related activities will greatly contribute to awareness raising amongst staff as they will feel concerned and cared for by the employer. This will empower them to get involved in addressing mainstreaming HIV in the external sphere. Assessing current and future implications of the evolving epidemic should create additional commitment to mainstreaming HIV leading a sector/project/programme to address the key question «How can we contribute to the HIV response? Where do we have a comparative advantage to limit the spread of HIV by reducing risk and vulnerability or strengthen resilience and how can we mitigate the impact of the epidemic?»
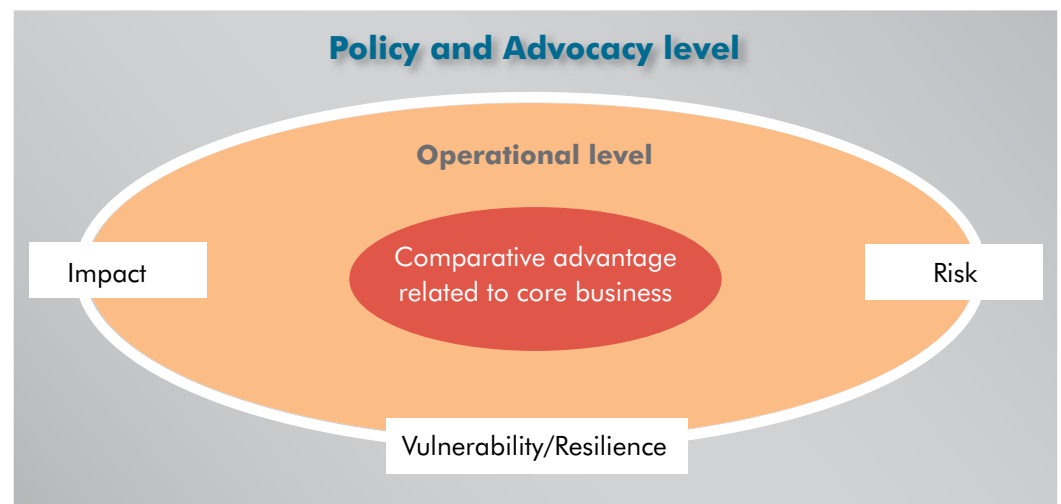
Ideally, mainstreaming HIV is considered within projects and programmes right from the beginning at the planning stage. The CD Rom contains a number of fact sheets and other documented experiences both from SDC and other agencies on how the mainstreaming concept can be translated into projects or programmes.

Linking the AIDS epidemic to the core business of a sector/programme/project helps to determine possible contributions.

At first sight, the core business (e.g. strengthen small scale business, support decentralization or support a ministry in the introduction of a Sector Wide Approach (SWAp), etc) may not seem to have much to do with HIV. Identifying comparative advantages of your sector/programme/project in contributing to the HIV response- addressing dimensions such as risk, vulnerability/resilience and impact- both at the level of policy and operations helps to establish this link.

It is important to address the following questions:

- To what extent can your activities help to reduce risk by promoting information and behaviour change interventions targeting staff, partners and beneficiaries?
- To what extent can your activities help to reduce vulnerability and strengthen resilience of men (boys) and women (girls) to HIV infection- and consequently address the mediators of the epidemic?
- To what extent can your activities strengthen the capacities of individuals, households, organisations and institutions to cope with the impacts of HIV infection, long term consequences- and consequently mitigate the impact of the epidemic?

Comparative advantage: For example, it may not be advantageous for agricultural extension workers to take on a whole new workload of HIV prevention activities within the communities they serve. This may not only lead to ineffective HIV prevention work, but could also undermine the time and capacity they need to do effective agricultural extension work. Recognizing the comparative advantage in this case means to concentrate on reshaping the agricultural activities so that they better meet the needs of households affected by AIDS. For the HIV prevention work skilled input from others working in this field may be used (e.g. local NGO or experts in health promotion from the Ministry of Health). (Source: Elsey and Kutengule, 2003)

If a project/programme uses its comparative advantages to address these dimensions, it can contribute in an important way to the HIV response. The mainstreaming HIV process can even contribute to strengthening and enriching the core activities of a programme. Mainstreaming does not always mean doing something new, but it can mean modifying what you are already doing to make it more AIDS specific and relevant, as shown in the two examples below. It means that mainstreaming HIV is «not extra work, but added value» (GTZ) for your activities. A good illustration of an example how mainstreaming can actually enrich your core business is that of the rural radio Magneva Menabe in Madagascar, to be found on the CD Rom under the SDC experiences. Two other examples are presented below.

Example 1

Budget support for municipalities, PADEM SDC Mozambique:
The SDC supported Programme in Support of Decentralisation and Local Government (PADEM) project›s core business is strengthening decentralisation. Capacity building of municipal leaders in management capacities is one component. PADEM decided to use its contribution to the HIV response as an opportunity for strengthening project and financial management capacities of these municipal leaders. Municipalities were given access to small grants for HIV related activities on a competitive ground passing through a process of proposal development. They were then accompanied throughout the process of planning, implementation and evaluation of their small projects.

Example 2

Rendering female alphabetisation classes more relevant to HIV by mainstreaming:
- introducing sex education, gender relations and HIV and AIDS as subjects in the curriculum
- introducing income generating activities to decrease vulnerability of women and girls that otherwise risk to sell sexual services for survival or of women and girls affected by HIV and AIDS
- specifically target AIDS affected communities when offering classes
- etc.

Being aware of the different entry points for mainstreaming HIV helps you to assess potential contributions. The list below only gives some examples. In low prevalence countries, health projects may provide a good entry point for mainstreaming HIV in a country portfolio. They in turn can play a vital catalyser role for other sector programmes and project.

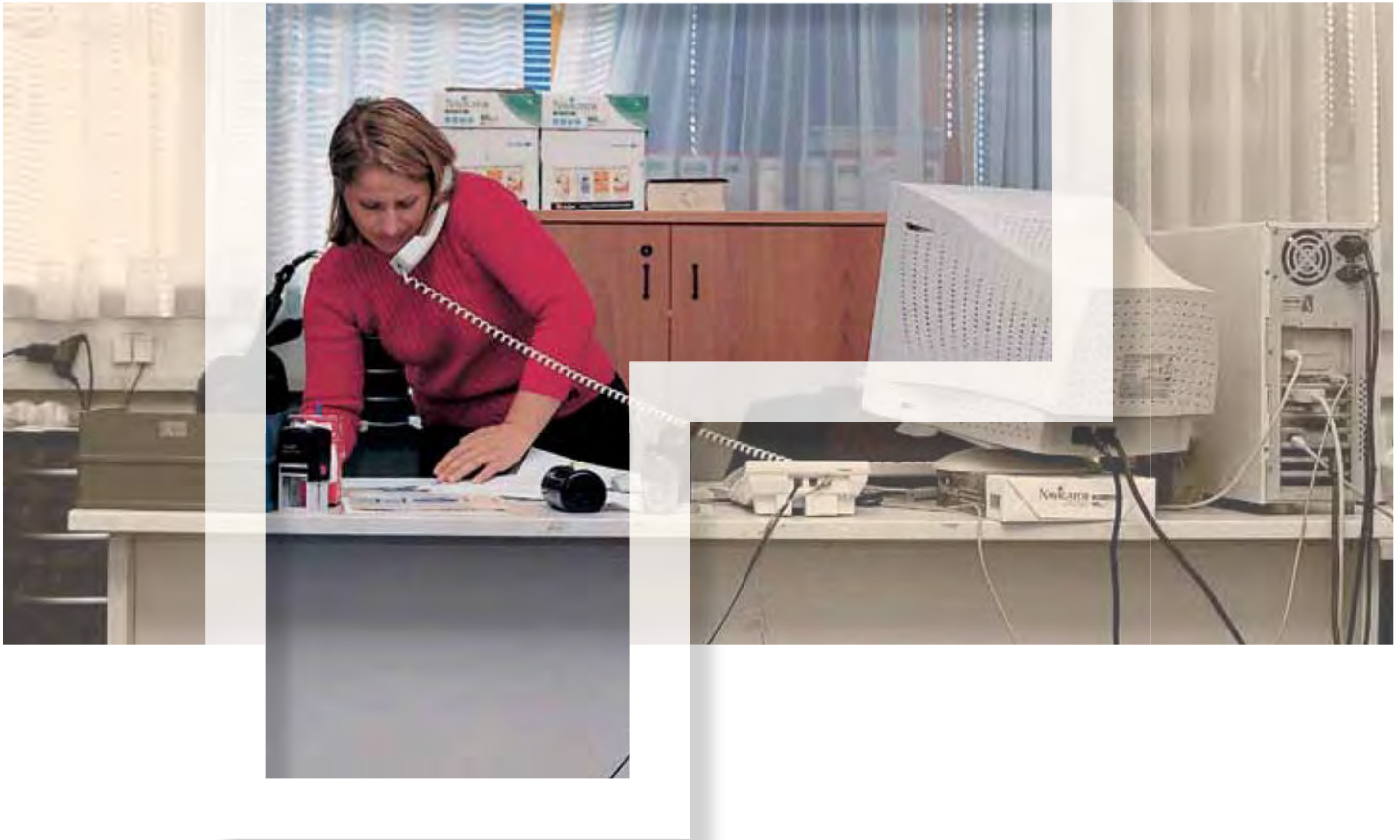| Entry points for mainstreaming HIV		
Policy Level	**Workplace Level**	**Operations level**
SWAps	Developing overall employment policies	Considering HIV in all credit proposal
Poverty Reduction Strategy Paper (PRSP)	Briefing of new staff members	Mainstreaming HIV into budgets (country pro-grammes, Cooperation Offices, Projects and programmes)
Donor Coordination	Staff meetings	Integrating HIV in Terms of Reference for assessments, evaluations, consultancies, tenders
Contacts with sector ministries of partner countries	Staff outings and family picnics	Subcontracts with NGOs and implementing agencies
Revision of policies, strategies, legal instruments		Taking account of HIV and AIDS when developing yearly plans of operations; determining objectives and indicators
Planning of country programmes and strategies		All training organised

The matrix of influence in Chapter II gives further examples of how different sectors can act on risk, vulnerability/resilience or impact mitigation. Many of these examples are mainstreaming examples.

Below are some selected examples of mainstreaming at the national policy and advocacy level.
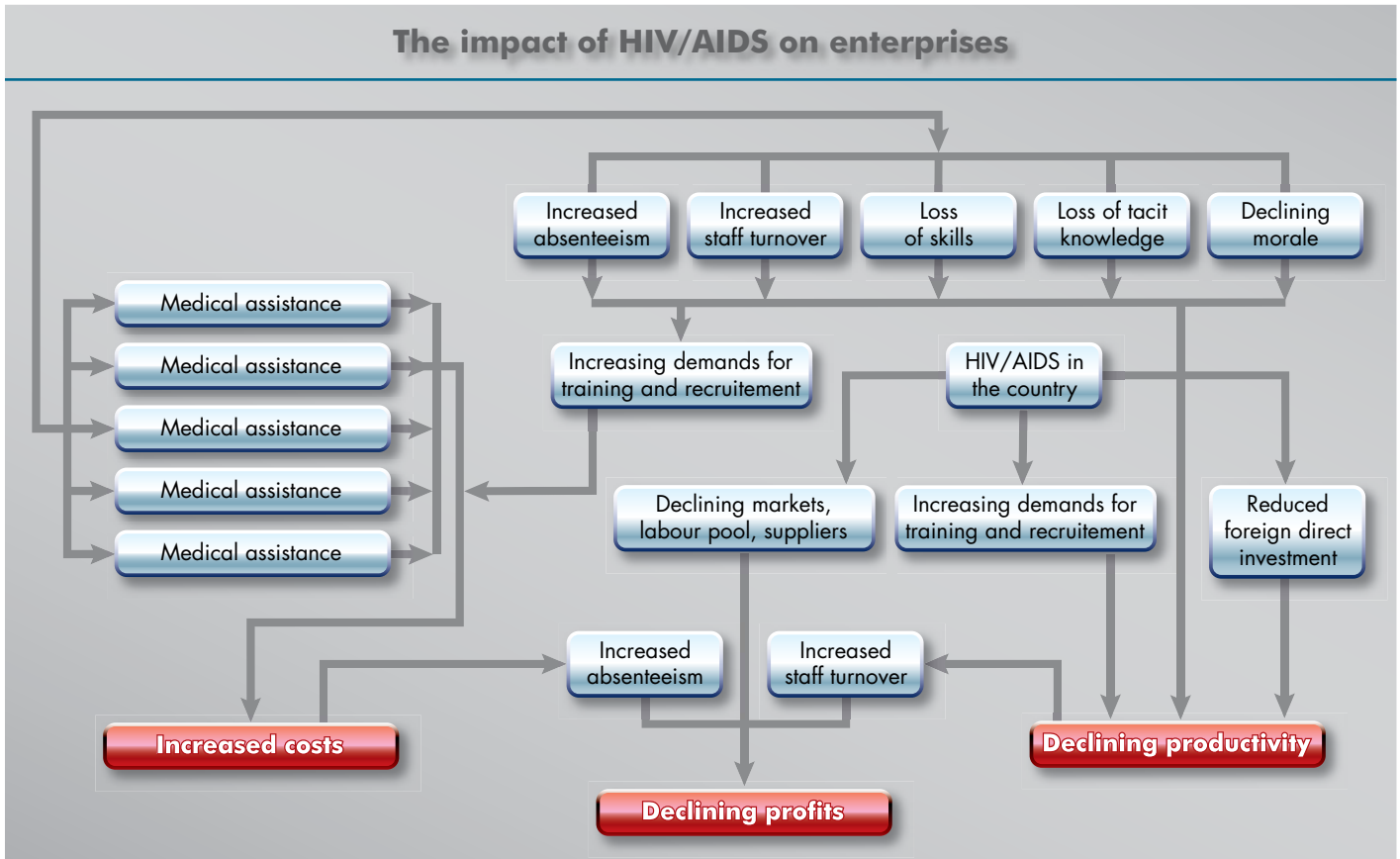
Mainstreaming examples from the national policy and advocacy level:

- In Cameroon, early in the debt negotiations the government and the World Bank identified AIDS as one of the most important areas to benefit from additional resources from debt relief (earmarking debt relief funds). This encouraged the government of Cameroon to accelerate the development of a nationwide plan to curtail the epidemic. Cameroon has committed to include increased condom use among men in uniform, truck drivers and commercial sex workers as conditionality in the Heavily Indebted Poor Countries dept initiative (HIPC) 2000.
  (source: UNAIDS and World Bank 2001)
- Work in collaboration with the legal sector and affected communities to strengthen national capacity in the area of ethics, including developing ethical standards for access to antiretroviral therapy.
- Build a coalition to support the Ministry of Finance and the sector ministries in ensuring that AIDS gets on the PRSP and debt relief agenda and is adequately covered within the SWAp. Focusing national media attention on AIDS as a poverty issue and a threat to development can also be effective in influencing national policy and AIDS in the PRSP and debt relief process. This was achieved in Uganda where the AIDS Commission succeeded through a participative process to incorporate AIDS into all the goals of the country's Poverty Eradication Action Plan. A way to influence national policy on HIV and AIDS was to gain national media attention on AIDS as a poverty issue and a threat to development.
  (source: UNAIDS and World Bank 2001)
- Mainstream HIV into the national development plans.
- Support budget mainstreaming for HIV in the public expenditure plans. Line ministries often fear allocating money to HIV and AIDS as this will squeeze their other priority programmes. On the other hand, there is also reluctance to budget for HIV, since they are aware of important parallel budget resources that can be accessed outside the national budget process. In addition to budget mainstreaming, coding HIV in the budget may help to track planned and actual expenditure on HIV and AIDS in a country.
  (source: DFID Health Systems Resource Centre 2004)

While doing mainstreaming of HIV, synergies should always be established with mainstreaming gender by using a gender sensitive approach. The fact sheet «Gender, HIV and AIDS» gives further details on how to make your HIV response more gender sensitive.

The Swiss Agency for Development and Cooperation (SDC) is not only a development organisation but also an employer.
In 2008 the agency employed some six hundred international staff and more than a thousand local staff worldwide. Both the SDC and its implementing agencies have been confronted with staff and family members affected or infected by HIV and AIDS, resulting in loss of staff, absenteeism, increased financial costs, higher staff turnover, lower morale and burn out.

The impact of HIV/AIDS on enterprises

Increased absenteeism	Increased staff turnover	Loss of skills	Loss of tacit knowledge	Declining morale

Medical assistance

Medical assistance

Medical assistance

Medical assistance

Medical assistance

Increasing demands for training and recruitement

HIV/AIDS in the country

Declining markets, labour pool, suppliers

Increasing demands for training and recruitement

Reduced foreign direct investment

Increased absenteeism

Increased staff turnover

Increased costs

Declining productivity

Declining profits

Source: Implementing the ILO Code of Practice, 2002

SDC is committed to preventing suffering, illness and discrimination amongst its staff by mainstreaming HIV within the organisation. HIV and AIDS related workplace issues are relevant for development and humanitarian cooperation, as well as for cooperation with the East. Therefore, in all countries where SDC supports international cooperation efforts, it should be an objective to mainstream HIV in the workplace, to enhance the ability of the organisations and their staff to:

1. anticipate and prevent infection
2. manage and minimize the effects of HIV and AIDS on the workplace
3. provide care and support to those affected or infected
4. protect workers' rights and eliminate stigma and discrimination on the basis of HIV status

SDC strongly encourages its Cooperation Offices and implementing agencies to integrate HIV and gender aspects into their workplace policy (sometimes also called Code of Conduct) using the guidelines of the International Labour Organization (ILO). Switzerland is a member of the ILO's governing body, and as such, committed to supporting the implementation of ILO policies and guidelines at the places of work. In June 2010 a landmark labour standard was adopted by governments, employers and workers at the annual conference of the ILO. The standard, which builds on ILO's 2001 «code of practice on HIV and AIDS, and the world of work», aims to strengthen the global response to HIV in the workplace.

The new international labour standard on HIV and AIDS is based on the following principles:

- The response to HIV and AIDS should be recognized as contributing to the realization of human rights and fundamental freedoms for all (workers, families and dependants)
- HIV and AIDS should be recognized and treated as a workplace issue, which should be included among the essential elements of the national, regional and international response to the pandemic with full participation of employers' and workers' organizations
- There should be no discrimination against or stigmatization of workers, in particular jobseekers and job applicants, on the grounds of real or perceived HIV status or the fact that they belong to segments of the population perceived to be at greater risk of or more vulnerable to HIV infection
- Prevention of all modes of HIV transmission should be a fundamental priority
- Workers, their families and their dependants should have access to and benefit from prevention, treatment, care and support in relation to HIV and AIDS, and the workplace should play a role in facilitating access to these services
- Workers' participation and engagement in the design, implementation and evaluation of national and workplace programmes should be recognized and reinforced
- Workers should benefit from programmes to prevent specific risks of occupational transmission of HIV and related transmissible diseases, such as tuberculosis
- Workers, their families and their dependents should enjoy protection of their privacy, including confidentiality related to HIV and AIDS, in particular with regard to their own HIV status
- No workers should be required to undertake an HIV test or disclose their HIV status
- Measures to address HIV and AIDS in the world of work should be part of national development policies and programmes, including those related to labour, education, social protection and health
- The protection of workers in occupations that are particularly exposed to the risk of HIV transmission

Source: www.ilo.org

There is no blueprint workplace policy which fits all needs. While the basic principles of the international labour standard on HIV and AIDS apply globally, the nature and size of the workplace programmatic response need to be adapted to the local epidemic situation and the number of staff employed. An organisation should carefully consider whether to develop a stand alone HIV policy, or integrate relevant aspects into a broader health or workplace policy. A general rule is that an HIV workplace policy should be developed as early as possible – before the employer is faced with a first case amongst its employees or their families.

Ownership and participation of all staff, including management, is key. A workplace policy should be elaborated by a joint committee of employers and employees, balancing the rights and responsibilities of both the organisation and its staff, as well as taking into account the national AIDS strategy and labour laws. In some cases, such as for the SDC Cooperation Offices in Dar es Salaam and Maputo, workplace policies have been developed together with the Swiss embassy.

The workplace policy should be presented to, and discussed with all new employees. Implementing agencies, partners and headquarters should also be informed. Developing a workplace policy is not a one off activity, but needs regular follow up, keeping discussions alive and periodically revising and adapting to changing realities.

It is crucial to translate the policy on paper into action for change at the workplace. For small offices, employers should look into the possibility to organise joint workplace programmes together with other agencies or offices. While awareness raising for staff and their families (particularly spouses and children) are important, a workplace programme is not limited to behaviour change activities. Information provided should also include policy issues and information on the employer's commitment to support their staff's access to testing, treatment and care, and to prevent and counteract discrimination at the workplace. Employers and staff should avoid «positive discrimination». Positive discrimination means actively favouring one category of people over others because they are considered to be disadvantaged – in itself, a form of discrimination (see example in the box).

An example of positive discrimination at the workplace

A Middle Eastern country wanted to develop a national HIV and AIDS law. In an effort to combat the widespread discrimination of people living with HIV, the draft law included a paragraph that would have forbidden employers to dismiss people living with HIV and obliged them to pay a lifelong salary, even if the person became unfit for work. While it is important that no one be discharged based on his or her HIV status, such a law would positively discriminate people living with HIV and consequently result in further discrimination against them, as employers would certainly hesitate before employing such a person, knowing that they could never end the contractual relation and that they might have to pay heavy social charges for as long as the employee was alive. Based on this analysis, it was strongly suggested that this paragraph in the draft law be revised.
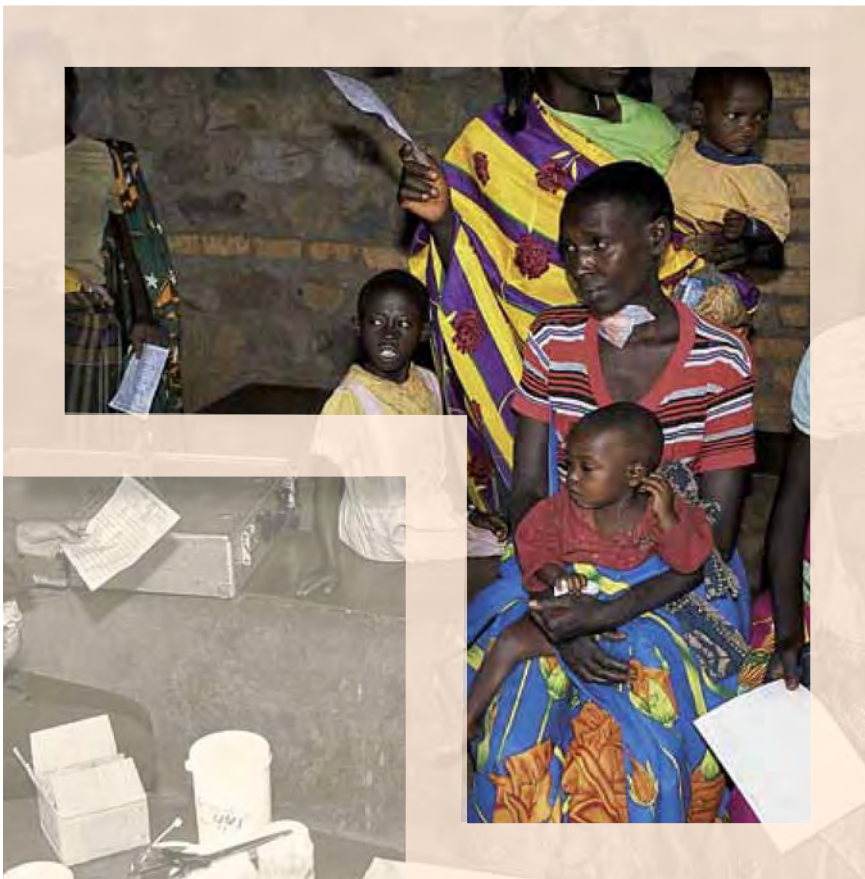
As part of their workplace programmes, some employers have promoted HIV testing campaigns at the workplace. While encouraging staff to know their HIV status and facilitating access to voluntary counselling and testing are important elements of such a programme, related campaigns should be carefully planned and possible harmful consequences should be anticipated. No staff member should be coerced for testing. Strict confidentiality about test results must be guaranteed and peer pressure for disclosure should be prohibited. Finally, the employer should be prepared to deal with the consequences when employees test positive. Successful testing campaigns at the workplace include those where members of the senior management served as role models and went for HIV testing as part of a workplace sensitisation effort to encourage all employees to know their HIV status.

In countries that are heavily affected by the epidemic, organisations that employ a great number of staff should anticipate the implications of HIV and AIDS by developing a human resources plan. Such a plan should also address issues of recruitment and training, career development, employee benefits (medical, funeral, pension, etc.) and cost implications. Another effective tool to alleviate the burden of those affected in high prevalence countries are solidarity funds fed by contributions from collaborators and the employer.

A good practice example from the wider sphere of SDC's partner organisations comes from the Delegation of Intercooperation (DIC) Madagascar. Following an initial SDC funded technical support mission to develop the concepts and strategies a very strong HIV mainstreaming approach was developed, both externally in their programmes, as well as internally in the workplaces at central, and more importantly, decentralised levels. The group was periodically inspired by tools and platforms offered by the SDC supported Community of Practice for HIV and AIDS. The CD Rom contains a report from a Knowledge, Attitude and Practice (KAP) study, conducted in 2006, and repeated in 2009, to assess progress with the HIV workplace programme. The results highlight the achievements in knowledge and attitude change of the staff. Impressive is also the fact that 69% of the 95 survey participants had an HIV test at least once in the last two years and received the results. 80% of the respondents state that the mainstreaming HIV «at their workplace is not a waste of money». (For the full report, see the CD Rom)

STOP AIDS NOW! has produced an interesting publication with lessons learned from civil society organisations and donors when addressing HIV and AIDS in the workplace.

Selected lessons learned by STOP AIDS NOW!

- It is important for donors to walk the talk. It is difficult and less effective to attempt to support others in something which you have not yourselves dealt with. As part of their own internal mainstreaming, staff from donor organisations should receive training regarding awareness, stigma and so on. A side-effect of this is that they are then better able to discuss HIV and AIDS issues in a meaningful way with local partners.
- Donors working in countries of high HIV prevalence need to incorporate the costs of HIV to partners in their plans. This may mean accepting the higher «overhead» costs and reduced outputs that working in contexts of high HIV prevalence entails. It will also mean making expected results and timeframes more realistic for an HIV context. It will require donors to invest, not just in capacity building, but even in simple capacity maintenance.
  - Appointment of focal points for HIV can make HIV mainstreaming initiatives more effective. Important conditions are that:
  - The individuals hold a position in the organisation that enables them to influence management, programme and support staff
  - There is wider ownership, which gives them a better platform from which to play their role
  - There are at least two focal points, or a rotating focal committee/steering committee
  - Dedicated time is part of the job description of each focal point.
  - Partnerships and co-operation are needed: With service providers to increase access for staff, with other stakeholders to learn from each others' experiences and build upon these, and for joint lobbing for all necessary services to become available freely.
  - Extending workplace programmes to employees' immediate family members and positively and meaningfully involving people living with HIV makes them more effective.
  - A learning community of capacity builders in Sub-Saharan Africa exists to stimulate reflection on practice, sharing of experiences, and learning from new tools. See http://www.intrac.org/pages/en/learning-group-for-capacity-building-providers.html

Source: Addressing HIV and AIDS in the workplace: Lessons Learnt from Civil Society Organisations and Donors, by STOP AIDS NOW! 2009

Imagine Susan, who got infected with HIV at the age of 14, when she used to have sex with an older man – a so called «sugar daddy» – in exchange for nice gifts and money. Susan dropped out of school when she was nine, because her parents needed her to earn money to sustain the family. She only learned that she was HIV positive after she married and was pregnant with her first child. When her husband learned of this, he rejected her and sent her away. Today, Susan lives with her elder brother. She cares for his wife, who is sick with AIDS. Would her situation be different if she was a man?

Why consider Gender in HIV and AIDS?

Gender is inextricably linked to the HIV epidemic. Today, the feminization of the HIV and AIDS epidemic is widely acknowledged. Women – and especially young women – are disproportionately affected by HIV and AIDS, not only because women account for a bigger proportion of new infections, but also because women tend to bear the main burden of caring for sick family members. Gender inequalities, poor respect of women's human rights and sexual and gender-based violence are drivers of the HIV epidemic. If we do not take gender into account in our AIDS work we tend to risk, among other things:

- that women, and in certain cases also men, may be excluded from or may have unequal access to HIV and AIDS services, information and activities
- issues of gender-based violence and power relations that drive the epidemic may not be addressed
- gender stereotypes may be reinforced
- the stigma attached to AIDS may be associated with women or homosexual men
- the burden of the epidemic continues to be carried mainly by women and girls
- that myths about male and female sexuality persist

What is Gender?

Gender does not refer to the biological sex of a person; neither does gender mean women. Gender is socially constructed and describes the roles, responsibilities, and functions women and men have in a specific cultural context. To learn about gender roles is part of the socialisation of each girl and boy. Gender relations are power relations and women and men do often not have equal opportunities and equal level of freedom to make choices and develop personal abilities. For a more detailed discussion of the gender concept and definition, see page 1 in the SDC Gender Toolkit (available on the CD Rom).

How does gender influence vulnerability to HIV infection?

There are social, cultural, economic, religious, political and physiological factors, which in a complex way, and at different levels influence women's, girl's, men's and boy's vulnerability to HIV infection. It is important to not only look at people's vulnerability to HIV, but also at the factors that strengthen their resilience[1] and increase their capacities to prevent themselves from becoming HIV positive. Many of these influencing factors do have a gender dimension, i.e., they do mean different things for women and men. Education, for example, plays an important role in increasing a person's resilience to HIV infection. Education also has a gender dimension, as access to education is often more constrained for girls than boys. Gender norms and stereotypes may increase people's vulnerability to HIV infection. They, therefore, need to be addressed and become an essential element in the AIDS response and any effort to improve the health and well-being of both women and men.

How can I make my HIV and AIDS work gender sensitive?

Gender analysis is a tool that provides the data and information necessary to ensure that policy, programme and project planning addresses the needs of women, and men, and benefits both. When doing gender analysis, look at the programme and the context in which it will be implemented through «gender lenses». The SDC Gender Toolkit that can be found on the accompanying CD Rom provides more information on gender analysis and on how to go about it. In this toolkit there are also a number of other mainstreaming tools organised around guiding principles and key questions.

Gender analysis can be integrated into any programme or project – and especially into HIV and AIDS work. To know which questions to ask, and at what moment in order for gender to be integrated at the different stages of HIV and AIDS programmes, it is important to consider the following criteria:

- **Risk:** Does the programme take into account the particular needs and different risks of men and women, girls and boys?
- **Vulnerability:** Does the programme address the structural gender imbalances that drive the AIDS epidemic? Does it clearly identify these factors?
- **Impact:** Does the policy or programme address the structural gender imbalances that characterise the epidemic in terms of access to information, treatment and care and its impacts? Does it clearly identify those impacts?

[1] «Resilience» refers to the ability of an individual or a group to «thrive, mature, and increase competence in the face of adverse circumstances (Gordon 1995)». Using a resilience oriented approach therefore, means looking at resources and coping mechanisms that people draw upon to avoid risk or cope with stress and adversities, and focus on how these abilities can be strengthened.

Below is an example of a more detailed list of questions that should give an idea of how to go about integrating gender into the AIDS response. It is built around the theme of providing improved care and services. For more information on gender mainstreaming, checklists and tools see the respective section on the CD Rom. Developing gender-sensitive indicators for your programme is key to measuring the progress towards the realisation of gender equality. The choice of appropriate gender-sensitive indicators varies according to project goals, the state of the epidemic, the level of understanding of how gender issues affect the spread of HIV, and the availability of both quantitative and qualitative sex-disaggregated data.

In this Toolkit you find a factsheet on monitoring and knowledge sharing with more guidance on how to include gender and HIV into monitoring and evaluation systems.

Guiding questions for a gender sensitive approach to improving sexual and reproductive health and HIV care and services

- Is adequate provision made to ensure that people living with HIV and AIDS – particularly women and girls and their representative organisations – are involved in the design, implementation and monitoring of the programme?
- Does the programme challenge and transform stereotypes and stigma associated with AIDS, in particular those that, unconsciously or deliberately, place blame for the spread of HIV on women/girls in general, on specific groups of women/girls or specific groups of men/boys?
- Does the programme contribute to equitable access to, and use of appropriate health care and treatment options for both, women and men, girls and boys?
- Is the programme informed by an assessment (conducted with people living with HIV) of the specific treatment, care and support needs of both, males and females living with HIV or AIDS?
- Does the programme develop culturally sensitive approaches to promoting improved and gender equitable access to prevention, treatment, care and support services?
- Do Home-Based Care programmes seek to involve both men and women?
- Are Home-Based Care programmes accompanied by appropriate systems of reward and recognition, to avoid that such programmes add to the (unrewarded) burden of care on women and girls?
- Are clear and gender-specific indicators adopted to review whether equitable access to treatment translates into equitable use and benefit for women/girls and men/boys?

Adapted from UNAIDS 2006, Resource Pack on Gender and HIV/AIDS. A Rights-Based Approach. Operational Guide on Gender and HIV/AIDS, p. 14-15.

Gender Mainstreaming in Practice – Some Examples

Gender and HIV Mainstreaming: Experiences from SDC Cooperation Offices

Gender, HIV and AIDS are all intrinsically linked and can be mainstreamed into a programme of work in an integrated way. Gender mainstreaming and HIV mainstreaming can be jointly addressed during planning, implementation, monitoring and evaluation. For the SDC Cooperation Offices in Tanzania, Mozambique and South Africa, gender and HIV mainstreaming has been a critical component in development work for many years. A series of workshops have been conducted to introduce SDC staff and local partners to methodologies incorporating gender and AIDS perspectives in their work. Trainings and a capitalization study have been conducted. Today, the integrated efforts have been evaluated in Tanzania. The results of a similar exercise in South Africa will feed into the the new country strategy and will provide useful information on which direction to take and which role to play in mainstreaming activities.

IPPF: Mainstreaming Gender at policy level

Gender has to be mainstreamed at all levels of intervention – policy, programme and project. In 2008 the International Planned Parenthood Federation (IPPF) adopted a new policy on «Men and Sexual and Reproductive health»[2]. This policy reflects the need to work with men and boys, together with women and girls, as equal partners in the provision of comprehensive sexual and reproductive health services – including HIV and AIDS.

The policy provides guidance for working with men and boys in many areas, such as for example in promoting gender equity in health, fostering healthy sexual attitudes and behaviours, working with men as partners in HIV prevention, in the provision of safe abortions as well as towards the elimination of gender based violence.

EngenderHealth: Challenging traditional gender roles

EngenderHealth is an international NGO engaged in reproductive health, HIV and AIDS, working with men to address and challenge traditional gender roles and attitudes about «what makes a man» and «what makes a woman». Through its «Men As Partners®» programme and other gender initiatives, EngenderHealth enhances men's awareness of, and support for their partners' reproductive health, increases men's access to, and use of reproductive health services and mobilizes men to take part in promoting gender equity, and work against gender-based violence. Nyambu Albert, for example, a 20 year old serviceman with the national youth service of Kenya, tells how he changed his attitudes and views about men and women: [3]

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[2] For more information see:
http://www.ippf.org/

[3] http://www.engenderhealth.org/our-work/success-stories/

Who I was: «I confess to have been a gender-insensitive person. Where sex was concerned, I believed a young man should experiment with many girls before he decided which one to marry. I wondered how one's girlfriend could claim to be raped by her boyfriend. I never thought my girlfriend had any sexual rights, and we never discussed sex, since I assumed that she should comply with my demands. I have had many unhealthy relationships because I have been brought up in an environment where women are considered inferior to men and are not involved in decision making, since they have nothing to offer.»

Who I am today: «Now I know why it is important to know one's status. HIV could ruin my future. It is not [just] a disease for prostitutes, and even my girlfriends could be infected. I used to think young people could not do without sex. I thought sexuality was only about sexual intercourse. I have now made a personal commitment to stick to one partner, and I proposed to my girlfriend that we visit the nearest voluntary counseling and testing site to know our current status.»

Why should health care providers not talk about HIV prevention when they counsel clients about family planning methods? Why would a pregnant woman living with HIV want to go to one clinic for her antenatal check-up and then go to another one to get her antiretroviral medicine? The importance of linking Sexual and Reproductive Health (SRH) and HIV is widely recognised. The main challenge today remains with translating this concept into practice. The field of SRH involves family planning, maternal and infant health – including antenatal, delivery, postnatal and neonatal care. Abortion care and the prevention and management of gender-based violence and sexually transmitted infections (STI) are also main elements of SRH. Other issues include the prevention and treatment of cancers or dysfunctions of the reproductive organs. The response to the AIDS epidemic includes HIV education and prevention, HIV counselling and testing, the prevention of mother to child transmission (PMTCT) and the treatment, care and psychological support for persons living with HIV or AIDS (PLWHA) and those affected by it. Clearly, these are overlapping issues that should be addressed in a comprehensive, rather than a vertical approach. What should motivate us most is that linking SRH and HIV in our interventions and services meets the reality and the needs of the people we work with.

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HIV/AIDS

Policy & Advocacy
Access to information
Access to services
Quality of services
Coverage

Prevention of
HIV transmission
Sexually transmitted infections
(STIs)
Opportunistic infections

Treatment & Care
Treatment of opportunistic
infections
Antiretroviral therapy (ART)
Treatment of STIs
Psychosocial support

* provided that ethical and human rights safeguards
are in place and access to services exists

- Comprehensive safer sex services, including contraception for all and for groups with special needs, such as young women and men, people living with HIV and other vulnerable population groups
- Condom use for dual protection (protection against HIV and STIs as well as unwanted pregnancies) as part of all family planning and HIV prevention and treatment programmes
- Clinics for the control of sexually transmitted infections that offer an HIV service package, including safer sex information and counselling, routine HIV testing and condoms
- HIV testing and counselling, information on safer sex and condoms and antiretroviral treatment available in antenatal care and maternal and child health service points in high prevalence settings
- Services for victims of gender-based violence that include counselling, diagnosis of STIs and HIV, and offer emergency contraception and HIV post exposure prophylaxis

Linking SRH and HIV means making use of the synergies, which are offered through these common objectives, at all levels: (1) advocacy, (2) policy, (3) programmes and (4) services. The endeavours for linking SRH and HIV need to go in both directions, namely by integrating HIV and AIDS interventions into SRH services and, by integrating SRH services into services and programmes initially set up to address the AIDS epidemic. The list below provides examples of linked services, policies and programmes[1].

1 Adapted from: WHO, UNFPA, UNAIDS and IPPF. 2006. Sexual and Reproductive Health and HIV/AIDS: A Framework for Priority Linkages.

Where do SRH and HIV meet?

The links that exist between SRH and HIV become apparent when we apply a client-centred approach and develop services around their needs. The diagram shows that links where SRH and HIV interventions share common objectives are many.

SRHR

Policy & Advocacy
Access to information
Access to services
Quality of services
Coverage

Prevention
Family planning
Prevention of mother-to-child-transmission (PMTCT)
Prevention of STI
(e.g. syphilis screening)
SRH services for PLWHA

Treatment & Care
Maternal & infant care
Post abortion care

Common obj

Promotion of sa
reproductive be
(including dual
against uninten
and STI/HIV)

People should k
status*

Safe pregnancy

Healthy childre

Information and
available to pop
in need

Enabling enviro
empowerment o

Guiding principles:

▸ Equality of rights and opportunities

▸ Gender sensitivity

▸ Multi-sectoral approach

▸ Health system strengthening

▸ Focus on vulnerable populations and those most in n

▸ Solidarity and non-discrimination

Source: BMZ, DSW, GTZ, InWEnt and KfW. 2008.
Policy Brief: Promoting Linkages and Synergies for
Sexual and Reproductive Health and Rights, and
HIV/AIDS. Key Issues and Opportunities, p. 7.

Good Reasons for Linking SRH and HIV

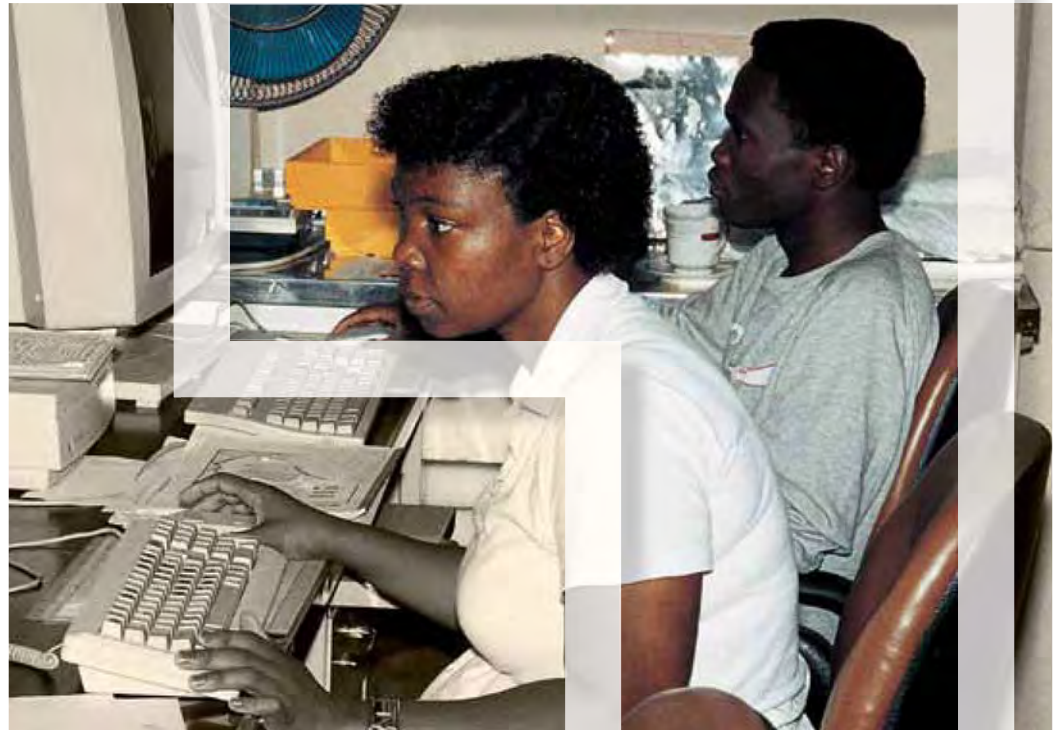**Linking creates win-win situations, because:**

- It allows a shift away from the artificial separation at service level, towards a client-centred approach offering comprehensive services based on the needs of people – especially for sexually active women, youth and marginalised groups, such as sex workers, men who have sex with men and transgender people.
- Sexual and reproductive ill-health and HIV affects the same population groups and their root causes are similar. Poverty, stigma and discrimination, cultural taboos, as well as structural determinates such as gender inequality, and lack of access to information and services, all contribute to increased vulnerability to contracting HIV or developing SRH problems (see also VI Gender, HIV and AIDS).
- Integrated HIV and SRH services strengthen health systems by increasing effectiveness, and efficiency, and may ultimately result in public health benefits through improved access and uptake (i.e. more individuals are tested, early treatment of STIs, increased uptake of PMTCT and dual protection, etc.). Closer links can reduce duplication of services, reduce overhead costs and help make joint use of often scare human and financial resources.
- HIV or SRH can, depending on the context, create an entry door for each other in situations where one of the topics seems less of a priority to the public and decision makers, or where one of these topics is highly sensitive and difficult to address. For example in a country such as Swaziland with a high HIV prevalence and well established services to prevent mother to child HIV transmission, HIV prevention services can provide an ideal platform to address SRH and offer treatment for other STIs. In Central Asia, on the other hand, where HIV prevalence is still low, but rapidly increasing, SRH services can offer an entry to raise awareness about HIV and to provide access to testing and treatment.
- The availability of a variety of SRH services, including HIV testing and treatment, under one single roof, and not in separate facilities, has a potential for reducing HIV and AIDS-related stigma and discrimination.

What are the challenges and opportunities for linking SRH and HIV?

Today's context offers opportunities, but also challenges, for those committed to better linking SRH and HIV. A considerable amount of funding still flows into vertical programmes, which do not provide incentives for operational integration. Vertical programmes still develop technical guidance and lists of essential drugs that are condition specific, and pay little attention to related areas in SRH and rights. In many countries separate policies and institutional processes continue to persist. For various reasons, professional and political resistance to an integrated approach is still common. Understaffed health systems, inadequate infrastructure, the prevailing stigma and the preference for easy, quick wins and magic bullets are other factors that inhibit effective linking, client centred approaches and systems thinking.

Conversely, there is a growing commitment at national and international level to linking SRH and HIV. New aid modalities and development strategies, such as Sector Wide Approaches (SWAPs) and Poverty Reduction Strategies, favour integrated approaches and offer opportunities forlinkage.

International commitments build on the «Glion Call to Action» (May 2004) and the «New York Call to Commitment» (June 2004). Concerns have been expressed that too many policies have failed to exploit potential linkages between SRH and HIV. The United Nations' General Assembly Special Session on HIV/AIDS (UNGASS, 2001 and 2006) emphasised that investment in SRH is a major foundation for HIV prevention and treatment. A main focus of the «Maputo Plan of Action» (2006) is the integration of SRH services into primary health care. Coordination activities and joint publications by several multilateral and bilateral agencies, and non governmental organisations have multiplied as a result.

A four steps approach to linking SRH and HIV

Step 1 – Situation analysis:
Analyse how far policies, the health system and the services offered are integrated. The assessment takes place at three different levels:

i) Policy level: national policies/strategies, laws, guidelines, operational plans, budgets and funding
ii) Systems level: partnerships, management/administration, human resources and capacity building, logistics and procurement, use of infrastructure, laboratory services, monitoring and evaluation
iii) Service/programme level: SRH services/interventions integrated into HIV services/interventions and vice versa

For more details and guidance of how to go about this step, please refer to the Rapid Assessment Tool for Sexual and Reproductive Health and HIV Linkages, which you find on the CD Rom.

Step 2 – Identify gaps and comparative advantages:
Identify and discuss with partners the main gaps where you and your organisation have the possibility to become engaged to bring about change.

Step 3 – Use guiding questions to help address priority actions:

Address the selected priority action areas by strengthening policies, health systems and services with the help of the detailed questions for each area provided in the Rapid Assessment Tool. Capacity building may be needed at various levels to allow decision makers, managers and service providers to act in an integrated way.

Step 4 – Help others to learn:

Document, capitalize and share your experiences to contribute to the generation of evidence to improve current and future programmes, and to help address the challenges. While there is a broad consensus that strengthening SRH and HIV linkages should be beneficial for clients, only limited evidence is published regarding the benefits, feasibility, costs and implications for health systems. With rigorous monitoring and evaluation you can contribute to bringing about change.

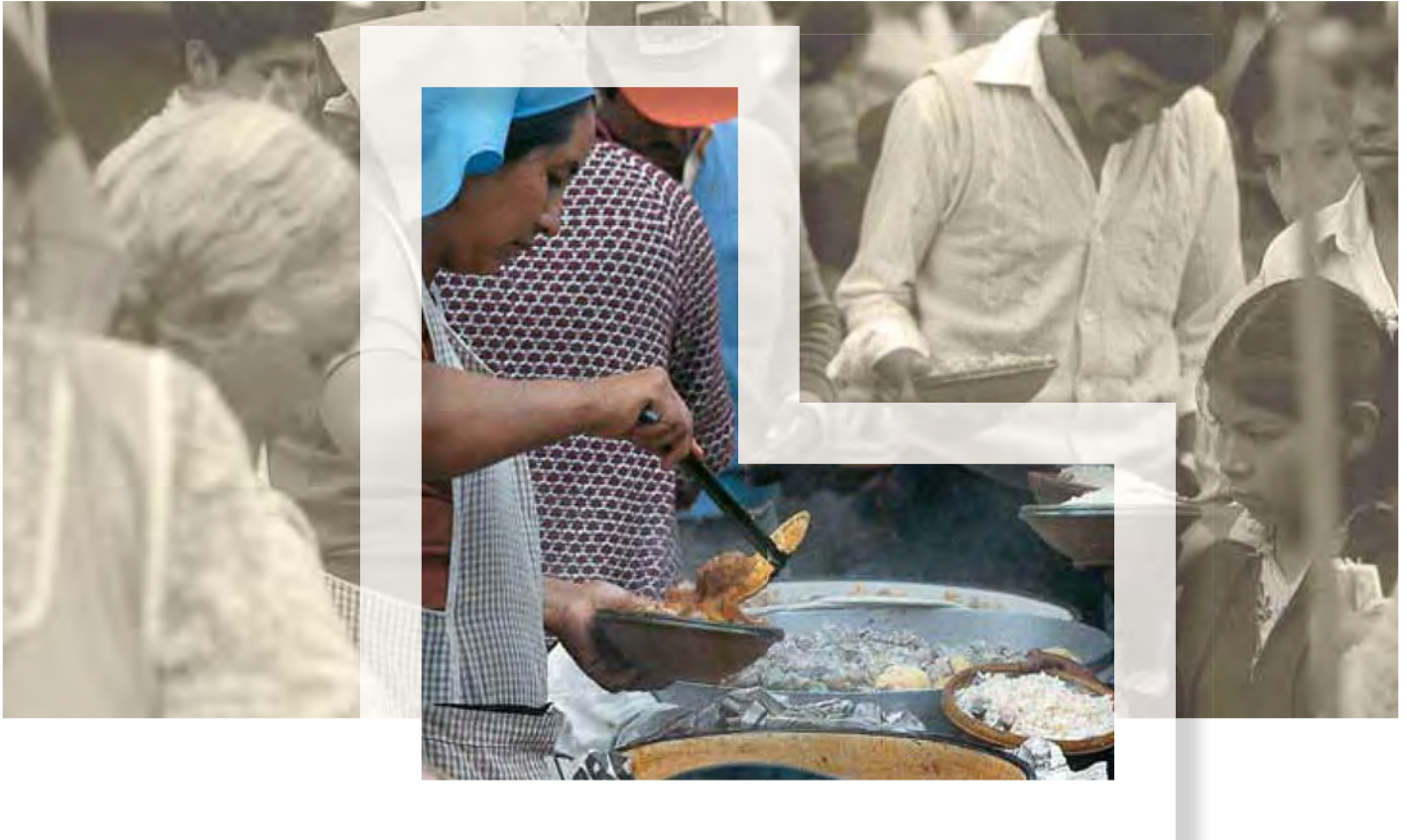## Everything under one roof: Integrating SRH and HIV Services in Haiti

The case study from Haiti nicely demonstrates the two-way flow between SRH and HIV health care services and reflects the diversity of integration models.

Haiti has one of the oldest AIDS epidemics and highest rates of HIV infection in the world outside of Sub-Saharan Africa. In 1982 a group of doctors initiated the research institute GHESKIO (Groupe Haitien d'Étude du Sarcome de Kaposi et des Infections Opportunistes). Two years later, GHESKIO began providing voluntary counselling and testing (VCT), and treatment of opportunistic infections in one of the poorest neighbourhoods of Port au Prince. The integration of SRH into HIV services at the GHESKIO centre happened subsequently, over more than 10 years, as the needs became apparent and operational research showed what was feasible. What were the steps taken by GHESKIO to use VCT as an entry door for comprehensive SRH services?

- 1985: VCT and treatment of opportunistic infections
- 1988: Distribution of condoms to prevent sexually transmitted infections including HIV
- 1989: Diagnosis and treatment of tuberculosis
- 1991: Diagnosis and treatment of sexually transmitted infections
- 1993: Family planning
- 1999: Antiretroviral therapy and maternal health programme, including prevention of mother to child transmission
- 2000: Care for survivors of sexual violence and youth programme

In 2008, the centre had over 200 staff members and services were offered to a population of around 1.5 million. GHESKIO has played a major role in influencing policy and the Haitian national health system. The GHESKIO model of service provision has been applied in 22 public and private health centres and hospitals nationwide.

Source: WHO, UNFPA, UNAIDS and IPPF. 2008. Linking Sexual and Reproductive Health and HIV/AIDS. Gateways to Integration: A Case Study from Haiti (available on the CD Rom).
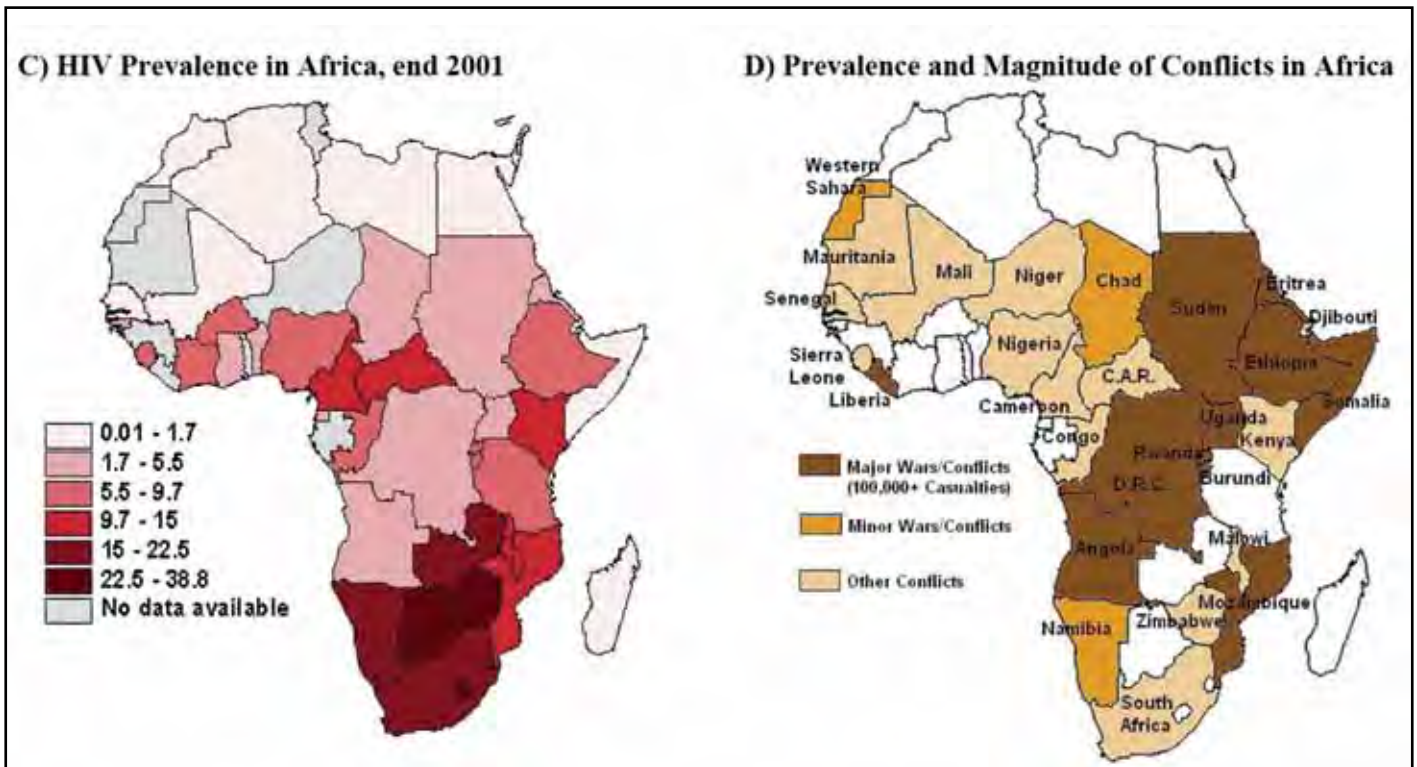
Why mainstream HIV into the humanitarian response?

Food aid and temporary shelters are regular components of emergency responses, but not always condoms, antiretroviral medicines or treatment for sexually transmitted infections. Other items of daily necessity, such as sanitary towels, are also not part of the ordinary relief supplies. Sexual and Reproductive health (SRH) needs of people do not cease during an emergency situation. Women continue to menstruate, people are having sex and babies do not wait to be delivered until the emergency is over. It is therefore crucial to ensure continuity in covering the SRH needs throughout a period of humanitarian crisis – including those related to HIV and AIDS. Humanitarian crises often arise in areas already contending with a high HIV burden (see map on following page). It is estimated that around 200 million men, women and children are affected by humanitarian emergencies at any given time and that about 10% of the global AIDS burden is carried by people living in humanitarian settings. In 2006, 1.8 million people living with HIV were affected by emergencies. HIV is not simply a long-term development issue but, depending on the epidemiological situation, can also be of high relevance in emergency situations. A high HIV infection rate increases the vulnerability of a population, as the coping capacity to respond to

external shocks such as natural disasters, civil unrest and conflict is weakened. HIV has major long-term implications for a population, even if it is not an immediate life threatening disease such as malaria or cholera. Additionally, it is impossible to achieve universal access to treatment, care and support without taking into account the special needs of people of humanitarian concern.

C) HIV Prevalence in Africa, end 2001

0.01 - 1.7
1.7 - 5.5
5.5 - 9.7
9.7 - 15
15 - 22.5
22.5 - 38.8
No data available

D) Prevalence and Magnitude of Conflicts in Africa

Major Wars/Conflicts (100,000+ Casualties)
Minor Wars/Conflicts
Other Conflicts

Graph: Overlap of HIV and conflict
Source: Mock et al Conflict and HIV: A framework for risk assessment to prevent HIV in conflict-affected settings in Africa; Emerging Themes in Epidemiology 2004, 1:6

The potential for increased risk of HIV transmission in emergencies has been recognised by humanitarian agencies and steps have been taken towards effectively integrating HIV into the humanitarian response. Opportunities to address HIV and AIDS in emergencies are many, and can include, for example, workplace programmes in the relief phase of an emergency, or linking HIV programmes to food assistance, and food security issues, but also programmes relating to the prevention of sexual violence and protection of unaccompanied minors and other vulnerable groups. HIV and AIDS should be addressed in an integrated way, linking it to SRH needs and rights (for further details, see the fact sheet on Linking SRH and HIV).

The «Do No Harm» principle

«Do No Harm» is an important principle in humanitarian assistance. Aid can become part of the dynamics of a conflict, may increase the vulnerability and risks related to HIV, or aggravate the immediate and long-term consequences of the disease. In the context of HIV, applying the «Do No Harm» principle means looking at whether the planned or ongoing activities increase the vulnerability of staff, partners or beneficiaries to contracting HIV. Assessing potential harm is equally valid for low prevalence countries as the importance of preventing the spread of HIV is crucial in all settings. Some examples of potentially harmful decisions and behaviour of relief agencies and their staff in emergency settings are:

- Distribution of goods, such as jerry cans for water collection to HIV affected families only, increases stigma and discrimination.
- Poor lighting in camps for displaced people together with a lack of fuel puts girls and women at risk of rape and sexual abuse while collecting firewood or using the latrines.
- Food distribution linked to antenatal care and Prevention of Mother to Child Transmission (PMTCT) services runs the risk of encouraging pregnancy in areas of high food insecurity.
- In some situations, relief staff in charge of distributing or transporting food have been found to exchange goods for sex.
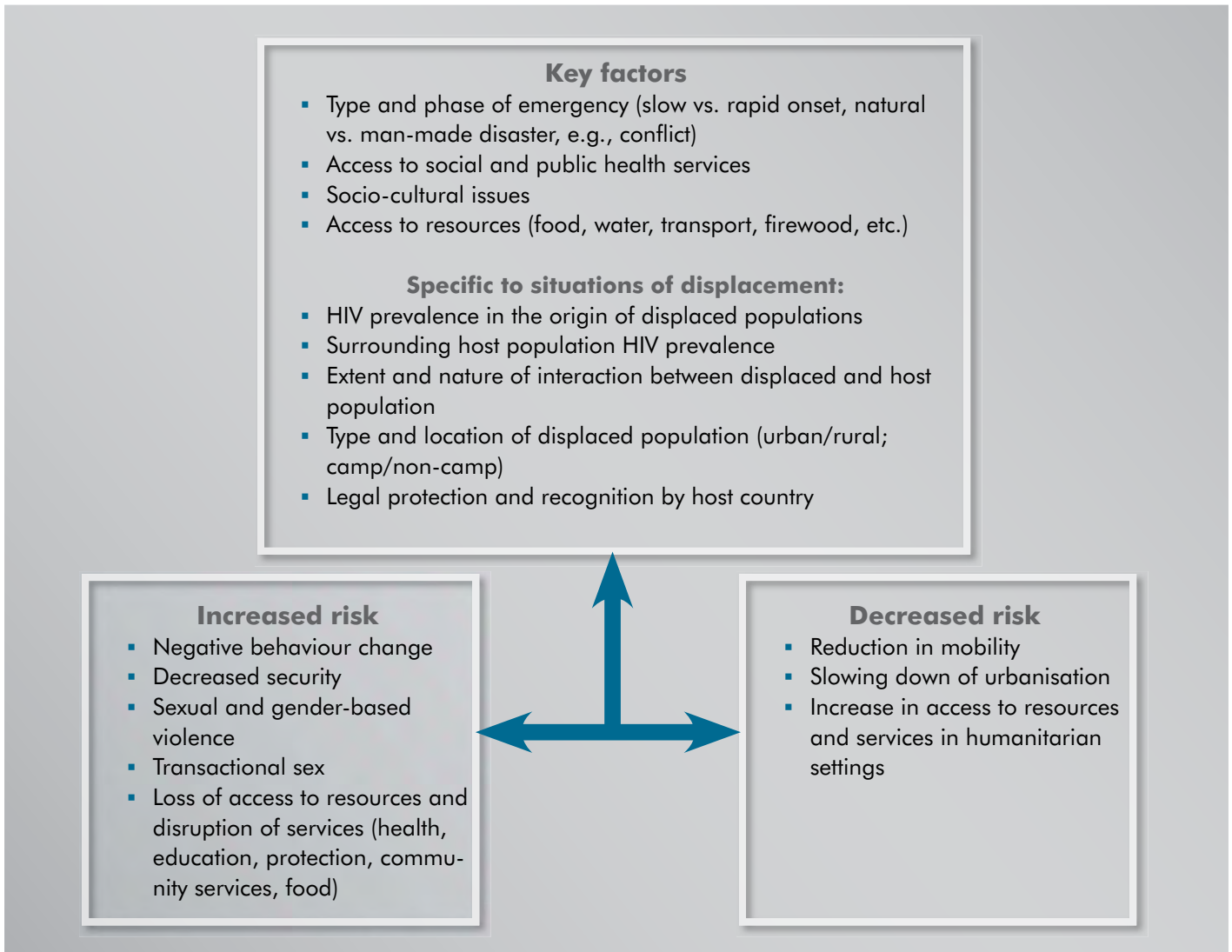
Risk and vulnerability to HIV in emergencies

Emergency situations have the potential to amplify the risks of and vulnerabilities to HIV transmission in many ways – especially for women, children and marginalised groups. However, the relationship between emergencies and HIV is complex. A number of factors related to affected populations and their demographic composition, people's behaviour, the type of emergency, the services available and their accessibility and other vulnerability factors such as illiteracy, social disruption, unemployment, sexual coercion and sexual violence influence the level of risk. Additionally, many of these factors are interrelated, for example, food insecurity and transactional sex. On the other hand, in some contexts conflict and disaster situations can also have a protective effect as the presence of aid organisations can improve such things as access to condoms, antiretroviral treatment and access to paid work.

The figure below highlights the key factors in humanitarian emergencies and how they can affect risk[1].

Key factors

- Type and phase of emergency (slow vs. rapid onset, natural vs. man-made disaster, e.g., conflict)
- Access to social and public health services
- Socio-cultural issues
- Access to resources (food, water, transport, firewood, etc.)

Specific to situations of displacement:

- HIV prevalence in the origin of displaced populations
- Surrounding host population HIV prevalence
- Extent and nature of interaction between displaced and host population
- Type and location of displaced population (urban/rural; camp/non-camp)
- Legal protection and recognition by host country

Increased risk

- Negative behaviour change
- Decreased security
- Sexual and gender-based violence
- Transactional sex
- Loss of access to resources and disruption of services (health, education, protection, community services, food)

Decreased risk

- Reduction in mobility
- Slowing down of urbanisation
- Increase in access to resources and services in humanitarian settings

Adapted from Spiegel, Paul. 2004. HIV/AIDS among conflict-affected and displaced populations: Dispelling myths and taking action.
In: Disasters 28 (3):322-339.

[1] For more information on HIV risk and vulnerability factors in humanitarian aid situations see Oxfam 2007 Humanitarian Programmes and HIV and AIDS: A Practical Approach to Mainstreaming available on the CD Rom.

How to mainstream HIV into the emergency response

During the early phase of emergencies, the HIV and AIDS response is steered by the 2009 Inter-Agency Standing Committee (IASC) Guidelines for Addressing HIV in Humanitarian Settings[2]. These guidelines enable governments and cooperating agencies, including the UN and NGOs, to deliver the minimum required multi-sectoral response. The IASC guidelines set out specific interventions according to the various sectors.

The Cluster Approach[3] defines the reformed way in which UN agencies, international organisations and NGOs respond to humanitarian emergencies and clarifies the division of labour among the organisations involved. The clusters are agriculture, camp coordination, early recovery, education, shelter, telecommunications, health, logistics, nutrition, protection, water, sanitation and hygiene. Mainstreaming of HIV as a cross-cutting issue is particularly important in the protection, nutrition and health clusters.

Assessing HIV and AIDS needs during emergencies and in protracted humanitarian situations can be achieved through the integration of core HIV questions into cluster-specific assessments, situational analyses or rapid assessment procedures. The context and the type and phase of emergency will determine the appropriate type of assessment to be carried out. Much of the information required to design a mainstreamed humanitarian response should be available prior to the onset of the emergency. This includes HIV prevalence rates, and the number of men, women and children in need of HIV and AIDS prevention, care and treatment services.

[2] See: http://www.who.int/hac/techguidance/pht/hiv

[3] For more information on the Cluster Approach see: http://www.humanitarianreform.org/

Mainstreaming HIV in humanitarian assistance requires a multi-sectoral response and needs to be linked to existing national AIDS policies, programming and activities, especially of local actors such as community-based organisations and NGOs.

Example of HIV questions integrated into cluster assessment for nutrition

- How does HIV contribute to poverty, food insecurity and malnutrition within the community?
- Who collects food assistance? Who manages food within the household and how is it distributed among family members?
- Do people living with HIV have special food or nutritional needs that should be considered when developing food rations?
- Where do people living with HIV live and who is supporting them?
- How do poverty and food insecurity affect the spread of HIV within the community?

Different tools have been developed to support humanitarian actors to assess HIV programming needs during a crisis. Please check the CD Rom for further resources. In summary, an assessment should address the following questions.

Elements for a situational analysis regarding HIV and SRH needs:
- What type of emergency are you confronted with?
- What are the main vulnerability and resilience factors of relevance to HIV and SRH?
- What are the main HIV and SRH related risk behaviours?
- What is the composition and demographic structure of the population(s)?
- What is the epidemiological situation in terms of prevalence and transmission?
- What is the impact of HIV and AIDS on the population/sub groups?
- What services are already available? Are they accessible?
- Who are the actors? What response have they already engaged in?

Further details for each of theses analytic areas are given in the chart «Selected HIV/ SRH Elements for the Situational Analysis» on the CD Rom.

REPSSI: Mitigating the psychological impact of HIV, poverty and conflicts among Children

REPSSI (The Regional Psychological Support Initiative) provides technical support, and works in partnership with local NGOs and Community Based Organisations (CBOs), whose main focus is to offer care and support to children affected by HIV and AIDS, poverty and conflict. REPSSI has brought the issue of psychological needs to the forefront of the agenda for vulnerable children and has significantly influenced regional and national responses to include psychosocial support in planning actions for children.

The tools developed by REPSSI are widely used within the regions of East and Southern Africa, and beyond. One example is **Memory Work**, which was originally developed by a group of HIV positive mothers in Uganda. They used memory books and boxes to help them disclose their positive status to their children as well as prepare them for a life to come without their mothers. The **Hero Book** is a document and process by which, groups and individuals are led through drawing and autobiographical storytelling exercises. The book is designated to help children, youths and adults to come to terms with specific challenging or traumatic events in their lives. Another example is **Body Mapping**, which starts with outlining the shape of the human body that later on develops into a life-size picture of a person. The body mapping process includes drawing and painting, but also talking in groups, singing and quiet times for reflection. Body Mapping can be used in many ways, for example, as a therapeutic tool, an advocacy tool, a biographic tool or an intergenerational dialogue tool.

To read more about REPSSI see the factsheet on REPSSI and other SDC supported HIV responses in emergency settings available on the CD Rom or visit www.repssi.org.

LONG LIFE BODYMAPS – BAMBANANI SUPPORT GROUP

Nomawethu   Npndumiso Hlwele   Babalwa Cesiko

source: REPSSI and Banbanani Women's Group
http://www.memorybox.co.za/

The Haiti earthquake: Implications for HIV services and those in need

On 12 January 2010, a devastating earthquake struck Haiti – the country with the most severe AIDS epidemic among the Caribbean states, and home to half of all people living with HIV in the region. The country's epidemic has been aggravated by extreme poverty, low levels of education, poor quality and availability of health and social services, and chronic political instability.

The earthquake left hundreds of thousands of people struggling to access housing, water and food. The vulnerability of people living with HIV increased dramatically, because on top of daily struggles to meet their basic needs, their support systems have broken down. HIV and health centres have been damaged or destroyed, and transport to functioning health facilities has been badly affected, interrupting access to essential medicines and antiretroviral treatment. With the massive casualties and mortality, the support networks of people living with HIV – social networks of family and friends – have collapsed and, coping has become much more difficult, especially for the sick.

In disasters, people living with HIV do not receive immediate high priority as governments and emergency services struggle to assess damage and its implications, attempt to restore security and provide basic shelter, food, water, sanitation and medical care for survivors. An initial situational analysis indicated immediate short term needs include limiting treatment interruption, providing nutritional support for people on treatment, and ensuring that PMTCT services are resumed. Support is needed to re-establish the AIDS infrastructure as well as strengthening civil society, ensuring special attention to HIV prevention, treatment and care, and support services to populations at higher risk. A coordinating authority must be put in place to ensure no gaps or overlaps in the national response. However, this support has to compete with funds allotted to high profile emergency responses such as medical, nutrition, water and sanitation.

Sources: Irin PlusNews/Haiti, 29 Jan 2010 and UNAIDS 2010: Helping Haiti rebuild its AIDS response
http://unaids.org/en/media/unaids/contentassets/dataimport/pub/factsheet/2010/20100226_haiti_aidsresponse_en-1.pdf

Monitoring the activities related to mainstreaming of HIV and their effects is crucial to enable institutional learning and use scarce resources in an efficient and accountable way. Analysing and documenting lessons learned is also important to motivate others who are at a less advanced stage. Networking and knowledge sharing around mainstreaming HIV helps to create an environment of continuous learning and contributes to strengthening commitments and improving approaches.

Monitoring

As part of quality management, monitoring[1] should be performed on a regular basis covering all major components of a project/programme to answer «are we doing the right thing and are we doing it right?».

SDC proposes an integrated approach to planning, monitoring and evaluating mainstreaming HIV efforts. This means using existing mechanisms and make sure that the monitoring of mainstreaming is integrated rather than developing a separate M&E system for mainstreaming HIV.

M&E of mainstreaming HIV follows similar rules as any other monitoring system. Often, however, people have faced difficulties when it comes to finding appropriate indicators that can be used in monitoring mainstreaming at the level of the sphere of influence. This chapter will therefore recall the major levels of analysis currently used by SDC in monitoring and then focus on the essential questions, fields of observation and criteria[2] in order to develop appropriate

outcome and impact indicators. Once indicators have been selected based on respective criteria (for details see the CD Rom), it is important to consider whether they can be made more gender specific. Of course, each programme has to select criteria and indicators according to its objectives. How you assess change - expected and non expected –and what change you assess depends very much on the given context, sector and particularly your mainstreaming objectives. Usually it is sufficient to find one or two appropriate indicators for each level. Keep in mind that many indicators will need a baseline measure to be meaningful. Less, but realistic indicators are a prerequisite for a monitoring system actually being implemented. Avoid choosing indicators that will set you up for failure!

An interesting tool, which could help you finding very practical indicators is the self assessment checklist developed for the «NGO Code of Good Practice for NGOs responding to HIV/AIDS»[3] that you can find on the CD Rom.

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[1] See glossary for the SDC definition of monitoring

[2] «Criteria» are not measuring instruments but standards by which to judge the situation. In this logic «indicators» are a means of measuring the realisation of the standards. E.g. «Change in awareness about HIV/AIDS amongst staff» would be a «criteria». An indicator to measure this criterion could be «until the end of year xy, at least 80% of the staff state that HIV has something to do with them/or more classically: can cite at least three means of transmission of the HIV virus».

[3] http://www.hivcode.org/

Major levels of analysis[4]

Two major levels should be distinguished:
- the sphere of SDC's projects/programmes direct responsibility (inputs, activities, outputs) to which we will refer as progress monitoring
- the sphere of SDC's influence and impact, regarding also its influence through working with partners and beneficiaries, to which we refer as outcome monitoring, hypothesis of impact and analysis of impact

For an integrated monitoring approach, it is recommended to elaborate criteria and indicators during routine planning or reviewing of programme/project activities. This could be during the annual «planning» workshop or a biannual monitoring meeting. When mainstreaming HIV is first introduced into an already ongoing programme, an initial specific meeting to plan and develop the monitoring system may be useful.

Monitoring inputs, activities and outputs of mainstreaming activities should not be too difficult and should be treated according to the processes applied in project management. However, dealing with outcome and impact measures related to mainstreaming HIV may pose initial problems. The following chapter therefore concentrates on these issues.

In addition to progress/outcome and impact monitoring it is also recommended to do process monitoring. Process monitoring, which can be done at each organisational level, helps to understand what SDC and/or partners do well/not well with regard to mainstreaming HIV. Examples of criteria that could be used for developing indicators at that level are given on the CD Rom.

[4] See CD Rom for a summary «different spheres of responsibility and influence» from the SDC Gender mainstreaming toolkit.

Outcome monitoring

Outcome monitoring is used to assess immediate or mid-term effects of programmes and the mainstreaming process (in the workplace and on programme level). These effects are compared with the mainstreaming HIV objectives. Outcome should be within reach of the programme and therefore represents the principal level of interest. The outcome level focuses on effectiveness. Key questions are: To what extent and how have we achieved the objectives? Why have we achieved something? How have we collaborated with other stakeholders? Examples of criteria (focusing on the outcome of improved understanding and behaviour change) that could be used for developing indicators at that level are given on the CD Rom.

Development of impact hypothesis and impact analysis

Impact monitoring is used to assess long-term effects and changes (direct and indirect, intended and unintended, positive and negative) on beneficiaries, affected groups and institutions. Long-term development effects should be used as references to indicate whether programme strategies and objectives are relevant or not.
Hypothesis of impact and impact analysis should periodically answer the following key questions: Does it make sense? Are we doing the right things? The vision of impact guides our action.

The impact of an HIV specific intervention is usually assessed in terms of change in health status (e.g. HIV-prevalence, AIDS

related morbidity or mortality of a population). In the case of mainstreaming HIV, it would be a pitfall to measure impact in terms of change in health status. Changes in morbidity or mortality usually happen over years or decades and are influenced by many factors. It may be difficult or impossible to attribute any merit in observed changes to the mainstreaming activities. Also, mainstreaming HIV is only one aspect of a cooperation activity which has another core mission (e.g. promote education, agriculture, etc) to which most of the efforts and available resources are allocated. As long as improving health is not the prime objective of such a project/programme, significant and measurable change in health status cannot be expected as a result of mainstreaming HIV.

It is more feasible and appropriate to apply a multisectoral approach within impact analysis, considering not only health related impact. Changes in terms of the three dimensions determinants/vulnerability and impact mitigation should be monitored. Examples of criteria that could be used for developing indicators at that level are given on the CD Rom.

For those confronted with how to measure the criteria, a number of instruments do exist, such as for example KAP studies (Knowledge, Attitude and Practice) that include indicators which could be used or if necessary adapted. As far as possible, internationally and nationally existing indicators should be used. Experts in your country (working in UNAIDS, NGOs dealing with HIV and others) can help you find suitable indicators and tools.

Knowledge Sharing

Sharing lessons learned on failures and successes is crucial for advancing mainstreaming HIV. This is the case for any field of cooperation work but it is even more important for mainstreaming HIV, since this concept is still quite abstract for many. Prerequisites to knowledge sharing are regular reporting and capitalisation, monitoring and evaluation. SDC Nepal has conducted an external evaluation of 10 years experience with mainstreaming HIV. SDC Mozambique conducted an auto-evaluation and review of its mainstreaming activities in 2003. Recently, SDC Tanzania (see box) commissioned a joint evaluation on mainstreaming HIV and gender and a similar exercise is planned by SDC South Africa. Intercooperation Madagascar used a different approach and conducted for the second time an internal review of its work place activities related to mainstreaming of HIV. The report can be found on the CD Rom. Further, SDC headquarter is supporting a community of practice in the East and Southern Africa region, where members can exchange information, questions and news related to HIV and AIDS during periodic physical meetings and via electronic exchange. SDC headquarter also produces a periodical electronic «Focus on HIV/AIDS» newsletter which welcomes contributions on mainstreaming HIV.

Good practice example- SDC Tanzania evaluating mainstreaming gender and HIV

Following SDC institutional policies, the SDC Cooperation Office (Coof) Tanzania is committed since 2003 to consider Gender Equality and HIV/AIDS as crosscutting issues in its programmes. After a capacity building workshop in 2003, a capitalization of experiences in 2006 and a backstopping mandate in 2007, a team of two evaluators and a peer reviewer from Coof Pretoria conducted an external evaluation in early 2010. The evaluation was based on the methodology of «the Web of Institutionalisation». Elements for the evaluation were grouped into the four spheres of the «web», being:

- the organisational sphere (mainstreaming responsibility, staff development and procedures)
- the citizen sphere (women's and men's experiences and their interpretation of their reality, pressure of political constituencies, representative political structure)
- the delivery sphere methodology (delivery of programmes and projects, theory building and applied research)
- the policy sphere (political commitment, resources and policy, planning and legislation)
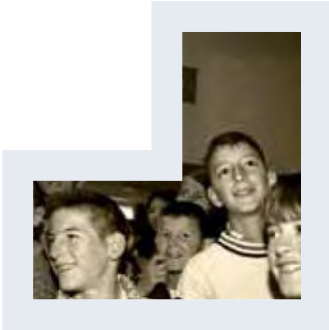
A major finding of the evaluation was that the commitment to mainstreaming of both gender and HIV remains high. Based on the guidance given by the «minimal standards» for mainstreaming, the SDC Coof and all partner organisations in charge of supported projects and programmes have designated focal points for HIV. SDC Tanzania also has a strong culture of capitalisation and institutional learning, as reflected by this being the third major event aimed at strengthening mainstreaming both at the Coof and projects. However, while the commitment is there, the evaluation highlighted that policies and guidelines often did not effectively materialise in effective and fully mainstreamed approaches at the operational level. Also, mainstreaming of HIV was often limited to sensitisation and awareness raising at the workplace level- mostly around protection and prevention- while a deeper understanding of the concept and the potentials of mainstreaming HIV has to be developed further. Project partners still need great support to take mainstreaming of both HIV and gender as an integral part of their project implementation. Mainstreaming should not be seen as an additional workload. It should also be a shared responsibility that should be backed up by a strong management support in order for it to be a success. At the projects and programmes level, they are well resourced as there is a budget line within their credit proposals for mainstreaming activities. At the Coof level, there is a credit proposal that has a component for mainstreaming of HIV and Gender mainstreaming is resourced through the small actions that is at the discretion of the Head of Cooperation.

These good practice examples should inspire similar initiatives taking place elsewhere. Any contributions on lessons learned and good practices on mainstreaming HIV are greatly welcome- they can be shared through «Focus on HIV/AIDS». Please send your contributions to SDC: health@deza.admin.ch (mention: toolkit mainstreaming HIV)
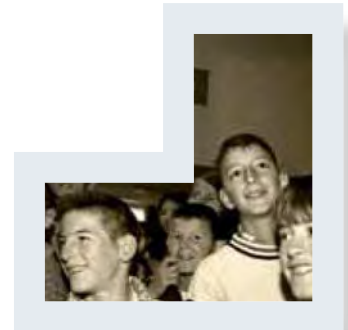
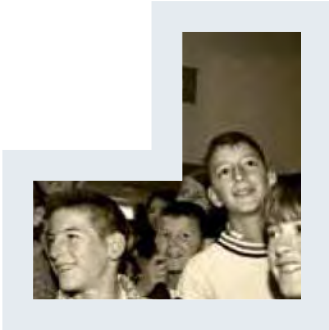|	
Beneficiaries	The individuals, groups, or organisations, whether targeted or not, that ultimately benefit, directly or indirectly, from a programme/project (≈ target group).
Cultural approach	Any population's cultural references and resources (ways of life, value systems, traditions and beliefs, and the fundamental rights of persons) will be considered as key references in building a framework for strategies and policies and project planning, but also as resources and basis for building relevant and sustainable actions (UNESCO).
Epidemiological scenarios of HIV and AIDS (UNAIDS 2007)	**Low Level Scenarios** are those with HIV prevalence levels of below 1% and where HIV has not spread to significant levels within any subpopulation group. **Concentrated Scenarios** are those where HIV prevalence is high in one or more sub-populations such as men who have sex with men, injecting drug users or sex workers and their clients, but the virus is not circulating in the general population. **Generalised scenarios** are those where HIV prevalence is between 1–15% in pregnant women attending antenatal clinics, indicating that HIV prevalence is present among the general population at sufficient levels to enable sexual networking to drive the epidemic. **Hyperendemic scenarios** refer to those areas where HIV prevalence exceeds 15% in the adult population driven through extensive heterosexual multiple concurrent partner relations with low and inconsistent condom use.

Gender	«Gender» refers to the socially constructed roles, behaviours, activities, and attributes that a given society considers appropriate for men and women. (WHO)
Humanitarian Aid	The goal of Swiss humanitarian aid is to save lives and linder suffering worldwide. Humanitarian aid can take on different forms: Payments in kind, particularly the distribution of food, cash contributions and the assignment of specialists and deployment teams primarily in cases of disaster, as well as every other form which serves the purpose. Where appropriate, the individual forms of humanitarian aid are interconnected. (SDC)
Impact	*AIDS impact:* long term changes that HIV and AIDS cause at an individual, community or a society level (on physical and mental health, socio economic and cultural level, etc) *Project management*: Positive and negative, primary and secondary long-term changes/effects produced by a programme/project, directly or indirectly, intended or unintended (influences on the context, societal or physical environment).
Incidence	HIV incidence is the number of new HIV infections in the population during a certain time period (usually a year). People who were infected before that time period are not included in the total, even if they are still alive.
Linkages	The bi-directional synergies in policy, programmes, services and advocacy between SRH and HIV. It refers to a broader human rights based approach, of which service integration is a subset. (WHO, UNAIDS, IPPF, UNFPA)
Mainstreaming	Mainstreaming stands for the process of integrating in a meaningful way transversal/crosscutting issues into programmes, projects and our ways of working. «Mainstreaming HIV is a process that enables development actors to address the causes and effects of HIV and AIDS in an effective and sustained manner, both through their usual work and within their workplace» (UNAIDS). It means «wearing AIDS glasses» while working in all sectors and at all levels.
Monitoring	SDC defines monitoring as continuing observation using systematic collection of relevant and selected data to provide management and the main stakeholders of a programme/project with indications of the extent of progress and achievements of objectives (process and impact).

Multisectoral	The AIDS epidemic is a general development problem which can only be fought effectively by a maximum of different sectors (e.g. health, education, armed forces, finance, agriculture, transport, the corporate sector, etc).
Outcome	Results of a programme/project relative to its objectives that are generated by its respective partner's outputs (≈ results, effects at purpose level).
Resilience	Resilience refers to the ability of an individual or a group to «thrive, mature, and increase competence in the face of adverse circumstances (Gordon 1995)». Using a resilience oriented approach therefore means looking at resources and coping mechanisms that people draw upon to avoid risk or cope with stress and adversities, and focus on how these abilities can be strengthened.
Risk	Risk is determined by individual behaviour and situations such a s having multiple sexual partners, having unprotected sex, sharing needles when injecting drugs or being under the influence of alcohol when having sex.
Partners	Organisations, institutions that collaborate to achieve mutually agreed upon objectives and share responsibility and accountability, benefits as well as risks and endeavours.
Prevalence	The HIV/AIDS prevalence rate in selected populations refers to the percentage of people tested in each group who were found to be infected with HIV.
Sexual and Reproductive Health and Rights	Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Sexual and reproductive health therefore implies that people are able to have satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable methods of family planning methods of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. (ICPD 1994).

Specific HIV interventions	Specific HIV and AIDS interventions are those whose primary objective (core business) is to respond to HIV and AIDS.
Transversal theme	A transversal theme (or **cross-cutting issue**) is one central to development and humanitarian cooperation that cannot be addressed by one sector alone and that should be addressed appropriately in all projects, programmes and in the ways we work. Examples of cross-cutting issues are, for example, gender, natural resource management or HIV.
Vulnerability	Vulnerability stands for an individual's or a community's inability to control their risk of infection due to factors that are beyond the individual's control. Such factors could be poverty, illiteracy, gender, living in rural areas, being a refugee, etc.

I   The Scope of the AIDS Epidemic Today

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III   Mainstreaming – Some Basics

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IV How to do Mainstreaming HIV – An Overview

- AMICAALL (Alliance of Mayors' Initiative for Community Action on AIDS at the Local Level). 2007. Toolkit: Local Governance and AIDS (English and French version).

- GTZ. 2009. Fact Sheets: Mainstreaming HIV in various Sectors.

- UNDP. 2007. AIDS Mainstreaming: Curriculum and Training Manual.

- UNDP. 2007. AIDS Mainstreaming: Participant Pack.

Essential Links:

- UNAIDS E-Library on Mainstreaming: http://www.unaids.org/mainstreaming/elibrary

- German HIV Practice Collection Website (promising practices and toolboxes): http://www.german-practice-collection.org/en/successful-programmes/hiv

V Mainstreaming HIV: Step-by-Step

Step 1: Context and Organisational Analysis

- UNAIDS. 2007. Practical Guidelines for Intensifying HIV Prevention - Towards Universal Access

Checklists:

- SDC. 2004. Context analysis for mainstreaming HIV/AIDS.

- SDC. 2004. Organisational analysis for mainstreaming HIV/AIDS.

- SIDA. 2002. How to «Invest in future generations» – Guidelines for Integrating HIV/AIDS in the Development Cooperation.

Practical examples:

- Organisational analysis: the example of Intercooperation Madacascar, 2004.

- Elements of a context analysis: the example of Intercooperation Madacascar, 2004.

Sector resources:

- Biesma RG et al. 2009. The effects of global health initiatives on country health systems: a review of the evidence from HIV/AIDS control.

- Tool 3 HIV/AIDS impact assessment decision matrix for local governments- from: http://www.amicaall.org/publications/toolkit/toolkit.htm

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Step 2: Do no harm

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Step 3 internally: Workplace Policy and Programme

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Step 3- externally

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- SDC/MiETA. 2009. The Media in Education Trust Africa.

- SDC. 2009. Parlamentarians for Global Action.

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- SDC/Solidarmed. 2009. SDC support for Solidarmed's Antiretroviral Treatment Project (SMART)

- SDC. 2009. Technical Assistance for the World Food Programme's HIV and AIDS Response

- SDC/Swiss TPH 2010. PSP Rwanda: from mainstreaming HIV to creating partnerships for income generating activities for persons living with HIV. 2010.

SDC experiences:

- SCD Mozambique. 2003.Mainstreaming HIV/AIDS in SDC – practice example and presentation.

- SDC Nepal. 2002. Looking back on 10 years of mainstreaming HIV/AIDS – external evaluation, report and presentation.

- SDC Tajikistan. 2003. Mainstreaming HIV/AIDS – Reproductive health at family medicine level in Dangara and Varzob.

- SDC Tanzania. 2006. Agreed minimal standards – SDC gender and HIV/AIDS workshop.

- Mainstreaming HIV/AIDS with SDC support: the example of Intercooperation Madagascar.

Other agencies:

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- UNAIDS. 2001. AIDS, Poverty Reduction and Debt Relief.

- UNAIDS, World Bank, UNDP. 2005. Mainstreaming HIV and AIDS in Sectors and Programmes. (English and French Version)

VI   Gender, HIV and AIDS

- IPPF and WHR. 2002. HIV/Gender Continuum. How Gender-Sensitive Are Your HIV and Family Planning Services?

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- UNAIDS 2006. Resource Pack on Gender and HIV/AIDS. A Rights-Based Approach. Includes the following documents:

  1. Operational Guide on Gender and HIV/AIDS.

  2. 14 Fact Sheets on Gender and HIV/AIDS: Global and international commitments, human rights, education, young people, male participation, violence against women, conflict situations, mother to child transmission, sex work, microbicides, female condoms, the world of work, care economy, food security, rural development and monitoring and evaluation

- WHO. 2009. Integrating Gender into HIV/AIDS Programmes in the Health Sector. Tool to improve responsiveness to women's needs.

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- SDC. Undated. Checklist for gender equality mainstreaming and reporting.

Essential Links:

■ On the Gender and Development website of the World Bank are tools for gender, HIV and AIDS, and a list of best practices and publications on gender, HIV and AIDS. http://web.worldbank.org/WBSITE/EXTERNAL/ TOPICS/EXTGENDER/0,,contentMDK:21399423~menuPK:489230~pagePK:210058~piPK:210062~theSite PK:336868,00.html

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■ BMZ, GTZ, KfW, Inwent and DSW. 2008. Policy Brief: Promoting Linkages and Synergies for Sexual and Reproductive Health and Rights and HIV/AIDS. Key Issues and Opportunities.

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■ WHO, UNFPA, UNAIDS and IPPF. 2008. Linking Sexual and Reproductive Health and HIV/AIDS. Gateways to Integration: A Case Study from Haiti.

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■ WHO, UNFPA, UNAIDS and IPPF. 2008. Linking Sexual and Reproductive Health and HIV/AIDS. Gateways to Integration: A Case Study from Serbia.

Essential Links:

■ WHO Sexual and Reproductive Health: http://www.who.int/reproductivehealth/topics/linkages/en/index.html

■ IPPF International Planned Parenthood Federation: http://www.ippf.org/en/What-we-do/AIDS+and+HIV/Linkin g+sexual+and+reproductive+health+and+HIV.htm

VIII HIV in Emergencies

■ Chart: SDC Selected HIV/SRH Elements for the Situational Analysis, 2010.

■ SDC Toolkit Gender and Humanitarian Aid. Thematic Checklist HIV/AIDS (sheet 7) and General Gender Checklist (annex 1) (English and French Version)

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■ CAFOD. 2008. Development and Disasters in a time of HIV and AIDS. An HIV Mainstreaming Toolkit for Development and Humanitarian Response Workers.

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- UNAIDS, WPF and UNHCR. 2007. The development of programme strategies for integration of HIV, food and nutrition activities in refugee settings. UNAIDS Best Practice Collection.

- UNHCR and UNAIDS. 2007. HIV-related Needs in Internally Displaced Persons and Other Conflict-affected Populations: A Rapid Situation Assessment Tool.

Essential Links:

- IRIN PlusNews: Web-based news and analysis on HIV issues in humanitarian settings www.plusnews.org

- Inter-Agency Working Group on Reproductive Health in Crises: http://www.iawg.net/

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- International HIV/AIDS Alliance. Undated. NGO Code of Good Practice. Self-Assessment Checklist: Monitoring and Evaluation

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