How to "Invest for Future Generations" – Guidelines for Integrating HIV/AIDS in the Development Cooperation

Prepared by

SODECO – Social Development Consultants

November 2002

for Sida,
Department for Democracy and Social Development,
HIV/AIDS Secretariat in Stockholm

Table of Contents

Foreword

The AIDS-crisis now outstrips the worst-case scenarios of a decade ago and sub-Saharan Africa remains by far the worst affected region in the world. In the "AIDS epidemic update – December 2001", UNAIDS states that an estimate 40 million people globally are living with HIV/AIDS. About one-third of those are aged 15–24.

At the same time as we see the epidemic growing, we can also se a new global commitment to recognise the epidemic as a major development crisis and to scale up the global response. This can be illustrated by the commitments made by world leaders in the United Nations Special Session of the General Assembly in June 2001, and by the fact that combating the epidemic is part of the goals of the United Nations Millennium Deceleration. The recently established Global Fund to fight AIDS, Tuberculosis and Malaria also demonstrates a resolve to increase investments in the fight against AIDS.

The Swedish response to HIV/AIDS is described in the strategy "Investing in Future Generations" where the pandemic is seen as a fundamental issue for development co-operation and for poverty eradication. Both the causes and the consequences of the epidemic reaches far beyond the health sector and includes all areas of society.

This multisectorial view on the epidemic means that HIV/AIDS has to be considered in all development co-operation. Sida has therefore developed a set of tools, firstly a manual for the analysis and consideration of HIV/AIDS in the country strategy and secondly a series of guidelines for the use of Sida staff and collaborators in the identification, monitoring and evaluation of projects and programs.

These guidelines have been developed with the assistance of the consultancy firm SODECO, and in close collaboration with the relevant departments/divisions at Sida. They should not be seen as the final manual on how to integrate HIV/AIDS into the different sectors but rather as an instrument to initiate and stimulate a concrete discussion on what this integration means in practice when we work with the project cycle in the different sectors.

Anders Molin
Head
HIV/AIDS secretariat

Lotta Sylwander
Head
Department for Africa

1. HIV/AIDS – a health and broad development issue

The HIV/AIDS epidemic is today the leading cause of death in many Sub Saharan African countries and an emerging threat in many Asian, Latin American, and Central and Eastern European countries. The Swedish HIV/AIDS strategy, *Investing for Future Generations*, adopted in 1999, describes Sweden's international response to HIV/AIDS in the form of four goals:

- to prevent HIV transmission;
- to provide care and support to infected and affected people;
- to increase efforts to mitigate the impact of HIV/AIDS; and
- to stimulate political commitment to HIV/AIDS.

A major conclusion in *Investing for Future Generations* is that HIV/AIDS cannot be explained only in terms of individual risk-taking behaviour. There are direct relations between levels of HIV-infection and poverty, inequality, women's status, social disruption, illiteracy and lack of human rights. A sustained response requires that HIV/AIDS be considered within all sectors of development co-operation. The very nature of the epidemic demands persistence from all involved.

The AIDS epidemic is a long-wave phenomenon, and it seems impossible to predict where it will end. The epidemic first strikes with HIV-infection, then through AIDS-related disease and death. As a rule of thumb, only one tenth of all HIV infected in a country are openly sick with AIDS. Nine tenths will reach that stage during the next ten years, and in their footsteps come new waves of infected groups. Successful prevention will gradually reduce the number of newly infected, but cannot prevent excess adult deaths to be present in – and affect – society for a long time ahead, with a mounting social and economic impact on society as a whole.

In order that HIV/AIDS be considered in all development co-operation, Sida has decided to develop a set of tools. Firstly, a manual has been developed for the analysis and consideration of HIV/AIDS in the country strategy process. Secondly, a series of sector guidelines have been developed, for the use of Sida staff and collaborators in the identification, monitoring and evaluation of projects and programmes. Guidelines have been prepared for the following sectors:

- Democratic governance
- Health
- Education
- Infrastructure/road construction
- Micro-finance
- Private sector
- Agriculture/rural development

1.2 HIV/AIDS and development

HIV/AIDS threatens to reverse development in numerous countries all over the world. In the worst affected countries, AIDS can no longer be seen as a threat to development – the effects are already present. In many Sub-Saharan African countries, AIDS is reversing decades of hard won development gains.

Life expectancy is back to levels similar to what they were 30–40 years ago. Infant mortality increases; in East and Southern Africa infant mortality rates are now about 70 percent higher than they would have been without AIDS. All sectors in society will be affected by the premature death of people. On an individual level, people infected or affected by HIV/AIDS may be hindered by stigma, shame and discrimination.

Health services, that were insufficient already before HIV/AIDS, are being overwhelmed. Reportedly, 70 percent of hospital beds in Botswana are now occupied by HIV/AIDS patients. Schools are closed down for lack of teachers. Poverty forces many families to keep their children – not least girls – home from school. Farming land is neglected due to the loss of labour. Farming skills as well as housekeeping skills are lost with the death of household heads Many children will never have the chance to learn from their parents how to properly work the land, or prepare nutritional meals or maintain a hygienic household. Food production is reduced and/or changed, and malnutrition increases. Important functions in society fail for lack of trained staff. In Zambia, frequent electricity cuts in the last few years have been attributed to the death of certain key personnel.

Some sectors have reacted more rapidly than others. Among these are some large commercial companies, where preventive measures, training programmes, insurance schemes etc. have been introduced. Non-governmental organisations – both national and foreign – are important early actors, primarily focusing on information and prevention. Generally, public sector resources are badly insufficient for reaching out over an entire country.

Poverty

Although HIV/AIDS is found in all countries of the world, the fact is that 95 percent of people currently HIV-infected – and the same proportion of those who have died in AIDS – come from the developing world.

Poverty is part of the explanation for the rapid spread of HIV in Sub-Saharan Africa. Poor people are less informed. Poor people have less access to general health care, which leaves them more vulnerable to infection. Poor people have fewer options and face agonising choices, e.g. of risking infection by a virus that will kill them some years later in order to be able to feed their children today. The gender dimensions of poverty makes poor women very vulnerable.

For poor households, AIDS creates tough additional burdens through the time members, notably women and girls, have to spend on care instead of in productive work, and through money spent on drugs, hospital and funerals. HIV/AIDS leads to increased poverty in the household. The financial impacts reach the community and finally the country's economic and social structures and institutions.

There is growing evidence that rising HIV prevalence causes both total national income and incomes per capita to fall significantly. UNAIDS estimates that the impact on GDP in countries with adult prevalence rates of less than 5 percent will only be modest, while a prevalence rate of 20 percent or more implies an annual decline of 2 percent in the GDP growth rate. In the light of historical economic performance in Sub-Saharan Africa, such losses are very significant.

Consequences in relation to children

HIV is now the single largest cause of child death in an increasing number of countries in Sub-Saharan Africa, through infants born with HIV and dying in childhood, and through the neglect children suffer when orphaned.

The fact that HIV affects men and women in their childbearing years means that many children lose one or both parents in AIDS. The emergence of large numbers of orphans has historically been a sporadic, short-term problem caused by war, famine or disease. Before AIDS, orphans made up about 2 percent of children below 15 years of age; by 2000 this figure had jumped to between 7 and 12 percent in many African countries. The HIV/AIDS epidemic has transformed orphanhood into a serious long-term problem and an unprecedented threat to child health and welfare.

Orphaned children are under psychological distress, and need support in areas like food, clothing, housing, education and health care. Orphans run a greater risk of physical and sexual abuse, and of being exploited as child labour. Girls and young women risk violence, coerced sex and rape. The stigma attached to AIDS increases the problems for the affected children.

In the statistics, these children are considered "orphans" only until they reach the age of 15. In reality, their problems and needs may increase during the difficult years between childhood and adult life. If neglected, many orphans may develop into adults with considerable social problems. The need for support to AIDS-orphans is thus not only large, but also by necessity a long term need.

Gender aspects

Unequal gender relations are a key cause of rapid HIV transmission. Biologically, women are more susceptible to sexually transmitted HIV, a risk amplified by women's lower status and weaker position in society at large and in sexual relations in particular. On average, women are infected and die at lower ages than men – a reflection of age differences between partners/spouses. This difference is particularly pronounced in Sub-Saharan Africa.

Globally, women are still in minority among HIV-infected people, but the gender gap is closing everywhere. In Sub-Saharan Africa, women outnumber men, possibly by up to 20 per cent. New community-based studies document situations where extraordinarily high proportions of girls are infected during their teens and before marriage. Most of these girls have been infected by men much older than themselves, and the sexual encounters are often the result of sexual coercion and violence. The significant role men play in fuelling the epidemic is gradually being recognised, and needs to be addressed in all policies to fight HIV/AIDS.

In HIV/AIDS affected communities, women's workloads increase. Older women and young girls provide care to sick household members and have to compensate for labour shortage and loss of income. Increasing numbers of AIDS-widows find their access to life-supporting assets threatened. They and their children are often exposed to "property grabbing", when relatives of the deceased husband claim land and/or other assets. A widow's best security is to have sons old enough to claim land and property. But AIDS-widows are generally young with dependent children who can only marginally participate in farm work or other income-generating activities.

Women's experience of and fear for violence markedly increases their risk of getting infected by HIV. Threat of violence limits their ability to refuse sex or to insist on safe sex, if they suspect that their partner or they themselves are HIV infected. Fear of stigma might get pregnant women to avoid seeking treatment that can reduce HIV-transmission to their unborn child, and mothers may continue breast-feeding their infants even if that increases the risk of HIV-transmission, all for fear of violence from people who suspect the women to have HIV.

Human rights

Many of the factors fuelling the epidemic are best understood within the principles of human rights. Sexual and reproductive rights, the right to privacy and confidentiality, and the right to information and education, are essential in preventing HIV transmission.

Male behaviour and attitudes are increasingly recognised as driving forces behind the spread of the epidemic. To halt the epidemic, the subordinate position of women and girls need to be addressed. The success of preventive efforts depends on women's right to physical integrity, their right to say no to sex, and to be protected from violence.

People living with HIV and AIDS are at risk of being denied their right to freedom of expression and association, the right to liberty and security, and not least the right to work. The stigma and shame connected with HIV/AIDS often leads to discrimination and violation of human rights.

Many of those suffering from HIV/AIDS-related discrimination already belong to vulnerable groups in society, e g sex workers, men having sex with men and injecting drug users.

1.3 National mobilisation

National and local government

The importance of political commitment has been underlined over and over again, and the enhancement of political commitment is a key feature in the Swedish strategy against HIV/AIDS. For most parts government responses have been delayed and weak, and many countries are still in a state of official denial.

The reluctance of national governments to address HIV/AIDS might be understandable, given the private nature of HIV transmission, the initial invisibility of HIV, the political sensitivity of the matter and the lack of short-term solutions to the epidemic. But experiences – both from Western countries and from a number of countries in the South where the epidemic has been halted – demonstrate the importance of strong and enlightened political leadership. Denial among political – and religious – leaders has the potential to perpetuate stigma, and thus multiply death, while engaged and committed leadership is capable of creating an atmosphere where HIV/AIDS can be addressed with strength.

Many countries have established National AIDS Programmes, either within ministries of health, or – in many hard hit countries – in structures close to the head of government. Increasingly, HIV/AIDS units are created in other badly affected departments, e .g. Ministry of Education and Ministry of Labour. Local government offices in areas where the epidemic is advanced are known to have initiated resource mobilisation and co-ordination.

Civil society action and participation

Many non-government organisations were early to react to the HIV/AIDS epidemic, and have also exerted pressures on governments. There are numerous NGOs addressing HIV/AIDS that operate on local levels. In many countries, People Living With AIDS have formed NGOs (often called PLWA). Other organisations have been formed by affected families, by women's groups and by networks and organisations helping AIDS orphans. But in many parts of the world, HIV/AIDS still does not have "a face", and no pressure is exerted for recognition or political action.

Active involvement of other civil society organisations becomes important, especially where government responses are weak. Trade unions, religious organisations and human rights organisations are today found to include HIV/AIDS in their work. The religious organisations can have a central role in HIV

prevention activities, given their strong influence and high credibility among many people. They also have a long time involvement in questions relating to life and death, education and care. The quality of the involvement may vary, but their potential should not be underestimated.

1.4 Strategic responses

According to its strategy *Investing for future generations,* Sida will consider HIV/AIDS in all development co-operation. Obviously, the response will depend on the HIV/AIDS situation in the country. The World Bank has developed a typology in three stages, related to how widespread HIV/AIDS is. The epidemic is considered *nascent,* when HIV levels are relatively low in groups practising so-called high-risk behaviour. In a *concentrated* epidemic, HIV levels have increased in the "high-risk-groups" but remain low in the general population. In a *generalised* situation, HIV is widespread among the general population, and AIDS mortality is evident.

Even though the classification has its limitations, we still find it a useful framework for the identification of responses to the epidemiological situation.

In a country where the epidemic is *nascent*, every effort should be spent on containing it. Programmes should be directed to people practising high-risk behaviour, e g injecting drug users, women selling sex and men having sex with men, and also to mobile men buying sex. General HIV/AIDS-information should be spread widely, to give women and men the knowledge and tools necessary to protect themselves against the risks of relating to people in high-risk groups.

Where an epidemic is *concentrated* and begins to reach out among people in general, HIV/AIDS education must be introduced through all possible channels; school, media, culture, religious institutions etc. At the same time, health services need to be better prepared to receive AIDS-sick people, and systematic efforts should be made to reduce the prevalence of sexually transmitted infections, STI, in the population at large. As far as possible, government and other actors should begin to develop coping mechanisms for future unavoidable socio-economic impacts of AIDS-related disease and deaths.

Where the HIV/AIDS epidemic has reached a *generalised* stage, the response needs to be broad, covering care and support to households and communities, as well as support to different coping mechanisms. To meet and mitigate the effects of rising adult mortality on all sectors of society becomes imperative.

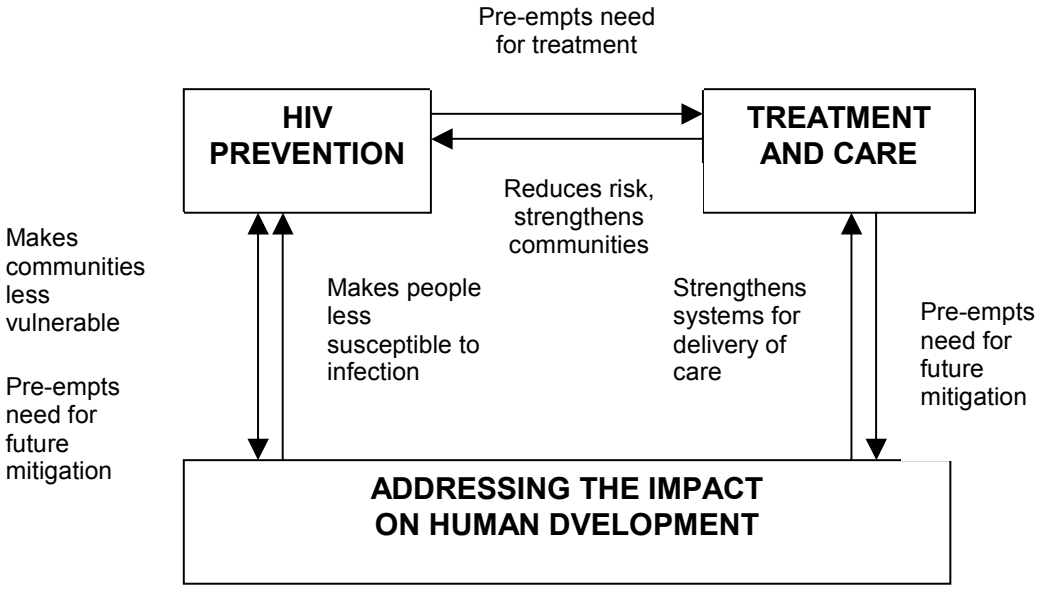
The spread of HIV is partly an effect of time; the longer HIV/AIDS has been in a country, the more generalised is the HIV-spread. Cultural, social and economic factors explain why the epidemic has seemingly been halted in some Sub-Saharan African countries, while it is running rampant in others. In many rich countries, successful prevention campaigns have limited the epidemic at a *nascent* stage. In Thailand, the epidemic was halted when it was still *concentrated*. Uganda had a *generalised* epidemic before the country managed to stabilise and to some extent reduce the number of newly infected.

Prevention is number one

Prevention remains a priority of utmost importance in all stages of the epidemic. Every new young generation provides a new opportunity and a challenge to halt the spread of HIV. Preventive HIV/AIDS education needs to be incorporated in every possible activity, in individual counselling, as life skills programmes in schools, through the media, in vocational training and at all places of employment. Information should be accompanied by reliable and easy access to services and condoms.

The interrelation between prevention, care, and efforts to mitigate the effects is strong. Where care is visibly available, people may feel encouraged to seek testing and counselling. When people know that they

have HIV, they may take precautions to protect partners and plan more actively for the future of their children. Successful impact mitigation makes communities less vulnerable, renders preventive efforts more efficient and strengthens systems for care and support. Where such "virtuous circles" can be created, the different efforts tend to reinforce each other, as illustrated in the graph below.



Successful HIV prevention pre-empts the need for future treatment and impact mitigation; effective treatment reduces risk as well as impact, while mitigation impact makes individuals and communities less susceptible to risk. An effective response to HIV/AIDS must focus on all three areas of intervention, in the context of a broader development agenda, forming a virtuous circle that will produce real and sustainable results.

2. Electronic information on HIV/AIDS

There is a wealth of information on HIV/AIDS available on the Internet. Below you will find a number of key websites with information and resources on different aspects of the epidemic, and links to other relevant sites. The listed websites are regularly updated, and most of them have good site maps showing different sections and search functions to facilitate the search for information and documents related to particular issues or topics. No direct addresses to specific documents are provided, as locations tend to change when new documents are added.

In addition to the websites listed, the websites of many other international (e.g. ILO, WHO), regional (e.g. the European Commission), donor (e.g. USAID), private sector (e.g. World Economic Forum, Global Business Council) and non-governmental organisations (e.g..PANOS) carry substantial amounts of information and resources on HIV/AIDS.

The UNAIDS homepage is first on the list, followed by other websites listed in alphabetic order.

UNAIDS http://www.unaids.org/

UNAIDS' homepage is probably the most comprehensive website available for information on the HIV/AIDS epidemic. A few of the most relevant sections are listed below with direct links and examples of their contents.

Best Practice Collection

http://www.unaids.org/bestpractice/collection/index.html
Practical experience from countries around the world selected by UNAIDS to give examples of the best up to date models available for HIV prevention, care and impact alleviation. Documents are organised by country and more than 50 subjects including:

- Agricultural/ rural development
- Antiretroviral therapy
- Gender and HIV/AIDS
- Home and community-based care
- Human rights, ethics, and law
- Impact on countries' development and economies
- Sectoral impact – development
- Mobile populations: displaced people, migration, refugees, mobile workers
- World of work/ HIV in the workplace

HIV/AIDS and Human Rights

http://www.unaids.org/humanrights/index.html

Reports and documents from recent conferences; fact sheets etc.

HIV/AIDS Information and Data

http://www.unaids.org/hivaidsinfo/index.html

Epidemiological documents and reports by subject; Global HIV/AIDS surveillance by country (fact sheets); Global HIV/AIDS and STD surveillance; links; full text versions of reports and other documents.

Publications
http://www.unaids.org/publications/index.html
Publications on HIV/AIDS sorted by subject and 19 main headings (most documents are possible to download); a Bibliographic Database with lists by title, country, global area, topic and language; Graphics; a Glossary; etc.

The Partnership menu
http://www.unaids.org/partnership/index.html

A tool to help the private sector find innovative HIV/AIDS partnership opportunities in developing countries. The first series of menus feature Brazil, India and Zambia.

2.1 Other Websites with information and resources on HIV/AIDS

AIDS Education Global Information System
http://www.aegis.org

Latest information on HIV/AIDS research including daily HIV news updates, key topics in the field of HIV/AIDS, publications, a reference service and numerous links to organisations dealing with HIV/AIDS.

AIDS Law Project Centre for Applied Legal Studies
www.hri.ca/partners/alp

Information on the AIDS Resource Centre including publications, research papers, conference papers, annual reports and press statements.

Association François-Xavier Bagnoud
http://www.fxb.org/

Information on humanitarian initiatives focused on children and HIV/AIDS. A twice-a-month e-mail update with news related to international health and human rights topics, links for children and young people, publications, programs and a list of newsletters focusing on children's issues.

Business Responses and Labour Responses to AIDS Programmes (BRTA/LRTA)
www.brta-lrta.org

The site of an American Center for Disease Control that provides information and resources needed to build HIV/AIDS programmes in the workplace, including toolkits and guidelines.

Family Health International
http://www.fhi.org

Gives details of FHI programmes including FHI partnership with the private sector to design, implement and evaluate workplace prevention programmes. Provides access to FHI publications on HIV/AIDS including a semi-annual magazine on HIV/AIDS prevention and care.

FAO, Sustainable Development Dimensions, HIV/AIDS
http://www.fao.org/sd/BRkey_en.htm

A large number of reports and other documents related to HIV/AIDS, agriculture and rural development.

HEARD (The Health Economics & HIV/AIDS Research Division) University of Natal, Durban
http://www.und.ac.za/und/heard/

Reports and documents on different aspects (Education, Health, Private Sector etc) of the HIV/AIDS epidemic, including briefs and toolkits on AIDS interventions and preventions targeted at specific sectors, professionals and government ministries or departments.

HIV Insite
http://hivinsite.ucsf.edu/InSite

Comprehensive up-to-date information on HIV/AIDS treatment, prevention and policy from the University of California, San Francisco.

International AIDS Vaccines Initiative (IAVI)
http://www.iavi.org/

Information on the science of vaccines, global research programmes to find an AIDS vaccine, recent scientific breakthroughs, fact sheets, background information, briefing papers and blueprints.

International Council of AIDS Service Organizations (ICASO)
http://www.icaso.org

Information and analysis concerning NGO positions on issues related to HIV/AIDS. Links to on-line editions of the ICASO Update newsletter, position statements and documents.

The POLICY Project of the Futures Group
http://www.tfgi.com

Information about the work of the Policy Project in different countries to strengthen the capacity of public and private sector institutions to develop and implement efficient HIV/AIDS policies and programmes. The site also has a wide range of publications for downloading, and access to the searchable **HIV/AIDS Policy Compendium Database** http://209.27.118.7/ containing documents related to HIV/AIDS and Human Rights.

The Population Council: Horizons
http://www.popcouncil.org/horizons/horizons.html

Information on "Horizons: Global Operations Research on HIV/AIDS Prevention and Care project", including reports, summaries and fact sheets.

The Synergy Project
http://www.synergyaids.com/

Information and resources on HIV/AIDS programme management and policy development including a searchable Resource Centre with documents on HIV/AIDS project management and research.

UNDP/UNOPS South East Asia HIV and Development Project
www.hiv-development.org

Information, including a large number of reports and other documents, primarily focused on HIV risks linked to development projects and mobile populations.

UNDP
http://www.undp.org/hiv/

Information on UNDP activities (including documents and reports) to help developing countries to meet the governance challenges posed by the epidemic, and to mitigate the impact of the disease on efforts to reduce poverty.

World Bank/Development Topics/AIDS
http://www.worldbank.org/html/extdr/thematic.htm

World Bank policy and lending on AIDS; Prevention activities in different regions; Publications & Data (including a searchable project data base); links to related sites etc.

3. Democratic Governance and HIV/AIDS – a check-list on prevention, care, and impact mitigation

3.1 When should the checklist be used – and why?

Stigma and discrimination constitute immense barriers to effective responses to the HIV/AIDS epidemic. Human rights and democratic governance are vital in all efforts to prevent, provide care, and mitigate the effects of the epidemic. All Swedish development co-operation should have a democracy and human rights perspective, and guidelines for this have been prepared by DESA. The efforts to mainstream democracy and the human rights of women, men and children into Sida's work will directly benefit the struggle against HIV/AIDS.

DESA's co-operation to enhance democratic governance is highly relevant for HIV/AIDS. These guidelines applies DESA's division into four sub-areas, i e. good governance, political institutions, the justice sector and civil society and participation. A number of HIV/AIDS-related questions need to be raised in the dialogue – during program or project planning, assessment and follow-up, when monitoring and in evaluations – in order to improve the integration of HIV/AIDS aspects into the development co-operation. The main dialogue partners are the co-operating Ministries and officials, civil society organisations, including human rights organisations. UN organisations, other bilateral organisations and research institutions should be tapped for information. The answers should serve to

- guide Sida's decision-makers in an analysis of how HIV/AIDS affects the co-operation;
- identify possible areas where HIV/AIDS prevention and mitigation can be integrated into ongoing co-operation in projects for good governance, participation, improved judicial systems and support to civil society;
- enhance political commitment to the struggle against HIV/AIDS.

3.2 Strategic framework

Investing for Future Generations, Sida's strategy on HIV/AIDS, sets four strategic goals: prevention, care, coping and political commitment. These goals form a framework that can be used when applying the many human rights relevant to HIV/AIDS. Application of the human rights, as defined in the various UN conventions, can support political solutions, underpin legal change and mobilise human as well as financial resources.

Unequal gender relations are a key cause of rapid HIV transmission, and programme officers need to be aware that women, men, girls and boys are affected differently, and responses must build on this fact.

There is a strong correlation between HIV/AIDS and poverty. HIV/AIDS increases poverty, and poor people are particularly vulnerable to HIV/AIDS. HIV/AIDS contributes to undermining of poor people's opportunities, security and power. Their possibilities to prevent HIV, to access care and to mitigate the effects of HIV/AIDS need to be specifically addressed in the poverty alleviation strategies.

Addressing immediate causes	Addressing immediate effects
Prevention of HIV/AIDS – the right to sexual and reproductive health – the right of youth to sexual and reproductive health information and services – the right of women to participate in matters concerning their lives – the right of women to protection against trafficking and exploitation of prostitution – the right to equal access to education – the right to marry and found a family – the right to share in scientific advancement and benefits	*Providing care, counselling and support* – the right to the highest attainable standard of health – the right to social security, assistance and welfare – the right to privacy and confidentiality
Addressing underlying causes	**Addressing long term effects**
Enhancement of political commitment – the right to non-discrimination, equal protection and equity before the law – the right to freedom of opinion and expression – the right to freely receive and impart information – the right to an adequate standard of living	*Enhancement of coping mechanisms* – the right to education – the right to work – the right to participate in public and private life – the right to freedom of movement – the right to freedom of association

3.3 Interrelations between HIV/AIDS and democratic governance

Openness about HIV/AIDS among political leaders, and a political will to affront the situation are of major importance in dealing with the epidemic. Committed leaders are important to ensure that preventive information is disseminated from all possible channels, for the provision of care and support and for measures to enhance coping with the effects of HIV/AIDS.

AIDS can erode the capacity of governments and their ability to deliver goods and services, but there has not been enough research yet to say if AIDS has the same or similar impacts on different countries, and what the relations are between impacts and political processes, such as democratisation.

Few data exist on current national costs and even fewer projections for the future. AIDS will inevitably have an impact on public sector revenues and spending, and therefore on the budget balance and public saving or borrowing. For example, an analysis made in the mid-1990s of the HIV/AIDS impact on the Ministry of Finance in Zambia, showed e.g. that loss of skilled staff had a major impact on efficiency, cost of long-term training was doubled, and the "institutional memory" was severely eroded.

Good governance

HIV and AIDS cause fear, sub-performance, illness and death among politicians and civil servants in central and local government. The ability to counteract the epidemic may be undermined by ignorance and denial among these categories, and this is disastrous for efforts to curb the spread of the epidemic, and for mitigation of its effects. HIV/AIDS undermines efforts to build capacity. Information and education need to be directed to politicians, decision-makers, planners and managers, parliamentarians, judges, police-officers and so on, so that they understand the scope of the problem, get correct information, safeguard that human rights of women, men and children are respected, discrimination dealt with, and that they can protect themselves against HIV. The information need to be crafted with care, based on gender awareness, as well as deep knowledge about local customs, political culture and so on.

- How does HIV/AIDS affect the finances of the country, and the role of budget and programme support?
- How can financial management secure that allocated funds reach the poor and HIV/AIDS affected?
- Can tax authorities and other actors be strengthened to cope with decreased production and reduced tax base?
- How is HIV/AIDS treated in the national statistics? How far do the data allow monitoring of the HIV/AIDS situation according to gender, age, geographical distribution? Do the data include indicators to monitor improvements in the situation? Is the country dependant on international data?
- How is HIV/AIDS treated within the planning function? Has there been any institutional audit of what the capacity is and how it will be affected?
- What administrative rules apply to civil servants affected by HIV/AIDS? Is there any in-service HIV/AIDS education to civil servants in the government, at central and/or local levels?
- To what extent is the public sector responsive to the particular needs of people affected by HIV/AIDS?
- How can civil society get access to HIV/AIDS data? How can they access resources and knowledge?
- Do land-surveying projects show changing ownership-patterns in HIV/AIDS affected areas?
- Can badly HIV/AIDS affected geographical areas be targets for direct, decentralised support?
- How can twinning projects include HIV/AIDS and human rights education to both parties?

Political institutions

”Denial” has been an initial reaction in country after country, and of many individuals. It may be an understandable reaction, given the wide-ranging political implications of the HIV/AIDS epidemic. Many individuals also feel awkward to talk about HIV/AIDS and its close connection to sexuality and/or to different marginal groups. However, political commitment is a key factor for an effective response to the epidemic, and a strategic goal for Sida’s HIV/AIDS co-operation. A number of questions can be raised in support of such political commitment, at central as well as local levels.

- How can the political system be supported towards greater openness in relation to HIV/AIDS?
- Have political leaders received any training in talking about HIV/AIDS?
- How can parliament enhance an HIV/AIDS-perspective in their decisions and legislation?
- How has legislation changed as a consequence of HIV/AIDS; in relation both to enhancing prevention and facilitating coping?
- How can local level initiatives receive resources?
- To what extent are HIV/AIDS affected people allowed to influence, participate or be represented in public decisions that affect their lives?

The Justice Sector

Rule of law is important for all, including people affected by HIV/AIDS. It is a fact that many people do not have access to law for reasons of distance, cost, discrimination or ignorance. For HIV/AIDS infected or affected people, stigma and shame are additional obstacles to seeking justice. Many women and girls are hindered by violence, fear of violence and of sexual exploitation. In many cases people live under customary law with traditional conflict solving mechanisms that may favour men and disempower women, e g by allowing "property grabbing". Whatever the route for seeking justice, the human rights principles need to be implemented in the legal system, as well as incorporated in social attitudes and values.

- What training do representatives of the formal juridical system (judges, police, prosecutors, lawyers etc.) get about the human rights related to HIV/AIDS?
- Does the police get any HIV/AIDS education for their own protection? How are they taught to deal with HIV/AIDS related stigma and discrimination?
- How does the legal system respond to violence and abuse against women and girls? Has there been any change in the reaction to perpetrators?
- Do AIDS orphans need any special legal protection?
- How can human rights values be implemented in social and formal attitudes towards the HIV/AIDS affected?
- What civil society organisations exist to enhance and protect the legal rights of HIV/AIDS affected? Can they be strengthened?
- Do prison authorities recognise HIV/AIDS as a problem among prisoners? How can awareness and protection of prisoner's human rights increase?

Civil Society and Participation in Good Governance

Civil society organisations have a fundamental role for good governance. Many NGOs reacted early to the HIV/AIDS epidemic and exerted pressure on governments. There are signs that civil society e.g. in Uganda has been strengthened by HIV/AIDS in this way, but in most poor countries AIDS poses threats to civil society. Declining life expectancy erodes the strength and leadership on which civil society is founded. People who have – or believe they have – a fatal disease, or are burdened with the care of people with HIV/AIDS, may have fewer incentives to participate in political life.

In many parts of the world, HIV/AIDS still does not have "a face", and no pressure is exerted for recognition or political change. Shame, stigma and discrimination are obstacles to participation for people affected by HIV/AIDS. Many belong to marginal – or even illegal – groups, e.g. women selling sex, injecting drug users or men who have sex with men. Still, their active participation, not only as beneficiaries, is needed in the fight against AIDS.

The active involvement of other civil society organisations is also important, e g trade unions, religious organisations, women's movements, child rights activists, and human rights organisations; all need to include HIV/AIDS in their work.

- How can the organisations of people living with AIDS, PLWA, contribute in the work to fight HIV/AIDS? What creates an enabling environment? What support do they need? Are there any networks?
- How do the PLWA organisations relate to the poor, and to issues of importance to the poor?

- Are there any organisations for (or adressing the situation of) poor HIV/AIDS affected women? Can they be strengthened?
- Do the service organisations (for care, counselling, orphans) have any networks? How do they influence government policies?
- How can different marginal and/or illegal groups be reached, e g injecting drug users, men who have sex with men, women who sell sex?
- How can government mechanisms be sensitised to participation of marginal groups/people (e g migrant labour, men who have sex with men)?
- What do other organisations, e g trade unions, human rights organisations, do in relation to HIV/AIDS?
- How can the faith-based organisations be strengthened to provide social service and spiritual care?
- What role can media have in promoting human rights and reduce stigmatisation?

3.4 Democracy and human rights

Example 1

In Malawi, voluntary HIV-testing is provided in the capital Blantyre by an organisation of People Living With AIDS; PLWA. The services started before the existence of ARV therapy, and provides extensive information and training about the epidemic. The organisation is operating openly, and a UN agency is financing a number of its members to work as UN-volunteers in different organisations that are active on HIV/AIDS issues. By this measure, many people learn to relate to HIV-positive persons, an important step in the fight against social stigmatisation

Source: B Egerö, UNFPA consultancy Malawi , 2000

Example 2

In the conservative city of Chittagong, Bangladesh, homosexual contacts are publicly condemned. Still, a study of a random sample of rickshaw pullers revealed that 60 percent of the men had engaged in sex with other men in the last year. The local culture tacitly permits older men to have sex with younger men, because it contributes to the maintenance of female purity. Faced with this double standard, the Bandhu Welfare Society, a local organisation has developed an effective, discreet strategy for reaching men who have sex with men. Bringing these men together and giving them a safe space to discuss their sexual health issues has proved to be useful.

Source: John-Manuel Andriote, *Helping men make a difference in HIV Prevention,* Ur Impact on HIV, Vol 2, No 2, Dec 2000

4. Sida's health sector co-operation and HIV/AIDS – a checklist on prevention, care and impact mitigation

4.1 When should the checklist be used – and why?

The health sector is more affected by HIV/AIDS than any other sector. In order to assess how Sida may support the health sector a number of questions need to be raised in preparation, monitoring and evaluation of the health sector development co-operation. The questions are not a blueprint to be applied always and everywhere, but they should be posed selectively. The main dialogue partner is the Ministry of Health, but answers may be solicited from others, e g from UN organisations, NGOs, and research reports. The answers should

- guide decision-makers in Sida in an analysis of how the HIV/AIDS epidemic affects the health co-operation;
- identify possible areas where HIV/AIDS prevention and mitigation can be integrated into ongoing health co-operation;
- Raising the questions should also be seen as a means to enhance political commitment to HIV/AIDS.

4.2 Strategic framework

Investing for Future Generations, Sida's strategy on HIV/AIDS, sets four strategic goals, that can be used as a framework. When analysing the effects on the health sector of HIV/AIDS, programme officers should be aware of both gender and equity dimensions. Women and men are affected differently, and any response must build on this fact. Poor people are particularly affected by HIV/AIDS, and their possibilities to prevent and mitigate it need to be specifically addressed. Many people with HIV/AIDS are discriminated, and the epidemic poses numerous risks to the human rights of men, women and children, incl. their right to information and confidentiality.

Addressing immediate causes	**Addressing immediate effects**
Prevention of HIV/AIDS – Sex education and service (to patient & others) – Control of STDs – Prevention of mother/child transmission – Improved blood routines – Harm reduction programmes	*Providing care, counselling and support* – Creative response to increasing numbers of HIV/AIDS patients – Treatment of opportunistic infections – Provision of terminal care. – Voluntary testing and counselling
Addressing underlying causes	**Addressing long term effects**
Enhancing political commitment – Monitoring the epidemic – Providing data to political leaders – Stimulate informed leadership	*Protecting the health system* – Promote planning to handle HIV/AIDS among health staff – Find ways to counteract burnout among staff – Overcome difficulties motivating people to work as medical doctors and nurses in severely HIV/AIDS affected countries

4.3 How does HIV/AIDS affect the health system?

The health sector is directly affected through:

- many more patients.
- additional tasks; to prevent, provide treatment, co-ordinate, and to monitor the epidemic.
- loss of human resources.
- reduced financial resources, increased costs and competition for public and private funds.

4.4 More patients

In order to make the best use of available resources, patients must be treated at the lowest possible level of care. Planning is needed for increased mortality in the homes, and to prevent patients from being rushed to hospital to die.

- Does the number of patients increase at clinics and hospitals? What is the male/female ratio? Does the length of stay increase?
- Are diseases increasingly HIV-related? Does mortality in hospitals increase?
- Is there any plan – nationally, regionally, locally – to handle increasing numbers of patients?
- At what level of care are HIV/AIDS patients cared for?
- How does the public health care co-operate with community based care?
- Are women recognised for their role as health care providers?

4.5 Additional tasks

Prevention

Prevention of HIV should be an ongoing process, in all countries. Where the epidemic is at an initial phase and/or limited to specific groups practising high risk behaviours, i.e. have many sex partners, exchange injection equipment or simply being single mobile men, preventive efforts should be directed to them. But prevention must be a continuing process, and every new generation provides an opportunity to stop the spread of HIV. Many women get HIV from coerced sex, and prevention must include advocacy and action against rape, sexual violence and other forms of coerced sex.

- What resources are spent on prevention of STD? Urban/rural areas? Efforts to reach the poorest? People with risk behaviours?
- What does the health services do to reach young people – boys and girls, respectively?
- Is there access to drugs to prevent HIV-transmission from mother to child?
- Has the health system in any way adapted to increasing numbers of AIDS orphans?
- Can the health sector reach commercial sex workers with information, counselling and service?
- How can the health service get involved in activities against sexual coercion?
- Are there any harm reduction programmes for intravenous drug users?

Testing

In order to achieve better prevention and reduced stigmatisation, access to voluntary testing and counselling is important. If early treatment for opportunistic infections can be offered, this can become a tool for health services to motivate people to get tested. Knowledge of ones HIV-status can be the basis for people to act upon, to care for themselves, protect partners and plan for children and family.

– Is counselling and testing part of the health services? Where? How? Cost?

Treatment

In order to provide care for opportunistic infections and to give antiretroviral (ARV) treatment, it is possible that laws must be revised and changed in relation to who has the right to prescribe drugs and to develop treatment schemes for peripheral staff. Please refer also to Sida's policy document (in Swedish) "HIV/AIDS och tillgång till läkemedel – ett Sida-förhållningssätt" (2001 05 08).

– Have guidelines for prescription of drugs been adapted to the situation caused by HIV/AIDS?

– What is the official policy towards antiretroviral treatment (ARV)? How is the real situation?

– How is the access to drugs against opportunistic infections?

– How are TB-patients treated? Are there any special efforts directed towards the poores

Co-ordination

Co-ordination is necessary in order to make use of available resources and avoid duplication. Regular meetings and improved communication make increasing demands on already weakened health ministries.

– How does the health sector – at various levels – co-operate with schools, work-places and other sectors in societies in order to prevent HIV/AIDS?

– How does the health sector co-operate with the traditional health sector?

– How are different actors co-ordinated? How is communication handled between care-givers in the public and private sector, traditional health care, pharmacies?

4.6 Loss of human resources

Staff members are lost through HIV/AIDS mortality. A number of efforts are needed to counter the effects of this, e g to provide in-service training for existing staff, increase their status, delay retirement age, make use of family based care, reduce paper work, retrieve trained staff who have left the health sector, try new categories to alleviate existing staff.

– How has training plans for doctors, nurses etc. been affected by HIV/AIDS?

– Has training of different staff categories in the health sector increased? Been reduced? Is it unchanged?

– Is there any plan on how to meet increased staff turnover?

– Is there a policy on testing of health staff? How is HIV-infected staff being treated – helped to continue work, supported, fired?

– What kinds of HIV/AIDS preventive information and services do staff get for themselves?

– Do staff have access to post-exposure prophylactics? How can HIV-infected staff be protected against TB infection? Prophylactics? Can health staff get access to ARV?

– How do you address "burnout" among health staff?

– How has staff policies been affected by HIV/AIDS; has the staff placement policy changed?

4.7 Financial situation

The health sector is seriously affected, and will need increased resources. In order to argue for increased resources, the effects on the health sector need to be assessed and analysed. In order to assess the needs and possibilities in a specific country, the Sida programme officer should have an overall knowledge of the resources available for HIV/AIDS to the health sector.

– How has the national health budget accommodated HIV/AIDS? Size, distribution and changes?

– What other important actors provide support to the health sector for HIV/AIDS? How?

– Does the number of patient increase at clinics and hospitals? Does the length of stay increase?

– Are diseases increasingly HIV-related? Does mortality in hospitals increase?

4.8 Health

Example 1

There is a great potential for reduction in HIV-transmission if people who seek treatment for sexually transmitted diseases, STD, can be reached with HIV-preventive messages. That they have contracted an STD is a clear sign that they have engaged in unprotected sex. A study in South Africa showed that 20 percent of the miners who came for STD treatment for the first time had HIV. Of those who returned ten times or more, about 80 percent had HIV. Thus, effective HIV-preventive messages had not reached them, and they had continued to have risky, unprotected sex.

Source: AIDS: The Challenge

Example 2

Home based care of AIDS-sick in Malawi is seriously deficient, according to an evaluation from 2000. The volunteers providing the care received neither supervision nor supplies from the health services. They could not provide patients with e.g. soap, condoms or painkillers, and they did not give any HIV prevention information, so that spouses and children could be protected. Most of the patients were women, since men were cared for by wives or daughters.

Source: AIDS: The Challenge

5. Education and HIV/AIDS – a checklist on prevention, care, and impact mitigation

5.1 When should the checklist be used – and why?

In order to assess how Sida can support the education sector to persist and participate in efforts against HIV/AIDS, a number of questions need to be raised in project preparation, monitoring and evaluation. The questions should be included in the dialogue. They are not a blueprint to be applied always and everywhere, but should be posed selectively. The main dialogue partner is the Ministry of Education, but answers may be solicited from other sources, such as UN organisations, NGOs, and research reports. The answers should serve to;

- guide decision-makers in Sida in an analysis of how the HIV/AIDS epidemic affects the education co-operation;
- help identify possible areas where HIV/AIDS prevention and mitigation can be integrated into ongoing co-operation;
- Raising the questions with official representatives should also be seen as a means to enhance their political commitment to HIV/AIDS.

5.2 Strategic framework

Investing for Future Generations, Sida's strategy on HIV/AIDS, adopted in 1999, sets four strategic goals, to be applied in an analysis of the education sector. When analysing the effects of HIV/AIDS on the education sector, programme officers should be aware of gender dimensions; girls and boys are affected differently. Responses need to be tailored to their respective needs of e g knowledge, empowerment or protection. AIDS orphans are particularly vulnerable to discrimination and to impoverishment. Radical interventions may be justified to protect their education. All preventive education should contain teaching of human rights in relation to HIV/AIDS, including the sexual and reproductive rights of girls and women.

Addressing immediate causes	**Addressing immediate effects**
Prevention of HIV/AIDS – HIV/AIDS and life skills education integrated in formal and non-formal education, in schools, at university, in teacher training and adult education – Educational material for HIV/AIDS and life skills – Peer education in HIV/AIDS and life skills – Protection of girls in child safe schools	*Providing care, counselling and support* – Adapt the education system to pupils, teachers and staff who are affected and infected – Establish linkages to social welfare and health systems & define responsibilities for these sectors – Define the role of the school system with regard to HIV/AIDS
Addressing underlying causes	**Addressing long term effects**
Enhancing political commitment – Stimulate informed leadership – Teach human rights – Denounce discrimination and stigma – Promote gender equality – Support research and analysis – Provide monitoring and evaluation	*Protecting the education system* – Stabilise the education system to provide relevant quality education, also when teachers and pupils are HIV/AIDS affected – Keeping educator numbers up and promote staff planning – Allow creative response to new and more complex learning needs

5.3 How does HIV/AIDS affect the education system?

HIV/AIDS interrelates with the education sector in a multitude of ways, including through:

- loss of human resources – among teachers and other school staff and at the Ministry of Education,
- declining demand – fewer and poorer children,
- additional tasks – demand for HIV/AIDS prevention education,
- reduced financial resources and increased costs – competition for public and private funds.

5.4 Loss of human resources

Teachers, as a group, are subject to HIV risk factors related to their greater mobility, posting away from families and power position in relation to pupils. The loss of one teacher is estimated to affect at least 20–50 pupils. Loss of other qualified staff in the education sector such as administrators, headmasters, and teacher trainers also has far-reaching effects. Various measures to counter effects are needed, including increased training of new staff, in-service training, exchange of experience, calling back retired teachers, use of community capacity, "barefoot teachers" and revision of posting practises.

- How does HIV/AIDS affect supply of teachers and other school staff, e g. headmasters, school managers, teacher trainers, and Ministry staff at different levels?
- Is staff planning built on good estimates of current and expected mortality and morbidity among school staff?
- How many classes have lost their teacher? What is the trend of the student/teacher ratio?
- Are certain geographical areas more affected than others? How can these areas be supported?
- Has there been a change in the policy to post teachers; e.g. close to home or with their families?

5.5 Fewer pupils

Schools will have to adapt to a new situation, with more widespread poverty, reduced number of students, and many students affected by the HIV/AIDS epidemic in different ways. Measures are needed to reduce the direct cost of education to families, but it may be counter productive to single out AIDS orphans. Excluding other orphans and other equally poor children may lead to increased stigmatisation of AIDS orphans. Comprehensive measures directed at badly affected schools and/or severely affected areas may be more appropriate.

- Have enrolment rates declined? School attendance? Have drop out rates gone up? How are girls and boys, respectively, affected?
- What regions are hardest hit?
- Is there a policy to secure that AIDS-orphans continue school?
- Has the school system changed to facilitate for vulnerable children to attend school – e.g. flexible hours to meet labour needs, school feeding, school health, help with homework?
- Are there any innovative activities such as school based programmes for income generation?
- What do schools do to enhance the pupils' possibilities to practice what they learn about protecting themselves against HIV?

5.6 Additional tasks

Knowledge is at present the only "vaccine" against HIV, and schools provide an opportunity to reach young people from an early age with HIV/AIDS education. But sex education has met with opposition from many stake-holders, e g parents, politicians, and religious institutions. Gradually, these attitudes are changing in the most affected countries, but there is an overall lack of methods and material for HIV/AIDS education. Many teachers feel embarrassed to talk about sexuality, and may need back-up from a local midwife, nurse or medical doctor. Schools must also foster non-discriminatory attitudes towards HIV/AIDS affected families and people, and teach the human rights so important to societies hit by the epidemic. Schools must be a secure place for children and young people – particularly girls – where sexual harassment is firmly dealt with. In order to undertake all these tasks in HIV/AIDS prevention and mitigation, teachers need new knowledge and skills, and they need support to serve as trustworthy role models.

Ethical issues

- What does the school system do to secure that everybody within a school are protected from HIV/AIDS?
- Is there a policy on how schools should meet those affected by the epidemic, HIV-infected or AIDS-affected or sick male and female pupils, teachers and staff?
- Do educators have the understanding, skills and support to recognise and respond to special needs created by HIV/AIDS?
- Can schools encourage and provide voluntary testing?
- Can school teachers take on a role as counsellors; do they receive any such training?
- What is being done to prevent sexual exploitation of pupils by teachers?
- What is the opinion and reaction in relation to sexual harassment and/or sexual relations between students?

HIV/AIDS education

- Is there a compulsory HIV/AIDS education policy? Does it cover teachers, other personnel and pupils?
- Is HIV/AIDS part of compulsory teacher training? In-service training?
- Does HIV-teaching start before pupils are sexually active/start drug injecting behaviour?
- Is there resistance or support from the community/parent associations to HIV/AIDS education at primary level?
- Has coverage and effectiveness of HIV prevention and life skills programmes been evaluated? Have they been strengthened wherever appropriate?

Community involvement

- Can schools become centres for dissemination of HIV/AIDS information?
- Is there any established co-operation between the community and school?
- How can schools reach out-of-school youth with preventive education?

5.7 Reduced financial resources

The education sector will need to compete with other social sectors, notably the health sector, for additional resources. The risk is that declining numbers of students and increased poverty in society will further reduce incomes for schools. At the same time, HIV/AIDS creates new demands on the education system, such as need for more staff training and inclusion of additional tasks to prevent and mitigate effects of the epidemic on the young. To avoid duplication of efforts, co-ordination and communication is needed, at all levels.

- How can you ensure that pupils learn what they should, in spite of HIV/AIDS?
- How are the finances of the education system – income and/or expenditure – affected by HIV/AIDS?
- Has AIDS led to any changes in the government budget to the education sector?
- Will funding from the community and parents decrease?
- Are funds tied down by salaries for sick, inactive teachers and other staff, financial support to dependants, funerals, etc.?
- What do other donors do in relation to HIV/AIDS and education?
- How is co-ordination taking place; UN, bilateral, NGOs?

5.8 Education

Example 1

Studies in Eastern Cape, South Africa, demonstrate that education alone is not always sufficient to change behaviour. Young girls attending school run a risk of getting infected through sexual contacts at the school. What they learn about HIV appears insufficient to empower them to withstand group pressures, and pregnancies and HIV infections are increasingly common. "Clearly, the educational system in and of itself provides no shield of knowledge against the pandemic…."

Source: Shell & Zeitin, 2000

Example 2

A study undertaken of three universities in southern Africa revealed that even though university staff is lost to AIDS, and many students are likely to be HIV-positive, silence reigns over the epidemic. Thus, not even in higher education do the future leaders of public and private sectors in society get the preparation they need to survive – let alone lead the struggle against AIDS.

6. Infrastructure and HIV/AIDS

Guidelines on Issues and Responses

These guidelines contains a short general introduction followed by a set of questions to be used in the dialogue with ministries and local level government representatives, as well as with other counterparts such as consultants and entrepreneurs responsible for project implementation of infrastructure projects.

6.1 When and Why should this Guideline be Used?

In countries with a running HIV/AIDS epidemic, development co-operation involving infrastructure projects may both affect and be affected by the epidemic. In order to avoid negative effects, a number of questions need to be raised during preparation, monitoring and evaluation of development co-operation projects within the infrastructure sector. The checklist is not a blueprint, it should be adapted to each particular setting and used selectively. Local knowledge and experience should inform the selection of questions. The answers to these questions should serve to guide programme officers in:

- analysis of how HIV/AIDS affects development co-operation involving infrastructure;
- identify possible responses that can be integrated into ongoing and planned projects;
- enhance awareness of HIV/AIDS among counterparts.

A response framework for the infrastructure sector is presented in Table 1 (section 4) and the entry points for addressing HIV/AIDS in the project cycle are shown in Table 2 (section 5).

6.2 Strategic Framework

Sida's strategy on HIV/AIDS (*Investing for Future Generations),* identifies four strategic goals. These goals provide a useful framework.

When analysing interrelations between the infrastructure sector and the HIV/AIDS epidemic, programme officers should be aware of the gender and equity dimensions of issues related to mobility and large mobile workforces. It is also important that the responses are co-ordinated with national and local counterparts as well as with other donors.

Addressing immediate causes	**Addressing immediate effects**
Prevention of HIV/AIDS: – HIV/AIDS information – Provision of condoms – Control of STDs	*Recruitment, care and support:* – Recruitment of extra staff – Provision of HIV testing and counselling – Provision of care & support for AIDS sick staff and their families.
Addressing underlying causes	**Addressing long-term effects**
Limit worker separation from family: – Prioritise local recruitment of workers – Facilitate accommodation of workers' families at work camps – Provide workers with possibilities for regular visits to their families	*Training* – Training extra staff (where relevant) – Multi-skilling &, task sharing (where relevant)

6.3 Interrelations between HIV/AIDS and the Infrastructure Sector

Infrastructure projects are to a large extent intended to improve the movement of people and goods. It is this increased mobility, which is the ominous link between HIV/AIDS and infrastructure projects.

There is now strong evidence to suggest that mobility and mobile populations, especially when large numbers of mobile workers are involved, are linked to the spread of HIV. The largely male workforce involved in infrastructure projects is highly susceptible to HIV infection due to its high mobility and long periods of separation from wives and regular girlfriends. Its relative wealth also creates a market for commercial sex. Infrastructure projects also increase the risk of HIV-infection among the local population living close to the work camps, along transport routes and in transport centres. The loss of human resources, among workers and managers at all levels, which will also impact negatively on the project itself**.**

Thus, in order to avoid projects fuelling the epidemic, all planning, implementation and monitoring of infrastructure projects should consider HIV/AIDS.

6.4 Issues of Concern and Possible Responses

The following lists of questions focus on different HIV/AIDS related issues and indicate possible response alternatives.

Situation and Policy

It is necessary to get a general picture of the HIV/AIDS situation in the project area. It is also important to avail of the knowledge of counterparts and other actors on the state of the epidemic and information on the existence of HIV/AIDS-related policies in this field.

- What is the HIV/AIDS situation in the project area compared to the country situation and how is it likely to unfold?
- Do counterparts and other actors consider HIV/AIDS a problem?
- What experiences do counterpart organisations and other actors engaged in infrastructure projects in the country have of HIV/AIDS? Regarding e.g. absenteeism, increasing health and other costs, loss of workers and other staff, and recruitment?
- Is there concern for HIV/AIDS and an open discussion between actors and organisations in the national infrastructure community? What can be done to further encourage this discussion?
- Do counterparts have policies on HIV/AIDS issues? Regarding staff? Regarding contractors and consultants? Regarding the local community?
- Do donors and other actors in the infrastructure sector operating in other countries or regions with high HIV/AIDS incidence have experiences that can be drawn on?

Awareness and Prevention

Infrastructure projects will be compromised if information on how to avoid HIV-infection does not reach the workforce and the local population and if access to practical prevention measures, such as condoms is limited. It may be necessary to provide the project workforce with HIV/AIDS education and condoms, to consider the inclusion of HIV prevention components targeting the local population and/or commercial sex workers, or to support the upgrading of existing services and programmes.

- What is the level of HIV/AIDS awareness in the project area and among different groups and organisations (e.g., Ministry of Transport staff, project workers and management, and local population)?

- How can the project contribute to raising the awareness among the different groups?
- Have project management introduced or considered introducing HIV/AIDS prevention measures targeting workers? Does the project provide condoms to workers? Does the project health programme include STI-service?
- Are there any HIV/AIDS related activities (projects, information campaigns etc) in the area that the project could link up with?
- Have project management or counterpart organisations formed (or considered forming) strategic partnerships or co-operation with HIV/AIDS organisations? How can such partnerships be encouraged?
- How can the project organisation be used for HIV/AIDS prevention programmes targeting the local population?
- What kind of HIV/AIDS education/prevention measures do the Ministry of Transport and other counterparts provide to their staff?

Impact on Projects

When increasing numbers of workers and other employees fall ill in AIDS, project operating costs will rise as a result of the increase in health service related costs. The impact of HIV/AIDS for projects in severely affected countries will make it necessary to reconsider recruitment and training policies, and eventually also the time and cost framework.

- Have actual and potential increases of project costs due to AIDS been assessed?
- Have any responses or contingency measures (e.g. training of extra staff, multi-skilling, task-sharing etc) been introduced? If so, have they been evaluated?
- Does project budget contain contingencies for increased costs due to AIDS?
- Have projects considered increased recruitment of local workers to reduce the need for migrant labourers? How can this be encouraged?
- Have the possibility to accommodate workers' families at the work camp or more frequent possibilities for workers to visit their families been considered? Can this be encouraged?
- Does the Ministry of Transport and other counterparts have any contingency plans for increased illness and death (e.g. training extra staff or task sharing etc.)?

Tenders and Contracts

Inclusion of HIV/AIDS clauses in tender documents and contracts is the most important tool to address the epidemic within development co-operation in the infrastructure sector. Standard format clauses and contracts are available through UNDP/UNOPS South East Asia HIV and Development Project. (Chapter 4 of the Toolkit for HIV prevention among mobile populations in the Greater Mekong Subregion, Part Two, Country Resources at http://www.hiv-development.org/text/publications/toolkit-part2.doc).

- Are HIV/AIDS clauses included in tender documents and contracts/ sub-contracts for the project?
- Do contracts require contractors to maintain a dialogue concerning HIV/AIDS activities?
- Do contracts require contractors to report and evaluate HIV/AIDS activities?

Table 1. A Response Framework for the Infrastructure Sector

Activity	Possible problem	Potential remedy	Wider Action
Building/maintenance			
Mobility of Workers	Increase in number of sexual partners due to separation from family and relative wealth of labour force.	Increased use of local labour. Contract documents: i) include HIV/AIDS clauses in tender documents and contracts requiring contractors to a. provide HIV/AIDS education, distribute condoms and treat STIs . b. maintain a dialogue on issues concerning financing of HIV/AIDS activities, selection of and contracts with service providers, follow-up etc.	Min. of Health and National AIDS Control programme.
	Increased illness and death among workers.	Plan human resources and benefits accordingly.	Company and government Co-operation on the issue of human resource requirements, and HIV prevention.
Transport & Infrastructure Services			
Mobility of service operators	Highly mobile group with likely increased exposure to STIs and HIV/AIDS.	Targeted health education, AIDS prevention including condom distribution.	AIDS Control programmes, NGOs and operators.
		Reduce time spent away from home.	Operators.
		Provide controlled rest areas.	Operators.
		Reduce time at border posts.	Governments.
Management			
Planning and running transport & other types of infrastructure	Professional and skilled cadres also experience HIV-related mortality and morbidity, - hard to replace. Govt. benefits allow long periods of sick leave.	Identify key personnel and develop human resource plans to take account of increased morbidity and mortality.	Government. Operators.

6.5 HIV/AIDS in the Project Cycle

The earlier in the project cycle HIV/AIDS is considered, the better.
Table 2 shows the HIV/AIDS entry points in the project cycle.

Table 2 Entry Points for HIV/AIDS in the Project Cycle

PHASES	INVOLVED PARTIES	ENTRY POINTS FOR HIV/AIDS ISSUES	RELEVANT DOCUMENTS
PROJECT PLANNING	Sida-S Embassy Country representatives Counterparts or implementing organisation Line Ministry	Preparatory studies Participatory planning workshops Drafting of project documents ToRs	Sector studies Feasibility studies Fact-finding missions
IMPLEMENTATION MONITORING	Counterpart or Implementing organisation Consultants Embassy Sida-S	Annual plans Annual reviews Sector plans Sector reviews Mid-term reviews ToRs	Inception report Annual reports Sector reports Mid-term reports
EVALUATION	Evaluation Unit Regional and sector desk Consultants	ToR evaluations	Evaluation Reports

6.6 Infra: Two large-scale World Bank infrastructure projects and HIV/AIDS

Example 1 – Infrastructure – The Akosombo/ Volta River Dam contributed to the spread of HIV/AIDS

The construction in the 1960's of the Volta Rived Dam dam displaced some 80 000 families and arable land was lost. The men found jobs on the construction site, and female farmers began working in hotels and bars close to the construction site, poverty forced many to resort to prostitution. When the dam was completed, the women migrated to other parts of West Africa, sending substantial remittances to their families. Daughters of these women often followed their mothers' example into prostitution. By 1995, these links between the Volta dam area and to the commercial sex market of large West African cities, had led to HIV infection rates in the area five to ten times above the average level for Ghana.

Example 2 – The Chad-Cameroon Oil Pipeline Project: A project planned not to exacerbate the HIV/AIDS epidemic

A risk analysis of he construction of a 1 100 km oil pipeline through areas with extremely high levels of HIV, showed that the project involved a potential risk of fuelling the epidemic. The project would employ about 2 000 mainly single male workers from Chad and Cameroon and some 500 truck drivers. They would spend considerable time away from home, in temporary camps. The project manage-ment from the start therefore introduced a package including monitoring of STDs and HIV status of the workforce; condom distribution; HIV information/education; treatment of STDs; coordination with existing government and NGO HIV-programmes. The effects are still to be evaluated, but the example shows how infrastructure projects can build in mechanisms to reduce the risk of fuelling the epidemic. - The involvement of the local population may prove crucial for the outcome of these kinds of interventions.

Source: "Infrastructure Projects in Rural Areas", in *Sustainable Agricultural/Rural Development and Vulnerability to the AIDS Epidemic*, (Eds.) D. Topouzis & J. de Guerny, FAO/UNAIDS, UNAIDS Best Practice Coolection, December 1999.

7. Microfinance and HIV/AIDS

Guidelines on Issues and Responses

These guidelines contain a short general introduction followed by a set of questions intended for contacts with microfinance institutions and other microfinance actors. The aim is to integrate HIV/AIDS aspects into microfinance development co-operation and to identify possible responses.

7.1 When and Why Should this Guideline Be Used?

Development co-operation involving microfinance will be affected by HIV/AIDS in countries with a generalised epidemic. In order to avoid negative effects a number of questions need to be raised in preparation, monitoring and evaluation of development co-operation involving microfinance activities.

The checklist is not a blueprint, but rather pointers and relevant suggestions. Use will depend on the context. Local knowledge and experience should be applied to exclude some questions and add others. The answers to the questions should help the programme officer to:

- Analyse how HIV/AIDS affects development co-operation involving microfinance.
- Identify possible responses that can be integrated into ongoing and planned interventions.

Raising the questions is also a means to enhance awareness of HIV/AIDS among counterparts.

7.2 Strategic Framework

Sida's strategy on HIV/AIDS, *Investing for Future Generations,* sets four strategic goals. These goals provide a useful framework. When analysing interrelations between microfinance and the HIV/AIDS epidemic, programme officers should be aware of both gender and equity dimensions. Poverty and HIV/AIDS are closely interrelated. Microfinance services may slow down the spread of HIV by strengthening poor communities. Microfinance projects aimed at women may be particularly important to the prevention of HIV/AIDS.

Addressing immediate causes	**Addressing immediate effects**
Prevention of HIV/AIDS – HIV/AIDS information (staff & clients) – Provision of condoms (staff & clients)	*Contingency measures, care and support* – Recruitment of extra staff – Provision of HIV testing and counselling (staff) – Provision of care & support (staff)
Addressing underlying causes	**Addressing long term effects**
Modifying lending policy – Expansion of microfinance support – Increase participation of poor communities and women in microfinance programmes – Demanding HIV/AIDS and gender training from counterparts	*Modify lending policy and training* – Developing products adapted to needs of sick clients – Introducing more flexible lending conditions – Developing products to minimize institutional risk related to HIV/AIDS – Training extra staff, multi-skilling & task sharing

7.3 Interrelations between HIV/AIDS and Microfinance Activities

Persons and households affected by the epidemic are likely to belong to the same poor communities as the microfinance clients. Microfinance institutions are probably – unknowingly – already serving quite a few persons living with HIV, since about 90% of people infected don't know that they carry the virus. Increased illness and death among clients and their families' leads to reduced repayment capacity and cause a rise in exit rates and other operating costs of microfinance institutions. Costs also rise when micro-finance institution staff fall ill and die in AIDS. All planning, implemen-tation, monitoring and evaluation of microfinance activities in affected countries and regions therefore have to consider how they may prevent HIV/AIDS and deal with its effects.

7.4 HIV/AIDS in Programme Management

7.4.1 Project Cycle

The earlier in the project cycle HIV/AIDS is considered, the better. Table 1 shows the HIV/AIDS entry points in the Sida project cycle.

Table 1 Entry Points for HIV/AIDS in the Sida Project Cycle

PHASES	INVOLVED PARTIES	ENTRY POINTS FOR HIV/AIDS ISSUES	RELEVANT DOCUMENTS
PROJECT PLANNING	Sida-S & Embassy Country representatives Counterparts or implementing organisation Line Ministry	Preparatory studies Participatory planning workshops Project documents ToRs	Sector studies Feasibility studies Fact-finding missions
IMPLEMENTATION MONITORING	Counterpart or Implementing organisation Consultants Embassy & Sida-S	Annual & sector plans Annual, Mid-term & Sector reviews ToRs	Inception report Annual reports Sector reports Mid-term reports
EVALUATION	Evaluation Unit Regional and sector desk Consultants	ToR evaluations	Evaluation Reports

7.4.2 Sector Analysis

Include HIV/AIDS related question in sector analysis – strengths and weaknesses – including: What is known about the epidemic? What has been done already? For details see sections 5.1, 5.2, 5.3 and 5.4.

7.4.2 Institutional Analysis

Add questions related to HIV/AIDS to the CGAP standardized format for appraisal of microfinance institutions. Questions could include: How are microfinance institutions affected today? What actions are taken to mitigate the impact of HIV/AIDS? For details see sections 5.2, 5.4 and 5.5.

7.4.3 Product and Methodology Development

It is important to know what new products/methodologies are being developed to minimise the institutional risks related to HIV/AIDS, meet new demands, and to get information on the products introduced as a response to demand from AIDS affected clients. For details see section 5.6.

7.5 Issues of Concern and Possible Responses

The following lists of questions focus on different HIV/AIDS related issues and indicate possible response alternatives.

7.5.1 Situation and Policy

It is necessary to get a general picture of the HIV/AIDS situation in the country or region. It is also important to find out the views of counterparts and other actors about the state of the epidemic and the existence of HIV/AIDS-related policies in this field.

- What is known about the HIV/AIDS situation in the country or region (adult HIV prevalence and for different groups, AIDS mortality etc) and how it is likely to unfold?
- Is HIV/AIDS perceived a problem by microfinance institutions? In what way?
- Is there an open discussion and concern about HIV/AIDS within the national microfinance community? What can be done to further encourage this discussion?
- Do counterparts or other microfinance institutions have policies and/or strategies on HIV/AIDS issues? Regarding staff? Regarding clients? Regarding the general community?

7.5.2 Awareness and Prevention

The microfinace-programmes may be compromised by high rates of HIV/AIDS. Information is needed on how the target population can avoid HIV-infection and get access to practical prevention measures, such as condoms. Microfinance institutions may consider the inclusion of HIV prevention components in their programmes or liase with existing services and programmes.

- What is the level of HIV/AIDS awareness in the country or region and in different groups (e.g. general population, youth, and microfinace institution staff) and organisations?
- How can microfinance institutions contribute to raise the awareness at a reasonable cost?
- How can the outreach channels and experiences of microfinance institutions be used for HIV/AIDS information and education?
- Are there any HIV/AIDS related activities (projects, information campaigns etc) in the project area? How could microfinance institutions link up with them?
- What are the obstacles for microfinance institutions to introduce HIV/AIDS prevention activities targeting staff and clients?
- What is done or can be done regarding HIV/AIDS though national microfinance networks?
- Have counterpart organisations formed partnerships with HIV/AIDS organisations regarding HIV/AIDS information or prevention activities? How can such partnerships be encouraged?

7.5.3 Anti-Discriminatory Measures

Discrimination and stigma are among the more nastier effects of the HIV/AIDS epidemic. At the same time HIV/AIDS affected households need to develop coping strategies. One such strategy is to participate in a microfinance-programme. It is thus important that affected households are not excluded as clients. In severely affected areas microfinance institutions may need to take action to counteract discrimination in lending policies both among their staff and clients.

– Do microfinance-programmes sensitise management, staff and clients to counteract stigma and discrimination related to HIV/AIDS?

– Do persons living with HIV/AIDS have access to microfinance services? How can their participations be facilitated?

– Do microfinance-programmes in severely affected areas hire HIV+ persons with suitable skills?

7.5.4 Impact on Clients

With an increasing number of clients and their family members falling ill in AIDS, or being affected by the epidemic in other ways (e.g. by taking care of orphans or ill relatives), exit rates and other operating costs will rise and incomes will fall. The impact of HIV/AIDS can make it necessary to reconsider the sustainability of microfinance-programmes and/or the conditions for support.

– Have microfinance institutitons assessed the impact of AIDS on its clients and the repercussions on microfinance activities?

– Have microfinance institutions detected increased difficulties in loan repayments that can be attributed to AIDS?

– Have rising client exit rate due to illness and death in AIDS increased the cost of maintaining or expanding the client base of microfinance-programmes?

– Have the HIV/AIDS epidemic affect the demand and use of microfinance products (e.g. requests for smaller loan sizes)?

  Has the introduction of increased loan insurance preemie and other risk reducing measures due to HIV/AIDS led to the exclusion of some groups? If "yes", what can be done to avoid the exclusion?

– How are solidarity groups affected by, and how do they respond to HIV/AIDS?

– Has anything been done to alleviate stress on solidarity groups in severely HIV/AIDS affected communities?

– Can the solidarity groups support the coping strategies of HIV/AIDS affected households? How can this be encouraged?

7.5.5 Impact on Staff

When staff or their family members fall ill and die in AIDS the costs of Microfinance institution will increase and productivity fall as a result of increased absenteeism, loss of experienced staff, and additional costs (e.g. for medical care, burials, and support to dependants, recruitment and training of new staff)

– Have counterpart organisations analysed their vulnerability to sickness and loss of staff due to AIDS?

– Have counterpart organisations assessed the costs related to sickness and death of staff in AIDS?

– Have any responses or contingency measures (e.g. budget contingencies to cover extra costs, training of extra staff, multi-skilling or task-sharing) been introduced?

7.5.6 Call for New Products/Modified Lending Technologies

In countries or region serious affected by HIV/AIDS, the epidemic may create a demand for new products and/or make it necessary to modify lending technologies. The following responses have been tried:

- Developing products that are particularly helpful to sick clients (lump-sum or flexible savings products; education trust for minors; emergency loans etc).
- Allowing a healthy adult in the household to replace a sick microfinance client.
- Allowing clients to offset accumulated compulsory savings against outstanding loans.
- Allowing for selective debt relief to mitigate HIV/AIDS effects.
- Providing death insurance (burial expenses, cash payment or dept wipe-out).
- Creating small loans programme for members of a sick person's family.
- Developing pre-paid medical payment products.
- Developing community-based programmes for families caring for AIDS orphans and/or providing care for terminally ill persons.
- Helping clients with legal protection and advice in case of death of spouse.
- Have counterpart organisations or other national/local microfinance institutions considered or introduced any of the measures mentioned above?
- Have any other measures been considered or introduced?
- If any measures have been implemented, have they been evaluated? How can they be strengthened and disseminated?
- If no measures have been implemented, what are the reasons and obstacles?

7.6 Microfinance

Example 1 – Microfinance as buffer when AIDS strikes in Malawi and Zambia

A woman in Malawi made a living selling fried donuts. When she got a loan from a Save the Children microcredit project she could move into the more lucrative fish trading business, which allowed her to build up a bit of savings. When a sister of hers fell ill in AIDS, she took on caring for her. Which meant that she had to shift back into the donut trade, using her savings to make ends meet. When the sister eventually died, she was able to return to fish trading.

Members of a CARE microfinance project in Zambia were asked why they joined a credit group. Most did so to increase or diversify their business, and among these several joined because persons in their extended family were ill or had died in AIDS, leaving children behind. The credit group members knew they had to do something to be able to absorb the extra costs involved in taking care of the orphans.

Source: Jill Donahue, *HIV/AIDS & Economic Strengthening via Microfinance*, Report for USAIDS, February 2000.

Example 2 – Combining microfinance services and HIV/AIDS education in Uganda

Some microfinance institutions (MFIs) in Uganda have incorporated 30–45 minutes of HIV/AIDS and other health and nutrition education into the weekly meetings with their female clients. A study has shown that this combination of credit and education has had positive effects on household income and food security, including women's nutritional status and health. Other MIFs in Uganda use the weekly meetings to bring in AIDS service organisations to give education/information on HIV/AIDS. These organisations like to work with MFIs because this give them access to existing groups of interested persons. In both cases, the weekly meetings provide a forum for MFI clients to discuss the difficult issues related to HIV/AIDS, and a possibility for proactive group- mobilisation in the fight against the epidemic.

Source: Amy McDonagh, *Microfinance strategies for HIV/AIDS Mitigation and Prevention in Sub-Saharan Africa*, Working paper no. 25, April 2001.

8. The Private Sector and HIV/AIDS

Guidelines on Issues and Responses

These guidelines contain a short general introduction followed by a set of checklists to be used in contacts with private sector institutions and actors, such as chambers of commerce, and national or regional business organisations. The aim is to integrate HIV/AIDS aspects in private sector development co-operation and identify possible responses to the epidemic.

8.1 When and Why Should This Guideline Be Used?

In HIV/AIDS affected countries the epidemic will have potentially serious implications for the private sector. In order to avoid negative effects, a number of questions need to be raised during preparation, monitoring and evaluation of development co-operation projects within the private sector. The checklist is not a blueprint, it should be adapted to each particular setting and used selectively. Local knowledge and experience should inform the selection of questions. The answers to the questions should help the programme officer to:

- analyse how HIV/AIDS affects development co-operation involving the private sector.
- identify possible responses that can be integrated into ongoing and planned interventions.

Raising the questions is also a means to enhance awareness of HIV/AIDS among counterparts.

8.2 Strategic Framework

Sida's strategy on HIV/AIDS (*Investing for Future Generations)*, identifies four strategic goals. These goals provide a useful framework. When analysing interrelations between the private sector and the HIV/AIDS epidemic, programme officers should be aware of the gender and equity dimensions. It is important that international experiences and best practices of private sector involvement in HIV/AIDS related activities are propagated, and that co-operation and exchanges between private sector organisations in different countries in this field is encouraged.

Addressing immediate causes	**Addressing immediate effects**
Prevention of HIV/AIDS: – HIV/AIDS information (staff & clients) – Provision of condoms (staff) – Control of STDs	*Recruitment, care and support:* – Recruitment of extra staff – Provision of HIV testing and counselling – Provision of care & support for AIDS sick staff and their families.
Addressing underlying causes	**Addressing long-term effects**
Limit worker separation from family: – Prioritising local recruitment of workers – Facilitating accommodation for workers' families close to the work place – Providing workers with possibilities for regular visits to their families	*Training and change of benefits* – Training extra staff (where relevant) – Multi-skilling &, task sharing (where relevant) – Changing conditions for pensions and sickness benefits

8.3 Interrelations between HIV/AIDS and the Private Sector

The main problem is the loss of labour force due to AIDS, particularly the loss of highly trained and experienced staff, affecting costs and productivity. Other more indirect effects include falling demand, negative business climate, falling international investments and tourism. The private sector may also be seriously affected by the negative impact of HIV/AIDS on government finance and on the performance of public services and administration. All planning, implementation and monitoring of development co-operation related to the private sector in affected countries and regions therefore have to consider how they may prevent HIV/AIDS, and deal with its effects.

8.4 Issues of Concern and Possible Responses

The following lists of questions focus on different HIV/AIDS related issues and indicate possible response alternatives.

Situation and Policy

It is necessary to have a general picture of the HIV/AIDS situation in the country or region. It is also important to find out the views of counterparts and other private sector organisations concerning the state of the epidemic and the existence of HIV/AIDS-related policies in this field.

- What is known about the HIV/AIDS situation in the country or region (adult HIV prevalence and for different groups, AIDS mortality etc) and how is it likely to unfold?
- Is HIV/AIDS perceived as a problem by private sector institutions? In what way?
- Is there an open discussion and concern about HIV/AIDS within national private sector organisations? What can be done to further encourage this discussion?
- Do counterparts or other private sector institutions have policies and/or strategies on HIV/AIDS issues? Regarding staff? Regarding customers? Regarding suppliers? Regarding the general community?

Awareness and Prevention

Private sector activities may be compromised by high rates of HIV/AIDS. Information is needed on how staff, customers, suppliers, and the surrounding community can avoid HIV-infection and gain access to practical prevention measures, such as condoms. Private institutions may need to consider the inclusion of HIV prevention components in their programmes, or liase with existing services and programmes. Co-operating Swedish private sector organisations and individual businesses will need to raise their level of awareness.

- What is the level of HIV/AIDS awareness in the country or region and in different groups (e.g. general population, youth, in firms of different sizes, private sector organisations, unions)?
- How can private sector institutions contribute towards awareness raising at a reasonable cost?
- Are HIV/AIDS components integrated in private sector organisation competence development programmes and other regular staff training? How can such activities be encouraged?
- What is done or can be done regarding HIV/AIDS through national private sector organisations?
- How can the outreach channels and experiences of private sector institutions be used for HIV/AIDS information and education? How can such activities be encouraged?

- Are there any HIV/AIDS related activities (projects, information campaigns etc) at national or regional level that private sector institutions could link up with? How can such co-operation be encouraged?
- What are the obstacles for private sector organisations to introduce HIV/AIDS prevention activities targeting staff, member firms, customers, suppliers and the general community?
- Do private sector organisations co-operative with unions on HIV/AIDS related issues? How can such co-operation be encouraged?
- Have counterpart organisations formed partnerships with HIV/AIDS organisations regarding HIV/AIDS information or prevention activities? How can such partnerships be encouraged?
- What is the level of HIV/AIDS awareness in co-operating Swedish private sector organisation and individual firms? How can they be encouraged to obtain relevant information?

Discrimination

Discrimination and stigma are among the nastier effects of the HIV/AIDS epidemic, which may also effect the work atmosphere and productivity. In severely affected areas, private institutions may therefore need to take action to counteract discrimination within the workplace.

- Do private sector organisations sensitise management and staff to countereffect stigma and discrimination related to HIV/AIDS within the workplace? Can these activities be encouraged?
- Do private sector organisations encourage and support that HIV+ employees continue working?
- Do private-sector organisations in severely affected areas hire HIV+ persons with suitable skills? If not, what are the obstacles?

Impact on staff

- Have counterpart organisations analysed vulnerability of their production due to AIDS, such as sickness and loss of staff at different levels?
- Have counterpart organisations assessed the costs related to sickness and death of staff in AIDS?
- Are counterpart organisations aware of institutional or organisational auditing as a tool to analyse vulnerability to AIDS, and are these services available? If not, can they be facilitated through support to training programmes?
- Have private sector organisations introduced responses to the HIV/AIDS epidemic such as e.g. budget contingencies to cover extra costs, training of extra staff; multi-skilling; task-sharing; reduction of hierarchical constraints to team work; decentralisation of decision making; reduction or other changes of contractual pension, sickness and other benefits.
- Does the private sector co-operate with the public sector to meet the increased demand for trained personnel? How can such co-operation be encouraged?

When staff or their family members fall ill and die in AIDS the costs for private sector institutions will increase and productivity fall as a result of increased absenteeism, loss of experienced staff, and additional costs (e.g. for medical care, burials, and support to dependants, recruitment and training of new staff).

Impact of Customers

With an increasing number of customers and their family members falling ill in AIDS, or having their incomes affected by the epidemic in other ways, (e.g. by taking care of orphans or ill relatives) possibilities to consume goods and services will decrease and consequently demand will fall. (The same reasoning is relevant for firms and public customers.) Some business sectors, such as in the field of health and insurance, will (potentially) experience an increased demand.

- Have private sector institutions assessed the impact of AIDS on their customers?
- Have private sector institutions detected changing demand for some kinds of goods and services that can be attributed to AIDS? Which sectors are most affected? What responses have been introduced? Have they been evaluated?

Impact of Suppliers

Suppliers can also be affected by AIDS with implications for their capacity to deliver goods and services as timely as required, resulting in delays or interruptions in production.

- Have private sector institutions detected increased problems to get their invoices paid on time or other similar difficulties? Which sectors are most affected? What responses have been introduced? Have they been evaluated?
- Have private sector institutions detected increased problems with the supply of goods and services from the private sector that can be attributed to AIDS? Which sectors are most affected? What responses have been introduced? Have they been evaluated?

Impact of the Public Sector

The negative effects of AIDS on public sector demand and capacity to deliver public services, like construction and maintenance of transport, and energy and water infrastructure, will have similar repercussions. Have private sector institutions detected increased problems with the delivery or maintenance of public goods and services or mounting bottlenecks in public administration that can be related to the HIV/AIDS epidemic? Which sectors are most affected? What responses have been introduced? Have they been evaluated?

- Have private sector institutions foreseen increased recruitment problems due the effects of AIDS on public education? Which sectors are most affected? What responses have been introduced? Have they been evaluated?
- The same goes for bottlenecks in public administration in areas like border/custom control and import/export licensing caused by loss of experienced staff in AIDS, and reduced resources due to increased demand by the health sector. The serious effects of AIDS on the public education system will further compound recruitment problems.

8.5 HIV/AIDS in the Project Cycle

The earlier in the project cycle HIV/AIDS is considered, the better. Table 1 shows the HIV/AIDS entry points in the Sida project cycle.

Table 1 Entry Points for HIV/AIDS in the Sida Project Cycle

PHASES	INVOLVED PARTIES	ENTRY POINTS FOR HIV/AIDS ISSUES	RELEVANT DOCUMENTS
PROJECT PLANNING	Sida-S & Embassy Country representatives Counterparts or implementing organisation Line Ministry	Preparatory studies Participatory planning workshops Project documents ToRs	Sector studies Feasibility studies Fact-finding missions
IMPLEMENTATION MONITORING	Counterpart or Implementing organisation Consultants Embassy & Sida-S	Annual & sector plans Annual, Mid-term & Sector reviews ToRs	Inception report Annual reports Sector reports Mid-term reports
EVALUATION	Evaluation Unit Regional and sector desk Consultants	ToR evaluations	Evaluation Reports

8.6 Framework for Assessing vulnerability to loss of staff due to AIDS

It is principally the effects of AIDS on the labour force that makes the private sector vulnerable to the epidemic. There are three key issues related to labour:

- Will there be enough labour of the right type at the right time?
- What effects will increased illness and death in AIDS have on the cost of employee benefits?
- How is labour used (mobility)?

To get a broad idea of the vulnerability of the sector or for a particular project, the following checklist may be applied. Different kinds of labour should be assessed separately.

Framework checklist for assessing vulnerability to labour force loss

Labour Availability	Employee Benefits	Use of Labour (mobility)
– Is there sufficient labour? – Are new recruits available? – Are there seasonal constraints? – Does the work require experience? – Is there sick leave provision (how much)? – Is there compassionate leave (how much)?	– Are medical services or medical aid provided? – Is insurance provided? – Are death benefits provided for employees? – Other benefits (e.g. housing, transport) – Is a pension provided for dependants?	– Does work demand travel overnight? – Are migrant workers employed? What % of work force? – Are most employees male or are they female? How are they housed?

8.7 Private sector involvement in HIV/ADS Education/ Information

Challenges		
Convincing business that HIV/AIDS can affect them	Obtaining management commitment to act	Getting business to adopt relevant policies
Ensuring confidentiality & non-discrimination	Supporting staff with HIV/AIDS	Dealing with attitudes of co-workers
The Responses		
Organising one-off activities	Adopting HIV/AIDS policy	On-going HIV/AIDS education for employees
Education for customers & suppliers	Collaboration with NGOs & GO's*/ to educate the wider community	
Providing jobs for PLWHA	Supporting fund-raising efforts of NGO's	Providing creative and business expertise to NGO's and GO's

*/ GO= Government Organisation

8.8 Private sector

Example 1 – Unilever raising awareness among staff

Lever Brothers is a Malawi branch of the multinational Unilever. The London HQ has instructed Lever Brothers to make all possible efforts to stem the losses in AIDS among its staff. One of the awareness raising measures used was a questionnaire where every employee had to judge himself/herself according to risk of catching HIV. Interestingly. The exercise showed, among other things, that senior management staff tended to see themselves as fairly high-risk – perhaps a reflection of the opportunities going with high status and income.

Source: Bertil Egerö, visit to Lever Brothers July 2000

Example 2 – Quote on Apartheid, the migrant worker system and HIV/AIDS in South Africa

"If you want to spread a sexually transmitted disease, you'd take thousands of young men away from their families, isolate them in single-sex hostels, and give them easy access to alcohol and commercial sex. Then, to spread the disease around the country, you'd send them home once every once in a while to their wives and girlfriends. And that's basically the system we have with the mines."

Source; Mark Luire, South African Medical Research Council, from an article by Mark Schoofs in *The Village Voice* Apr. 28, 1999 Retrieved from www.thebody.com.

Example 3 – Workplace projects in Kenya

At the Kenya Ports Authority, a work place with 7000 mostly male employees 200 peer educators hold weekly meetings and informal talks with their co-workers. Qualitative evaluation suggests that such workplace programs are beginning to affect norms of social behaviour and that they have stimulated demand for HIV prevention services such as STI treatment and condom social marketing. Most programs, however, have been donor-driven, and only a few businesses are directly funding HIV/AIDS prevention activities.

Source: George Obanyi and Lee Pyne-Mercier, Realizing the HIV Prevention-to-Care Continuum in Kenya in IMPACT ON HIV, Volume 2, No. 2, December 2000

9. HIV/AIDS Guidelines for Agricultural and Rural Development

9.1 HIV/AIDS impact on the rural sector

In AIDS-affected countries, HIV/AIDS exacerbates existing development problems in areas such as agricultural production, food security, rural poverty, the position of women, and access to services. HIV/AIDS should therefore be considered in all agricultural and rural development interventions. In order to do this, the following information is needed: Data about the impact of HIV/AIDS in the project area, and information on HIV/AIDS-related issues to be considered in agricultural and rural development projects and possible responses. The information needed in each particular case depends on the character of the local and national AIDS epidemic, the nature and scope of the project, the phase of the project cycle, and information and experience already accumulated from other similar projects.

9.2 Assessing the HIV/AIDS Situation in an Area

It is usually difficult to get information on the HIV/AIDS epidemic at district level and other sub-national levels. National HIV/AIDS-data should be used until more detailed information can be obtained. Contacts with NGOs, religious organisations and researchers active in the project area may yield potentially important complementary data. The Swedish Embassy and Sida's Regional HIV/AIDS Secretariat may also be able to provide useful information and contacts. Other sources of information for background data should be used as far as time and resources permit. For detailed information on how to assess the HIV/AIDS situation, see Annex 1.

9.3 HIV/AIDS in Agricultural and Rural Development Projects

In AIDS-affected areas, the AIDS epidemic compromises development activities and may eventually prevent the achievement of the objectives. All planning, implementation, and monitoring of interventions in affected areas, including dialogue with counterpart organisations, has to consider HIV/AIDS. It may be necessary to redirect projects and reconsider their sustainability and goals. Additional actions may have to be planned for or HIV/AIDS components added. In severely affected areas it may be necessary to consider relief activities in order to make development projects meaningful.

9.3.1 HIV/AIDS in the Project Cycle

The earlier HIV/AIDS is considered in the project cycle, the better. Table 1 shows the HIV/AIDS entry points in the Sida project cycle.

Table 1 Entry Points for consideration of HIV/AIDS in the Project Cycle

PHASES	INVOLVED PARTIES	ENTRY POINTS FOR HIV/AIDS ISSUES	RELEVANT DOCUMENTS
PROJECT PLANNING	Sida-S & Embassy Country representatives Counterparts or implementing organisation Line Ministry	Preparatory studies Planning workshops Drafting of project documents ToRs	Sector studies Feasibility studies Fact-finding missions Project documents
IMPLEMENTATION MONITORING	Counterpart or Implementing organisation Consultants Embassy & Sida-S	Annual & Sector plans Annual, Sector & Midterm reviews ToRs	Inception report Annual, Sector & Midterm reports
EVALUATION	Evaluation Unit Embassy & Sida-S Consultants	ToR evaluations	Evaluation Reports

9.3.2 Issues and Possible Responses

Responses have to consider livelihood strategies and division of labour in the rural communities concerned, and emphasise livelihood and food security, farming and domestic labour constraints, and existing household and community coping mechanisms.

Response alternatives should focus on issues such as improving returns to labour inputs, extending the planting period, diversifying of crops, and reducing external input needs. Income generating activities and small-scale credit schemes may in some cases play an important complementary role. If considered necessary, responses should include HIV/AIDS information and prevention components.

These Guidelines should be used selectively according to the needs of programme officers, consultants and partners in each particular case. Issues relevant to project planning and monitoring of interventions are presented below, each with a list of questions focusing on different aspects and indicating possible response alternatives. The checklist is not a blueprint, but rather pointers and relevant suggestions. Use will depend on the context. Local knowledge and experience should be applied to exclude some questions and add others.

HIV/AIDS Awareness and Prevention

To halt further spread of HIV, information on how HIV/AIDS is transmitted should reach the target population, and access to practical measures such as condoms should be secured. The project might need to consider whether HIV prevention components can be handled by other actors, or must be part of the project itself.

- How is HIV/AIDS information/education provided in the area?
- Does information/education reach all groups, including youth?
- Has the project established links with HIV/AIDS programmes in the area?
- Have possible local partners for HIV/AIDS related activities been identified?
- Are there any traditional mutual support groups (such as production groups, women's groups, youth groups or religious groups) or other local institutions that can be supported or revitalised to play a role in HIV/AIDS information and prevention programmes?
- Do existing HIV/AIDS prevention programmes and services need to be upgraded?
- Can distribution and access to condoms be improved?

Crop Farming

The loss of adults with farming skills leads to a reduction of the variety of crops and area of land cultivated. Less time for tillage leads to falling yields and increased post-harvest losses. These effects are compounded by a reduction in the use of farming inputs and hired work, due to falling incomes. Altogether this leads to falling nutritional status of household members with negative effects on labour productivity and health.

- Are there labour-saving cultivation practices for staples and other crops that can be introduced?
- Are there labour saving methods (e.g. inter-cropping) that can be used to maintain the widest possible range of crops?
- Are there labour-saving new crop varieties that can be introduced?

- Is it possible to introduce simple labour-saving cultivation techniques?
- Can storage of crops be improved?
- Can input requirements be reduced?
- Are there successful experiences in increasing returns to labour in crop farming from other parts of the country, or internationally, that can be readily adapted to local conditions?
- Can small-scale credit schemes, money lending clubs or savings and loans groups play a role in supporting the coping capacity of farmers?
- Has participation in project activities been affected by the epidemic?
- Is additional support, e.g. seeds or farming implements, or some other change in the project design necessary, to enable more people to participate in project activities?
- Are there local social institutions for labour exchange or mutual support between households that can be supported or revitalised?

Livestock

Loss of household labour and skills leads to less time for or neglect of animal care, resulting in diminishing quality and quantity of livestock. This may have potentially serious knock-on effects on household nutrition, income and farming through the loss of milk for consumption and sale, manure and draught animals.

- Are there labour saving practices for care of large livestock?
- Can pooling of draught animal resources be organised?
- Can rearing of poultry and small stock be supported in order to provide income and improve diets?
- Are there successful experiences in increasing the return on labour in animal husbandry in other parts of the country or internationally that readily can be adapted to local conditions?

Intergenerational Transfer of Skills

Increased adult morbidity and mortality threatens the transfer of local agricultural skills to a new generation of farmers.

- How are orphans cared for?
- Is there any support to children-headed households?
- Is there awareness of the problem of intergenerational transfer of agricultural skills?
- Has something been done to ensure that orphaned children receive adequate training in local farming techniques?
- Is the local community or other organisations taking on this task, or can they be encouraged to do so?
- Have the local schools been engaged?

Workloads of Rural Women

In AIDS-affected households, growing demand for care and support in most cases leads to an increased workload and longer working days for women and girls. This leaves less time available for subsistence food production, food preparation, childcare and school with negative effects on nutrition, health etc. While the main short-term challenge is to find ways to alleviate the workload of women and girls, long-term solutions would have to include ways to strengthen the position of rural women. Examples of questions to explore for short-term responses are:

- Could access to household water be facilitated?
- Could food processing and preparation be facilitated by labour and time saving methods?
- Could time saving alternatives be introduced, to reduce the burden of maintaining energy or fuel supplies?
- Would childcare facilities enable women to engage more in productive activities?
- What can be done to facilitate school attendance by girls in AIDS-affected households?
- Are there traditional institutions for labour exchange or mutual support between households that can be supported or revitalised to alleviate the workload of women and girls?

Property Rights

Where traditional land tenure and inheritance rights of women are weak, AIDS widows and their children may lose their rights to household land and other assets. New legislation must be introduced or existing legal protection enforced, in collaboration between local government and civil society. Means of supporting such processes need to be found.

- What is known about local and regional customary inheritance rights for women and children, and how are they played out in situations of rising AIDS mortality?
- Is there any reporting system on property grabbing, and what is done to support affected households?
- What can be done to strengthen and protect land and property rights of widows (and orphans) – by legal action, through traditional leaders and other civil society actors?

Agricultural and Rural Infrastructure

Loss of household labour and skills and/or disruption of work (e.g. to attend funerals etc.) affect the maintenance and construction of rural infrastructure such as irrigation systems and labour intensive soil management (e.g. terracing).

- Are there any signs of neglect, deterioration or other changes in maintenance or use of rural infrastructure (e.g. irrigation systems, wells, pumps and pipes for household water, rural roads and bridges) and soil management (terraces etc) due to labour shortage?
- Are there possibilities to support pooling of labour or encouraging existing labour and exchange activities in order to facilitate rural infrastructure and soil management activities?
- Are there labour economising soil management alternatives?

Extension Messages

Extension messages may need to be adapted to the changing needs of farmers due to the impact of the HIV/AIDS epidemic. One example is the traditional gender-based division of labour, which often compounds the impact of AIDS illness and death on smallholder households.

- Have extension messages adapted to changes in farmers' needs and priorities with respect to e.g. labour saving methods and crops, or nutrition?
- Has the extension service adapted to changes in the farmer population (increased number of women, elderly and child farmers)?
- Can extension messages be better adapted to the needs of women or child farmers with respect to e.g. livestock care, farm implements or crop storage?
- Has anything been done to facilitate the marketing of farm products from AIDS affected households?

Extension Services

Extension staff and their households may also fall victim to AIDS. Increased staff absenteeism and loss of experienced staff due to death inevitably disrupts existing extension services. This also makes it more difficult to adapt extension messages to the changing needs of farmers.

- Is there any noticeable increase in illness and death among extension service staff in the area?
- Have lost staff been replaced?
- Has the performance of extension service been affected? How?
- Have extension service staff been targeted with HIV/AIDS information and prevention measures? If so, have these activities been evaluated?
- Have sexual health education and HIV-prevention been integrated into extension service activities?
- Are there non-public sector organisations (e.g. NGOs or religious organisations) engaged in extension activities that can be supported?

9.3.3 Counteracting Adverse Effects of Project Activities

Some projects or activities may inadvertently contribute to further spread of HIV. Relevant questions in this context would be:

- Has the possible impact of project activities on the epidemic been considered in preparation and monitoring?
- Can project organisation and activities be adapted to reduce unnecessary mobility?
- Do project activities increase the mobility of the target population?
- Do project activities attract an inflow of people (e.g. labour migrants or traders)?
- Do project activities create a market for commercial sex?
- Are project and counterpart staff trained and encouraged to integrate HIV/AIDS prevention components into their work or projects?

– Do project or counterpart organisations cooperate with NGOs and other organisations providing HIV/AIDS information/education activities?

9.3.4 Issues and Responses Internal to a Project

Project and counterpart organisation staff are not immune to the HIV/AIDS epidemic, and may in fact – due to their high mobility and relatively high income – be more exposed to infection than other groups. Apart from the suffering of individuals and their families, AIDS will affect project activities and costs through increased absenteeism, loss of staff, reduced work productivity and additional costs. Relevant question in this context would be:

– Has AIDS affected the project or counterpart organisation? In the case of new projects, have the risks and vulnerabilities been analysed and taken into consideration in project design?

– Has the impact of AIDS been assessed, and what response measures have been implemented?

– Is HIV/AIDS included in the regular dialogue with counterparts?

– What is the level of HIV/AIDS awareness among project and counterpart staff?

– Does the project include HIV/AIDS prevention activities (e.g. information and condom provision) directed to project and counterpart staff? If so, have these activities been evaluated?

– Does regular staff training include HIV/AIDS components?

– Is HIV/AIDS a regular topic on the agenda of internal workshops?

– What measures have been taken to maintain HIV/AIDS awareness among project staff?

– Have HIV/AIDS Focal Points with specific mandates and responsibilities been appointed within the project and counterpart organisations?

– Is there a policy regarding the care and support for AIDS-affected project staff and their families?

– Does the project budget include contingencies to cover additional staff-related costs due to AIDS (e.g. medical care, burials, and support to dependants)?

– Have AIDS contingency measures such as training of extra staff or task- sharing been implemented?

– Is HIV/AIDS a part of the regular dialogue with agricultural and rural development organisations in the area?

9.4 Three A&RD

Example 1 – Impact of HIV/AIDS on smallholder agricultural production in Gweru, Zimbawe

A study in Gweru district, Zimbabwe, shows that land left fallow during the 1997/98 season due to AIDS inflicted considerable income loss on the 53 households surveyed. Land was not cultivated because of labour shortage due to death, lack of agricultural inputs due to death of the main provider, and lack of draught power and farm implements (sold to cover medical and funeral expenses). Shortage of labour and inputs also resulted in further income loss through poor management of crops and livestock. The study further shows that extension workers in the area spent on average three days a month attending AIDS-related funerals in their communities.

Source: Article with the same title by N.M. Ncube, in *Aids and African Smallholder Agriculture.* 1999. Edited by Gladys Mutangadura, Helen Jackson and Duduzile Mukurazita. SAfAIDS.

Example 2 – AIDS impact on a rural household in Rakai, Uganda – From relative prosperity to deep poverty in ten years

In 1980 the household is prosperous. Five children (12–1 year) live with their parents. Two older sons have left home, and send remittances used to hire two seasonal labourers and buy small amounts of agro-chemicals. The household cultivates a wide variety of food crops and coffee as cash crop.

By the mid 1980s the migrant sons have died in AIDS and remittances cease. Extra farm labour can no longer be hired and there is no cash to buy agrochemicals. The farm starts to deteriorate; a process which accelerates when the father falls ill in AIDS. Neglect of the coffee plantation reduces the income. More cassava is grown at the expense of other crops. The oldest daughter is taken out of school to reduce costs and add labour force to the household.

By 1989 both parents have died in AIDS. The youngest brother is left with his grand-mother and all children are taken out of school. The coffee plantation is abandoned. Three children manage to cultivate last resort crops like cassava and yams, while the fourth spends most of her time away selling beer to earn cash. Clothing and food for survival becomes a problem. The brothers sometimes get employment as farm labourers, and neighbours provide some food and assistance on the farm.

Source: Example adapted from Barnett and Blaikie (1992) *AIDS in Africa.* Belhaven Press, London.

Example 3 – Impact of AIDS on fishing communities

Fishing communities are particularly vulnerable to HIV/AIDS due to the mobility of fishermen, their access to cash, and long periods of separation from their families. Labour input in the fishery sector is less seasonal than in subsistence agriculture, and the reduction in the labour supply may not directly affect production. In Malawi, staff from the Fisheries Department have noted that an increased mortality means that knowledge and skills in the sustainable use of aquatic resources are lost, and that more resources must go to training. At the same time, increased mortality among fishery extension staff means that fewer opportunities for training can be offered.

Source: Hemrich, G. & Schneider, B., 1997, *HIV/AIDS as a Cross-Sectoral Issue for Technical Cooperation. Focus on Agriculture and Rural Development*, GTZ, Eschborn.

Annex 1 Assessing the HIV/AIDS situation in an area

1. The general HIV/AIDS situation

Ideally, information to get a general view of the HIV/AIDS epidemic in an area would include data on present situation and trends in:

- HIV prevalence (% of the population carrying the virus);
- AIDS illness and death (or, in the absence of data, information on changes in adult and/or child mortality).

Complementary data useful to assess the situation is information on:

- Organisations in the area engaged in HIV prevention and other HIV/AIDS related activities;
- Ongoing and planned HIV/AIDS-related activities in the area;
- HIV/AIDS awareness in the area and in different groups (e.g. general population, youth, authorities and extension agents).

As gender differences and age are important indicators when assessing the HIV/AIDS situation, data should whenever possible be disaggregated by sex and age.

2. Vulnerability to HIV/AIDS

Due to differences in farming systems and other local conditions, vulnerability to AIDS, including the capacity to cope with loss of labour and income, may vary considerably even over short distances. The general rule is that conditions that limit flexibility also increase vulnerability. Information on differences in vulnerability between areas may be useful when planning and monitoring projects. The vulnerability of a certain area can be analysed using the following or similar questions.

- Is the rainy season short or rainfall erratic?
- Is the range of crops limited?
- Are there marked labour peaks in the agricultural cycle?
- Are there bottlenecks in labour supply (due to e.g. labour migration)?
- Is there a strict labour division between men and women?
- Is the food surplus during a normal year low?
- Is there a tradition of labour exchange or other forms of mutual support between households?
- Is it possible to substitute labour intensive with less labour demanding food crops?
- Are there income possibilities outside farming?

3. General socio-economic effects of HIV/AIDS

Particularly in the early stages of the epidemic, with relatively few households affected, the impact of HIV/AIDS in an area would be difficult to detect without good knowledge of local conditions. The effects unfold slowly and are often hard to disentangle from impacts of e.g. drought or other "crises" affecting rural areas. Once the effects of HIV/AIDS are visible – in the form of increased morbidity and mortality among adults and infants – this means that the epidemic has taken a firm hold of the area. One way to get a view of the AIDS impact in an area is to analyse the socio-economic trends during the past 5–10 years through questions such as:

- Are there signs of increased poverty? (Any particular groups affected?)
- Has the food security situation changed? If so, why?
- Are there reports of a switch to less labour demanding food crops (e.g. cassava) If so, why?
- Has cash crop production been reduced? If so, why?
- Are there any sign of an increase of plant/animal pests? If so, why?
- Are there reports of a decrease in school enrolment? If so, why?
- Are there signs of an increase in the number of orphans?
- Has the number of female-headed households increased?

4. Effects on households

When AIDS strikes a household, incomes fall rapidly. Sick persons are not able to work and the income generating time for caregivers is reduced. At the same time, the household might face additional expenditures for medical care, medicine and eventually funeral costs. When small farmers survive on a knife's edge, AIDS may tip the balance and start a downward spiral of falling production, reduced income and consumption, i.e. worsening poverty.

The effects of AIDS illness and death can however vary considerably between households. Young households with infants and young children are generally more vulnerable than older households. The most vulnerable households are those that depend on one or a few working adults, have shortage of land and poor soils, live on small and unreliable incomes and with few or no assets to sell. Wealthier households have at least initially better possibilities to cope successfully.

Some commonly observed effects of the epidemic on affected farming households are:

- a reduction of area in cultivation;
- a reduction in range of crops cultivated;
- a shift to less labour-demanding (and less nutritional) staple crops;
- a reduction (or neglect) of cash crop production;

– a reduction (or neglect) of land management practices;

– sale of land, livestock or farm implements;

– deteriorating nutritional standards;

– signs of child malnutrition;

– children being taken out of school.

5. Assessing information on the HIV/AIDS situation

When assessing the information on the epidemic in a particular area the following questions would be helpful:

– How old is the information?

– Are there reasons to believe that the information is exaggerating or downplaying the HIV/AIDS situation?

– If information is contradictory, how can it be explained? What information would be most trustworthy?

– Does available HIV/AIDS-information indicate similarities between project area and, neighbouring areas, or other parts of the country? If not, how can the differences be explained?

– Are there particular conditions or other factors favouring (e.g. regular large-scale labour migration, proximity to important transport centres or routes) or limiting (e.g. relative isolation) the spread of the epidemic in the area?