

Programming Principles

4.1 Introduction

As the devastating impact on individuals, communities and the social and economic development of nations most affected by HIV/AIDS has become increasingly apparent, there is an urgent need to scale up proven strategies, such as targeted HIV prevention programmes and access to antiretroviral therapies (ARVs). However, HIV/AIDS-focused responses alone will not address the inequities that drive HIV infection and worsen the consequences of the pandemic. We must also respond to HIV/AIDS indirectly by addressing developmental factors through a process of mainstreaming HIV/AIDS (see Development in section 2.4).

The term **HIV/AIDS programmes** refers to work such as HIV prevention and treatment, care and support programmes for PLHA, or HIV/AIDS-focused interventions that are integrated within broader health and related programming. The goal of HIV/AIDS programming relates specifically to HIV/AIDS (for example, preventing HIV transmission or reducing HIV-related stigma and discrimination).¹

The term **mainstreaming HIV/AIDS** refers to adapting development and humanitarian programmes to ensure they address the underlying causes of vulnerability to HIV infection and the consequences of HIV/AIDS. The focus of such programmes, however, remains the original goal (for example, improving household incomes or food security, or raising literacy rates).²

This chapter considers both direct and indirect approaches to responding to HIV/AIDS. Section 4.2 provides good practice principles for HIV/AIDS programming, including integrating HIV/AIDS-specific interventions within broader health programming, drawing upon the impressive body of knowledge that exists about how to respond effectively to HIV/AIDS. Section 4.3 considers mainstreaming HIV/AIDS within development and humanitarian programmes. The idea of mainstreaming HIV/AIDS is relatively new, but there is an emerging practice that seeks to strengthen responses to HIV/AIDS by paying particular attention to HIV/AIDS and its consequences in the context of long-term development and humanitarian work.³ Section 4.3 draws on the available experience to date to guide this process.⁴

HIV/AIDS programming and mainstreaming HIV/AIDS in broader programmes are mutually reinforcing approaches. For example, micro-financing programmes can assist households to increase their income and build assets, both of which can reduce vulnerability to HIV infection and improve capacity to respond to the consequences of HIV/AIDS.⁵ Similarly, successful HIV/AIDS programming can reduce vulnerability to HIV infection and stigma and discrimination and maximise access to treatment, care and support, thus facilitating an environment that supports development efforts. Responding to the complexities of HIV/AIDS is best achieved through the combined efforts of NGOs with different areas of expertise doing what each does best, with a heightened understanding of how their work contributes to addressing HIV/AIDS. Different sections of this chapter will be relevant to different kinds of NGOs responding to HIV/AIDS, depending on the nature of their work.

We recognise that the distinction between HIV/AIDS programming and mainstreaming HIV/AIDS is somewhat artificial. For example, humanitarian programming principles for orphans and children made vulnerable by HIV/AIDS (OVC), considered in section 4.3, are often a hybrid of HIV/AIDS and mainstreaming approaches, combining HIV/AIDS-specific interventions, such as HIV/AIDS and sexual health initiatives, with addressing the causes and consequences of HIV/AIDS – for instance, by working to improve access to education. Furthermore, OVC programmes may be stand-alone, or they may be integrated within development programming, or be the product of joint initiatives between HIV/AIDS and development NGOs.⁶ Nevertheless, the distinction between the two types of programming is used here to draw out ways in which different NGOs can contribute, and are contributing, to an HIV/AIDS response, both directly and indirectly.

The programming principles set out in this chapter apply to specific kinds of work undertaken by different types of NGO. Therefore the relevance of these good practice principles will depend on the nature of each NGO's work.

The positive interaction between AIDS work and development work

HIV Prevention

- Education about: modes of HIV transmission; means of preventing, or reducing the likelihood of, HIV infection; how HIV differs from AIDS
- Condom promotion and distribution
- STI treatment

Reduces susceptibility to infection, and increases effectiveness of prevention work:

- Better nutrition and health status → lower biological susceptibility
- Less poverty and livelihoods insecurity → less need to sell sex for survival
- Better health services → greater access to STI treatment and condoms and less iatrogenic infection
- Greater gender equality → women and men more able to act on prevention messages

Reduces *numbers* of people infected with HIV, and therefore numbers needing care

Education counteracts stigma by challenging misinformation about how HIV is transmitted

Promotes counselling, HIV testing, positive living and seeking treatment. Involvement of HIV+ people may provide role models for this

Care and support to HIV+ people makes AIDS more visible, which counters denial in the general population

Voluntary counselling and testing enables people to discover their HIV status and encourages safer sex practices

Care and support helps HIV+ people to accept their condition and to live positively, including practising safer sex

Reduces numbers of people infected, therefore reduces all impacts of AIDS on development

Delayed sexual initiation and use of condoms also affect non-AIDS problems, such as unwanted pregnancies and associated school drop-outs, and STIs

Development

- Poverty alleviation
- Food and livelihoods security
- Health, water and sanitation
- Education
- Humanitarian work following environmental crisis and conflict

Better health services → strengthened systems for provision of counselling, testing, treatment and care for people with AIDS

Less poverty and improved nutrition, water supply and sanitation promote health of HIV+ people

AIDS Care

- Voluntary counselling and HIV testing
- Support for positive living, including material and spiritual support
- Treatment of opportunistic infections
- Antiretroviral treatments
- Care when AIDS develops, at home or in a medical setting

Care and support reduce the impact of illness and death:

- Treatments enable HIV+ people to live and work longer
- Positive living reduces unproductive spending on 'cures', and encourages planning for death, e.g. making a will and arrangements for dependants

4.2 HIV/AIDS programming

Cross-cutting issues



Our HIV/AIDS programmes are integrated to reach and meet the diverse needs of PLHA and affected communities.

The global commitment to providing access to ARVs to the millions of people in the developing world provides new opportunities to improve the effectiveness of the HIV/AIDS response. Maximising access to life-saving drugs will improve the health status of many people living with HIV/AIDS, enhancing their well-being and their capacity to participate in society, and contribute to reducing the stigma associated with HIV/AIDS. It will also provide new incentives for people to find out their HIV status. A massive increase in the provision of voluntary counselling and testing (VCT) and investment in health infrastructure is needed to enable delivery of ARVs.⁷ This will provide new opportunities to improve the reach of HIV prevention and improve access to treatment, care and support.

In order to prevent the spread of HIV and respond to the complex effects of HIV/AIDS upon individuals, families and communities, we need to:

- ensure integration between HIV prevention, testing, treatment, care and support programmes within our own organisations, including effective referral pathways
- ensure integration between our programmes and other relevant health and related services and programmes (see also section 4.3 Mainstreaming HIV/AIDS), and
- foster strategic partnerships to facilitate effective referral to other programmes and joint initiatives to meet the diversity of needs of PLHA and affected communities (see section 3.3 Multi-sectoral partnerships).

Given that many people remain unaware of their HIV status, non-HIV/AIDS-specific health services are a vital entry point for the provision of, or referral to, VCT, HIV prevention and HIV/AIDS treatment, care and support programmes (see Voluntary testing and counselling on page 64). Sexual and reproductive health programmes are essential in reducing the risks of HIV transmission and meeting the health needs of both women and men. Preventing and treating sexually transmitted infections (STIs) reduces the risk of people transmitting and acquiring HIV.⁸ Integration of programmes and services for family planning, maternal and child health, antenatal care, and prevention and management of STIs and HIV provides a holistic approach to sexual and reproductive health.⁹ This is particularly so for women, who are likely to access such services for a range of health needs but who may not perceive themselves to be at risk of HIV infection, despite the possibility of exposure to HIV through their partner.

People living with HIV are particularly susceptible to tuberculosis, and TB accounts for up to a third of AIDS deaths worldwide.¹⁰ Interventions for TB and HIV prevention and care need to be mutually reinforcing, with joint TB/HIV interventions required to prevent HIV infection, prevent TB, and integrate TB and HIV care for PLHA.

Prevention of Mother to Child Transmission (MTCT) needs to go beyond specific interventions, such as ARVs, counselling on infant feeding¹¹ and caesarean deliveries, to include HIV and STI prevention among young women and men, quality pre-natal care, access to contraception and counselling about reproductive health options. Effective referral within networks of services enables pregnant women living with HIV/AIDS to have access to VCT services and to HIV treatment, care and support to address their own health needs. A holistic approach to sexual and reproductive health is also likely to meet the range of health needs of sex workers. It is crucial that sexual and reproductive health services are accessible and appropriate for sex workers.



Our HIV/AIDS programmes raise awareness and build the capacity of communities to respond to HIV/AIDS.

Our community education and social marketing¹² programmes need to:

- maximise communities' understanding of the consequences of HIV infection
- inform communities about how HIV is and is not transmitted
- increase capacity for risk reduction and risk elimination techniques, including how to access and use prevention commodities
- improve knowledge about and access to VCT, treatment, care and support services
- improve community knowledge about the forms, causes and effects of HIV-related stigma and discrimination
- encourage and support community leadership and community-led initiatives, and
- provide communities with opportunities to participate in addressing HIV/AIDS¹³ (see also Addressing stigma and discrimination on page 70).



We advocate for an enabling environment that protects and promotes the rights of PLHA and affected communities and supports effective HIV/AIDS programmes.

We advocate for:

- review and reform of legislation, such as public health and criminal laws, to ensure that they are appropriately applied to HIV/AIDS and that they are consistent with international human rights obligations¹⁴
- enacting or improving anti-discrimination and other protective laws and policies, including ethics in research, privacy and informed consent to testing and treatment¹⁵
- monitoring and enforcement mechanisms, including complaint systems that are appropriate for and accessible to PLHA and affected communities, to guarantee the protection of HIV-related human rights¹⁶

- establishing or improving legal and related services to enable PLHA and affected communities to know about and enforce their rights¹⁷
- reform of laws and policy that stigmatise or discriminate against PLHA and affected communities and/or undermine access to information, education and the means of prevention¹⁸
- review and reform of laws regulating HIV-related goods to ensure widespread availability of prevention commodities¹⁹
- active political and community leadership on the value and effectiveness of comprehensive harm reduction programmes for people who inject drugs
- reform of health systems to promote application of universal infection control, including safe injection practices and the securing of a safe blood supply
- the development of health service infrastructure to support comprehensive and integrated prevention, testing, treatment, care and support programmes
- wider availability of affordable male and female condoms²⁰
- HIV vaccines and microbicide development, including access to community preparedness measures,²¹ and
- access to safe, effective and affordable medications,²² including improved supply of affordable drugs by governments. This also includes international issues regarding compulsory licensing, parallel importing and low international prices for HIV/AIDS-related drugs²³ and national laws relating to regulation of HIV-related goods, to ensure widespread availability of safe and effective medication at affordable prices.²⁴

(See also sections 2.4 A human rights approach to HIV/AIDS and 3.8 Advocacy.)

Voluntary counselling and testing (VCT)



We provide and/or advocate for voluntary counselling and testing services that are accessible and confidential.

In many parts of the world severely affected by HIV/AIDS, as few as one in ten people with HIV know that they are infected.²⁵ VCT is not only a gateway to treatment, care and support for people living with HIV/AIDS, but also a critical component of HIV prevention.²⁶

Increased access to antiretroviral (ARV) therapy is likely to provide new incentives for people to know about their HIV status. It is estimated that by 2005 there will be up to 180 million people in need of VCT annually.²⁷ There is an urgent need for VCT services on a much larger scale than has occurred to date, including implementing VCT within different types of health settings in order to maximise entry points to HIV prevention and treatment, care and support.²⁸

In establishing or scaling up VCT services, we need to provide and/or advocate for VCT services that:

- are voluntary, enabling people to give their informed consent to be tested, based on pre-test information about the purpose of testing and the treatment, care and support available once the result is known
- are confidential, and

- incorporate post-test support and services that advise those who test HIV-positive on the meaning of their diagnosis, and on referral to the treatment, care and support and prevention programmes and services available to assist them. For those who test negative, post-test counselling or discussions offer an important opportunity to reflect on personal risk reduction strategies or to refer people to prevention programmes.

VCT is an important example of the ways in which public health strategies and human rights protection are mutually reinforcing. VCT protects people's rights by ensuring confidentiality, providing information about HIV transmission and personalising discussions of an individual's risk, thus enabling people to make informed decisions about testing and their own risk. In turn, this builds trust between those at risk and the health system, maximising the effectiveness of prevention programmes and ensuring access to treatment, care and support services where necessary. Mandatory testing, on the other hand, engenders fear and erodes trust and co-operation between the individual being tested and the health system, thus undermining prevention efforts.²⁹

HIV prevention

There is an impressive body of evidence and experience to guide effective HIV/AIDS prevention. Given that prevention efforts reach fewer than one in five of those at risk, one of the most significant challenges we now face is ensuring that this knowledge is consistently applied in scaling up prevention efforts to reach the millions of people at risk of HIV infection worldwide³⁰ (see section 3.10 Scaling up).



We provide and/or advocate for comprehensive HIV prevention programmes to meet the variety of needs of individuals and communities.

Multiple prevention approaches must be employed in combination in order to support individual behaviour change, influence the social norms regarding risk behaviours and address social, economic, legal and policy barriers to effective prevention. Prevention programmes that ensure that the whole spectrum of prevention options is available to those most at risk, including access to and use of condoms and sterile injecting equipment, have been shown to substantially reduce new HIV infection throughout the world.³¹

We need to provide and/or advocate for a comprehensive range of HIV prevention strategies that include:

- accessible and appropriate information about the risks of HIV infection and means of prevention in relation to these risks
- tailored information, education and communication programmes, including sexual health promotion, counselling, discussion groups and peer support
- access to and information about the use of commodities for prevention, including male and female condoms and/or sterile injecting equipment
- social marketing and community education programmes that mobilise communities and influence community norms to support and sustain safer behaviours

- access to voluntary counselling and testing and treatment, care and support programmes, including prevention of MTCT, and
- advocacy efforts to address social, economic, legal and cultural barriers to effective HIV prevention.

There is no evidence that single-focus HIV prevention strategies, such as the provision of condoms alone or abstinence-only approaches, are effective in preventing HIV transmission.^{32,33} Single-focus abstinence programmes, particularly for young people, are a response to concerns that comprehensive sexual health and HIV programmes for young people will hasten sexual debut or lead to promiscuity. However, an analysis of research regarding the impact of sexual health and HIV programming on the age of sexual debut of young people and levels of sexual activity does not bear out these concerns.³⁴ An analysis of national-level survey data from Uganda concluded that among the range of interventions employed in that country – including abstinence, delays in sexual debut, reducing the number of sexual partners and increased condom use – increased abstinence by itself may have made the smallest contribution to lowering the risk of HIV transmission. Interventions had a far greater effect in reducing the number of sexual partners and increasing condom use than they did on the proportion of young people abstaining from sex.³⁵

In the context of individual behaviour change, abstinence, fidelity and use of condoms (ABC: *Abstinence Be Faithful Condoms*) all have a role to play in reducing HIV transmission. However, it is critical that abstinence and fidelity are not promoted as the preferred approach, with condoms as a last resort, thereby stigmatising condom use. People vulnerable to HIV infection must have access to the full range of prevention options, provided in a manner that is free of judgement, in order for people to be empowered to assess their own risk and make informed decisions about adopting practices appropriate for them. In relation to sexual behaviour, this may include abstaining from sexual activity, reducing the number of sexual partners, delaying commencement of sexual activity, deciding to be faithful to one partner, accessing treatment for STIs and using condoms to prevent HIV and other STIs. In relation to injecting drug use, this may include abstaining from, stopping or reducing drug use, accessing drug treatment, utilising non-injecting methods of drug use and effective use of sterile injecting equipment.

Furthermore the ABC approach, while promoted as a comprehensive approach to HIV prevention, is focused on individual behaviour alone and does not address the societal factors that shape vulnerability. Fidelity requires the agreement of both people in a relationship and does not take into account previous experience or HIV/AIDS status of the individuals involved. Where there is unequal power in sexual relationships, women and girls often do not have the power to negotiate condom use. Sexual violence and coercion, both inside and outside marriage, in peacetime and in conflict, increase the threat of HIV infection for women and girls.³⁶ This underscores the need for a comprehensive approach to HIV prevention that addresses the underlying causes of vulnerability to HIV and its consequences.



Our HIV prevention programmes enable individuals to develop the skills to protect themselves and/or others from HIV infection.

Information, education and communication (IEC) programmes can comprise a range of approaches, including:

- mass media to inform and establish positive community norms for sustaining safer behaviours for prevention of HIV transmission
- intensive, interactive and personalised counselling, and
- discussion groups and peer support.

We need to address the needs of PLHA and people vulnerable to HIV infection by providing IEC programmes that:

- establish positive community norms for sustaining safer behaviours
- equip people with the necessary understanding and skills to reduce their risk of infection and reduce the risk of transmitting HIV by adopting and sustaining safer sex, safer injecting practices and/or making informed decisions about treatment, birthing and feeding practices to reduce mother-to-child transmission
- provide information, support and strategies to cope with sustaining safer behaviours
- enable discussion of problems and issues people may encounter in sexual and emotional relationships, including the real-life difficulties of sero-discordant relationships, disclosure to sexual partners and the risks of re-infection with different strains of virus where relevant because of the availability of ARV therapies, and
- cover household hygiene and infection precautions.



Our HIV prevention programmes ensure that individuals have access to and information about the use of commodities to prevent HIV infection.

Tailored resources and commodities need to be provided for those who cannot afford or access them. These include:

- condoms and lubricant, including choices that exist locally and information on how to use them effectively, and alternatives such as the female condom³⁷
- sterile injecting equipment, or in its absence commodities for effective sterilisation, such as bleach, and information on how to use them
- commodities provided through outreach programmes to sites and settings where sexual and drug-taking activity occurs, such as commercial sex premises, non-commercial outdoor sites where people meet to make sexual encounters and places where drug injecting commonly occurs
- commodities provided through a variety of healthcare settings, such as sexual and reproductive health programmes, and
- targeted resources to accompany the distribution of commodities, to ensure their effective use and to promote access to VCT, HIV prevention and treatment, care and support programmes.



We provide and/or advocate for comprehensive harm reduction programmes for people who inject drugs.

The term **harm reduction** refers to policies and programmes that aim to prevent or reduce the harms associated with injecting drug use.³⁸

Injecting drug use is a major factor in epidemics in Asia, North America, Western Europe, parts of Latin America, the Middle East and Northern Africa. In some Eastern European countries, especially the countries of the former Soviet Union, injecting drug use is driving an epidemic among young people.³⁹ A comprehensive range of harm reduction interventions is essential to effectively address the risks of HIV transmission among people who inject drugs.

We need to provide and/or advocate for comprehensive harm reduction programmes that:

- provide appropriately targeted information preventing HIV transmission, including access to sterile injecting equipment⁴⁰
- provide HIV information, education and communication programmes for people who inject drugs⁴¹
- provide access to treatment for drug dependence, including substitution treatments such as methadone⁴²
- use community outreach strategies to enable people who inject drugs to access HIV prevention information, the means of prevention, drug treatment, VCT and treatment, care and support programmes,⁴³ and
- address the HIV prevention and treatment, care and support needs of prisoners.⁴⁴

Treatment, care and support

Health systems in the worst-affected countries are often ill-equipped to meet the basic health needs of communities, let alone to provide a comprehensive range of treatment,⁴⁵ care and support services for PLHA, their partners, family members and carers. Nonetheless, the global commitment to expand access to ARVs provides new opportunities to advocate for an approach to scaling up that strengthens health systems and builds community capacity. In contexts where health infrastructure is weak and resources are limited, the good practice principles can guide NGOs in advocating for comprehensive and integrated treatment, care and support programmes.

The impact of HIV/AIDS on PLHA, their families, partners, dependants and carers are complex and far-reaching, and include:

- despair about the consequences of progression of the disease, the effects of illness, the possibility of death and the effects of bereavement
- fear of becoming infected or infecting others
- social isolation, including deterioration of family relationships and reduction or loss of social status

- economic implications, including reduction or loss of livelihood or employment, inability to support dependants, pressures on children and young people to provide for or contribute to meeting families' economic and care needs, and
- the many manifestations of stigma and discrimination.

While this section provides good practice principles in HIV/AIDS-related treatment, care and support, the complex consequences of HIV/AIDS on individuals, families and communities underscore the need to foster strategic partnerships to facilitate effective referral to other programmes and joint initiatives to meet the diversity of needs of PLHA and affected communities (see sections 3.3 Multi-sectoral partnerships and 4.3 Mainstreaming HIV/AIDS).



We provide and/or advocate for comprehensive treatment, care and support programmes.

Generally, individual NGOs provide only some components of comprehensive treatment, care and support services and programmes, most often home-based care and support programmes, although there are NGOs that provide a wider range of services, including clinical services.

We need to provide and/or advocate for a comprehensive and integrated range of treatment, care and support services and programmes,⁴⁶ including:

- accessible and high-quality VCT services (see Voluntary testing and counselling on page 64)
- tailored health information on ARV treatment, including side-effects and adherence issues; treatment for opportunistic infections; and available HIV prevention, care and support services and related health issues, including TB, STI and HIV prevention programmes
- tailored support programmes, including counselling, discussion groups, peer support and spiritual support
- care services, including home-based care, nursing care and palliative care
- HIV treatment programmes, including clinical management of opportunistic infection and HIV-related illness, monitoring and management of disease progression and access to ARV therapy (see also good practice principle in advocating for an enabling environment, including access to treatment, in section 3.8 Advocacy on page 50)
- treatment and prevention of TB and STIs⁴⁷
- support and assistance in relation to non-clinical aspects of treatment, including peer support, adherence and nutritional needs
- information about household hygiene and sterilisation precautions
- a range of support programmes including food, clothing and legal assistance and socio-economic support, and
- support, respite and training for family members and carers of PLHA.

(See also section 4.3 Mainstreaming HIV/AIDS.)



We enable PLHA and affected communities to meet their treatment, care and support needs.

When providing treatment, care and support services for PLHA, we need to:

- involve PLHA, their families, partners, dependants and carers in programme design, implementation and evaluation.⁴⁸ This includes the process of building literacy on ARV treatment and HIV health in preparing communities for access to ARV treatment, to ensure that treatment service providers understand community beliefs, knowledge and needs⁴⁹
- provide individual assessment of the treatment, care and support needs of PLHA, taking into consideration the needs of their partners, children, other family members and carers
- provide tailored support programmes that enable people to deal with the consequences of HIV and make informed decisions about their treatment, care and support needs, and
- ensure that the social, economic and psychosocial affects of HIV/AIDS on PLHA, their family and carers are addressed (see Development and humanitarian programmes in section 4.3 on page 76).

An essential part of the response to HIV/AIDS has been, and will continue to be, home- and community-based care. Our care and support programmes need to support partners, other family members, and friends and volunteers providing care and support for PLHA by:

- providing training and resources to ensure carers have appropriate information about HIV/AIDS prevention and care and knowledge of available health services
- supporting carers to develop and maintain the necessary skills to provide quality care, and
- ensuring carers are supported to avoid burn-out, through counselling, peer and social support and respite.

Addressing stigma and discrimination

Stigma is a process of producing and reproducing inequitable power relations, where negative attitudes towards a group of people, on the basis of particular attributes such as their HIV status, gender, sexuality or behaviour, are created and sustained to legitimatise dominant groups in society. **Discrimination** is a manifestation of stigma. Discrimination is any form of arbitrary distinction, exclusion or restriction, whether by action or omission, based on a stigmatised attribute.

HIV-related stigma and discrimination emerge from and reinforce pre-existing gender, race and socio-economic inequities and prejudices about injecting drug use, sex work and men who have sex with men. Pre-existing prejudices and inequities, combined with fears about HIV infection, provide a fertile environment for HIV-related stigma and discrimination to flourish.⁵⁰ A significant body of research demonstrates that HIV-related stigma and discrimination is widespread: for example, police harassment of sex workers, injecting drug users and men who have sex with men;

PLHA being refused access to health care; breaches of confidentiality; discrimination in employment; and sexual abuse and violence against women and girls.⁵¹ Families, partners and children of PLHA also frequently bear the burden of stigma and discrimination.⁵²

Stigma and discrimination compound vulnerability, and have damaging health, financial, social and emotional consequences for PLHA and affected communities. The effect of stigmatisation and discrimination is to alienate those most affected by HIV/AIDS, making people fearful of knowing their status, adopting preventive measures and accessing counselling, testing, treatment, care and support services.⁵³ Experience of stigma and discrimination, as well as fear of them, can be internalised, resulting in self-isolation, undermining people's self-esteem, their capacity to sustain safer behaviours and their motivation to exercise control over their own health.⁵⁴

In order to address stigma and discrimination, multiple approaches are needed to ensure that:

- individuals know about their rights, and are supported to respond to stigma, discrimination and their consequences
- communities are supported to examine the nature and impact of stigma and discrimination and play an active role in preventing and eliminating stigma and discrimination
- institutions, such as workplaces and healthcare settings, are supported to promote non-discrimination through effective workplace policies and programmes, and
- laws and policy do not stigmatise PLHA and affected communities.

(See also section 2.4 A human rights approach to HIV/AIDS; section 3.8 Advocacy; and advocating for an enabling environment in Cross-cutting issues for HIV/AIDS programming on page 62).



We enable PLHA and affected communities to understand their rights and respond to discrimination and its consequences.

Individuals and communities must be able to name their experience as one of discrimination, understand their rights and have sufficient information and resources in order to take action in response to any discrimination they experience.

We need to provide PLHA and affected communities with:

- easily accessible information about their rights
- advice and support to take action in response to discrimination, through individual advocacy services or effective referral to agencies that can provide them, such as human rights organisations, legal services and unions, and
- support in responding to and addressing the consequences of discrimination, including peer support, counselling, discussion groups and effective referral to housing, employment and related services.



We monitor and respond to systemic discrimination.

Monitoring HIV-related stigma and discrimination, raising awareness about their impact and utilising this knowledge to inform education and advocacy efforts is essential in combating the epidemic. It is important that programmes incorporate a systematic approach to documenting and analysing people's experiences of stigma and discrimination and their efforts to respond to discrimination, in order to understand:

- the nature of stigma and discrimination within a given context, and
- the experiences of individuals and communities of using anti-discrimination complaint mechanisms, other legislatively-based complaint mechanisms and informal strategies for addressing discrimination.

Relevant research, including data derived from monitoring the experiences of stigma and discrimination of PLHA and affected communities, can be used to:

- identify systemic discrimination in particular settings, such as health care, employment, education and prisons
- identify specific institutions that promote stigmatisation of PLHA and affected communities, such as police services, immigration authorities,⁵⁵ military services, and the media
- prioritise and inform targeted advocacy and education initiatives in settings where discrimination is common, and
- inform advocacy efforts to reform laws and policies that stigmatise PLHA and affected communities (see advocating for an enabling environment in Cross-cutting issues in HIV/AIDS programming on page 62).

For example, where widespread discrimination in healthcare settings occurs, priority could be given to advocating for the development and implementation of HIV policies and practices that prevent discrimination, including effective procedures to ensure that:

- confidentiality is protected
- testing is voluntary and supported by pre- and post-test counselling
- informed consent is given to testing and treatment
- universal infection control is applied
- staff are trained to support implementation of anti-discrimination policies in practice, and
- complaint mechanisms are available and accessible to address discrimination when it occurs.



We enable communities to understand and address HIV/AIDS-related stigma.

We need to address stigmatisation of PLHA and affected communities by:⁵⁶

- involving them in the design, delivery and evaluation of programmes designed to address stigma and discrimination
- enhancing community knowledge about the forms, causes and effects of HIV-related stigma and discrimination
- creating opportunities for communities to examine their prejudices and address fears and misconceptions about transmission of HIV
- utilising a range of strategies, including public awareness campaigns, participatory workshop activities and active involvement by communities, in delivery of prevention and care programmes, and
- involving political, religious and community leaders in challenging HIV-related stigma and discrimination.⁵⁷



We foster partnerships with human rights institutions, legal services and unions to promote and protect the human rights of PLHA and affected communities.

We need to foster partnerships with human rights organisations and institutions, legal services, lawyers, unions and related advocacy agencies in order to:

- develop awareness of HIV-related stigma and discrimination and encourage the development of HIV-related legal and advocacy expertise
- ensure access to legal advice and advocacy for individuals seeking to enforce their rights
- ensure access to organisations and individuals who can assist in training staff and volunteers on HIV-related legal issues and referral networks, and
- develop joint advocacy strategies and programmes, including among NGOs with human rights expertise and other NGOs responding to HIV/AIDS, to prevent and respond to HIV-related discrimination and stigma and promote the protection of human rights more broadly, including promoting the rights of women and children and addressing the underlying causes of vulnerability, such as poverty and inequities in access to education.

(See also section 3.3 Multi-sectoral partnerships and the good practice principle on advocating for law and policy reform to address the underlying causes of vulnerability to HIV/AIDS on page 83).

4.3 Mainstreaming HIV/AIDS

Section 4.1 defines ‘mainstreaming HIV/AIDS’ and considers its inter-relationship with HIV/AIDS programming. Mainstreaming HIV/AIDS is a learning process that requires changing attitudes, developing skills and understanding the effects of HIV/AIDS in communities in order to adapt development and humanitarian programming to respond effectively. Mainstreaming requires organisational changes as well as changes to programming. In relation to the organisational changes necessary to support effective mainstreaming, see Chapter 3 – Organisational Principles, particularly Section 3.5 Organisational mission and management; section 3.6 Programme planning, monitoring and evaluation; and Section 3.10 Scaling up. This section focuses on mainstreaming HIV/AIDS in development and humanitarian programmes.

The process of mainstreaming HIV/AIDS



We review our development and humanitarian programmes to assess their relevance to reducing vulnerability to HIV infection and addressing the consequences of HIV/AIDS.

The nature of development and humanitarian work means that all the people with whom we work are likely to be vulnerable to HIV/AIDS and its consequences to some extent. However, a sharper focus on how HIV and AIDS have changed the context for development and humanitarian work is needed, to enable the expertise of development and humanitarian NGOs to be brought to bear in responding to the causes and consequences of HIV/AIDS.

Development and humanitarian NGOs need to explore and understand the way HIV and AIDS affect people’s daily lives: in income-generating activities such as agriculture, trading or holding a job; in household activities such as raising children, attending school, caring for family members who are ill, and managing one’s own illness; and in how people engage in their communities.⁵⁸ The increased burden of illness and caring for those who are sick most often falls on women and girls and older family members, such as grandparents. In turn, this affects people’s capacity to participate in the community, rendering them invisible and reducing their access to development and humanitarian programmes. Poverty escalates as the result of illness or death of an income-generating family member. Changes in household composition, such as child-headed, female-headed or grandparent-headed households, may mean that programmes need to be targeted differently or ways of working need to be adjusted in order to reach those who need them and address their particular needs.

Humanitarian NGOs need to understand the nature of vulnerability to HIV infection and the implications of HIV/AIDS in emergency settings. Emergencies involve an array of factors that affect vulnerability to HIV infection and compound the affects of HIV/AIDS:

- poverty and social instability affect the cohesion of families and communities, often weakening social norms that regulate behaviour
- women and children are at increased risk of violence, and can be forced into having sex to gain access to basic needs such as food, water and sanitation
- displacement can bring populations, each with different HIV prevalence levels, into contact with one another
- health infrastructure may be stressed, affecting access to basic care for PLHA and affected communities, and
- poor infection control, lack of availability of condoms and the presence of military forces, peacekeepers or other armed groups can contribute to increased transmission rates.⁵⁹

Mainstreaming HIV/AIDS is a learning process that requires development and humanitarian NGOs to understand:

- how HIV and AIDS change the context for their programming and affect the nature of their work
- whether and how programmes may reduce or inadvertently increase vulnerability,⁶⁰ and
- how specific programmes can respond to vulnerability to HIV/AIDS and its impacts, given the particular expertise of NGOs.

Community research is vital to understanding the way in which HIV and AIDS affect people in a given context.⁶¹ We need to involve PLHA and affected communities, including families, partners, dependants and carers of PLHA, in participatory assessment to understand and respond to unmet needs, and in the design, implementation and evaluation of programmes that are adapted to meet identified needs⁶² (see sections 3.2 Involvement of PLHA and affected communities and 3.10 Scaling up).



We work in partnerships to maximise the access of PLHA and affected communities to an integrated range of programmes to meet their needs.

We need to focus on our own unique expertise, while working in partnerships with organisations that can address the needs of PLHA and affected communities. Effective referral systems and partnership initiatives between HIV/AIDS programmes and development and humanitarian programmes ensure that PLHA and affected communities have easy access to the range of services and programmes that are appropriate to meet their needs. Measures to address the material and psychosocial needs of PLHA and their families, partners, dependants and carers are also considered in the section on Treatment, care and support in section 4.2 HIV/AIDS programming on page 68 (see also section 3.3 Multi-sectoral partnerships and Cross-cutting issues in section 4.2 on page 62).

Development and humanitarian programmes

Compared with the wealth of knowledge and experience accumulated in HIV/AIDS programming, experience in mainstreaming HIV/AIDS is still relatively limited. Given this, rather than outlining good practice principles informed by evidence, this section draws on experiences to date by providing some examples of how specific kinds of initiative may be adapted to pay particular attention to HIV/AIDS, in the context of long-term development and humanitarian work.⁶³ These experiences highlight the need to learn by doing, to share experiences and to improve our capacity to monitor and evaluate the effectiveness of our efforts.⁶⁴ In turn, this will support advocacy for other sectors to mainstream HIV/AIDS within their core business and the mobilisation of more resources for mainstreaming HIV/AIDS (see sections 3.6 Programme planning, monitoring and evaluation and 3.9 Research).



We design or adapt development programmes to reduce vulnerability to HIV infection and meet the needs of PLHA and affected communities.

HIV/AIDS is having a major impact on household **food security, nutrition, and livelihoods**, most visibly in high-prevalence countries. Household food security declines as HIV/AIDS-related illness and death affects agricultural production, transmission of knowledge about farming practices, availability of labour and seasonal employment opportunities for labourers. Food availability decreases through falling production; food access declines due to loss of income; and food utilisation is compromised because of changes in the type and quantity of food consumed. As food consumption declines, malnutrition increases. Malnutrition inhibits immunity to disease and increases the likelihood of opportunistic infections among PLHA.

The need for food can lead to the sale of productive assets, undermining long-term food security; encourage families to withdraw children, especially girls, from school; and result in coping strategies that increase the risk of HIV transmission, notably migration for work and selling sex. The common impact is a decline in income, savings and livelihood opportunities that can increase household and community vulnerability. The impact on individual households depends on a variety of factors, such as economic status, size of the household, which family/members are ill, and the strength of social networks and support.

We need to ensure that development programmes:

- reach households where there are limited employment options, where food supplies are insecure and/or income-generating capacity is affected by HIV/AIDS-related illness or death, and where there is reduced productivity due to increased burden of care, and/or changes in family composition, including grandparent-, women- and child-headed households⁶⁵
- support the capacity of individuals, households and communities to be resilient in the event of ill health, including strategies such as building up protective assets and preserving and investing in family and community relationships⁶⁶

- develop and promote technologies and approaches that address changes in labour and other resources
- facilitate the transfer of traditional and institutional knowledge about life skills and livelihoods across generations
- assess the wider effects of HIV/AIDS, beyond the household, to address the impacts on social systems, human capital, infrastructure, environment and other community assets, and
- track changes in vulnerability over time as households and communities respond and adapt to the impact of HIV/AIDS, and respond accordingly.

Different kinds of development programme can be adapted to respond to the ways that HIV/AIDS has affected the lives of individuals, families and communities. The following are some examples.

Agricultural programmes have a vital role to play in reducing vulnerability to HIV/AIDS and its impacts among rural communities. Several studies have found that agricultural outputs fall by up to 50 per cent in AIDS-affected households, not only decimating earnings, but also leading to a reduction in land under cultivation, the forced sale of productive assets and loss of knowledge as families revert to subsistence crops.⁶⁷

NGOs providing agricultural programmes need to:

- develop and promote labour-saving agricultural technologies
- promote appropriate diversification of crop production, including introduction of new, appropriate technologies that match the labour and nutrition needs of affected households, and
- ensure that PLHA and affected communities have access to appropriate credit, tools and knowledge, such as transfer of customary and institutional knowledge about agricultural practices and skills across generations.

Adjustments to agricultural programmes may include:

- use of threshing machines, mills, wheelbarrows and carts to reduce demands on labour-constrained households
- tools and techniques that are better suited to young, elderly or weak people
- livestock that is better suited to vulnerable households in producing quick returns and aiding accumulation of assets, such as rabbits and chickens, which are easier to look after and reproduce more rapidly
- composting, mulching and applying manure and ashes from the burning of crop residue to increase production, without the use of expensive chemicals⁶⁸
- locating production outside the home, including in kitchen gardens, and intercropping to reduce weeding work.⁶⁹

Micro-finance projects or savings and credit schemes can help households to increase their income and build up assets, so as to reduce their vulnerability to HIV/AIDS and to address its consequences. NGOs providing **micro-finance** and **micro-credit schemes** need to consider how these schemes can be adapted to meet the needs of PLHA and affected communities, without compromising the sustainability of such initiatives. Approaches to doing so may include:

- flexibility in rules governing schemes and allowing for breaks within the savings and credit cycle while retaining membership

- introducing rules to protect the savings of married women, which may otherwise be acquired by their husbands' relatives if they are widowed
- enabling household members to take on responsibility for, or take over, loans if the original member becomes ill or dies, and
- setting up a simple community bank so that people excluded from credit schemes because they are too economically vulnerable can save money and, in time, gain access to the credit facilities of the micro-financing scheme.⁷⁰

The dual challenges of HIV/AIDS and unsafe **water and sanitation** predominantly affect poor and marginalised populations, particularly women and girls and PLHA. Collecting water can make woman and girls vulnerable to sexual violence. Lack of water can force women and girls to exchange sex for access to resources.⁷¹ Water and sanitation issues also affect PLHA, as unsafe water and food often cause diarrhoea, which hastens the progression of HIV-related disease. Access to safe and adequate water is also essential for people taking medicines.

Adjustments to water and sanitation programmes to address access to, and safety of, water for PLHA and affected communities may include:⁷²

- establishing a management role in water and sanitation projects for women's groups, particularly widows and other marginalised women, and making them the caretakers of water points, with appropriate incentives for their time
- establishing a safety net to ensure access for the poorest households, who cannot afford to pay for access
- establishing community mobilisation strategies around access to safe water, including addressing misconceptions about contamination of water with HIV and raising awareness among all community members about the rights of PLHA and affected communities, particularly women and girls, and their access to facilities
- establishing mechanisms for reporting and handling complaints regarding access
- placing latrines and water points appropriately to reduce risk of sexual violence
- involving PLHA and women's groups in the promotion of point-of-use safe water treatments
- ensuring safe water strategies and education in all clinic- and community-based HIV/AIDS programmes, including home-based care of PLHA, and
- ensuring safe water and hygiene education in all antenatal care, and that HIV-positive mothers who choose formula feeding have access to safe water.



We ensure that our humanitarian programmes reduce vulnerability to HIV infection and address the needs of PLHA and affected communities.

Increasingly, attention is being directed to addressing vulnerability to HIV infection and the effects of HIV/AIDS in emergency settings, including natural crises such as droughts and earthquakes, as well as situations of armed conflict.⁷³ Humanitarian work in emergency settings has much in common with development work, where programmes address the water and sanitation, food security, housing and healthcare needs of people who are not displaced from their homes.

The Inter-Agency Standing Committee's *Guidelines for HIV/AIDS Interventions in Emergency Settings* (the *Guidelines*) utilise a range of strategies to address vulnerability and the effects of HIV/AIDS, including HIV/AIDS-specific responses such as making condoms available, integrating HIV/AIDS within sexual health and wider primary healthcare programmes, and mainstreaming HIV/AIDS (for example, taking HIV/AIDS into consideration when planning water and sanitation facilities).

The *Guidelines* provide detailed guidance on considering the HIV/AIDS dimensions of emergencies in the preparedness phase, minimum responses in the midst of emergencies, and comprehensive responses in the stabilised phase, in each of the following **sectoral responses**:

- coordination
- assessment and monitoring
- protection
- water and sanitation
- food security and nutrition
- shelter and site planning
- health
- education
- behaviour change communication and information, education and communication (IEC), and
- HIV/AIDS in the workplace.⁷⁴

The extent to which it is possible to mainstream HIV/AIDS in an emergency setting depends upon the stage of the emergency. In the emergency preparedness phase, depending on the different role of NGOs, preparation for an effective response to HIV/AIDS in emergencies should include:

- developing indicators and tools for assessing HIV/AIDS risk and vulnerability in a given context
- including HIV/AIDS in humanitarian action plans and training relief staff on HIV/AIDS, gender and non-discrimination
- protecting and promoting the human rights of PLHA and affected communities, including minimising the risk of sexual violence, exploitation and HIV-related discrimination, and
- planning interventions, developing resources and training staff on the special needs of PLHA and affected communities in each of the areas of sectoral response outlined above.⁷⁵

The *Guidelines* provide **minimum standards** for responses in the midst of emergency and **comprehensive responses** for the stabilised phase of emergencies, in relation to each of the sectoral responses outlined above. Different aspects of each of these responses can be adapted to

respond to the ways that HIV/AIDS has affected the lives of individuals, families and communities in emergencies. The following are some examples.

Targeting food aid to HIV/AIDS-affected households is complex, given that the vast majority of people in developing countries are not aware of their HIV status, both because of a lack of availability of testing and fear of testing due to the stigma associated with HIV/AIDS. When providing **food security and nutrition programmes**, food aid needs to reach PLHA and affected communities and the nutritional needs of PLHA need to be addressed. In order to do this, we need to:

- target food-insecure individuals, regardless of their HIV/AIDS status, paying attention to female-, child- and elderly-headed households, families supporting OVC and families caring for chronically ill people
- ensure food aid does not increase stigmatisation when provided to PLHA and affected communities
- plan food baskets that accurately reflect the dietary and nutritional needs of PLHA, including adequate intakes of energy, protein and micronutrients essential to coping with HIV and fighting opportunistic infections, and
- strengthen community capacity to respond to the needs of PLHA and affected communities, including ensuring access to programmes designed to address long-term food insecurity.⁷⁶

Sites in emergencies may take the form of dispersed settlements, mass accommodation in existing shelters or organised camps. When **planning sites and providing shelter**, we need to consider safety and access issues for PLHA and affected communities, including:

- layout of shelters and location of, and access to, facilities that reduce the physical risks for women and girls, such as separate toilet blocks for men and women, and
- layout of shelters and location of, and access to, facilities that address the vulnerability of separated children, especially girls and female-headed households, PLHA and/or those with chronic health conditions.⁷⁷

When providing **health programmes**, NGOs need to integrate HIV prevention and ensure access to basic health care for PLHA and those vulnerable to HIV and its consequences, including:

- ensuring access to basic health care for PLHA and those vulnerable to HIV/AIDS and its consequences
- ensuring a safe blood supply and implementation of universal infection control
- securing condom supplies, together with effective condom distribution and appropriate information for their effective use
- ensuring comprehensive management of STIs, reducing their incidence by preventing transmission through safer sex promotion and treating curable STIs to reduce their prevalence
- ensuring appropriate care for people who inject drugs, including risk reduction information and access to needles and syringes
- ensuring safe and clean delivery of babies, and
- managing the consequences of sexual violence.⁷⁸



Our programmes for orphans and vulnerable children affected by HIV/AIDS (OVC) are child-centred, family- and community-focused and rights-based.

Why do we use the term ‘orphans and children made vulnerable by HIV/AIDS (OVC)’?

Children are affected by HIV/AIDS in a multitude of ways, and not only when a parent dies of AIDS. There are increasing numbers of children living with sick or dying parents. Children are often required to drop out of school to provide care or generate an income for the family. Many children affected by HIV/AIDS are excluded, abused and subjected to stigma and discrimination.

Programmes for orphans and children made vulnerable by HIV/AIDS (OVC) are often a hybrid of both HIV/AIDS and mainstreaming approaches. This section illustrates the use of a human rights approach to programming and the need for partnership approaches that involve different types of expertise in addressing the vulnerability of a particular population group to HIV/AIDS and its consequences (see also sections 2.5 Cross-cutting issues: addressing population vulnerability and 3.3 Multi-sectoral partnerships).

Rights-based approaches to programming for OVC are guided by the principles set out in the Convention on the Rights of the Child (CRC – see Chapter 2). The principles in the CRC include:

- the right to survival, well-being and development
- non-discrimination (see Chapter 2 and section 3.7 Access and equity)
- giving primacy to the best interests of the child in all actions regarding him or her
- fostering participation of children, including the right to express their views freely in all matters affecting them, the right to freedom of expression, and freedom to seek, receive and impart information and ideas of all kinds
- protecting children from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, and
- protecting children from economic exploitation and from performing any work that is likely to be hazardous or to interfere with the child’s education, or to be harmful to the child’s health or physical, mental, spiritual, moral or social development.⁷⁹

OVC programmes need to:

- involve children and young people as active participants
- increase the capacity of children and young people to meet their own needs, through access to quality education, protection from exploitation and developing the skills to care for themselves
- recognise that families and communities are the primary social safety net for OVC and strengthen community-based responses, including engaging leaders in responding to the needs of OVC
- support parents living with HIV/AIDS to fulfil their parenting role, including succession planning for children

- strengthen the caring capacity of families and communities to protect and care for OVC by provision of economic, material and psychosocial support and development of life skills of children, parents and carers (see Treatment, care and support in section 4.2)
- ensure that OVC have access to essential services, including birth registration, schooling, health and nutrition services, safe water and sanitation, and appropriate placement services for those without family or community care⁸⁰
- support children facing stigma and discrimination to cope with and respond to their situation (see Addressing stigma and discrimination in section 4.2)
- pay particular attention to the roles of girls and boys and women and men, including addressing gender roles and norms that affect the vulnerability of women and girls to HIV/AIDS and its consequences
- build and strengthen partnerships with governments, donors, the public sector and the full range of NGOs to coordinate responses, and
- develop responses that are sustainable and capable of replication to meet the long-term needs of OVC.⁸¹



We advocate for an environment that supports effective mainstreaming of HIV/AIDS.

It is critical that global resource mobilisation for the HIV/AIDS response provides additional resources, and that resources are not merely shifted from development work to HIV/AIDS programming or vice versa. Resources for sustainable development initiatives need to be expanded in order to support mainstreaming of HIV/AIDS, just as additional resources are required for HIV/AIDS programming. To bring this about, we need to contribute to creating an environment where there is a common understanding about what mainstreaming HIV/AIDS means and how it can best be achieved.

Given that mainstreaming HIV/AIDS is evolving and evidence of its effectiveness is still limited, it is often difficult to mobilise different sectors to mainstream HIV/AIDS within their core business or raise additional resources to support mainstreaming.⁸² However, there are also factors that give impetus to advocating for the need for mainstreaming HIV/AIDS, including:

- a growing recognition that HIV/AIDS work alone does not address the underlying causes of vulnerability to HIV/AIDS and its effects
- the fact that in countries worst affected the impacts of HIV/AIDS are impossible to ignore, and
- recognition that mainstreaming HIV/AIDS draws on the existing expertise and capacity of different sectors that can and should be applied to addressing HIV/AIDS and its impacts through their core business.

We can contribute to creating and sustaining an environment that supports mainstreaming HIV/AIDS by:

- learning by doing, sharing experiences and improving capacity to monitor and evaluate mainstreaming initiatives
- conducting, participating in and/or advocating for research to improve understanding about what is effective

- advocating for governments and private and public sector agencies to mainstream HIV/AIDS within their core business
- advocating for mainstreaming within the HIV/AIDS, humanitarian and development sectors
- advocating for transparency in resource allocation to ensure additional resources are provided for mainstreaming of HIV/AIDS and for specific HIV/AIDS programming, and
- advocating for inclusion of mainstreaming HIV/AIDS within strategic national AIDS frameworks.



We advocate for an enabling environment that addresses the underlying causes of vulnerability to HIV/AIDS.

We need to advocate for review and reform of laws and policy to ensure:

- gender equity for women in accessing credit and income-generating activities and property ownership
- universal birth registration
- protection of the inheritance rights of widows and orphans
- protection of access to land, natural resources, services and credit for PLHA and affected communities
- protection of children against neglect and abuse (physical, sexual and emotional)
- prohibition of exploitative and harmful child labour
- availability and accessibility of social welfare support
- regulation of institutional facilities caring for children, including locating family and community-based care as soon as practicable
- access to education for both girls and boys, especially for girls⁸³ (see discussion on education below), and
- appropriate placement and guardianship of children who lack adequate adult care.

(See also sections 2.4 A human rights approach to HIV/AIDS and 3.8 Advocacy.)

HIV/AIDS is spreading most rapidly among young women aged 15-24. Improving access to education for girls and boys can make a powerful contribution to reducing vulnerability to HIV infection and the impacts of HIV/AIDS, both directly and indirectly. The UN Millennium Declaration recognises that universal access to primary education and equal access for girls and boys to all levels of education are vital in making the right to development a reality.⁸⁴ Literate women are four times more likely than illiterate women to know the main ways to avoid HIV/AIDS.⁸⁵ Education also accelerates behaviour change among young men, making them more receptive to prevention messages and more likely to adopt condom use.⁸⁶

NGOs working to improve access to, and quality of, education need to advocate for:

- a diverse range of educational opportunities, including vocational training to enhance income-generating opportunities
- education that enables individuals to develop life skills that will enhance their capacity to reflect on problems, find solutions, make decisions and acquire skills to earn a living
- strategies to ensure that educational environments are non-discriminatory, that they challenge

gender roles and norms and that they encourage changes in attitudes and behaviour that affect the vulnerability of women and girls

- strategies to ensure that educational environments do not expose students to vulnerability to HIV infection, including implementation of policies and procedures for universal infection control and the prevention of sexual exploitation
- strategies to address exclusion from learning of children vulnerable to HIV/AIDS and its impacts, including reducing fees and the cash costs of school attendance, and flexible programming to enable children with competing responsibilities to attend
- creating incentives for school attendance, such as provision of meals
- integration of HIV prevention within the curriculum, including information on sexual health and HIV transmission, and
- effective referral to HIV/AIDS programmes to address the needs of children and young people living with and affected by HIV/AIDS (see section 4.2 HIV/AIDS programming).

Notes

- 1 In *Mainstreaming HIV/AIDS in Development and Humanitarian Programmes*, (Holden, S., Oxfam, ActionAid and Save the Children, 2004) the author refers to this as 'AIDS work' and 'integrated AIDS work', p.15. See pp.16-17 for a discussion of similarities and differences between AIDS work and mainstreaming HIV/AIDS externally.
- 2 In the same publication, the author distinguishes between mainstreaming HIV/AIDS internally, which refers to addressing HIV/AIDS within the organisational environment, and mainstreaming HIV/AIDS externally, which refers to adapting programmes. The extent to which mainstreaming HIV/AIDS is applicable where HIV rates are low is considered on pp.40-41. In the Code, the term 'mainstreaming HIV/AIDS' refers to adapting programming (see section 3.5 Organisational mission and management for good practice principles relating to the organisational environment).
- 3 Ibid., pp.47-49.
- 4 In particular, section 4.3 draws on a small number of key texts, particularly Holden, S., *Mainstreaming HIV/AIDS in Development and Humanitarian Programmes*.
- 5 Ibid., pp.81-88.
- 6 See, for example, Hope for African Children Initiative (HACI), www.hopeforafricanchildren.org
- 7 *Treating 3 million by 2005: Making it Happen*, WHO, December 2003. www.who.int/3by5/publications/documents/en/3by5StrategyMakingItHappen.pdf
- 8 WHO estimates that over 300 million people are infected each year with curable STIs, a significant proportion of which occur among young people. The presence of such infections during unprotected sex magnifies the risk of HIV transmission by as much as ten-fold. *Report on the Global HIV/AIDS Epidemic 2002*, UNAIDS, p.90.
- 9 Askew, I. and Berer, M., *The Contribution of Sexual and Reproductive Health Services to the Fights against HIV/AIDS: A Review*, *Reproductive Health Matters* 2003; 11 (22): pp.51-73. See also the *International Conference on Population and Development (ICPD) Programme of Action*, UN General Assembly, 1994 and *ICPD+5: Key Actions for the Further Implementation of the ICPD Programme of Action*, UN General Assembly, 1999. www.unfpa.org/icpd/docs/index.htm
- 10 About a third of the 40 million PLHA worldwide at the end of 2001 were co-infected with *Mycobacterium tuberculosis*. For examples of joint TB and HIV interventions, see WHO: www.who.int/hiv/topics/tb/tuberculosis/en
- 11 See *Guidelines on HIV and Infant Feeding*, www.who.int/child-adolescent-health/New_Publications/NUTRITION/HIV_IF_DM.pdf
- 12 Social marketing is the marketing of public health goods or ideas through traditional marketing channels. See discussion of social marketing of condoms in *Cost Guidelines for HIV/AIDS Prevention Strategies*, UNAIDS, 2000. www.unaids.org/en/in+focus/topic+areas/cost-effectiveness+analysis.asp
- 13 *Community Mobilisation and Participatory Approaches: Reviewing Impact and Good Practice for HIV/AIDS Programming*, International HIV/AIDS Alliance, 2004, and *How to Mobilize Communities for Health and Social Change*, Health Communications Partnership.
- 14 *HIV/AIDS and Human Right: International Guidelines – Revised Guideline 6*, OHCHR and UNAIDS 2002. See Guidelines 3 and 4 www.ohchr.org/english/issues/hiv/guidelines.htm and *Criminal Law, Public Health and HIV Transmission: A Policy Options Paper*, UNAIDS, June 2002. Search by title, www.unaids.org/en/default.asp
- 15 *HIV/AIDS and Human Right: International Guidelines – Revised Guideline 6*, 2002. See Guidelines 5 and 11.
- 16 Ibid., Guidelines 5 and 11.
- 17 Ibid., Guidelines 7 and 8.
- 18 Ibid., Guidelines 3 – 9.

- 19 Ibid., Guideline 6.
- 20 The female condom has been proven effective in reducing the risks of transmission, and surveys indicate that the product would be used more widely by many sexually active women were it more widely available. *Global Mobilization of HIV Prevention: A Blueprint for Action*, Global HIV Prevention Working Group, July 2002, p.14, www.kff.org/hivaids/200207-index.cfm; WHO, *Evidence for Action on HIV/AIDS and Injecting Drug Use* series).
- 21 See *Joint Advocacy on HIV/AIDS, Treatments, Microbicides and Vaccines*, www.aidslaw.ca/Maincontent/issues/vaccines.htm#mtv
- 22 The term 'effective medications' includes ARVs and treatment for opportunistic infections and fixed-dose combinations to support cost-effective delivery and promote adherence, in turn limiting drug resistance. See *Scaling Up Antiretroviral Therapy in Resource-Limited Settings: Treatment Guidelines for a Public Health Approach*, WHO, 2003 revision, p.12 and p.15. www.who.int/hiv/pub/prev_care/en/arvrevision2003en.pdf. Also see Chapter 2, endnotes 17 and 18 for international resolutions useful in advocating access to treatments.
- 23 See range of resources produced by Médecins Sans Frontières, Access to Essential Medicines Campaign: www.accessmed-msf.org
- 24 *HIV/AIDS and Human Rights International Guidelines*, Revised Guideline 6.
- 25 *The Right to Know – New Approaches to HIV Testing and Counselling*, WHO, 2003. www.emro.who.int/asd/backgrounddocuments/egy0703/RighttoKnow.pdf
- 26 *Global Mobilization of HIV Prevention: A Blueprint for Action*, p.11. Global HIV Prevention Working Group, 2002.
- 27 *The Right to Know – New Approaches to HIV Testing and Counselling*, WHO, 2003.
- 28 See, for example, *Integrating HIV Voluntary Counselling and Testing into Reproductive Health Settings: Stepwise Guidelines for Programme Planners, Managers and Service Providers*, IPPF and UNFPA, 2004. www.ippf.org/resource/IPPF_UNFPA_HIV/IPPF_UNFPA_HIV.pdf
- 29 *The Right to Know – New Approaches to HIV Testing and Counselling*, WHO. For an analysis of the case against mandatory testing, see *Info Sheet 12: Mandatory Testing*, Canadian HIV/AIDS Legal Network, 2000. www.aidslaw.ca/Maincontent/issues/testing/e-info-ta12.htm
- 30 *Access to HIV Prevention*, Global HIV Prevention Working Group, May 2003.
- 31 *Global Mobilization of HIV Prevention: A Blueprint for Action*, pp.8-18, discusses evidence of the effectiveness of combined approaches, including behaviour change, VCT, ARVs, harm reduction programmes and prevention of MTCT. The need for comprehensive prevention programmes is reflected in paragraphs 47-54 of the Declaration of Commitment on HIV/AIDS.
- 32 *Global Mobilization of HIV Prevention: A Blueprint for Action*, Global HIV Prevention Working Group, p.10.
- 33 Research indicates that comprehensive programmes are more effective in reducing HIV risk than programmes that promote abstinence alone: Jemmott, J. et al, *Abstinence and Safer Sex: HIV Risk Interventions for African-American Adolescents: A Randomized Controlled Trial*, JAMA 1998, 1529-1536, cited in *Global Mobilization of HIV Prevention: A Blueprint for Action* pp.8-18. See also the Eldis guide, which provides a review of the evidence base in relation to abstinence-only programmes, broad-based sexual health programmes, peer education, mass media HIV awareness and behaviour change, providing summaries of research on the key issues, with links to further sources; www.eldis.org/hivaids/abstinence.htm. The Institute of Medicine, the federal body of experts responsible for advising the United States federal government on issues of medical care, research and education, found that scientific literature, as well as experts who had studied the issue, showed that comprehensive sex and HIV/AIDS education programmes and condom availability programmes could be effective in reducing high-risk sexual behaviours, while no such evidence supported abstinence-only programs (cited in *Ignorance Only: HIV/AIDS, Human Rights And Federally Funded Abstinence-Only Programs In The United States*, Human Rights Watch, September 2002. hrw.org/reports/2002/usa0902/).

- 34 *Dying to Learn: Young People, HIV and the Churches*, Christian Aid, October 2003. www.christian-aid.org.uk/indepth/310learn/index.htm
- 35 Cohen, S., *Beyond Slogans: Lessons From Uganda's Experience With ABC and HIV/AIDS*, December 2003, The Alan Guttmacher Institute, www.guttmacher.org/pubs/journals/gr060501.html; Singh, S. et al, *A, B and C in Uganda: The Roles of Abstinence, Monogamy and Condom Use in HIV Decline*, December 2003, www.guttmacher.org/pubs/or_abc03.pdf
- 36 *2002 Report on the Global HIV/AIDS Epidemic*, UNAIDS, p.65.
- 37 Research demonstrates that condoms, when used consistently and correctly, are highly effective in preventing transmission of HIV. CDC, National Center for HIV, STD and TB prevention, www.cdc.gov/nchstp/od/latex.htm
- 38 Harm reduction is one of the three complementary approaches to addressing illicit drug use, the others being supply reduction and demand reduction. Supply reduction includes seizing drugs through customs operations, assisting drug producers to grow legal crops and prosecution of drug traffickers. Demand reduction encompasses a range of measures designed to promote a healthy lifestyle free from drugs and to prevent drug use. See *Harm Reduction Principles*, Central and Eastern Europe Harm Reduction Network, www.ceehrn.lt/index.php?ItemId=4805
- 39 *Report on the Global HIV/AIDS Epidemic 2002*, UNAIDS, p.94.
- 40 There is compelling evidence that increasing the availability and use of sterile injecting equipment among people who inject drugs contributes substantially to reducing HIV transmission, without contributing to an increase in drug use. *Policy Brief: Provision of Sterile Injecting Equipment to Reduce HIV Transmission*, WHO, 2004, p.2. Early implementation of needle and syringe programmes (NSPs) has been a critical factor in avoiding serious outbreaks of HIV among IDUs. *Global Mobilization of HIV Prevention: A Blueprint for Action*, p.15, Global HIV Prevention Working Group, July 2002.
- 41 *Effectiveness of HIV Information, Education and Communication Interventions for Injecting Drug Users*, WHO (forthcoming, 2005).
- 42 Numerous studies demonstrate that substitution treatments reduce drug use, the frequency of injecting and levels of associated risk-taking behaviour. *Policy Brief: Reduction of HIV Transmission Through Drug-Dependence Treatment*, WHO, 2004, p.2. See *Evidence for Action on HIV/AIDS and Injecting Drug Use* series, WHO.
- 43 *Evidence for Action: Effectiveness of Community-Based Outreach in Preventing HIV/AIDS Among Injecting Drug Users*, WHO, 2004.
- 44 *Policy Brief: Reduction of HIV Transmission in Prisons*, WHO, 2004. See *Evidence for Action on HIV/AIDS and Injecting Drug Use* series, WHO.
- 45 'Treatment' includes treatment of opportunistic infections, as well as ARVs.
- 46 *HIV Care and Support: A Strategic Framework*, Family Health International, June 2001 (www.fhi.org) provides a useful analysis of the components of a comprehensive approach to treatment, care and support.
- 47 Approximately one-third of PLHA worldwide are co-infected with *M. tuberculosis*, and 70 per cent of them live in sub-Saharan Africa. Tuberculosis is the leading cause of death among HIV-infected people, and HIV has been responsible for a global surge in the number of cases of active tuberculosis. *Report on the Global HIV/AIDS Epidemic 2002*, UNAIDS, p.151.
- 48 *Policy Briefing No.2: Participation and Empowerment in HIV/AIDS Programming*, International HIV/AIDS Alliance, 2000. www.aidsalliance.org/ngosupport/resources/429a_participation_polbrief_eng.pdf
- 49 *Improving Access to HIV-Related Treatment*, International HIV/AIDS Alliance; *Antiretroviral Therapy in Primary Health Care: Experience of the Khayelitsha Programme in South Africa*, WHO, 2003, www.who.int/hiv/pub/prev_care/en/South_Africa_E.pdf
- 50 *HIV and AIDS-Related Stigmatization, Discrimination and Denial: Forms, Contexts and Determinants*, UNAIDS, 2000, www.unaids.org; and *HIV-Related Stigma and Discrimination: A Conceptual Framework and an Agenda for Action*, Horizons Program, 2002. www.popcouncil.org/pdfs/horizons/sdcncptlfrmwrk.pdf

- 51 *AIDS Discrimination in Asia*. Asia Pacific Network of People Living with HIV/AIDS (APN+): www.gnpplus.net/regions/files/AIDS-asia.pdf; and Human Rights Watch reports, for example: *Policy Paralysis: A Call for Action on HIV/AIDS-Related Human Rights Abuses Against Women and Girls in Africa*, December 2003; *Locked Doors: The Human Rights of People Living with HIV/AIDS in China*, August 2003; *Ravaging the Vulnerable: Abuses Against Persons at High Risk of HIV Infection in Bangladesh*, August 2003; *Just Die Quietly: Domestic Violence and Women's Vulnerability to HIV in Uganda*, August 2003; *Abusing The User: Police Misconduct, Harm Reduction And HIV/AIDS in Vancouver*, May 2003. hrw.org/doc/?t=hivaids_news
- 52 See, for example, the role of stigma and discrimination in increasing vulnerability of children and youth infected with and affected by HIV/AIDS, Save the Children (UK), 2001: www.savethechildren.org.uk/temp/scuk/cache/cmsattach/1104_stigma.pdf
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