

World Vision

ADP Toolkit for HIV/AIDS Programming



HIV/AIDS Hope Initiative

July 2004, second edition

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The *ADP Toolkit for HIV/AIDS Programming* is intended to be a useful, accessible resource that equips ADP staff to start, expand, and enhance HIV/AIDS responses. The toolkit will continually evolve as additional experience is gained and new lessons are learned. Input is welcomed and appreciated. Please send comments and suggestions to the Models of Learning director, Mark Lorey, at models_of_learning@wvi.org.

Acronyms and Abbreviations

ADP	AREA DEVELOPMENT PROGRAM
AFRHS	ADOLESCENT FRIENDLY REPRODUCTIVE HEALTH SERVICES
AIDS	ACQUIRED IMMUNE DEFICIENCY SYNDROME
ANC	ANTENATAL CARE
ARV	ANTI-RETROVIRAL
BCC	BEHAVIOR CHANGE COMMUNICATION
CBO	COMMUNITY BASED ORGANISATION
CRC	CONVENTION ON THE RIGHTS OF THE CHILD
CSW	COMMERCIAL SEX WORKER
FBO	FAITH-BASED ORGANISATION
FGM	FEMALE GENITAL MUTILATION
FP	FAMILY PLANNING
GIK	GIFTS IN KIND
HBC	HOME BASED CARE
HBCT	HOME BASED CARE TEAM
HIV	HUMAN IMMUNODEFICIENCY VIRUS
IEC	INFORMATION, EDUCATION, AND COMMUNICATION
IGA	INCOME GENERATING ACTIVITY
IMCI	INTEGRATED MANAGEMENT OF CHILDHOOD ILLNESS
KAP	KNOWLEDGE, ATTITUDES, PRACTICES
MCH	MATERNAL AND CHILD HEALTH
MIS	MANAGEMENT INFORMATION SYSTEM
MoL	MODELS OF LEARNING
MTCT	MOTHER-TO-CHILD TRANSMISSION
NGO	NONGOVERNMENTAL ORGANISATION
NO	NATIONAL OFFICE
OI	OPPORTUNISTIC INFECTION
OVC	ORPHANS AND VULNERABLE CHILDREN
PLA	PARTICIPATORY LEARNING AND ACTION
PLWHA	PEOPLE LIVING WITH HIV/AIDS
PM&E	PARTICIPATORY MONITORING AND EVALUATION
PMTCT	PREVENTION OF MOTHER-TO-CHILD TRANSMISSION
PLA	PARTICIPATORY LEARNING AND ACTION
PRA	PARTICIPATORY RURAL APPRAISAL
PTA	PARENT TEACHER ASSOCIATION
SO	SUPPORT OFFICE
SRH	SEXUAL AND REPRODUCTIVE HEALTH
STI	SEXUALLY TRANSMITTED INFECTION
SWAA	SOCIETY OF WOMEN AGAINST HIV/AIDS IN AFRICA
TASO	THE AIDS SUPPORT ORGANISATION
TB	TUBERCULOSIS
TD	TRANSFORMATIONAL DEVELOPMENT
UNAIDS	UNITED NATIONS JOINT PROGRAMME ON HIV/AIDS
UNGASS	UNITED NATIONS GENERAL ASSEMBLY SPECIAL SESSION
UNICEF	UNITED NATIONS CHILDREN'S FUND
VCT	VOLUNTARY COUNSELLING AND TESTING
WHO	WORLD HEALTH ORGANISATION
WV	WORLD VISION

I. INTRODUCTION

A. PURPOSE, CONTENTS, AND INTENDED USERS OF THE TOOLKIT

Welcome to the *ADP Toolkit for HIV/AIDS Programming*. This toolkit is designed to equip World Vision Area Development Programs (ADPs, the clusters of communities within which World Vision implements most of its transformational development work) to start, expand, and enhance HIV/AIDS responses. The toolkit is also intended to provide ADP staff with concrete assistance to achieve the FY05 goals for HIV/AIDS programming established by World Vision International. (See section C.5. below.)

The toolkit includes both practical programming guidance and a range of hands-on tools that ADP staff can apply in their contexts. The toolkit is based on the sound practices of HIV/AIDS programming developed by World Vision, as well as lessons learned by partners.

The primary intended users of the toolkit are ADP staff: ADP managers and coordinators, development facilitators, and other members of the ADP team. This toolkit is also intended to be of use to World Vision program staff and leadership in the national, regional, and global offices that support World Vision's local-level work. The toolkit is meant to be a resource for World Vision's technical staff in support offices and regional offices. Finally, the toolkit is intended to be a helpful resource for other organisations interested in integrating and expanding HIV/AIDS responses within community development programming.

This version of the toolkit is designed primarily for ADPs in the high prevalence countries where World Vision works: those with HIV prevalence of 5% or higher in the adult population. However, much of the toolkit's content is also applicable in lower prevalence countries. In late 2004, four region-specific editions of the toolkit will be distributed – for South Asia, Southeast Asia, Latin America and the Caribbean, and the Middle East and Eastern Europe.

B. BACKGROUND OF THE TOOLKIT

The idea for the *ADP Toolkit for HIV/AIDS Programming* was first raised at the January 2002 conference of World Vision leaders from countries with high HIV prevalence. The Models of Learning program of the HIV/AIDS Hope Initiative was asked to lead the process of compiling the toolkit. (See Annexes A and B for full descriptions of the HIV/AIDS Hope Initiative and the Models of Learning program.) The Models of Learning team, based in Uganda and Zambia, is comprised of specialists in the key dimensions of HIV/AIDS programming prioritised by World Vision. The program's mandate is to serve as a learning laboratory for research and development of large-scale HIV/AIDS responses, fully contextualised for World Vision's modes and areas of operation.

In early May 2002, the Models of Learning team worked with the Africa regional HIV/AIDS advisor to organise and facilitate a workshop for World Vision HIV/AIDS coordinators from across Africa. From this workshop emerged the programming strategies and examples that became the basic building blocks for the toolkit.

During the following months, the Models of Learning team worked to identify sound practices of HIV/AIDS programming implemented by World Vision and by partners: churches and other faith-based organisations; local, national, and international NGOs; government agencies; and many others. Throughout this period, the structure and format of the toolkit was refined in discussions with ADP staff and many of World Vision's senior technical experts and leaders.

The initial draft of the toolkit was distributed in October 2002 to World Vision national directors, HIV/AIDS coordinators, and selected ADP staff across Africa. The HIV/AIDS coordinators and ADP staff met in Johannesburg in late October to review the toolkit and to plan how it will be used to support ADP HIV/AIDS programming in each of their country contexts.

The initial draft was revised extensively by the Models of Learning team, based on the feedback provided in Johannesburg. A second edition was distributed widely across the World Vision international partnership. The second edition was refined based on the comments received from colleagues in many countries to form a final 2003 edition available in printed and CD versions, on the Hope Initiative website, and on other relevant World Vision websites and databases. This 2004 edition has been revised based on learnings gained since the 2003 edition was distributed and put into practice.

The *ADP Toolkit for HIV/AIDS Programming* will continually evolve as new experience is gained and new lessons are learned by the Models of Learning team, colleagues across World Vision, and partners. Comments, suggestions, and questions are warmly welcomed. Please send feedback to models_of_learning@wvi.org.

C. WORLD VISION AND HIV/AIDS

I. Why HIV/AIDS is a top priority for World Vision

At the end of 2002 it was estimated that 42 million people were living with HIV, two thirds of them in Africa. More than 25 million people have died of AIDS since the epidemic started, more than a quarter of them children. Over 3.2 million children under 15 have the virus today. More than 14 million children have lost their mother or both parents to AIDS, and that number is rising rapidly — especially in Africa.

Why is HIV/AIDS a top priority for World Vision? Because HIV/AIDS is the greatest single challenge facing the development community today as it devastates entire communities and rolls back decades of development progress. HIV/AIDS is aggravated by poverty and has a disproportionate impact on the poor.

More specifically, HIV/AIDS is a priority for World Vision because:

- World Vision cares about children and is particularly concerned about the more than 25 million children who will lose one or both parents to HIV/AIDS by 2010.
- World Vision has over 900,000 sponsored children in the 30 worst hit countries and nearly 2 million sponsored children at risk worldwide.
- World Vision is investing almost \$200 million a year in the 30 worst hit countries.
- World Vision's worldwide staff are at risk, and many are personally affected by HIV/AIDS in their own extended families.
- As a Christian organisation, we have a unique opportunity to share God's hope with those who are affected by HIV/AIDS.

World Vision recently celebrated 50 years of work to promote the well being of children and communities. Tragically, the hard-won progress from those 50 years of relief and development work is now jeopardised by HIV/AIDS. Reduced child mortality, improved health, rebuilt communities, reinforced food security and increased educational opportunities — all of this progress could be reversed. The Christian and humanitarian imperative, which undergirds everything World Vision does, compels us to respond in the face of such pain and suffering.

2. The HIV/AIDS Hope Initiative

World Vision has been implementing HIV/AIDS programs for more than a decade. However, in light of the enormity and severity of the pandemic in Africa and the increasing potential for catastrophic prevalence rates in Asia, Latin America, and Eastern Europe, World Vision has decided it is essential to dedicate special time, attention, and resources to HIV/AIDS response.

Accordingly, in early 2001 World Vision launched the HIV/AIDS Hope Initiative: a high-level effort to increase and intensify responses to HIV/AIDS in all of the countries where World Vision operates. The primary goal of the Hope Initiative is to reduce the global impact of HIV/AIDS through the enhancement and expansion of World Vision programs and collaborations focused on HIV/AIDS prevention, care, and advocacy.

World Vision’s HIV/AIDS Hope Initiative is our commitment to do our part to address this unprecedented crisis, in respectful partnerships with governments, churches and other faith-based organisations, other agencies, communities, families, and children.

A summary of the HIV/AIDS Hope Initiative goals, values, and design principles is displayed below. These were developed through a broadly consultative process across the partnership and now serve as World Vision’s overall framework for HIV/AIDS response.

World Vision			
HIV/AIDS Hope Initiative - Goals			
The overall goal of the HIV/AIDS Hope Initiative is to reduce the global impact of HIV/AIDS through the enhancement and expansion of World Vision programs and partnerships focused on HIV/AIDS prevention, care, and advocacy			
	Prevention	Care	Advocacy
Track goals	Make a significant contribution to the reduction of national HIV/AIDS prevalence rates	Achieve measurable improvements in the quality of life of children affected by HIV/AIDS	Encourage the adoption of policies and programs that contribute to minimizing the spread of HIV/AIDS and maximizing care for those living with or affected by HIV/AIDS
Target groups	<ul style="list-style-type: none"> • Children aged 5-15 years • Pregnant and lactating mothers • High risk groups 	Orphans and other children made vulnerable by HIV/AIDS, and their caregivers	Policy makers (local, national, international)
Values	Bring a Christian response to HIV/AIDS, reflecting God’s unconditional, compassionate love for all people and the affirmation of each individual’s dignity and worth		
Partners	Work with a wide range of partners in HIV/AIDS response at local, national, and international levels, with a special focus on churches and other faith-based organizations as primary and indispensable partners		

3. HIV/AIDS and Transformational Development

World Vision's action to address HIV/AIDS is an integral part of our commitment to transformational development (TD), defined as 'a process through which children, families, and communities move toward wholeness of life with dignity, justice, and hope'. (1) In areas with high HIV prevalence, World Vision cannot contribute meaningfully towards communities' transformational development without actively addressing HIV/AIDS. In areas of lower HIV prevalence, present progress and future potential for transformational development are severely jeopardised by the threat of HIV/AIDS. To protect communities' gains to date in transformational development and to prevent future losses, it is essential that World Vision programs worldwide work with partners to increase and intensify action on HIV/AIDS.

All of World Vision's HIV/AIDS programming should be guided by the transformational development frame adopted by WV globally. Specifically, World Vision's HIV/AIDS programming should contribute toward transformational development in the following domains of change defined in the TD frame:

1. Well-being of children and their families and communities
2. Empowered children to be agents of transformation
3. Transformed relationships (with God, one another, the environment, and all partners)
4. Interdependent and empowered communities
5. Transformed systems and structures

In its HIV/AIDS response as in all its programming, World Vision's role is to 'work alongside the poor and oppressed as they pursue their transformational development, in partnership with sponsors, donors, governments, churches, and other NGOs'.

4. World Vision Support Offices' authorisation to expand allocation of sponsorship funds to HIV/AIDS programming

Recognising the magnitude and severity of the HIV/AIDS crisis and the urgent need to expand programmatic responses within ADPs, World Vision support offices have actively encouraged and authorised ADPs to increase the proportion of sponsorship funds allocated for HIV/AIDS programming. Below is the statement of commitment on which World Vision support offices have jointly agreed, followed by an explanation of the types of HIV/AIDS programming they encourage.

World Vision Support Offices' Authorisation to Allocate Sponsorship Funds to HIV/AIDS Programming

All ADPs are encouraged to review their programs and sponsorship budgets, together with community project committees, and henceforth, to allocate budgets in order to integrate appropriate child-focused HIV/AIDS prevention, care and advocacy interventions into the ADP projects. Decisions to allocate budgets should be based on the specific context of the ADP and an assessment of what is most appropriate in addressing HIV/AIDS along with other development priorities.

Suggested guidelines:

- *For countries with HIV prevalence of 5% or higher – it is suggested that approximately 15% or more of the ADP budget be considered for allocation to HIV/AIDS prevention, care, and advocacy programs, with an emphasis on programs which target orphans and vulnerable children. Amounts in excess of 15% should be made in consultation with the appropriate support office.*
- *For countries with HIV prevalence rates between 1% and 5% - it is suggested that approximately 10% or more of the ADP budget be considered for allocation to specific HIV/AIDS programs. Amounts in excess of 10% should be programmed in consultation with the appropriate Support Office.*
- *For countries with prevalence rates under 1%, it is suggested that up to 10% of the ADP budget be considered for allocation for the integration of basic prevention awareness activities into the ADP health program.*

To support the ADPs in their efforts to address HIV/AIDS prevention, care and advocacy, a toolkit outlining appropriate responses will be made available to all ADPs through the Hope Initiative during the first quarter of FY03.

The above statement has been agreed by all of the following support offices:

WV Australia	WV Malaysia
WV Austria	WV Netherlands
WV Canada	WV New Zealand
WV Finland	WV Singapore
WV Germany	WV Switzerland
WV Hong Kong	WV UK
WV Ireland	WV US
WV Japan	
WV Korea	

Some explanatory comments

ADP HIV/AIDS programming funded with sponsorship funds should be within the ADP project area and should meet the following criteria:

- Reallocation of funding should enhance and not jeopardise the basic transformational development goals of sponsorship programming, e.g. primary health care, access to water and education, food security and Christian witness. By using creative, multisectoral approaches, ADPs can integrate HIV/AIDS focus into other sectoral activities.
- ADP prevention, care and advocacy projects should focus on orphans and vulnerable children highly impacted by HIV/AIDS. WV identifies orphans as children under 18 years of age who have lost one or both parents from any cause. Vulnerable children include children under 18 years of age who have one or more parents who are HIV positive or otherwise chronically ill or absent, who are living in families which are fostering orphans, or who are HIV-positive themselves. OVC projects may incorporate aspects of home-based care for infected adults in order to lengthen and improve the quality of life of care-givers and parents and prepare all members of the family spiritually, emotionally and materially for death and orphaning. (See the section on care for OVC in the *ADP Toolkit for HIV/AIDS Programming*).
- For those countries with mature epidemics that will be focusing on care of orphans, it is suggested that the model outlined in the above document be utilised. The minimum or basic intervention package should include the community home visitors or “guardian angels”. Other interventions described are contextual to each ADP and dependent on available funds.
- Projects should be designed to mobilise community initiative, with emphasis on involving the local church and other partners, to identify and provide holistic prevention and care for orphans and vulnerable children.
- Projects should include community advocacy efforts to overcome stigma and discrimination associated with HIV/AIDS and be carefully designed to avoid stigmatising OVC and their parents through targeting.
- Prevention activities should focus on measurable behavior change intervention - with emphasis on abstinence and fidelity as the critical preventive behaviors - especially among the “window of hope” population group – children from 5-15 years of age. This emphasis is not meant to prohibit inclusion of proven prevention methods and services, including condom use, reproductive health services and voluntary counseling and testing, where appropriate.
- Project designs should be based on careful context-specific research into the behavioral, cultural and economic drivers of HIV transmission and the specific awareness and response of the community members.
- Where a sizeable high-risk population (e.g. truck drivers, migrant workers, commercial sex workers, etc.) is living within the limits of an ADP, prevention strategies should be developed, as appropriate, following established best practices including harm reduction focus and use of peer educators.

5. World Vision's FY05 goals for HIV/AIDS response

To accelerate World Vision's expansion of HIV/AIDS response, each of World Vision's four regions was asked to develop HIV/AIDS goals for fiscal year 2005. At the time this toolkit was released, WV's Africa region had established the ten ambitious goals below. Goals 1, 2, 4, 6, 8, and 10 are specifically applicable to ADPs. Other regions will finalize and distribute their goals in advance of the start of FY05.

These goals set the priorities for ADPs to pursue in addressing HIV/AIDS. This toolkit has been designed to help ADPs achieve these goals.

World Vision's FY05 Goals for HIV/AIDS Response in Africa

Prevention

1. All ADPs in high prevalence countries (HPCs) and 50% of ADPs in non-HPCs are promoting HIV prevention for all primary school-going children in the ADP through age-appropriate, values-based education and skills training, and through linkages to other relevant services.

Care

2. All ADPs in HPCs are facilitating community-led care for orphans and vulnerable children (OVC) for at least 75% of OVC identified in the ADP, using the approach described in the ADP Toolkit for HIV/AIDS Programming.

Advocacy

3. All National Offices are engaging regularly and effectively with their respective National AIDS Commissions, relevant government ministries, and HIV/AIDS-focused networks.
4. All ADPs in HPCs are engaging regularly and effectively with district level governmental agencies and HIV/AIDS-focused networks.

Church/Faith-Based Organisation (FBO) Partnerships

5. All national offices have forged partnerships with churches and FBOs on HIV/AIDS response at the national level.
6. All ADPs have forged partnerships with churches and FBOs on HIV/AIDS response in the ADP.

Non-ADP Projects

7. All new non-ADP projects in HPCs have HIV/AIDS interventions.

World Vision Staff

8. All World Vision staff in all National Offices have received HIV/AIDS training using the World Vision HIV/AIDS Prevention and Education Handbook for staff and the related training guide.
9. All National Offices have formulated and implemented a workplace HIV/AIDS policy based on the World Vision partnership policy framework.
10. Every ADP and/or cluster of ADPs has a full-time HIV/AIDS point person.

* High prevalence countries: Those with HIV prevalence of at least 5% in the adult population.

D. HOW TO USE THE TOOLKIT

The *ADP Toolkit for HIV/AIDS Programming* is intended to be a user-friendly, accessible resource that provides concrete help to ADP staff seeking to enhance and expand HIV/AIDS responses. The toolkit is organised into ten units:

- I. Introduction
- II. Toward a Biblical Perspective on HIV/AIDS
- III. Preparing for HIV/AIDS Programming in the ADP
- IV. Developing Partnerships for HIV/AIDS Response in the ADP
- V. Developing HIV/AIDS-Specific Programming in the ADP
- VI. Integrating HIV/AIDS Response into Existing ADP Programming
- VII. Addressing HIV/AIDS in the ADP Workplace
- VIII. Monitoring and Evaluating HIV/AIDS Programming in the ADP
- IX. Documenting and Communicating HIV/AIDS Programming in the ADP
- X. Annexes

It is recommended that ADP staff begin using the toolkit by reviewing units I, II, III, and IV. It is best if these can be reviewed by all ADP staff who will be responsible for HIV/AIDS programming — particularly the ADP manager and the development facilitator(s). Based on these units, the ADP staff can — in consultation with communities, supervisors, the national HIV/AIDS coordinator, and other relevant World Vision staff — begin planning how to move forward with starting new HIV/AIDS programming or strengthening existing efforts.

Then ADP staff can consult the remaining units as necessary, based on the priorities, opportunities, and constraints within the ADP. All units are intended to be mutually reinforcing.

If ADP staff have questions or would like additional help in developing HIV/AIDS programming, there are a number of potential sources that can be consulted:

- The National Office HIV/AIDS coordinator
- Other National Office staff with relevant experience (e.g. health coordinator, monitoring and evaluation coordinator, program development coordinator, etc.)
- The Models of Learning team (Email MoL director Mark Lorey with questions and requests)
- The regional HIV/AIDS advisory team (In Africa: regional HIV/AIDS advisor Hector Jalipa and regional HIV/AIDS program officer Boniface Maket)
- The regional technical services team (Africa Technical Services includes psychosocial advisor Lincoln Ndogoni and advocacy advisor Amboka Wameyo)
- The church/FBO partnerships group of the HIV/AIDS Hope Initiative (including church/FBO partnership advisors Gideon Byamugisha and Christo Greyling)

E. REFERENCE

- I. Quotations in section C.3 are drawn from Jayakumar Christian et al, *Transformational Development Core Documents*, July 2002.

II. TOWARD A BIBLICAL PERSPECTIVE ON HIV/AIDS

CONTENTS

1. Introduction
2. Seeing HIV/AIDS from God's perspective
3. Answering the difficult questions

I. INTRODUCTION

Seldom in the course of human history has the human family been confronted with a phenomenon that has had such far-reaching and devastating impact.

As of December 2001, more than 60 million people have been infected with the HIV/AIDS virus, for which there is no cure. Twenty-two million people have already died. Forty million people are living with a virus that will eventually kill them. More than 13 million children have already lost one or more parents to AIDS. Tragically, all of these numbers continue to grow.

No corner of the Earth has been spared from the onslaught of HIV/AIDS. While Africa has been affected most severely, incidence rates on every other continent continue to grow. Many of you have felt the personal pain of HIV/AIDS in your own families or among your friends.

Where is God in the midst of such tragedy? How can we begin to grasp an event like the HIV/AIDS epidemic in light of Scripture and our understanding of God and the world He created?

This introduction will provide a starting place for answering these and other questions related to HIV/AIDS.

2. SEEING HIV/AIDS FROM GOD'S PERSPECTIVE

The purpose of this World Vision handbook on HIV/AIDS is to prepare World Vision staff to confront this epidemic and those affected by it from a position of understanding and awareness and to encourage staff to assume personal responsibility for self-protection. To this end, it is important to lay the groundwork for a Biblical perspective on HIV/AIDS.

Before exploring answers to some of the most difficult and complex questions related to HIV/AIDS, let me suggest that we look at the HIV/AIDS epidemic through three lenses: 1) God's ideal world, 2) The real world we live in, and 3) God's desire to renew and redeem.

2.1 God's ideal world

The Bible is clear that God created the world and all its inhabitants for His own delight and glory. All men and women have been formed in the image of God and as such bear infinite value and dignity. God's ideal plan was to commune together in perfect harmony with all creation. This was God's ideal world.

In such a world there would be no pain and suffering. Sickness, death, anguish, and fear would have no part in this world. Instead, all would rest in the continual embrace of an infinitely loving God and find constant joy in Him.

2.2 The real world we live in

But the Bible also tells us that God gave man the prerogative to choose whether to love God or not. And our first parents, Adam and Eve, when tempted to disobey God, chose to seek their own will instead of God's. Thus began the real world which we experience today. Disobedience led to estrangement from God and to the proliferation of sin. Instead of seeking to glorify God in all things, people sought to glorify themselves and disobey or disregard the God who created them. None of us have escaped this temptation, and, as we're told in the Bible, we have all sinned and fallen short of the glory of God.

The consequence of our collective disobedience and sin is to create a world that is unlike God's ideal world. Sin has tarnished both our spiritual relationships with God as well as our own physical well being. A quick glance around us confirms a world where sickness and death abound, where half of the Earth's population live in poverty, where greed, corruption, disease, famine, abuse, and pain are common companions. This is the real world in which we live.

2.3 God's desire to renew and redeem

However the Bible is also clear that from that first moment of disobedience, God has provided a plan to renew and redeem His creation. Central to His plan was sending Jesus to bear the price of sin and disobedience so that all who place their trust in Him could be restored to their intended relationship with God. We are told that, as believers in Christ, we are redeemed, transformed by the renewing of our minds. We are new creatures. And, we are given the confident certainty that we will enjoy an eternity restored to our rightful relationship with our Creator. We can live with hope and joy — even though we continue to live in a real world that bears the consequences of sin and disobedience.

In God's ideal world, HIV/AIDS would not exist — nor would murder or lying or sickness or anger. HIV/AIDS needs to be seen as one consequence, among many, of a world that has estranged itself from God.

3. ANSWERING THE DIFFICULT QUESTIONS

These lenses give us a framework to begin answering the difficult questions that arise in the face of HIV/AIDS:

- Why does God allow such pain and suffering?
- Does God love the person who is HIV-positive?
- Is HIV/AIDS God's judgment for sinful behaviour?
- Does condom use fit within the Biblical perspective?
- What is "Christian hope" in the context of HIV/AIDS?
- How do we bring hope to those affected by HIV/AIDS?
- What does God expect us to do, as followers of Jesus, in the midst of this tragedy?

The list could go on and on. The questions are difficult but through God's Word and from His perspective we can begin to explore answers.

3.1 Why does God allow such pain and suffering?

Pain and suffering are not part of God's ideal world. Isaiah tells us that in the new Earth, '...the sound of weeping and of crying will be heard in it no more' (Isaiah 65:19). Revelation promises that 'He will wipe every tear from their eyes. There will be no more death or mourning or crying or pain, for the old order of things has passed away' (21:4).

But, in the present world, God has allowed pain and suffering to exist — not because He chooses it but because we, as His creation, have chosen it by our collective disobedience.

3.2 Does God love the person who is HIV-positive?

God's Word teaches that God's love for each and every human being is immeasurable. It was His love for each individual that persuaded Him to sacrifice His own Son on our behalf. The Scriptures are clear — God has an infinite love for each of us — and this includes those who are HIV-positive and those who are not.

3.3 Is HIV/AIDS God's judgment for sinful behaviour?

There is not a simple answer to this question. Clearly, HIV has been spread, in part, by sexual behaviour that violates God's Word. In God's ideal world, sex is to be enjoyed within the context of marriage. Those who are married are instructed to be faithful to their spouse. Those who are not married are instructed to practice abstinence until they become married. By doing so, the richness of marriage and family can be enjoyed.

But, many have chosen not to follow God's instructions and untold consequences have resulted. Many do not enjoy the full richness of marriage and family. Divorce occurs, children grow up without the benefit of a mother and father in the home, and sexually transmitted diseases run rampant — including HIV/AIDS.

But, it is equally true that many who are suffering from the consequences of HIV/AIDS (either directly or indirectly) have done nothing to violate God's commands for sexual purity. Faithful spouses have been infected by unfaithful partners. Children have borne the pain and fear of losing parents due to no fault of their own. Thus, one cannot conclude that those who are infected or affected have sinned, or that those who are not, have not.

God's Word cautions us against trying to identify specific consequences to specific sins. It is not our role to judge (James 4:12). Instead, our challenge is to encourage people to follow God's law regarding sexual behaviour and to enjoy the benefits of sexual purity and God-honoring lifestyles.

3.4 Many are promoting the use of condoms as one means of reducing the transmission of HIV. Won't that also promote sexual promiscuity?

When used consistently and correctly, it has been shown that condoms can significantly reduce the transmission of HIV. Obviously, the Bible doesn't have a chapter on condom use. However, we can glean some understanding by looking at a few Biblical principles.

As mentioned above, the Bible gives us clear instruction about the sanctity of marriage. Marriage is a God-designed relationship. God gives us clear instruction to be faithful within marriage and abstinent outside of marriage. The marriage relationship is central to God's teaching. We should do everything we can to promote choices and lifestyles that conform to God's ideal.

God's Word also gives us clear instruction about the sanctity of life. Life is sacred to God. We are not to take life away. We are to do all we can to protect and preserve life.

As World Vision staff, we should do all we can to honor both the sanctity of marriage and the sanctity of life. The promotion of condom use creates a tension between these two ideals. Condoms can protect lives by preventing the spread of HIV. However, it's also true that some might misuse the availability of condoms to engage in sexual behaviour that violates God's desire for sexual purity and the sanctity of marriage.

Which to choose? After careful reflection on this difficult question, World Vision has taken the position that we need to do all we can to honor both the sanctity of marriage and sanctity of life. Thus, we will clearly promote fidelity within marriage and abstinence outside of marriage as God's desired sexual behaviour. At the same time, we will promote the responsible and appropriate use of condoms in situations where abstinence is not chosen and human life must be protected, because condoms have been demonstrated to be a reliable preventative to the transmission of the deadly HIV virus.

3.5 What is "Christian hope" in the context of HIV/AIDS?

Hope is not an easy thing to define. How do you offer hope to a young mother who has already lost her husband to AIDS and is herself dying knowing that her young children will have no one to care for them? What does hope feel like for a child of 12 who lives alone with his younger siblings in a meager house next to the two piles of rocks covering the grave of their mother and father? How would you describe hope to a young man in the prime of life who realizes that he will likely never see his 25th birthday?

Hope is one of the pillars of our faith — 'And now these three remain: faith, hope and love' (1 Corinthians 13:13). God wants us to overflow with hope (Romans 15:13). And, it delights our God when we put our hope in His unfailing love (Psalm 147:11).

3.6 How do we bring hope to those affected by HIV/AIDS?

The ultimate hope that any of us can experience comes through a renewed relationship with God through our faith in Jesus Christ. The Bible is clear that, as believers, we can enjoy a new hope. This hope is both for the future and the present. The future, because we know we will share eternity with God. The present, because we have new meaning in life. As Paul prayed for the believers in Rome, 'May the God of hope fill you with all joy and peace as you trust in him, so that you may overflow with hope by the power of the Holy Spirit' (Romans 15:13).

The blessing of a new life in Christ also helps us put the real world in perspective. Paul wrote, 'our light and momentary troubles are achieving for us an eternal glory that far outweighs them all' (2 Corinthians 4:17).

Thus, the ultimate answer to the question of hope for those affected by HIV/AIDS is to renew their relationship with God by responding by faith in Jesus Christ. This is the central message of the Bible and we have the privilege of sharing it with all those with whom we work.

At the same time, not all will choose to respond to Jesus' invitation to 'come unto Him'. Nevertheless, they still have a need for hope in their lives. How can we respond?

Our experience has demonstrated that hope and encouragement can be ministered in a number of ways. Simply being there when someone is going through difficult times, showing her or him that you care, is a means of bringing hope. Providing for their needs when they are unable to do so by themselves can bring a sense of hope.

Many who are dying of AIDS are primarily concerned with what will happen to their children. Giving them the confidence that their children will be cared for can strengthen their hope significantly.

Often, helping people focus on the opportunities they have rather than what they don't have can bring hope. A young mother who is HIV-positive and has two young children recently said, 'it is not how long you live that's important, but how you use the time you have'.

God has called us to be instruments of hope. We can do this by helping people understand and embrace the good news of the Gospel. And, we can do this by reaching out in very practical ways to help people struggling with challenges in their lives.

3.7 What does God expect us to do, as followers of Jesus, in the midst of this tragedy?

God's instruction to His children is clear. He wants us to love our neighbor as ourselves. He is especially concerned that we give special attention to the poor, the orphans, the widows, and those who are disadvantaged. Jesus modeled this love and compassion as He interacted with people on a daily basis. We are told that we should show the same love and compassion because as much as do this for the least of these, we are doing it for Him (Matthew 25:40).

Our human nature, when faced with the reality of HIV/AIDS, is quick to be judgmental and condemning. But God has called us to be instruments of His love, bearers of burdens, and servants to those in need. It is God's role to judge, not ours.

Our response to those affected by HIV/AIDS should be compassionate, caring, and full of God's love.

God has called us to be salt and light. Salt preserves. Light illumines. In the face of HIV/AIDS, we have been given a unique opportunity to do all we can to preserve and enrich the lives of those affected by HIV/AIDS. We are also afforded an extraordinary opportunity to be God's light in a darkened world so that through our loving response, people might find hope and their eyes might be opened to the loving beauty of the God we serve.

May God give us the grace to faithfully steward this sacred opportunity.

*Ken Casey
Special Representative to the President for the HIV/AIDS Hope Initiative*

III. PREPARING FOR HIV/AIDS PROGRAMMING IN THE ADP

A. HIV/AIDS-FOCUSED SITUATION ANALYSIS

CONTENTS

1. What is a situation analysis?
2. Why is a situation analysis important?
3. Basic principles in conducting a situation analysis
4. Who participates in a situation analysis?
5. Options for a situation analysis
6. Collecting data for a situation analysis
 - 6.1 Written questionnaires and oral interviews
 - 6.2 Focus group discussions
 - 6.3 Participatory learning and action
7. Interpreting and reporting on the findings of a situation analysis

Appendix 1: Quantitative survey tool for HIV/AIDS programming situation analysis

Appendix 2: Questionnaire to assess knowledge of HIV/AIDS transmission

I. WHAT IS A SITUATION ANALYSIS?

Conducting a situation analysis is not a new activity in ADPs. The purpose of this section is to help ADPs improve their skills in conducting a situation analysis with a specific emphasis on HIV/AIDS programming.

When planning HIV/AIDS programming, ADP staff should not presume that they understand the HIV/AIDS situation in their area well enough to define the core needs without a situation analysis. A situation analysis puts the HIV epidemic in its social, economic, and cultural context in an ADP. It looks at who is infected or is vulnerable to infection and tries to explain why. It looks for explanations not just in people's behaviour, but in the social, economic, and cultural situations which underlie that behaviour. A situation analysis seeks to identify factors that favour or impede the spread of HIV and favour or impede achieving the best possible quality of life for those living with HIV and their families. Along with assessing HIV-related needs in the community, a situation analysis should find out what interventions are already underway.

A situation analysis sets the tone, direction, and subsequent steps in the development of a program. In conducting a situation analysis, the *process* of gathering and analysing information is key. It may even be more important than the specific results of the analysis. The reason is that through this process all the people involved in the situation analysis begin to articulate their perceptions and understanding of the situation and begin to learn from each other. In HIV/AIDS programming, the situation analysis can be a first step in countering stigmatisation, denial, and reluctance to discuss sexuality.

A situation analysis is (or should be) the first step in a dialogue. It is the best way for the program developers and the community stakeholders to begin to work together effectively and come to a joint understanding of how they wish to proceed. While the activities necessary to gather information and develop project goals might differ from setting to setting, the overall process of a situation analysis should be guided by several principles. In most contexts the situation analysis will follow a similar sequence, which is detailed in parts 4-7 of this section.

2. WHY IS A SITUATION ANALYSIS IMPORTANT?

Conducting a situation analysis helps the program manager and key stakeholders assess the real situation. They can use the findings to ensure that HIV/AIDS programming is based on the right assumptions. They can determine what the problems actually are and what is currently being done to address them. Then they will be prepared to decide what needs to occur for effective HIV/AIDS programming in the ADP. The situation analysis can also provide a useful first step in identifying and involving potential partners in HIV/AIDS programming.

Those participating in a situation analysis have often found that the process builds their own motivation, commitment, and sense of ownership of HIV/AIDS programs. Going out into the community and interacting with people means that the program implementers build rapport with community members, develop an understanding of the local situation, get to know the problems faced by different people, and therefore form a much deeper understanding of how to design effective programs.

HIV/AIDS is often a sensitive issue to discuss in communities. It involves talking about issues that are normally avoided. The situation analysis can be the first stage of building trust between the ADP staff and the rest of the community. It can give community members a sense of value because in their first interaction with the ADP staff they are asked to give their opinions and talk about their experiences. It can also be the first stage in supporting local community members in identifying their problems and finding their own solutions.

3. BASIC PRINCIPLES IN CONDUCTING A SITUATION ANALYSIS

Principle I: Keep an open mind

Although this is a general principle in programming, it is particularly important in the formulation of HIV/AIDS programs because of the complexity of the epidemic. Working with communities that are affected by HIV/AIDS means being sensitive to their feelings, beliefs, and cultural practices. This cannot happen if assessors prejudge important issues.

In defining the problem, those conducting a situation analysis should seek to understand the nature of the needs and concerns in the context within which the ADP will be working, rather than assuming that they are prepared to define problems based on their prior experience. Frequently program planners assume that a problem identified elsewhere (in another country, or in another district in the same country) is also the main problem in the current setting. This may not turn out to be true once you have delved beneath the surface of the situation.

In working toward an appropriate solution or strategy, program planners should be cautious about importing a model developed elsewhere, particularly if there is no research evidence to suggest its effectiveness in the local context. Everyone comes to a new situation with experiences from elsewhere. If program planners have been involved in a successful HIV/AIDS program in another setting, the temptation may well be to suggest that the current program use the same model or approach. While that model may be an important option, it is not the only one, and it may not be the best option.

Principle 2: Foster participation by establishing a participatory process from the beginning

Participation, in its truest sense, means active involvement with others in a process. This involves more than simply consulting with various groups; it includes sharing responsibility for decisions with these groups. Participation involves the contribution of each individual to a common endeavour — a contribution of time, labour, money, knowledge, or of several of these resources. Fostering participation is crucial to the process of respecting cultural differences and makes it possible to begin where people are. Participation also builds a base for sustainability in programs; it is critical to a sense of ownership and empowerment.

It is not easy to engage people in active participation, particularly when the topic is as sensitive and multi-faceted as HIV/AIDS. Participation can be very threatening to those who hold positions of power. Program planners and implementers may also encounter two other problems: a lack of people available to participate and the absence of a culture of participation. There are different factors that influence the extent to which people participate and the forms of this participation. In many communities, for example, there are various barriers which hinder women from participation. These include personal barriers such as lack of self-esteem and a lack of vision for women as agents of change. If a woman is able to get beyond these constraints, she often encounters social and cultural barriers.

Principle 3: Take a constructive rather than a compensatory approach

Taking a constructive approach means beginning by identifying positive practices within the community. A situation analysis should not be concerned only with trying to identify what is lacking so that deficits can be compensated. It should also be concerned with identifying what is being done well even in circumstances of poverty, so that local strengths can be built upon in the new project.

Assessors should look for similarities and differences between locally valued goals and practices and the ADP's goals and practices and then seek reasons for the differences. It is also useful to see if there are families or organisations in the community that are *positive deviants* in the sense that they have found a way to overcome a particular problem. The actions and activities of these so-called *positive deviants* are examples of locally viable solutions. These solutions can be incorporated into the project. By building upon constructive approaches in the communities, ADPs will find it easier to introduce changes in the way things are done while maintaining the support of the community.

4. WHO PARTICIPATES IN A SITUATION ANALYSIS?

When ADPs plan new HIV/AIDS programming, the initial situation analysis will generally be undertaken by ADP staff in consultation with community members and stakeholders. Another option is for the ADP to convene a Task Group of community members to plan and implement HIV/AIDS programming, and to train this group to undertake the initial situation analysis. (This approach is detailed in the Toolkit for HIV Prevention Among Mobile Populations in the Greater Mekong Sub-region.)

Those undertaking the situation analysis should identify key informants on HIV/AIDS transmission and risk and on the impact on the community.

People with direct or expert knowledge of HIV transmission and risk might include:

- Sex workers and their clients
- Counselors at VCT facilities
- Doctors or nurses who frequently treat HIV/AIDS patients
- Traditional healers
- Community-based health workers
- Members of women's groups

People with direct or expert knowledge of the impact of HIV/AIDS on the community might include:

- Female-headed households
- Child-headed households
- Orphans and community workers who care for them
- Members of women's groups
- Teachers and school administrators
- Members of churches

The situation analysis should also seek to identify and interview organisations and individuals currently involved in addressing HIV/AIDS in the community.

5. OPTIONS FOR A SITUATION ANALYSIS

When planning a situation analysis, ADPs may encounter any of the following circumstances and options:

- A situation analysis focusing on HIV/AIDS has already been undertaken in the community. In this case, the ADP can consider the results of this previous situation analysis. The previous analysis will have to be assessed for the information needed for the ADP's programming. If the needed information is not available, then a supplementary analysis will have to be conducted.
- No specific situation analysis has been conducted for HIV/AIDS programming, but community organisations have collected data for other reasons. This data can be collated and reviewed to ensure that the new situation analysis does not duplicate previous efforts.
- No situation analysis has been conducted. A rapid assessment of the current situation within the community might then take place before the HIV/AIDS programs begin.
- No situation analysis has been conducted. A more complex situation assessment using multiple techniques, which might have different components relevant to different stages of the HIV/AIDS programming, might be conducted.

Generally, situation analyses for HIV/AIDS programming focus on knowledge, attitude, and practice (KAP) surveys. These surveys can be conducted through:

- Written questionnaires or oral interviews
- Focus group discussions
- Participatory learning and action exercises with community groups

Information generated by the KAP approach should be complemented by other types of information:

- Epidemiological data about prevalence rates and most vulnerable key groups. This may be available from government health and social service departments or other groups who collect information about the local community.
- Major risk factors that are driving the epidemic in that particular area. Statistical information about risk factors may also be available through government departments and other organisations.
- An inventory of current responses to HIV/AIDS and critical gaps in these responses. This information may be sought through meetings with groups and organisations providing health and social services to the community.

6. COLLECTING DATA FOR A SITUATION ANALYSIS

6.1 Written questionnaires and oral interviews

Written questionnaires are only feasible in communities where literacy levels are high. Under other circumstances, assessors should conduct oral interviews. ADPs should ensure that everyone conducting interviews asks questions using identical language. Translations of interview questions into local languages and cultural vocabularies must be consistent for survey results to be valid. See Appendix I for an example of an HIV/AIDS interviewing tool.

6.2 Focus group discussions

Because addressing HIV/AIDS involves discussing sexual practices, stigmatisation, and other sensitive subjects, it is especially important to assure people of the confidentiality of their contributions in the focus group and to encourage them both to share their feelings openly and to listen respectfully to one another.

Questions raised in focus group discussions might include:

- What kinds of health problems do people here face?
- What do people know about AIDS?
- How serious is the AIDS problem in your community? On what evidence is your answer based?
- Have people's lives changed because of AIDS? On what evidence is your answer based?
- How have members of this community responded to AIDS?
- What kinds of risk behaviour are you observing in your community?
- Who do you think is most at risk of contracting the disease? Why?
- How is HIV transmission likely to occur in this community?
- What are the characteristics of people here that could make them more or less vulnerable to HIV?
- Which groups in your communities have the greatest number of sexual partners?
- Are young people having sex in the community? If so, at what age? Who are their partners? What are the different reasons young people have sex?
- Who in this community can positively influence people to adapt behaviours that prevent HIV transmission?
- What do people do to protect themselves from HIV and STI infections? Is there anything else they would like to do, but can't always do?

- What will help create an enabling environment so that people find it easy to change their behaviour to avoid HIV transmission?
- What will make it difficult for people to change their behaviour in this community?
- Who are the most vulnerable people in your community? What are the reasons for their vulnerability?
- What strategies do widows and children use to obtain resources, care, and support?
- How are sick people cared for in your community?
- How are orphans cared for in your community?
- Are there certain individuals or groups that care for vulnerable members of the community? Who helps them?

6.3 Participatory learning and action

Participatory learning and action (PLA) exercises help community members analyse what is going on in their lives and find solutions to challenges they identify. These exercises have been successful in many parts of the world and are now often included in manuals and used to set a direction for new programs. ADPs can access information about undertaking PLA exercises in the “five minute reference booklet” put out by World Vision India. Some of these exercises and their applicability to HIV/AIDS are briefly explained on the following table:

Name of Exercise	Possible use
FAMILY LINE	To understand how HIV/AIDS has affected individual families what they have done to adapt in times of crisis and afterwards
TREND ANALYSIS	To understand how various aspects of the community like agriculture, health, medical treatment, worship, education, etc. have changed over the years due to HIV/AIDS
PARTICIPATORY RESOURCE MAP	To see an overview of the entire community with its resources
CONFLICT ANALYSIS (Pie diagram)	To understand the local causes of conflicts and local means of conflict resolution that may affect HIV/AIDS interventions
LIVELIHOOD ANALYSIS (Pie diagram)	To understand what options the local community has explored to earn a living. This exercise can identify mobility patterns that contribute to HIV transmission
CHAPATTI DIAGRAM (Venn diagram)	To understand which institutions and individuals are important to the community and need to be considered in order to work in the community effectively
CAUSAL DIAGRAM	To understand how things link together and affect each other, for example how traditional sexual practices impact on HIV transmission. This exercise provides an understanding of what changes are required to reverse negative processes
WEALTH RANKING	To locate the poorest of the poor within the community, including widows and children made vulnerable by AIDS
HEALTH RANKING	To locate the weakest and those in need of immediate health interventions
MATRIX RANKING OR SCORING	To understand the rationale behind the various choices of the community, including choices that impact on HIV prevention and care
SEASONAL LAND USE ANALYSIS	To understand how land is used by the community during different seasons. This exercise can identify mobility and income patterns that affect HIV transmission
STUDY OF WOMEN'S WORK LOAD	To understand the nature of the workload of the women in the community and how that workload has changed due to HIV/AIDS
PROBLEM RANKING	To prioritise problems related to HIV/AIDS with the help of the community
COMMUNITY/VILLAGE RESOURCE DEVELOPMENT PLAN	To assist the community in framing an overall development plan classified by priorities and sorted into what they can do for themselves and what requires outside help

7. INTERPRETING AND REPORTING ON THE FINDINGS OF A SITUATION ANALYSIS

Interpreting the data collected in a situation analysis involves looking for patterns in the information provided by key informants, questionnaire respondents, interviewees, and discussion groups. This analysis can either be quantitative or qualitative. (For more information on data analysis, see part VIII.5.5 of this toolkit.)

Quantitative analysis might identify:

- The number of community members with accurate knowledge about HIV transmission and AIDS
- The number of people in the community engaging in behaviour that puts them at risk of HIV infection
- The number of children in the community orphaned or made vulnerable by HIV/AIDS

Qualitative analysis might identify:

- Common modes of HIV transmission in the community
- Common misunderstandings about HIV transmission and AIDS in the community
- Groups who are the most vulnerable to HIV infection
- Groups who are the most vulnerable to the socioeconomic impacts of AIDS
- Problems the community encounters when trying to address HIV/AIDS
- Successes the community has achieved in addressing HIV/AIDS

Sometimes the information that a situation analysis assessment yields will be inconsistent. In this situation, try to compare the knowledge, experience, and attitudes of different informants in order to determine which are the most reliable. Try to confirm the information provided with multiple sources.

Once information has been collected and interpreted, the situation analysis should be summarised in a report. This report should include:

- The objectives of the situation assessment
- The process(es) used
- A summary of the outcomes of questionnaires, interviews, focus group discussions, and PLA activities
- A summary of what was learned in discussions with key informants, community stakeholders, and other groups undertaking HIV/AIDS programs in the community
- An outline of possible actions to be taken

This report should be shared with all community stakeholders, including those who participated in the situation analysis, community leaders, institutions and programs already undertaking HIV/AIDS work in the community, and possible program beneficiaries and partners.

8. REFERENCES

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Appendix I: Quantitative survey tool for HIV/AIDS programming situation analysis

Developed by World Vision Mozambique under the leadership of Dr. Omo Olupona, in partnership with World Vision US.

HIV/AIDS Situation Analysis — Quantitative Survey

Capacity Building in HIV/AIDS Programming in Support of the HOPE Initiative

Cluster Number: _____

Household Number: _____

Household ID:

Person ID:

(Leave blank, computer will generate)

Name of ADP: _____

ADP Code: 1= ABC
2= DEF
3=GHI

Name of community: _____

Name of interviewer: _____

Date: ---/---/----

Name of Supervisor: _____

Initials of Supervisor: _____

Section A: Household Identification

The questions in this section are for the person who is most knowledgeable about the household members.

A1. Can you please tell me the names of all the members of your household who usually live here, sleep here, and eat from the same source, including yourself? Please include children, relatives, or orphans, even if they are not at home at the time of interview, but do not count temporary visitors.

After asking about names, continue with the other questions about each person, i.e. gender, relationship to the head of the household, age, etc.

Use rows 1 through 9 to collect information about persons below 15 years and rows 10 and above for the other household members. If someone younger than 15 is married use rows 10 and above to collect his/her data.

Member No	First Name	Gender Male = 1 Female = 2	Relationship to head of household (see code below)	Birth date	Age yrs/mo	Father alive Yes=1 No=0	Mother alive Yes=1 No=0	Educational status (see code below)
1				/	/			
2				/	/			
3				/	/			
4				/	/			
5				/	/			
6				/	/			
7				/	/			
8				/	/			
9				/	/			

Member No	First Name	Gender Male = 1 Female = 2	Relationship to head of household (see code below)	Age	Marital status (see code below)	Occupation (see code below)	Educational status (see code below)
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							

Educational Status
 0=No formal schooling
 1=1-6 yrs of schooling
 2=7-12 yrs of schooling
 3=More than 12 yrs
 4=Vocational training

Relationship
 1=Head
 2=Spouse
 3=Child
 4=Grandchild
 5=Ward
 6=Other blood relative
 9=Others

Marital status
 1=Single
 2=Married
 3=Separated
 4=Widow/Widower
 5=Divorced
 6=Co-habiting

Occupation
 0=Unemployed
 1=Farming
 2=Trader
 3=Artisan
 4=Student
 5=Fishing
 9=Others

Section B: Knowledge about HIV/AIDS

Interviewer: randomly select a child between 10 and 14 years old and one adult (15 years and above) in the household and address questions in this section to those selected. The interview must be conducted individually to exclude interference from persons that may influence the respondent's answers.

	Child (10-14 years)	Adult (15 years and older)
	Name	Name
	Household No. _____	Household No. _____
B1. Have you heard of HIV/AIDS? 1 = Yes, 0 = No (If no, go to Section C)		
B2. Where did you hear of HIV/AIDS? <i>Multiple answers possible, tick corresponding box</i>		
1. Radio		
2. During family discussions at home		
3. In the school from peers/teachers		
4. In the church/mosque		
5. At the health centre/hospital		
6. During community meetings		
7. On the television		
8. In the newspaper or other print materials		
B3. In which ways is AIDS virus transmitted? (Read options to the respondents and code the answers in the corresponding box) 1 = Yes, 0 = No, 2 = Don't know		
1. Through sexual relationships with an infected partner		
2. From an infected mother to her child during pregnancy, child birth, or breastfeeding		
3. Through transfusion of infected blood		
4. Through sharing of meals, cups, or eating utensils with an infected person		
5. Through mosquito bites		
6. Through the sharing of contaminated sharp instruments, e.g. blade or needle		
7. Through sharing of toilets, bathrooms, etc. with an infected person		
8. Through witchcraft		
9. Through playing with an infected person		

B4. The following are ways a person can reduce the risk of contracting the AIDS virus (<i>Read options to the respondents and code the answers in the corresponding box</i>) 1 = Yes, 0 = No, 2 = Don't know		
1. By abstaining from having sexual relationship		
2. By having one uninfected sexual partner who also has no other partners		
3. By using a condom correctly every time someone has sex		
4. By not having anything at all to do with a person infected with the AIDS virus		
5. By avoiding sharing unsterile needles and other sharp objects		
6. An infected pregnant woman and her newborn baby should receive special medicine to prevent mother-to-child transmission		
B5. Please respond to the following statements/questions concerning HIV/AIDS (<i>Read options to the respondents and code the answers in the corresponding box</i>) 1 = Yes, 0 = No, 2 = Don't know		
1. You are not at risk of contracting the AIDS virus therefore none of the preventive measures is relevant.		
2. If you know that someone has HIV/AIDS will you let him/her teach you or your child in school?		
3. If a member of your family is sick with AIDS will you be ashamed to let people know the cause of his/her illness?		
4. AIDS is God's punishment for man's sin, therefore AIDS sufferers do not deserve our love.		
5. The cure for AIDS is to have sexual relationship with a virgin.		
6. If an AIDS orphan were brought to live with your family, will you be willing to accept him/her into your household?		
7. It is possible for a healthy-looking person to have the AIDS virus.		
8. Do you know where a youth can obtain information about reproductive health services, including treatment for sexually transmitted diseases?		
9. Do you know of anyone suspected to have died of AIDS in your neighborhood within the last 12 months?		
10. Do you know of a place where you could test for the AIDS virus if you wanted to?		

Section C: Impact of HIV/AIDS in the community

Interviewer: the questions in this section should be directed to the same child (aged 10-14 years) and same adult who responded to Section B above.

We would like to know your feelings and observations about chronic illness either in your family or in the neighborhood. Please answer yes, no or don't know to the following questions.

Code: 1 = Yes, 0 = No, 2 = Don't know

	Child (10-14 years)	Adult (15 years and older)
	Household _____	Household _____
C.1 Has any member of your family living here been sick for more than 3 months? <i>If Yes skip to Question C.3</i>		
C. 2 Is there anyone in the neighborhood who has been sick for more than 3 months? <i>If No skip to Section D.</i>		
C.3 Does the sick person have any of the following symptoms <i>(Read options)</i>		
(a). Cough that has lasted more than one month?		
(b). Diarrhea on and off – more than one month?		
(c). Gradual loss of weight?		
(d). Prolonged fever – more than one month?		
(e). Gets tired easily and looks weak?		
(f). Oral thrush?		
(g). Generalized skin problem with black spots for example		
(h). Generalized swelling of nodes, e.g. in the neck?		
(i). Loss of memory and inability to function intellectually?		
(j). Frequent illness?		
C.4 As a result of this illness, would you say <i>(Read options)</i>		
(a). There has been shortage of food in the affected family?		
(b). There has been a drop in the family income?		
(c). Some children in the family have stopped going to school?		
(d). Community members are avoiding having anything to do with the sick person or members of his family?		
(e). Other members of the family who are not sick cannot go to work because they have to care for the sick?		
(f). The sick person has died?		
(g). You are afraid?		
(h). You cannot sleep very well any more?		
(i). You are feeling sad?		
(j). Some health workers or volunteers visited to provide care for the sick person at home?		
(k). The church pastor/leader, imam, or other religious group members visited the sick person to talk about spiritual matters?		
(l). The sick person or his family received support to ensure the family has food to eat?		
(m). The sick person or his family received support to ensure the family can continue to earn some money?		
(n). The widow of the deceased has been sent away from her husband's house?		
(o). The children of the deceased have lost their father's or mother's property to other relatives?		
(p). Some public institutions, e.g. school or health facility, are no longer functioning properly because of prolonged illness or death of a teacher or a health worker in the institution?		

Interviewer : thank the child below 15 years for his/her time and continue the rest of the interview only with the adult member of the household.

Section D: Sexual Behaviour

The questions in this section are to be addressed ONLY to adults (15 years and older, or those who are already married even if younger than 15). Use the same adult who has responded to Sections B and C. Tick appropriate column.

We would like to ask you some personal questions and would like to reassure you that we will not disclose your answers to anyone else. No one will know that you provided the answers to the questions we will ask you.

Code: 1=Yes, 0=No, 2=Don't know, 3=Not applicable

	Yes	No	Don't Know	Not applicable
D1. At what age did you have your first sexual relationship? _____ years				
D2. Did you have sexual relationship with anyone who is not your spouse or a non-cohabiting partner within the last 12 months? <i>If No, skip to Question D5.</i>				
D3. Did you use condom during the act? <i>If Yes, skip to Question D5.</i>				
D4. What were the reasons for not using condom? <i>Multiple answers possible, check all that the respondent mentions.</i>				
(a). Partner did not like condom				
(b). Did not like condom				
(c). None was available at that time				
(d). It was too expensive				
(e) Religion forbade the use of condoms				
(f) Others (State)				
D5. What changes have taken place in your life style since you became aware of the existence of HIV/AIDS? <i>Multiple answers possible, check all that the respondent mentions. Do NOT read options.</i>				
(a) No change whatsoever				
(b) Reduced the number of sexual partners				
(c) Has been using condom whenever s/he has sex with a non-spouse or a non-cohabiting partner				
(d) Stopped sexual relationship with those who are not his/her spouse or co-habiting partner				
(e) Has taken religion more seriously				
(f) Decided not to have any sexual relationship until marriage				
(g) Others (state)				

D6. If you discover that you have HIV, (<i>Read out the options to the respondent</i>)				
1. Will you inform your spouse?				
2. Will you inform other members of your family?				
3. Will you inform your sexual partners?				
4. Will you make sure you infect other people as well since someone else infected you?				
5. Will you prepare a will?				
6. Will not let your employer or colleagues at work know about it?				
7. Will you join an association of persons living with HIV/AIDS?				
8. Will you reject the result of the test and probably go to other testing centres until someone tells you that you do not have HIV?				
9. Will you seek medical help as soon as you feel sick?				
10. Will you seek spiritual support of your pastor/imam and other religious group members?				
11. Will you always use condom any time you have sex?				
12. Will you limit your sexual relationships to only your spouse or co-habiting partner?				
13. Will you abstain completely from sexual relationships?				
14. Will you not share any sharp object such as razorblade or needle with anyone else?				
15. Will you abandon your spouse/sexual partner because she/he is the one who infected you with the virus?				

Thank the respondent for his/her time and cooperation.

Appendix 2: Questionnaire to assess knowledge of HIV/AIDS transmission

Date:

Occupation:

Sex:

Age:

Location:

No.	Questions	Agree	Disagree	Don't know
1.	HIV is now curable.			
2.	HIV can be prevented.			
3.	Everybody is at risk of contracting HIV nowadays.			
4.	You can tell by looking at someone if they have HIV infection.			
5.	You can get HIV by sharing utensils with infected persons.			
6.	You can get HIV by kissing HIV-infected persons.			
7.	You can get HIV by mosquito bite.			
8.	You can get HIV by sexual relationships with HIV-infected persons without using condoms.			
9.	AIDS is a disease of immoral persons.			
10.	If sex workers know how to use condoms correctly in all sexual relationships then they can prevent HIV.			
11.	If a drug user uses clean and properly sterilized needles and syringes and uses condoms correctly in all sexual relationships then they can prevent HIV.			
12.	If you abstain from sex before marriage you will be safe from HIV infection.			
13.	If you are faithful to your sexual partner then you can prevent HIV infection.			
14.	If your friend is HIV positive then you avoid meeting her or him.			
15.	Is there any discrimination in your area between people who have HIV and those who do not have HIV?			
16.	A good person has never accepted using condoms in a sexual relationship.			

Adapted from World Vision Vietnam / World Vision Australia Survey questionnaire (May 2001) with a few amendments.

Additional questionnaires can be found in Section IV.A.1, Appendix 2 of this toolkit.

B. HIV/AIDS-FOCUSED BASELINE SURVEYING

CONTENTS

1. What is a baseline survey?
2. Steps in planning a baseline survey
3. Sampling
4. Survey instruments
5. References

I. WHAT IS A BASELINE SURVEY?

A baseline survey is the first step in setting up a monitoring and evaluation system through which program managers, stakeholders, and donors can assess a program's progress in meeting its goals. This survey provides a "baseline" measurement of indicators that will be reassessed throughout the project's lifespan.

Like a situation analysis, a baseline survey collects information about the current situation in a community. But while a situation analysis comes *before* project design in order to identify existing conditions, facilities, behaviours, attitudes, and knowledge to be addressed in program planning, a baseline survey is done *after* a project has been designed. While a situation analysis is meant to facilitate program planning, a baseline survey is meant to facilitate monitoring and evaluation.

A situation analysis and baseline survey for a particular project may share similar questions or approaches. But often the information gathered in a situation analysis is not adequate or appropriate for a baseline survey. The indicators measured in a baseline survey should provide information that is directly and specifically relevant to the program's goals. Later assessments of the program can then be compared to this original baseline.

2. STEPS IN PLANNING A BASELINE SURVEY

1. Determine what indicators can be used to assess the program's progress in meeting its goals. Keep these indicators focused: some surveys try to obtain far too much information, some of which may never be used.
2. Determine the methods you will use to obtain the information, who will provide the information, and what the time frame will be for collecting the information. This step may involve the following activities:
 - Obtaining permission to conduct the survey from local/government officials. In some cases the ADP may be required to get permission from the relevant authorities before conducting a survey.
 - Training of research assistants. It is important to train the people who are going to collect data. This training should lay emphasis on the type of methods that are going to be used.
 - Selecting a sample population. ADP staff may not be able to involve every member of the community in the survey, so they should consider selecting a sample population. See part three of this section for information on sampling.

- Selecting appropriate survey methods. See part four of this section for details on the strengths and weaknesses of various survey instruments.
 - Preparing and pre-testing survey instruments. Preparing the instruments involves designing questions that will help the ADP achieve the objectives of the survey. The purpose of pre-testing is to find out whether the questions are well presented, clearly understood, and easy to answer. A pre-test also helps to show how long the interview will take.
3. Collect the data using the survey instruments and strategies that have been selected.
 4. Analyse the data. (See part VIII.5.5 of this toolkit for more information.)
 5. Share the survey findings. (See part VIII.5.7 of this toolkit for more information.)

3. SAMPLING

Sampling involves looking closely at part of something in order to learn more about the whole. A sample consists of a number of people, households, communities, or other units of a population that have been selected in a systematic way and will be used to study the characteristics of a population. A sample is usually a randomized selection of people who accurately reflect the make-up of the wider community from which they are drawn.

Samples are used for a number of reasons:

- They help researchers determine whether it is technically possible to obtain statistically valid answers to the questions posed.
- They help clarify the objectives of a study and will clarify the categories of information to be collected from the appropriate number of subjects at the required time.
- A well-designed sample will obtain the required information at the least cost.
- By using the correct procedures for estimating sample size, the study can avoid collecting more information than necessary yet obtain sufficient information to attain the required degree of precision.

A sample can be selected in many ways. Three commonly used approaches are:

- Simple random sampling. In this approach, every member of the population (household, person) has an equal chance of being selected. This type of sample is simple to design and is usually quite adequate when the population to be studied is relatively small and concentrated in a small geographical area.
- Cluster sampling. In this approach, the population is divided into clusters, such as communities, villages, and other small and easily definable units, and interviews are conducted in a relatively small number of randomly selected clusters.
- Stratified sampling. This approach targets groups of special interest to program evaluators. When evaluators are concerned about a subgroup of the population, a simple random sample would be expensive and inefficient. The cost of sampling can sometimes be reduced by dividing the population into strata or subgroups.

4. SURVEY INSTRUMENTS

Although the most widely used survey instrument for baseline surveys is the questionnaire, other tools can be used for surveys as well.

Main types of survey instruments and their strengths and weaknesses

Instrument	Advantages	Disadvantages
Questionnaire	<ul style="list-style-type: none"> Flexible and can be applied in many surveys Easy to use by inexperienced researchers 	<ul style="list-style-type: none"> Analysis relies on written records only Confusion over phrasing of questions can yield misleading answers
Attitude scale	<ul style="list-style-type: none"> Assesses intensity of opinions Allows rigorous comparisons of attitude between groups and over time 	<ul style="list-style-type: none"> Expensive and complex to develop Only measures one-dimensional variables Agree-disagree formula produces bias
Observation guide	<ul style="list-style-type: none"> Studies variables that subjects are unable or unwilling address through question-and-answer Provides consistency check for questionnaire responses Allows observation of behaviour as well as verbal and written responses 	<ul style="list-style-type: none"> Observation can be misleading if not combined with questions Difficult to interpret meaning of what is observed, especially cross-culturally
Telephone and mail surveys	<ul style="list-style-type: none"> Cheap and rapid way to obtain information Can prepare respondents for written survey or interview Allows access to people too busy for personal interview 	<ul style="list-style-type: none"> Most people in developing countries do not have telephones Sampling bias, because it covers only telephone users
Written test	<ul style="list-style-type: none"> Gives respondents time to provide more detailed data Ensures respondents read and understand questions 	<ul style="list-style-type: none"> Difficult to use where literacy is low

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C. CRITICAL CONSIDERATIONS FOR ALL HIV/AIDS RESPONSES

C.I. GENDER

CONTENTS

1. Introduction
 - 1.1 What is gender?
 - 1.2 Gender and the church
 - 1.3 The relationship between gender and HIV/AIDS
 2. Incorporating gender into HIV/AIDS interventions
 - 2.1 Gender and prevention
 - 2.2 Gender and care
 - 2.3 Gender and advocacy
 3. Incorporating gender into the programming process
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 4. References
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- Raising gender awareness
 - Involving men
 - HIV-positive women supporting each other

I. INTRODUCTION

I.1 What is gender?

The term “gender” refers to differences between women and men that are culturally or socially determined. Gender includes the different ways women and men are perceived, how responsibilities and roles are divided between men and women, and expectations about how women and men think and act.

Gender is learnt through a process of socialisation, in which girls are taught to exhibit what the community defines as “feminine” traits and boys are taught to exhibit what the community defines as “masculine” traits. Gender expectations are reinforced by families, friends, opinion leaders, religious and cultural institutions, schools, the workplace, and the media. These expectations reflect and influence the different roles, social status, and economic and political power of women and men in society.

Every society uses biological sex as one criterion for describing gender, but beyond that simple starting point no two cultures completely agree on what distinguishes one gender from another. Because gender is culturally and historically determined, it is subject to change. Inequalities between men and women, therefore, are neither “natural” nor inevitable. They can be transformed.

Historically, men have had greater economic, political, and legal power than women. For instance:

- Women perform 2/3 of the world's work.
- Women earn 1/10 of the world's income.
- Women are 2/3 of the world's illiterates.
- Women own less than 1/100 of the world's property.

Incorporating gender concerns into programming, then, generally means remedying this inequality by making sure that the perspectives, priorities, and particular vulnerabilities of women are taken into consideration. In designing programs, it is also important to consider the unique aspects of men's experiences.

1.2 Gender and the church

Men and women are of equal value in the sight of God. Jesus valued women and defended them against the condemnations of an oppressive culture. But sometimes religious institutions mirror societal norms instead of the Bible's teachings. For example, women are often excluded from holding positions of religious authority. Christianity nonetheless offers the promise of equality and justice, a promise that ADPs can help fulfill by including women in every part of the programming process and addressing women's special needs.

The church can play a positive role in gender relations by educating both men and women on their rights and responsibilities, emphasising selflessness, compassion, and fidelity in men's and women's relationships with one another.

1.3 The relationship between gender and HIV/AIDS

Gender inequalities in terms of roles, control over resources, status, and power affect the individual's risk of HIV infection and communities' abilities to cope with the epidemic. For instance, the low status of women restricts their options for taking control of their lives in relation to HIV/AIDS. For this reason, up to thirteen African women are HIV-positive for every ten HIV-positive African men. Societal pressures may also make it difficult for men to change risky behaviours.

Gender can influence an individual's vulnerability to HIV infection in a number of ways:

- Women are physiologically more vulnerable to HIV infection than men. Sexual practices that increase abrasion increase this vulnerability.
- In many cultures, men are expected to be sexually adventurous and women are expected to be submissive. These expectations discourage men from acting responsibly and women from protecting themselves.
- In many cultures, men have more power than women to determine when, how, and with whom to have sex. This makes it difficult for women to negotiate for safer sex.
- Sex within marriage is often regarded as a woman's duty, making it difficult to negotiate for safer sex.
- In many cultures, it is acceptable for unmarried and married men to have multiple sexual partners, including commercial sex workers.

- In many cultures, young women are expected to have sexual relationships with or to marry older men, who are more likely to be infected with HIV. Men sometimes seek young partners or virgins in order to avoid or cure HIV infection.
- Early marriages increase the risk of HIV infection because young brides lack education and economic independence.
- Low social status and economic dependence often prevent women and young people from controlling their own risk. Some women, girls, and boys may have little other choice than to barter sex for survival.
- Women, girls, and boys are vulnerable to sexual abuse, including rape.
- Lack of education and literacy make it more difficult for women to receive HIV prevention messages.
- Female genital mutilation (FGM) carries a high risk of HIV infection because the same instrument is often used to circumcise hundreds of girls. Male initiation rituals involving circumcision or other forms of cutting carry a similar risk.
- Women are exposed to higher risk of HIV infection because they are often the caretakers of those who contract AIDS.

Gender can also influence an HIV-positive individual's ability to find support and care:

- In some communities, women are more likely to be blamed for the spread of HIV than men, making it difficult for them to obtain care and support.
- As society's traditional caregivers, women carry the main psychological and physical burdens of AIDS care. Yet they have the least control over and access to the resources they need to cope effectively. Often men do not share domestic responsibilities and family care with their partners.
- HIV-infected women often experience poorer health and a faster weakening of the body because of their heavier workload.
- Women may lack care because the main expenditure of energy and resources may be for the men in the family.
- With fewer resources, women are more likely to lack money for medical care.
- Women are more likely than men to take on the burden of caring for children orphaned by AIDS.
- Discriminatory or poorly enforced property and inheritance laws make women vulnerable to having their property seized.

2. INCORPORATING GENDER INTO HIV/AIDS INTERVENTIONS

HIV/AIDS programs undertaken in the ADPs should be deliberately gender responsive. Paying attention to gender differences makes prevention, care, and advocacy interventions more effective. By encouraging men and women to be mutually responsible and supportive, gender-sensitive programming helps communities better cope with the epidemic. Everyone stands to benefit.

HIV/AIDS programming in the ADPs might include the following objectives:

- Create an environment enabling women and men to protect themselves and each other
- Create an environment enabling women and men to collaborate equally in providing care and support for those directly affected by the epidemic
- Sensitise men to women's rights and needs
- Encourage women to assert their rights

2.1 Gender and prevention

Any program designed to encourage the prevention of HIV/AIDS should consider how gender expectations make both men and women more vulnerable to the epidemic. ADPs can further the goals of gender equality and HIV prevention by assisting community members in exploring the following questions:

- What are the qualities of a good male-female relationship?
- Who usually makes the decisions in a male-female relationship? What are the implications?
- What circumstances in male-female relationships increase or decrease the risks of HIV infection?
- Why, with whom, and under what circumstances do women and men engage in sex?
- What needs and desires do women and men have regarding sex?
- What do men and women understand of each other's needs?
- What types of sexual practices and needs are or are not considered normal and why?
- How do various aspects of male and female sexuality relate to risks of HIV infection?

ADPs can use these questions to challenge beliefs that hinder the prevention of HIV, for example, the myths that men need to release semen to stay healthy, that women must receive semen to promote an unborn baby's growth, that having sex with a virgin girl cures AIDS, etc.

ADPs can also incorporate gender into prevention programming by:

- Involving women and men in creating gender-appropriate prevention messages
- Placing men and women in separate groups for BCC and making messages gender-specific
- Training women to be more confident, particularly when negotiating for safer sex
- Mobilising men to take greater responsibility for preventing HIV/AIDS. Men can be approached through workplace programs at businesses and factories, through interventions for sex workers' clients, through school-based programs, and through activities carried out through churches and recreational groups.
- Ensuring that men and women have equal access to VCT
- Working against sexual violence. This intervention could involve awareness campaigns, advocating for laws against sexual violence, and partnering with or training law enforcement personnel.

2.2 Gender and care

ADPs can promote gender awareness as it relates to the care of those infected and affected by HIV by raising the following questions:

- Who provides what types of care and support to family members and needy people in the community?
- Why is caretaking divided between women and men in a particular way?
- What needs to be done to ensure that women and men both participate actively in providing care and support?

ADPs can also incorporate gender into care interventions by:

- Training counselors to assist HIV-positive women with decisions about family planning, pregnancy, breastfeeding, and discussing their status with their partner
- Designing programs to fight the stigmatisation of HIV-positive women and men with special attention to how gender affects the experience of stigmatisation
- Encouraging HIV-positive women to form support groups
- Ensuring that men and women have equal access to STI and HIV treatments
- Advocating for laws to protect women from losing their property if their husband dies and ensuring that these laws are enforced
- Providing women who are caring for sick family members or vulnerable children with resources and support
- Introducing microcredit schemes for women who are caring for sick family members or vulnerable children
- Encouraging men to take on more caregiving roles and responsibilities
- Including men as volunteers providing community and home based care

2.3 Gender and advocacy

Advocating for gender equality can happen at many levels, from raising individuals' awareness about the assumptions that govern some of their most private practices to lobbying the government to create new laws and policies. Options for ADPs include:

- Media campaigns against all forms of sexual violence, highlighting the link to HIV
- Partnerships with civil society organisations and human rights groups to lobby for laws that prevent sexual violence and property-grabbing
- Education campaigns to inform women about their legal rights

Any advocacy campaign designed to improve women's educational, legal, social, economic, or health status is also likely to contribute to HIV prevention.

3. INCORPORATING GENDER INTO THE PROGRAMMING PROCESS

When possible, there should be an equal number of women and men involved in program development and decision-making processes. Situation assessments, implementation, and monitoring and evaluation should be designed to give both women and men a sense of ownership of the program's goals.

3.1 Situation assessments

The lack of attention to women's needs in HIV/AIDS programs stems from a lack of gender awareness among those who plan and implement the programs. Target groups are often treated as undifferentiated groups of 'people' rather than groups consisting of men and women who may have different needs. Worse still, sometimes a male-biased vocabulary is used to describe the target group, which then translates as 'men' rather than 'people'. In this situation, women actually disappear from sight and thought.

When assessing the underlying causes and effects of the spread of HIV/AIDS, it is important to:

- Allow equal participation of girls, boys, women, and men in the assessment process
- Plan to address the causes and effects of HIV/AIDS for girls, boys, women, and men as differentiated categories
- Identify by age, gender, and other appropriate categories which groups are most at risk and should be prioritized

3.2 Implementation

At the stage of implementation, the most important factor in incorporating gender into HIV/AIDS programming is the level of gender awareness and sensitivity of the implementing team. This team should work to:

- Create an environment that encourages equal participation of women, men, boys, and girls in activities
- Encourage women, who may be disproportionately silent, to express their opinions and feelings
- Encourage boys/men and girls/women to listen and respond to one another in a constructive manner
- Group women, men, boys, and girls separately when necessary and assign a facilitator of the same gender
- Conduct meetings in venues where men and women feel equally comfortable
- Select times and venues equally convenient for men and women
- Provide childcare services during activities and meetings
- Use gender-sensitive language
- Use gender-sensitive materials that neither depict women in inferior positions nor promote male dominance
- Educate men on gender-sensitive behaviour
- Educate women about their rights and appropriate ways to assert them

3.3 Monitoring and evaluation

Program monitoring and evaluation indicators should be gender-specific. For example, rather than counting how many children have received life skills training, monitors should determine how many boys and how many girls have received life skills training.

ADPs should also consider including indicators specifically designed to assess the impact their program is having on gender equality. For example, monitors and evaluators could consider:

- How the program affects division of labor, allocation of resources, and power relations between men and women
- The proportion of men and women among program beneficiaries
- The proportion of men and women involved in project planning, management, implementation, and evaluation

Possible indicators of improved gender equality could include:

- Changed attitudes regarding harmful traditional practices such as polygamy, FGM, and early marriages
- Reduced occurrence of harmful traditional practices
- Reduced occurrence of sexual violence
- Shared decision-making power between women and men at the level of personal relationships, community affairs, and political and economic institutions
- % of men/women with their own income
- % of men/women owning property
- % of women with secure inheritance rights

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Appendix I: Case studies

Raising gender awareness

Juliet Awino, a widowed mother in Uganda, stars in “Strings Attached”, a play portraying her personal experience with HIV/AIDS. It emphasises practices that undermine women’s role in society and the home, making them vulnerable to HIV transmission, such as male pre-and extra-marital sexual activity, hostility from in-laws who blame wives for family problems, and abandonment without rights and property if a woman refuses sexual “ritual cleansing” when she becomes a widow. The drama has contributed to an increase in people writing wills to regulate inheritances.

In Kalabo, Zambia, women aware that girls in their area were especially vulnerable to HIV formed a committee to focus on communal attitudes towards sexuality and behaviour affecting women. They organised seminars for women through churches, hospitals, and health centres to stimulate community discussions about female sexuality and gender roles. As a result, the traditional initiation ceremony for girls was revised to include information and reproductive health and HIV/STIs.

In Mali, a primary health care project (SSP-Segou) and program focused on improving women’s status (PROFED) generated discussion on gender and sexual health among the general community and young women in particular during a needs assessment study. To break down barriers against discussing sexuality, they developed a drama with the villagers about a woman who has problems giving birth. It was acted out for the entire village, following an introduction by a male village leader concerned about women’s situation. The audience became highly involved, worrying about the sick woman and giving advice to the husband. In this climate male and female researchers could address all kinds of topics from the perspective of both sexes. Some previously taboo subjects, like the negative consequences of female circumcision and sexual violence against women as a risk factor for HIV/AIDS, were dealt with publicly for the first time. The group discussions were geared towards analysing the villagers’ problems and mobilising them into action. The first step was to reestablish a village pharmacy.

World Vision designed a sex and family education program for low-income adolescent girls in Bombay, India. The girls had little information about reproduction and almost none about HIV and STIs. They seemed trapped in a “culture of silence” that did not permit them to voice their opinions, feelings or concerns on any issue. A community AIDS/STI awareness program was therefore implemented, including meetings with mothers, teenage boys, and young men, and a street play dramatising women’s status at different stages in life. Topics discussed with the girls included being a woman, female puberty, sexuality, sexual exploitation and harassment, health problems (with specific reference to HIV and STIs), and the development of an action plan to protect oneself against infection. The program encouraged the girls to talk. The feedback was very positive, with the girls asking for more sessions.

Involving men

The Thai Health Project for Tribal People (HPTP) has trained influential male community leaders as health educators for isolated hill tribe communities. The training seminars include practice teaching sessions. One headman, for example, used a picture of a young girl being sold into sex work to talk about the man who had taken her away and what happened to her once she was in town. HPTP teams visit the headmen several months after the seminars to ask about any problems they have using the materials and what is going well. Knowledge changes are occurring in villages taught by headmen. In one tribe, the initial survey showed that 85% of the people had heard of AIDS, but none understood that it could be transmitted from mother to child. After teaching by the headman, 98% of the villagers understood this. (Lori Rowe, Thailand)

A Filipino NGO, HAKIK, has developed a gender training program for male staff in various types of organisations to address gender inequality through games, exercises, songs, dance, and discussions. The men articulate their own ideas about why women are oppressed. Then they address how to change the institutions and determine gender roles, concluding with the formulation of action plans, which help the men translate what they have learned into goals and strategies.

The Heterosexual Men's Project in New South Wales, Australia, conducted focus-group discussions with building workers aged between 17-60 years to determine what was important to them in preventing HIV infection. Two issues highlighted by the workers were the role of alcohol in promoting unsafe behaviour and difficulties in communicating about sex with women. Based on the men's suggestions, a campaign was designed using messages on beer coasters and toilet stickers in pubs and clubs. The beer coasters used slogans to demystify safe sex and challenge some male sexuality myths. The toilet stickers aimed to facilitate discussion of condom use between men and women by providing humorous icebreakers. Billboard, bus and magazine advertising messages addressed the link between STIs and HIV/AIDS. Evaluation showed that 50% of the men familiar with the campaign saw it as personally relevant: 19% of those who had read the beer coasters and stickers said they were helpful in providing conversation starters on safe sex with their partners; 27% said it led them to discuss with their colleagues.

HIV-positive women supporting each other

Women and men around the world often feel isolated when they learn their diagnosis. Women especially have difficulties in contacting peers in the same situation. Yet this provides great psychological benefits: “When the woman at the clinic said, ‘would you like to meet another woman with HIV?’ and gave me her phone number, I couldn’t wait to get home ... as soon as I met her, it just changed my life. I realised I hadn’t done anything wrong. I wasn’t a criminal ... we’ve formed a women’s support group ... I can talk about problems that have happened. Not just to do with HIV... just supporting each other, having good fun, having a laugh” (England).

In 1992, the International Community of Women Living with AIDS (ICW) was formed in Amsterdam. This coordinating body has provided women most directly affected by the epidemic with a voice at global and regional levels. Through a network of worldwide representatives, they provide policy input to UN agencies. Such an initiative can be replicated at ADP level with women at local levels.

The experience of ICW has also inspired the formation of association of HIV-positive women in many other countries. For example, the Argentine Network of Women Living with HIV/AIDS (ANW) gives women information about AIDS, helps them access treatments and medications through state and private services, and makes referrals to NGOs and governmental social services.

In England, regional seminars were organised on the theme, “Women, AIDS and the future” in collaboration with local women’s organisations. Activities carried out by participants afterwards included:

- Reporting on HIV/AIDS to local organisations and the press
- Planning similar seminars in their area
- Talking with men, family, friends, and colleagues about HIV/AIDS
- Writing advocacy letters to government ministers
- Holding study days/meetings with church groups

The Society of Women and AIDS in Africa (SWAA) raises political awareness concerning gender in relation to HIV/AIDS and STDs and provides a voice for women in many parts of the continent. SWAA has national member organisations in more than 20 countries.

C.2 CHILD PROTECTION

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1. Introduction
 - 1.1 Child rights
 - 1.2 Child protection principles for HIV/AIDS programming
2. Child protection and HIV/AIDS prevention
 - 2.1 Sexual abuse in the home
 - 2.2 Sexual exploitation
 - 2.3 Harmful traditional practices
3. Child protection and care for those affected by HIV/AIDS
 - 3.1 Neglect
 - 3.2 Child labour
 - 3.3 Property rights
4. Child protection and HIV/AIDS-related advocacy
 - 4.1 Child participation
 - 4.2 Advocating on behalf of the girl child
5. References

I. INTRODUCTION

The impact of HIV/AIDS on children in the developing world is vast and multifaceted. More than 13 million children under the age of fifteen, most of them in the sub-Saharan Africa, have lost one or both parents to AIDS. This number is expected to increase to more than 25 million by the year 2010. In 2001, 12% of the children in sub-Saharan Africa were orphaned, compared to 6.5% in Asia and 5% in Latin America. Children affected by HIV/AIDS suffer psychosocial distress and may suffer from lack of food, shelter, health care, and other material goods. They may be forced to drop out of school or required to care for chronically ill parents. They may be exposed to abuse, discrimination, or stigma.

HIV/AIDS makes the task of protecting children both more difficult and more urgent. Because of the threat of AIDS, children subjected to sexual abuse and exploitation not only face severe psychosocial damage and physical injury; their very lives are endangered. Children orphaned or made vulnerable by HIV/AIDS are in greater danger of sexual abuse and exploitation, and also may face neglect and destitution. When designing HIV/AIDS programming, planners should not merely adhere to WV's Child Protection Policy; they should also plan programming to specifically address the ways in which HIV/AIDS places children in greater danger.

I.1 Child rights

In its broadest definition, child protection means protecting the rights of children. Both the UN and WV define children as every human being below the age of eighteen years. The UN Convention on the Rights of the Child (CRC) categorises the rights of the child as follows:

- Survival rights, including adequate living standards, shelter, nutrition, and medical care
- Development rights, including education, recreation, cultural activities, and access to information
- Protection rights, requiring that children be safeguarded against all forms of abuse, neglect, and exploitation
- Participation rights, requiring that children be given the opportunity to take an active role in their communities and nations

WV affirms the Convention on the Rights of the Child from a Biblical perspective, with the following beliefs:

- The human race, including every child, is created in the image of God.
- Jesus' call for us to love our neighbors as ourselves reflects profound respect for others as equal in worth before God.
- The Biblical sense of justice means restoring right relations between people as groups and individuals, as well as between people and God.
- Christians are to treat all others as if they belong to God. (1)

HIV/AIDS threatens every category of child rights. It threatens children's survival rights by taking away their parents and hence their source of physical sustenance and support. It threatens their development rights when they are forced to leave school and spend most of their time and energy caring for sick parents or fending for themselves. It threatens their protection rights by making them more vulnerable to exploitation and abuse. And it threatens their participation rights by damaging the social fabric of their communities and their nations.

WV's Hope Initiative seeks to defend children's rights against the threat of HIV/AIDS by focusing on HIV prevention among 5-15 year-olds (see section IV.A.1 of this toolkit) and by helping communities care for orphans and vulnerable children (see section IV.B.1). This section focuses on the relationship between HIV/AIDS and a narrower definition of child protection: protecting children from abuse, exploitation, and neglect.

1.2 Child protection principles for HIV/AIDS programming

All ADPs should work to promote the rights and interests of children and help restore or maintain their dignity. The following are some general principles to follow when planning HIV/AIDS programming:

- The best interests of the child should always be put first.
- Children's rights to decide for themselves should be respected at all times. This means that children should be involved as much as possible in the design and evaluation of prevention programs targeting them. If they have chronically ill parents who are being counseled in succession planning, the children should be involved in choosing potential foster parents. Programs addressing the needs of OVCs should seek the input of the children they are trying to help.
- Children's rights to confidentiality and freedom from discrimination should not be compromised. In HIV/AIDS programming, this means that children's and their families' HIV status should be kept in maximum confidentiality. ADPs should work to ensure that children are not discriminated against at school, at home, or in the community because of their or their families' HIV status. Children taken in by foster parents should be treated the same as the biological children of those parents.
- Children should participate in an environment where they feel safe with their own peers so that they do not feel threatened or used. When providing care for OVC, ADPs should make every effort to provide children with safe environments and peer support.
- Children should not be portrayed in a negative or disadvantaged way. When ADPs document their work with a vulnerable child, they should portray the child with the child's consent in a way that reflects the child's dignity.
- Children should not be exploited for commercial, medical, or research purposes.

2. CHILD PROTECTION AND HIV/AIDS PREVENTION

2.1 Sexual abuse in the home

In a recent study on child sexual abuse, WV found that in five developing countries, a chronic lack of awareness created contexts in which the sexual abuse of children could take place undetected. In each location, no local provision existed to respond to children claiming abuse and indeed, any child raising such concerns would routinely be disbelieved. (2) This situation is especially dangerous in countries where there is a high prevalence of HIV.

By taking steps to reduce the incidence of child sexual abuse, ADPs can both protect children from trauma and injury and stop one mode of HIV infection. Possible activities include:

- Ensuring that vulnerable children under WV's care are protected from sexual abuse. Community caregivers whom WV helps train should be screened and monitored to ensure that they do not abuse their charges
- Working with churches and schools to inform children of their rights and encourage them to speak out if they feel they are being treated inappropriately
- Organising a formal or informal system in which there is a designated adult in the community to whom children can report abuse and who can make the proper referrals
- Educating the community about the definition and effects of child sexual abuse

- Finding culturally appropriate ways to counter the myth that sex with a virgin can cure HIV/AIDS
- Advocating for the drafting and enforcement of laws which protect children from sexual abuse

2.2 Sexual exploitation

In a study in Southeast Asia, WV found that the problem of AIDS has increased demand for younger prostitutes, who are believed to be less likely to carry the disease, to the extent that one million children now work in the Asian sex trade. Researchers believe that some five thousand children have been sold for sex in Luanda, Angola, and in Brazil, it is believed that a staggering three percent of children under the age of eighteen sell themselves for sex. (1)

Sexual exploitation of children also takes subtler forms. In some cultures, it is common for school age girl children to form relationships with older men in exchange for cash and gifts. Male teachers may pressure female students for sex. Like their sisters and brothers in the formal sex trade, these children are at great risk of HIV infection. At the same time, HIV/AIDS makes more children vulnerable to sexual exploitation, because more children lack families, homes, and material support. It is a vicious circle that must be broken.

To protect children from these forms of abuse, ADPs could consider:

- Focusing their programs targeting commercial sex workers on sex workers under the age of eighteen (see part IV.A.2 of this toolkit)
- Strengthening community support and care for orphans and children made vulnerable by HIV/AIDS (see part IV.B.1 of this toolkit)
- Appealing to the consciences of the clients of underage sex workers through the churches, traditional leaders, and other venues.
- Advocating for the drafting and enforcement of laws which protect children from sexual exploitation
- Ensuring that children are protected from sexual exploitation by their teachers by educating children about their rights, educating teachers about their responsibilities, and setting up a reporting and enforcement system

2.3 Harmful traditional practices

In some communities, harmful traditional practices violate children's rights and put them in danger of HIV infection. For example, in Zambia and other parts of Africa, girl children as young as eight years old are betrothed for marriage in exchange for livestock or money for the children's guardians. (3) When girl children are forced into early marriage with older, more sexually experienced men, they are robbed of their childhood and also put at risk of HIV infection. To fight against this and similar practices that hurt children and put them at risk of HIV/AIDS, ADPs can work with the churches and other traditional leaders to advocate for these practices to be changed.

3. CHILD PROTECTION AND CARE FOR THOSE AFFECTED BY HIV/AIDS

3.1 Neglect

One of the greatest tragedies of the HIV/AIDS pandemic is how it has exposed countless children to neglect. When parents fall seriously ill and when they die, they are no longer able to address the needs of their children. The extended family system, which has traditionally provided care to

orphans and vulnerable children in Africa, has become overburdened. The result is a large number of children who are left more or less on their own to secure shelter, food, medical care, and emotional support. ADPs can address this problem of the neglect of children by helping to strengthen and support communities' abilities to care for orphans and vulnerable children. Section IV.B.1 of this toolkit suggests concrete ways of doing so.

3.2 Child labour

Children should be protected from labour that involves long hours of work, heavy loads and tasks, the use of dangerous tools, and exposure to chemicals or dangerous substances. Children should only be expected to undertake light chores, with the supervision and support of their families and in a way that does not interfere with their ability to attend school. Unfortunately, poverty and the problem of HIV/AIDS have made it difficult in many countries to protect children from heavy labour. Children whose parents are terminally ill or have died may have little other choice than to work long hours farming, getting water, caring for their parents or younger siblings, or seeking ways to earn an income.

ADPs can help protect children from heavy labour by:

- Organising and training home based care teams to visit ill adults and relieve children of some of the duties of caring for sick parents
- Paying or helping communities pay children's school fees so that they can remain in school
- Providing or helping communities provide material support to households that have been affected by HIV/AIDS
- Teaching children farming or other skills that require less labour and provide greater nutrition or income

3.3 Property rights

All too often, when children lose their parents to HIV/AIDS, they are vulnerable to having their parents' property grabbed by other relatives. ADPs can help protect children from this form of abuse by:

- Helping chronically ill adults write wills and undertake succession planning to ensure that their property will remain with their children
- Advocating for the drafting and enforcement of laws that protect children's inheritance rights
- Working through churches, traditional leaders, and local government to assure that children's inheritance rights are understood and respected by everyone in the community

4. CHILD PROTECTION AND HIV/AIDS-RELATED ADVOCACY

4.1 Child participation

Children have the right to play an active role in their communities. They should be given the freedom to express their opinions, to access information, and to have a say on matters affecting their lives. In WV's HIV/AIDS advocacy work, this means that children should be given the opportunity to define their greatest needs and challenges. Whether ADPs are advocating on the government level for a change in policy or on the community level for a change in attitudes or new kinds of support, children's priorities should be a key consideration.

Children should not only be involved in defining the priorities that govern advocacy activities; they may also be involved in advocacy work itself. Children can be powerful spokespeople for their own needs and struggles, and may be considered as more authentic sources of information about conditions on the ground than their adult allies. This type of participation must always be fully voluntary on the part of the child, and the child's right not to be used for someone else's purposes must be respected.

4.2 Advocating on behalf of the girl child

While both male and female children are made vulnerable by HIV/AIDS, the girl child often bears unique burdens. In many communities, female children bear some responsibilities for cooking, cleaning, fetching water, and caring for younger siblings. When the adults in the family become chronically ill or die, these burdens become far heavier. Often the girl child must drop out of school to care for sick parents or younger siblings. Girl children are also more vulnerable to sexual exploitation and abuse.

ADPs can advocate for the rights of the girl child by:

- Encouraging a division of labour in which domestic chores and care taking are shared equally by boys and girls
- Training boys as well as girls in home based care techniques to care for chronically ill adults
- Encouraging the community to find ways to keep more girl children in school
- Working with churches and community leaders to stop harmful traditional practices that harm girls, such as early marriages
- Advocating for the drafting and enforcement of laws to protect girl children from sexual exploitation and abuse

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C.3. PEOPLE LIVING WITH HIV/AIDS

CONTENTS

1. Introduction
2. Dealing with unhelpful attitudes
3. Providing care and support
 - 3.1 Information
 - 3.2 Psychosocial care
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I. INTRODUCTION

People living with HIV/AIDS (PLWHA) have personal experience of the epidemic and are therefore strategic partners in combating new HIV infections, promoting care for those infected or affected, and scaling up global, national, and community-level advocacy campaigns. Through personal testimony and example, PLWHA can both reinforce the seriousness of the epidemic and inspire hope in a way no other group of individuals can.

As campaigners, educators, counselors, and caregivers, a growing number of HIV-positive people are at the forefront of effective global, regional, national, and community-level responses to HIV/AIDS. Yet in many countries and communities, people with HIV/AIDS still fear rejection by their families, friends, and neighbours, and discrimination at their places of work, worship, and education. Even within the health services, discrimination against people known or believed to be HIV positive is not uncommon.

It is therefore not surprising that many people who know or believe that they are HIV positive prefer secrecy and isolation to the risk of exposure, rejection, and discrimination. Many remain cut off from information, care, counseling, support, and HIV/AIDS program activities in their communities. As a result, they may continue practicing unsafe behaviour. This makes community, national, and global prevention efforts more difficult. Furthermore, when communities harbour negative attitudes towards people living with HIV/AIDS, they are less likely to initiate or expand HIV/AIDS-focused activities. Stigma and discrimination thus hurts everyone.

Dealing with the challenge and reality of HIV/AIDS by promoting love, care, and acceptance of HIV-positive people and their involvement in HIV/AIDS programs is therefore not only a moral requirement for all World Vision staff but also an integral part of HIV/AIDS prevention, care, and support.

2. DEALING WITH UNHELPFUL ATTITUDES

In many parts of the world, the general public has reacted to the HIV/AIDS epidemic with a mixture of fear, panic, doubt, and denial. This reaction has created prejudice against people known or believed to have HIV/AIDS, a situation that leads to both social isolation and self-stigma for PLWHA. Self-stigma occurs when PLWHA believe and internalise negative attitudes, responses, and reactions

from other people. They may receive negative messages within their families, places of work, worship, residence, education, or health care services. If not handled or defeated, self-stigma leads to feelings of shame, self-hate, denial, depression, withdrawal, and even self-destructive and suicidal acts.

Social stigma occurs when out of ignorance, irrational fear, or judgmental attitudes, people wrongly blame others for their misfortunes, diseases, and other societal ills. These people talk and conduct themselves in ways that cause those living with HIV/AIDS (and those close to them) to feel devalued. In its worst form, social stigma can lead to outright rejection, isolation, and even the torture or killing of persons living with HIV/AIDS. In partnership with other stakeholders, World Vision needs to proactively support people living with HIV/AIDS in dealing with this kind of stigma. Efforts should also focus on changing negative attitudes in communities where World Vision works.

WV staff can fight stigma by:

- Identifying and encouraging role models who are willing to stand up against stigma and discrimination at their places of work, residence, education, worship, business, entertainment, etc. These can be individuals, communities, groups, or institutions.
- Developing a new positive language about HIV/AIDS that replaces fear and fatalism with hope, courage, and respect within individuals, families, communities, and countries living with HIV/AIDS.
- Promoting good, balanced, and hopeful media reporting that does not stereotype, diminish, or ridicule PLWHA but rather encourages them and supports them with accurate information, skills, and services.
- Helping communities to differentiate between behaviour that is 'lawful' and 'acceptable' according to social norms and behaviour that is 'safe' from a medical or public health perspective. Confusion between the two contributes to stigma against PLWHA.
- Promoting the establishment of associations, clubs, and networks of PLWHA to put a human face on an otherwise invisible and fear-invoking virus, correct misconceptions and myths about HIV/AIDS, and provide social support to the members.
- Promoting partnerships between religious institutions, religious agencies, business entities, and communities for purposes of training and enlisting the services of men and women with correct knowledge and skills as regards HIV/AIDS.
- Integrating PLWHA into all aspects of HIV programming, implementation, and evaluation, and pursuing policies for equal recruitment, equal employment, equal promotion, and equal pay irrespective of HIV status, both within WV and other communities in which we serve.
- Finding out their own HIV status and living openly, confidently, and positively with the result.

3. PROVIDING CARE AND SUPPORT

Being diagnosed as having an incurable, terminal disease is a traumatic experience. When the disease in question is HIV/AIDS, which is inaccurately associated in the public mind with sexual promiscuity, adultery, prostitution, and other high risk behaviour, it is not very surprising that HIV-positive people often respond to news of their infection with feelings of shock, fear, anger, denial, guilt, and depression.

To cope with and overcome such feelings, to accept oneself and to live a positive, meaningful, and productive life, is far from easy. It demands tremendous reserves of courage and determination on the part of the person concerned but more than that, it requires a great deal of love, care, and support from friends, families, neighbours, employers, religious leaders, government services, and community organisations.

The care and support which ADPs and National Offices can mobilise for people living with HIV/AIDS are summarized in the following sections.

3.1 Information

The first information that a person concerned about her or his HIV status needs to know is whether or not she or he is infected. At the moment, many HIV-positive people in the countries where WV operates (whether the HIV prevalence in the country is high or low) do not yet know that they are infected. They are therefore less likely to seek treatment for potentially life threatening infections, to take good care of their health in general, or to take their rightful place in prevention, care, and advocacy programs as people living with the HIV infection. Voluntary counseling and testing should be made available and accessible in every community where WV works.

Once informed of their HIV status, HIV-positive people will need more information about:

- The exact nature of HIV infection and AIDS
- The difference between HIV and AIDS
- Modes of transmission and re-infection
- How to take care of themselves
- Where to seek and obtain services such as medical care, condoms, material support, and legal aid (if available)
- Where to seek help combating stigma, denial, and discrimination
- Risks and options for pregnancy and child-bearing, including preventing mother-to-child transmission

3.2 Psychosocial care

Peer and professional counseling can help people cope with the psychological impact of learning that they are HIV positive and the emotional strain of living with the virus from day to day. Counseling should take place before and after a patient is tested for HIV, and should be continued regularly to help HIV-positive people cope with emotional crises, make decisions about their personal and social lives, consider treatment options available for each stage of infection, and eventually plan for the future of their families in case of incapacitation or death. Planning for the future can be especially important and comforting to those concerned about what will happen to their children.

The support and solidarity of other people living with HIV/AIDS can also be of immense help. Support group members can help each other develop strategies for survival and find purpose in life. (See the Appendix to part II.C.I of this toolkit for examples.)

A range of books, other materials, and resource personnel on this topic are available and World Vision staff is encouraged to make use of them.

3.3 Emotional support

People living with HIV/AIDS have special needs for emotional support. For some feelings of guilt, anger, despair, and isolation drain the capacity of the individual to keep going. Many testify that prayer and compassionate practical support is essential to their lives. The understanding and loving support of family members, friends, workmates, and employers can help people with HIV overcome their sense of loss and being unworthy and enable them live life to the fullest.

Giving people living with HIV/AIDS the love, care, and acceptance they need and deserve is the first line of defence against the illnesses that accompany HIV infection.

3.4 Acceptance and nondiscrimination

In order for them to play their full role in the struggle against HIV/AIDS, people who are HIV-positive need to be accepted by their wider community. Under these circumstances, PLWHA themselves can be included in delivering HIV/AIDS care and support programs. They can become a source of peer support and powerful catalyst for change. Also, this work can provide PLWHA with real goals, continued meaning in life, and a sense of 'being useful' which is invaluable for their own mental well-being.

More generally, PLWHA need protection against discrimination with regard to specific rights such as security of employment, pensions, health care, medical confidentiality, education, freedom to visit other countries and communities, and rights to inherit property. WV staff can help in this regard by facilitating the development of HIV/AIDS policies in their places of work, worship, education, entertainment, residence, etc. These policies should promote acceptance, nondiscrimination, and the involvement of HIV- positive people in HIV/AIDS programming and general community activities.

3.5 Medical care and nursing

Although the disease AIDS cannot be cured at the moment, most opportunistic infections associated with it can generally be treated successfully with standard drugs. The other good news is that currently there are medicines that can help suppress the reproduction of the virus, thereby strengthening the immune system. It is therefore important that a person living with HIV/AIDS gets treated promptly for any opportunistic infections before they become life threatening, while exploring the possibility of initiating anti-retroviral treatment (ARV).

Good nursing, which includes the promotion of good nutrition and hygiene, is also important. In fact, with appropriate medical treatment, a healthy diet, good hygiene, safe sexual practices, and psychological and emotional support, persons with HIV can enjoy a high quality of life for years after being diagnosed HIV positive.

ADPs, NOs, and other WV partners should do every thing they can to ensure that the life and productivity of people with HIV/AIDS are enhanced as much as technically, socially, financially, and humanly possible.

3.6 Material assistance

AIDS is an expensive disease. It reduces middle-income families, communities, and countries to poverty and brings the poor to the point of destitution. PLWHA are often the breadwinners of their families, and when they become too weak to work, there is often no one to support them. At the same time, their illness can increase their physical needs. For example, they may need food but be unable to prepare it.

ADPs, NOs, SOs, and their partners are encouraged to do everything possible to mobilise support for individuals, families, and communities in resource-constrained settings. Partnership building, networking, and advocacy can help ensure that those living with HIV/AIDS in resource-constrained settings get the support they need to live a dignified life.

4. CONCLUSION

The HIV/AIDS Hope Initiative provides an opportunity to sensitise families and whole communities against blaming people living with HIV/AIDS for the epidemic or regarding them simply as its helpless victims. Instead, PLWHA should be loved, supported, respected, and involved as valued partners in all aspects of HIV/AIDS prevention, care, and advocacy.

People living with HIV/AIDS need to accept themselves and reject the negative things said about them. What is true is that people living with HIV are potentially the most effective AIDS educators, counselors, campaigners, and caregivers in society. They need to be given the opportunity, support, and services needed to help them realise this potential.

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IV. DEVELOPING PARTNERSHIPS FOR HIV/AIDS RESPONSE IN THE ADP

A. NETWORKING FOR HIV/AIDS RESPONSE IN THE ADP

CONTENTS

1. Introduction
 - 1.1 Definitions and benefits of networking
 - 1.2 Who can ADPs network with?
 - 1.3 Networking beyond the ADP
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3. Dealing with challenges to networking for HIV/AIDS response
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I. INTRODUCTION

The magnitude of the HIV/AIDS crisis is unparalleled. The only way that ADPs can begin responding to this crisis at the scale required is through partnering with many other contributors to the fight against HIV/AIDS — including the government, the church, and other faith-based organisations (FBOs), NGOs, CBOs, businesses, and other institutions. This section of the toolkit provides a framework for ADPs to use in developing or strengthening networks with other partners involved in HIV/AIDS work.

1.1 Definition and benefits of networking

There is no single definition for the term ‘networking’. The definition from the International Council of AIDS Service Organisations’ HIV/AIDS Networking Guide is useful: ‘Networking is a process by which two or more organisations and/or individuals collaborate to achieve common goals’. This toolkit uses the term ‘network’ to refer to a set of organisations and/or individuals that join in collaboration to attain a common purpose. (1)

Many organisations and individuals are involved in HIV/AIDS networks because the problems and issues they face are too many and too vast for a single individual or organisation to handle. ADPs will be able to make a greater impact on HIV/AIDS in the community if efforts to address HIV/AIDS are conducted by many partners working together.

The benefits of networking for HIV/AIDS response in the ADP include:

- Creating effective referral systems for the benefit of vulnerable populations (orphans and vulnerable children, PLWHAs, children ages 5-15, etc.)
- Promoting effective wider coverage of area of operation
- Coordinating efforts and approaches to enhance quality and ensure efficient and effective service delivery
- Providing a forum for HIV/AIDS advocacy and coordinating lobbying on policies and other issues affecting people affected by HIV/AIDS at district and community levels
- Reducing duplicative efforts and the wasting of resources
- Promoting exchange of information, ideas, insight, experience, skills, and lessons learnt on HIV/AIDS and other issues
- Providing a sense of solidarity and mutual psychosocial support
- Broadening understanding on HIV/AIDS issues by bringing together different constituencies

- Assisting in resource mobilisation to scale up HIV/AIDS work
- Creating linkages between local communities and national and international partners involved in HIV/AIDS work

Networking means working with others to make the most of strengths and opportunities and to address weaknesses and barriers in responding to HIV/AIDS.

1.2 Who can ADPs network with?

This will depend on the ADP's needs, opportunities, and priorities. Those with whom the ADP may network on HIV/AIDS response include:

- Community leaders and members
- Other NGOs involved in work related to the ADPs
- Local churches and other FBOs
- Government ministries including health, agriculture, education, welfare, and community development
- Extension workers, social workers, local economic development officers
- Health facilities and workers
- Educational institutions
- Teachers and headmasters
- Traditional healers and birth attendants
- Traditional leaders
- Politicians
- Media organisations
- Groups of women, men, youth, and PLWHAs
- Service clubs (e.g. Rotary, Lions, etc.)

ADPs should make a special effort to network with district-level government agencies and coordinating committees, e.g. District HIV/AIDS Task Forces or Coordinating Committees. This will facilitate closer collaboration with other partners in the district.

Engagement at district level can also position ADPs to learn about and access the funds that are increasingly becoming available at district level to support HIV/AIDS response. These funds include those provided by governments; the World Bank; and the Global Fund to Fight AIDS, Tuberculosis, and Malaria. ADPs are strongly encouraged to advocate that substantial portions of this funding be provided to community based organisations, churches, and other faith-based organisations for their efforts to address HIV/AIDS. ADPs are also encouraged to strengthen the capacity of these CBOs and churches/FBOs to access, utilize, and report on these funds.

Identifying all the possible partners with whom to network is an important part of the situation assessment recommended to precede HIV/AIDS work in the ADP.

1.3 Networking beyond the ADP

Networking beyond the ADP will be critical to achieve some of the benefits listed above. Other NGOs and coalitions working on HIV/AIDS issues at national level can be important sources of ideas and information, and the ADP should be in communication with these partners so as to increase the impact of local networking. Linkages to national level organisations and coalitions can also help the

ADP to identify and access funds for its own work and for local-level partners, including CBOs, churches, and other FBOs.

Joining WV networks on HIV/AIDS-related issues (e.g. the partnership-wide HIV/AIDS policy and advocacy network that has recently started) is another important activity to consider and can often save time and energy. However, for the sake of consistency and coherence, it is advisable that membership of these networks be coordinated at the National Office level by the HIV/AIDS or Advocacy Coordinator.

Participating in national networks requires good communication between ADPs and the NO. ADP managers or CBO leaders need to be aware of groups that can take up issues for them at national level, and national office staff need to be aware of specific local issues to be raised at national level.

2. NETWORKING FRAMEWORK FOR ADPS

It may not be easy to network with all the organisations within an ADP because different organisations have different values, missions, approaches, and philosophies. ADPs need to consider these factors carefully before networking with any organisation. This section provides a framework to guide ADPs to begin or strengthen networking on HIV/AIDS. It may not be necessary for each ADP to work systematically through all the steps in the framework. This framework is intended to provide a list of options that ADPs can adapt to their context.

1. Define the ADP's and community's priorities for networking to address HIV/AIDS. This stage involves the ADP staff defining their HIV/AIDS priorities in collaboration with the community. (See part IV.C.3 of this toolkit for ideas about how to go about this.) Based on this definition, priorities that can best be addressed through networking and the creation of partnership can be identified.
2. Set goals for building a network. In this stage, an ADP develops the goals that it seeks to achieve through networking. For example, a prioritised challenge in the ADP could be training staff and community members in counseling skills. The goal for networking could therefore be, 'To work with partners who could provide counseling training for the ADP staff and volunteers'.
3. Select partners with whom to work. After setting the goals for networking, the ADP can decide which partners to work with to reach those goals. ADP staff can make an assessment of WV's current relationship with chosen partners, decide what they want to do accomplish through the partnership, and consider how to most productively network with new partners. In planning for networking, the ADP will need to think critically about the benefits and constraints of working with each current and potential partner.
4. Decide how to approach potential partners. The ADP is now ready to consider how to approach each partner. The ADP should decide on the best way to make an initial contact in order to create a good first impression. This involves choosing the appropriate team, which may be a combination of ADP staff and community members with whom the ADP works, to attend the initial meeting. The approach should be appropriate to the position and interests of the partner being approached. The ADP should find effective ways to communicate what it seeks to achieve and what it can contribute to the partnership or network.

5. Decide on the network activities. Networking activities around HIV/AIDS are diverse. ADPs may choose to network with several different partners or to be part of several different networks, according to community needs and priorities. Below are some of the activities of HIV/AIDS-related networking that an ADP can engage in:

- Information generation and sharing — it is important to exchange information on HIV/AIDS issues and analyse it to achieve common goals and objectives.
- Skills and capacity building — this can be through training or sharing of training materials. ADPs should identify partners to whom they can offer training or who can train them in specific relevant skills for HIV/AIDS competence.
- Creation of a referral system — different agencies have different specialisations. Networks should be sought for the purpose of creating a referral system in which particular services and resources can be made available to those who need them.
- Resource mobilisation — ADPs can work jointly with another agency for purposes of raising resources. This could be through joint proposal writing, etc.
- Advocacy — networking is a pivotal part of HIV/AIDS advocacy work. The ADP can identify advocacy issues and then partner with other agencies with similar advocacy interests. This may need to be coordinated at national level by the Advocacy Coordinator (if the country has one) or the HIV/AIDS Coordinator.

Network activities will vary from community to community; many can be added to the list above.

6. Establish ground rules/ working principles. After selecting the partner(s) and early in the relationship, it is important to spell out how the ADP will interact with each partner as they collaborate. Many organisations involved in networking have developed ground rules. Ground rules help create a safe space in which partners can work with each other. They help create and sustain an atmosphere of safety and mutual respect. In the ground rules, the ADP should define what it is bringing to the partnership/network, and the potential partners should also define what they are bringing to the network. These are some general suggestions for what to include in the ground rules:

- Attend and participate in all network meetings.
- Be on time for meetings.
- Come to meetings prepared to listen, ponder, debate, question, and contribute.
- Do not interrupt while people are speaking.
- By all means come with a point of view, but be prepared to change it if the evidence suggests change is in order.
- Show respect for each other. Challenge statements, not the person making them.
- To enable the creation of a safe space where everyone can participate equally, please consider the language you are using. Racist, sexist, or any other oppressive terms or behaviour are not appropriate.
- Respect the need for confidentiality. No information should be shared without the permission of the person who volunteered the information in the first place.
- Be prepared to act in the best interests of the total network, not just a single interest or organisation.

- Use your role in the network to build group strength and to facilitate decision making with which everyone can feel comfortable.
 - Once the network makes a decision, be willing to act as a spokesperson for the network as a whole and to explain and defend the final position of the group even if you originally objected.
7. Prepare a communication plan. One of the greatest challenges for networks is effective communication — the timely transmission and receipt of information among partners. It is best for all partners in a network to establish clear procedures for information to be circulated promptly to all those who need it to perform their functions effectively. Steps to ensure effective communication within the partnership include:
- Listing the key people in the network who are to receive communication
 - Deciding which of the network members involved in each task will have responsibility for communication among the people engaged in the task
 - Outlining who will receive specific communication when, who will be asked for feedback, and how to obtain the feedback (1)

3. DEALING WITH CHALLENGES TO NETWORKING FOR HIV/AIDS RESPONSE

ADPs may face a variety of challenges when networking for HIV/AIDS response. These include:

- Different attitudes and beliefs among partners
- Varied institutional policies and practices
- Difficulties of maintaining confidentiality
- Language used to describe HIV/AIDS work that may not be similar
- Competing priorities: partners might be more interested in addressing other issues than responding to HIV/AIDS
- Negative image or reputation of one or more partners that affects all partners
- Resentment about different levels of resources among partners
- Competition among NGOs in the community

These challenges can be overcome to an extent if the ADP gets to know and understand its partners. This can involve:

- Making a partner analysis to understand how the ADP and each partner view each other
- Identifying any differences between the ADP and each partner
- Finding ways of reducing misunderstandings and accepting differences
- Finding a basis for mutual respect for each other (2)

The process of building networks often does not go smoothly. Therefore it is important for all partners in the network to commit to maintaining communication and to finding constructive ways to address problems that arise.

4. MONITORING AND EVALUATION OF NETWORKING INITIATIVES

ADPs need to monitor and evaluate the performance of their networking efforts in order to assess progress and revise their plans as necessary.

Below is an example of indicators that can be used for monitoring and evaluation of networking initiatives.

Objective/Activity	Monitoring Process Indicators		Evaluation Effectiveness Indicators	
	Input	Output	Outcome	Impact
Share information and lessons learnt	# of staff, community members, and amount of resources committed	# of staff and community members accessing information	# of staff applying the lesson learnt	Incorporation or review of lessons learnt in plans
Conduct trainings in identified areas	-do-	# of staff or client trained in HIV/AIDS issues/skills	Improved skills in HIV/AIDS work	Improved quality of services delivered
Engage in HIV/AIDS advocacy issues	# of staff and community members involved	# of consultative meetings conducted	# of advocacy issues put on agenda	Advocacy issues that affect OVC and PLWHAs addressed
Create referral systems for care	-do-	# of clients referred for care	# of clients receiving care services	Improved quality of life for the clients
Procure HIV/AIDS materials/resources for reading.	-do-	Amount of materials procured	# of staff reading the materials	Increased knowledge and skills in HIV/AIDS programming
Mobilise resources for HIV/AIDS	-do-	# of proposals developed	Amount of resources mobilised for HIV/AIDS work	Scale up in HIV/AIDS work

5. REFERENCES

1. Kenya AIDS NGOs Consortium, *Networking Guide for NGOs, CBOs, and Religious Institutions*, Nairobi, Kenya 2000.
2. *The International HIV/AIDS Alliance: Building Partnerships*, London 2000.

B. PARTNERING WITH CHURCHES AND OTHER FBOs ON HIV/AIDS RESPONSE

CONTENTS

1. Introduction
 - 1.1 What does partnership mean?
 - 1.2 Why partner with churches and FBOs?
2. Church and FBO partnership framework for ADPs
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 - 2.2 Initial steps
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 - 2.4 Approaching potential partners
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 - 2.5.3 Other activities to consider
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Appendix I: Proposed model for church/FBO partnership in ADPs

I. INTRODUCTION

The Church is one of World Vision's primary partners in the fight against HIV/AIDS, and this calls for every NO, ADP, and WV staff member to develop partnerships with churches and church leaders. The Christian Witness policy on partnership states in part: 'World Vision will support strategies that support the church's role in witnessing to the gospel of Jesus Christ as good news for all people and especially witnessing through life, work, word, and sign among the poor'. One of the Hope Initiative's key programming principles is to empower, engage, and equip the local church as a primary partner, as well as other faith-based organisations (FBOs).

In many HIV/AIDS-affected areas, volunteers from churches and other FBOs are in the lead in helping families cope with HIV/AIDS, providing care and support for the sick, the widowed, and the orphaned. The church's potential to promote constructive behavior change for HIV prevention is under utilised. Equipping the church and other FBOs to expand and sustain their responses to HIV/AIDS is a major priority.

ADPs should seek partnerships with churches and FBOs for the purpose of:

- Catalysing the churches and FBOs to respond to HIV/AIDS in terms of prevention, care, and advocacy
- Making a significant contribution to the reduction of national HIV/AIDS prevalence
- Achieving measurable improvement in the lives of children affected by HIV/AIDS
- Encouraging the adoption of public policy and programs that will minimise the spread of HIV/AIDS and provide maximum care for those living with or affected by HIV/AIDS

This section of the toolkit is intended to help ADPs develop effective partnerships that will lead to effective mobilisation of churches and church leaders.

1.1 What does partnership mean?

Many WV staff have experience in building partnerships. This section aims to help them reach out to churches and FBOs in a planned and strategic way. Through building partnerships with churches and FBOs, ADPs can take part in a mutually enriching exchange of knowledge, skills, and resources. In this way, ADPs can increase the overall impact of their work in HIV prevention, care, and advocacy.

Different groups and organisations have defined partnership in different ways depending on their needs. There is no single correct definition of the concept. A definition that is general enough to cover a variety of relationships would be that partnership is a relationship in which two or more parties join together in mutual trust and share responsibility for combining skills and resources to achieve a common goal for the benefit and empowerment of those they serve. (Adapted from the East African Tearfund partners meeting report, 2001)

Effective partnerships have the following characteristics:

- The partners work closely together on a few carefully selected problems towards specific practical goals. Partnering is different from public relations or networking, in which activities are likely to be broader and less deep.
- The involved parties share a common goal based on similar values.
- The involved parties have a clear understanding of each other's identity and values because they have taken adequate time to get to know each other.
- The partners are able to focus on a common cause while retaining their individual identities and values.
- The partnership is planned for the long term (though this can vary according to what the partners need to accomplish).
- The partnership includes mutual trust, shared responsibilities, and the pooling of resources for mutual benefit, as opposed to a giver-receiver relationship, which can be controlling and dependent.
- The partnership is as equal as possible to preserve the dignity and independence of each partner.
- The partnership focuses not on finances but relationships. In view of this, it is possible to have a partnership without any financial implication, for instance standing together in solidarity for a common cause.
- All issues in the common agenda have been clarified from the beginning, so that the partners have realistic expectations of each other.
- The partnership is not an end in itself but a means for taking effective action.

1.2 Why partner with churches and FBOs?

By building partnerships with churches and FBOs, ADPs can widen and sustain the impact of their work and assist churches and FBOs in strengthening their response to HIV/AIDS. The benefits for both ADPs and churches in partnering with each other include:

- A wider response, potentially involving:
 - Sunday schools
 - Youth groups
 - Mothers' Unions/Women's Fellowships
 - Fathers' Unions/Men's Clubs
 - Choirs
 - Church-run health units
 - Social security initiatives such as Women of Vision in World Vision US
- A more coordinated and continuous response, including a better referral system. This may include HIV/AIDS programming that addresses church members at each stage of their lives, from childhood through puberty, marriage, and parenting.
- Better support and policies for people living with HIV/AIDS, for example:
 - Abolishing of compulsory pre-training HIV testing for church leaders
 - Creating post-HIV test clubs
 - Bringing about better attitudes and a better working environment for HIV-positive church leaders and Christians
- More financial and technical support
- Stronger services and increased access for vulnerable communities
- More effective and creative HIV/AIDS programs

Through partnership with Stromme Foundation, UNFPA, and Christian AID, the Diocese of Namirembe was able to attract over 600 million Uganda shillings to bridge its local resource gaps for HIV/AIDS prevention and care over a seven-year period. Other churches and faith-based organisations have been able to raise even more funding through partnerships.

Many health units run by faith missions in Uganda and Zambia have been constructed and run with support from partnerships. These health units (most of them found in rural areas) have been pillars in providing support services, including:

- Treatment of opportunistic infections
- Voluntary counseling and testing
- Support of home based care
- Referral services

Along with partnering with individual churches and FBOs in the communities where they work, ADPs should coordinate with NO efforts to partner with national church leaders. If NO staff know what is happening in individual communities, they can both advocate for national support for the local efforts and use local success stories to further national partnerships.

2. CHURCH AND FBO PARTNERSHIP FRAMEWORK FOR ADPS

2.1 Preliminary questions

The following questions are intended to assist ADPs in preparing to initiate or expand partnerships with churches and FBOs:

- What are the major strengths, weaknesses, opportunities, and tensions or threats of working in partnerships?
- Given the answers to the above question, how can parties working in partnership make the approach effective?
- On the basis of the ADP's current relationships with churches and FBOs (if they exist), are the churches/FBOs and ADP in partnership? If not, why not?
- What gaps (if any) exist between the ADP's current relationships with churches and FBOs and what an ideal partnership should be?
- What needs to be done by all the parties to address these gaps?

As ADPs endeavour to build partnerships, they should reflect on the following questions.

- What kind of contribution can the community churches/FBOs make towards HIV/AIDS prevention, care, and advocacy?
- What kinds of skills and resources can be accessed through working with local churches/FBOs on HIV/AIDS prevention, care, and advocacy?
- What kinds of skills and resources can the ADP offer to churches and FBOs to support their response to HIV/AIDS?

2.2 Initial steps

1. Define the ADP's and community's priorities for church/FBO involvement in addressing HIV/AIDS. This stage involves the ADP staff defining their HIV/AIDS priorities in collaboration with the community. (See part IV.C.3 of this toolkit for ideas about how to go about this.) Based on this definition, priorities that can best be addressed through partnership with churches and FBOs can be identified.
2. Set goals for establishing partnership with church/FBOs. In this step, the ADP develops the goals that it seeks to achieve through partnering. For example, a prioritised challenge in the ADP could be low response to HIV/AIDS due to limited information and skills among churches/FBOs. The goal for partnering could then be to educate the church/FBO on HIV/AIDS issues or to train church/FBO leaders in pastoral care and counseling for people living with HIV/AIDS.
3. Identify churches and FBOs in the area. The ADP staff might begin with churches that they identify with in terms of membership or leaders to whom they have access.

2.3 Selecting potential partners

To select potential partners, it is advisable to conduct an assessment of the churches/FBOs present in the ADP. In order to do so:

1. Make a list of potential church/FBO partners in your area.
2. Grade the list using categories like most important, important, and not very important.
3. For the potential church/FBO partners listed in the 'most important' category, list the strengths, opportunities, weaknesses, and barriers of the potential partnership.

The ADP can then decide which partners to work with to reach its goals. It can make an assessment of its current relationship with potential partners and consider how the various parties could collaborate to meet mutual objectives. The ADP should also think critically about the benefits and constraints of working with each current and potential partner.

The following are groups to consider prioritising when choosing partners:

- Churches and FBOs that are already involved in HIV/AIDS-related activities
- Churches and FBOs in strategic locations in the ADP
- Churches and FBOs that have initiated requests for partnering in response to HIV/AIDS

2.4 Approaching potential partners

Church/FBO leaders from all faith communities are key door openers or agents of change for compassion, care, support, and prevention within communities. It is therefore essential to mobilise them to become ambassadors for the fight against HIV/AIDS within the churches/FBOs and their wider spheres of influence. Both men and women leaders should be approached so that the needs of all parts of the congregation will be addressed.

Church and FBO leaders can be approached through small meetings between ADP staff and the leaders of an individual church or FBO and/or through larger meetings of church/FBO leaders in the ADP area.

2.4.1 *Small meetings with individual churches/FBOs*

Initial contact will often be made through an introductory visit. The impression this visit makes will play a large part in determining the success of establishing the desired partnership. The visit should target the leadership of the church or FBO. The ADP staff should be willing to listen and learn as they present their agenda. The staff should come in with some basic background information about the potential partner being visited but should also use this visit as an opportunity for gathering further information about the stance of the church or FBO on HIV/AIDS and what if any interventions the church/FBO is undertaking. Raising these questions will help highlight any gaps in HIV/AIDS response and suggest issues for dialoguing. The ADP should be ready to explain what it would like to achieve and what it can bring to the partnership.

2.4.2 Area-wide meetings for church/FBO leaders

ADPs may also want to consider inviting all of the church/FBO leaders in the area to a meeting to share issues related to HIV/AIDS in their congregations and communities. This meeting could include the following elements:

- Facts about HIV/AIDS
- Information about the impact of HIV/AIDS on the church/FBO family and wider community
- Case studies and success stories illustrating how churches/FBOs have responded to HIV/AIDS
- Possible intervention options

The ADP should follow up with interested churches/FBOs while continuing to encourage other churches/FBOs to participate. This will ensure prioritisation of the most interested and committed churches/FBOs, based on self-selection rather than the external selection of individual churches/FBOs.

2.4.3 Mobilising congregations

Following meetings with church/FBO leaders, the next steps should focus on mobilising and equipping committed leaders and their congregations to respond to HIV/AIDS. One way to do so is through addressing church/FBO members directly by:

- Seeking an audience with entire congregations through their leadership on the days they meet, e.g. Sundays
- Bringing in an openly HIV-positive speaker to give personal testimony of the impact of the epidemic
- Providing information on the general trends of HIV/AIDS
- Providing information on what is being done by churches/FBOs elsewhere. Use case studies and describe the impact of these interventions
- Describing intervention options that could address HIV/AIDS-related problems in the community

Another good way to mobilise congregations is by organising a workshop for representatives of multiple interested congregations. Selection of the right people to attend this workshop is crucial for the success of this project. Both men and women should be included. Six key representatives may be selected from a maximum of five congregations. These people must be able to initiate and steer a congregational AIDS action group after the workshop. They must also represent the different ministries within the congregation.

The topics covered by congregational workshops typically include the following:

- Sharing up-to-date epidemiological data on the epidemic and its impacts
- Providing in-depth information on the transmission of HIV, its prevention strategies, treatment options, etc.
- Introducing participants to HIV infected and affected people who share their life stories with the group
- Explaining the emotional phases and needs experienced by people living with HIV as the illness progresses, if possible facilitated by a PLWHA

- Providing a strong theological message about God’s calling on His Church in the age of HIV/AIDS, which could guide them in a pastoral approach to HIV/AIDS in their sermons and ministry
- Introducing them to NGOs, CBOs, and other churches/FBOs that are already engaged in different HIV/AIDS responses, and that can share the needs of the communities they work in
- Providing enough time for participants to plan what can be done at local level

Plans made at the workshop need to be translated into action. Over the next months these congregation members, in collaboration with their leaders, should implement their plans in their congregations and community. They are encouraged to link these projects to every existing ministry of the congregation so as to create a wider support base, but also to develop new initiatives as they are confronted with new needs.

Follow-up by the ADP is necessary to monitor what congregations are doing and examine challenges faced in the implementation process to provide technical support where necessary.

2.5 Deciding on activities

2.5.1 Making an inventory of current and planned HIV/AIDS programming

There are a wide variety of activities that ADPs may choose to undertake in partnership with churches and FBOs. To choose between them, the ADP might start with making an inventory of its current and planned HIV/AIDS activities to determine which could be strengthened by forming partnership with churches or FBOs.

The chart below can be used for the ADP to list its existing and planned activities in prevention, care, and advocacy and describe what kind of church/FBO partnerships might complement or strengthen its work.

TYPE OF HIV/AIDS RESPONSE	EXISTING/PLANNED ACTIVITIES	POSSIBILITIES FOR PARTNERSHIP	BENEFITS/COSTS OF PARTNERSHIP
Prevention			
Care			
Advocacy			

2.5.2 Building the capacity of churches/FBOs

As ADPs seek to partner with churches/FBOs, they should bear in mind that meaningful partnership should include building the capacity of those with whom they seek to partner. The church/FBO leaders in the areas where ADPs work often have limited capacity to address HIV/AIDS effectively. ADPs may consider building capacity in the following areas.

1. General organisational skills such as:

- Proposal writing
- Strategic planning
- Financial planning, including records and bookkeeping
- Group work dynamics
- Action planning
- Report writing
- Monitoring

2. Theological skills such as:

- Developing an overall HIV/AIDS congregational response
- Clarifying theological messages relating to HIV/AIDS
- Integrating HIV/AIDS into worship and liturgy
- Biblical leadership, including how to lead a Bible study focused on HIV/AIDS

3. Service provision skills such as:

- Home based care
- OVC care
- Spiritual and psychosocial counseling

2.5.3 Other activities to consider

The following are other activities ADPs may want to consider undertaking with the churches and FBOs with whom they partner:

- Information generation and sharing — it is important to exchange information on HIV/AIDS issues and analyse it together to define common goals and objectives.
- Working through congregation-based social groups, e.g. women's groups, youth groups, singles clubs
- Forming HIV/AIDS-focused groups, such as home based care teams
- Creating a referral system:
 - Finding out what services are available to people affected by HIV/AIDS at the church
 - Informing the church of community services to which they can refer people affected by HIV/AIDS
- Resource mobilisation — churches/FBOs and ADPs can work together to provide material support to those affected by HIV/AIDS
- Advocacy — the ADP and churches/FBOs can identify advocacy issues on which to partner.

An example of partnership for HIV prevention

An ADP wants to prevent the spread of HIV/AIDS among young people in a particular village. Through one of its programs, the ADP works directly with young people in schools so that they get the help and information they need to reduce their risk of HIV infection.

Through partnerships with a church and a mosque in the area, the ADP staff works with religious leaders to:

- Target young people who are not in school through the church/mosque structures of Sunday school, youth fellowships, and Madrasa
- Improve parent-to-child communication on sexual health issues through church/mosque groups for women and men
- Subsidise and bring VCT services into the community
- Treat sexually transmitted infections through a church-run/mosque-supported health unit
- Encourage life skills programs that are value-based

The following are activities that might be undertaken at the local congregation level with the support of the ADP:

- Child-to-child peer education through the Sunday school
- Youth-to-youth peer education and influence through youth fellowships
- Subsidised and facilitated access to VCT for youth intending to get married
- Post-HIV test clubs for positive living and awareness raising
- Training for positive parenting
- Home based care for the terminally ill
- Care and support of OVC through parent/guardian fellowships or clubs
- Promotion of secure household incomes and nutrition through innovative activities
- Support for opportunistic infections treatment and antiretroviral treatment referrals
- Integration of HIV/AIDS issues into worship (music, sermons, testimonies, prayers, poems, drama, etc.)
- Visits from other churches or organisations who can share experiences responding to HIV/AIDS

2.5.4 Providing direct funding to churches/FBOs for HIV/AIDS response

Churches are often as poor as the communities they serve. Very few have assistance from their mother bodies/headquarters. ADPs should therefore consider providing start up funds for certain interventions that require a financial investment for them to take off.

Below are criteria to consider when assessing applications from churches/FBOs for funding for an HIV/AIDS response:

- Is the church/FBO already doing something about the situation?
- Does the church/FBO have clear goals and objectives?
- Does the church/FBO have enough membership willing to work in voluntary service?
- Has the church/FBO demonstrated the capacity to manage the program?
- Will the project be able to sustain itself after a period of time?

2.6 Ground rules and communication

After selecting the partner(s) and early in the partnering relationship, it is important to address the issues of how the ADP will interact with each partner as they collaborate. The ADP and the church/FBO should work together to develop guiding principles or ground rules. Ground rules help create a safe space in which partners can work with each other. They help create and sustain an atmosphere of safety and mutual respect. In the ground rules, the ADP should define what it is bringing to the partnership and the church or FBO should also define what it is bringing to the partnership. These are some general suggestions for what to include in the ground rules:

- Attend and participate in all network meetings.
- Be on time for meetings.
- Come to meetings prepared to listen, ponder, debate, question, and contribute.
- Do not interrupt while people are speaking.
- By all means come with a point of view, but be prepared to change it if the evidence suggests change is in order.
- Show respect for each other. Challenge statements, not the person making them.
- To enable the creation of a safe space where everyone can participate equally, please consider the language you are using. Racist, sexist, or any other oppressive terms or behaviour are not appropriate.
- Respect the need for confidentiality. No information should be shared without the permission of the person who volunteered the information in the first place.
- Be prepared to act in the best interests of the total network, not just a single interest or organisation.
- Use your role in the network to build group strength and to facilitate decision making with which everyone can feel comfortable.
- Once the network makes a decision, be willing to act as a spokesperson for the network as a whole and to explain and defend the final position of the group even if you originally objected.

One of the greatest challenges for networks is effective communication — the timely transmission and receipt of information among partners. It is best for all partners in a network to establish clear procedures for information to be circulated promptly to all those who need it to perform their functions effectively. Steps to ensure effective communication within the partnership include:

- Listing the key people in the network who are to receive communication
- Deciding which of the network members involved in each task will have responsibility for communication among the people engaged in the task
- Outlining who will receive specific communication when, who will be asked for feedback, and how to obtain the feedback

3. DEALING WITH CHALLENGES OF PARTNERING WITH CHURCHES/FBOS FOR HIV/AIDS RESPONSE

ADPs may face a variety of challenges when partnering with churches/FBOs for HIV/AIDS response. These may include:

- Different attitudes and beliefs among partners, including different beliefs about how to reconcile HIV/AIDS with God's plan, the acceptability of condoms as a prevention device, the balance between judgment and forgiveness when dealing with extramarital sex, etc.
- Lack of visibility of HIV/AIDS in a community: a great deal of denial may still be prevalent among Christians and church leaders. Even though many church members are dying, HIV/AIDS often remains 'invisible' since people are afraid to disclose their HIV status. On the other hand, where it is 'visible', they may want to cover it up
- Different levels of comfort when discussing HIV/AIDS and risk behaviours associated with it
- Institutional policies and practices that resist change. Churches/FBOs may tend to uphold familiar beliefs, practices, and institutional policies unless they are convinced otherwise. They may play a role in upholding traditional practices and societal norms, such as the subordination of women or the condemnation of those who are HIV-positive, which make HIV/AIDS responses more difficult.
- Difficulties of maintaining confidentiality
- Difficulties with language, concepts, and jargon: the language used to describe HIV/AIDS work may not be familiar or consistent in different churches/FBOs
- Competing priorities: churches and FBOs might be more interested in addressing other issues than responding to HIV/AIDS
- Subject fatigue: churches/FBOs may feel they know enough about HIV/AIDS and be reluctant to listen or participate in HIV/AIDS-related activities
- Limited capacity on the part of the churches/FBOs to skillfully conduct an HIV/AIDS response
- Limited resources and time and other pressing priorities on the part of both the church/FBO and the ADP
- Unwillingness on the part of churches/FBOs to work with the ADP based on previous experiences or WV's reputation
- Misperceptions on the part of the church about the ADP's resources: churches/FBOs may underestimate or overestimate what the ADP can do
- Competition among NGOs: partnerships can create an atmosphere of tension or mistrust among competing NGOs, CBOs, and other implementing agencies in the area

Many of these challenges can be overcome with patience and careful planning and communication. Some strategies for addressing these challenges include:

- Searching for common ground with potential church/FBO partners. If the church/FBO and ADP cannot agree on joint prevention efforts, perhaps they can agree on helping each other care for children made vulnerable by HIV/AIDS. It is not necessary to agree on everything, only on the goal that will be worked towards together
- Accepting and where appropriate respecting the church/FBO's differences
- Developing presentations about the causes and effects of HIV/AIDS in language that church and FBO leaders can relate to
- Working patiently and creatively to help church/FBO leaders understand the magnitude of the HIV/AIDS crisis and the importance of addressing it openly

- Embracing the opportunity to support people in churches and FBOs as they confront their prejudices and uncertainties about HIV/AIDS so that they are equipped to speak openly and confidently add their voice to the call for compassion and action
- Bringing openly HIV-positive speakers, including HIV-positive clergymen and women, to address religious congregations
- Challenging traditional practices and norms indirectly, by showing how certain practices or attitudes have negative effects on members of the church or FBO
- Helping churches and FBOs respond more effectively to HIV/AIDS by providing them with necessary skills and resources. The accusation sometimes heard that churches/FBOs are refusing to co-operate in HIV/AIDS-related work is probably not accurate. They may simply require training and support
- Being as clear as possible about what kinds of assistance WV can and cannot provide
- Keeping the lines of communication open to address misunderstandings
- Nurturing an atmosphere of cooperation and mutual support

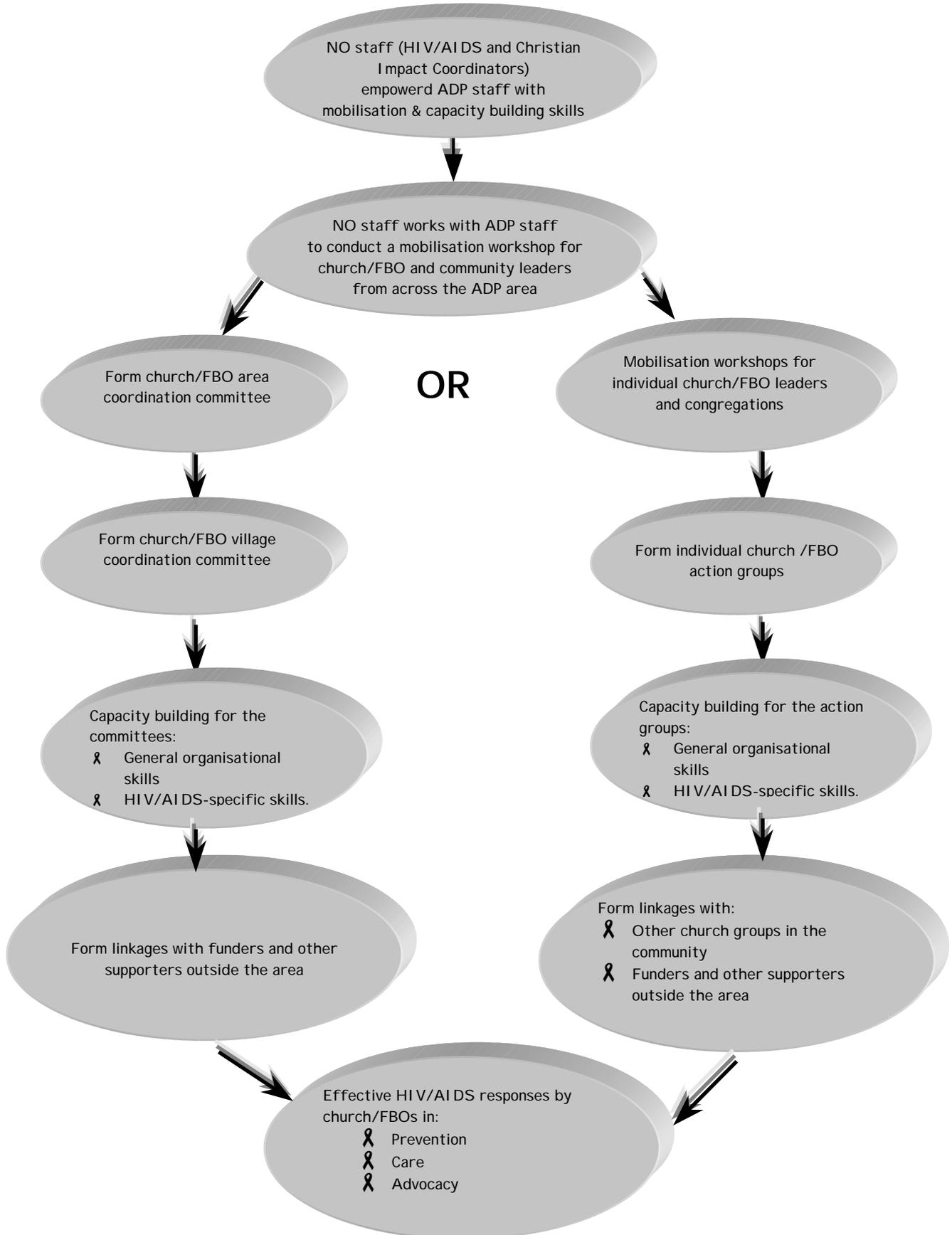
4. MONITORING AND EVALUATION OF CHURCH/FBO PARTNERSHIPS

ADPs need to monitor and evaluate the performance of their partnerships with churches and FBOs in order to assess progress and revise plans as necessary.

The chart below provides examples of indicators that can be used to monitor and evaluate ADP partnerships with churches and FBOs.

Objective/Activity	Monitoring Process Indicators		Evaluation Effectiveness Indicators	
	Input	Output	Outcome	Impact
Share information about HIV/AIDS and lessons learnt by the ADP staff with leaders of churches/FBOs in the ADP	# of churches/FBOs visited and amount of resources committed to communication	# of church/FBO leaders accessing information and adapting it	# of churches/FBOs applying the lessons learnt	Incorporation of new lessons learnt in new HIV/AIDS initiatives
Conduct trainings in identified areas for church/FBO responses to HIV/AIDS	-do-	# of church/FBO leaders trained in HIV/AIDS issues and skills	# of church/FBO members showing improved skills in HIV/AIDS work	Improved quality of services delivered
Engage churches/FBOs in HIV/AIDS advocacy issues	# of church/FBO leaders and members involved	# of consultative meetings involving churches/FBOs conducted	# of advocacy issues put on agenda among churches/FBOs	Advocacy issues that affect OVC and PLWHAs addressed
Refer people affected by HIV/AIDS to churches/FBOs for care	-do-	# of clients referred to churches/FBOs for care	# of clients receiving care services from churches/FBOs	Improved quality of life for the clients
Church-based HIV/AIDS best practices documented as a result of partnering	# of ADP staff and churches/FBOs involved	Amount of materials developed and procured	# of churches/FBOs reading and using the materials for improving their responses	Increased knowledge and skills in HIV/AIDS programming
Mobilise resources for HIV/AIDS.	-do-	# of proposals developed	Amount of resources mobilised for HIV/AIDS work	Scale up in HIV/AIDS work

Proposed model for church/FBO partnerships in ADPs



V.A. PREVENTION

World Vision recognises HIV prevention as an integral part of an effective HIV/AIDS response. World Vision has prioritised three target groups for its efforts to promote HIV prevention: children aged 5-15 years, pregnant and lactating mothers, and high risk groups.

World Vision's Policy Statement on Abstinence, Fidelity, and Condom Use

Scripture teaches us that God intended marriage as a sacred relationship between a man and a woman with sexual relations as a gift to be enjoyed within the context of marriage. In accordance with Scripture, WV advocates for and strongly encourages sexual abstinence outside of marriage and fidelity within marriage.

The Scriptures also teach us of the sanctity of life: God highly values each individual life and instructs us to do all we can to preserve and enhance life. In regards to HIV/AIDS, it has been demonstrated that when used correctly and consistently, condoms can be an effective barrier to the transmission of the deadly HIV virus. Therefore, WV encourages the use of condoms as a means of preserving and protecting life.

In summary, WV promotes abstinence and fidelity — not just as protection against HIV/AIDS, but because it represents God's intended means of sexual and marital wholeness and fulfilment. In addition, WV supports the use of condoms as a practical step to reduce the transmission of HIV and its deadly impact on human life.

A.1. PREVENTION FOR CHILDREN AGED 5-15

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Appendix 1: Case studies

Case study 1: Youth Activists Organisation (Zambia)

Case study 2: Adolescent Friendly Reproductive Health Services (Uganda)

Appendix 2: Model pre-tests and post-tests

I. INTRODUCTION

I.1 Overview

Young people are particularly vulnerable to HIV/AIDS because many become sexually active before they have the knowledge and maturity to protect themselves from infection. Even adolescents with some understanding of HIV transmission may not connect this knowledge with their own behaviour. Young people are also in particular danger of HIV infection because the AIDS pandemic has dramatically increased their social and economic vulnerability, depriving them of parental guidance and exposing them to sexual exploitation and abuse. Substance abuse and gender inequalities add to the problem. Yet it is also young people who offer the greatest hope for changing the course of the HIV/AIDS epidemic, if given the tools and support. (1)

World Vision has identified children aged 5-15 as a *window of hope* for HIV prevention. This group is generally not yet sexually active and has among the lowest HIV/AIDS prevalence rates in the overall population. The goal of the Hope Initiative is to reach children in this age group with value-based and age-appropriate information about the prevention of HIV/AIDS. This education will give them the opportunity to develop healthy attitudes and behaviours before they are exposed to the sexual pressures of adolescence and lay the foundation for minimising HIV risk in adulthood. To date, very little prevention work has targeted this age group. World Vision has a major challenge in this area. It is an opportunity that must be taken.

I.2 Types of HIV prevention programs for children aged 5-15

Projects designed to prevent HIV infection among children aged 5-15 can be categorised in two groups, in-school and out-of-school.

1.2.1 In-school prevention programs

Schools are a key location for HIV prevention efforts because they provide a means of maximising the number of children reached with minimal resources. A study conducted by the University of Sussex in February 2002 in Uganda, Botswana, and Malawi recommended that a full-time Sexual and Reproductive Health (SRH) life skills teacher be employed and that the topic be included from the beginning of primary education. It also recommended that for older children, in addition to abstinence the role of other preventive methods such as condoms should be included. (2)

1.2.2 Out-of-school prevention programs

Many children in ADPs are out of school and will have to be reached innovatively. Churches, FBOs, traditional leaders, and youth clubs are potential partners in this area. Children can also be reached through special events like sports activities and drama performances in the communities. These events could be deliberately targeted towards children who are out of school.

1.3 Involving family members, teachers, and church leaders

Programs targeting children in and out of school need the support of the family and community if they are to be effective. If in-school programs are to make a difference, they need to receive support in the home. Parents and families can supplement information provided in the program and reinforce healthy attitudes and behaviour. Children out of school are even more dependent upon family and community reinforcement of prevention messages.

1.3.1 Encouraging acceptance of HIV education in the community

One challenge that ADP workers may encounter is resistance on the part of parents and community leaders to providing sex and HIV education before a child is sexually active. Some hold the mistaken belief that HIV prevention information encourages sexual activity in young people. Yet studies that compare groups of young people who received such education with others who did not show that sex and AIDS education do not promote earlier or increased sexual activity. On the contrary, sex education may delay sexual debut and cause those who are already sexually active to practice safer sex. Studies have also shown that education programs that promote both postponement of sexual activity and safe sex are more effective than those promoting abstinence alone. By emphasising that sexual love is a gift from God to be shared in marriage, World Vision encourages abstinence and fidelity. This message ensures that sex and HIV education will not be interpreted as a license to sexual activity.

Involving parents from the beginning is one way of easing possible resistance in the community, and has the added benefit of promoting ties between families and schools on other issues. The need for preventive education before children become sexually active should be explained to family members. They usually need reassurance that sex education does not encourage sexual experimentation in adolescents, but instead makes them aware of the risks involved. Most parents are favourable to programs to prevent HIV once they understand the threat that AIDS poses to their children.

1.3.2 Ways to involve parents and family members

- Parenting programs, which give 4-5 days training to parents, can be instrumental in helping parents get the skills to enable children to develop positive values. Scripture Union in Uganda provides a curriculum for such training (see 2.3 below).
- When schools offer HIV prevention programs, parents can be informed in writing about the program. They can also be invited to attend a meeting with the teacher or school head to discuss the program, look at the materials, and ask questions.
- Parents can be invited to the school for a show of prevention-related projects, a short play, role-play sessions, puppet shows, etc.
- Parents can be invited to religious or political gatherings and other community events, where leaders are present to discuss the best way to protect their children from AIDS.
- Children can be encouraged to ask parents questions about dating and their experiences with the opposite sex when they were young.

- A parents' guide can be prepared and distributed. This would provide basic information about HIV/AIDS and the extent of the problem in their country, particularly among young people. It can include an outline of the curriculum being implemented in the community and advice on how parents can best help their children learn responsible behaviours and ways to protect them.

1.3.3 Ways to involve teachers and school authorities

- Where schools have an HIV prevention curriculum already in place, World Vision can support prevention messages by training peer educators and organising extra-curricular activities such as drama activities and debates.
- Where schools do not have an HIV prevention program, World Vision can advocate for the introduction of such a program, provide education sessions for teachers and school authorities, introduce a life skills curriculum (see 2.1 below), and provide teacher training.

1.3.4 Ways to involve church leaders

- ADP workers can meet with church leaders and offer support for prevention efforts already underway.
- World Vision can encourage church leaders to include prevention messages in sermons, Sunday school classes, and special presentations.
- World Vision can help churches access HIV prevention curricula.
- Churches can be encouraged to hold special events, such as choir festivals, to encourage HIV awareness.

1.3.5 Involving other adults

One of the issues that is frequently raised in meetings with young people is their need for opportunities to discuss problems with concerned adults, since often they cannot or do not want to discuss sexual issues with parents or family members. Schools, churches, or other groups may organise training sessions in counseling techniques for parents, teachers and, other community members. The expertise may come from health professionals, religious organisations, NGOs, or social workers. Training should cover HIV/AIDS and STIs, pregnancy, sexual abuse, and drug use. After training, the volunteers can be made available for 2-3 hours per week on a roster basis. Students should be able to visit these counselors with the complete assurance of confidentiality.

2. PROGRAMMING OPTIONS FOR HIV PREVENTION AMONG CHILDREN AGED 5-15

2.1 Life Skills Training

In schools, life skills can be taught as a separate subject or topic or as an extra-curricular activity, or be incorporated into different subjects. Life skills provide the foundation that will enable children and adolescents to take decisions to protect themselves. After reviewing many different life skills curricula, World Vision recommends the use of materials developed by Scripture Union. These are value-based, Biblically sound, and appropriate for the target age groups.

The Scripture Union curriculum for training children is referred to as *Adventure Unlimited* and the curriculum focused on adolescents is referred to as *Choose Freedom*. The topics addressed in these curricula include:

- Self-image and self-esteem
- Communication with family members, peers, parents, etc.
- Decision-making consequences
- Sexuality
- Romance without regret
- Importance of family
- Negotiation skills

The Youth Alive Christian ministry, which also focuses on children and adolescents, has added a *Behaviour Building Model* to the Scripture Union curriculum. In this model, children are encouraged to identify their values, which usually include honesty, fear of God, self-discipline, and love. These values are clarified through discussion and applied to the children's relationships with family members, peers, teachers, and themselves. These values are shown to influence children's attitudes towards other people, and these attitudes are in turn shown to influence children's behaviour. Throughout the process, Youth Alive trainers endeavor to act as friends to the children, encouraging them to open up and share even the most private aspects of their lives. Normally, this training takes five days for a class of 50 children, categorised in age groups of 7-10 and 11-15 years.

The purposes of the life skills taught by Youth Alive are to:

- Prepare the child to handle her or his present and future (teenage) life
- Encourage both girls and boys to appreciate themselves
- Help children understand what is expected of them
- Help children identify what they want to be and guide them on what they can do to achieve their goals
- Equip them with skills in praying for themselves, their parents, and others

In Zambia and Uganda, World Vision is partnering with trainers from Scripture Union and Youth Alive to train all primary school teachers in ADPs on how to equip their students with life skills, using the *Adventure Unlimited* curriculum. Copies of the *Adventure Unlimited* curriculum will be reproduced and distributed to all ADPs across Africa for use in training primary school teachers, in order to achieve the FY03 and FY04 goals for HIV prevention.

2.2 Peer Educators

Peer educators and counselors typically have backgrounds similar to those of their young clients. They are not professionals, but they are trained to assist young people who need reproductive health information and services. Peer educators receive special training in decision-making, client referrals, and in providing commodities or services. In recognition of the work they do in motivating young people to obtain the information and services they need, peer educators and counselors are sometimes called 'peer promoters.'

Peer promoters usually work with participants in one-to-one or small group settings. But they often have other responsibilities. They make presentations in front of large groups, represent the organisations they work for on boards and councils, and consult with program managers. Peer projects are often part of larger programs that have added a youth-to-youth outreach component. At times, they operate as independent projects.

A peer educator is a student who is selected for his or her leadership potential. He or she is trained to help other students learn through demonstrations, listening, role-playing, encouragement, giving feedback, and supporting healthy decisions and behaviour. Program designers and teachers should bear in mind that peer leaders may be used for any of these activities — whenever they feel this would be useful and appropriate.

Many successful programs have involved peer leaders. Studies have shown that:

- Young people are likely to model their behaviour on that of well-liked or respected peers.
- Young people are more likely to listen to what respected peers say.
- Peer leaders who exhibit healthy, responsible behaviours can positively influence the behaviour of other peers.
- Peer leaders can support, encourage, and help their peers both inside and outside the classroom.
- Peer leaders can help the teacher in the classroom.

Training should ensure that the peer leader:

- Understands the purpose of the HIV/AIDS and STI program and the importance of the peer leader's role
- Is a good listener, provides feedback, and is able to understand the feelings of peers
- Has the ability to help small groups of students operate effectively and to solve problems when they arise
- Has the skill to help the teacher and students with the more difficult activities
- Knows the resources for information and counseling so that students can be referred for appropriate help

2.3 Strengthening parenting/guardian skills

An important way of promoting HIV prevention among children aged 5-15 is to strengthen the skills of their parents and guardians. Children are exposed to sexual messages from an early age, and some have been sexually abused. Parents have an important role as the first educators of their children. However, in most cultures, sex is not openly discussed between children and parents or adults generally. There is a need to help parents appreciate the importance of discussing sex with their children and to provide them with the information and skills they need to do so. ADPs can help parents answer their children's questions and give them values-based direction.

Scripture Union in Uganda has developed a parenting program that helps bridge the gap between parents and children. This program, called *Positive Parenting*, offers several manuals to strengthen the relationship between parents and children. The aim of the study is to provide parents with new skills of parenting, thereby making issues of sexuality easier to discuss than they might otherwise be.

The 4-5 day positive parenting training addresses the following topics with parents/guardians:

- Confident children — explains how to raise confident, not fearful, children
- Discipline for freedom — highlights the difference between battering and discipline
- Family fun — encourages fun in the home setting so that children will not need to look for fun elsewhere
- Communication — teaches that communication is the essence of every relationship, including that between parent and child
- Praying for children — encourages parents to acknowledge that children are a gift from God and that He has complete control over them
- Dealing with teenagers — enables parents to realise that as children grow, their needs change. They turn to their peers for comfort, security, etc., but parents can still find ways to fit into the picture
- Sensible sexuality — teaches parents to help children discover themselves and to safely deal with the knowledge of this aspect of their lives
- How to help children study — equips parents to help children with their schoolwork from an early age
- Making the most of your time — helps parents set priorities and make time for their children and themselves

A group study guide is also available, with a more participatory approach.

2.4 Discouraging harmful traditional practices

In some communities, children in the 5-15 age group are made vulnerable to HIV infection by traditional practices meant to initiate them into adulthood. These practices include:

- Female genital mutilation (FGM)
- Initiation rites involving cutting or sexual activity
- Early marriages

ADPs can work against these practices by:

- Building relationships with traditional leaders
- Educating traditional leaders about HIV prevalence in the community and modes of infection
- Advocating to make harmful traditional practices safer
- Advocating to end harmful traditional practices

3. DESIGN AND IMPLEMENTATION OF HIV PREVENTION PROGRAMMING FOR CHILDREN AGED 5-15

3.1 Assessing the situation

The following are key questions to ask when conducting a situation assessment for HIV prevention programming:

- How much knowledge and understanding do children in the community have of HIV/AIDS?
- What community practices make children aged 5-15 most vulnerable to HIV/AIDS? (Possible examples: early sexual debut, sexual abuse, disempowerment of girls, harmful traditional practices)
- Does the school curriculum include HIV prevention information for children aged 5-15?
- Do churches, FBOs, youth clubs, or other groups provide HIV prevention information for children aged 5-15?
- What kind of support is there among parents, church leaders, and community leaders for HIV prevention education?

It will also be helpful to have an idea of the HIV prevalence rates among adolescents in the community, to cite when advocating for expanded HIV education, and to know what percentage of children are in school, to consider when planning in-school and out-of-school interventions.

This information can be collected through individual interviews, group discussions, and small surveys with the following constituencies:

- Children aged 5-15
- Parents and guardians
- Parent-teacher association representatives
- Teachers and school heads
- Youth leaders and counselors
- Community health providers
- Church and other religious leaders
- Traditional leaders

In the classroom, the pre-tests provided in Appendix 2 can also be used to make an initial assessment.

Because discussions of sexuality and HIV/AIDS, particularly with children, are taboo in many communities, situation assessments for HIV prevention programming must be undertaken very carefully. When interviewing children, assessors should ensure that the questions asked are age-appropriate and that World Vision's child protection guidelines are scrupulously followed. When interviewing parents and community leaders, assessors should pay attention to their attitudes as well as to the information they provide. This will help program planners determine which interventions are likely to be acceptable to most sections of the community. The situation assessment stage of HIV prevention programming provides an important opportunity for building support in the community. By seeking wide participation and conducting interviews with sensitivity, assessors can pave the way for community acceptance.

When considering in-school interventions, first find out whether the government issues a curriculum or guidelines for HIV prevention in the schools. Before introducing a new curriculum to the schools, including *Adventures Unlimited*, be sure to seek the permission of the relevant authorities.

3.2 Developing a plan of action

After assessing the situation, there should be a period to consult members of the community and find out how they would like to tackle the problems that have been identified. Community members can also be given the opportunity to communicate their desired contributions to and involvement in the HIV prevention program. The target groups and all stakeholders should be approached.

Interventions should be selected on the basis of the needs revealed by the situation assessment and the desires and strengths of the community. Special attention should be paid to the views of the children interviewed during the initial assessment — the words they use to describe particular aspects of the subject and the situations in which they say they most often find themselves.

When planning interventions, it may be appropriate to categorise the children in age groups, e.g. 5-10 and 11-15 year olds. The communities should be involved in selecting the learning objectives for each selected intervention.

3.4 Notes on implementation

When one or more interventions for HIV prevention among children 5-15 years old have been selected, they should be implemented through partnerships whenever possible. Possible partners for these interventions include schools, churches and other faith-based organisations, youth groups, and children's groups.

4. MONITORING AND EVALUATION OF HIV PREVENTION PROGRAMMING FOR CHILDREN AGED 5-15

4.1 Indicators for monitoring/process evaluation

By carrying out a process evaluation study, the ADP will be able to:

- Determine which program components are most successful
- Assess the acceptability of the program to teachers and incorporate their suggestions where appropriate
- Detect any difficulties with the materials and revise accordingly
- Assess the receptivity of students, peer leaders, parents, and administrators to the program
- Determine the appropriateness of the teaching methods

Possible indicators include:

- # of children trained as peer educators
- # of children receiving behaviour change intervention messages through peer education, community activities, formal or informal HIV/AIDS educational sessions, media communication messages, and church messages
- # of children able to accurately cite at least two modes of transmission for the spread of HIV/AIDS

4.2 Indicators for impact evaluation

Impact evaluation of the HIV/AIDS prevention program will enable implementers to:

- Determine whether there have been measurable effects on the students' knowledge, attitudes, skills, and behaviour intent as a result of the program
- Demonstrate to education officials, the general public, teachers, and students how effective the programs have been
- Gauge the level of support of teachers, parents, students, and communities for the program

Possible impact indicators include:

- # of children reporting a delay in sexual debut
- # of children reporting a reduction in number of sexual partners
- # of children reporting a commitment to abstinence
- # of children making reduction-of-risk plans
- # of children maintaining risk reduction behaviour

The impact of the program can also be measured by the post-tests in Appendix 2. In this method, the same test is administered to classes before the program starts, after it is completed, and later on annually. Results from the pre-test give useful indications to the teacher about the most common misconceptions or incorrect attitudes and enable the teacher to ensure that these issues are properly covered and emphasised. Program planners have responsibility for revising curricula and teaching techniques in response to the evaluation process.

To measure whether the training is effective in meeting its objectives, should also seek the opinions of teachers, parents, peer leaders, students, and school administrators in the areas where the training was conducted. Perceptions of the training should be used to revise, modify, and update the curriculum.

5. REFERENCES

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3. Handbook for Curriculum Planners, *School Health Education to Prevent AIDS and STI*, WHO/AIDS Series No.10, WHO/UNESCO.
4. Scripture Union Africa, *Aid for AIDS and Design for Family Life Skills Manuals*, Adventure Unlimited, Choose Freedom, 2000.

APPENDIX I: CASE STUDIES

Case study I: Youth Activists Organisation (Zambia)

The Youth Activists Organisation (YAO), a nongovernmental youth organisation, was formed in 1995 by high school graduates. Managed almost entirely by youth, its objectives are to increase young people's knowledge of sexual and reproductive health, increase young people's negotiation, decision-making, and communication skills, and advocate for the acknowledgment of young adult reproductive health rights at the national level.

YAO pursues its objectives through the following programs:

- Youth Football and Sexual Reproductive Health Camp — targets 14-24 year-old boys and their parents. A professional football coach teaches male responsibility in sexual decision-making, HIV/AIDS prevention, and child health.
- Inter-Faith Peer Educators project — encourages youth leaders to discuss sexual and reproductive health, HIV/AIDS and STI prevention, and family planning in religious environments.
- School Outreach program — implements an awareness curriculum including drama, testimonies, discussions with celebrities from a youth radio program, anti-AIDS clubs in schools, and a youth theatre group. Participants spend two days building communication, facilitation, and program design skills and three days applying the methodology.
- Training of Trainers workshops — anti-AIDS club leaders train students and youth from religious groups in facilitation and communication skills.

Case study 2: Adolescent Friendly Reproductive Health Services (Uganda)

In 2001, the Ministry of Health and the NGO program Delivery of Improved Services for Health launched the Adolescent Friendly Reproductive Health Services (AFRHS) project in 11 districts. The objectives were:

- To increase adolescents' utilisation of reproductive health services by 20%
- To improve the attitudes of health providers towards adolescent health needs
- To increase community knowledge about adolescent reproductive health

These objectives were realised through the following activities:

- Health facilities were identified to provide the AFRHS based on factors such as number the population of adolescents in the area and number and type of adolescent organisations already operating locally.
- Four service providers were trained in adolescent friendly service provision. They were trained in family planning, STI treatment, HIV counseling and testing, adolescent physical and emotional development, and effective communication with adolescents.
- Each health centre was provided with four volunteer trained peer educators, who were the first point of contact for many adolescents and also coordinated activities at the health centre, drama and dance groups, and debates on topics affecting adolescents.
- The health centres were made attractive for adolescents, offering activities such as indoor games and video and sports equipment. The adolescents themselves were involved in organising these activities.
- Posters were displayed in the community to encourage adolescents visit the health centre, and peer educators were involved in mobilising adolescents for health education, discussions, and games.
- For every health centre that was participating, there was a “Teen Bash” to launch the services. Teen Bashes are interactive events consisting of drama, skits, and activities that encourage youth to use the health centre.

APPENDIX 2: MODEL PRE-TESTS AND POST-TESTS FOR LIFE SKILLS TRAINING

I. Instructions to teachers

1. Tell the students that the questionnaire asks for personal answers so it is important to work alone and not communicate with anyone.
2. Remind students that they are not to write their names on the questionnaires. Explain that the questionnaire is confidential (no one will know who has given the answers). The answers will only be seen by researchers.
3. Tell the students that this is not a test on which they will be graded.
4. Read the instructions aloud to the students.
5. Tell the students that you will not walk around the room during the test, so that their answers will be completely private.
6. Ask the students if they have any questions about the questionnaire. Answer these questions, and then ask them to complete the questionnaire.
7. Because some of the students may believe that some of the false statements are, in fact, true, it is important to discuss the correct answers with students as soon as possible following the questionnaire's completion and collection.

2. Instructions to students

The purpose of this questionnaire is to obtain information about your knowledge, attitudes, and skills with respect to the prevention of HIV infection and AIDS. As well, you are asked to describe some of your intentions in the near future. The information you provide will be used to improve the quality of an HIV/AIDS and STI education program.

We encourage you to answer all of the questions because your responses are important to this study.

Your answers will be kept confidential. No one will know how you answered these questions.

When you have completed the questionnaire, do not sign it.

Thank you for completing the questionnaire.

Questionnaire I: Your knowledge

Instructions: Read each question. Put a cross to indicate the answer that fits best. Some of these questions use the words 'having sex'. This means sexual intercourse.

Age	Sex	Date
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	True	Don't know	False
1. STIs can be cured, but there is no cure for AIDS.			
2. One can recognise a person infected with HIV by how she/he looks.			
3. HIV is transmitted through semen and vaginal fluids and blood.			
4. You can get HIV if you have sex once, without a condom.			
5. You can get HIV by hugging or touching a person who has HIV or AIDS.			
6. A person can get HIV by giving (donating) blood.			
7. The more sexual partners a person has, the greater the chance of getting infected with HIV or a sexually transmitted disease.			
8. People who choose only healthy-looking partners won't get infected with HIV.			
9. There are drugs available that can help prolong the life of a person with AIDS.			
10. A good reason to delay sexual intercourse is the risk of HIV, STIs, and pregnancy.			
11. Assertive people get their way by overpowering others.			
12. If a person tries to get you to do something you don't want to do, you should either refuse, delay, or bargain with that person.			
13. Condoms protect a person from HIV and STIs if they are used correctly every time.			
14. A condom can be safely reused.			
15. "No condom, no sex" is a good rule to protect yourself from HIV and STIs.			
16. It is important to keep condoms in a warm, moist place before use.			
17. A person with HIV who is not allowed to attend school is an example of discrimination.			
18. A person can get HIV from living in the same home with a person who has HIV or AIDS.			
19. A person with AIDS who is sweating, vomiting, and has diarrhea needs extra food.			
20. Alcohol can hurt a person's ability to make good sexual decisions.			

Questionnaire 2: Your attitudes

Instructions: Read each statement, and mark a cross in the box of your answer.

	Agree	Not Sure	Disagree
1. Young people should realise that if they do not protect themselves, they could get infected with HIV.			
2. It is ok to have sex without a condom, because your chance of getting infected with HIV is very low.			
3. It is ok not to have sex while you are a teenager.			
4. It is ok for young people to have sex without a condom if they know each other well.			
5. If people think they might have sex with a partner, they should carry a condom with them.			
6. A young person can inject drugs once in a while without the risk of getting infected with HIV.			
7. It would be ok with me to be in the same classroom with someone who has AIDS.			
8. People who have AIDS should be forced to live far away from other people.			
9. I would feel comfortable hugging a close friend who had AIDS.			
10. It is ok to say “no” to friends when they want me to do things I do not want to do.			
11. If your boy/girlfriend wants you to have sex, it is better to agree rather than to lose him/her.			
12. It is ok to encourage someone to have sex if they have been drinking alcohol.			

Questionnaire 3: Your skills

Instructions: Try to imagine yourself in the story. Cross the boxes below accordingly.

Stories	Very confident	Somewhat confident	Not at all confident
1. You like your boy/girlfriend very much. He/she wants to have sex with you, but you don't. How confident are you that you could refuse and still remain friends?			
2. You have been going out with someone and you have been having sex without condoms. You have heard that using a condom is a good way to avoid getting infected with HIV. Your partner does not like condoms. You do not want to have sex anymore without a condom. How confident are you that you could refuse?			
3. You have bought condoms to protect yourself and your partner when you have sex. You really want to use condoms. How confident are you in being able to use the condoms properly?			

Questionnaire 4: Your intentions

Instructions: read each statement and circle the one that is most true for you

In the next six months...

1	A. I do not intend to have sex. B. I might have sex. C. I might have sex with 2 or more people.
2	A. I do not intend to inject drugs. B. I might use injecting drugs.

If you circled 1B (I might have sex) or C (I might have sex with 2 or more people), please circle the appropriate statement below.

In the next six months...

3	A) I will use condoms with my sexual partners. B) It is unlikely that I will use condoms with my sexual partners.
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Questionnaire 5: Additional knowledge questions

	True	Don't Know	False
1. People with AIDS die from serious illnesses.			
2. Gonorrhoea is an example of a sexually transmitted disease.			
3. HIV may be passed from a mother to her unborn child.			
4. You may get HIV from sharing unsterilised needles for drugs, tattooing, and ear or nose piercing.			
5. You may get HIV by drinking from the same glass that a person with AIDS has used.			
6. You may get HIV by eating food prepared by someone who has HIV or AIDS.			
7. The best method of protection against HIV and STIs is to abstain from sexual intercourse.			
8. Some methods of protection against HIV or STIs are better than others.			
9. The birth control pill protects you from HIV and STIs.			
10. There is no way to find out if you are infected with HIV.			
11. AIDS can be cured if you are given medicines early enough.			
12. Vaseline is a good lubricant to use with a condom.			
13. Lubricated condoms break more often than those that are not lubricated.			
14. If a condom slips off the penis into the vagina, a girl/woman will become sick.			
15. It is safe to have sex just once without a condom.			
16. Being compassionate to a person with AIDS is dangerous because there is a good chance you will become infected with HIV.			
17. People with AIDS should be encouraged to do as much as they can for themselves.			
18. People with AIDS who are upset should be encouraged to cry or be angry.			
19. You may get HIV from sharing injecting needles and syringes for use of drugs.			
20. You may get HIV by cutting your skin with an unsterilised razor blade or other sharp instrument that was used by someone else.			
21. You may get HIV from toilet seats.			
22. You may get HIV from wearing clothes that have been worn by another person with HIV.			
23. A person who has an STI is at greater risk of getting HIV.			
24. There is evidence that HIV can be spread by some types of insects.			
25. There is no way to kill HIV on a drug injecting needle or syringe.			

	True	Don't know	False
26. Once you are infected with HIV, you are infected for life.			
27. Only a person who is sick with AIDS can give HIV to others.			
28. A person can have a negative test for HIV and still be infected with HIV.			
29. People infected with HIV are usually very thin and sickly.			
30. The time from being infected with HIV to developing AIDS can be as short as 6 months and as long as 10 years or more.			
31. There are drugs available that can help prolong the life of a person with AIDS.			
32. A reason to get tested for HIV is so that you will not infect others.			
33. The test for HIV looks for HIV antibodies.			
34. Men and women often have very different thoughts about sexual intercourse.			

Questionnaire 6: Additional attitudes questions

Instructions: Read each statement, and cross the boxes adjacent to indicate whether you agree, you are not sure, or you disagree.

	Agree	Not Sure	Disagree
1. It is a good idea for teenagers to delay having sex until they are older or married.			
2. A person does not have to feel bad about delaying or refusing sex.			
3. If I chose to, I could easily abstain from having sexual intercourse.			
4. I would be too embarrassed to use a condom.			
5. I would be too embarrassed to buy a condom.			
6. Using shared instruments (razors, knives) to cut the skin is ok if you do it only once or twice.			
7. A person who has AIDS should not be allowed to eat lunch with others.			
8. I would stay away from someone in my class who had someone in their family with AIDS.			
9. People who have AIDS are getting what they deserve.			
10. I would be comfortable caring for someone who had AIDS.			
11. I feel we should do more to help people who have AIDS.			
12. I don't like it when friends talk to me into doing things that I know are dangerous.			
13. I think it is ok to accept gifts or presents from people I do not know.			
14. I would get tested if I thought I might have HIV.			
15. If I wanted to, I would be able to be affectionate without having sexual intercourse.			
16. I am an assertive person.			
17. I try to support my friends when they do something that is healthy.			
18. If I were using drug injecting needles I would clean them with bleach.			

Questionnaire 7: Additional skills questions

Instructions: Try to imagine yourself in the story. Cross the boxes adjacent to the stories accordingly.

	Very confident	Somewhat confident	Not at all confident
1. You are at a celebration where some of your friends are drinking alcohol. They want you to join them and are pressuring you to do so. If you did not want to join your friends in drinking, how confident are you that you could refuse?			
2. It is a Sunday afternoon, and you have been putting off your chores and homework all weekend. You have got enough work to fill the rest of the day. Your best friend calls to invite you out. You did not want to go with your friend. How confident are you that you could refuse?			
3. You are with a group of friends. One friend brings equipment to inject drugs. Some of your friends join in and seem to be having a great time. They urge you to join them. You know that sharing needles to inject drugs is an easy way to get infected with HIV. If you did not want to join your friends in injecting drugs, how confident are you that you could refuse?			
4. You find yourself alone in a deserted area with a boy/girl you thought was quite nice. Suddenly he/she is saying things and touching you in a way that makes you feel very uncomfortable. He/she begins to pressure you to have sex with him/her. If you do not want to have sex, how confident are you that you could refuse and get out of the situation?			
5. You have been going with a boy/girl for some time now and you have decided to have sex with him/her. One evening, when the two of you are alone, the opportunity for sex occurs. You even have a condom because you do not want to get HIV. He/she rebukes you for thinking that he/she would use a condom. If you definitely do not want to have sex without a condom, how confident are you that you could refuse?			
6. You have selected a package of condoms and now you must pay for them. As you get near the counter to pay for them, you notice the shop assistant is someone of the opposite sex. You really wanted those condoms. How confident are you that you would still be able to buy them?			
7. You do not have money to buy a condom but you have heard that you can get them free at the local health centre. If you wanted to use a condom, how confident would you be to go to the health centre for condoms?			

Answer Keys

Questionnaire 1

Scoring procedures for knowledge test

Each correct answer receives one point.

"Don't know" scores count 0 points.

The higher the score, the greater the knowledge.

- | | | | |
|----------|----------|-----------|-----------|
| 1. true | 6. false | 11. false | 16. false |
| 2. false | 7. true | 12. true | 17. true |
| 3. true | 8. false | 13. true | 18. false |
| 4. true | 9. true | 14. false | 19. false |
| 5. false | 10. true | 15. true | 20. true |

Questionnaire 2

Scoring procedure for attitude test

Higher scores on each item reflect positive attitudes

- | | |
|-------------------|--------------------|
| 1. A=3, NS=2, D=1 | 7. A=3, NS=2, D=1 |
| 2. A=1, NS=2, D=3 | 8. A=1, NS=2, D=3 |
| 3. A=3, NS=2, D=1 | 9. A=3, NS=2, D=1 |
| 4. A=1, NS=2, D=3 | 10. A=3, NS=2, D=1 |
| 5. A=3, NS=2, D=1 | 11. A=3, NS=2, D=1 |
| 6. A=1, NS=2, D=3 | 12. A=1, NS=2, D=3 |

Questionnaire 3

Scoring procedures for skills test

Higher scores reflect better skills.

Very confident = 3

Somewhat confident = 2

Not at all confident = 1

Questionnaire 4

Scoring procedures for intentions test

Higher scores reflect safer behavioural intentions.

Question 1: A=2, B=1, C=0

Question 2: A=2, B=0

Question 3: A=1, B=0

Questionnaire 5

- | | | | |
|----------|-----------|-----------|-----------|
| 1. true | 10. false | 19. true | 28. true |
| 2. true | 11. false | 20. true | 29. false |
| 3. true | 12. false | 21. false | 30. true |
| 4. true | 13. false | 22. false | 31. true |
| 5. false | 14. false | 23. true | 32. true |
| 6. false | 15. false | 24. false | 33. true |
| 7. true | 16. false | 25. false | 34. true |
| 8. true | 17. true | 26. true | |
| 9. false | 18. true | 27. false | |

Questionnaire 6

Higher scores on each item reflect positive attitudes.

- | | |
|-------------------|--------------------|
| 1. A=3, NS=2, D=1 | 10. A=3, NS=2, D=1 |
| 2. A=3, NS=2, D=1 | 11. A=3, NS=2, D=1 |
| 3. A=3, NS=2, D=1 | 12. A=3, NS=2, D=1 |
| 4. A=1, NS=2, D=3 | 13. A=1, NS=2, D=3 |
| 5. A=1, NS=2, D=3 | 14. A=3, NS=2, D=1 |
| 6. A=1, NS=2, D=3 | 15. A=3, NS=2, D=1 |
| 7. A=1, NS=2, D=3 | 16. A=3, NS=2, D=1 |
| 8. A=1, NS=2, D=3 | 17. A=3, NS=2, D=1 |
| 9. A=1, NS=2, D=3 | 18. A=3, NS=2, D=1 |

Questionnaire 7

Higher scores reflect better skills.

Very confident = 3

Somewhat confident = 2

Not at all confident = 1

A.2. PREVENTION OF MOTHER-TO-CHILD TRANSMISSION

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Appendix 1: WHO, UNICEF, UNAIDS, Statement on Current Status of HIV and Infant Feeding WHO/UNAIDS/UNICEF Policy Guidelines`

Appendix 2: Guide for PMTCT Situation Assessment

I. INTRODUCTION

I.1 Overview of Mother-to-Child Transmission (MTCT)

Mother-to-child transmission (MTCT), also called vertical transmission, is by far the largest source of HIV infection in children below the age of 15 years. (1) Global estimates of children below the age of 15 years living with HIV/AIDS in 2001 stood at 2.7 million, of which 2.4 million were from Sub-Saharan Africa. Africa accounts for such a large proportion of child infections because of high fertility rates combined with very high levels of HIV infection among women. (2)

HIV/AIDS threatens to reverse years of steady progress in child survival achieved through such measures as the promotion of breastfeeding, immunisation, and oral rehydration. UNAIDS believes that by the year 2010, AIDS may have increased mortality of children under 5 by more than 100% in the areas most affected by the virus. (3)

MTCT can occur in the womb, during delivery, or through breastfeeding. Of the children born to women living with HIV/AIDS, 15-25% becomes infected during pregnancy and delivery. Another 10-20% may subsequently become infected through breastfeeding. (4)

1.2 Mechanisms of MTCT

1.2.1 MTCT during pregnancy

HIV transmission can occur at all stages of pregnancy. It can occur any time the mother's blood mixes with the fetus's blood, for example through placental tears. It can also occur by the progressive infection of different placental layers.

1.2.2 MTCT during labour and delivery

Transmission can occur when the baby comes into contact with its mother's blood and genital secretions during passage through the birth canal. The baby can be infected through the fetal membranes, amniotic fluid, or its digestive tract. The mother's and baby's blood sometimes mixes during uterine contractions in labour.

1.2.3 MTCT during breastfeeding

It is still unclear whether infection takes place through HIV-infected cells or through cell-free HIV in breast milk. Cell-free forms of the virus may penetrate the lining of the infant's digestive tract and then infect cells or enter the bloodstream directly through tears in the digestive lining. If HIV infection only occurs through HIV-infected cells, then colostrum (the pre-milk fluid secreted by the breast) may be more infectious due to its high cellular content. Damage to the intestinal tract of the infant caused by early introduction of other foods increases its permeability and results in increased rates of infection for the infant. The immature digestive tract of the newborn can also facilitate transmission. (5)

1.3 Risk factors for MTCT

Factors associated with the risk of MTCT include:

- The amount and type of HIV in the mother's blood
- The mother's health, including the strength of her immune system and her nutritional status
- Behavioural factors such as drug use and sexual practice
- The characteristics of labour and delivery, including the amount of tearing and bleeding and the mode of delivery
- Infant factors, which may increase the risk of transmission through breastfeeding (6)

1.4 Prevention of MTCT

The prevention of mother-to-child transmission (PMTCT) can involve many different kinds of interventions. Any program that contributes to the prevention of HIV/AIDS in adults or to the prevention of unwanted pregnancies also contributes to PMTCT. Any activity that improves the accessibility and quality of health care for pregnant women furthers the goal of PMTCT.

In the ADPs, the feasibility and desirability of particular interventions will depend largely upon the availability of health care in the community. In communities with few health care facilities and services, activities might focus on making labour and delivery safer for women or making voluntary

counseling and testing (VCT) for HIV available to pregnant women. In communities with a more developed health care infrastructure, projects might include strengthening linkages between VCT services and other services provided to pregnant women, finding ways to make anti-retroviral drugs (ARVs) available to women in labour, and offering HIV-positive women alternatives to breastfeeding. Because successful PMTCT requires strong health care institutions and infrastructure, partnering will be an important strategy for ADPs.

2. PROGRAMMING OPTIONS FOR PMTCT

2.1 PMTCT during pregnancy and labour

2.1.1 Voluntary counseling and testing (VCT)

VCT services are necessary in order to identify women who will benefit from MTCT interventions. Counseling and testing can encourage HIV-negative women to continue safe sex behaviour. HIV-positive women can receive help planning for PMTCT.

ADPs can help pregnant women get the counseling and testing they need by:

- Supporting community-based VCT program
- Providing rapid HIV test kits and necessary supplies for testing (GIK)
- Helping train laboratory technicians
- Promoting VCT awareness, education, and support in the community
- Positioning VCT to counter the fear, ignorance, and stigma surrounding HIV
- Supporting the formation of post-test clubs
- Training HIV counselors in PMTCT
- Ensuring adequate space for the confidential counseling of pregnant women
- Supervising and monitoring VCT services for pregnant women
- Reviewing training curricula for counselors and other health workers to integrate MTCT and VCT issues
- Making referrals for family planning and obstetric care available at VCT centres (7)

2.1.2 Improving obstetric practices

Countries with high rates of MTCT are also likely to have high rates of infant and maternal mortality. Countries in Sub-Saharan Africa still have some of the highest maternal mortality rates in the world. By working to improve obstetric practices (practices surrounding the labour and delivery of pregnant women), ADPs can contribute to PMTCT while improving the lives of pregnant women more generally.

ADPs can help improve obstetric practices by:

- Facilitating the training of health workers in safe delivery techniques and life-saving skills for mothers and infants
- Providing HIV/AIDS and PMTCT education to maternal child health (MCH) clinics
- Providing safe delivery kits and essential obstetric drugs (GIK)
- Updating Safe Motherhood programs and policies to incorporate HIV and MTCT
- Improving the capacity of health providers to monitor and supervise obstetrical services and practices, including those related to PMTCT (8)

- Encouraging mothers to deliver in a hospital or clinic
- Training traditional birth assistants (TBAs) in safe delivery techniques, providing them with safe instruments, and encouraging them to send mothers to health care institutions

2.1.3 Short course anti-retroviral (ARV) provision

While long-term ARV therapy is not yet practical in many parts of the world, short-term ARV drugs used for the prevention of MTCT are much simpler to administer and are less costly because they are given in a small dose for a short duration. Nevirapine is increasingly the ARV of choice for PMTCT due to its comparatively low cost (approximately US \$4 for a mother/child pair) and ease of administration (single dose for mother and newborn). The cost of the drugs, however, is only a part of the total cost of ARV use, and other program components including VCT, infant feeding counseling, and monitoring and evaluation must be supported as well.

The box below shows different recommended regimes for prevention of MTCT using ARVs.

Possible drug regimes for HIV-positive pregnant women:

1. Nevirapine tablet 200mg taken orally as single dose at the onset of labour.
And Nevirapine syrup 2mg/kg body weight single dose to the baby within 72 hours of birth.
- OR**
2. Zidovudine (ZVU, AZT) tablets 300mg taken orally twice a day from 36 weeks of gestation until onset of labour;
Then 300mg taken orally, 3 hourly from onset of labour until delivery of the baby;
Followed by 300mg taken orally twice a day for one week after delivery.
And Zidovudine syrup 4mg/kg body weight, twice a day to the baby for the first week after birth.
- OR**
3. Zidovudine (ZDV, AZT) tablets 300mg and Lamivudine (3TC) tablets a day from 36 weeks of gestation until onset of labour;
Then 600mg – loading dose of Zidovudine taken orally followed by 300mg 3 hourly, with 15mg of Lamivudine taken twice a day from onset of labour;
And then 300mg Zidovudine with 150mg Lamivudine twice a day for one week after delivery of the baby.
And Zidovudine syrup 4mg/kg-body weight, twice a day to the baby for the first week after birth.

ADPs can support ARV use for PMTCT by:

- Helping communities access ARV drugs
- Encouraging the bulk purchase of ARV drugs
- Negotiating for reduced costs of the drugs
- Helping with drug supply and logistics management
- Fostering drug supply and logistics partnerships among organisations
- Advocating for essential drug programs to include short-course ARV drugs for prevention of MTCT

- Supporting training of health care professionals in the use of ARVs for PMTCT
- Supporting community mobilisation efforts to increase acceptance of ARV prevention (9)

2.2 PMTCT during breastfeeding

Up to 20% of infants born to HIV positive mothers may acquire HIV through breastfeeding. HIV transmission through breastfeeding has made safe infant feeding one of the most complex and emotional aspects of MTCT prevention. Though breastfeeding can pass HIV from mother to child, breastfeeding also has many health, nutritional, birth spacing, emotional, and psychosocial benefits. Also, the safety of replacement feeding depends upon the availability of clean water and other supplies. UNAIDS, WHO, and UNICEF offer the following guidelines:

WHO/UNAIDS/UNICEF Statement on HIV and Infant Feeding

“As a general principle, in all populations, irrespective of HIV infection rates, breastfeeding should continue to be protected and supported . . . Counseling for women who are aware of their HIV status should include the best available information on the risks and advantages of breastfeeding and on the risks and possible advantages associated with other methods of infant feeding . . . It is important that women be empowered to make fully informed decisions about infant feeding, and that they be suitably supported in carrying them out.”

WHO, UNICEF, and UNAIDS make the following policy recommendations:

- Breastfeeding among mothers who are HIV negative or do not know their HIV status should be protected, promoted, and supported.
- HIV-positive mothers can be given other options to breastfeeding:
 - Replacement feeding with commercial formula or home-prepared formula
 - Breastfeeding exclusively and stopping early (when infant is 3-6 months old)
 - Use of heat-treated breast milk
 - Wet-nursing

More information about the WHO/UNICEF/UNAIDS recommendations is included in Appendix I.

ADPs can undertake the following activities to support safe infant feeding:

- Review and update national breastfeeding and related infant feeding practices
- Encourage and expand Baby Friendly Hospital Initiatives and ensure that all infant feeding training includes updated information on MTCT
- Conduct research to adapt United Nations guidelines on infant feeding and HIV to local settings, and to ascertain locally available replacement feeding options
- Adapt integrated management of childhood illness and other feeding guidelines to local settings, as needed
- Support training on counseling about HIV and infant feeding options (using or adopting the WHO/UNICEF/UNAIDS training package)
- Train health facility staff in lactation management.
- Promote and support exclusive breastfeeding for 6 months for all breastfeeding mothers, including mother-to-mother support in the first months of life
- Support nutrition and health for HIV infected mothers during breastfeeding

- Provide skills training for HIV infected mothers who choose replacement feeding
- Explore ways to make replacement feeding safer for HIV infected mothers including clean water, food hygiene, and sanitation improvement (10)
- Work against the stigma associated with changes in infant feeding practices by educating male partner, extended family, and community

3. DESIGN AND IMPLEMENTATION OF PMTCT PROGRAMMING

3.1 Assessing the situation

3.1.1 Identifying PMTCT-related needs

The first step is to assess the nature and extent of the problem using the information available from existing reports and surveys. Find out:

- The number of pregnant women in the population in the area to be served
- The number of women and children infected by HIV, and whether this varies between areas or population subgroups

It should be remembered that most women do not know their HIV status. In high prevalence areas, all pregnant women should be encouraged to attend VCT within antenatal care so that the PMTCT counseling can start.

Information about community attitudes towards HIV/AIDS and infant feeding will also be helpful in planning programming. Surveys of community knowledge, attitudes, and practices can be conducted to find out:

- The extent to which people with HIV are stigmatised
- How women feed their infants, including whether they practice exclusive breast-feeding, duration of feeding, and the type of supplementary feeding
- The support given to HIV-positive women not breast feeding in the community

3.1.2 Identifying existing resources

When planning for the introduction of VCT and PMTCT services it will be important to identify existing services and resources, including physical infrastructure, personnel, and finances. This information can be gathered by interviews with:

- Provincial and district health management boards, hospitals, and local health centres
- Healthcare workers, who can give a broad picture of the needs of pregnant women now and in the future
- Women themselves, whose needs assessment will ensure the comprehensiveness and acceptability of the program

Through these interviews, find out:

- National policies on PMTCT, VCT, and infant feeding
- What kind of information is available in the community about HIV, PMTCT, VCT, and infant feeding
- The capacity of antenatal services, including the staffing and supplies available

- The perception of the women about service delivery at antenatal services
- The availability and quality of VCT services
- The number of staff trained in PMTCT, psychosocial counseling, and breastfeeding counseling
- The existence of support groups to assist mothers

A comprehensive list of information useful to planning PMTCT programming can be found in Appendix 2.

3.2 Developing a plan of action

3.2.1 Preparing the community

For PMTCT interventions to be successful it is important that they be guided and supported by:

- National policy and strategy plans, including the national AIDS program and maternal child health program
- Institutions who will authorise their services
- Community leaders and the community as a whole

The potential benefits of VCT and PMTCT are often not understood in communities. Many people, for example, are unaware of the recent advances in PMTCT even in the countries most affected by HIV/AIDS. Furthermore, in the majority of high prevalence countries, many people are reluctant to be tested. Women may face pressure from their husbands, family members, and community not to get tested.

ADPs can prepare the community for PMTCT programming by:

- Raising awareness about HIV and fighting stigma and discrimination
- Educating the population about MTCT
- Educating the population about the benefits of VCT and PMTCT
- Providing information about antenatal care to pregnant women and key caregivers
- Educating men about preventing transmission to women and children
- Providing information about infant feeding to pregnant women

These messages can be transmitted in a variety of ways, including:

- Pamphlets distributed at health and community centers. These can be reproduced in local languages.
- Popular newspapers and magazines
- Posters and billboards with simple messages in written and picture form displayed in public places
- Public health messages on radio and television
- Community presentations and discussions by health or social workers or People Living with HIV/AIDS (PLWHA) in church halls or school buildings

3.2.2 Defining objectives

Objectives for PMTCT programming may include:

- Establishing VCT sites
- Testing and counseling pregnant women
- Referring pregnant women to various services to ensure overall care
- Providing interventions to prevent MTCT
- Ensuring follow-up so that care does not end abruptly following delivery

Because health services vary widely from community to community, a phased approach to the work plan may be the most suitable. For example, basic antenatal care and VCT services must be in place before PMTCT interventions are implemented. When defining objectives, program planners should take existing services into account, working to strengthen antenatal care and VCT services if necessary before implementing PMTCT interventions.

Procedures for VCT and PMTCT interventions and for referral to related services need to be defined. Planners should develop a list of ‘who does what’ in HIV care, antenatal care, family planning, and infant feeding support in the community. The work plan should include procedures for monitoring and evaluating the new services. Besides improving the coverage and range of antenatal and VCT services, improving the quality of service delivery is critical. This will benefit the health of mothers and children overall.

3.3 Notes on implementation

Partners in implementing PMTCT might include health administrators, VCT and antenatal staff, church leaders (for example the hospital chaplain), health care staff already involved in counseling, community groups, representatives of NGOs, and PLWHA.

Because ownership of PMTCT interventions falls between MCH and AIDS prevention and care programs, promoting cooperation between these programs will be very important. Women will often be seen by different health care workers for pre- and post-test counseling, antenatal care, antiretroviral drugs (ARVs), and post-natal care and support. Facilitating liaisons and referrals between these workers will help ensure that the patient’s needs are met.

Confidentiality in VCT and PMTCT should be strictly guarded. Women frequently suffer violence, abuse, and abandonment when their HIV status is disclosed to others, particularly their partners. Furthermore, when people are not reassured that their confidentiality will be protected, they may not come forward for testing or treatment.

4. MONITORING AND EVALUATION OF PMTCT PROGRAMMING

PMTCT and VCT services associated with MCH services in developing countries are new and data is lacking on effectiveness and acceptability, particularly in local settings. For this reason, it will be especially important to monitor and evaluate the PMTCT intervention’s effectiveness. (18)

4.1 Indicators for monitoring/process evaluation

Process evaluation monitors inputs and outputs and assesses the service quality.

Examples of input indicators include:

- % of time ARVs are available at the health centre
- % of time HIV testing is available at the health centre
- % of time drugs to support women are available at the health centre

Examples of output indicators include:

- % women accepting VCT
- % women returning for test results
- % women practicing exclusive breast-feeding
- % HIV positive women accessing care and support services

4.2 Indicators for impact evaluation

Impact indicators include:

- HIV transmission rate from mother to child
- % of babies with HIV at 3 months, 6 months, 2 years
- % of underweight babies
 - HIV positive babies
 - HIV negative babies, born to HIV positive mother
- % of women suffering from adverse consequences of VCT
 - HIV positive women
 - HIV negative women

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Appendix I: WHO, UNICEF, UNAIDS, Statement on Current Status of HIV and Infant Feeding WHO/UNAIDS/UNICEF Policy Guidelines

A recent early report of evidence that HIV is less likely to be transmitted through exclusive breastfeeding does not warrant a change in existing WHO/UNICEF/UNAIDS policy.

In the last ten years, evidence has accumulated that HIV can be transmitted through breast milk. Where resources permit, many HIV positive mothers now choose to feed their babies artificially and to avoid breastfeeding altogether. In resource poor settings, where the risk of artificial feeding may be particularly high, the decision for both individual mothers and policy makers is more difficult. This has led in some settings to a loss of support for initiatives to promote breastfeeding, and to some women avoiding breastfeeding even if they do not know their HIV status.

In 1997, UNAIDS, WHO, and UNICEF issued a joint policy statement on HIV and infant feeding, which stated that “As a general principle, in all populations, irrespective of HIV infection rates, breastfeeding should continue to be protected and supported”, and “Counseling for women who are aware of their HIV status should include the best available information on the risks and advantages of breastfeeding and on the risks and possible advantages associated with other methods of infant feeding”, and “It is therefore important that women be empowered to make fully informed decisions about infant feeding, and that they be suitably supported in carrying them out.”

In 1998, WHO, UNICEF, and UNAIDS held a technical consultation on HIV and Infant Feeding, and issued guidelines with a human rights perspective, based on the joint policy statement. These guidelines call for a strengthening of initiatives to protect, promote, and support breastfeeding among mothers who are HIV negative or unknown HIV status, and they describe several infant feeding options for consideration by HIV-positive mothers. These include: replacement feeding with commercial formula or home prepared formula breastfeeding in the way generally recommended, breastfeeding exclusively and stopping early, use of heat treated expressed breast milk, and wet-nursing, in all cases with timely and adequate complementary feeding. There is no attempt to favour any one of these options over the others, as the principal recommendation is for mothers to receive counseling that will enable them to make a fully informed decision appropriate to their situation and resources. The responsibility of the policy-maker and health care manager is to provide the necessary support to enable mothers to make and carry out their choice, whether to breastfeed or to use replacement feeds.

The studies on which existing estimates of transmission are based do not distinguish between infants who are exclusively breastfed and those, usually the majority, who are both breastfed and receive other foods and receive other foods or drinks. A recently published early report suggests that exclusive breastfeeding, that is, when an infant is given no other food or drink of any sort, may be less likely to transmit infection than mixed feeding, possibly because other foods can damage the infant’s digestive organs, and make it easier for the virus to cross the intestinal mucosa. This report has raised the hopes of many health workers, who are concerned about the adverse effects on child health from decreasing rates of breastfeeding. The question has been raised as to whether or not WHO should revise its infant feeding recommendation.

The information contained in this early report is interesting and important. However, because of limitations of the study size and design, firm conclusions cannot be drawn without further research. That such research should be conducted as a matter of urgency is clear, and has been

identified by WHO as a priority.

The current guidelines clearly indicate that for HIV-positive mothers who choose to breastfeed, the safest option is to breastfeed exclusively to minimise the risk of other childhood infections such as diarrhea, using a good technique to reduce the risk of mastitis and nipple damage which could increase transmission of HIV. Stopping breastfeeding when the infant is 3-6 months old is an option to avoid late postnatal transmission, and at this older age the health hazards for the child and the social difficulties for the mother associated with not breastfeeding are fewer.

Short-term exclusive breastfeeding is already included in the WHO/UNICEF/UNAIDS guidelines at one of the feeding options. The information in the early report, if confirmed, would strengthen the case for choosing it as both feasible and effective. However, there can be no justification for dropping replacement feeding as one of the options, for mothers who wish to use it, while there is possibility of transmission of HIV through breast milk.

The existing WHO/UNICEF/UNAIDS policy and guidelines remain appropriate according to existing scientific evidence, and there is no present indication that they should be changed. The guidelines accommodate all reasonable infant feeding options for mothers with HIV, and support a fully informed choice, which will allow mothers to be provided with better information as it becomes available.

Appendix 2: Guide for PMTCT Situation Assessment

Extracted from Vertical Transmission of HIV: Rapid Assessment Guide, UNICEF/UNAIDS

1. Statistics about HIV/AIDS

- What is the HIV prevalence?
- HIV prevalence among women of childbearing age

2. Morbidity and mortality

- Infant mortality rates and under five mortality rates
- Rates of diarrhea among women
- Maternal mortality rate
- Fertility rate
- Rates of exclusive, continued breast feeding
- Qualitative assessment of risks of artificial feeding

3. Existing policies

- Protection and services for HIV positive people
- Contraception
- Abortion
- Infant feeding
- Counseling and testing
- Is there a coordinating committee for AIDS?

4. Nature and coverage of services

- Mapping of existing individual testing and counseling services
- % women attending prenatal services
- Timing of visits
- % of assisted births
- Availability of essential obstetric care services, basic and comprehensive care facilities
- Proportion of births in the basic and comprehensive essential obstetric care services

5. Awareness of MTCT problems among key partners and in the population

Do key persons in these organisations/populations have basic knowledge of vertical transmission?

- Medical associations
- MOH
- NGOs
- General population
- In the media

6. Access to information concerning HIV and VCT

- Guidelines
- Clinical trials
- Other research

7. Summary of existing services

- UN
- NGOs
- Local /international research institutions
- Women's organisations

8. Health facilities and services

- **Nature of available services**
 - Fees for services
 - Linkage between antenatal/maternity/post-natal care and VCT, family planning, and social services
 - Standard antenatal check up
 - Malaria prevention
 - Lab: Hb, RPR, HIV, blood transfusion
 - STI diagnosis and management
 - C/section and blood transfusion at hospital
- **Use of services**
 - % population with access to antenatal services
 - # of pregnant women attending services by trained health personnel
 - Timing of ANC visits
 - % of hospital deliveries among women receiving antenatal services
 - % of post-natal services
- **Quality of services**
 - % of delivering women who developed obstetric complications and received essential obstetric care
 - % of women attending antenatal screen for syphilis
 - % of deliveries that are C/section
 - Availability of protective materials for health workers
- **Services provided by community change agents**
 - % of pregnant women who seek services of TBAs
 - Nature of services provided by TBAs
 - Pre-marriage counseling services organised by churches and faith-based organisations

9. VCT services

- **Availability and nature of testing services**
 - General information on functioning
 - Are trained counselors available at all sites?
 - Level of education of counselors
 - Are there referrals from antenatal care, health, family planning and other services?
 - Description of the processes (pre- and post-test counseling)
 - Content of messages for HIV+/HIV- patients
 - Is testing done on a voluntary and confidential basis?
- **Accessibility of testing and counseling services**
 - % of pregnant women tested
 - # of tests done last year among adults
 - What % are tested with partners?
 - What % return for test results?

- **Quality of testing and counseling services**
 - Precautions taken to ensure confidentiality
 - Types of tests used
 - Support /referral for those tested
- **Counseling for those who decide not to be tested**
 - For those not tested, is information given on prevention?
 - Is information given on infant feeding?

10. Infant Feeding Options

- **Rates and trends**
 - Rate of exclusive breastfeeding in local area
 - Approx. % of women who introduce complementary foods at about 6 months, general complementary feeding practices
 - Community attitudes towards non-breast-feeding women
 - Is wet nursing practiced/accepted?
 - Has HIV already changed infant feeding beliefs/behaviours?
 - Who makes decisions about infant feeding?
- **Distribution/commercialisation of infant foods**
 - Do social or health services or NGOs distribute infant foods of any kind?
 - If so, what quantity is distributed per child?
 - Apart from distribution programs, what is the general availability of commercial infant formula?
- **General breastfeeding counseling and related services**
 - What % of women give birth at baby-friendly hospitals?
 - # of health workers at the site trained in breastfeeding counseling
 - Is there use of expressed breast milk or heat-treated breast milk in the hospital/maternity ward?
 - Are newborns kept in close contact with HIV+ mothers (even if there is no breastfeeding)?
- **Post-test counseling on infant feeding**
 - Nature of information given to HIV+ women for their infant feeding decisions
 - What is said about the cost of artificial feeding?
 - Do workers tell women what to do or let them decide?
 - Questions raised by women during counseling
 - What steps are taken to encourage breastfeeding among HIV- mothers?
 - What support and referral services are recommended to HIV+ women? Are they given commercial information about infant formula?
- **Artificial feeding counseling and follow-up:**
 - Existence of alternatives: what is available and at what cost?
 - Are women shown how to feed artificially (preparation of formula, use of cup, etc.) by health workers?
 - What difficulties do women have obtaining breast milk substitutes and other animal foods?
 - Is there special follow-up for artificially fed infants?
 - How do health workers judge the availability of locally of clean water, fuel, etc. for women using artificial feeding?
- **Cost of artificial feeding:**
 - Approx. cost of artificial feeding (e.g. 20 kg formula, 20 kg. milk or equivalent for one year, as a % of minimum wage or other approximation)

II. Community Mobilisation/Partnerships

- **Involvement of key partners including government, NGOs, UN organisations and local groups:**
 - What are they doing in the field of HIV/VCT and how can we collaborate with them?
- **Availability of support groups/services for HIV positive people:**
 - Opinion of leaders/religious groups/NGOs (HIV+, HIV- mothers, orphans)
 - Sources of information for community groups
 - How social system copes with HIV/VCT
 - Existence of CBOs and NGOs supporting HIV+ persons and linkages with medical services
- **Access to and use of community support systems:**
 - # of families supported by CBO
 - Type of support
 - Duration of support, when/why does it stop

A.3. PREVENTION FOR HIGH RISK GROUPS

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I. INTRODUCTION

Luke 7:37-39, 44-47, New Revised Standard Version

37 And a woman in the city, who was a sinner, having learned that He was eating in the Pharisee's house, brought an alabaster jar of ointment.

38 She stood behind Him at His feet, weeping, and began to bathe His feet with her tears and to dry them with her hair. Then she continued kissing his feet and anointing them with ointment.

39 Now when the Pharisee who had invited Him saw it, he said to himself, "If this man were a prophet, He would have known who and what kind of woman this is who is touching Him — that she is a sinner."

44 Jesus said to the Pharisee, "Do you see this woman? I entered your house; you gave me no water for my feet, but she has bathed my feet with her tears and dried them with her hair.

45 You gave me no kiss, but from the time I came in she has not stopped kissing my feet.

46 You did not anoint my head with oil, but she has anointed my feet with ointment.

47 Therefore, I tell you, her sins, which were many, have been forgiven; hence she has shown great love.

There are three important factors responsible for the vulnerability of specific populations that are categorised as high risk groups:

1. Their socioeconomic circumstances such as poverty, lack of education, and displacement (separation from families) may hinder their ability to protect themselves, and may reduce their access to information on HIV prevention and care.
2. HIV prevalence among their social networks may be higher than in the general population.
3. They may engage in specific high risk forms of behaviour such as drug abuse or having unprotected sex with persons whose HIV status is unknown.

Reaching high risk groups is vital for the success of an AIDS response. By targeting groups that have a disproportionately high incidence of HIV infection, prevention programs can make a disproportionately large impact on HIV prevalence. Many high risk populations do not have access to mainstream HIV/AIDS services. Therefore, outreach and peer network approaches must bring services to where they work, live, and socialise. The most effective interventions and programs are those that are tailored to the specific realities and needs of the people for whom they are intended.

(1)

Over the last two decades, many lessons have been learned regarding effective interventions for HIV prevention. Effective methods for preventing HIV have long been known, but providing people with information about how to protect themselves against infection has proven to be insufficient. People require enabling environments that will reduce their susceptibility and vulnerability, and allow them to modify their behaviour based on their knowledge gained through access to information. The ultimate goal of prevention programs targeting high risk groups is behaviour change and whole person recovery — the transformation of a destructive lifestyle into a positive one.

2. PROGRAMMING OPTIONS FOR PREVENTION FOR HIGH RISK GROUPS

2.1 Commercial Sex Workers (CSWs)

2.1.1 Overview

HIV prevalence among sex workers is considerably higher than among the general populace. For example, in Zimbabwe the HIV infection rate among sex workers is as high as 86%.

Sex workers are a highly marginalised group and as such are vulnerable to:

- Sexually transmitted infections (STIs), which increase their risk to HIV infection, especially if their power to negotiate for safer sex is weak
- Violence and abuse by men who are drunk, unwilling to use condoms, or unwilling to pay for services
- Ignorance about HIV because they are difficult to reach with prevention, care, and support interventions
- Health workers who are judgmental and unreceptive. This leads to low uptake among sex workers of reproductive health services, including STI screening and treatment

HIV/AIDS prevention among sex workers calls for a three-pronged approach: prevention of entry into sex work, protection of those involved in sex work, and assistance in leaving sex work. Each of these can, in turn, be addressed on three levels: individual, community, and policy-making. At all response levels, it is necessary to have clear policy standpoints and to establish programs with multiple components.

2.1.2 Preventing entry into sex work

The factors that increase sex workers' vulnerability to HIV infection are often the same factors that cause an individual to enter sex work:

- Poverty and limited economic opportunities
- Gender inequalities
- Sexual exploitation including trafficking
- Cultural and traditional beliefs and practices

Successful vulnerability reduction responses involve broad-based programs that focus on the socioeconomic forces driving entry into sex work. For example:

- Expansion of education and employment opportunities for young women
- Programs that provide continuing education scholarships to young women living in particularly vulnerable communities
- The creation of local industries that employ young women
- Strengthening the family and community structure to create a strong culture of protecting young people from sexual exploitation
- Mobilising religious leaders, educators, and other community leaders to advocate for an environment that will not tolerate exploitation (2)

2.1.3 Reducing HIV infection in CSWs

Sex workers are more vulnerable to HIV infection because of the nature of their work, which exposes them to a large number of sexual partners of unknown HIV status. It can be difficult or impossible for sex workers to insist on safe sex. Reluctant clients might react with violence or simply move on to someone willing to forego a condom. It is quite common that clients are willing to pay almost double the fees for sex without a condom. (3)

Other factors make this basic vulnerability worse:

- Stigmatisation and marginalisation
- Lack of access to health and social services
- Limited information, skills, negotiating power, and access to means of prevention
- Alcohol consumption
- Exposure to violence (physical and sexual)
- Increasing mobility

Some populations of sex workers are particularly difficult to reach. These include sex workers who do not identify themselves as such, do part-time or casual sex work, or work illegally under particularly repressive or difficult conditions. Efforts should be made to reach these groups when possible.

ADPs can undertake two key activities to reduce HIV infection in CSWs: behaviour change communication (BCC) and treatment for STIs.

2.1.3.1 Behaviour change communication (BCC)

Sex workers need information, education, and communication (IEC) on HIV/AIDS that is tailored to their specific culture. Information campaigns are usually conducted through mass media, group education discussions, and distribution of printed material. Their main thrust is to promote healthy behaviour by providing the basic facts and correcting wrong perceptions or myths that surround HIV/AIDS. Any such campaign must specifically address the traditional and cultural sexual behaviour in the local sex work environment and take into account the various forms of sex work that occur there (e.g. brothel-based, indirect or occasional sex work, and male or transgender sex workers).

But general awareness activities are often not enough to bring behaviour change. Sex workers need special support to help them to make behaviour change relevant to them.

ADPs can undertake the following activities for behaviour change communication (BCC) among sex workers:

- Providing or training others to provide direct, supportive personal contact that supports behaviour change
- Promoting consistent condom use and modification of risky sexual practices
- Building social and workplace support for condom use
- Ensuring that sex workers have access to condoms and enough information on how to use them correctly and consistently
- Promoting the use of female condoms, which offer sex workers more control in negotiating safe sex
- Strengthening sex workers' negotiating skills to help them impose safer sex practices on partners
- Ensuring that sex workers have access to VCT
- Educating the community about the dangers of using unsterilised needles, where drug use is an issue
- Introducing them to Christian values
- Encouraging church leaders to reach out to sex workers and training church leaders in counseling skills
- Encouraging church leaders to support the use of condoms for HIV prevention

A final important way to promote behaviour change among sex workers is by establishing peer education programs. Experienced sex workers can best teach peers some features of safer sex work that can play an important role in protecting sex workers. These would include knowledge of sexual techniques that cause less abrasion and therefore limit paths of HIV transmission as well as an increased repertoire of non-penetrative sexual acts. Improved variation in sexual services, combined with different pricing for different modes of service, can offer sex workers options, which they can exercise based on their risk assessment of the client.

If taken to scale, peer education can eventually influence and change community social norms and activate program and policy changes at higher level. Because an individual's sexual behaviour is strongly influenced by social norms, these norms become entry points for peer educators, either to be challenged or built upon, depending on the social context. Effective peer education aims to create a supportive environment for sex workers to apply the assertive skills they need to negotiate safe

sex and improve their living and working conditions.

2.1.3.2 STI prevention and care for sex workers

STIs and HIV are linked at three levels:

1. They share the same risk behaviour.
2. STIs facilitate the acquisition and transmission of HIV, and some STI pathogens become more virulent in the presence of HIV-related immunodeficiency.
3. Effective STI treatment reduces not only the rates of STI complications but also the efficacy with which HIV is transmitted.

In addition, individuals are more receptive to condom use and other prevention messages when they are delivered along with good quality, non-judgmental curative services. It is therefore important that programs addressing sex workers include an STI component. STI testing, counseling, and care should be made accessible, acceptable, and affordable to sex workers.

2.1.4 Providing assistance in leaving sex work

While it is important to make sex work as safe as possible for those who are unable or unwilling to leave this trade, it is even more important to try to provide viable alternatives to sex work. The empowerment of sex workers should ultimately help them establish an alternative living in which they honor God and themselves. All efforts must be made to reach out to sex workers as God's children and help them to find legal gainful ways of living.

ADPs can undertake the following activities:

- Introducing income-generating alternatives by which sex workers can strengthen their economic position. As a result, they may be able to reduce the number of their clients, feel empowered to refuse a client who insists on unprotected sex, and eventually leave sex work.
- Providing skills training to help sex workers obtain gainful employment. Such training plays an important role reducing the chances of them falling back into the same habit after being exposed to the same environment.
- Providing life skills training to help rehabilitated sex workers face the challenges in their day-to-day life
- Networking with other agencies that provide services for the rehabilitation of sex workers

2.2 Mobile groups/clients of CSWs

Along with targeting sex workers themselves, it is important to direct programming towards their clients. These clients include men from all walks of life seeking extra-marital sex, but in particular men who are mobile. Mobile groups include:

- Long distance truck drivers
- Bus and minibus drivers and conductors
- Money changers and other traders at the border
- Estate/commercial farm workers
- Cattle traders
- Fishermen

- Miners
- Construction workers

Possible activities targeting mobile groups for ADPs include:

- Providing STI testing and care
- Improving STI case management at selected health clinics
- Undertaking behavioural change communication
- Training and providing follow-up and support for peer educators for BCC
- Utilising participatory, interactive peer education approaches to maintain interest and maximise behaviour change
- Recruiting border personnel who interact regularly with truckers, trucking companies, customs and revenue officials, and guesthouse and bar personnel as peer educators
- Participating in the social marketing of condoms
- Developing and running a Multi-Purpose Drop-In Centre that integrates some of the above activities
- Lobbying the government to contribute some of the taxes collected by customs and excise to benefit the people at the border through provision of social amenities such as entertainment, sport, parking, and public convenience facilities
- Lobbying the government to shorten the unnecessarily long customs procedures that keep truck drivers at customs too long and to provide communication facilities to ease communication problems truck drivers and the populace face
- Lobbying trucking companies to station their representatives at the border to avoid truck drivers staying at the border for unnecessary long periods

2.3 Other high risk groups

Individual ADPs may also contain one of the following subpopulations that are at a high risk of HIV infection. In these cases, special programming may be developed to specifically target these populations.

2.3.1 People who inject drugs

In many parts of the world, injecting drug use is a major mode of HIV transmission. Directly injecting drugs into the blood stream using needles contaminated with HIV is the most efficient way that the virus can be transmitted. In addition, some drugs increase sexual risk behaviours that could result in HIV transmission.

ADPs can promote HIV prevention among people who inject drugs by:

- Working to improve the sexual health and sexual practices of drug users
- Focusing on harm reduction as well as rehabilitation
- Undertaking BCC activities, including training peer educators
- Undertaking HIV prevention activities when HIV prevalence is still low
- Providing access to VCT, along with appropriate referrals
- Providing access to sterile injection equipment and condoms
- Introducing a needles and syringe exchange program
- Partnering with NGOs or government agencies to provide detoxification services, including substitute drugs

- Combining any of the above interventions in a multi-pronged approach involving drop-in, mobile, and/or outreach services

2.3.2 Men who have sex with men (MSM)

Men have sex with men in most societies. They are often stigmatised, so their behaviours are hidden. Sex between men involves anal intercourse, which carries a very high HIV risk for the receptive partner. HIV prevention programs for this group are important.

ADPs can contribute by:

- Undertaking BCC activities, including training peer educators
- Providing access to VCT, along with appropriate referrals
- Providing high quality condoms with water based lubricants
- Assisting with STI testing and treatment

2.3.3 Prisoners

Around the world, prevalence of HIV is much higher inside prisons than outside prisons. There is also usually a much higher rate of diseases, such as hepatitis B and C, syphilis, and tuberculosis. Prisoners are at high risk of HIV infection because of practices such as injecting drugs with shared needles and syringes and forced or unprotected penetrative sex between men. Many countries have started projects on HIV/AIDS and STIs in prisons with success.

ADPs can contribute by:

- Providing peer education programs for prisoners or former prisoners and former drug addicts
- Providing easy access to condoms
- Linking prisoners to spiritual nurture

2.3.4 Uniformed Services

International and national uniformed services, including peacekeepers, peace observers; national defense, and civil defense forces have high infection rates for HIV/AIDS and STIs. In peacetime, sexually transmitted infection rates among armed forces are generally two to five times higher than in the general populace. This difference could be much greater in times of conflict, with infection rates increasing as much as fifty times. UNAIDS and the UN Security Council have prioritised this issue and are working on policies both nationally and internationally to tackle STIs and HIV in the uniformed services.

Several aspects of the military environment put its armed forces personnel at risk, including the fact that most soldiers are in the age group at the greatest risk of HIV infection (15-24 years) and the ethos of risk-taking that characterises the military. The risk is increased by the practice of posting personnel away from their own communities and families, groups that are then put at greater risk when soldiers are demobilised.

Military and other uniformed services need to address HIV/AIDS within their ranks and among those they have a mandate to protect. Changing the perceptions and behaviour of soldiers, police officers, and border and customs officials can produce significant benefits for the general population. This is especially true in countries affected by war or civil unrest. Uniformed services also represent a

unique opportunity for providing HIV prevention and education to a large ‘captive’ and influential audience — particularly the new young recruits, who represent an important peer group both within the uniformed services and their own wider communities.

ADPs can contribute by:

- Advocating for a non-stigmatising and non-discriminatory environment in the military
- Helping military personnel access VCT
- Training and supporting peer educators for BCC
- Coordinating uniformed service interventions with civilian interventions

2.3.5 Refugees and displaced people

Refugees and internally displaced people are some of the most vulnerable groups in the population. Cut off from their communities and lacking basic security, these people are prone to high risk sexual behaviour and are exposed to sexual abuse. Women and girls are sometimes forced into sex to obtain food and shelter. HIV/AIDS spreads quickly in these conditions, but often HIV prevention is neglected in favour of other priorities.

The factors that increase spread of HIV/AIDS among refugees include:

- Vulnerability of women and children to sexual abuse and violence
- Earlier sexual debut for children
- Practice of commercial sex as a source of income
- Lack of information about HIV/AIDS
- Lack of clean injection equipment
- Blood transfusion without proper screening for HIV (4)

HIV-related programming will depend upon the type and stage of the emergency that has created the displaced people. Natural disasters such as earthquakes, droughts, and floods will disrupt the HIV/AIDS prevention program temporarily. In war situations there may be no infrastructure at all. For purposes of planning, emergencies are divided into different stages. HIV prevention programs should be tailored according to the stages.

Stage 1: The destabilising event

This is the event that causes the emergency threatening people’s lives.

Possible activities for ADPs:

- Ensure blood for transfusions are screened for HIV
- Gather information about the HIV and STI situation in the emergency area
- Distribute guidelines about HIV/AIDS for emergency workers

Stage 2: Loss of essential services

During this period there is breakdown of access to basic needs such as food, water, shelter, security, and health care. Death and disease rates may be high and hunger acute. At this stage, relief work may begin.

Possible activities for ADPs include those listed above and also:

- Provision of basic HIV/AIDS information to displaced people
- Provision of condoms

Stage 3: Restoration of essential services

Relief work accelerates and essential needs are met. Relief agencies can now start more proactive HIV/AIDS interventions.

Possible activities for ADPs:

- Needs assessment:
 - Gathering information about HIV/AIDS situation in the affected area in order to understand existing risk behaviours and attitudes to interventions
 - Assessing the infrastructure of the existing health system and deciding what materials and skills are needed for HIV/AIDS activities
- Physical protection of refugees, especially women and children
- Continuing IEC and BCC for the refugees and community
- STI diagnosis and management
- Precaution measures where there is drug injecting
- Mobilising communities of refugees and displaced people and including them in prevention efforts

During the final two stages of the crisis (stage 4: relative stability and stage 5: return to normalcy), these activities should continue. (4)

3. DESIGN AND IMPLEMENTATION OF PROGRAMS FOR PREVENTION FOR HIGH RISK GROUPS

3.1 Assessing the situation

3.1.1 Assessing the situation of CSWs

Sex work and its particularities vary within cities, countries, and regions. A situation assessment should seek to find out:

- The types of sex workers in the community (full-time, part-time, casual, etc.)
- The types of clients using sex workers
- The types of third parties are involved (brothel owners, bars, etc.)
- Where sex work is undertaken
- Perceptions of HIV risk
- Whether there is easy access to condoms
- How often and under what circumstances condoms are used
- Whether there is easy access to VCT
- What existing programs assist sex workers
- What kind of health care is available to sex workers

A participatory learning and action program (PLA) for sex workers can be useful, because it involves the sex work community from the early stages of the prevention interventions, offers them ownership, and helps build trust.

3.1.2 Assessing the situation of mobile groups/clients of CSWs

A situation assessment of these groups should seek to find out:

- Composition of mobile populations in the area
- Travel patterns of mobile populations
- How frequently and under what circumstances they have sex with CSWs
- Whether there is easy access to condoms
- The acceptability of condom use
- Perceptions of HIV risk
- Whether there is access to VCT or STI testing and treatment at border posts and other locations where mobile groups have stop-overs
- Whether mobile groups have access to VCT or STI testing in their home communities

3.2 Developing a plan of action

ADPs should consider convening a local task group to plan interventions. This group might include:

- Local leaders, including church leaders
- Representatives of local departments or organisations implementing HIV prevention programs
- Commercial sex workers
- Mobile people in the community

At a minimum, this group can be consulted as the ADP plans its interventions. This group could also be trained to implement HIV prevention interventions. Members could be provided with information about HIV transmission and prevention and trained in BCC.

The planned interventions should take the needs and perspectives of all stakeholders into account and build upon the services already available in the community.

4. MONITORING AND EVALUATION OF PROGRAMS FOR PREVENTION FOR HIGH RISK GROUPS

4.1 Indicators for monitoring/process evaluation

Examples of monitoring and process evaluation indicators include:

- # of condoms made available
- # of CSWs or members of other high risk groups seeking VCT
- # of CSWs or members of other high risk groups seeking STI testing and treatment
- # of members of high risk groups receiving HIV-prevention messages through IEC or BCC
- # of members of high risk groups able to demonstrate accurate knowledge about HIV prevention and transmission

4.2 Indicators for impact evaluation

Examples of impact evaluation indicators include:

- # of CSWs and their clients using condoms
- # of girls and women prevented from becoming sex workers
- # of girls and women rehabilitated from sex work
- # of members of high risk groups reducing risky behaviour
- HIV prevalence among high risk groups

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V.B. CARE

B.1. CARE AND SUPPORT FOR ORPHANS AND VULNERABLE CHILDREN

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Appendix I: Sample registration card for OVC

I. INTRODUCTION

More than 13 million children under the age of fifteen, most of them in the sub-Saharan Africa, have lost one or both parents to AIDS. This number is expected to increase to more than 25 million by the year 2010. In 2001, 12% of the children in sub-Saharan Africa were orphaned, compared to 6.5% in Asia and 5% in Latin America.

The impact of HIV/AIDS on children is complex and multifaceted. Children made vulnerable by HIV/AIDS suffer psychosocial distress and may suffer from lack of food, shelter, health care, and

other material goods. They may be forced to drop out of school or required to care for chronically ill parents. They may be exposed to abuse, discrimination, or stigma.

To change this situation and improve the well being of the children, there is need for immediate sustainable action and scaling up of existing interventions at all levels. Many organisations are already responding to the problem of orphans and vulnerable children (OVC). There are a lot of lessons that have been learnt and good practices that are being implemented.

This section guides ADP staff on how to program large-scale interventions to respond to the needs of OVC. These suggestions have been compiled with reference to the lessons learned from existing responses to children made vulnerable by HIV/AIDS.

1.1 Definition of OVC

World Vision defines orphans as children below 18 years who have lost either a mother, a father, or both parents to any cause.

Vulnerable children are:

- Children whose parents are chronically ill. These children are often even more vulnerable than orphans because they are coping with the psychosocial burden of watching a parent wither and the economic burdens of reduced household productivity and income and increased health care expenses.
- Children living in households that have taken in orphans. When a household absorbs orphans, existing household resources must be spread more thinly among all children in the household.
- Other children the community identifies as most vulnerable, using criteria developed jointly by the community and World Vision staff. One of the critical criteria will be the poverty level of the household.

At the community level, defining OVC is complex and should not be dictated by World Vision. Not all orphans are vulnerable, and some of the most vulnerable children may not fall into the categories that have been defined by World Vision. The term 'AIDS orphans' should not be used because parents rarely know their HIV status. The term may lead to stigmatisation and discrimination against orphans.

1.2 Why focus on OVC?

There are a number of compelling reasons for ADPs to focus on OVC:

- World Vision is a child-focused organisation.
- Caring for OVC fulfils God's calling to look after orphans and widows (James 1:27) and to defend the cause of the weak and the fatherless and maintain the rights of the poor and oppressed (Psalm 82: 3-4).
- OVC are among those most severely affected by AIDS and most neglected in AIDS programming.
- Investing in OVC is investing in the future strength and security of communities and countries.
- Care for OVC is a powerful common ground for initiating AIDS responses in communities.

1.3 Guiding principles for OVC programming

The following guiding principles were developed by UNICEF and other partners to protect and fulfil the rights of children and adolescents. They encourage actions that are child-centred and family and human rights based:

- Strengthen the caring and economic coping capacities of families and secondary caregivers (guardian angels) through community based approaches
- Enhance the capacity of families and communities to respond to the psychosocial needs of orphans, vulnerable children, and their caregivers
- Strengthen the protection and care of orphans and vulnerable children within their extended families and communities
- Encourage approaches that allow children to remain in communities rather than being institutionalised
- Foster linkages between HIV/AIDS prevention activities, home based care, and efforts to support orphans and vulnerable children
- Target the most vulnerable children, not only orphans
- Ensure gender awareness in all the interventions
- Encourage children and adolescents to participate in identifying solutions and making decisions that affect them
- Support schools and ensure access to education
- Reduce stigma and discrimination
- Accelerate learning and information sharing
- Strengthen partners and partnerships at all levels and build coalitions among key stakeholders
- Ensure that external support strengthens and does not undermine community initiative and motivation

In practice, these guidelines mean that ADPs should not act primarily as a direct implementer, but work to strengthen communities' capacity to ensure that the well being of OVC is improved. The two core approaches for ADPs should be forming community care coalitions and supporting community caregivers.

2. PROGRAMMING OPTIONS FOR OVC CARE AND SUPPORT

2.1 Community care coalitions

Community care coalitions are groups or committees of individuals who are currently or would like to provide support to the OVC. Community care coalitions may include members of support groups of PLWHA, churches and other FBOs, women's and men's groups, cooperative groups, youth groups, households caring for OVC, government departments in the community, traditional leaders, political leaders at grassroots level, OVC themselves, and/or local authorities at the district level. Members of the coalition may be elected, volunteer, or be nominated at a community meeting (WV can facilitate this meeting).

Different communities use different terms for coalitions (Village AIDS Committees, Mutual Aid Societies, etc.). It is important to use terms that the community is already using or familiar with.

2.1.1 Why form coalitions?

There are a number of good reasons for forming coalitions:

- The problem of OVC is big and complex. No one institution can respond to all the needs of OVC.
- Care and support of OVC should as much as possible be community-owned and community-managed. The coalition provides the platform for a sustainable community based approach towards caring and supporting OVC.
- Many such coalitions are already providing care and support to OVC; hence their input is vital.
- Coalitions help communities caring for OVC avoid duplication and ensure maximum use of available resources.
- Coalitions create community ownership of program interventions and outcomes.
- Coalitions ensure participation of all the stakeholders in the community.

2.1.2 Roles of coalitions

Coalitions can:

- Mobilise the community to form OVC care committees
- Develop OVC assessment criteria
- Develop criteria for identifying caregivers (guardian angels)
- Conduct continuous monitoring of child well being (including health, nutrition, education, psychosocial support)
- Identify care providers
- Protect children against abuse and neglect
- Provide spiritual and psychosocial support to caregivers, OVC, and their guardians
- Conduct local-level advocacy for policy, practices, and resources to benefit the OVC and their guardians
- Mobilise resources to support the caregivers, OVC, and their guardians

2.1.3 Roles of WV in support of coalitions

WV ADPs can provide the following forms of support for community care coalitions:

- Assisting in formation of coalitions
- Training of coalition members in such fields as:
 - Leadership skills
 - OVC care and support
 - Psychosocial counseling
 - Caring for the chronically ill parents
 - Participatory monitoring
 - Resource mobilisation
 - Planning
 - Proposal writing
 - Budgeting
 - Other key organisational development skills that would enable the coalition to access resources to address critical needs

- Linking coalitions with referral systems and other relevant institutions (for technical support, financial support, and other relevant support available) at district and national levels
- Advocating at local and national levels for allocation of additional resources for local groups caring for OVC
- Arranging for coalition members to visit successful programs
- Helping the coalition to mobilise resources within and outside WV, for example writing proposals and concept papers to possible sources of funds
- Providing bicycles to help coalition members reach out to more community members and monitor the program effectively
- Producing IEC materials that are related to HIV prevention and OVC care and support (such as T-shirts, posters, pamphlets, video, radio programs, and drama)
- Facilitating quarterly coalition review and planning meetings
- Providing technical support in the form of trainers, facilitators, planning, and designing

2.2 Caregivers

Caregivers (also known as home visitors or guardian angels) are individuals living in the same community with the OVC who provide them with care and support. They may be nominated by the church, OVC coalition members, or self-nominated to provide care to OVC on a day-to-day basis. Most caregivers will likely be women and men who are already visiting vulnerable family members and neighbours on their own or as members of a church group, a women's group, a youth group, or some other community body. These caregivers, who volunteer their time to support OVC and affected households, form the backbone of a strategy for care and support of OVC.

2.2.1 Why work with caregivers?

The following are reasons why working with caregivers is a good strategy:

- Voluntary community care is a cost-effective way of rapidly achieving a large-scale response to reach many OVCs.
- It builds on local structures and strengths.
- It can be implemented rapidly through existing channels and partners.
- It is complementary to other ongoing initiatives.
- It enables churches and community groups to leverage many more resources to benefit OVC.
- It is developmentally sound and sustainable.
- It will result in tangible, measurable, and meaningful impacts on the lives of OVC and their families.
- It is adaptable to diverse contexts, with the potential to be replicated.

2.2.2 Roles of caregivers

Many orphans and vulnerable children live in households that are not able to provide the care they need. These households include:

- Grandparent-headed households
- Child-headed households
- Aunt's, uncle's, or neighbour's (foster) homes
- Single parent-headed households
- Households headed by someone who is chronically ill

The OVC often cannot cope with the numerous problems that they face. The community caregiver partially fulfils some of the roles of a parent, giving the children the psychosocial support of someone who cares about their well-being, assisting with household chores or responsibilities beyond the skills or strength of the children, and providing adult wisdom and counsel to help address problems, fears, or issues the children may be facing. The caregiver can fill these roles even before the parents of the children die.

The caregivers try to visit children weekly at a minimum, and are trained in how to carry out the visit, assess and record the status of the family members, and record the assistance provided. The caregivers will usually provide some of the following services:

- Observe any signs of abuse (e.g. sexual abuse, hard labour) and directly intervene to stop the abuse, if appropriate, or seek assistance or refer the case according to the protocol established by the community coalition/ADP
- Ensure that the OVC have adequate food, shelter, and access to health services and school, according to standards established by the community coalition/ADP. Facilitate access to services and resolution of problems according to protocols established by the community (e.g register children for food aid if available/needed; arrange for school fees support if available/needed; arrange for community assistance to repair the shelter; enroll the family in community garden project if available/needed, etc.)
- Assist ill parents in disclosing their HIV to children and other family members
- Provide counseling to OVC and their guardians
- Provide active listening to permit OVC and ill family members to grieve and to share their problems and fears
- Care for chronically ill guardians to delay orphaning of the children
- Provide spiritual counseling to OVC
- Assist ill parents in preparing their children for transition (will writing, identifying foster parents, developing memory books)
- Mobilise resources to support OVC
- Train guardians on OVC care
- Maintain a record of each visit using a simple standardised form provided by the ADP, which will record the status of family members, services required, and assistance rendered
- Meet regularly with other caregivers and OVC coordinators from the community/ADP in order to hand in monthly visit reports, discuss problems and issues of OVC, and get assistance, advice, and support in their work

2.2.3 Roles of WV in support of caregivers

In areas where the caregiver approaches has been implemented, caregivers have embraced opportunities to gain skills and knowledge that will enable them to provide care more effectively. ADPs can provide training in:

- OVC care and support
- Child assessment through standard observations and interview techniques
- Spiritual and psychosocial counseling, including grief counseling and counseling parents on disclosure of HIV status
- Care of the chronically ill parents
- Health and nutrition
- Microenterprise development

- HIV/AIDS transmission, prevention, and universal precautions
- Child protection, including World Vision child protection standards
- Record keeping and reporting
- Helping parents plan for transition, including understanding customary and statutory inheritance laws and rights, preparing a will, identifying foster parents, working on memory projects
- Protocols to follow if abuse is suspected

There is some debate as to whether or not ADPs should provide other forms of support, such as material incentives, to caregivers. Retention of experienced caregivers should be a key output of project design. It is inefficient, more costly, and less beneficial to the children to have constant turnover and training of new caregivers. Program design should pay careful attention to workload, caregiver/child ratio, support, and motivation for caregivers.

Whether to provide material or financial incentives for ‘volunteer’ caregivers needs to be determined within the context of each ADP and community, although having widely divergent practices in ADPs within the same country may bring about confusion, distrust, and resentment. There are concerns that providing material support (hats, shirts, food, etc.) will draw people to be involved out of desire for personal gain rather than genuine concern for children and families. In addition, provision of incentives may undermine community ownership and the sustainability of these initiatives — when incentives end, assistance to the children might also end.

It may be effective to have the community recommend the incentives that they believe appropriate and sustainable by the community. The community may recommend ways to publicly recognise, appreciate, and encourage caregivers, for instance. An alternative approach is to provide caregivers with tools that enable them to provide care to OVC more effectively, for example:

- Bicycles that enable them to visit children in good time
- Basic palliative care kits for ill children and adults
- Raincoats, umbrellas, and rain boots
- Carrier bags for their record keeping, etc.

Ndola Catholic Diocese has used incentives in Zambia. The caregivers participate in making decisions about what should be provided. Some of the incentives that have been provided include training in microenterprise development; badges for identity; training in HBC, counseling, and spiritual care; subsidised mealie meal; health schemes; raincoats, umbrellas, and shoes; care bags; bicycles; and seed money for microenterprise.

2.3 Assistance by sector

OVC may require assistance in multiple aspects of their lives. The following headings describe some of the types of assistance that ADPs and community care coalitions may want to provide. Wherever possible, the community care coalition should take the lead in providing these services.

2.3.1 Education

One of the most important priorities for OVC programming is to enable children to remain in school so that they can learn skills to care for themselves.

Interventions that assist them to remain in school must address the factors that cause them to drop out. Girls may drop out because of early marriages, lack of school fees, poor sanitation facilities at the school, initiation ceremonies, or household and babysitting responsibilities. Boys may stop school because the family is unable to pay school fees or because additional farm labour or income generation is needed when the parents fall ill or die. Some children may drop out of school because of the stigma they feel being orphaned or being very poor.

Depending on the local context, support to education for OVC may include:

- School fees, books, and uniforms
- Establishing community schools
- Negotiating with PTA or local school administrators to waive or reduce school fees for OVC
- Advocacy at national level for free universal primary education
- Construction or rehabilitation of classrooms to increase space and enrollment in schools
- Provision of teaching and school materials
- Refresher courses for teachers
- Support for vocational skills in schools
- Support for vocational training for out-of-school OVC
- Help with household chores or farming/small business responsibilities
- Childcare or nursery school for the pre-school age children

2.3.2 Health care

An OVC program cannot provide all the services of a community primary health care program, but it can ensure that the OVC are able to access the existing health facilities and resources to the same extent as other children. Depending on the context this type of programming may include:

- Transport and fees for health checkups and consultations
- Ensuring access to full immunisation coverage
- Provision of essential medicines and equipment to health units
- Training or refresher courses for health personnel, including traditional birth attendants and community health workers, in OVC care, counseling, and home based care
- Referrals to home based care and public sector agencies
- Provision of insecticide-treated bed nets
- Nutrition support/supplementary feeding
- Home based care kit for chronically ill children and adults (to be used by volunteers and other outreach workers)
- Establishing a home based care centre
- Training for home visitors in basic health, hygiene, and HIV/AIDS prevention messages
- Shelter, clothing, and blankets (where available and necessary)

2.3.3 Care for chronically ill adults

Community home based care of adults who have children and are chronically ill is a valuable OVC intervention because:

- It delays orphaning of the children
- It may help relieve the heavy psychosocial burdens (fear, anxiety, sorrow, feelings of guilt and inadequacy) of the children of chronically ill parents or guardians

- It may help relieve the additional workload that children must shoulder when caring for ill parents (domestic and farm chores, childcare, patient care)
- It prepares the children emotionally for the death of their parents

Details on setting up home based care programs can be found in the following section of this toolkit, IV.B.2.

2.3.4 Psychosocial support

Along with the means of physical survival, OVC need the following forms of psychosocial support:

- Cultural support in the form of access to a store of knowledge, values, connectedness, belonging, and traditional practices which help define the child's sense of identity
- Emotional support in the form of love, encouragement, security, motivation, self-esteem, confidence, trust, sense of belonging, and guidance
- Mental support in the form of formal and informal education and skills building
- Social support to help the child integrate into the community without feeling stigmatised and enable the child to develop a sense of belonging, acknowledge peers, learn socially acceptable behaviour, learn the limits, and learn how to access help and support
- Spiritual support in the form of help relating to a higher being and help developing hope for the future

(Source: Masiye Camp, Bulawayo, Zimbabwe)

Community care coalitions and ADPs can provide psychosocial support to orphans by:

- Training visiting caregivers in sympathetic active listening, grief counselling, and recognition/referral of psychosocial trauma, such as post-traumatic stress disorder or depression
- Training psychosocial counselors
- Training youth peer educators in peer-to-peer (child-to-child) counselling and/or starting school clubs
- Establishing youth-friendly services. This can be done in partnership with the health centre in the community, churches, or any other relevant institution where youths can seek counsel and support
- Supporting recreation activities
- Supporting children and youth camps

Memory projects

One of the most important forms of psychosocial support that can be provided to OVC is helping them and their families make memory books and boxes. This project gives ailing parents the opportunity to pass family history down to their children and leaves children with memories that help them retain a sense of identity after they have lost their parents. A memory project can help the family plan the children's future and open up discussion between child and parent.

A memory project could include a memory book where the family history, experiences shared by the child and the parent, and dreams of the parent for the child are recorded. A memory box could also be introduced to store important objects given by the parent to the child, such as pictures, birth certificate, jewelry and other items identified by the child and parent.

2.3.5 Spiritual support

Spiritual support and nurturing activities could include:

- Bible study
- Drama
- Youth and children camps
- Youth conferences
- Christian IEC materials
- Support to Sunday schools

2.3.6 Early child development

Providing early child development programs for OVC 2-6 years old has a number of benefits:

- The guardian will have time to venture into productive activities, including agriculture and income generation.
- Reduced workload for the guardian may also reduce his/her stress levels.
- Older girl children will not be kept out of school because of childcare responsibilities.
- The children will receive improved care from childcare workers, which should contribute to improved nutritional status and physical and cognitive development.

Support to early child development programs may include:

- Helping the community coalition to understand the need and purpose of such programs
- Helping the community coalition to mobilise volunteer caregivers, identify a safe and appropriate location, gain governmental approvals if necessary, and gain public support
- Helping establish a childcare committee to supervise
- Assisting the childcare committee to articulate standards of care, including child protection, safety, hygiene, record keeping, nutrition, teacher qualifications and training, activity planning, site standards, etc. World Vision child protection standards should be considered
- Providing books, developmental toys, and other learning materials
- Providing simple user-friendly tools for keeping attendance, inventories of food and learning materials, and recording daily activities
- Training childcare workers in early child development, standards of care, child protection, record keeping (attendance and supply inventory), hygiene and safety, food storage and preparation, and activity planning
- Providing a meal and/or take-home nutrition packages for children. If possible, all children should have one balanced, nutritious meal for every three hours they are present in the centre. It is recommended to consult with the WV nutrition or food security advisors or the local government concerning the caloric and nutritional content and balance most appropriate for the age group, keeping in mind availability of local and donated foods
- Constructing or renovating day care centres managed by communities for children under six years old
- Constructing multi-use community centres to be used for community based childcare, programs, youth club meetings, and community care coalition meetings

When setting up the day care a number of issues have to be considered:

- Distance: is the centre within reach of children? Can the guardians easily walk to drop and pick up the children?
- Scaling up: can the program be replicated without any financial constraints? Many times, fancy expensive structures affect scaling up of the day care centres. It is important to build the structures using local materials, which are readily available and cheap, or to identify existing buildings, such as churches, community centres, or even houses.
- Caregivers: are there enough caregivers for the day care? Care of children below 6 years old is very labour-intensive. To ensure safety and adequate supervision, a caregiver should only care for a maximum of 6 to 8 children depending on the age range and national standards from the Ministry of Education or Child Welfare.
- Skills: do the caregivers have the skill to care for young children in a group setting meeting national standards? All caregivers should receive the basic training described above. Never assume that all caregivers have all these skills already.

2.3.7 Water and sanitation

It is not possible or desirable for an OVC intervention to replace or provide an entire water development program. The regular ADP program should provide this and the OVC program should ensure that OVC are accessing clean water at the same standard of all children.

2.3.8 Food security

The ability of households to care for children or take in orphans depends largely on their socioeconomic strength, and food security is key. Improving food security means improving the ability of households to produce food, generate income to buy food, and/or utilise food more effectively. An OVC program cannot necessarily replace or include a full agricultural development program, but it should try to ensure that all OVC are consuming two balanced meals per day, including the recommended amounts of proteins, carbohydrates, fats, and vitamin and mineral-rich foods.

Depending on the local context, achieving these goals may require:

- Assistance to community farms to enhance crop production, including provision of agricultural inputs and training and introduction of low-labour methods and highly nutritious crops, such as backyard vegetable gardens
- Provision (loan or grants) of small animal breed stock (chickens, rabbits, honeybees, pigs, etc.) and training for families or groups in livestock management
- In-kind or cash loans for productive assets (dairy animals, oxen, maize mills, etc.)
- Provision of seed capital for development enterprises
- Training of households in various skills and microenterprise development
- Provision of nutritional supplements (food rations) through institutions (clinics, schools) or direct distribution. Such programs need to target children with severe food shortages and need to include provisions to avoid stigma and discrimination against enrolled children

2.3.9 Local-level advocacy

There are many issues affecting OVC that can be addressed through local-level advocacy. For example, OVC are often left destitute because inheritance laws do not protect them or are not enforced. Community care coalitions can develop strategies to protect the inheritance rights of children. Other advocacy projects could include seeing that the legal protection of children from physical and sexual abuse is enforced or lobbying for the suspension or reduction of school fees.

3. DESIGN AND IMPLEMENTATION OF OVC PROGRAMMING

The problems of OVC and most of the solutions lie within the community. For children whose extended families cannot provide adequate care, the community becomes the safety net. The main task that ADPs face in the design and implementation of OVC programming is supporting community members in their work. This involves helping community members strengthen and scale up care initiatives already underway and facilitating the introduction of new care initiatives.

3.1 Assessing the situation

3.1.1 Conducting initial community meetings

The ADP's first step will be conducting initial community meetings to discuss the problem of OVC in the community. These meetings should involve the churches, traditional leaders, OVC, affected households, CBOs, NGOs, and government representatives in the community.

The objectives of these meetings are to:

- Create awareness about the need to respond to the effects of HIV/AIDS
- Raise awareness about the number and needs of OVC in the community
- Identify community leadership and coalitions to spearhead OVC activities

To ensure participation by all the stakeholders, a participatory approach should be used. This will enable the community to share their experiences and ideas about what can be done within their environment. Participation of the OVC themselves in the identification and implementation of strategies is particularly important. Some participatory tools that can be used are social and resource maps, activity profiles, focus group discussions, and seasonal calendars.

3.1.2 Assessing the situation of OVC

The second step is to help the community assess their situation in relation to OVC and identify priorities for assisting them.

At this stage WV and the community will:

- Identify the number of OVC
- Project the growth trend in OVC for at least five years into the future of the community
- Identify major needs of OVC
- Identify critical community strengths and weaknesses in caring for and supporting OVC
- Identify strategies, activities, and actions that will address the identified needs of OVC
- Develop community plans indicating what the community itself can do and what World Vision will do
- Identify other possible partners to meet any gaps

- Develop OVC assessment criteria and registers

Identifying OVC and affected households

The process of registering orphans and vulnerable children is a useful mechanism for:

- Assessing the scale of need in a particular community
- Ensuring that benefits reach the right children
- Building awareness of the scope of the problem in the community

Registering should be done by the community through care coalitions and caregivers. Registration cards can include the OVC's name, sex, age, school status (in or out of school, grade level), village, parental situation (paternal, maternal, or double orphan, or other kind of vulnerability), and head of household (single, female, male, child, grandparent, neighbour, uncle, aunt, etc.). A sample registration card is provided in Appendix I.

This information is important because interventions to support OVC will vary according to the head of their households. For example, OVC in child-headed and grandparent-headed households may require more direct material support while the OVC in female- and male-headed houses may require minimal material support but need long term, sustainable, production-oriented activities.

Knowing the number of affected households will help in determining the size of the interventions and how many resources would be required for an effective and sustainable OVC care program.

3.2 Developing a plan of action

Program planning will involve the following activities:

- Assessing how the identified community based strategies will address the identified needs of OVC. When assessing the strategies the issue of sustainability should be taken into consideration
- Identifying resources and skills required to implement the program
- Utilising existing community structures (e.g. churches) or designing sustainable community structures (community care coalitions) to ensure continued OVC care
- Gathering more information about how ADP teams can assist the community to mobilise resources and technical support
- Developing a community action plan to determine who does what, when, and how. This will be the first tool for monitoring the planned activities
- Deciding on standards of care for OVC and how the necessary services can be mobilised and needs can be met by accessing ADP, government, community, or other resources and facilities
- Deciding what expertise from outside the community will be needed to train community members or volunteer caregivers in special skills such as grief counselling, home based care, HIV/AIDS education, etc and identifying source of trainers and technical assistance
- Mobilising resources internally (within the community) or externally (outside the community — from World Vision, World Bank, etc.). External resource mobilisation is usually done using concept papers and proposals. Internal resource mobilisation is the preferable approach, because it a faster and more reliable way of securing resources

3.3 Notes on implementation

3.3.1 Launching the program

Launching the program is conducted once resources have been accessed and activities are ready to be implemented. It can just be a half-day workshop facilitated by the ADP team.

Objectives of the project launch workshop:

- To inform the community of the resources that have been accessed and seek new commitment
- To clarify the criteria and requirements of using the resources
- To facilitate a process that allows the community coalitions and the intended beneficiaries to agree on the project activities and prepares the community to attain the agreed-upon goals
- To clarify the roles and responsibilities of the ADP team, the coalitions, and the intended beneficiaries
- To develop an implementation and monitoring plan

3.3.2 Scaling up

Scaling up OVC programming means increasing the number of OVC reached and the variety of services offered to them. At the moment, many OVC are not receiving adequate care, and the OVC problem is expected to grow during the next decade. Rapid and effective scaling up is the only way this need will be met.

In their scale up workshops, the International HIV/AIDS Alliance identified three issues to consider when scaling up:

- Coverage of the activities. When programming to scale up existing OVC programs, coverage should either increase the number of OVC benefiting or increase the interventions and activities supporting OVC.
- Impact of activities. Activities must have a proven positive impact on OVC and their households.
- Sustainability of outcomes. The outcomes should be sustainable by the community. This can be achieved by keeping children within their extended families and communities and basing programming on community initiatives.

OVC programs should be expanded if:

- The results are positive and an impact has been measured.
- There is an identified need in the community to increase coverage.
- Sustainability measures are in place.
- Resources are available.

In scaling up, program planners should be wary of the following pitfalls:

- Increased workload leading to caregiver stress and burn out and high caregiver turnover
- Difficulty in coordinating increased activities
- Poor monitoring
- Strain on resources
- Compromised quality and reduced impact
- Implementing undesired activities because of donor pressure
- Rapid organisational growth, which may lead to poor program management
- Poor logistics
- Reduced benefits to the OVC and their households
- New community expectations, which may not be fulfilled

4. MONITORING AND EVALUATION OF OVC PROGRAMMING

In partnership with the coalition, the ADP team will:

- Facilitate the supervision and monitoring of OVC projects and report on the progress according to agreed indicators
- Monitor community performance, including financial management, according to agreed indicators and schedule
- Monitor the status and well being of OVC by reviewing monthly visit reports of volunteer home visitors
- Organise or undertake spot checks on OVC homes
- Organise or undertake accompanying caregivers on visits to observe quality of care
- Ensure that the coalition documents the assistance provided to OVC
- Facilitate community monitoring meetings to ensure accountability
- Regularly compile the information from all the coalitions within the ADP and use it to prepare an OVC report twice a year
- Prepare a human interest story with photos illustrating the difference that OVC sponsorship has made in the life of an orphan or highly vulnerable child and her/his family, in the two quarters before the OVC report is sent

Monitoring of OVC status and well being can be done directly by the volunteer home visitors and reported using a simple, standardised, user-friendly form. The reports on OVC status should be turned in monthly to the OVC coordinator on the community coalition. It may be helpful for groups of volunteers who live near each other to meet on a regular basis with the OVC Coordinator or ADP program manager to discuss their reports and clients in order to obtain advice and assistance with problems and share ideas about how to help the children.

Monitoring should be done in a participatory manner and can be done through community meetings, visits to OVC households, meetings with the children themselves, and reports from the community committees. Feedback meetings are very important. These should be agreed upon and planned for by the community at the project launch. These meetings will help the community review what has happened since the last meeting, including what has succeeded and what has failed, why interventions have failed or succeeded, lessons learned, and issues that need further resolution.

4.1 Indicators for monitoring/process evaluation

During the planning and proposal writing stage, the community and the ADP team will identify indicators that will show them whether their interventions are proceeding according to plan. These may include:

- Existence of OVC registers
- # of caregivers trained
- # of coalitions trained to manage community OVC activities
- Amount of funds generated internally by communities
- Amount of funds mobilized externally by communities
- Retention/turnover rate of volunteer caregivers
- # of churches involved
- # of OVC registered
- % of OVC registered who are visited regularly

4.2 Indicators for impact evaluation

The community and ADP team will also identify indicators that show them whether their interventions have yielded or will yield the desired outcomes. These may include:

- # or % of registered OVC and their households receiving support
- # or % of OVC in school
- # or % of OVC accessing specific services like health care, home based care, psychosocial counseling, etc.
- # of OVC reporting that they eat at least two meals per day
- # of OVC accessing day care facilities

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Appendix I: Sample registration card for OVC

#	Name of OVC	Name of village/ section	Sex		Age	In School?	Grade in school	Household Head*	# of people in house
			F	M					

F - Female

M - Male

* CH - Child-headed

GH - Grandparent-headed

FH - Female-headed

MH - Male-headed

B.2. HOME BASED CARE FOR ADULTS

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I. INTRODUCTION

Families and communities all over the world are helping individuals and households affected by HIV/AIDS to meet their physical, social, psychological, and spiritual needs through home based care programs. This assistance is urgently needed because of the continuously increasing number of people living with HIV/AIDS (PLWHA) and because of the limited health care facilities in many parts of the developing world. Home based care (HBC) helps improve the length and quality of life of the chronically ill.

A number of ADPs have already started home based care programs to extend care to families affected by HIV/AIDS and terminal illness in the high prevalence countries. The purpose of this section of the toolkit is to prepare more ADPs to initiate or scale up home based care programs in the communities in which they work.

I.1 Definition of home based care

Home based care broadly means any form of care given to sick people in their own homes. It involves all the care given to them by family, friends, neighbours, or health workers to improve their quality of life.

Home based care is a combination of active and compassionate therapies that meet the physical, social, psychological, and spiritual needs of the ill person and her or his family, and improves the quality and length of life of people living who are chronically ill.

The objectives of home based care are:

- To support chronically or terminally ill patients psychologically, spiritually, and physically
- To promote family and community awareness of HIV/AIDS prevention and care
- To promote long term family support and strengthen family bonds

While home based care includes components specifically intended for PLWHA, it is useful for any chronically ill person. In most HIV/AIDS-affected areas, testing is not widely available and most people do not know their HIV status. ADPs should seek to facilitate community-led home based care for any chronically ill people in the community, in order to avoid creating discrimination and stigma.

1.2 Benefits of home based care

Organised home based care has many advantages for a chronically ill person, the person's family, the community, and the health system.

The benefits for the individual include:

- Improved psychosocial well being, including less mental stress and more positive and hopeful feelings, as a result of being in a supportive home atmosphere
- Generally improved quality of life
- Avoidance of the exposure to infections that the individual might experience in hospital
- Reduced sick days and increased productivity, and increased opportunity to continue to contribute to the family and society

The benefits for the family include:

- Preservation of family togetherness
- Assistance in accepting the condition of the PLWHA or chronically ill person
- Assistance in providing care and support to the chronically ill person
- Reduction in medical costs
- Assistance for family members who provide care to the chronically ill person in attending to other responsibilities
- Delay in orphaning, providing a chance for the parents or guardians to prepare for their children's future

The benefits for the community include:

- Promotion of awareness of methods for preventing of HIV/AIDS
- Assistance understanding the disease and the correction of myths and misconceptions
- Reduction of cost
- Assistance in providing care and support
- Assistance in maintaining community cohesiveness

The benefits for the local health care system include:

- No requirement for extra services where resources and services are already inadequate
- Less demand on the health system
- Sharing of caring responsibility with family and community

1.3 Major components of home based care

Home based care for PLWHA involves comprehensive care that consists of four related elements: disease management, nursing care, counseling, and social support.

1.3.1 Disease management

Disease management involves monitoring the progression of HIV/AIDS in the patient (if the patient has been tested) and diagnosing and treating opportunistic infections. The care provider's ability to manage the patient's diseases will vary according to the health facilities and medicines available in the community. Some services the home based care team may be able to provide, depending on the local context, include:

- Administration of drugs to treat pain and opportunistic infections and, where possible, to control HIV infection
- Referrals to appropriate medical facilities for illnesses that cannot be treated at home
- Care for wounds and sores
- Control of diarrhea
- Home and traditional treatments

1.3.2 Nursing care

Nursing care, sometimes called palliative care, involves maintaining the hygiene of the patient and his or her environment, promoting good nutrition, and making the patient as comfortable as possible. Specific activities include:

- Helping the patient keep her or his body clean
- Ensuring that food is hygienically stored and handled
- Helping the patient keep her or his eating utensils, clothes, and bedding clean
- Helping the patient keep her or his compound clean
- Maintaining universal precautions to protect the care provider and family members from HIV infection
- Ensuring that the patient has a balanced and nutritious diet including food from the three food classes (energy-giving, protective, and body-building)
- Encouraging the patient to drink plenty of liquids to avoid dehydration
- Encouraging the patient to avoid alcohol and tobacco
- Guiding the patient in physical therapy exercises
- Giving the patient therapeutic massages

1.3.3 Counseling

Home based care counseling of PLWHA and the chronically ill can involve a wide variety of activities. These may include:

- Information about avoiding re-infection and infecting others
- Instruction on condom use and provision of condoms
- Information about preventing mother-to-child transmission
- Discussion of the patient's treatment options
- Succession planning, including drafting a will and/or selecting foster parents for children
- Psychological counseling, to help the patient maintain a positive attitude towards life and cope with the challenges her or his illness brings
- Emotional support, in the form of active and compassionate listening
- Spiritual support, to help the patient find hope and peace

1.3.4 Social support

Providing social support involves connecting the patient to the wider community resources that may be available to her or him. These may include:

- Support groups for PLWHA
- Church groups
- Welfare services
- Legal advice
- Material assistance

Along with these main components, any coherent home based care response to the AIDS epidemic should seek to link the care of PLWHA with the care of vulnerable children and prevention activities. Community caregivers can be trained to identify vulnerable children and to assist parents in discussing HIV with their children and spouses. Caregivers can also be trained to identify HIV/AIDS prevention needs among family members. The teams can help children in AIDS affected households to better understand their parents' condition and to protect themselves from HIV. Advice from people they trust regarding AIDS prevention has proved to be more effective than the messages children receive from mass media, education, and communication campaigns.

2. PROGRAMMING OPTIONS FOR HOME BASED CARE

The appropriate approach for setting up or expanding HBC programming will vary according to the situation in the community. Efforts that build on current family and community responses and existing structures and systems (both formal and informal) should be supported. ADP staff should first investigate to see what responses are already underway and look for ways to support those who by necessity or choice are on the front lines of care.

In most communities, family members will be looking after chronically ill relatives, and helping these individuals should be a primary priority. Next, broader traditional networks of care, for example through kinship networks or churches, should be identified and supported. Finally, the ADP may want to consider starting its own home based care program. Each of these approaches is outlined below.

2.1 Working with families caring for the chronically ill

ADPs should first attempt to identify the families in a community who are caring for a chronically ill person in their household. This information could be sought from local churches, clinics, or welfare societies, or through a survey. ADP staff should also find out what kind of training and support, if any, these family members receive. Depending upon the needs that community members and these families identify, ADPs could:

- Train trainers to provide family members with on-site instruction in disease management, nursing care, counseling, and social support
- Train trainers to instruct family members about how to use universal precautions to protect themselves from HIV infection
- Inform family members of support services available in the community
- Find ways to help the community provide extra support and supervision to children who are caring for sick adults
- Help organise a visiting system in which neighbours regularly check on the family and provide support. These visits could be informal or they could involve trained home based care providers
- Supply families with equipment, medicine, or food
- Help families who are caring for the chronically ill organise support groups

Activities intended to assist families caring for the chronically ill can be informal and flexible. Formal training in home based care techniques and a monitoring system to ensure that the techniques are being followed properly, as described below, are helpful. But more important than designing and implementing a highly organised system is making sure that those who are bearing the greatest care burdens are getting immediate, effective, and sustainable support.

2.2 Strengthening home based care programs that are already underway

If there are already home based care programs in the community, then ADP staff should look for ways to support, strengthen, and expand these programs rather than starting a new program. This may involve partnering with government agencies, NGOs, CBOs, churches, the Salvation Army, women's groups, or any other group running a home based care program in the community. The Catholic church often implements effective home based care programs.

Depending on the context, ADPs could offer the following services and resources:

- Assistance training and monitoring more home based care providers
- Introduction of new skills (i.e. counseling skills, nutritional advice, physical therapy skills) to current home based care providers
- Assistance to HBC programs in obtaining medicines to treat opportunistic infections
- Supplies for home based care kits or home based care centres
- Assistance in expanding the home based care program to more churches or community groups

2.2 Forming and implementing home based care programs

Where home based care teams do not exist, ADPs should consider starting new programs. Doing so involves identifying or creating a community group that can identify volunteer care providers and manage the program with the help of ADP staff. Often churches are a natural partner for home based care programs because they are a good source of committed volunteers who wish to follow the Christian mandate to care for the sick, oppressed, and helpless, and widows and orphans (Luke 4:18, Matthew 10:42).

Information about how to start a home based care program is given in part three of this section, below.

2.3 Establishing social support networks and referral systems

The goal of comprehensive care is to link an interdependent array of providers and services that can address comprehensively the care needs of people living with HIV/AIDS and their caregivers in a wide range of environments. To help meet this goal, ADPs can map out the resources and institutions that exist in the community and develop a referral system for the chronically ill in order to provide comprehensive care and support. Caregivers will then have information about where to make referrals and gaps in community care can be identified.

ADPs can also improve the care and well being of PLWHA by facilitating the creation of self-help groups. These groups offer PLWHA the opportunity for companionship, support, and a chance to share expenses and discuss problems openly. Such groups are a practical response to isolation and a forum for PLWHA to engage in advocacy issues that affect them.

2.4 Establishing a home based care centre

ADPs may also consider establishing a home based care centre, which can serve as a storage facility for home based care supplies, a location for home based care training and meetings, and an outpatient clinic for those patients who can walk. The centre could be expanded to provide a range of care and prevention services, including:

- VCT
- STI diagnosis and treatment
- Prevention information and materials (such as condoms)
- Rotational lending and saving
- Demonstrations of food preparation for improved nutrition
- Income generating initiatives to improve household incomes
- Psychotherapy services
- Group meetings and discussions
- Video shows, role-plays, and drama

3. DESIGN AND IMPLEMENTATION OF HOME BASED CARE PROGRAMMING

ADPs should try to design and implement home based care programming in a way that maximises community initiative and ownership and minimises dependence.

Appropriate roles for ADPs may include:

- Helping to catalyse and train the home based care teams
- Linking different home based care teams in the community with others and promoting networking
- Identifying agencies and individuals who can provide resources and facilitating linkages with the home based care teams
- Offering support to families facing a crisis or emergency through home based care teams
- Contributing towards existing initiatives identified by the home based care teams to raise household income
- Monitoring the program and building volunteer caregivers' capacity to monitor
- Organising and coordinating a participatory evaluation of the initiative, facilitating reflection and dissemination of lessons learned
- Advocating with government and other agencies for support for HBC programs
- Ensuring the sustainability of the initiative

If the ADP finds it necessary to start a home based care program, there are several steps to be taken, which are outlined in this section. These steps are meant to be a flexible guide for programming. They may not be sequential as outlined here since some ADPs are starting and others are expanding their home based care programs. The interventions suggested here are not exhaustive and ADPs' programming may not be limited to these. Prior to any of these steps, an ADP should obtain any national home based care policies, guidelines, manuals, and other training materials that may exist in the country.

3.1 Assessing the situation

The ADP staff needs to find out two kinds of information: the number of chronically ill adults in the community who need more and better care and the types of home based care, both informal and formal, that are already underway in the community.

The following information will be helpful to know:

- # and % of recent deaths due to HIV/AIDS
- # and % of orphans
- # and % of PLWHA or other chronically ill people
- # of widows and widowers
- # and % of those who cannot access the food they need
- # and % of those who cannot access the medical treatment they need
- # of chronically ill people who are visited and not visited
- # of people who are in pain
- # of grandparents who are caring for grandchildren
- # of children who are caring for their parents

3.2 Developing a plan of action

3.2.1 Sensitising the churches and community about the needs of PLWHA

This step applies to communities where little or no formal home based care programs are currently taking place. ADP staff should identify churches or community groups that may be interested in providing care for chronically ill individuals. The staff should not impose its own program on the community or church but instead help the church or community develop its own priorities based on the community's needs. This can be done through community or church meetings.

The objectives of this step are to:

- Facilitate group discovery of the HIV/AIDS needs that exist in the area
- Identify what initiatives are already helping those affected by HIV/AIDS
- Explore the value of care activities targeting those infected and affected
- Identify who the caregivers are in the community
- Show church members that Jesus was involved in home based care activities (Mark 1:29-31)

3.2.2 Selecting volunteer caregivers

Next, ADP staff and the community or church members should identify the particular activities that can be undertaken to support HIV/AIDS affected families and the organisations, facilities, and resources that can be utilised. Assuming that the community wishes to initiate a home based care program, the next step is identifying caregivers.

Caregivers are usually understood to be community volunteers who visit neighbours who require care and support. This group is important in HBC responses, but it is even more important to provide support to family members, including children and the elderly, who are caring for sick adults. ADP staff and church or community members can begin by providing family members with basic skills in disease management, nursing, and counseling, and helping them access the medical supplies and material support that they require.

Young people should be involved in the care and support of people living with HIV/AIDS. In Zambia, the Society of Women Against HIV/AIDS in Africa has developed a program to provide young people with skills and knowledge to improve their caregiving roles, and to expand caregiving from the family to the community so that other children without sick relatives can help their friends and school mates. They are trying to make caregiving by boys a community norm, so that girls are not so burdened.

At the same time, volunteer visitors should be selected by the church or the community. A number of people should be involved in the selection process to avoid any possible bias. The process should be flexible and undertaken with care. Churches are usually an excellent source of volunteer caregivers, because of the Bible's emphasis on active compassion. No volunteer should be chosen who expects a financial gain.

Factors to consider when selecting volunteers include:

- Age — a caregiver should be mature.
- Gender — older women have been especially effective volunteers, because of their cultural role as nurturers. However, the workload and burden placed on women in the community should be considered. Male participation should be encouraged, especially to help male patients.
- Commitment — the individual should have shown prior commitment to caring for others.
- Religious background — it is desirable for the caregiver to possess spiritual faith, hope, and love. Persons of the same faith as their patients may bring more understanding and comfort to them.
- Time — the volunteer should have enough time to carry out the work.
- The volunteer should live in the same community as the clients and their families.
- The volunteer should demonstrate a clear understanding of the problems faced by clients.
- The volunteer should have an interest in the clients.
- The volunteer should be a reliable person who can be trusted.
- The volunteer should be honest and faithful.
- The volunteer should have the ability to relate well with people.
- The volunteer should respect the patient's confidentiality.
- The volunteer should be a good listener.

It is not necessary that volunteers have a high level of education. Volunteers who cannot read or write have in most cases worked effectively if they are well trained and supervised.

3.2.3 Training volunteer caregivers

The training of volunteer caregivers should be conducted as regularly as possible. Training should be as concise and simple as possible, with a focus on enabling team members to acquire practical skills quickly. Volunteers should be presented with a certificate at the end of their training to motivate them in their work.

All volunteers will need basic training in disease management, nursing, counseling, and social support. One way to approach more specialised training is to organise the home based care team (HBCT) into sub-committees of five or so people, with each sub-committee focusing on a special topic (i.e. nutrition, children's needs, resource mobilisation). Specialised personnel can then be brought in to provide further training on these topics. This training may be done in phases.

The course content for home based care team training should include:

- Basic facts about HIV and other STIs
- Basic counseling skills
- Practical home based care skills
- Nursing care for the chronically ill, e.g. bed baths, dressing, feeding
- Nutrition and hygiene
- Care and counseling for children in need
- Treatment for the sick
- Infection control and care of opportunistic infections
- Spiritual support to the clients
- Community mobilisation skills
- Resource mobilisation skills

- Record keeping
- Simple needs assessment
- Simple monitoring skills
- Simple evaluation of the progress of the program
- Information about the rights of PLWHA

In selecting, training, and supporting community caregivers, ADPs should also consider the following guidelines:

- The training of home based care providers should be based on established country standards. These standards can be appropriately adapted to cultural norms and should include emotional and psychological support.
- Home based care providers and their clients should be trained to recognise when referral for medical, social, or psychological assistance is needed.
- Caregivers should be given ongoing support so that they are able to regularly monitor their provision of basic care and access further training. Volunteers also need to be emotionally supported as caring for the terminally ill can be overwhelming.
- Community care providers should be encouraged to develop relationships with spiritual leaders in the community so that PLWHA can access spiritual support.
- The networking of community care providers in different localities to facilitate mutual learning and nurture relations between communities and government health care workers should be supported.

ADPs should facilitate the training of care givers in home based care skills and help them obtain a home based care kit to care for the sick. The home based care kit may include the following materials:

- Waterproof bag
- Gloves, heavy duty and disposable
- Towel
- Antiseptic soap
- Clients' register and assessment cards
- Referral forms
- Monitoring forms
- Volunteer's diary
- Pens
- Pair of scissors
- Apron or chitenge/wrapping cloth (for the volunteer to wear when cleaning the sick and the surroundings)
- Oral rehydration salt
- Gallipots and receivers for cleaning wounds
- Cotton wool
- Bandages, crepe and cotton

The ADP or care committee may also wish to consider providing care providers with bicycles.

Other home based care equipment can be provided to a clinic or home based care centre, including:

- Bathroom scale
- Blood pressure machine
- Basic medicines
- Thermometer
- Storage cupboards

3.3 Notes on implementation

3.3.1 Motivation and support for home based care teams

One major concern people have when working with volunteers is how motivation can be sustained. Incentives are often defined in a narrow materialistic sense. They can, however, be both material and non-material. An incentive is something that motivates and encourages a person by recognising their contribution and worth.

Whether to provide material or financial incentives for ‘volunteer’ caregivers needs to be determined within the context of each ADP and community, although having widely divergent practices in ADPs within the same country may bring about confusion, distrust, and resentment. There are concerns that providing material support (hats, shirts, food, etc.) will draw people to be involved out of desire for personal gain rather than genuine concern for PLWHA and their families. In addition, provision of incentives may undermine community ownership and the sustainability of these initiatives — when incentives end, assistance to those who are ill might also end.

Possible material incentives include:

- Food packs
- Soap
- Pens and notebooks
- Money for transport
- Uniforms or badges
- Agricultural inputs
- Income generation assistance and training
- An allowance

Non-material incentives include:

- Personal fulfillment
- Compassion
- Community gratitude
- Group identity
- Self-worth
- Sense of identification with PLWHA
- Increased knowledge through training
- Formal community appreciation at special gatherings and occasions
- Mutual support and supervision among HBC providers
- The opportunity to act on one’s faith

As ADPs plan ways to support volunteer caregivers, they should also be careful to avoid de-motivating their volunteers. De-motivating factors include:

- Unfulfilled expectations — the material incentives to be provided must be carefully explained to avoid misunderstanding. The volunteer must understand that she or he is not being offered employment. Some form of written agreement is useful in this regard. Promises made should be clearly explained.
- Misunderstandings about expected conduct — volunteers sometimes perform poorly or behave in an unacceptable way. Written codes of conduct, signed by volunteers, are useful in such situations, as are clear standards of care. Volunteers themselves should be involved in this problem solving process. This process can be formalised into a management committee as the program develops.
- Negative staff attitudes — volunteers are essential to community programs. However, they can easily become de-motivated if the work they are doing is not valued by paid staff. The tendency to regard people as ‘just volunteers’ can be very damaging.

Supervision and support

Often NGOs organise training courses for community volunteers in the hope that they will then return to their communities and implement what they have learnt smoothly and perfectly. Unfortunately, this does not often happen.

Learning how to carry out all the tasks of a home based care program while meeting the standards of care established by the program is vital to achieving the goals of that program. A short, formal course is usually insufficient and needs to be followed up over a prolonged period of time through supervision, support, and refresher training by program trainers, community coordinators, and ADP managers.

Ongoing supervision and support is vital to the success of volunteer programs and should be part of the planning stage. Too often, though, this aspect is overlooked. The purpose of supervision is to ensure that volunteers are adhering to performance standards and codes of conduct, to identify gaps for additional training, to positively reinforce and appreciate their efforts, to help solve problems that volunteers face, and to facilitate access to needed tools, resources, or information which will improve their effectiveness.

Possible forms of supervision and support include:

- Organising HBC volunteers into small squadrons with an HBC team leader selected from the community, who may receive extra training and may have more responsibilities for support, problem solving, and reporting on behalf of other members (this can be balanced with a lighter client load for the team leader if necessary)
- Helpful responses by program staff to correspondence and reports from volunteers
- Telephone contact with between program staff and volunteers, where possible
- Support visits by program staff
- Opportunities for volunteers to visit the program office
- Program newsletters
- Regular meetings, training, peer support, and information sharing.
- Working in pairs (particularly for new volunteers) for mutual support and problem solving and to ensure cover when one is absent

Mutual support meetings are a powerful motivator because they provide an opportunity to share information about the program, solve problems, obtain expert advice or access to needed services from a supervisor or community coordinator, and involve volunteers in the decision making process. Meetings can also be a time when monitoring reports are turned in by volunteers to program management. But volunteers should not be overburdened with meetings because they need to carry out visits and fulfill their own domestic commitments.

A volunteer’s best support, after initial training, is to have clear, mutually agreed goals and standards of care, work plans, protocols for referrals, and knowledge of how and where to obtain assistance and resources as needed. Support from a supervisor or program manager then becomes a matter of helping the volunteer to meet goals, adhere to standards, analyse gaps and shortfalls, overcome constraints, and celebrate success.

3.3.2 Resource mobilisation

The objectives of resource mobilisation are to:

- Identify the support resource pillars in the community
- Establish ways of mobilising and sustaining resources

The entire home based care team should be involved in resource mobilisation, with the sub-committee focused on resource mobilisation (if it exists) taking the lead. The first step is identifying community resource support pillars. This can be done through resource mapping.

Resource mapping

1. Draw the village map on the ground.
2. Use local materials to identify resource individuals and institutions.
3. List the resource support pillars on a sheet of paper.

Example of support pillars:

<u>Name</u>	<u>Resource/title</u>
Mutenyo	Head teacher (funds, knowledge, food)
Wakholi	Teacher (knowledge)
Khaukha	Shopkeeper (funds, materials)
Mayelo	Shopkeeper (funds, material)
S. Khaukha	Pastor (spiritual help, materials)
Washaki	LV counselor (funds, food, etc.)
Malisa	Farmer (skills, food)
Namasake	LCI Chairman (funds, mobilisation)
Wamukota	Nurse (health care treatment referral)

Methods of mobilising and sustaining resources include:

- Conducting regular meetings to discuss resource allocation and mobilisation
- Holding door-to-door collection of resources from the support pillars
- Persuading churches to have a day for collection of resources for the home based care program
- Approaching resource support pillars individually, for example by sending a letter

- Holding a meal/tea for fundraising at a church or the home of a believer and inviting different people
- Ensuring that the support pillars are sent accurate accounts of what their support has made possible
- Holding meetings with the support pillars and sharing success stories
- Conducting plays, drama, and competitions for fundraising
- Writing letters of appeal for support to NGOs and government agencies
- Establishing small income generating projects for the affected families
- Working through local and district committees
- Writing thank you letters and cards to supporters

4. MONITORING AND EVALUATION OF HOME BASED CARE PROGRAMS

The HBCT should maintain a master register of all clients being cared for. The register is completed at the time of the client's admission to the program. It may include information such as name, client number, marital status, gender, and contact address as well as a column for additional comments (e.g. bedridden or not, level of acceptance by the family). The register will assist the program in knowing how many clients the program is caring for. An A4 handbook is suitable for this purpose.

Checklists are one way of monitoring the provision of services. Checklists assist the HBCTs to determine whether particular activities of a visit were completed or not. A checklist should include what the HBCT member is expected to do in every home visit. The HBCT member should indicate whether he/she did particular actions or not and whether particular situations exist or not. The checklist may then be easily transformed into a monitoring report.

Here is an example of a home visit checklist to be completed by HBCT members.

Name of Client _____ Name of volunteer _____ Date of visit _____

ASPECT/ELEMENT	YES	NO	Action taken/ service provided
Are the houses and surroundings clean and tidy?			
Is the toilet clean?			
Is the client able to walk by him/herself?			
Was there food in the house?			
Did you pray and read a scripture with the client?			
Does the client need any medical care?			
Has the client had any medical problems?			
Did the client receive any medical care?			
Do the members of the family care for the client?			
Is the client bedridden?			
Does he/she eat normally?			
Did you carry out any practical care for the client?			
Are there family members who help care for the client?			
Notes for referral or follow up			

Most volunteers have low literacy levels and may not fill in the checklist in English. This checklist can be translated into the local language. Alternatively, for illiterate volunteers, checklists may be simplified and use pictures which represent each activity.

Along with the checklist, HBCT members should be trained to keep records of their visits that capture the following information:

- Name of client
- Date of visit
- Findings/observations
- Activities performed
- Needs
- Recommendations

This information can be recorded in a large analysis book and kept by the HBCT members.

4.1 Indicators for monitoring/process evaluation

Indicators for monitoring home based care programs include:

- # of home based care volunteers trained
- Amount of material support made available to the clients of home based volunteers (i.e. food, medicine)
- # of visits made by home based care volunteers to patients
- # of referrals of PLWHA or their children to appropriate services

4.2 Indicators for impact evaluation

Volunteer caregivers should be involved in developing impact indicators. These may include:

- # or % of clients cared for
- # or % of families visited
- # of family members caring for the sick
- Amount of resources mobilised
- # of children being cared for
- Volunteer retention rate
- # or % of clients who have written wills or undertaken other kinds of succession planning
- # or % of PLWHA who report at least three positive lifestyle changes (e.g. eliminating alcohol, proper nutrition, improved psychosocial well being, etc.)

V.C. ADVOCACY

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Appendix 1: Case studies of HIV/AIDS Advocacy

Case study 1: Education for AIDS orphans

Case study 2: Reaching beer promotion girls in Cambodia

Case study 3: Persuading school authorities to include HIV education in Botswana

Case study 4: Reaching young workers in Mauritius

Case study 5: Influencing local authorities in Myanmar

Appendix 2: Template for an advocacy action plan

Appendix 3: Critical analysis development tool

Appendix 4: Problem and solution trees

Appendix 5: Additional resources and information

Appendix 6: WV Partnership HIV/AIDS advocacy strategy

I. INTRODUCTION

In the fight against HIV/AIDS, advocacy is a critical tool for raising awareness, influencing decisions, promoting solutions, increasing funding and resource allocation, and precipitating changes in policies and programs. In short, it can bring about lasting changes that go beyond what programming alone can do.

Advocacy takes many forms, including networking, coalition building, and awareness raising. Many ADPs are engaged in some forms of advocacy. But often these efforts are ad hoc and are not connected to other advocacy efforts within WV (of which there are many). This section of the toolkit provides guidance for making ADP-level, HIV-focused advocacy strategic and effective.

1.1 Advocacy and the Hope Initiative

World Vision's HIV/AIDS Hope Initiative has highlighted advocacy as a key strategic component in scaling up responses to the HIV/AIDS pandemic in the ADPs. It is prioritised alongside prevention and care because for change to occur at the pace and scale at which it is needed, national and international government policy and corporate will have to be influenced to bring about the changes and funds that are so urgently needed.

The goal of the advocacy track is to encourage the adoption of public policy and programs that will minimise the spread of HIV/AIDS and provide maximum care for those living with or affected by HIV/AIDS. WV has identified three principles to guide its international HIV/AIDS advocacy, which are also relevant to ADP-level advocacy:

- Ending stigma, denial, and indifference
- Mobilising research and resources to effect change
- Ensuring good quality and effective prevention, care, and treatment

The newly formed World Vision HIV/AIDS Advocacy Network held meetings in Kampala, Uganda in June 2003 to chart the way forward for World Vision's' HIV/AIDS advocacy. Based on the WV HIV/AIDS advocacy strategy developed by the policy and advocacy group in late 2002 (attached as Annex 6 in this unit), meeting participants agreed on the four top HIV/AIDS advocacy priorities for the World Vision partnership:

1. Strengthening care for orphans and vulnerable children
2. Reducing the vulnerability of girls and women to HIV
3. Increasing access to treatment and care
4. Mobilizing resources for expanded HIV/AIDS response

Advocacy is important to WV's HIV/AIDS work because it can:

- Raise awareness of HIV/AIDS-related issues among community members and local decision-makers
- Seek to change laws, practices, policies, and community and individual attitudes on specific HIV/AIDS issues
- Build community sympathy for those affected by HIV/AIDS and support for HIV/AIDS-related interventions
- Address issues related to inequality and oppression as causes of poverty and communities' vulnerability to HIV/AIDS infection and its impacts
- Encourage the allocation of resources for the implementation of HIV/AIDS interventions

Advocacy can and should be undertaken from the village to the national level, the latter to be coordinated with other ADPs and NGOs.

1.2 Integrating advocacy with HIV/AIDS programming

Although this section discusses advocacy as a separate topic, advocacy in practice is always a part of other kinds of programming. Effective advocacy requires specific activities, strategies, and skills, but it should always be planned for and designed with other parts of HIV/AIDS programming in mind. Advocacy is one response that should arise from the same situation analysis, baseline survey, and assessment of need that also inspires other responses.

At the same time, most HIV/AIDS responses can and should include an advocacy component. Advocacy is necessary any time the root causes of a problem are shaped by decisions made by those in positions of power or finding a solution means changing a system that is not working effectively. ADP staff may find that more research needs to be done into causes and solutions of various issues when they have an advocacy perspective. Therefore, as part of the effort to increase ADP capacity and effectiveness in advocacy, consideration should be given to advocacy early on when planning HIV/AIDS programs.

While it is important to integrate advocacy into all types of programming at the ADP level, it is also important to integrate community advocacy into national and international advocacy efforts. Advocacy requires very good levels of communication and coordination for it to be effective. If it is done just at the ADP level without being linked to national-level work, and ultimately to WV's international advocacy, it will be piecemeal and unlikely to succeed.

For this reason, at its recent High Prevalence Workshop, WV defined its short-term advocacy objective as developing and implementing interlinked local, national, and global advocacy strategies on HIV/AIDS. It would be advisable for NO management to review the current communication systems and structures that exist between the NO and the ADP and between the NO and the Partnership, and consider whether action needs to be taken to ensure communication, information sharing, networking, and coordinated planning is optimised.

1.3 Definitions of advocacy

There are many definitions of advocacy. Here are some examples, which may be used as a source of inspiration and direction in helping communities to understand what advocacy is.

Advocacy is:

- The process of using influence to bring long term, sustainable benefit to the poor
- Action directed at changing the policies, positions, or programs of any type of institution or community
- The process of people participating in decision-making processes which affect their lives
- Speaking up, drawing a community's attention to an important issue, and directing decision makers towards a solution
- A natural outcome of the process of mobilisation and conscientisation of the poor
- A tool that can draw on program experience to show the impact existing policies have on the poor and to suggest alternatives
- Putting a problem on the agenda, providing a solution to that problem, and building support for acting on both the problem and solution
- Different strategies aimed at influencing decision making at the organisational, local, provincial, national, and international levels. These can include lobbying, social marketing, information, education, communication, community organisation, and many other tactics

- To work with the poor and marginalised people to eradicate poverty by overcoming the injustice and inequality that cause it
- Changing the knowledge, attitudes, and behaviour of those who have power to influence people's lives (1,2)

2. IMPORTANT PROGRAMMING PRINCIPLES

The 'how to' of advocacy can be a complex process requiring flexibility and adaptability to the local context. However, there are certain principles that apply to a number of contexts and that are outlined broadly here. These principles are designed to help ADPs think through the development of a deliberate and strategic approach to advocacy. (3)

2.1 Partner with people who are affected by HIV/AIDS

The people on whose behalf ADPs are advocating need to be involved in the advocacy process from the start. Involving PLWHA, children made vulnerable by AIDS, and the families and communities who care for them will increase the likelihood of long term sustainable changes that can be monitored long after WV has left the community. These groups should be involved in defining the problem that the advocacy campaign will address, proposing the solutions, and determining the advocacy strategy.

Advocacy which fails to represent the needs and wishes of local people is not likely to lead to useful long term change. By working with people as partners ADPs are:

- Respecting them and their contribution
- Building a more relevant strategy which is based on better information
- Laying the groundwork for a better, more sustainable solution

As the relationship between the ADP advocacy planners and community members develops, it is important to find ways to shift from speaking "for" people to "speaking with"/ "working with" them as partners, and ultimately to empower community members to undertake advocacy for themselves. (4)

2.2 Build community capacity

ADPs can make a lasting contribution to the communities in which they work by helping community members develop the skills to advocate for themselves. When ADPs help people learn about the causes of the problems they face and how they can develop their own solutions, they help build a basis for long term sustainable development. Participatory learning and action (PLA) exercises can help community members define their problems and develop strategies to address them. A useful tool for building critical awareness and analysis skills within the community is included in Appendix 3.

2.3 Build strategic partnerships

It is critical that ADPs work in coalitions with partners who are working on similar advocacy issues in the community. ADPs can significantly improve their ability to achieve their objectives through working with allies, and often being part of a network or coalition can reduce the time and resources ADPs need to expend as they find others who have complementary skills and experience.

Similarly, communicating and working with other advocates within the WV partnership is essential. Many HIV/AIDS-related issues require changes at the international and national levels as well as the Unit V, Section C

local level. Staff throughout the partnership can provide links, resources, advice, and timely advocacy on the ADP's behalf if they are aware of local efforts. Similarly, the information ADPs possess about conditions at the grassroots can be invaluable for WV's advocacy with national or international bodies.

2.4 Form relationships with policymakers

Advocacy is more powerful if it is done through relationships of respect and trust. This means that the same people should work with the same target organisations over a period of time — it is not effective to frequently change the persons involved with direct advocacy activities. It is important that policy and decision makers are not treated as 'the enemy' even when the advocacy campaign may be challenging them to change their priorities. Some people in positions of power may be potential allies whom ADPs can work with to bring about desired changes. Advocacy is not always confrontational: it can be collaborative, with all groups working towards a shared goal and overcoming the obstacles to it.

2.5 Establish credibility

Advocacy requires that ADP staff have credibility both with decision makers and with the community affected by their proposed changes. ADPs will need to be able to show that they understand the issues and the factors that will shape change. A carefully planned and implemented situation analysis is a good first step. Credible recommendations based on sound understanding of the problem are critical — good advocacy does just state the problem, it offers a solution.

2.6 Focus on a limited range of achievable objectives

There is no shortage of things that could be changed. The challenge in planning an advocacy campaign is narrowing down and focusing on what can be changed rather than trying to do everything. To achieve changes, it is best to focus energy and resources strongly on a very narrow issue. What are one or two main areas that the ADP can begin with? In making this decision, ADPs should consider:

- What are the greatest needs in the community?
- What can be most efficiently and effectively accomplished, given WV strengths and resources?

It is important to have clear objectives, even if these are revised once the advocacy campaign is underway.

2.7 Assess risk

Because talking about HIV/AIDS involves addressing difficult and controversial subject matter, advocating for change around this issue will mean taking risks. When assessing risks and planning strategies, ADP staff might ask:

- What issues have sparked political violence or community conflict in the past?
- How have people successfully worked across the lines of community conflicts?
- How do the issues of concern relate to controversies in the community?
- What ways of approaching issues will be regarded as acceptable?

ADPs may choose a less risky advocacy strategy that can be accomplished relatively easily — for example, working to have the property rights of widows and orphans recognised and enforced — rather than a more risky advocacy strategy that is likely to encounter more obstacles — for example, persuading area churches to accept condoms as a legitimate prevention tool.

2.8 Develop necessary skills

ADP staff may require capacity development in some of these basic advocacy skills:

- Analytical skills
- Empowerment and mobilisation skills
- Information and communication skills
 - Expression (verbal/non-verbal)
 - Reception (listening/reflecting)
- Persuasion skills — logical arguments, negotiating, and framing of issues
- Partnership skills — building coalitions, alliances, etc.

3. DESIGN AND IMPLEMENTATION OF ADVOCACY PROGRAMMING

Advocacy is not an event but a process, which takes place in stages. This section lays out key steps for planning HIV/AIDS advocacy. Remember that this is a flexible framework to be adapted by each ADP for its context.

3.1 Assessing the situation

HIV/AIDS creates problems that advocacy can help to solve. Identifying these problems involves working with the community to think beyond the immediate and obvious circumstances, to the root causes of problems. For example, the community may identify the problem that more and more of its productive adults are falling ill. The ADP could help community members understand that this new illness is HIV/AIDS, and that the disease can be prevented. Then the ADP could help the community analyse the political, economic, and social environment — in other words, the power relations — that permit HIV/AIDS to thrive.

ADP staff may utilise PLA exercises, Participatory Rural Appraisal (PRA) exercises, or other approaches to working with the communities to identify their advocacy priorities. A critical analysis tool is provided in Appendix 3 and is useful for working with communities that are not familiar with seeking the root causes of their problems. Problem and solution trees are also useful tools for sorting through what are ‘causes’ and what are ‘symptoms’ of particular problems. An example is provided in Appendix 4.

It is important to be aware that factors contributing to the spread and economic impacts of HIV/AIDS may well lie beyond the community, at national or international level, and that the community may not be aware of this. In this circumstance, ADP staff can provide broader contextual analysis for the community. To help them provide this perspective, ADP staff should be in good contact with WV’s worldwide advocacy staff and with other NGOs at the national and international level.

Along with helping the community determine its advocacy priorities, ADPs must find and provide their own data. This may involve:

- Obtaining key statistics about HIV prevalence and mortality rates both locally and nationally. This information can help the community to understand the nature and magnitude of the problem they are facing and persuade policy makers that the problem is important
- Seeking human impact stories, which illustrate how HIV/AIDS impacts upon individual community members. If these are accompanied with broader statistics, the combination makes for a powerful advocacy tool
- Identifying existing research relevant to the issue, including not just research about the problem(s) associated with HIV/AIDS, but also about existing and possible solutions
- Conducting some simple research to obtain additional data where necessary.
- Contacting WV policy and staff or accessing the WV website where research resources on many issues exist

3.2 Developing a plan of action

3.2.1 Prioritising the issues

This step involves:

- Reviewing the problems identified, the analysis of the causes, and some possible solutions, and identifying the issues
- Selecting the issues on which to focus advocacy efforts. These should be the issues that community members are most concerned about and that the community feels can be addressed effectively. It is often best to begin with smaller issues on which victories can be won; these successes can form the basis for more ambitious efforts later
- Finalising the list of the few issues on which to focus initially

When setting priorities, ADPs should bear in mind the advocacy priorities set by the WV Partnership. ADPs need not be restricted to these priorities, but the greater the coordination between local, national, and international advocacy campaigns, the greater their effectiveness is likely to be.

World Vision has identified the following issues as priorities for local level advocacy on HIV/AIDS:

- Substantially increasing funding and other support for efforts to assist orphans and vulnerable children in HIV/AIDS-affected areas (with an emphasis on community-led, home-based models of care)
- Reducing the vulnerability of girls and women to HIV/AIDS
- Increasing recognition of and support for church and faith-based responses to HIV/AIDS
- Increasing openness to discussing HIV/AIDS and surrounding issues, with leaders and opinion formers modeling this by speaking on the subject
- Preventing discrimination against people living with HIV/AIDS
- Encouraging the allocation of additional public resources to address HIV/AIDS
- Increasing funding and other support for efforts to assist orphans and vulnerable children in HIV/AIDS-affected areas (with an emphasis on community-led, home based models of care)
- Providing affordable access to anti-retroviral drugs and treatment of opportunistic infections

3.2.2 Identifying key players

This step involves identifying all those individuals and institutions that have influence over the issues that have been prioritised. Once they are identified, specific actions can be planned to gain their support on the issues or to neutralise their opposition.

In the communities and districts where ADPs work, key players may include:

- Government officials at community and district level
- Political leaders
- Reporters, editors, broadcasters, and other members of the media
- Chiefs, headmen/women, and other traditional leaders
- Church/faith-based organisation leaders, including pastors, priests, imams, chairs of church boards, heads of mothers' unions, etc.
- Leaders and staff of other NGOs, CBOs, etc.
- Business leaders
- Labour unions

It is also important to actively engage those intended to benefit from the advocacy effort from planning to implementation. These potentially include:

- Households affected by HIV/AIDS
- Children affected by HIV/AIDS
- Women and girls
- Institutions affected by HIV/AIDS
- The community as a whole

3.2.3 Building coalitions

Advocacy is not a one-person show. It is always necessary to work with other people and agencies for successful results. Start with whomever in World Vision is already working on the issue (a WV HIV/AIDS advocacy network of staff working on this issue around the world has recently been set up) and with local NGOs. Once potential allies have been identified, meetings should be arranged to discuss cooperation on issues of common concern. Building coalitions involves making compromises and finding ways to accommodate different opinions. Allies need not agree on all issues, as long as they agree on the issues that are the focus of the advocacy efforts.

3.2.4 Components of an action plan

ADP staff together with the community and allies can now develop an advocacy action plan. See Appendix 2 for a template for an advocacy action plan. The components of the action plan may include:

1. Problem statement. State the problem that has been prioritised as clearly as possible, along with the reason behind it.

Example problem statement: PLWHA in the community lack access to drugs. This is a result of the lack of a local medical clinic.

2. Statement of overall goal. The goal is the long term solution sought to address the

problem. It is important to define an advocacy goal before undertaking an advocacy activity and ensure that the goal is accepted by all the groups and persons involved.

Example goal: To obtain access to drugs for PLWHA.

3. Statement of objectives. Objectives are the specific positive results that are desired. They describe intent or a proposed change. Objectives should be determined by asking: what does the community want? Is it realistic? Who can bring it about? How?

Example objective: To persuade the district government to budget for a local medical clinic so that PLWHA can access drugs for opportunistic infections

4. List of activities. These are actions to be conducted in order to achieve the advocacy objectives.

Examples of advocacy activities developed by the HIV/AIDS Hope Initiative and some ADPs include:

- Awareness-raising workshops with traditional leaders to stop harmful cultural practices that promote the spread of HIV/AIDS
- Training in advocacy skills for community stakeholders
- Lobbying district decision-making bodies
- Education and dialogue with employers to encourage them to employ HIV-positive people
- Participating in the government's poverty assessment exercise to ensure that HIV/AIDS-related issues are included and the budget for drugs is increased
- Writing articles in the papers and speaking on the radio about the need for increased budgets for affordable HIV/AIDS drugs
- Encouraging the police to protect the property rights of widows and orphans
- Participating in district HIV/AIDS events to influence policy, e.g. World AIDS Day
- Engaging the church in HIV/AIDS prevention, care, and support interventions

5. List of target audiences for advocacy activities

6. Statement of outcomes and outputs. These are the expected results of the advocacy activities to be undertaken.

Example outcomes/outputs: The government invites representatives from three ADPs to take part in drafting an HIV/AIDS strategy for the southern district; The Daily Chronicle features articles about the need for affordable drugs for HIV-positive mothers.

7. Chart showing time and people to be involved

8. Measures of success. Develop the indicators that will serve as signals for the success of the advocacy strategy.

3.3 Notes on implementation

The ADP staff together with the community need to integrate this action plan into the existing ADP plans. As much as possible, utilise existing resources to implement the action plan and monitor progress.

Challenges that ADPs may encounter in operationalising the action plan include:

- There may be inadequate community capacity for advocacy.
- It may be difficult to change entrenched, harmful cultural practices.
- Advocacy sometimes is long term, while there is often pressure to respond quickly to immediate needs.
- Advocacy can be high profile and high risk.
- Access to policymakers may be limited.
- The resources available to carry out advocacy may be inadequate.

ADPs should devise means of overcoming these challenges. These may include:

- Providing training in advocacy skills
- Making links with HIV/AIDS networks and groups that operate at national and international levels, including World Vision
- Establishing contacts and building relationships with policymakers and government officials
- Engaging in resource mobilisation
- Regularly participating in community and district meetings
- Strengthening networks of people living with HIV/AIDS

4. MONITORING AND EVALUATION OF HIV/AIDS ADVOCACY

The monitoring and evaluation of advocacy is a discipline which is still developing. Measuring the impact of advocacy can be very difficult owing to the various actors involved in pressing for change and the different factors that can bring it about. However, with that challenge taken into consideration, it is possible to measure the effectiveness of advocacy if clear and realistic objectives are set in the first place.

ADP staff and the community need to:

- Agree on how the action plan will be monitored
- Select indicators for monitoring and evaluating advocacy work
- Agree on how data will be collected concerning the indicators
- Agree on how data will be analysed
- Agree on how the resulting report will be written
- Agree on how information will be shared with partners

4.1 Indicators for monitoring/process evaluation

Possible indicators for monitoring include:

- # of ADP staff and community members involved and resources committed to any given intervention
- # of churches mobilised to advocate for the rights of children affected by HIV/AIDS
- # of community members trained in advocacy skills
- # of consultative meetings with the district government WV has been invited to

4.2 Indicators for impact evaluation

Possible indicators for evaluation include:

- % of PLWHA who have access to affordable HIV/AIDS drugs
- % of children whose rights are being observed
- Harmful traditional practices suspended
- % of widows whose property rights are being enforced

5. REFERENCES

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5. IPPF, *Advocacy Guide for HIV/AIDS*, London 2001.
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Appendix I: Case studies of HIV/AIDS Advocacy

Adapted from International Planned Parenthood Federation Global Advocacy Guide for HIV/AIDS (2001) and WV sources

Case study 1: Education for orphans of AIDS

In the rural districts of Rakai and Masaka in southwest Uganda, WV implemented programs of assistance to orphans and other vulnerable children in the 1990s. WV, together with several other NGOs, formed the Uganda Community Based Orphan Care Association (UCBOCA). This was a forum for sharing information as well as undertaking advocacy. This group would hold regular consultations with government on a range of issues central to the welfare of orphans and vulnerable children. Included among the issues given exposure were the practice of robbing HIV orphans of their inheritance and the rampant abuse of orphans. This expressed concern triggered the government to draft legislation on inheritance in which the rights of survivors were given legal protection.

UCBOCA remained a vocal entity on issues of child protection, and was instrumental in calling for the establishment of a special wing of the police that was then trained on issues of child abuse and deployed.

Lastly, during the 1995 election campaign, UCBOCA turned the issue of orphan education into a major campaign issue to which the competing candidates felt compelled to make pledges. Further input was made into other networks that were active in the debt issue, including the preparation of the country's PRSP. The outcome of this process was to strengthen the commitment of the country to launch the Universal Primary Education program in 1997, which was partly funded by the UK government.

Case study 2: Reaching beer promotion girls in Cambodia

Beer promotion girls (BPGs) supplement their meager earnings from the beer companies who employ them by selling sex to male clients, mostly without a condom. Some twenty percent are HIV-positive. The Reproductive Health Association of Cambodia (RHAC) is training 100 BPGs in the capital Phnom Penh to become peer educators who will reach 1,500 other BPGs in their workplaces. In a new project, RHAC is contacting key managers of each beer company, the Ministry of Women's Affairs, and the municipality to discuss the project and involve them in designing appropriate implementation plans. RHAC is persuading the company managers to allow RHAC motivators to include education topics during BPG meetings with their supervisors, and to provide facilities for peer educators to talk to the BPGs about condom use and the RHAC clinics before they go on duty.

Case study 3: Persuading school authorities to include HIV education in Botswana

HIV prevalence among young adults in Botswana is around forty percent, one of the highest rates in the world. The Botswana Family Welfare Association (BOFWA) is working through schools, education authorities, and school management as well as with students and parents to increase knowledge and appreciation of HIV/AIDS education. BOFWA has the aim of providing youth access to HIV/AIDS and STI information and services as well as increasing Family Planning Association partnerships with other institutions. To further increase understanding of the issues, the project aims to train forty trainers of trainers, including teachers, youth community based service providers, and students.

Case study 4: Reaching young workers in Mauritius

The Family Planning Association (FPA) of Mauritius has for some years run a highly successful project entitled 'Reproductive health among unmarried workers in the Export Processing Zone.' This project involves the organisation of young unmarried workers around the concept of sexual reproductive health (SRH). Young worker leadership and the FPA engage in mutual advocacy to create a supportive environment for SRH in the home, workplace, and society. They undertake participatory research to identify the needs and resources of young workers and promote an approach to behavioural change which emphasises peer-to-peer education and young worker support for behavioural change. Advocacy activities have included the creation of a radio and TV series based on the lives of young workers, the setting up of a Young Worker Advisory Committee, meetings with personnel and health and safety officers from targeted industries, and individual contacts with key Members of Parliament, Ministry officials and company representatives.

Case study 5: Influencing local authorities in Myanmar

The FPA in Myanmar is working with the local authorities in the remote district of Tamu near the Indian frontier where there is a large floating population, high injecting drug use, high STI incidence, and an unmet need for health services. The strategy is to reach district leaders and religious leaders through advocacy workshops and interviews and to reach the general public in order to raise awareness of the prevalence and dangers of HIV/AIDS.

Appendix 2: Template for an advocacy action plan

Name of ADP: _____

Problem: _____

Overall goal: _____

Objective: _____

Activities	Target Audiences	Outputs	Outcomes	Responsible persons	Time Frame in Quarters			
					1	2	3	4
1								
2								
3								

Appendix 3: Critical analysis development tool

From Tearfund's Advocacy Toolkit

The following is a useful process to go through as a way of building analysis and reflection skills with those communities and partners that have a restricted level of understanding of the processes affecting their situation. If ADPs want to do some thorough analysis with the community for the purposes of advocacy or other programs, this is a helpful tool to start with.

1. Start with a role play/case study depicting a familiar situation with an emphasis on unequal power relations, groups being marginalised, power being abused, bad relationships, etc.
2. Request a description of the situation by the participants. What was happening? The purpose of this step is to ensure that they have understood the main facts that the case study portrayed.
3. Request an analysis of the situation by participants. Why did they think certain things happened? What was the problem? What were the causes of the problem? Why did certain people react as they did? The purpose of this step is to help the participants come to an understanding of why the situation unfolded the way it did, primarily in terms of power relations and relationships. It can also help air assumptions that the participants have.
4. Encourage the participants to reflect personally on the situation. Do they think this type of situation happens in their country or community? What are the similarities between this situation and situations they have experienced? This step helps the participants to apply what they have seen to their own lives and communities and increases understanding of the dynamics of power in their local area.
5. Encourage the participants to make links. Does the problem portrayed lead to other problems or concerns? This step enables people to place the events they have seen in the context of their wider situation and start to see how decisions, relationships, structures, etc. affect many aspects of their daily lives. It helps them to go beyond a linear analysis that sees problems in terms of lack of money, for example, to one that understands some of the structural and power reasons for problems.
6. Encourage the participants to search for solutions to the problem that has been portrayed. What can be done about it? Suggest solutions or actions. This encourages thinking among participants about what needs to be done in the example that has been used. It helps them to think creatively about how to bring about change.

At the end of the exercise participants should have:

- Learned various tools for analysis through the questions they have been asked
- Understood some of the political causes of events and have a correct analysis of why problems have arisen
- Thought about certain issues in their own communities or countries
- Thought creatively about solutions and started to see that solutions are possible, and that they can do something to bring them about

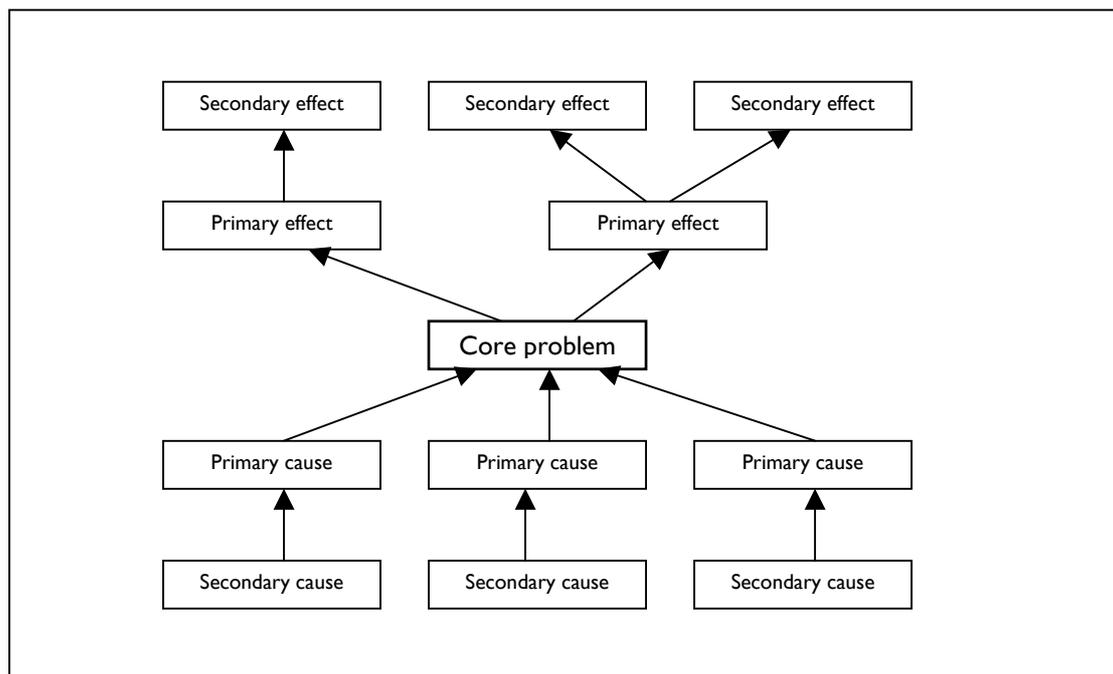
If this tool is then applied to real situations that participants find themselves in, it will enable them to start to find some solutions for their own problems.

Appendix 4: Problem and solution trees

Problem Trees are used to help analyse a situation and identify a core problem that the community wants to focus on. The tree has a trunk that represents the core problem, roots that represent the causes of the problem, and branches that represent the effects.

As a visual mapping tool, this is appropriate for using in a participatory approach.

Problem Tree

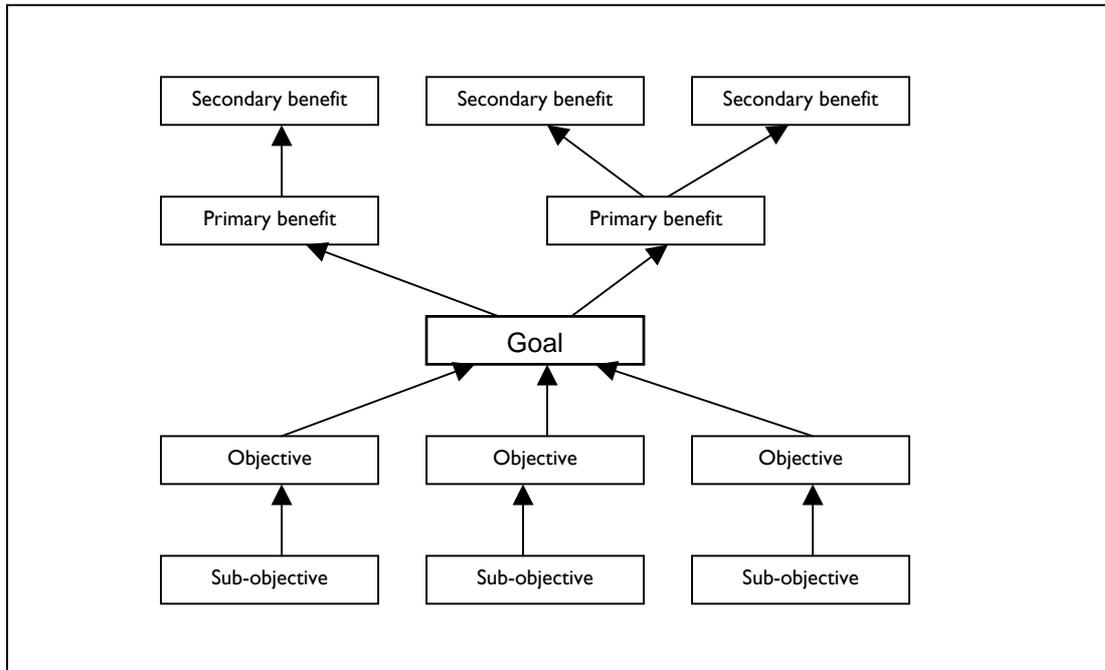


To start the tree, generate the causes and effects on Post-it notes and stick them onto a large piece of paper. (An alternative, especially with large groups, is to make a large wall chart with several flip chart sheets and spray it all over with spray glue. The causes and effects can be written on index cards and stuck onto the wall chart).

The group can then negotiate the relationships between the cards and how they should be placed. The tree can be reframed by making one of the causes or effects as the core problem and readjusting the other cards around it. Groups may want to do this to focus their issue to one that they can better influence.

The group can then use the Problem Tree to produce a Solution Tree, where the trunk is their main aim, the roots are sub-objectives, and the branches are the benefits that will arise from their aim being met.

Solution Tree



Working from the Problem Tree, reverse the core problem to create a goal (cover the card with a new one with the goal written on it). Similarly convert the 'effects' to 'benefits', and 'causes' to 'objectives'.

N.B: The objectives do not all have to be advocacy objectives. They can also be objectives that are best met through other types of development interventions. Using this technique enables groups to devise an integrated strategy of projects and advocacy.

Appendix 5: Additional resources and information

For more information on advocacy skills, tools, WV resources, and training initiatives, see the following:

1. A PARTNERSHIP PURSUING JUSTICE: WORLD VISION ADVOCACY POSITIONS & PRACTICE — CD ROM and booklet setting out all the relevant information ADPs need to know about advocacy in WV, including protocols and procedures, positions, research documents, international legal documents such as the Convention on Rights of the Child, WV paper on the Biblical understanding of Child Rights, etc. To be produced in Spring 2003. Contact policy_advocacy@wvi.org or Alan Whaites, Director of Policy & Advocacy, for more information.
2. POLICY AND ADVOCACY WEBSITE — for information on the latest global campaigns, on the three networks, and for a comprehensive list of resources and reports and more, visit www.globalsociety.org or www.wvi.org/policy.
3. WVI EDUCATION TOOLKIT — toolkit written to help ADPs work more effectively in education. Includes a section devoted to advocacy on education issues. Released January 2003. Includes lots of references to other web links and resource manuals. Very ADP-friendly.
4. ADVOCACY CAPACITY BUILDING COORDINATOR — for information on training workshops and resources contact Siobhan Calthrop. Email: siobhan_calthrop@wvi.org.
5. ADVOCACY NETWORKS — three networks of staff from around the partnership involved in advocacy. Networks share information, plan campaigns, and agree on positions. For more information, visit the Policy & Advocacy website, or contact the relevant convenor: Child Rights (CRnet) — Melanie_Gow@wvi.org, Peace & Conflict (PAXnet) — Chris_Derksen-Hiebert@wvi.org or Rudo_Kwaramba@wvi.org, Economic issues (EJnet) — Brett_Parris@wvi.org, HIV/AIDS (HIVnet) — Joe Muwonge@wvi.org.

Appendix 6: WV Partnership HIV/AIDS advocacy strategy (December 2002)

Executive summary and core recommendations

Daily, World Vision staff work amongst people living with AIDS or those impacted by the pandemic – orphans and other vulnerable children, widows, young mothers, elders, indeed entire communities. Too often our staff watch suffering and pain or are themselves directly impacted. The HIV/AIDS Hope Initiative is World Vision's response.

The Hope Initiative is a central ministry in the work of the World Vision partnership. With three core tenants - prevention, care and advocacy – the partnership has a clear platform to move forward in action.

This document seeks to provide a guide as to how World Vision could make a decisive commitment to a strong HIV/AIDS advocacy strategy based on three overarching principles:

- a) Ending stigma, denial and indifference
- b) Mobilising research and resources to effect change
- c) Ensuring good quality effective treatment, care and prevention

These principles are articulated in this paper in five priority advocacy areas:

- Substantially increasing funding and other support for efforts to assist orphans and vulnerable children in HIV/AIDS-affected areas (with an emphasis on community-led, home-based models of care)
- Reduce the vulnerability of girls and women to HIV/AIDS
- Increase recognition of and support for church and faith-based responses to HIV/AIDS
- Increase commitments of bilateral and multilateral aid for HIV/AIDS by developed countries
- More effective inclusion of HIV/AIDS as a primary component of PRSPs

Any World Vision strategy requires action in each of these areas at the local, national, regional and international levels. The most effective advocacy strategies are those that seek to bring about both short term and long term changes. In addition, HIV/AIDS advocacy must be about impacting policies as well as lobbying to increase HIV/AIDS funding and accessing those funds.

This paper seeks to provide a framework for an overall partnership wide strategy. It is not an attempt to develop a national or ADP level strategy though it is recommended that these are done at the national and local levels. However, any partnership wide strategy will make natural links to actions required at the national level, consequently some of those are included in this paper. In addition, there may well be elements of this strategy paper which are of value as national offices and ADPs begin to develop their own contextualised approaches.

It has become clear that World Vision is currently ill-equipped to mount a fully effective advocacy strategy with existing resources. Whilst some good advocacy is already happening around the partnership at a number of levels, it has been largely uncoordinated, ad hoc and based on individual rather than organisational commitment.

If World Vision is to mount an effective strategy and attempt just some of the things outlined in this document, a renewed commitment will be required. World Vision should consider what an HIV/AIDS strategy which did not have a strong advocacy component - that is, focused only on prevention and care - might actually achieve. Effective advocacy can bring about long term, sustainable change. Such change is imperative if we are to make a real impact on this global pandemic.

Core Recommendations

- That World Vision's advocacy strategy focus on the five core priority areas highlighted above in any partnership wide strategy.
- That World Vision revise and substantially increase its commitment to HIV/AIDS advocacy, most particularly in relation to financial support and staffing levels.
- That any strategy seek to ensure clear and coordinated links between local, national, regional and international advocacy
- Any advocacy strategy – whether set at the local or international level should reflect WV's stated commitment to the most vulnerable, especially women and children, and particularly marginalised groups of children such as girl children.
- Ensure that the Hope Initiative strategy builds on, and dovetails with, existing World Vision advocacy work such as the Imagine campaign (ending violence against children).
- That the Hope Initiative in conjunction with the Global Relations Team consider forming an HIV/AIDS Network
- That local, national and international WV staff engage actively in key HIV/AIDS coalitions and networks, especially those involving other faith-based organisations (FBOs)
- That World Vision is intentional about documenting its own best practice experiences in preventing HIV/AIDS, supporting PLWA and advocating for change.

I. Background

More than 42 million people are currently infected with HIV. Nearly 70% of them are in Sub-Saharan Africa and the threat is increasing in Asia, Latin America and Eastern Europe. At least 22 million people have died of AIDS, more than a quarter of them children. Over 2.7 million children under 15 have the virus today and millions more are at risk of infection. Globally, girls are the most vulnerable population to HIV – according to UNAIDS, 60% of new infections occur among girls and young women aged 15-24.¹ At least 14 million children have lost one or both parents to AIDS- most of them in Africa. The number of children orphaned by AIDS is projected to grow to 40 million by 2010. The impact of the disease extends beyond those directly affected and is long term. This poses the challenge of how families, communities and indeed nations would cope.

Through its HIV/AIDS Hope Initiative, World Vision is committing itself to expanding and enhancing its response to HIV/AIDS worldwide. The Hope Initiative has three primary tracks - Prevention, Care and Advocacy. The goal of the Advocacy track is to:

Encourage the adoption of public policy and programs that will minimise the spread of HIV/AIDS and provide maximum care for those living with or affected by HIV/AIDS.

The targeted audiences for advocacy are policy makers at local, national and international levels.

¹ "What is Vulnerability to HIV?", www.unifem-eseasia.org/Resources/GenderAids/genderaids8a.htm
Unit V, Section C

At its recent High Prevalence Workshop, World Vision defined its short-term advocacy objective as:

To develop and implement interlinked local, national and global advocacy strategies on HIV/AIDS to end stigma, to combat denial and indifference and to mobilise research, resources and policies for treatment, care and prevention.

These three overarching principles of; i) ending stigma, denial and indifference, ii) mobilising research and resources to effect change and iii) ensuring good quality effective treatment, care and prevention, should inform our advocacy objectives, activities and implementation strategies.

2. Policy objectives and issues

World Vision's overall advocacy strategy should focus on five core areas of action. These priority areas reflect the organisation's stated commitment to the most vulnerable. Each area is also clearly articulated as a core policy objective;

To substantially increase funding and other support for efforts to assist orphans and vulnerable children in HIV/AIDS-affected areas (with an emphasis on community-led, home-based models of care)

To reduce the vulnerability of girls and women to HIV/AIDS

Increase recognition of and support for church and faith-based responses to HIV/AIDS

Increase commitments of bilateral and multilateral aid for HIV/AIDS by developed countries

Ensure more effective inclusion of HIV/AIDS as a primary component of PRSPs

Objective 1. To substantially increase funding and other support for efforts to assist orphans and vulnerable children in HIV/AIDS-affected areas (with an emphasis on community-led, home-based models of care)

In order to ensure increased funding and support, World Vision's advocacy strategy should recommend that leaders and policy makers at national, bilateral and multilateral levels:

Put in place policies that encourage the participation of people affected by AIDS, especially children. They are the greatest untapped resource.

Ensure that the Hope Initiative advocacy strategy builds on, and dovetails with, existing World Vision advocacy work that seeks to better protect vulnerable children such as the Imagine campaign (ending violence against children)

Acknowledge and promote the importance of community involvement in prevention efforts, including community-based health care as the basis for effective care and treatment.

Build on what has been learnt; especially the fact that prevention and care go together; effective programs give people options, focus on the young, and keep parents alive as long as possible as this ensures extended parental care and love to children.

Acknowledge that the face of HIV/AIDS extends beyond those directly affected, and that time lags between HIV infection, AIDS deaths and orphaning tend to mask the full impact of the HIV/AIDS epidemic on children. The medium term demographic shocks of AIDS are heavy and inevitable. Even if HIV infection rates were to be substantially reduced immediately, the demographic impact of this

will not be felt for another 7 to 10 years. Hence, addressing the impact of AIDS on children calls for significantly increased commitment of resources and on a long term basis.

Recognise that OVC are more likely to die and be malnourished, to suffer psycho-social problems, to drop out of school, to be abused and exploited, and are more vulnerable to HIV/AIDS infection than other children. In the most affected countries, families are not coping - desperation, vulnerability and disparity are increasing. This calls for the development of policies and strategies to (i) build and strengthen governmental, family and community capacities to provide a supportive environment for OVC including; (i) provision of appropriate counselling and psycho-social support, ensuring OVC enrollment in school and access to shelter, nutrition, health and other social services; and (ii) to protect OVC from all forms of abuse, violence, exploitation, discrimination, trafficking and loss of inheritance.

In addition, there are some internal strategies, which World Vision should consider. Such as:

Undertaking internal advocacy to ensure that our own policies and practices do not build stigma or indifference. For example, the manner in which World Vision reports on, or tells the story of those living with, or affected by HIV/AIDS, in particular children. The protection of children's rights must be a core component of any advocacy strategy undertaken by WV.

Some of these initiatives, whether internal or external, may be undertaken within existing resource structures and programs. For example, ICM are currently reviewing their reporting guidelines to ensure that WV protects the dignity and privacy of those affected by HIV/AIDS, especially children.

Objective 2. To reduce the vulnerability of girls and women to HIV/AIDS

Girl children are among the most vulnerable to HIV/AIDS. Broadly their vulnerability can be categorised as social, economic and physical.

The key challenge that emerges from this picture is to define specific program and policy interventions that sustainably reduce the vulnerability of the girl child to HIV/AIDS. This will require concerted action at all levels and involve addressing gender inequalities and discrimination in both policies and programs.

Prevention programs often fail women, assuming they are low risk, when in fact studies have shown that many women are infected by their one partner – their husband.² Effective prevention strategies must therefore promote attitudinal changes for both women and men, so that women are empowered to make decisions about condom use, abstinence, and mutual fidelity, and so that men can support and respect those decisions.

In care and support, at the community level, women and girls bear the lion's share of the responsibility, especially for such things as home-based care for those living with AIDS and support of orphans and vulnerable children. When the burden of responsibility rests on the shoulders of those already vulnerable, their risk of exploitation is heightened. For example, in a child headed household, the girls in the family are at particular risk of sexual exploitation from other members of their family or community.

Any World Vision advocacy strategy should seek to build on existing work being undertaken by national offices such as World Vision Canada and on the work of WVI's Director for Gender,

² Women and AIDS: UNAIDS Point of View. October 1997, UNAIDS Best Practice Collection.
Unit V, Section C

Fatuma Hashi. During 2003 two research studies will be undertaken on the girl child, one specifically in relation to HIV/AIDS and vulnerability (see Appendix B), as well as one in relation to access to service provision (Appendix C). These should inform our strategy.

In addition, World Vision's advocacy strategy should recommend to leaders and policy makers at national, bilateral and multilateral levels that:

Prevention programs should include the recognition of girls and women as high-risk groups, and target strategies accordingly. All the community, including boys and men, must be included in order for it to be effective.

Effective reproductive health programs must include increasing girls' access to health care, STD education/counselling and treatment, as well as information for boys and the wider community.

Resources are needed for programs that work with girls and boys to build skills for mutual value and healthy relationships.

Promote policies that ensure fair and equal access to care and treatment according to need and not depending on income, class or gender.

Put in place programs and policies that would eliminate traditional and cultural inequalities that exacerbate the vulnerability of women and children, especially girl children. This involves, among other things, the protection of women's and children's human rights and freedoms, and improving their economic independence and legal status, and in particular supporting women and children's participation in the political realm in order that they might influence policies and programs that impact them directly.³

Objective 3. Increase recognition of and support for church and faith-based responses to HIV/AIDS

As a Christian NGO, World Vision is in a unique position to support Church and faith-based responses to HIV/AIDS. Reflecting this, World Vision's advocacy strategy should recommend that leaders and policy makers at national, bilateral and multilateral levels:

Rapidly translate current promises into action such as the involvement of communities, NGOs and Faith-Based Organisations (FBOs), and realising that the inclusion and participation of these sectors requires resources.

Acknowledge the Church in Africa and elsewhere as a source of hope, and adopt policies that use its networks to extend the HIV/AIDS response.

Involve civil society, including FBOs in planning, implementation and monitoring of HIV/AIDS programs at local, national and international levels.

Call on religious leaders whenever possible to make use of their moral and spiritual influence in all communities to decrease the vulnerability of people to HIV/AIDS and to contribute to the highest level of care and support that is attainable.

³ "What is Vulnerability to HIV?", www.unifem-eseasia.org/Resources/GenderAids/genderaids8a.htm

Declare HIV/AIDS a national emergency using credible voices (including political and traditional leaders, as well as leaders of faith-based organisations, women's organisations as well as children, including adolescents). As members of communities, and as individual members of society, the participation of children – both boys and girls – in all matters that affect them is absolutely critical.

Objective 4. Increase commitments of bilateral and multilateral aid for HIV/AIDS by developed countries

Most countries now have strategic plans and ongoing AIDS programs. Most also have excellent isolated examples of AIDS prevention and care managed by government departments, community-based organisations, people living with AIDS, NGOs, faith-based organisations and the private sector. However, all these programs operate on too limited a scale, often reaching only a small fraction of the population, and too many remain limited to the health sector.

Routine sharing of information on best practices is limited. Many of these efforts have fallen short because they have been inadequately financed; there has been inadequate commitment, and support from governments and the international community, especially for scaling up programs that have proven effective.

Accordingly, World Vision should implement a number of advocacy objectives focusing on the need for more resources to be committed to HIV/AIDS and its broad socio-economic impact. World Vision should recommend to leaders and policy makers at national, bilateral and multilateral levels to:

Continue and intensify all efforts for debt relief of highly indebted countries to make sure that a significant proportion of the released funds are used for the fight against HIV/AIDS.

Call for the enhancement of multi-lateral funding devoted to the fight against HIV/AIDS and its total impact. Also call for a significant proportion of the funds to become available in the form of grants as opposed to loans, and with modalities that grant accessibility to NGOs including faith-based organisations (FBOs).

Fund the Global Fund on AIDS, Malaria and TB to its design level of \$7 billion to \$10 billion per year, and ensure that this fund is sustainable. Call for the adoption of policies that would ensure resources from the Global Fund reach the poorest, using modalities that are just, quick and accountable.

Encourage technical experts to undertake relevant research on HIV/AIDS and implement their findings, including intensification of the global efforts to find a vaccine. Call for investing more in the science while at the same time increasing developing country involvement.

Call on bilateral and multi-lateral partners, as well as civil society and the private sector to support the intensified action to curtail the spread of HIV/AIDS and to address its impact beyond the health sector. Encourage affected countries to set an example by increasing the budgeted amount committed to fighting HIV/AIDS.

Call on governments of countries belonging to the Organisation of Economic Co-operation and Development (OECD) to intensify their efforts to meet the 0.7% of GNP target for Official Development Aid (ODA). Acknowledge that HIV/AIDS can only be controlled if serious efforts to overcome global economic inequalities are undertaken. Hence support a call for an approach to African development, which combines increased debt relief, aid, as well as trade.

Put in place policies that ensure access to life saving drugs for the treatment of HIV/AIDS and its opportunistic infections, including antiretroviral drugs. This should include reduction of prices of patented drugs and generic production in highly affected countries where appropriate.

Make HIV/AIDS a priority in all development programs at the national and community levels; in other words, putting the HIV/AIDS response in the mainstream of all national socio-economic planning. Moreover, it is critical that the mainstreaming of one such strategy must also address the gender inequalities that exacerbate the impact of HIV/AIDS.

Objective 5. Ensure more effective inclusion of HIV/AIDS as a primary component of PRSPs

Make HIV/AIDS a vital component within the PRSP process; and encourage the most effective and transparent use of all resources allocated.

Develop policies that would ensure inclusion of HIV/AIDS issues within the country poverty assessment exercises and the related resource allocation framework. Often this has not been the case previously and this has led to the absence of actionable objectives on some aspects of AIDS within national budgets. This needs to change.

Develop policies and practices that encourage dialogue at all levels, on issues related to HIV/AIDS, especially those that facilitate an open and supportive environment for people living with AIDS (PLWA) or affected by HIV/AIDS. They are the greatest resource in monitoring the effectiveness of ongoing programs.

This indicates the need for a complex strategy that seeks to tackle the issue on a number of fronts and levels, even when priority objectives are clearly identified. A number of these strategies are already being undertaken, or plans are being developed by WV national offices. However, given limited resources, a prioritisation of activities and aims will be necessary.

World Vision should work to strengthen existing relationships with key institutions and networks. In addition, World Vision should not attempt to duplicate work being done but rather to build on that work.

3. Levels of engagement

Effectively meeting our core advocacy objectives will require World Vision to be engaged at several levels. In this way, the successful impact of the overall advocacy strategy is reliant on involvement at the national and local levels also. Core areas of engagement will be:

International level, geared at influencing multilateral policies and practices

The key technical agency leading the global effort on HIV/AIDS is UNAIDS. This, in turn has 8 sponsoring partners, namely: UNDP, WHO, UNICEF, UNFPA, ILO, UNESCO, UNDCP and World Bank. All these have a major role in determining the global HIV/AIDS agenda through UNAIDS. In addition, they have a significant HIV/AIDS portfolio of their own (e.g. 2 World Bank MAP initiatives for Africa total \$1 billion).

HIV/AIDS is also impacting the work of other UN agencies (especially WFP, UNHCR, FAO, IFAD, and WTO), and increasingly, many agencies are searching out ways on how they can incorporate its mitigation in their programming. One of the major outcomes of the UNGASS on HIV/AIDS was the decision to create a special funding agency, the Global Fund to combat AIDS, Malaria and TB

(GFAMT). This body promises to be a major player in the affairs of HIV/AIDS programming. It is being set up with the hope of administering up to \$10 billion of funds each year.

Clearly, it is vital that World Vision maintain regular liaison with each of the above agencies, to monitor the messages they release on HIV/AIDS and to mount such advocacy as would make their services felt at community level.

With the exception of the World Bank and Global Fund, all the above operational agencies fall under the UN Economic and Social Council (ECOSOC). This is the UN body, which is mandated to consult with NGOs. World Vision International maintains a consultative status with ECOSOC. This gives WV the right to designate representatives to UN offices in New York, Geneva and Vienna. It can also attend public meetings of the Council and its subsidiary bodies and may submit written statements relevant to the Council's work.

Bilateral level, geared at influencing bilateral decisions (especially within the G-8 countries)

Engagement with the bilateral aid agencies is handled by respective WV Support Offices but is an essential aspect of the overall strategy. This is a vital component of the HIV/AIDS advocacy link. As a group, G-8 governments provide the bulk of the funds both the UN and World Bank use. Up to one third of the funds for HIV/AIDS have traditionally come from the USA.

NGO networks within the G-8 capitals are thus in a position to exert major influence. These NGOs can state their desired action either directly to the agency concerned or through their government. Intervention can be timed to coincide with each UN agency's budget replenishment time, these NGO networks can exert incredible influence. Hence, being able to provide WVSO's with credible information from the field so that they can in turn enhance their credibility within the respective policy networks. This constitutes a vital component of the advocacy strategy.

National level, geared at ensuring that vital sectors are included

Each country now has a coordinating agency on HIV/AIDS. Hence World Vision NO's have unique access to influence the in-country process directly by making critical input on the basis of its experience working with communities.

Engagement at the national level is especially vital in countries that are undergoing the HIPC process. NGOs can impact policy through their participation in a country's Poverty Reduction Strategy Process (PRSP), ensuring that HIV/AIDS issues are centre stage in the budgeting process.

National NGOs, especially when working in networks, can exert considerable influence in determining the in-country work agenda of the various UN agencies. Most UN agencies undertake periodic reviews of their country programs. In the case of UNICEF, such exercise takes place every 5 years and is quite participative. As part of this review objectives are revisited and the amended work program forms the basis for the work plan for the following 5-year period.

NGO network level, geared at increasing awareness for specific actions

Almost each of the impacted countries now has a network/s of NGOs that engage with the bodies to ensure there is response to the HIV/AIDS crisis. Some of the networks are national while others belong to international chains.

For effective advocacy, it is vital that World Vision becomes an effective player within these networks. This helps to keep the organisation in the loop while at the same time building credibility. It is increasingly becoming difficult for a single agency to hope to champion a cause all by itself. The ability to create a critical mass of allies it is predicated on how an agency teams up with others in support of their issues.

The list of potential networks to work with is enormous. Some of the useful international networks WV has worked with on HIV/AIDS include: (i) the Ecumenical Advocacy Alliance, a loose umbrella of faith-based organisations that linked together during the UNGASS on HIV/AIDS under the coordination of the World Council of Churches. Christoph Benn, who acted as leader of this group, was recently named NGO Board member for NGOs in the North.

Other useful allies in the AIDS campaign include (ii) ICASO (International Council for AIDS Service Organisations) based in Canada but with a network that exists in a number of our high prevalence countries. Its network, which includes TASO is well represented on the technical review panel of the Global Fund, and is the premier voice of PLWA.

Then there is the (iii) GAA (Global AIDS Alliance), a Washington-based advocacy group responsible for mounting most of the pressure on the US government; (iv) the Christian Connections on International Health (CCIH), a Washington based group incorporating many Christian Health service providers in HIV/AIDS, Malaria and TB in many countries in Africa. CCIH is a useful network for fostering north to south church collaboration. Currently, our Dr. Milton Amayun is a vice president of this group.

Community level

Any effective advocacy should have a mechanism for staying connected with communities. This is crucial to ensure that the policy initiatives being promoted genuinely serve the interests of communities. In countries where HIV/AIDS programming has descended down to the local governmental level, engagement at the ADP level can be crucial in influencing local programming.

The Need for Engagement: Internally and Externally

In order to become credible in global advocacy on HIV/AIDS it is vital that WV remains engaged at several levels right from the global to the community. To ensure effectiveness calls for being able to respond timely, credibly and at the appropriate level. This in turn, calls for close networking and information sharing by those who are representing the organisation. Effective advocacy requires that the players be linked i.e. always knowing what the right hand is doing and vice versa.

Therefore, it is proposed that the Hope Initiative in conjunction with the Global Relations Team consider forming an HIV/AIDS Network. The purpose of the network would be to share information on cross cutting advocacy activities, develop joint strategies and in general, ensure that any advocacy campaigns undertaken have the broadest support from all key World Vision stakeholders.

World Vision is already doing good programmatic and advocacy work on HIV/AIDS. However, as a partnership, more could be done to effect long-term change. This document suggests some ways in which WV could become a strong advocate in the fight against HIV/AIDS. Much of what needs to be undertaken, can be identified, what is required are the resources and capacity to realise these.

Paper prepared by: Joe Muwonge, Linda Tripp, Sekai Shand, Joe Mettimano, Sara Austin, David Westwood, Colleen Daniels and Melanie Gow.

VI. INTEGRATING HIV/AIDS RESPONSE INTO EXISTING ADP PROGRAMMING

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I. INTRODUCTION

Until recently, most development and relief organisations viewed HIV/AIDS as a health problem. HIV/AIDS is now understood as a development crisis of enormous magnitude, affecting every sector of development work. Thus an effective response to HIV/AIDS requires action in every sector. Drawing on various documented best practices from World Vision and other partners, including UNAIDS, this section of the toolkit is meant to guide ADPs in integrating HIV/AIDS activities into WV's other development work.

Integration does not only mean including HIV/AIDS programming in each sector of development work; it means viewing each sector through the lens of HIV/AIDS. ADPs should make an assessment of how each of the activities they are currently undertaking impacts positively or negatively on HIV/AIDS prevention, care, and advocacy. Most development efforts have unexpected as well as expected effects, and sometimes positive development activities can have a negative effect on HIV/AIDS prevalence — for example, when a microcredit scheme means that men have more money to spend on sex workers. This section is meant to help ADP staff think as carefully and strategically as possible about how HIV/AIDS impacts and is impacted by each area of their activities.

When integrating HIV/AIDS programming into current projects, ADPs should consider their unique strengths in the communities where they operate and concentrate their energies on activities that can make the maximum impact. Each ADP is encouraged to consider which of the options laid out in this unit would be the most feasible, make the best use of resources, and be most effective in its particular context. ADPs are encouraged to consult with the NO senior management, the NO HIV/AIDS coordinator, community committees, and other key ADP stakeholders as they review, select, and implement actions to modify existing programming to address HIV/AIDS more effectively.

2. EDUCATION

The impacts of HIV/AIDS on the education sector are profound. For every teacher infected with HIV, the education of over 100 pupils will be affected. The epidemic raises important questions for education planners because the most severe impact in the education sector lies in the future. The long incubation period of the disease (the time between HIV infection and development of full-blown AIDS and death) means the impacts of HIV infection in the 1990s was felt in 2000, and the impact will be more severe over the period 2000-2010. This presents challenges for projecting future need for education facilities and staff.

It is uncertain exactly how HIV/AIDS will reshape the demographics that define community education needs. The best assumption in the absence of information on teacher mortality and morbidity is that teacher and administrator loss from AIDS will parallel what is happening in the overall adult population. School employees have increased absenteeism due to HIV/AIDS-related sicknesses and funerals. It may be that these sicknesses will take a higher toll over time than mortality. HIV-infected teachers and other education personnel are increasingly unproductive and need time off because of the opportunistic infections. Education has also been weakened because HIV/AIDS-affected households have fewer resources available for schooling.

The loss of teachers may be partially offset by the fact that there will be fewer school children in the future. This is because AIDS results in higher death rates among reproductive age adults and thus fewer births, and about one-third of infected mothers will transfer HIV to their infants, who will mostly die before reaching school age. In any case, school systems will need help surviving the intense social strains that will accompany rising death rates and declining life expectancies. If used effectively, the education sector can be a force for HIV/AIDS prevention and mitigation. It can be used to help bring the epidemic under control and to mitigate increasing social disruption and other impacts of AIDS.

2.1 Guiding principles for integrating HIV/AIDS and education

The integration process should be as participatory as possible to include all stakeholders in the education sector, i.e. parents, children, teachers, boards of governors, and the PTA.

ADPs should first approach district government education officials and departments about introducing life skills curricula, training teachers, etc. There should be an explicit understanding with the government about the government's and ADP's roles and responsibilities.

A value-based approach to prevention should be adopted, which emphasises abstinence, faithfulness, and only where inevitable, the use of condoms.

The goal should be to make schools community resources for training, information, and support on HIV/AIDS.

2.2 Programming options for integrating HIV/AIDS and education

ADPs can help schools struggling under the burden of AIDS with an education support scheme run on a cost-sharing basis. It could include rehabilitation and construction of schools, support in the training of teachers, and part payment of school costs. In some exceptional cases, such as when children are surviving on their own, World Vision can pay the full cost of education including uniforms and scholastic materials. Integration of HIV/AIDS in the education sector involves strengthening the education system and also the prevention, care, and advocacy activities described below.

2.2.1 Prevention and education

Schools are a key location for HIV prevention efforts because they provide a means of maximising the number of children reached with minimal resources. WV recommends that ADPs introduce the *Adventure Unlimited* and *Choose Freedom* curricula to the classroom. These materials contain lessons about life skills, decision making, communication, negotiation skills, romance and sexuality, and HIV/AIDS. They are value-based, Biblically sound, and age-appropriate. See section IV.2.1 of this toolkit for detailed information about the curricula and how they may be introduced to schools.

Schools are also good venues for the individual counseling of youth in HIV prevention and other life skills issues, including peer-to-peer counseling. (See section IV.2.2 for information about peer-to-peer programming.) ADPs could be involved in training and supporting these counselors. ADPs could also support the formation of school drama groups to stage role plays and communicate prevention messages, or organise competitions for the best prevention slogan. PTAs could be encouraged to initiate HIV/AIDS education and counseling programs.

2.2.2 Care and education

The following are HIV/AIDS care interventions ADPs might consider undertaking in the education sector:

- Train teachers in basic HIV/AIDS counseling and care
- Train students in peer counseling
- Train teachers and students to form HIV/AIDS care and counselling teams
- Help form school support groups for children from families affected by HIV/AIDS
- Support the establishment or strengthening of post-test or anti-AIDS clubs
- Establish counseling centres in schools
- Educate against HIV/AIDS stigma and discrimination in the schools
- Develop policies to protect and support infected children in schools
- Provide material support so orphans and vulnerable children can attend school
- Train teachers to teach basic home based care skills in school

2.2.3 Advocacy and education

The following are HIV/AIDS advocacy projects that could be carried out through the schools:

- Carry out a survey on sexuality and HIV/AIDS among school children and share the information with key stakeholders
- Develop IEC materials from the survey data
- Sensitise PTAs and boards of governors about the effects of HIV/AIDS on education with the ultimate aim of enhancing their support for the life skills program
- Contribute to the development of policy regarding care and support of OVC in school
- Support the development of guidelines for support of teachers who are HIV positive or affected by AIDS

2.3 Monitoring and evaluation indicators for integrating HIV/AIDS and education

Activities	Monitoring Process Indicators		Evaluation Effectiveness Indicators	
	Input	Output	Outcome	Impact
Prevention				
Support life skills training in WV-supported schools and other education institutions	Copies of <i>Adventure Unlimited</i> and <i>Choose Freedom</i> acquired	Copies of <i>Adventure Unlimited</i> and <i>Choose Freedom</i> distributed	# of schools with life skills training programs	# of children reporting delay in sexual debut
Distribute youth friendly, value-based HIV/AIDS IEC materials to schools	# of materials produced	# of materials distributed	# of schools receiving IEC materials	% of children demonstrating correct HIV/AIDS information
Care				
Train teachers in basic HIV/AIDS counseling and care skills	Materials to train teachers in basic HIV/AIDS counseling and care skills acquired or produced	# of training workshops held	# of teachers with basic HIV/AIDS counseling and care skills	# of HIV/AIDS affected families receiving psychosocial care
Support establishment or strengthening of post-test or anti-AIDS clubs	# of workshops conducted for establishing post-test and anti-AIDS clubs # of HIV testing centres supported	# of post-test and anti-AIDS clubs established	# of children in post-test or anti-AIDS clubs	# of children in post-test and anti-AIDS clubs with access to care and support
Advocacy				
Carry out a survey on sexuality and HIV/AIDS among school children and share the information with key stakeholders	Funds committed for survey on sexuality and HIV/AIDS among school children	Completion of survey reports on sexuality and HIV/AIDS	# of programs/policy documents using survey results	% of school children engaged in healthy sexual behaviours
Contribute to the development of policy regarding care and support of OVC in school	# of meetings/workshops attended to discuss the policy on care and support of OVC in school	Completion of care and support policy for OVC	# of schools using policy on care and support of OVC	# of HIV/AIDS affected school children receiving care and support

3. HEALTH

HIV/AIDS threatens to overwhelm the already struggling health care systems in the developing world. For example, it has been estimated that if all persons with AIDS were to be provided with adequate hospital in-patient care, the hospital beds per day required nationwide in 1998 in Uganda would exceed over three times the total beds per day available. The situation will likely grow worse as the epidemic continues. Fortunately, there are four cost effective ways that ADPs can help relieve overburdened health care systems and stem the tide of HIV/AIDS: by supporting voluntary counseling and testing, the prevention of mother-to-child transmission, the treatment of sexually transmitted infections, and home based care for the chronically ill.

Voluntary counseling and testing (VCT) has a critical role to play in promoting the prevention of HIV and the treatment of those who are infected. If ADPs work to improve the acceptability and accessibility of VCT, more people who have the virus will make an effort to keep from passing it to others. People living with HIV/AIDS will also have the opportunity to improve their health habits and thus prolong their lives.

VCT is also necessary for pregnant mothers to know whether they need to take precautions against transmitting HIV to their babies. Mother-to-child transmission (MTCT) of HIV remains a major public health problem worldwide, especially in resource-constrained countries. But MTCT can be prevented by ensuring that the mother is healthy, providing short-term ARVs at the time of birth, and providing contextually appropriate breastfeeding advice. ADPs can work to make these interventions possible.

There is evidence that controlling sexually transmitted infections (STIs) can significantly reduce the incidence of HIV. This strategy is a cost-effective way of impacting the HIV infection rates of the sexually active population, and HIV prevention messages are often better received if they come with effective treatment for another health problem.

Finally, training families and communities to care for the chronically ill at home is helping save the health system from overload and complete collapse. ADPs are well-positioned to support, strengthen, and expand home based care programs.

3.1 GUIDING PRINCIPLES FOR INTEGRATING HIV/AIDS AND HEALTH

A participatory approach involving all stakeholders and building on the existing experience in the Ministries of Health should be adopted. HIV/AIDS activities can be integrated into the reproductive health services department of the health unit.

Activities should take a facility-based approach, which ensures that all workers including non-clinicians are sensitised and are equipped with the basic skills to handle HIV/AIDS patients.

3.2 PROGRAMMING OPTIONS FOR INTEGRATING HIV/AIDS AND HEALTH

Some health activities that do not seem directly linked to HIV/AIDS nonetheless reduce its prevalence and impact. For example, an overall improvement in the quality of maternal and child health services can contribute to a reduction in mother-to-child transmission of HIV. It is probably accurate to say that any improvement in the health services provided in a community will contribute to the quality of life of people living with HIV/AIDS.

3.2.1 Prevention and health

ADPs can consider:

- Supporting improvement in the availability, quality, and use of maternal and child health services
- Investigating the possibility of providing ARVs to HIV-positive pregnant women
- Helping HIV-positive women decide what kind of feeding plan will best protect their newborn children
- Establishing appropriate VCT services in health units
- Training community counselors to provide basic counseling services and mobilise communities to use VCT services
- Training and monitoring the counselors at VCT centres
- Establishing clinics for STI diagnosis and treatment, to reduce people's vulnerability to HIV transmission
- Equipping health workers, including home based care providers, with equipment and training to protect them from work-related HIV infection

3.2.2 Care and health

ADPs can consider:

- Training health service providers in basic HIV/AIDS counseling skills and care for HIV/AIDS patients
- Establishing post-test clubs to facilitate follow-up and ongoing counseling, especially for HIV-positive clients
- Ensuring continuous availability of essential drugs for treatment of opportunistic infections
- Mobilising communities for involvement in the treatment of TB and malaria
- Establishing home based care services for all health units
- Organising support groups and networks for those who are caring for chronically ill family members at home
- Supporting, strengthening, and extending home based care programs
- Supplying equipment and medicine to home based care providers
- Supporting nutrition programs for AIDS-affected families

3.2.3 Advocacy and health

ADPs can consider:

- Advocating for the provision of ARVs to pregnant mothers
- If realistic, advocating for the availability of ARVs to all PLWHA
- Sensitising health unit management committees about the need to support HIV/AIDS activities
- Creating an environment free of stigma and discrimination within the health sector
- Lobbying for increased budget allocations for HIV/AIDS interventions
- Facilitating the development of a clear policy on the care of PLWHA
- Documenting best practices responding to HIV/AIDS in the health sector
- Mobilising resources to support home based care

3.3 Monitoring and evaluation indicators for integrating HIV/AIDS and health

Activities	Monitoring Process Indicators		Evaluation Effectiveness Indicators	
	Input	Output	Outcome	Impact
Prevention				
Establish appropriate VCT services in health units	Funds to establish and implement VCT services	# of health units equipped to provide VCT services	# of people tested for HIV	% of sexually active population tested for HIV in the ADP areas
Equip health units with equipment such as gloves to protect health service providers from work-related HIV infection	Funds to purchase protective equipment against HIV/AIDS	# of health units equipped with essential equipment for protection against HIV/AIDS	% of health units reporting to be in stock of essential equipment against HIV/AIDS infection	# of health workers who avoid getting infected while attending to HIV/AIDS patients
Care				
Ensure continuous availability and accessibility of essential drugs for treatment of opportunistic infections	Funds committed for essential drugs	# of health units supplied with essential drugs	# of registered AIDS patients with access to essential drugs	Increase in life expectancy of AIDS patients
Establish home care services for all health units	Funds for home care programs	# of health units with home care programs	# of AIDS patients covered by the home care programs	% of hospital beds occupied by AIDS patients
Advocacy				
Lobby and advocate for availability of treatment drugs in all health facilities	Information on people who need treatment drugs.	Strategy for lobbying for treatment drugs.	# of health units with treatment drugs	# of AIDS patients provided with treatment drugs
Document best practices in health sector	# of program implementers trained in documentation of best practices	# of best practices documented	# of best practices replicated	% increase in the number of people benefiting from the services

4. FOOD SECURITY

The challenges brought about by the AIDS pandemic have to be taken into account when designing and implementing agricultural and rural development programs. The illnesses and deaths of working adults reduce the amount of labour available in a farming family, disrupting the usual divisions of labour between men, women, and children. Children may be required to work longer hours, and women, who are traditional caregivers, may spend a considerable amount of time taking care of HIV/AIDS patients. This reduces the amount of time they give to specific agricultural tasks.

In many patrilineal African communities, custom dictates that when a woman is widowed, she has to remarry one of her husband's brothers. This custom allows the woman to continue accessing farmland and food; otherwise she has to leave the land on her husband's death. With the arrival of the AIDS epidemic, this custom has multiplied the risk of spreading the disease, given that the husband might have died from AIDS. Addressing the inequalities in access to land by men and women (and not only the custom of wife inheritance), as well as protecting the inheritance rights of children, will have a positive effect on limiting the spread and impact of AIDS.

HIV/AIDS impacts on labour productivity, levels of savings and expenditure, and family readiness to invest in agricultural production. Food insecurity and poor nutrition have tended to characterise households which are hard hit by AIDS. Shifts in types of crops from labour-intensive to less labour-intensive have resulted in less nutritious crops being preferred; this can have an adverse effect on the health of PLWHAs.

4.1 Guiding principles for integrating HIV/AIDS and food security

The agricultural sector provides an opportunity to reach the most vulnerable: the poor and disadvantaged in rural areas where the epidemic is rampant, who also carry the burden of caring for the sick who have returned from urban areas.

Integrating HIV/AIDS programming in the agricultural sector should have a two-pronged focus:

1. To help poor families improve the production of subsistence crops on their land and feed themselves better
2. To help families increase the income from their agricultural production

Rural poverty can have an unpredictable effect on HIV risk. Poverty may reduce an individual's ability or willingness to avoid becoming infected, but poverty may also lead an individual to engage in high-risk income generating activities such as commercial sex work. For this reason, it is important to consider all of the possible consequences of new programming in the community through an HIV/AIDS lens.

4.2 Programming options for integrating HIV/AIDS and food security

4.2.1 Prevention and food security

ADPs could consider:

- Implementing IEC and BCC campaigns targeting farm workers
- Incorporating HIV/AIDS messages in agricultural training material
- Educating the community about the impact of HIV/AIDS on agriculture
- Linking to government agricultural programs at sub-district level and training extension workers to deliver HIV/AIDS prevention messages to communities
- Launching and supporting HIV/AIDS drama groups among farmers to sensitise the farming communities on HIV/AIDS
- Training farmer-to-farmer educators on HIV/AIDS prevention and care
- Training staff on how to promote HIV prevention among high risk farmers, such as migrant farm workers
- Training staff in leading discussions on HIV/AIDS for male and female farmer groups individually using participatory methods
- Advocating for the end of harmful land inheritance practices, such as wife inheriting, which can fuel the spread of HIV

4.2.2 Care and food security

ADPs could consider:

- Introducing appropriate income generating activities (IGAs) which take into account the limitations of PLWHA, e.g. stigma in the service industry, difficulty of intense labour given frequent illnesses, problem of sustainability for family following breadwinner's death. Feasible IGAs need to be identified and popularised
- Introducing a simple and clear system of giving out loans/grants, keeping in mind the limitations of working with PLWHAs. Problems may arise such as recovery of the loan and frequent illness which may lead to diversion of funds from the IGA activities
- Creating communal fields for agricultural production for income or food where the land tenure system permits
- Organising community-based child care: cooperative day care and nutrition centres to free women to work in or outside the home
- Organising nutritional support for OVCs
- Providing apprenticeship and training in marketable skills for orphaned and vulnerable adolescents
- Promoting low risk, low input, and low labour-intensive sustainable agricultural practices
- Purchasing labour-saving tools for farmers with HIV
- Introducing nutritious and fast growing crops for families with a chronically ill member
- Providing marketing information to farmers
- Introducing integrated livestock farming for families of PLWHA modeled along the lines of the Send a Cow program Uganda

- Supporting production of food for AIDS affected families and child-headed households.
- Carrying out nutritional training programs for guardians, youth, women, and child-headed households

4.2.3 Advocacy and food security

ADPs could consider:

- Supporting agricultural action research
- Advocating for improved land tenure, ownership, and inheritance rights for widows and orphans
- Advocating for the end of harmful traditional practices, such as wife inheritance
- Documenting, sharing, and promoting best practices of food security and HIV/AIDS interventions

Best practices in nutrition and food security: Case studies

Food Security - In Zimbabwe, community committees assign land for use by home based care volunteers to plant basic staple foods such as maize and sweet potato, to provide foods to households caring for PLWHA. Surplus foods are then sold and the profits are used to purchase medicines and seeds and fertiliser to plant the following season. Proceeds are also used to pay school fees for orphans. Other income generating activities that communities have developed include raising small animals, growing fruit trees, and aquaculture.

Home Based Care - In Zambia, Chikankata hospital trains community care providers to teach AIDS-affected families how to prepare nutritious meals out of the foods available to them. Volunteers identify the most needy families and enroll them in supplement feeding programs.

Supplementary Feeding - In Malawi, food has been identified as a critical need for households affected by HIV/AIDS. Ensuring that food reaches the vulnerable households is a recurrent theme in supplementary feeding programs. Community committees in areas with high HIV prevalence select the most vulnerable households for supplementary food distribution. These include households caring for a person in his/her productive years (defined anywhere between 20-50 years) who is chronically ill in the last year; households caring for orphans and other vulnerable children; and single parent households, usually female or elderly, who are caring for children and have limited resources such as land.

Supplementary Feeding – In Uganda, It was clearly expressed in a survey by The AIDS Support Organisation (TASO) that AIDS weakens a person, thus affecting his/her health and digestive system and causing loss of appetite. Yet a person living with AIDS needs more food intake of different varieties and nutritional content than usual to cope with the illness, a time when food production is also diminishing due to labour losses. It becomes a vicious cycle that requires carefully planned interventions for the agricultural sector and food security.

Nutrition counseling has been an important component of clinic-based programs that care for persons living with HIV/AIDS. TASO provides iron sulphate tablets and other micronutrient supplements, and works with clients to plan nutritious meals taking into account the level of their resources. These programs are now an essential component of all clinic services and are one of the documented best practices in nutrition and food security in Africa.

Support Groups – Community groups are disseminating messages to improve PLWHA's nutrition, especially their intake of micronutrient rich foods. In Malawi, the Network for Persons Living with AIDS (NAPHAM) provides well-balanced meals to support group members. The support group meets once a week to prepare and share a meal, as well as advise each other on living a positive life. This includes eating a nutritious diet given the limited resources and managing opportunistic infections such as chronic diarrhea and fever.

4.3 Monitoring and evaluation indicators for integrating HIV/AIDS and food security

Activities	Monitoring Process indicators		Evaluation Effectiveness indicators	
	Input	Output	Outcome	Impact
Prevention				
Train extension workers and committees in basic HIV/AIDS counseling and care	# of training workshops held for extension workers	# of extension workers trained in basic HIV/AIDS counseling and care	Level of counseling knowledge among extension workers	# of HIV/AIDS affected farming families counseled by extension workers
Support and launch HIV/AIDS drama groups among farmers to sensitise the farming communities on HIV/AIDS	Guidelines for farmers' drama groups formation Funds for farmers' drama groups formation and training	# of farmers' drama groups formed and trained	# of farmers sensitised by the farmers' drama groups	% of farmers with correct information on HIV/AIDS
Care				
Introduce nutritious and fast growing crops for families caring for chronically ill individuals	# of ADPs with programs to introduce fast growing crops	# of chronically ill farmers introduced to fast growing crops	% increase in food production	Nutritional status of children from families caring for the chronically ill
Carry out nutrition training programs for guardians, youth, women, and child-headed households	Nutrition training program for guardians, youth, women, and child-headed households	# of guardians, youth, women, and child-headed households trained in nutrition	# of guardians, youth, women, and child-headed households utilising the nutrition knowledge acquired	Nutritional status of families caring for the chronically ill
Advocacy				
Support agricultural research	Funds for agricultural research	# of agricultural research projects commissioned	Agricultural reports	# of programs using the findings of the research

Document best practices of agriculture and HIV/AIDS interventions	# of program implementers trained in documentation of best practices in agriculture	# of best practices in agriculture documented	# of agricultural best practices replicated	% increase in the number of people benefiting from the best practices in agriculture
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5. WATER AND SANITATION

Water projects are meant to increase safe water coverage in the ADP areas and reduce the walking distance to water sources in order to spare time for productive work, particularly for women and children. The projects use community health workers to educate the community about the relationship between dirty water sources and diseases like diarrhea. The effects of HIV/AIDS on the water and sanitation sector have not been analysed to the degree that its effects on education, health, and food security have been. But it can be assumed that the loss of trained personnel and work hours that accompany HIV/AIDS have impaired the water and sanitation sector's progress in providing safe water just as they have hindered these other sectors in meeting their goals.

Water and sanitation projects, however, can also provide platforms for addressing the impacts of HIV/AIDS. At household level, it is evident that water requirements increase with the effects of HIV/AIDS. There is an extra need for sanitation in AIDS affected households, which in effect increases water needs. In many communities it is women's responsibility to provide water for the family and to care for the sick. This dual responsibility can become overwhelming when there is a long illness in the household. Projects that increase safe water coverage and reduce walking distances to water sources help address this need. Water points should be conveniently sited to cater for HIV/AIDS affected households and rainwater-harvesting programs should also give affected households priority.

Water projects involve the formation of committees to plan for the management and repair of water sources. These committees are potential networks for reaching out to the grassroots with HIV/AIDS messages and services.

5.1 Programming options for integrating HIV/AIDS and water and sanitation

5.1.1 Prevention and water and sanitation

ADPs could consider:

- Training water source committees in basic HIV/AIDS prevention and care
- Reviewing the water projects mobilisation material for inclusion of HIV/AIDS prevention messages
- Facilitating water committees to distribute HIV/AIDS IEC material to water users
- Establishing prevention and care teams among water committee members to provide care and support to the communities
- Launching and supporting drama groups among water committees to sensitise communities on HIV/AIDS

5.1.2 Care and water and sanitation

ADPs could consider:

- Supporting the provision of sanitation facilities for households caring for the chronically ill or OVCs, including the construction of latrines, drying racks, composite pits, charcoal stoves, provision of water jars, etc.
- Training water committees in basic HIV/AIDS counseling and care skills
- Facilitating water committees to provide care and counseling services to affected water users
- Training water committees to form HIV/AIDS care and counseling teams

5.1.3 Advocacy and water and sanitation

ADPs could consider:

- Carrying out a survey to establish the sanitary conditions of families caring for the chronically ill or OVC
- Lobbying for increased access to safe water for families affected by HIV/AIDS
- Advocating for the inclusion of PLWHA on water committees without stigmatisation or discrimination
- Carrying out research on the impact of poor water and sanitation on the care and support conditions of people affected by HIV/AIDS

5.2 Monitoring and evaluation indicators for integrating HIV/AIDS and water and sanitation

Activities	Monitoring Process indicators		Evaluation Effectiveness Indicators	
	Input	Output	Outcome	Impact
Prevention				
Review the water projects mobilisation materials for inclusion of HIV/AIDS messages	Reports on workshops to review the mobilisation materials	Reviewed water mobilisation materials to include HIV/AIDS messages	# of water committees utilising the reviewed materials	# of farmers reached with the messages
Facilitate water committees to distribute HIV/AIDS IEC materials to water users	Funds to reproduce and distribute IEC materials to water users	# of HIV/AIDS IEC materials produced for distribution among water users	# of HIV/AIDS IEC materials distributed among water users	% increase in knowledge about HIV/AIDS among water users

Care				
Support the provision of sanitation facilities to PLWHA and AIDS affected households that include construction of latrines, drying racks, composite pits, charcoal stoves, etc.	Reports on sanitation needs of PLWHA families Funds for provision of sanitation facilities to PLWHA	# of various sanitation facilities constructed for PLWHA # of PLWHA families provided with various sanitation facilities	Coverage of sanitation facilities among PLWHA	Hygiene status of PLWHA families
Train water committees in basic HIV/AIDS counseling and care skills.	# of training workshops held for water committees	# of members of water committees trained in HIV/AIDS basic counseling and care	Counseling knowledge level among committee members	# of HIV/AIDS affected water user's families counseled by the water committees
Advocacy				
Carry out a survey to establish the sanitary conditions of families of PLWHA	Funds committed for surveying the sanitary conditions of PLWHA	Reports on sanitary conditions of PLWHA	# of programs/policy documents using the survey results	% of PLWHA with proper sanitary facilities
Lobby for increased access to safe water for families affected by HIV/AIDS	Information on safe water coverage among HIV/AIDS affected families	Strategy to lobby for increased access to safe water among families affected by HIV/AIDS	Policy or guidelines for providing safe water for families affected by HIV/AIDS	Coverage of safe water among families affected by HIV/AIDS

6. CHRISTIAN IMPACT

Christian impact in the areas of HIV/AIDS prevention, care, and advocacy should be based on the mandate the Bible gives Christians to care for the sick, oppressed, and afflicted, and the widows and orphans (Luke 4:18, Mathew 10:42). Work responding to the impact of HIV/AIDS should be based on the compassion of Jesus Christ.

All ADP staff and committees should integrate practical Christian witness into their HIV/AIDS work in order to minister to the spiritual needs of those in the communities where World Vision works. The Christian impact component of ADP work should emphasise life-style evangelism as well as an

approach to development that addresses the whole person. Christian impact has an especially important role to play in the priority areas of caring for orphans and vulnerable children, prevention of HIV-infection among the 5-15 year olds through behaviour change, and home based care for those who are infected and affected by HIV/AIDS.

Religion is a very important aspect of people's life, particularly in Africa. In a study in rural Uganda, the Church was found to be an important agent for disseminating AIDS information. The Church can reach a wide range of people, including hard-to-reach out-of-school youth. The sexual and reproductive health needs of young people are complex, diverse, and demand urgent attention. Adult discomfort with young people's sexuality is almost universal. Use of multiple interventions in multiple settings to address young people's reproductive health problems is therefore necessary. The Church is well positioned to address young people given its unique role in society.

The Church is also ideally placed to assist in the care and support of orphans and vulnerable children and the chronically ill. Churches possess both the organisational experience and the compassionate volunteers necessary to run effective home based care programs and to undertake other forms of outreach towards those infected and affected by HIV/AIDS. Where churches lack certain capacities, WV can provide training and support. Christian impact carries a message of hope to all people who are struggling courageously against the HIV/AIDS epidemic.

6.1 Guiding principles for integrating HIV/AIDS and Christian impact

The Christian impact sector provides a good entry point into addressing the psychosocial and spiritual needs in the community. Currently World Vision undertakes three activities in the Christian impact sector:

- Youth programs
- Training of church leaders
- Sunday schools

These three activities can be used as entry points to HIV/AIDS activities for prevention, care, and advocacy.

6.2 Programming options for integrating HIV/AIDS and Christian impact

6.2.1 Prevention and Christian impact

The interventions to change behaviour among the children and youths should be value-based and can include:

- Life skills training for children and youths. Biblical values should be included in the life skills messages, which should equip children and youth to make decisions to protect themselves. The values should include:
 - Abstinence
 - Positive self-image and self-esteem
- Training children and youths to communicate with peers and parents according to the teachings of the Bible

- Training parents in child-rearing according to the teachings of the Bible
- Including HIV prevention messages in youth/child-friendly services and different media such as games, posters, radio programs, newsletters, etc.
- Training peer promoters to assist youths in education and counseling activities. These activities should reflect Christian values. As peer promoters work with participants in small groups, they should centre their discussions on examples from the Bible
- Training the church leadership in youth behavioural change. Attitude change workshops based on Biblical examples should be conducted among the church leaders. Church leaders should be encouraged to be supportive and not condemn the youth, so that the youth will be receptive to their behaviour change messages
- Avoiding night beatings or revivals, because these events can lead to sexual promiscuity

Scripture Union's Aid for AIDS: Family ministry and life skills education for HIV/AIDS prevention

Aid for AIDS is a behavioural change program which equips family members with life skills for positive moral living, i.e. sexual abstinence for single people and fidelity for married people through decisions made out of sound convictions. The life skills empower people against vulnerability to risky lifestyles and counseling helps people already at risk to be motivated to avoid self-destructive behaviour. The program aims at discouraging high-risk behaviour by providing information and building individuals' capacities to choose a wholesome life. These messages are communicated to the target group in seminars and other forums.

The project has two objectives: to influence lives to be transformed so that AIDS and other results of the breakdown of the family are slowed and finally stopped, and to teach the gospel of Jesus Christ as the true foundation for family life for every family member to be fulfilled. The project targets five categories of people — children, youth in school, youth out of school, parents, and married couples. Five reference materials are used to guide the program for each category of people. They include:

1. *Adventure Unlimited*, life skills for children
2. *Choose Freedom*, life skills for youth
3. *Engagement*, steps through searching, discovery, relating, and decision making before marriage for young single adults
4. *Positive Parenting*, for every kind of parent as a partner in the fight against HIV/AIDS
5. *Enjoy Your Marriage*, for couples, marriage enrichment and strategies for growing from strength to strength as one

6.2.2 Care and Christian impact

The following activities can be considered for integrating Christian impact and OVC care:

- Formation of community care teams based on Christian values to care for the OVC in their homes and in schools
- Training of ADP staff in Christian values to care for OVC
- Provision of spiritual and psychosocial support for OVC and their guardians. This could be through Christian values based counseling

- Protection of OVC against abuse and neglect
- Development of Christian messages that help change the attitude of the community towards abuse and neglect of children. The ADP staff and committees should be trained to use these messages to address the problem of child neglect and abuse
- Establishment of church and community-managed day care for children. The operation of these centres and the activities in these centres need to be based on Christian principles. They should be perceived as day care centres of excellence based on Christian values
- Assistant to PLWHA in succession planning. As ADP staff, counselors, and home visitors prepare children for the loss of a parent, Christian messages of hope should be encouraged and passed over to both the children and the sick parents
- Training for affected family members on how to support themselves and their family; user-sustaining skills offered to the children and their families should be based on Biblical examples of work
- Training of ADP staff, including church relations coordinators and HIV/AIDS coordinators, in attitude change for Christian witness among the OVC
- Care for chronically ill adults and children in the households. The attitude when providing cares should be that of Christ. Practical care, for example medical care, nutrition support, and hygiene training, and spiritual support, including prayer and psychosocial support, need to be offered with the compassion of our Lord Jesus Christ. This will also include praying for the sick and sharing testimonies

Christian impact should also address home based care for adults. This work could include:

- Sensitisation of the ADP staff, Church, and community about care for the sick. These groups should be shown that Jesus Christ was involved in home care activities (Mark 1: 29-31). This can be done through staff, church or community meetings
- Training of home based care teams in Christian values. As the home based care teams carry out their roles of visiting, care, and counseling, they should be encouraged to have the attitude of Jesus Christ. The spirit of volunteerism and Biblical values of caring for the sick should be sustained
- Counseling. ADP staff and those involved in counseling of patients and their families should be trained in Biblical counseling skills
- Social support. This can be in the form of spiritual support, emotional support, practical material support, and psychological support. As much as possible, support should be based on Biblical values and attitudes

6.2.3 Advocacy and Christian impact

All Christian impact work is advocacy, in the sense that Christians are always advocating for the compassionate example of Jesus Christ to be realised in all human relationships. In addition, ADPs might consider:

- Encouraging and helping church leaders who are uncomfortable discussing HIV/AIDS to do so more openly
- Speaking out against stigmatisation and discrimination against PLWHA in the Church
- Facilitating the development of policies to support HIV-positive clergymen and women

6.3 Monitoring and evaluation indicators for integrating HIV/AIDS and Christian impact

Activities	Monitoring Process Indicators		Evaluation Effectiveness Indicators	
	Input	Output	Outcome	Impact
OVC Care				
Formation of community care teams based on Christian values to care for OVC in their homes and in schools	Guidelines and materials based on Christian values for training care teams	# of care teams based on Christian values formed and trained	# of OVC cared for by community care teams	% of OVC with care and support
Training ADP staff in Christian impact to care for OVC	Training program for ADP staff in Christian impact	# of ADP staff trained in Christian impact	# of trainings carried out based on Christian impact	# of OVC cared for based on Christian impact
Home Based Care				
Sensitisation of the ADP staff, church, and community about care for the sick	Sensitisation program for ADP staff, church, and community about care for the sick	# of sensitisation workshops held for care for the sick # of ADP staff and church leaders sensitised about care for the sick	# of HIV/ADS affected people cared for by the church	% of HIV/AIDS affected people cared for by the church
Training of home based care teams in Christian values	Training program for home based care teams	# of home based care teams trained in Christian values	# of communities with home based care teams trained in Christian values	# of PLWHA supported by home based care teams

Youth Behavioural Change				
Train parents in bringing up children based on Biblical examples	Training program for parents based on Biblical examples	# of training workshops held for parents	% of parents who can comfortably talk to their children about HIV/AIDS using Biblical examples	% of children 5-15 reporting avoiding risky behaviour
Establish youth/child-friendly services	Funds to establish youth/child friendly centres	# of youth/child friendly centres established	# of children/youth attending youth friendly centres	% of children 5-15 reporting avoiding risky behaviour

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6. *Mainstreaming HIV/AIDS: Looking Beyond Awareness*, VSO, Experience in Focus: Sharing Skills — Changing Lives.
7. World Vision Uganda ADP Approach, official document.
8. Scripture Union, *Enjoy Your Marriage*, Leader's guide.
9. Cunningham, David & Janet Cunningham, *Adventure Unlimited: Growing up in Today's World*, Notes for Leaders.
10. Cunningham, David & Janet, *Choose Freedom*, Leader's guide, Scripture Union Africa.
11. Scripture Union, *Positive Parenting*, Design for the family (10 booklets: Confident children, Discipline for freedom, Family fun, Communication, Praying for your children, Teenagers, Sensible sexuality, How to help your children study, Making the most of your time, and Group study guide).

Useful Websites

<http://www.popcouncil.org/horizons/horizons.html>
<http://www.seats.jsi.com>
<http://www.unaids.org>
<http://www.fhi.org>
<http://eci.harvard.edu>
<http://hivinsite.ucsf.edu/ari/fogarty>
<Http://www.advanceafrica.org>

VII. ADDRESSING HIV/AIDS IN THE ADP WORKPLACE

CONTENTS

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2. HIV/AIDS training for staff
3. Care and support for staff
 - 3.1 Caring for oneself
 - 3.2 One-to-one caring approaches
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 - 3.4 Workplace caring approaches
4. Development and implementation of a workplace policy on HIV/AIDS
5. References

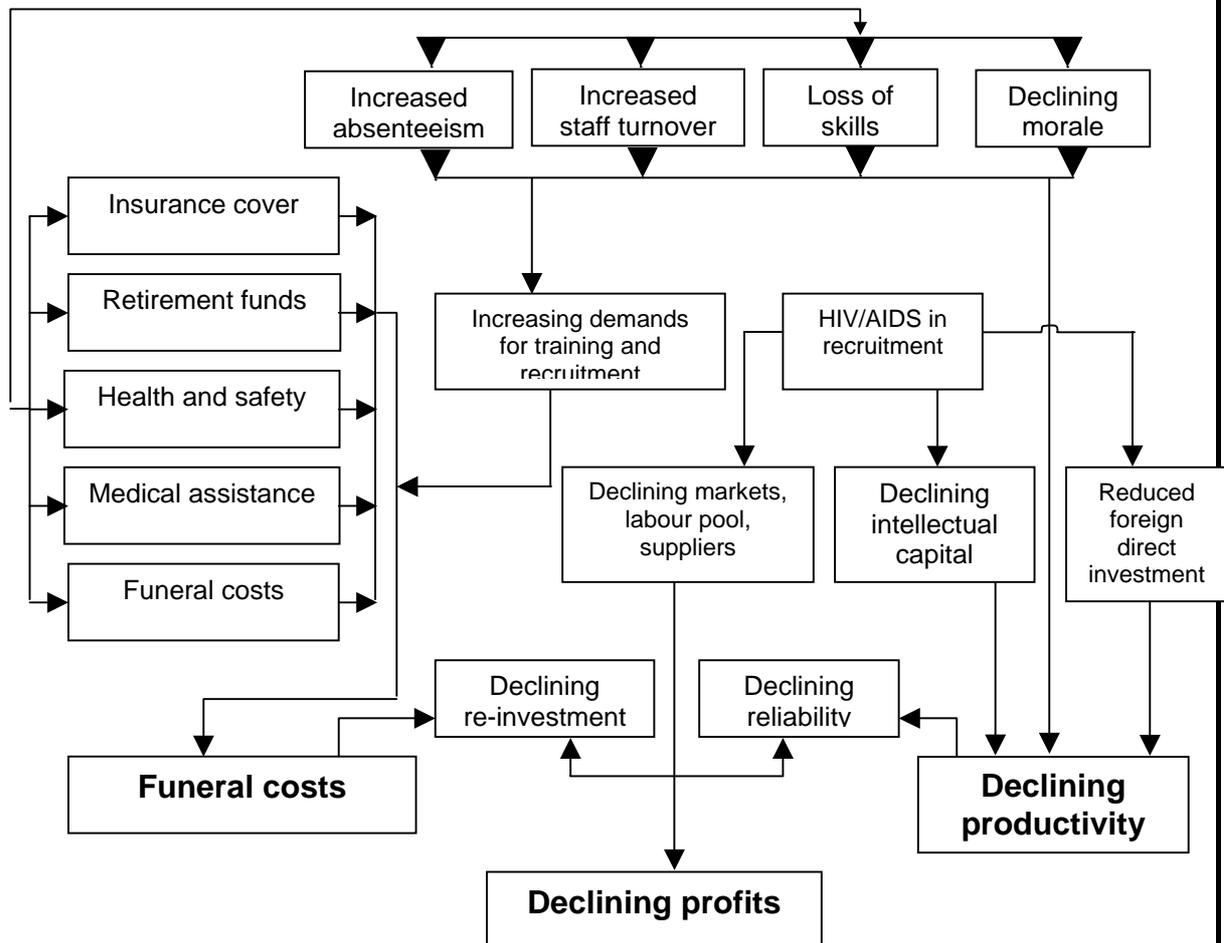
I. INTRODUCTION

The HIV/AIDS epidemic poses an enormous challenge to workplaces in HIV/AIDS-affected countries. Absenteeism due to AIDS, loss of productivity, and the cost of replacing skilled workers threaten the survival of many organisations in the business, government, and NGO sectors. AIDS remains the leading cause of death for the economically productive age group of 25-44 in many high prevalence countries. This is the most productive age group in most organisations, including World Vision. World Vision is committed to addressing the issue of HIV/AIDS in the workplace to protect its staff members and the important work they are doing.

In a number of countries, World Vision has contributed substantially to the prevention of HIV transmission and to the care and support of the people infected and affected by the virus. But more can be done to address the impact HIV/AIDS has had on the staff members who are on the front lines of HIV/AIDS training and support programs. In several World Vision national offices (e.g. Uganda, Zambia, Mozambique, Zimbabwe, and Malawi), some staff members are living with HIV/AIDS, some have died of the disease, and many others are supporting children who have been orphaned due to HIV/AIDS. Many staff members have also been emotionally affected by the constant pain and suffering they have witnessed, within the communities where they work and also in their own families.

Some organisations have dealt with the HIV/AIDS epidemic by developing workplace policies and programs on HIV/AIDS. Experience shows that these can result in a reduction of health care costs as well as increases in productivity. A Brazilian company called Villares, which employs 8,000 people with 18,000 dependants, has started offering HIV/AIDS and STI education through presentations, teamwork, training, and distribution of information materials, and selling condoms to workers and dependents at subsidised prices. Employees who are HIV positive are offered counseling, and the management has adopted policies that demonstrate commitment to HIV/AIDS prevention and care. The company reported a 31% reduction in the incidence of new HIV infections within the first year.

The Impact of HIV/AIDS on Organisations: An Overview



Source: UNAIDS (2000) Adapted from *The Business Response to HIV/AIDS: impact and lessons learned*.

Given these potential benefits, WV's National Offices will be formulating and implementing workplace HIV/AIDS policies in FY03. ADPs are encouraged to participate in this process by reviewing draft policies and participating actively in training workshops. To address HIV/AIDS in the workplace, World Vision's response will focus on:

- HIV/AIDS training for all staff employed by World Vision
- Facilitating care and support for World Vision staff
- Developing and implementing a workplace HIV/AIDS policy

This unit of the toolkit offers guidance on each of these areas of action.

2. HIV/AIDS TRAINING FOR STAFF

The World Vision partnership has made HIV/AIDS training for staff a very high priority. In 2002, the HIV/AIDS Hope Initiative developed the *World Vision HIV/AIDS Prevention and Education Handbook*. Copies for every staff member were distributed to all national offices, together with a *Training Guide* that can be used to introduce the handbook to staff. WVI has set the goal for FY03 that all WV staff in all national offices will have received HIV/AIDS training using the *World Vision HIV/AIDS Prevention and Education Handbook* for staff and the related training guide.

Five major areas are included in the HIV/AIDS prevention training for staff:

- Promoting HIV/AIDS education and awareness among World Vision staff
- Training staff in how to protect themselves from infection
- Equipping staff with basic counseling skills
- Training staff in communicating with children about HIV/AIDS
- Equipping staff with personal management skills to enable them to better care for themselves

Each National Office will be developing a detailed training plan to ensure that all staff in ADPs receive the HIV/AIDS staff training. This training is usually conducted by the HIV/AIDS coordinator and staff from human resources, often supported by the Christian impact staff.

According to the *Hope Alert*, a monthly newsletter from the partnership, WV Malawi has embarked on the training of staff in HIV/AIDS using the handbook and the training guide. In the training evaluation, one staff member wrote, 'This training has enabled me to remove fears which I had about the security of my job. Being a victim does not mean you cannot contribute to the development of the nation. The training has raised my hopes'.

In addition to the training, HIV/AIDS education materials will be provided to ADP staff. HIV/AIDS coordinators will collect, review, and distribute HIV/AIDS brochures, posters, videos, and other useful materials. In countries with operational resource centers, these materials will also be provided through them to the staff. The resource centers should find creative ways to enable staff to watch or read these materials. Materials in the form of posters with appropriate messages will be hung on walls in several places where staff can read and discuss them.

Case Studies

In Zimbabwe, a study conducted in 40 factories which strengthened prevention efforts in the workplace showed HIV spread was reduced compared to those factories which had weaker prevention programs.

At Volkswagen in Brazil, which employs 30,000 people, the potential impact of HIV was assessed early on. By 1996, the company considered that AIDS was accounting for high treatment costs and employees were experiencing frequent interruptions, precocious illness, and dying early. It quickly established an AIDS Care program that included medical care, clinical support, information, and the installation of condom machines. Volkswagen also adopted a technical protocol detailing the standard of assistance and care it should provide. Three years later, hospitalisations were down by 90% and HIV/AIDS costs by 40%.

American International Insurance, Thailand's largest life insurance company, began its efforts close to home by providing training in HIV/AIDS in its own offices. In 1995, it began a nationwide fundraising 'AIDSathon', which in turn led to the development, with the Thailand Business Coalition on AIDS, of group insurance benefits to policy holders that demonstrated they had effective policies for combating HIV/AIDS.

3. FACILITATING CARE AND SUPPORT FOR WORLD VISION STAFF

Many caregivers, including World Vision ADP staff, become so busy caring for others that they neglect their own emotional, physical, and spiritual health. The demands on a caregiver's body, mind, and emotions can easily become overwhelming, leading to fatigue, hopelessness and ultimately burn out. This situation can be avoided and World Vision will specifically address it through promoting four types of approaches to care and support:

- Caring for oneself
- One-to-one caring approaches
- Group caring approaches
- Workplace caring approaches

3.1 Caring for oneself

Staff members must remember not to forget about themselves because they are too busy. They should be encouraged to set aside time for themselves, even if it is only an hour or two. Staff should be told: 'taking care of yourself is not a luxury. It is an absolute necessity for caregivers'. This care taking involves:

- Good nutrition, including balanced and adequate meals, increased fruits and vegetables, and plenty of water (8 glasses per day)
- Recreation, including at least 30 minutes exercise daily if possible
- Setting realistic goals, accepting that help may be needed, and turning to others for help when necessary
- Knowing one's limits and doing a reality check of one's ability to provide required services

- Accepting one's own feelings — having negative feelings such as frustration and anger about responsibilities or the person being cared for is normal. It does not mean that the staff member is a bad person or a bad caregiver
- Developing tools for coping, such as lightening up, accentuating the positive, and using humor to ease everyday stresses
- Processing feelings with a trusted friend or family member
- Socialising with workmates and developing meaningful relationships, a sense of shared identity, and mutual responsibility leading to the creation of opportunities to discuss and disseminate information on HIV/AIDS
- Knowing one's status and living positively
- Lobbying and contributing to HIV/AIDS policy
- Contributing to HIV/AIDS prevention by living responsibly and avoiding transmission of the virus
- Adopting a healthy life style — respect basic rules of hygiene and avoid substance abuse

3.2 One-to-one caring approaches

In order for staff members to become sources of support to one another, the following actions may be taken:

- Learn to be a helpful and active listener
- When in need, talk to a professional counselor — clergy, social worker, and/or a colleague with counseling skills. Be open and actively engaged, as the rate of improvement will depend upon it.
- Do not discriminate against a workmate who is infected and caution colleagues who may do this
- Maintain confidentiality throughout the process of care

3.3 Group caring approaches

Staff members can find ways to care for each other in groups by:

- Planning for regular debriefing sessions and advocating for the support of those who are infected or affected by HIV/AIDS
- Facilitating the development of support groups where staff can share their feelings and experiences with other staff in similar situations. This will help in managing stress, locating helpful resources, and reducing feelings of frustration and isolation

3.4 Workplace approaches

The most important workplace approach to care is ensuring that the workplace is a loving, nonjudgmental environment in which people can openly discuss their stresses, difficulties, and griefs and also, if they wish, their HIV status. Every staff member should make a personal commitment to fostering an atmosphere of openness, non-discrimination, mutual support, and trust.

Other important approaches include:

- Providing training in counseling to all staff
- Encouraging staff to create time and space for one another

- Using discretion in attending to visitors during working hours; do not feel obliged if it is not necessary
- Initiating and planning for monthly/quarterly fellowship meals in divisions/departments and staff retreats that include half or full day focused mutual support
- Planning and prioritising of activities together
- Sharing tasks and solving problems jointly
- Providing, when feasible, compensation for additional hours worked on weekends, holidays, or overtime
- Ensuring that leave is taken and not interrupted
- Identifying and referring staff to external support resources: counselors, church leaders, etc. (It can be very useful to develop a directory of these resources)
- Recognising each person's capabilities and redistributing responsibilities where necessary
- Establishing or linking with recreation facilities (gymnasium, fitness center, etc.) that staff can use for exercise

Case study

For its staff carers, The AIDS Support Organisation (TASO) in Uganda has instituted a number of measures to minimise stress and the risk of burnout. The organisation has developed a culture of talking and sharing problems, in regular and frequent meetings between care teams and their supervisors, and in workshops which bring management and staff together to discuss policy issues and foster the feeling that TASO is a 'family'. Respect for the principle of confidentiality between staff members as much as between staff and clients means that people can feel safe in admitting stress and seeking help, even if some do still find it hard to show vulnerability. During their initial training, counselors are encouraged to identify someone among their peers as a personal counselor.

Members of staff who are sick continue to receive their salaries when they are unable to work, and will receive a further year's salary if they resign voluntarily because of ill health. There is also a policy in which at least two children of a sick staff member are supported through school and university.

A note from a psychologist

Pierre Brouard has worked in the AIDS field since mid-1980s. He trains counselors, and management of stress is a theme that runs throughout his courses because, as he says, 'Knowing how to preserve themselves is crucial for people to remain effective and committed over the long term'. He constantly emphasises to the trainees:

'You are not God; you cannot solve all the problems; you cannot prevent every infection; you cannot save the world. Give yourselves permission not to be perfect. In the training sessions, we look at a variety of things for coping with stress on a daily basis. We look at things like diet, exercise, getting enough rest and sleep, nurturing oneself a bit. We talk about strategies to have time out. We look at possible support mechanisms in the trainee's own lives — someone they can talk to like a spouse or a partner. I suggest that carers should have variety and take breaks from HIV work. And we discuss the idea of getting involved in other work, such as activism which can channel anger and frustration and helplessness'.

Visualisation — where people close their eyes and imagine a scene of beauty and tranquility into which they project themselves — is a relaxation technique that works. Another one is what he calls 'worry breaks', in which a person allows himself/herself to worry about everything bothering them in 10 minutes. 'There's a sense of deferring worry until the time you allow yourself to indulge it and putting it away again'. These are mind control strategies that people can use to help them cope.

Dr. Brouard encourages participants to talk and listen to each other as this can be very healing. Group support is a very powerful tool as people realise that others are struggling with the same things and there is a sense of shared endeavour and mutual concern. Deep breathing exercises are also beneficial in stress management, as when people are stressed they tend to breath more shallowly. Deep breathing releases hormones that can be calming.

4. DEVELOPMENT AND IMPLEMENTATION OF A WORKPLACE POLICY ON HIV/AIDS

World Vision International has set the FY03 goal that all national offices will have formulated and implemented a workplace HIV/AIDS policy.

The NO human resource division in charge of policy development, implementation, and monitoring will be responsible for developing the policy. Technical expertise will be sought from the national HIV/AIDS coordinator and from other partners who have already developed their own policies. The team developing the policy will align it with the laws of the country and with international best practice.

Guidance from UNAIDS Best Practice: Do not require HIV screening as part of general workplace physical examinations or when recruiting new staff. This cannot guarantee a workplace free of HIV/AIDS. It is preferred to offer voluntary, informed, and confidential testing and counseling for employees and their partners as part of the program.

It is essential that ADP staff be involved in the development of the workplace policy on HIV/AIDS — either in the initial policy formulation stage, or by reviewing and commenting on a draft policy. The HIV/AIDS training sessions for ADP staff are an excellent opportunity to present the draft policy and receive feedback that can be shared with human resources and the senior management team.

Once the draft policy has been adopted, annual reviews of the policy will be conducted. ADP staff will be encouraged to send their concerns for consideration throughout the year.

Examples of draft workplace policies on HIV/AIDS developed by several WV NOs in Africa can be reviewed in the HIV/AIDS section of the WV Africa website.

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VIII. MONITORING AND EVALUATING HIV/AIDS PROGRAMMING IN THE ADP

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I. INTRODUCTION

It is especially important to develop a strong monitoring and evaluation system when designing programs addressing HIV/AIDS, for a number of reasons:

- There is a lack of consensus regarding best practices in responding to HIV/AIDS.
- There is a lack of documentation on the effectiveness of various responses to HIV/AIDS.
- ADPs may have little experience in HIV/AIDS programming and need to learn quickly what approaches do and do not work.
- The HIV/AIDS epidemic is complex and rapidly evolving.

The purpose of this section is to guide ADPs in strengthening their monitoring and evaluation skills with reference to HIV/AIDS programming.

2. THE ROLES OF MONITORING AND EVALUATION

Monitoring and evaluation are related but different ways of measuring a program's performance. Monitoring happens continuously throughout a program's implementation. It determines whether planned activities are being implemented within the prescribed time frame and budget, and whether these activities are producing the short-term results intended. Monitoring is generally undertaken by the program's manager or staff. Evaluation happens at particular points during the program period, usually at the midpoint or end of the program term. It determines whether planned activities are

having the desired impact and meeting the program's longer-term objectives and goals. Evaluation can be undertaken by people within the management team, community members, or by outside assessors.

While monitoring and evaluation are different activities, there is some overlap in the way these terms are used. For example, assessing how well a program provides a service is sometimes called monitoring and sometimes called process evaluation. In any case, monitoring and evaluation should be considered complementary parts of an integrated system. Monitoring information can be useful to larger-scale evaluations, and information from evaluations can be used to improve the monitoring of project implementation. The ultimate goal of both monitoring and evaluation is to generate lessons that lead to better program design and implementation in the future.

3. INDICATORS

An indicator is a marker. It can be compared to a road sign that shows whether you are on the right road, how far you have traveled, and how far you still have to go in order to reach your destination or objective. Process indicators are associated with monitoring. They measure whether the activities needed to achieve the project objectives have been successfully carried out. Impact indicators are associated with evaluation. They measure whether the project objectives and goals have successfully been achieved.

If good impact indicators are difficult to establish, as may be the case, for example, when trying to measure behaviour change resulting from HIV prevention programs, then it may be necessary to resort to implementation indicators. It can be argued that if the theory underlying the intervention is sound and implementation is effective, then impact will be achieved even if it cannot be directly assessed. The individual prevention, care, and advocacy sections (part IV) of this toolkit each list suggested process and impact indicators.

A good indicator is:

- Substantial and significant. It reflects an essential aspect of an objective in precise terms. Precision is necessary in terms of quality, quantity, time, and place.
- Independent from other objectives. It is not possible to use the same indicator form more than one objective.
- Plausible. The changes stated in the indicator can be directly attributed to the intervention.
- Objectively verifiable. Different people using the same assessment procedure will obtain the same result independently of each other.
- Realistically achievable. The standard of performance indicated is attainable within the time and resource limits imposed on the project.
- Based on obtainable data. Means of verification that are available, reliable, practical, and affordable exist or can be set up.

4. DEVELOPING A MONITORING PLAN

4.1 Steps for developing a monitoring plan

1. Develop a program strategy.
2. Formulate goals and objectives for all interventions in the program strategy.
3. For each objective, determine the:
 - Input indicator(s) for tracking the human and material resources used by the program
 - Output indicator(s) for tracking the short-term, process-related results of the program
 - Outcome indicator(s) for tracking the medium-term results of the program

For example, for an HIV prevention program, the following indicators might apply:

Objective	Input	Output	Outcome
Help children build life skills to avoid HIV infection using the <i>Adventure Unlimited</i> curriculum	Number of booklets provided # of facilitators	Fifty children attended each of the twelve educational sessions	Forty-eight children demonstrated understanding of HIV transmission and prevention

4. Decide how, when, and by whom the information required for each indicator will be collected and analysed.
5. Implement the monitoring plan. Regularly review the progress of program implementation and revise program design and operation and the monitoring plan as necessary.
6. Identify, document, and share lessons learned.

4.2 Monitoring tools

A variety of charts and tables can be developed to monitor the progress of a program. They can include information about objectives, activities, indicators, time frames, budgets, responsible people, and/or successes or challenges.

4.2.1 Two bar chart

A two bar chart (or Gantt chart) can be used to track a program's activities over time. It compares a program's actual and planned progress toward each of its implementation targets. The chart lists the activities and shows the planned start and completion dates. Expected delays in weeks are also given, along with the present status of each component. For example:

Legend: X = Planned start and completion dates
X = Actual start and completion dates

Activity	January-March 2002	Revised Estimate (weeks)	Status
	Week 1 2 3 4 5 6 7 8 9 10 11 12		
Meeting with community members to discuss vulnerable children	X X		Completed
Identifying vulnerable children	XXX XXXX	+ 1	Completed
Identifying potential volunteers to visit vulnerable children	XXX XXX	+ 1	Completed
Training volunteers	XX XXX	+ 2	13 out of 15 volunteers trained
Meeting with community members to discuss how to support volunteers	X X	+ 2	Completed
Beginning of volunteer visits to vulnerable children	X X	+ 2	25 out of 30 children receiving visits

4.2.2 Logical framework analysis

In the logical framework or logframe approach, all project goals for a given time period are listed together with the criteria for measuring the degree to which each objective has been achieved. At the end of the period, the actual and intended progress is compared and reasons for any differences are examined. Logframe analysis typically divides its information into four columns:

- The narrative summary of project goals, purposes, inputs, and outputs
- Objectively verifiable indicators of whether each of the above has been achieved, produced, or obtained
- The means of verification
- Assumptions on which the verification is based

Logframes should be used critically and flexibly, and updated or adapted as needed. Qualitative as well as quantitative information about progress should be included.

4.2.3 Daily monitoring tool

This tool is used to keep track of day-to-day program activities. For example:

When?	What?	Where?	How?	Who?	Challenges
Date	Activities	Place	Method	Responsible person	
2 May 02	Training VCT counselors to work with CSWs	Chirundu clinic	Discussion Role-playing	CBI trainer	One counselor did not come, and one counselor expressed hostility to CSWs

5. DEVELOPING AN EVALUATION PLAN

5.1 The challenge of evaluating HIV/AIDS programs

Evaluating the impacts of HIV/AIDS programming can be especially difficult. Because HIV is a social issue as well as a disease, it is difficult to measure by scientific methods. Complex, multiple, and overlapping interventions can make attributions of cause and effect difficult. While it may be simple to monitor how much of a particular intervention was delivered to how many people, it is often less easy to evaluate intangible outcomes, such as the extent to which people have changed their behaviour or even what may have caused them to perceive things differently.

Several factors unrelated to program interventions can contribute to an observed stabilisation or decrease in the prevalence of HIV in a given setting. They include:

- Mortality, especially in mature epidemics
- Saturation effects in populations at high risk
- Behavioural change in response to the experience of HIV/AIDS among friends and relatives
- Differential migration patterns related to the epidemic
- Sampling bias and/or errors in data collection and analysis

(Source: Family Health International 2001)

Evaluators of HIV/AIDS programs must therefore be especially careful when attributing impacts to particular program activities.

5.2 Steps for developing an evaluation plan

1. For each project goal, determine the impact indicator(s) that will show whether the goal has been reached.
2. Decide how, when, and by whom the information required for each indicator will be collected and analysed. (See part II.A.6 of this toolkit and part 5.4 below for methods of collecting data.)
3. Conduct a baseline survey of these indicators before the project begins to use for later comparison. (See part II.B of this toolkit for details.)
4. Implement subsequent evaluations according to the planned time frame.
5. Identify, document, and share results and lessons learned.

5.3 Who should evaluate?

5.3.1 Internal or external evaluator?

Until recently it was thought that only outside experts could carry out project evaluations. Undoubtedly, there are still some types of evaluation that must be undertaken by external evaluators, who have not been involved in program design or implementation. But sometimes there are advantages to using an internal evaluator, who knows the program well.

Advantages and Disadvantages of External and Internal Evaluators

External	Internal
Can take a fresh look at the program	Knows the program too well
Not personally involved, so it is easier to be objective	May be influenced by friendships and personal dislikes
Is not part of the normal power structure	Is a part of the power and authority structure
Gains nothing from the program but may gain prestige from the evaluation	May be motivated by hopes of personal gain
Trained in evaluation methods. May have experience in other evaluations. Regarded as an expert by the program	May not be specially trained in evaluation methods
May not understand the program or the people involved	Is familiar with and understands the program and can interpret personal behaviour and attitudes
May cause anxiety as program staff and participants are not sure of his or her motives	Known to the program, so may pose less threat or disruption. Final recommendations may appear less threatening

5.3.2 Participatory monitoring and evaluation

The main focus of evaluation is often accountability — ensuring that a given project is achieving its goals and using its resources responsibly and effectively. But evaluation can also be a powerful tool for learning. An increasing number of practitioners embrace what is now referred to as participatory monitoring and evaluation (PM&E). They argue that evaluation works best when the emphasis is on learning for the future, and the process is initiated, designed, and owned by those directly involved in project work and those whom the work is supposed to be helping. PM&E represents a shift in who initiates the evaluation process and who gains from its findings.

PM&E is usually based on PLA exercises, whereby the PLA team helps the community to reach a consensus about which solutions to implement and which indicators to use to measure the progress of each solution. In addition, the community defines how and how often they want to conduct monitoring activities and when it would be appropriate to conduct a mid-term and final evaluation.

When ADPs involve people at the community level in the evaluation process, it is sometimes necessary to use words that are simpler than the technical terms used in this toolkit. In one country some community development workers compared evaluation to taking a bus on a long journey along an unknown road. While the riders could see through the glass windows they were happy because they could see that they were making progress. Then rain forced them to put wooden shutters over the windows and they could no longer assess their progress. They knew they were moving forward but could not tell along which road, how fast, or even whether they were nearing their destination.

Evaluation is like looking to see where and how fast you are going, and then estimating when you are likely to reach your destination. An evaluation is a way of looking at program activities, human resources, material resources, information, facts, and figures in order to monitor progress and effectiveness, consider costs and efficiency, show where changes are needed, and help to plan more effectively for the future.

5.4 Evaluation data collection methods

There are various data collection instruments that can be used to collect data for evaluation purposes. Deciding which instrument to use depends upon whether the assessment requires qualitative or quantitative information. Today, both quantitative and qualitative approaches are valued and recognized as legitimate for HIV program assessment. These methods are by no means incompatible and should be used in combination. Multiple techniques to examine the relationships between medical, behavioural, and socio-demographic data and linkages between program outcome data and patterns of HIV prevalence and incidence, as well as estimates of cost-effectiveness, can be employed.

Deciding what and how much data to gather involves difficult methodological decisions and trade-offs between the quality and utility of the information. Research priorities must be sensitive to competing needs for resources in an environment in which the HIV/AIDS epidemic is growing rapidly.

Data Collection Methods for Evaluation

Technique	Definition and use	Strengths	Weaknesses
Case studies	Collecting information that results in a story that can be descriptive or explanatory and can serve to answer the questions of what and how	<p>Can deal with a variety of evidence from documents, interviews, and observation</p> <p>Can add explanatory power when focus is on institutions, processes, programs, decisions, and events</p>	<p>Good case studies difficult to do</p> <p>Require specialized research and writing skills to be rigorous</p> <p>Findings not generalisable to population</p> <p>Time consuming</p> <p>Difficult to replicate</p>
Focus groups	Holding focused discussions with members of target population who are familiar with pertinent issues before writing a set of structured questions. The purpose is to compare the beneficiaries' perspectives with generalized concepts in the evaluation's objectives	<p>Similar advantages to interviews (below)</p> <p>Particularly useful where participant interaction is desired</p> <p>A useful way of identifying hierarchical influences</p>	<p>Can be expensive and time consuming</p> <p>Must be sensitive to mixing of hierarchical levels</p> <p>Not generalisable</p>
Interviews	The interviewer asks questions of one or more persons and records the respondents' answers. Interviews may be formal or informal, face-to-face or by telephone, and closed or open-ended	<p>People and institutions can explain their experiences in their own words and setting</p> <p>Flexible to allow the interviewer to pursue unanticipated lines of inquiry and to probe into issues in depth</p> <p>Particularly useful where language difficulties are anticipated</p> <p>Greater likelihood of getting input from senior officials</p>	<p>Time consuming</p> <p>Can be expensive</p> <p>If not done properly, the interviewer can influence interviewee's response</p>

<p>Observation</p>	<p>Observing and recording situation in a log or diary. This includes who is involved; what happens; and when, where, and how events occur. Observation can be direct (observer watches and records) or participatory (the observer becomes part of the setting for a period of time)</p>	<p>Provides descriptive information on context and observed changes</p>	<p>Quality and usefulness of data highly dependent on the observer's observational and writing skills</p> <p>Findings can be open to interpretation</p> <p>Does not easily apply within a short time frame to process change</p>
<p>Questionnaires</p>	<p>Developing a set of survey questions whose answers can be coded consistently</p>	<p>Can reach a wide sample simultaneously</p> <p>Allow respondents time to think before they answer</p> <p>Can be answered anonymously</p> <p>Impose uniformity by asking all respondents the same things</p> <p>Make data compilation and comparison easier</p>	<p>The quality of responses highly dependent on the clarity of questions</p> <p>Sometimes difficult to persuade people to complete and return questionnaire</p> <p>Can involve forcing institutional activities and people's experience into predetermined categories</p>
<p>Written document analysis</p>	<p>Reviewing documents such as records, administrative databases, training materials, and correspondence</p>	<p>Can identify issues to investigate further and provide evidence of action, change, and impact to support respondents' perceptions</p> <p>Can be inexpensive</p>	<p>Can be time consuming</p>

5.5 Data analysis

Data analysis consists of three main activities:

- Data reduction
- Data display
- Conclusion drawing/verification

Conclusion drawing and verification refers to the process of finding meanings by noting themes, regularities, and patterns. Researchers draw conclusions throughout the entire data collection exercise, but eventually this process becomes more explicit and firm at the point when the final report is written. Conclusions must also be verified as analysis proceeds. As researchers try to explain what the data means, explanations should be examined continually for plausibility and validity — do their explanations make sense within the context of the study? For example, in evaluating HIV prevention programming, it might be possible to test the validity of conclusions during presentations of preliminary research findings and interpretations to project stakeholders and/or members or target populations. Researchers could incorporate this feedback into a final version of the written report.

These three components of analysis need thorough documentation in the final reports of evaluation research so that readers can clearly understand how researchers arrived at their conclusions. Only by understanding just what is done during data analysis can readers verify or reproduce the evaluation process.

5.5.1 *Analysing qualitative data*

When working with qualitative data, such as field notes or transcriptions, data reduction means summarizing or coding large amounts of text into smaller amounts of text, and it occurs continuously throughout the evaluation research process. It involves selecting, focusing, simplifying, abstracting, and transforming the raw data of field notes or transcriptions into typed summaries organised around themes or patterns based on the original objectives of the evaluation research. Data reduction continues until a final report is written.

Qualitative data is usually displayed as narrative text, but this format sometimes overloads people's information-processing capabilities. Matrices, graphs, networks, and charts can present information in compact forms that make the data accessible to program managers.

During the conclusion-drawing phase, the principal investigator conducting qualitative research has a very different role than he or she does in quantitative research. Rather than simply tabulating responses and compiling statistics, he or she must hunt for patterns using code-mapping or overview grid construction. This work cannot be relegated to an assistant; therefore it is important to budget a sufficient amount of time for data analysis by the principal investigator.

5.5.2 Analysing quantitative data

Reducing and drawing conclusions from quantitative data is simpler than processing qualitative data: it involves tabulating and performing statistical tests upon responses. Use may be made of univariate analysis to analyse one variable at a time and frequency distribution to show the numbers and percentages of people or items that fall in different categories. Various computer packages can be used to analyse quantitative data including EPI-INFO, SPSS, and MS-Excel among others. Data can be displayed numerically and in graphs.

5.6 Triangulation

Triangulation is a process by which the researcher can show that a study's findings are not simply the result of a single method, a single source, or a single investigator's bias. The concept of triangulation is taken from land surveying, in which a person is able to identify his or her location on a map by taking bearings on two different landmarks and determining their intersection. The two landmarks and the surveyor become the three points of a triangle. In evaluation research, triangulation can be of four different types:

- Data triangulation — using several data sources
- Investigator triangulation — using several different researchers or evaluators
- Theory triangulation — using multiple perspectives to interpret a single set of data
- Methodological triangulation — using multiple methods to collect data

Methodological triangulation is ideal, but it is also expensive and poses problems for evaluators' limited budgets, short time frames, and political realities. Nevertheless, most evaluation experts agree that triangulation greatly reduces systematic bias in data.

An example of using triangulation in HIV/AIDS programming is assessing behavioural change through a combination of quantitative survey data and qualitative focus group data. Qualitative data can include group interviews with peer health educators and individual interviews with project managers. These qualitative sources of information can then be contrasted and compared with survey data on behavioural indicators, providing multiple methods as well as multiple interpreters as multidisciplinary teams prepare the final project report.

5.7 Sharing evaluation findings

Effective dissemination (the sharing of evaluation findings) is an ongoing process that begins when a survey or evaluation project is formulated — namely, at the proposal and development stage — and continues throughout the project period.

The elements of this process include:

- Building consensus among various stakeholders about the communities to be surveyed, the data to be collected and disseminated, and the forms of dissemination. This helps to build a sense of ownership of the findings and ensures that their presentation is appropriate and relevant for the various target audiences.
- Developing a complete dissemination strategy at the time the project is planned. This strategy should include dissemination of some key findings as soon as possible after data collection is completed to sustain interest and speed the implementation of prevention activities.
- Preparing target audiences to understand the meaning, limitations, and interpretation of results well in advance of their actual release to these audiences.

- Developing separate dissemination materials for each target audience that explain the findings in clear and simple language they can understand and that avoid jargon that has no meaning to that specific target audience.
- Actively following up with target audiences to answer questions.

5.7.1 Forms of dissemination

Those conducting surveys or any evaluation project cannot assume that they have finished their work when they produce a final report with detailed analysis. Though a technical report is necessary, most people do not know the meaning of “p-value” or “confidence interval” and such language is likely to confuse the issue in their minds rather than clarify them. To reach potential target audiences with the appropriate messages, a number of forms of dissemination will usually be required, including:

- A detailed report with complete statistical analysis. This report serves as a technical foundation for preparing other dissemination materials and may be appropriate for distribution to program managers and staff of organisations actively working with the communities surveyed. Even within such a report, project staff should highlight and summarize significant results in clear, non-technical language at regular intervals.
- Briefing materials for the press or other mass media. These materials should avoid all technical language. Each press release or briefing should focus on only one or two key findings and their implications so as not to confuse the reader.
- One and two-page policy briefs. Because policy makers and leaders of the surveyed communities are positioned to have a major impact on prevention measures, material specifically targeted at them is essential. Each policy brief should focus on one or two aspects of the findings, discuss implications for their own activities, and provide recommendations regarding actions they might take to influence activities positively. Separate briefs will often be necessary for different groups of policy makers or community leaders so that the material can be made directly relevant to them.
- Group dissemination meetings or presentations. Larger meetings or presentations can offer an opportunity to present the findings to members of the surveyed communities, large groups of policymakers or program managers, or the general public. The full process of dissemination may involve such meetings before, during, and after release of the data. Meetings before can be used to explain the data that are being collected, discuss issues of its interpretation, and prepare people to accept it. Meetings during and after offer an opportunity to present the findings, answer questions, clarify any misunderstandings, and discuss the implications for people in light of their respective responsibilities and the activities they can influence.
- Individualized meetings. Individual, personalised meetings with influential policy makers, community leaders from the surveyed groups, or interested NGOs and government program managers provide them with an opportunity to obtain and think about evaluation results and explore the implications for their own work in a non-threatening environment. Because such meetings are time consuming and preparation intensive, staff should pay careful attention to who can act effectively on the information when they are identifying the recipients of such individuals’ attention.

In preparing materials for each target audience, the basic goal of dissemination to each possible audience is to give them the information they need to encourage, target, or carry out meaningful HIV/AIDS prevention, care, and advocacy activities. Results should be presented in action-oriented terms. In the dissemination materials explain the relevance and importance of this information to the target audience in their specific context.

5.7.2 Tailoring dissemination to specific audiences

The persons to whom the results should be disseminated will vary from country to country depending on local conditions, influential groups, and social and political structures. Possible recipients may include:

- Policy makers, including senior officials in the office of the President, the Ministry of Health, other ministries and Parliamentarians
- Program managers in government agencies, NGOs, and CBOs
- Members and leaders of the communities surveyed
- Mass media
- Donors and funding agencies
- The general public
- Universities and research institutions
- Private employers
- Religious organisations
- Professional organisations
- District officials

The broadest dissemination of results is preferred. Each of the potential target audiences listed above has a role in reducing HIV transmission and can take action based on the findings. However, it must also be remembered that there are often local concerns and sensitivities about the open discussion of forms of behaviour that transmit HIV. These sensitivities are often strongest among the key government officials or high-ranking religious leaders, whose alienation might seriously impede prevention efforts.

In designing dissemination activities and materials, careful attention should be paid to these concerns, especially those of key stakeholders. Whenever possible, the data should be disseminated in a manner that respects the concerns of the target audience, involves them in the dissemination process, and presents the results in a language that will not be found offensive. It is also important to present the data in a way that does not increase stigmatisation or discrimination. Indirect avenues for dissemination, such as explaining the significance of the findings to those closest to influential policymakers and religious leaders with the hope that they may assist in reaching their colleagues, can also be explored.

Because members of the communities under evaluation are actively involved in data collection and have the ability to respond to the findings by changing behaviour, those who carry out surveys have a special obligation to ensure that the leaders and other members of these communities are informed of the findings. Their active participation throughout the entire process of design, implementation, and dissemination will strengthen the evaluation system and help to ensure its reliability and validity.

Other suggestions for tailoring dissemination to specific target audiences include:

- In material prepared for policy makers and community leaders, include recommendations for action in their spheres of influence. For example, materials for the Ministry of Education might emphasise the need for school-based sexual health education at early secondary level based on the number of young people reporting an early age of first intercourse. To maintain maximum credibility, any recommendations given in policy briefs should follow from the data findings themselves.
- In material prepared for other audiences, discuss the implications of the findings in the recipients' own situations. For example, a presentation about high levels of risk among factory workers might emphasise the need to increase condom use, or a presentation on high levels of male premarital sex might discuss implications for HIV exposure of young women about to marry.
- Always present data with appropriate age, gender, and other breakdowns to help people understand the meaning of the results. Because levels of risky behaviour change from one population to the next, vary between men and women, or change as people go through life, it is important that presentations take these factors into account. Far too often, such results have been presented with no sub-population, gender, or age breakdowns. This makes it difficult for people to see important patterns such as high levels of risk among adolescents.
- Present information that shows the audience why they should care about AIDS. A presentation for the Ministry of Finance or Planning should show that it would be very difficult to achieve economic development goals without addressing AIDS. For health specialists, the presentation should show how AIDS affects the achievement of goals for child survival and life expectancy. For labor unions, the presentation should show how union members and their families are affected by AIDS. Relating AIDS to the issues of most concern to the audience is an important component of an effective presentation.
- Show the audience that something can be done to improve the situation; otherwise a powerful presentation can create a feeling of hopelessness. The last part of a presentation or document should describe effective action that can be taken now. This may be action that those in the audience can implement themselves, or action by others that they should support.
- Use projections to illustrate how past trends may be changed and how AIDS affects the ability to achieve future goals. It can be useful to include epidemiological projections of the number of people infected, number of AIDS cases and AIDS deaths, and projections of the social and economic impacts of AIDS, such as effects on health care costs, the number of orphans, economic growth, women's lives, and rural development. Such projections can be used to show the full range of impacts that AIDS can have on families, communities, and nations.

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IX. DOCUMENTING AND COMMUNICATING HIV/AIDS PROGRAMMING IN THE ADP

CONTENTS

1. Introduction
2. Issues in documenting and communicating HIV/AIDS work
3. Skills needed to carry out documentation and communication
4. Developing a plan for documentation and communication
5. Choosing appropriate ways to present information
 - 5.1 Keeping information concise
 - 5.2 Using simple, appropriate, and accurate language
 - 5.3 Taking good photographs
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6. References

I. INTRODUCTION

Documentation and communication involve recording and sharing experiences, results, and lessons learned for the benefit of the program, organisation, and others.

Documentation involves:

- Compiling, analysing, and recording information
- Carrying out a process to facilitate learning
- Preserving ideas and challenges for future use and reference
- Using different media, such as writing, photographs, and videos

Communication involves:

- Communicating messages and promoting specific ideas
- Doing something that involves different stages
- Sharing our experiences and lessons among ourselves
- Sharing our findings with others
- Using different methods, such as reports, articles, and presentations

Together, documentation and communication contribute to:

- Maintaining the direction of the program
- Planning and assessing the program's work
- Raising the profile of the work being done in the ADP

Good documentation and communication does not need to be expensive or complicated. Instead, it needs to be appropriate and of good quality — in terms of style, format, content, and accuracy.

2. ISSUES IN DOCUMENTING AND COMMUNICATING HIV/AIDS WORK

Documenting and communicating HIV/AIDS activities follows a similar process to that of any other area of community development work. But because the issue of HIV/AIDS involves sensitive issues such as people's sexual lives and complicated medical information, ADPs will need to make an extra effort to document and communicate in a way that is accurate, interesting, and easy to understand as well as respectful to those involved.

Factors that make documentation and communication of HIV/AIDS work different:

- Deals with sensitive subjects such as sexual debut, adolescent sexuality, fidelity, traditional practices, sexual violence, commercial sex work, breastfeeding, etc.
- Deals with questions of sexual morality and religious belief
- Involves issues of confidentiality
- Deals with matters of stigma and discrimination
- Deals with issues of power between men and women; traditional, secular, and religious authorities, etc.
- Deals with complex, technical, scientific subjects

Guidelines for documenting and communicating HIV/AIDS work:

- Be gender and culture sensitive.
- Use respectful language. When sexual practice or other sensitive issues must be explicitly broached, use consistent, accurate, neutral language.
- Always check the accuracy of information and data.
- Uphold and promote human rights.
- Use local language that cannot be misinterpreted.
- Ensure that whoever is producing your documentation and communication is knowledgeable about HIV/AIDS.

3. SKILLS NEEDED TO CARRY OUT DOCUMENTATION AND COMMUNICATION

The following skills are needed to carry out a documentation and communication project successfully:

- Listening
- Analysing
- Collecting data
- Editing
- Recording/ Writing
- Prioritising
- Designing
- Word processing
- Planning
- Drawing

Different people in an organisation have different skills to contribute to documentation and communication work. It is useful for the ADP to think about the overall skills that they will need to carry out their work, to identify relevant strengths and weaknesses, and to develop ways to address any gaps.

4. DEVELOPING A PLAN FOR DOCUMENTATION AND COMMUNICATION

1. Decide the overall aims and objectives of the documentation and communication activity of the ADP. Spell out how this activity will contribute to the organisational mission.
2. Identify priority target audiences. These may include:
 - Current and potential donors
 - Internal audiences, such as staff of other ADPs and WV national offices
 - External audiences, such as other NGOs and CBOs
 - Individuals

To begin with, think about all the potential audiences that could be reached. Then select a specific audience for each documentation and communication product.

3. Choose key messages to achieve the documentation and communication objective. Key messages are the most important ideas that an ADP wants to communicate. They are the points that should remain in people's minds after they have read a report, watched a video, or listened to a cassette. Key messages need to be IMPACT-oriented:
 - **I**nspiring
 - **M**emorable
 - **P**ositive
 - **A**ttention-grabbing
 - **C**lear
 - **T**aken from practical experience
4. Select the appropriate documentation and communication products. These will vary depending on the needs and resources of the ADP. Examples include:
 - Case studies
 - Websites
 - Presentations
 - Newsletters
 - Videos
 - Abstracts
 - Leaflets
 - Policy reports
 - Annual reports
 - Photo-story books
 - Workshop reports
 - Radio programs
 - Video programs

5. Decide who will be responsible for producing the products, how the products will be produced, and determine a time frame.
6. Decide how the documentation and communication project will be disseminated. Options include:
 - Mail
 - Articles in journals
 - Special events
 - Meetings
 - One-to-one briefings
 - Launches
 - Conferences
 - Websites

See part VIII.5.7 of this toolkit for more ideas about dissemination.

7. Monitor and evaluate the effectiveness of the documentation and communication project. Process indicators may include number of printed materials issued, number of community members attending informational sessions, etc. Impact indicators may include percentage of target audience reading and remembering printed materials, percentage of community members taking action after a briefing, etc.

5. CHOOSING APPROPRIATE WAYS TO PRESENT INFORMATION

There are many different ways to present information in documentation and communication work, including drawings, bullet points, tables, graphs, and diagrams. It is also important that an ADP selects visuals that suit their organisation, product, and audience. When deciding what type of visuals to develop, it is useful to consider both practical issues (such as what relevant skills your ADP has) and design issues (such as whether the end product will be easy to understand and have a strong impact).

5.1 Keeping information concise

Keeping information short and concise — also known as summarising and synthesising — is a key skill for documentation and communication work. A product that is concise is much more likely to be looked at, understood, and acted on than one that is long and unfocused.

Many ADPs may find keeping information concise a challenge. But it is a skill that can be improved with practice and by thinking through some key questions, such as:

- What key messages do I want to communicate?
- What information is vital to include?
- What information is extra and could be left out?

5.2 Using simple, appropriate, and accurate language

Using simple language is an important part of effective documentation and communication. Simple language is that which is easy to understand and avoids complex terms. Sometimes complicated language can seem more official or impressive. However, the best kind of language allows people to communicate as clearly as possible. It is useful to remember that what makes good, simple sense to you will make good, simple sense to others.

In addition to using simple language for their documentation and communication work, ADPs need to choose language that is appropriate and accurate. Appropriate language means language that suits a particular context and is understood and appreciated by a particular audience. Accurate language means language that is correct. Using appropriate and accurate language means avoiding words and phrases that are easily confused, imprecise, or might have a negative effect.

5.3 Taking good photographs

Photographs are one of the most commonly used and effective means of visual documentation and communication. Improving skills in taking good photographs does not require highly technical equipment or training. It can be achieved through good preparation and following a few basic rules or useful ideas about how to use a camera and how to choose an image.

As well as taking good photographs, an ADP needs to think about how to use photographs effectively in its documentation and communication work. Important questions include:

- Is the photograph relevant to the subject matter?
- Is the photograph appropriate for the audience?
- Does the photograph present the person, place, or activity in an appropriate way?
- Does the photograph communicate the right message?

5.4 Making good visual aids

Visual aids such as flipcharts and overhead transparencies are an important part of documentation and communication work. The quality of flipcharts and overhead transparencies can make a real difference to the effectiveness of the ADP presentations and displays. As with other areas of documentation and communication, the most important rule is to keep the style and information as simple, appropriate, and focused as possible.

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The HIV/AIDS Hope Initiative

Launched in early 2001, the HIV/AIDS Hope Initiative is World Vision's effort to increase and intensify responses to HIV/AIDS in all of the countries where World Vision operates. The primary goal of the Hope Initiative is to reduce the global impact of HIV/AIDS through the enhancement and expansion of World Vision programs and collaborations focused on HIV/AIDS prevention, care, and advocacy.

World Vision and HIV/AIDS

At the end of 2002 it was estimated that 42 million people were living with HIV, two thirds of them in Africa. More than 25 million people have died of AIDS since the epidemic started, more than a quarter of them children. Over 3.2 million children under 15 have the virus today. More than 14 million children have lost their mother or both parents to AIDS, and that number is rising rapidly — especially in Africa.

Why is HIV/AIDS a priority for World Vision? Because HIV/AIDS is the greatest single challenge facing the development community today as it devastates entire communities and rolls back decades of development progress. HIV/AIDS is aggravated by poverty and has a disproportionate impact on the poor.

More specifically, HIV/AIDS is a priority for World Vision because:

- World Vision cares about children and is particularly concerned about the more than 25 million children who will lose one or both parents to HIV/AIDS by 2010.
- World Vision has over 900,000 sponsored children in the 30 worst hit countries and nearly 2 million sponsored children at risk worldwide.
- World Vision is investing almost \$200 million a year in the 30 worst hit countries.
- Our worldwide staff are at risk, and many are personally affected by HIV/AIDS in their own extended families.
- As a Christian organisation, we have a unique opportunity to share God's hope with those who are affected by HIV/AIDS.

World Vision recently celebrated 50 years of work to promote the well being of children and communities. Tragically, the hard-won progress from those 50 years of relief and development work is now jeopardised by HIV/AIDS. Reduced child mortality, improved health, rebuilt communities, reinforced food security and increased educational opportunities — all of this progress could be reversed. The Christian and humanitarian imperative, which undergirds everything World Vision does, compels us to respond in the face of such pain and suffering.

World Vision has been implementing HIV/AIDS programs for more than a decade. However, in light of the enormity and severity of the pandemic in Africa and the increasing potential for catastrophic prevalence rates in Asia, Latin America and Eastern Europe, we recognise that we must substantially increase our efforts.

World Vision's HIV/AIDS Hope Initiative is our commitment to do our part to address this unprecedented crisis, in respectful partnerships with governments, churches and other faith-based organisations, other agencies, communities, families, and children.

A summary of the HIV/AIDS Hope Initiative goals, values, and design principles is displayed on the next page.

World Vision

HIV/AIDS Hope Initiative - Goals

The overall goal of the HIV/AIDS Hope Initiative is to reduce the global impact of HIV/AIDS through the enhancement and expansion of World Vision programs and partnerships focused on HIV/AIDS prevention, care, and advocacy

	Prevention	Care	Advocacy
Track goals	Make a significant contribution to the reduction of national HIV/AIDS prevalence rates	Achieve measurable improvements in the quality of life of children affected by HIV/AIDS	Encourage the adoption of policies and programs that contribute to minimizing the spread of HIV/AIDS and maximizing care for those living with or affected by HIV/AIDS
Target groups	<ul style="list-style-type: none"> • Children aged 5-15 years • Pregnant and lactating mothers • High risk groups 	Orphans and other children made vulnerable by HIV/AIDS, and their caregivers	Policy makers (local, national, international)
Values	Bring a Christian response to HIV/AIDS, reflecting God's unconditional, compassionate love for all people and the affirmation of each individual's dignity and worth		
Partners	Work with a wide range of partners in HIV/AIDS response at local, national, and international levels, with a special focus on churches and other faith-based organizations as primary and indispensable partners		

Annex B: Summary of the Models of Learning Program

The Models of Learning program of the HIV/AIDS Hope Initiative is World Vision's learning laboratory for intensive research and development of large-scale responses to the HIV/AIDS pandemic. Centred in Zambia and Uganda, the program is working to generate programming models, strategies, and lessons learned that are applicable across Africa and beyond.

The Models of Learning program is developing integrated HIV/AIDS responses that optimise World Vision's contributions to HIV/AIDS prevention, care, and advocacy, with a special focus on orphans and other highly vulnerable children. To guide this work, the program is drawing on the best practices developed by World Vision offices around the world, as well as on the lessons learned by other partners.

The Models of Learning program is combining its commitment to rapid, large-scale action with a strong emphasis on monitoring, evaluation, and operations research. The MoL team is responsible for ensuring that new program approaches and strategies are designed, tested, validated, and documented for sharing throughout the World Vision partnership and with partner agencies.

Vision

Guided by God's call and World Vision's mandate, the Models of Learning program of the Hope Initiative is working to realise the following vision for transformation in a world living with HIV/AIDS:

- Effective, integrated HIV/AIDS programming in prevention, care, and advocacy for children and communities affected by HIV/AIDS is prioritised, expanded, and strengthened by World Vision in countries with significant HIV prevalence, in collaboration with churches, other faith-based organisations, community-based organisations, nongovernmental organisations, government, business, and other partners
- Sound practices of HIV/AIDS programming are documented and shared across World Vision
- Substantial resources are mobilised for expanded HIV/AIDS responses by World Vision and partners
- World Vision staff are equipped to protect themselves and their families from HIV infection, and to provide care and support to colleagues, family, and others infected and affected by HIV/AIDS.

The Models of Learning Team

To realise this vision, World Vision has assembled a strong team of specialists experienced in key aspects of HIV/AIDS response. Based in Kampala and Lusaka, the Models of Learning team includes expertise in:

- HIV prevention
- Care and support for orphans and other vulnerable children and their families
- Building the capacity of local and national NGOs and CBOs engaged in HIV/AIDS response
- Expanding and strengthening HIV/AIDS responses by churches and other faith-based organisations
- Monitoring, evaluation, documentation, and research
- Strategic and financial management

The Models of Learning team serves as a resource for multiple constituencies within World Vision:

- The World Vision offices in Uganda and Zambia
- World Vision offices in the rest of eastern and southern Africa, the world's two most heavily HIV/AIDS-affected subregions
- World Vision offices in the rest of Africa and the Africa regional office
- World Vision offices in other regions (Asia-Pacific, Latin American and Caribbean, and Middle East and Eastern Europe)

- World Vision support offices and the WV partnership office

Partnerships

Recognising that no single organisation can respond at a scale that matches the enormity of the HIV/AIDS crisis, the Models of Learning team is building close collaboration with many other partners in HIV/AIDS programming. Programming partners include communities, governments, multilateral and bilateral organisations, international and national NGOs, the private sector, and academic and research institutions.

A primary partner for World Vision's HIV/AIDS response is and will remain the church and other faith-based organisations. In many HIV/AIDS-affected areas, churches and other FBOs are in the lead in helping families cope with HIV/AIDS — providing care and support for the sick, the widowed, and the orphaned. The church's potential to promote constructive behaviour change for HIV prevention is undertapped. Equipping the church and other FBOs to expand and sustain their responses to HIV/AIDS is a central priority of the Models of Learning program.

Overall, the Models of Learning program is working to serve as a catalytic partner in local, national, and regional HIV/AIDS action, helping to knit together a web of responses that collectively measure up to the magnitude of the HIV/AIDS crisis.

Arenas of Action

The Models of Learning program is working in five distinct but overlapping arenas of action in order to undertake a comprehensive response to the HIV/AIDS crisis.

I. Within current World Vision areas of operation

This unprecedented crisis requires fundamental reconsideration of all World Vision's existing programs. The Models of Learning team is working with World Vision staff across Uganda and Zambia to re-examine all World Vision activities, and reconfigure as necessary to maximise each activity's contribution to preventing HIV transmission and mitigating the impacts of AIDS. The Models of Learning team is also collaborating with World Vision staff and partners to introduce new programming that responds effectively to the challenges raised by the pandemic.

II. Outside current World Vision areas of operation

The Models of Learning program is beginning its work in World Vision's existing areas of operation, but will not end there. The magnitude of the crisis engendered by HIV/AIDS is simply too great for World Vision to be able to make a major difference by working only within its current locations. In areas beyond those that World Vision presently covers, the Models of Learning team will collaborate closely with communities, churches, faith-based organisations, and other partners to catalyse and strengthen the capacity of church/community-led HIV/AIDS response initiatives. Many of these will focus on care for orphans and other highly vulnerable children and their families.

III. National level

The Models of Learning team is leading World Vision's active involvement in national policy and program dialogue on HIV/AIDS-related issues, partnering with the government and other national bodies and advocating for action that benefits HIV/AIDS-affected children and families.

IV. Regional and global levels

The Models of Learning program is engaging in HIV/AIDS networks and fora in Africa and worldwide, learning from and contributing to the international community's knowledge and practice of effective HIV/AIDS response strategies.

V. Among World Vision staff

Many World Vision staff are infected or affected by HIV/AIDS. The Models of Learning program is working with national office staff to promote HIV prevention and to develop supportive responses for staff members who are living with HIV/AIDS, caring for relatives who are HIV-positive, fostering children who have been orphaned, or otherwise facing hardship because of the pandemic.

Results and Deliverables

The most important impact of the Models of Learning program will be substantial and sustained improvement in the lives of many thousands of children affected by HIV/AIDS and their families and communities in Zambia, Uganda, and beyond. The key program outcomes that will enable the achievement of this impact will be the strengthened capacities of World Vision and its partners (families, communities, churches and other faith-based organisations, local and national NGOs, government, and others) to prevent the spread of HIV/AIDS and to mitigate its devastating human consequences.

The specific deliverables of the Models of Learning program include:

- Program models and strategies field-tested and proven effective in World Vision operational contexts for:
 - Increasing and strengthening care for orphans and other highly vulnerable children within and beyond current World Vision areas of operation
 - Expanding and enhancing responses to HIV/AIDS by churches and faith-based organisations
 - Promoting HIV prevention among high-risk populations, including commercial sex workers and truck drivers
 - Preventing mother-to-child transmission of HIV
 - Promoting HIV prevention among 5-15 year olds using a holistic, values-based approach
 - Engaging in effective HIV/AIDS advocacy at local, district, national, regional, and global levels
- A strong system of monitoring and evaluation for World Vision’s HIV/AIDS responses, including meaningful and reliable impact indicators
- Strong examples of workplace HIV/AIDS policies for World Vision national offices
- A large-scale church partnership initiative linking North American churches with African churches and communities struggling to address HIV/AIDS
- Innovative new marketing strategies and products that substantially expand resources available to support HIV/AIDS response

The development of each of these deliverables is being documented carefully, and the key findings and lessons learned are being distilled and shared widely across the World Vision global partnership and with other partners. Based on these lessons and findings, the Models of Learning team is producing a range of accessible, user-friendly materials to guide HIV/AIDS programming. These materials include a series of World Vision toolkits for HIV/AIDS programming, providing concrete programming guidance and tools for expanding and enhancing HIV/AIDS responses in World Vision operational contexts.

The Models of Learning team includes the following individuals:

<p>Mark Lorey Director, Models of Learning Program</p>	<p>Has a range of experience in HIV/AIDS programming, particularly focused on orphans and vulnerable children. Previously worked with USAID, Save the Children, the Francois-Xavier Bagnoud Foundation, and the Center for International Development at Harvard University and has resided in East Timor, Kenya, Malawi, and South Africa. Currently based in Zambia.</p>
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Zambia

Chibeta Nkwemu Monitoring, Evaluation, and Research Specialist	Has strong educational background and experience in reproductive health programming. Prior to joining World Vision, led program monitoring and evaluation at Planned Parenthood Association of Zambia.
Faith Ngoma Orphans and Vulnerable Children Specialist	Trained in child development and public administration in Zambia and Canada. Worked with national and international NGOs. Before joining World Vision, served as Vulnerable Groups and Gender Specialist with the World Bank-endowed Zambia Social Investment Fund.
Maurice Sepiso HIV/AIDS Prevention and Care Specialist	Formerly head of a government district health team and founder of an HIV/AIDS-focused NGO, with strong clinical, program development, and management experience.
Osborne Siamutwa Finance and Administration Specialist	A fully certified accountant with extensive experience in the private and public sectors, most recently as senior grant accountant with Zambia's Ministry of Health, where he managed multiple grants from more than ten foreign donors.
Siyani Zimba Church/FBO Partnership Specialist	A practicing pastor with years of experience collaborating with national religious leaders and working in World Vision field projects.

Uganda

Joel Kigenyi Church/FBO Partnership Specialist	Previously with the Ugandan organisation TAIP: The AIDS Intervention Program. Has seven years of strong experience mobilising church responses to HIV/AIDS and a background in social work and development.
Celia Kakande Monitoring, Evaluation, and Research Specialist	Has extensive experience in program monitoring, evaluation, and research with Ugandan NGOs focused on gender and development.
Grace Mayanja Orphans and Vulnerable Children Specialist	Has worked with World Vision for almost a decade, most recently as coordinator of Kakuuto ADP in Rakai district, where much of World Vision Uganda's work with orphans and vulnerable children was pioneered.
David Serukka HIV/AIDS Prevention and Care Specialist	Served as national health advisor for Christian Children's Fund in Uganda before joining World Vision. Has a MD/MPH and lengthy experience in health and HIV/AIDS program development and management.
Richard Wamimbi MoLU Director	Has extensive experience in program management, research, and advocacy. Before joining World Vision, served as the founding executive director of the Uganda Network of AIDS Service Organisations (UNASO), a nationwide network of NGOs engaged in HIV/AIDS work.

For additional information on the Models of Learning program, please contact:

*Mark Lorey
Director, Models of Learning Program
mark_lorey@wvi.org
Tel: +260 1 221 696 or +260 96 740 733
Fax: +260 1 221 954*

*Richard Wamimbi
Director, Models of Learning Uganda
richard_wamimbi@wvi.org
Tel: +256 41 340 283/294/300
Fax: +256 41 348 352*

Annex C: Overview of World Vision's HIV/AIDS-Related Position Statements

The vast majority of World Vision's work in HIV/AIDS will reflect prevention, care, and advocacy activities that would be considered normal and non-controversial by almost all observers.

However, we also recognise that HIV/AIDS raises a number of difficult issues in which choices need to be made. Well-meaning and thoughtful people will come to different conclusions. The position statements below were developed by World Vision after careful thought and consideration. Our desire in adopting these positions is to provide guidance to our programs staff on how best to achieve the goals of the Hope Initiative in these particular areas while honouring the core values of the organisation.

We acknowledge that some may disagree with our conclusions, and we respect those differences of opinion.

World Vision's HIV/AIDS-related position statements include:

1. Abstinence, Fidelity, and Condom Use
2. Commercial Sex Workers
3. Association with Gay Rights Organisations
4. HIV/AIDS and Intravenous Drug Users
5. Age of Responsibility and HIV/AIDS Education
6. HIV/AIDS and Breastfeeding vs. Infant Formula
7. Access to Affordable HIV/AIDS Drugs

I. Abstinence, Fidelity, and Condom Use

Scripture teaches us that God intended marriage as a sacred relationship between a man and a woman with sexual relations as a gift to be enjoyed within the context of marriage. In accordance with Scripture, WV advocates for and strongly encourages sexual abstinence outside of marriage and fidelity within marriage.

The Scriptures also teach us of the sanctity of life: God highly values each individual life and instructs us to do all we can to preserve and enhance life. In regards to HIV/AIDS, it has been demonstrated that when used correctly and consistently, condoms can be an effective barrier to the transmission of the deadly HIV virus. Therefore, WV encourages the use of condoms as a means of preserving and protecting life.

In summary, WV promotes abstinence and fidelity — not just as protection against HIV/AIDS, but because it represents God's intended means of sexual and marital wholeness and fulfilment.

In addition, WV supports the use of condoms as a practical step to reduce the transmission of HIV and its deadly impact on human life.

2. Commercial Sex Workers

World Vision opposes the commercial sex industry and the considerable damage it does to all those who are impacted by its existence.

Poverty forces many women and children into prostitution, often in countries with a significant HIV/AIDS problem. Many are unwilling participants in an industry that thrives on coercion and trafficking. We are particularly conscious of the millions of children forced into prostitution against their will.

World Vision will work with commercial sex workers to educate them about HIV/AIDS, to assist them in protecting themselves from the HIV virus, and to provide them with alternative economic opportunities.

3. Association with Gay Rights Organisations

World Vision often participates in coalitions of groups that seek to educate the public and policy-makers concerning this deadly disease. Some of these coalitions may include organisations representing homosexuals and gay rights.

While World Vision does not condone homosexual behaviour, it will, on occasion, participate in coalitions, which include gay rights groups when it is determined that such collective efforts can substantially contribute to the reduction of HIV transmission. Our involvement in such coalitions will be in ways that are both consistent with our core values and effective in addressing the HIV/AIDS epidemic.

4. HIV/AIDS and Intravenous Drug Users

World Vision believes that illicit drug use destroys lives, families, and futures. In the developing world, drugs also aggravate poverty and conflict.

World Vision believes that action should be taken against the drug trade and to diminish the demand of drugs. Nevertheless, drugs are addictive and the drug-users are often compelled by this addiction to indulge in behaviour that exposes them to the risk of HIV/AIDS.

World Vision believes that risk-reducing initiatives, such as needle exchange programmes can be effective in reducing the transmission of the HIV virus. As such, WV supports such initiatives, especially when combined with counseling and drug rehabilitation.

5. Age of Responsibility and HIV/AIDS Education

World Vision accepts 18 as the age at which childhood ends. Ideally, children should not be subject to marriage or sex prior to this age. Yet, in many countries the age of consent is considerably lower than 18, as is the age of legal marriage. The onset of sexual activity both within and outside of marriage often begins as young as age 10, especially for girls in developing countries.

To protect these young people from the transmission of diseases such as the HIV virus, to promote healthy motherhood and good decision-making skills, and to encourage moral behaviour, WV may include children in programs which offer sex education, family life and life skills training, and reproductive healthcare. In all its teaching, World Vision stresses abstinence and faithfulness as the key pillars in the prevention of sexually transmitted diseases.

6. HIV/AIDS and Breastfeeding vs. Infant Formula

World Vision affirms the joint policy of UNICEF, the World Health Organisation (WHO), and UNAIDS that breastfeeding should be promoted, protected and supported over the use of infant formulas in developing countries. In poor nations, formula fed infants are four to six times more likely to die of infectious diseases than breastfed babies. Breastfeeding is generally safer than infant formulas, because the safe preparation of infant formula requires clean water, decent sanitation, adequate fuel, and careful instruction: conditions often lacking in poor homes.

Nonetheless, a child whose mother is HIV-positive runs about a one in seven risk of being infected with the HIV virus through breastfeeding. Therefore, World Vision endorses the UNICEF/WHO/UNAIDS recommended approach for pregnant women and mothers: 1) voluntary and confidential HIV testing; 2) good prenatal care and anti-retroviral drugs for HIV-positive mothers; 3) counselling on the risks and benefits of feeding options; 4) affirming the right of HIV-positive mothers to choose a feeding option and assisting them in that choice.

7. Access to Affordable HIV/AIDS Drugs

In principle, World Vision affirms a rules-based, international trade system that protects patent rights on drugs. However, in exceptional circumstances such as the HIV/AIDS epidemic, a higher, humanitarian principle to protect public health takes precedence over corporate or commercial interests.

Poor countries should have access to anti-retroviral and other HIV/AIDS drugs at affordable prices. Affordability might be secured through price controls, discounting of patented drugs, or the manufacture or import of generic drugs.

Annex D: HIV Prevalence Rates in Countries with a World Vision Presence

Africa

Country	Prevalence Rate*
Angola	5.5%
Burundi	8.3%
Chad	3.6%
DRC	4.9%
Ethiopia	6.4%
Eritrea	2.8%
Ghana	3.0%
Kenya	15.0%
Lesotho	31.0%
Liberia	--
Malawi	15.0%
Mali	1.7%
Mauritania	--
Mozambique	13.0%
Niger	--
Rwanda	8.9%
Senegal	0.5%
Sierra Leone	7.0%
Somalia	1.0%
South Africa	20.1%
Sudan	2.6%
Swaziland	33.4%
Tanzania	7.8%
Uganda	5.0%
Zambia	21.5%
Zimbabwe	33.7%

The countries in **bold** are defined as high-prevalence countries: those with HIV prevalence of 5% or higher in the adult population.

All statistics are based on UNAIDS figures from December 2001.

Asia

Country	Prevalence Rate
Bangladesh	<0.1%
Cambodia	2.7%
China	0.1%
East Timor	--
India	0.8%
Indonesia	0.1%
Japan	<0.1%
Laos	<0.1%
Malaysia	0.4%
Mongolia	<0.1%
Myanmar	--
Nepal	0.5%
North Korea	--
Philippines	<0.1%
Singapore	0.2%
South Korea	<0.1%
Sri Lanka	<0.1%
Taiwan	--
Thailand	1.8%
Vietnam	0.3%

Oceania

Country	Prevalence Rate
Australia	0.1%
New Zealand	0.1%
Papua New Guinea	0.7%
Solomon Islands	--
Vanuatu	--

Europe

Country	Prevalence Rate
Albania	--
Armenia	0.2%
Austria	0.2%
Azerbaijan	<0.1%
Bosnia-Herzegovina	<0.1%
Finland	<0.1%
Georgia	<0.1%
Germany	0.1%
Ireland	0.1%
Kosovo	--
Macedonia	<0.1%
Yugoslavia	0.2%
Netherlands	0.2%
Romania	<0.1%
Russia	0.9%
Switzerland	0.5%
United Kingdom	0.1%

Middle East/Eastern Europe

Country	Prevalence Rate
Jerusalem/West Bank/Gaza	0.1%
Lebanon	--
Syria	--
Jordan	<0.1%

Latin America/Caribbean

Country	Prevalence Rate
Bolivia	0.1%
Brazil	0.7%
Chile	0.3%
Colombia	0.4%
Costa Rica	0.6%
Dominican Republic	2.5%
Ecuador	0.3%
El Salvador	0.6%
Guatemala	1.0%
Haiti	6.1%
Honduras	1.6%
Mexico	0.3%
Nicaragua	0.2%
Peru	0.4%
Venezuela	0.5%

North America

Country	Prevalence Rate
Canada	0.3%
United States	0.6%

Annex E: Declaration of Commitment and Call to Action on HIV/AIDS

Adopted at the World Vision HIV/AIDS Hope Initiative High Prevalence Country Workshop Johannesburg, South Africa, 14-17 January 2002

We, the participants of the Hope Initiative High Prevalence Country workshop, representing national and regional offices and the partnership office, and including managers, specialists and executives declare:

World Vision is called by faith to respond with urgency and compassion to the global HIV/AIDS pandemic. More than 40 million people are currently infected with HIV. Nearly 70 percent of them are in Sub-Saharan Africa and the epidemic is spreading in Asia, Latin America and Eastern Europe. At least 22 million people have died of AIDS, more than a quarter of them children. Over 2.7 million children under 15 have the virus today and millions more children are at risk of infection. At least 13.2 million children have lost one or both parents to AIDS – most of them in Africa. The number is expected to grow to 40 million by 2010. HIV/AIDS is aggravated by poverty and has a disproportionate impact on the poor. Families and communities are devastated by the social and economic impacts of the pandemic. HIV/AIDS undermines the impact of our work and we recognise it as the greatest threat to development of our era.

Our faith in Christ calls us to be instruments of hope, bringing a Christian response to HIV/AIDS and reflecting God's unconditional love for all people. HIV/AIDS is preventable and lessons from a number of countries point the way to successful action to reduce infection rates. WV can also reach out in practical ways to help people struggling with the stigma, fear, sickness, death, grief, and loneliness caused by AIDS. In the face of this challenge, the participants at the WV Hope Initiative High Prevalence Country Workshop commit ourselves and call the Partnership to the following vision, principles and strategies:

Vision: Hope for all people at risk of, infected with or affected by HIV/AIDS

Principles that will guide us to this vision

- **Focus on the children, the poor, the sick and marginalised** World Vision is committed to the poorest of the poor. Our work will value, benefit and involve the most vulnerable in our project areas, especially the orphans, children at risk, widows, and people living with HIV.
- **Care for staff** We have a special duty, within resources available, to preserve the well being of staff, who are at the front lines of our response. In our work environment, people living with HIV and AIDS will be accepted, valued and supported.
- **Effective partnerships** We will create and maintain effective relationships with and between community, district, national and international partners to share best practices, leverage our own capacity and increase scale and impact.
- **Community ownership** We will mobilise communities to embrace the challenge of AIDS and to take urgent and sustained action with local and other resources.
- **Holistic and integrated approach** HIV/AIDS requires a comprehensive, multi-sectoral, culturally appropriate approach that promotes the physical, psycho-social and spiritual well-being of the individual. We will integrate prevention, care and advocacy into our transformational development and emergency response programs.

- **Learning and innovation** We will document, analyse and share our experience, while learning from the experience of others. Programming will be informed by on-going, innovative research. Recognising that there is more to learn about responses to HIV/AIDS and behaviour, we seek to chart new territory.
- **Empowerment of women and girls** Seeking justice, we will take an inclusive, gender specific approach to empower the most vulnerable in our communities giving special attention to women and girls. This necessitates increased recruitment and advancement of women in WV staff.
- **Measurable results** We will monitor, measure and evaluate our work to constantly improve quality and to seek the highest possible standards of achievement and stewardship

Strategies to achieve this vision

- Develop and implement a comprehensive HIV/AIDS prevention and care program for WV staff. Develop policies to facilitate confidential and voluntary counseling and testing, guarantee non-discrimination in employment, and provide adequate information, health and psychosocial support to the extent of available resources.
- Build staff and community capacity to jointly design and implement effective and sustainable large-scale HIV/AIDS programs through learning, training, and on-going technical assistance
- Create a global WV HIV/AIDS research and information network
- Integrate community-owned prevention and care activities targeting orphans, vulnerable children and their affected families in and beyond WV ADPs.
- Support effective interventions to prevent mother-to-child transmission and promote linkages and referrals for pregnant women to improve their access to treatment.
- Implement behavior change programs to reduce infection in high-risk groups
- Facilitate, mobilise and collaborate with churches and other FBOs to strengthen, scale up and sustain a comprehensive, compassionate HIV/AIDS response
- Develop and implement interlinked local, national and global advocacy strategies on HIV/AIDS to end stigma, to combat denial and indifference and to mobilise research, resources and policies for treatment, care and prevention.
- Mobilise new and existing WV resources for HIV/AIDS. Develop new pledge products, grants, gift-in-kind and food aid resources. Review existing budgets in every office at every level to identify opportunities for realignment of funds to match the magnitude of the crisis.

Following the example of Jesus who embraced the poor, the sick, the outcast and the children and with faith in the transforming power of God's love, we commit ourselves to prayer and action and call on our partners throughout World Vision to do the same.