3

Synergy and integration

Introduction

The need for improved coordination, partnership, comprehensiveness and synergy is invoked in most statements of future challenges and strategic principles on HIV/AIDS made by UN bodies, national governments and regional organisations such as the African Development Forum's International Partnership for Action on AIDS (IPAAA). For example, one of the IPAAA's key strategies for expanding the scale and reach of HIV/AIDS responses in Africa is: 'involving all the actors, through a truly inclusive, multisectoral approach; no more fragmentation'. The IPAAA's critique of widespread fragmentation in HIV/AIDS responses has been mentioned in some detail in chapter one.

The report of the UNAIDS Executive Director to the UN Economic and Social Council in June 2001 emphasised the need for improved comprehensiveness and coordination (Textbox 3.1).

This chapter's discussion of synergy and integration in WV's HIV/AIDS interventions is divided into several parts:

- cooperation with other local stakeholders
    - government;
    - community;
    - private sector;
- synergy among WV projects;
- synergy among project components;
- integrating HIV/AIDS into a broader development program;
    - primary health care approach;
    - poverty-reduction program.

Cooperation with other stakeholders

Cooperation with other government, non-government, community and private-sector actors has already been touched on in the first chapter from the viewpoint of stakeholder participation, so the discussion here will be relatively brief.

High standard of collaboration with government

Integration with national strategy

Local HIV/AIDS interventions assisted by overseas aid should be integrated with the national government's HIV/AIDS strategy. All WV HIV/AIDS projects appear to be consistent with their respective national HIV/AIDS strategy, policy and program. The content of the programs is generally developed with relevant government ministries.

While such information is not reported in evaluations, there is no evidence that national AIDS committees are anything but supportive of the projects. In two evaluations, the district AIDS coordinators were included in the team (Arumeru, Nankumba). Both coordinators were complimentary and

UNAIDS Executive Director calls for synergy and integration

30. The key challenges confronting UNAIDS for the coming biennium include the following:

(a) promoting a shift from pilot projects and small-scale interventions for preventing transmission of the virus to more *comprehensive prevention programs*, including successful approaches for preventing transmission among young people, and taking into account the particular transmission dynamics and stage of the epidemic in different regions and countries;

(b) promoting expanded access to existing HIV-related commodities (e.g., male and female condoms, microbicides and diagnostic equipment and materials) through increases in financing from international and national sources and promotion of the *integration* of public health concerns in trade policies;

‘c) further *strengthening coordinated action* at the country level, through support to the development and implementation of national strategic plans and national AIDS commissions, and through the development of United Nations *integrated* workplans;

(d) demonstrating the *links* between the activities and accomplishments of UNAIDS and their actual impact on the response to the epidemic — i.e., through improving, monitoring and evaluation mechanisms;

(e) promoting the development of *comprehensive care strategies* that include the full range of care interventions, including voluntary counselling and testing, psychosocial support, and access to HIV-related medicines, consistent with national plans and priorities;

(f) enhancing UNAIDS capacity to support policy development and *coordination* within and between global, regional and national levels concerning prevention, care, impact alleviation and specific thematic issues;

(g) expanding civil society in the response, through *enhanced partnerships* with associations of people living with HIV/AIDS, community-based organisations, religious groups, non-governmental organisations working in relevant sectors and the private sector;

(h) mobilising the financial resources necessary to counter the epidemic, including international assistance and national and community-level funding.

Textbox 3.1
Source: Report of the UNAIDS Executive Director to the UN Economic and Social Council, 14 June 2001, p. 8-9 (emphasis added).

supportive of the respective HIV/AIDS project, one of whom later agreed to manage the project in the 12 months leading up to phase-out of ANCP funding.

Given the close cooperation between most projects and respective government health ministries, the WV HIV/AIDS projects are always an acknowledged part of the respective government's health program.[1] Most evaluations of WV HIV/AIDS projects complimented the projects on the good relations and networking with government, most commonly health ministries. Four examples follow.

Four good examples

1. Danang I

A few projects were also praised for their catalytic role in facilitating a more integrated HIV/AIDS response in the project area. The team evaluating Danang I, for example, found that:

- the project had led to greater interaction and networking between organisations and government departments working in the area than was previously the case;
- all departments and the preventative medicine centre (part of the MOPH and the organisation implementing the project) had started to synchronise their HIV prevention activities under the direction of the provincial AIDS committee.

2. Thai-Burma/Myanmar

While acknowledging and describing difficulties of smooth partnerships with governments, the 1998 Thai-Burma/Myanmar evaluation conveyed the important catalytic and capacity building role of the WV's cross-border program:

> Cross-border collaboration through WV offices is an important component of the project. WV has facilitated official exchanges through the highest

levels of government, bringing together Rangoon and Bangkok health officials and establishing regular meetings and exchanges between hospitals across the border. NGOs have been included in formal meetings and in informal exchanges. Such developments are at different stages in each of the three sites but are brought together in six-monthly sharing workshops.

At the highest level to the local exchanges there is an invaluable sharing of information along with practical efforts to work together on serious health problems, of which there are many in the area. HIV is the focus for the high level meetings and many of the other exchanges but the primary health care (PHC) has become an important component of programming which not only enhances the potential for cooperation but builds the capacity of WV to raise the awareness of HIV/AIDS populations that otherwise may be very difficult to reach.[2]

The Thai-Burma/Myanmar program was an attempt to develop an interconnected response to the issue of illegal migrants from Burma/Myanmar who made up a significant proportion of the resident and floating populations on the Thai side with interventions established in key linking points for the migrants. On the Burma/Myanmar side, project sites were established in the three sister cities that were major ports of entry to Thailand and thus either rest-and-departure points or returning points following voluntary return or involuntary repatriation, or residential points for daily commuters to Thailand.

The Songkhla project design included the establishment of an 'effective NGO and government networking system' as a project output or expected effect. The project established a project advisory committee that made a number of synergistic recommendations described below.

3. Greater Mekong subregion program

In this context, it is worth mentioning the program *The Preventing HIV/AIDS Among Mobile Populations in the Greater Mekong Subregion Program*, funded by the Asian Development Bank(ADB) and UNDP are implemented by WV. This program adopted an international-regional-program framework to facilitate planning in respect of specific mobile populations (construction workers, truck drivers, migrant sex workers and seafarers). It was explicitly designed to play a catalytic, capacity-building role in and between five countries in the region (Cambodia, Laos, Vietnam, China and Burma/Myanmar).

Promoting synergy in Songkhla

Effective NGO and government networking system established

Advisory committee meetings

Most [government organisations] in Thailand have an AIDS component in their annual budget. They generally operate independently of each other and the result is an uncoordinated AIDS campaign. The project sought to assist in bringing together the government organisations in Songkhla to better coordinate their responses. The project conducted a meeting on 11 July 1995 at the Songkhla VD Control and AIDS Centre (Region 12). The following attended:

1. Director of Infectious Disease Control (Region 12), Songkhla Province;
2. Project Adviser;
3. Director of Songkhla VD Centre (Region 12);
4. Health educator 6, Government Coordinator at the Songkhla VD Centre (Region12);
5. VD Control Officer 4, Government Coordinator;
6. Health Educator, Songkhla District Municipal office;
7. Chief of Infectious Disease and VD Control Section, Songkhla Provincial Health Office;
8. Assistant Director of Provincial Fishery Office, Songkhla Province.

In order to facilitate these decisions the project was given office space in the Municipality health section. This assisted the contact between project staff and municipality staff. During the final evaluation, the evaluation team met with a number of municipality officials, including the mayor, deputy mayor, chair of the primary health care department, and chair of the education department. All were aware of the project's activities and the project staff. Further, while undertaking the evaluation, a national television station began filming a news story on the project to coincide with World AIDS Day. The project has been recommended to them by the governor's office.

Textbox 3.2
Source: Songkhla II Project Completion Report (1996), pp. 33-34.

Strengthening collaboration in Mongla, Bangladesh

The project sought the active participation and collaboration with national STD/AIDS networks, USAID, Social Marketing Company and Thana Health Complex and various community organisations, WV Bangladesh management, the national health coordinator and Asia regional health advisor to ensure consistency with the government of Bangladesh AIDS Prevention Policy. At the local level there has been a strong partnership and working relationship with different local government and non-governement organisations, especially with those working in the health sector.

It has been the strategy to strengthen the local institute through training and support for STD case detection and management, AIDS prevention services and for sustaining the program in the community. At this time there is a referral partnership of STD cases with St. Paul's hospital, Thana Health Center, Dock Labor hospital and Mongla Port Mohila Sommity (local NGO). The project is conducting health education sessions among the clients coming to these health centres in cooperation and collaboration with them.

Though the project has a good relationship and cooperation with government and NGOs, it will continue to strengthen its working relationship and networks especially with local health providers in the impact area.

Textbox 3.3
Source: Mongla Evaluation Report (1999), pp. 16-17.

The program's steering committee consists of government officials from each participating country with representatives from SIDA, UNDP, UNICEF, the Asia Pacific Inter-Country Team (APICT) of UNAIDS and the ADB. The steering committee's role is to assist the ADB and the UN task force on mobility and HIV/AIDS to guide the work of the integrative program. This program has not been discussed earlier because it did not meet the key sampling criterion of having been evaluated but its promotion of international collaboration between governments, multilateral agencies and other stakeholders involved with key population groups is worthy of replication.[4]

4. Arumeru

The Arumeru project was an outstanding example of cooperation between the project, government and communities. The 1999 evaluation team praised for the full and seamless integration of the project into government and community structures. The project's HIV/AIDS-prevention emphasis, summarised in the evaluation report as a moral-reform approach, worked in well with state and church reform agendas and was a key reason for the enthusiastic involvement of many of the community volunteers who shared the project's moral-religious definition of the problem and solution of HIV/AIDS.

The 1999 Arumeru evaluation report noted that: 'the project approach is built on the felt community moral reform agenda of reducing alcoholism, adultery and loitering etc.'[5] This 'moral reform agenda' was also owned by the government and churches. It included more vigorous enforcement of existing government regulations concerning shorter opening hours for bars, promotion of non-hedonistic moral and spiritual values consistent with both Islam and Christianity, promotion of sporting and economic activities among youth and adults to reduce loitering and redirect energies towards activities positive and useful to the community.

Collaboration beyond health ministry

Several projects, such as Thanh Hoa, Kahama I and II, Arumeru, Songkhla II, Danang I and II collaborated with a government ministries beyond the ministries of health. Arumeru, for example, cooperated with extension workers from a range of line ministries, including agricultural extension workers, to provide support to PLWA and their families. In Arumeru, the extension workers in consultation with project volunteers supported families and help them establish or improve nutritional kitchen gardens. The Thanh Hoa community health and development project, building on the foundations of an earlier agro-forestry-credit project, facilitated the integration of HIV/AIDS training into the training and practice of local primary health care workers and agricultural extension workers.[6]

Local partnerships

No project by itself can cover all the necessary facets of HIV prevention and care in one project, nor is this necessarily desirable. However by networking and coordinating with other organisations and individuals, a project can have a far wider reach and impact (Aboagye-Kwarteng, 1995, p.68).[7]

The following table illustrates all the organisations (community, government and non-government) the projects have contact with. Some contacts were strong partnerships, while other contacts may have been relatively superficial.

WV AIDS project	Community groups, government organisations and NGOs involved
Ranong	Provincial Public Health UNICEF
Songkhla	Songkhla provincial Public Health Office Environment Sanitation Unit Labour and Social Welfare Office Venereal Disease and AIDS Control Centre VD and AIDS clinic Baan Sooksun Family planning Association in Thailand Ratchapat Institute
Mongla	USAID Social Marketing Company Thana Health Complex St Paul's Hospital Mahila Sommity local NGO
Kawthaung	Red Cross Maternal and Child Welfare Association Union Solidarity and Development Association
Mumbai	Directorate of Health Services of Mahashtra Bombay Municipal Council State AIDS Cell Local health centres NGO forum
Arumeru	District government Ministry of Education Community Development and Agriculture Village Committee Schools Religious leaders Traditional leaders Teachers
Quang Nam	Preventive Medicine Centre The Quang Nam Danang Province AIDS Committee Department of Social Welfare and Labour Red Cross CARE
Danang	Department of Education, Department of Health preventive medicine centre.

Textbox 3.3

Source: Milford, S., *AIDS and Best Practice for World Vision Projects,* unpublished paper prepared for MA in Development Studies, Deakin University, Melbourne, p.15.

Room for improved collaboration with government

The Kahama 1993 evaluation found that the project had good relations with the Ministry of Health. It recommended that 'relations with ministries of the Tanzanian government need to be more multi-sectoral' and that closer relationships with government community-development, adult-education and agricultural ministries could be further developed for sustainability. The Kahama 1998 evaluation recommended that the project participate in NGO forums to assist coalition-building and coordinated planning. It suggested that joint planning between the project and government could be improved.

The 1999 Nankumba evaluation found that the project's networking was strong but that there was room for improvement. For example, in response to the question 'What role do you play in project activities?' one of the local agricultural development officers told the evaluation team:

> Basically there is very little [role]. By nature of my job I don't associate much with youth. People think my work is agricultural yet our target is the same as health personnel. They [project staff] are biased towards health personnel. I am limited to play a small part and many farmers are not reached with AIDs messages. Not much on multisectoral approach. We meet farmers every day and we could have utilised that chance to disseminate messages.[8]

The communication between the district AIDS coordinating committee (DACC) and the Nankumba project was reportedly not always good. However, possibly influenced by the closer relations flowing from the participation of the district AIDS coordinator (DAC) in the 1999 evaluation, the DAC became the project coordinator during the project's final year of operation, being an appropriate bridge to the next phase of the HIV/AIDS response.

Cooperation with communities

Concerning projects' cooperation with communities, the main findings (presented in the previous chapter) are that:

- most projects cooperated with communities to a low degree during initial planning;
- most projects cooperated with communities, or parts of communities, extensively and well during implementation;
- all HIV/AIDS projects worked with and through community volunteers, an excellent way of *integrating* the intervention into communities;
- some projects sought higher levels of community cooperation in monitoring and overseeing project activities by inviting community representatives onto project committees;
- few projects took the cooperation to the stage where the project cooperated with the community rather than the community being in cooperation with the project.

Exceptions worthy of praise were Thai-Burma/ Myanmar's decentralised community

Activities of Iyolwa Nyemera sub-parish committee

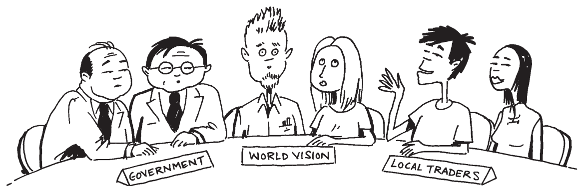
What are the activities of the committee?

- to monitor the project;
- we have selected the counsellors and monitor their activities;
- we have selected the vision clubs and draw the work plan.
- we mobilise the community in case of needs arise;
- we discuss the activities on question;
- create awareness about HIV/AIDS to the community;
- create awareness about general sanitation in the community in order to curb the spread of diseases;
- we also monitor the mini-committees;
- import awareness to the community about other disease apart from HIV/AIDS;
- we also collect community members for future sustainability of this project;
- we also monitor the counsellors' bicycles.

Textbox 3.4
Source: Focus group interview with six male and two female committee members, 29/8/2000. Interview facilitated and notes taken by community counsellors.

management structure and Arumeru's integrated triangle of community, government and project, although several projects had the potential to move in that direction having established community committees.

Cooperation with private sector



Calls to involve the private sector are much stronger and more widespread these days compared to ten years ago. For example, the *Abuja Framework For Action For The Fight Against HIV/Aids, Tuberculosis And Other Related Infectious Diseases In Africa* called for strengthened partnerships as one of the priority areas for action, including strengthened public-private partnerships.[9] The Abuja framework was developed at a special summit of African Heads of Government in Addis Ababa in December 2000. Its other 'partnership' priorities were to strengthen national and regional networks, establish developmental coordinating units, improve networks of experts and institutions and promote South-South cooperation.[10]

Several HIV/AIDS responses—mainly urban projects in Asia—attempted to develop cooperative relations with private enterprise. Some Asian responses worked to develop cooperative relations with brothel owners and sex workers (Kawthaung and Songkhla I and II), fishing-industry stakeholders including fishing boat captains, owners and fishing pier owners, fishermen (Kawthaung and Songhkla I and II), factory owners and workers (Songkhla II) and petty traders such as grocers, barbers, hairdressers, cyclo drivers (all Asian projects). The Vietnamese Highway One project attempted to develop cooperative relations with a medium-sized transport company.

Many volunteers active in WV-assisted HIV/AIDS responses have been petty traders who have given up trading time and money to be involved in HIV/AIDS prevention and/or care. People such as Timothy Ofwumbi and Frimony Owino in Iyolwa are in this category. The private sector is involved in this way in all WV HIV/AIDS projects.

Workplace-based approaches were not as common in HIV/AIDS projects assisted by WV given their location in rural contexts where small, peasant agriculture was the main means of livelihood, and petty trading the main instance of private-sector activity. In these contexts, the main workplaces were the field, the household plot, the shop and the small government office.

In the light of an increasing emphasis on promoting partnerships between the public and private sector, it would be good to see a higher proportion of future NGO projects including workplace action on HIV/AIDS. It would also be good to see WV supporting more urban HIV/AIDS programs in Africa. Among other things, each rural area has an urban centre that rural youth and adults visit, usually the district 'capital' where the district government headquarters are located.

The private-sector is being called on to play still more pervasive and influential roles in implementing and resourcing HIV/AIDS responses. Private-sector relations and roles are worthy of expansion in future HIV/AIDS responses.

Constraints

With all the talk about synergies, it is worth remembering that HIV/AIDS responses are usually working to facilitate changes in the face of a variety of constraints and blockages. Any appraisal of HIV/AIDS project performance in facilitating synergy and integration needs to acknowledge that opposing tendencies are often beyond the control of the project.

Many HIV/AIDS responses work in complex environments where some powerful government, church and business stakeholders do not support HIV/AIDS prevention activities. For example, government suppression of prostitution hampered the work of several projects, among other things making it difficult to develop relations with brothel owners and sex

workers (Songhkla II). Criminalisation of injecting drug use, and police raids to catch injecting drug users, hampered HIV/AIDS prevention work in some places (Danang I). Factory owners and trucking companies were not always sympathetic to project objectives and activities, (Highway One, Songhkla II).

Synergy among WV projects

The challenge of moving from a relatively fragmented project-by-project approach to an integrated program approach in responding to HIV/AIDS and other livelihood issues is a challenge for all overseas-aid donors and implementers.[11] HIV/AIDS design guidelines publicised by country donors such as AusAID and CIDA usually emphasise coordinated multisectoral or intersectoral approaches (Textbox 3.5 below).

Several HIV/AIDS interventions in our sample were components of broader WVmultisectoral programs: Mongla, Kahama I and II, Senegal, Kariobangi, Thanh Hoa. These were HIV/AIDS projects that went on directly or indirectly to become incorporated in broader development programs. Arumeru influenced the creation of a new HIV/AIDS project in Moipo ADP; Iyolwa HIV/AIDS broadened into Iyolwa area development program (ADP) with a continuing HIV/AIDS component.

Room for more inter-project synergy

Some evaluations pointed to the need for the development of a higher degree of cooperation between WV-assisted interventions, HIV/AIDS and otherwise.

For example, the Songkhla I evaluation team:

- found that the project had not fully utilised the benefits of networking with other organisations working on HIV prevention;
- acknowledged the already-planned workshop for all staff of Thai AusAID-funded AIDS projects focusing on training and sharing in community-based education strategies and monitoring and evaluation of community-based HIV projects;
- recommended that Thailand hold monthly and quarterly meetings of project coordinators in projects to discuss and resolve issues including training.

Multisectoral Approach

‘HIV/AIDS is not just a health problem. Australia should consider how projects in the areas of governance, infrastructure, education and rural development may contribute to a multisector strategy. Strategies must be adopted to counter any potential increase in risk of HIV/AIDS transmission to some groups resulting from the economic and social changes as a result of aid activities.

Broughton B. (1999), *Guide to HIV/AIDS and Development*, Commonwealth of Australia, Canberra, p.9.

Intersectoral Approach

CIDA’s programming in HIV/AIDS is guided by the following principles:

…. Addressing the determinants of HIV/AIDS through intersectoral strategies, including considering the potential impacts of other development programs on HIV/AIDS.’

Textbox 3.5
Source: Canadian International Development Agency (CIDA) (2000), *HIV/AIDS Action Plan*, second edition, p.1.

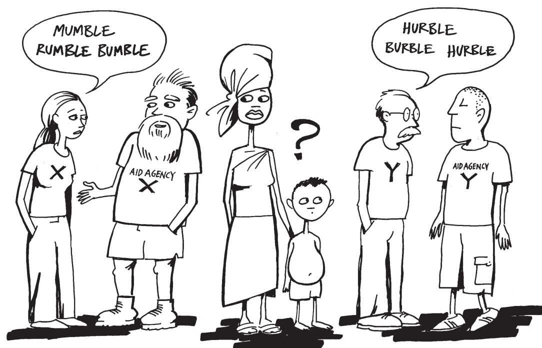
Author’s note: *Multisectoral* emphasises the involvement of a number of sectors in addressing a specific social issue. *Intersectoral* emphasises the mingling of a number of sectors in addressing an issue.

The Kariobangi evaluation team recommended increased integration between the three projects that together made up the Kariobangi ADP: Kariobangi Urban ADP, Kariobangi HIV/AIDS project and Kariobangi urban program. It recommended that the Kariobangi HIV/AIDS project:

- broaden its project area to encompass the three projects, but focus more on the specifically HIV/AIDS component;
- negotiate with the other projects to pass some components to them—such as the Youth Trainee Sponsorship Program involving the linking of selected youth with vocational training opportunities and part payment of fees;
- employ a monitoring and evaluation facilitator to help develop the community-based monitoring system for the three projects, together called the Kariobangi ADP.[12]

In the course of evaluating an attempt to mainstream an HIV/AIDS education component into four area development programs in Senegal, the external evaluator pointed to the need for building the integrative capacity of WV Senegal and the projects it supported:

> There is an absence of an overall integrative/integrated frame of reference capable of guiding both ADP structures and processes as well as additional [HIV/AIDS] projects auspiced by the national office (and possibly other organisations with whom Senegal co-operates); there seems to exist a high degree of segregation between various divisions of WV, everyone as a whole as well as between the various levels of operation'.[13]



While this sounds damning, much the same thing can probably be said for many development organisations, programs and projects,[14] remembering, too, the African Development Forum's comment on widespread fragmentation of HIV/AIDS responses cited in chapter one. Some projects reported that they found another organisation doing some of the things that they were doing and worked with the organisation to address the duplication.

Promote synergy within project components

The principle of promoting synergy within project components covers the idea of responses being multifaceted, multisectoral with all parts working together.

In sum, the principle encourages:

- multiple methods of prevention (given too, that some people prefer to learn by seeing or reading, others by hearing, others by touching and hands-on experience and so on);
- connections between prevention and care;
- integration of HIV/AIDS into a primary health care approach.

Multiple methods

Most projects used multiple methods to raise people's awareness about HIV/AIDS prevention. As noted earlier, Chiangmai I and II, for example, worked with the Ministry of Public Health (MOPH) to:

- train a range of key community members to disseminate information on HIV/AIDS prevention to others—community participants include monks, sub-district and village headmen, hairdressers, barbers, primary and secondary school teachers, taxi drivers, government officials, factory workers, construction workers, commercial sex workers, village youth and adults;
- train and encourage musicians to disseminate HIV/AIDS-related messages through music;
- assist villages to obtain equipment (amplifiers, tapes) for broadcasting HIV/AIDS related messages in villages;
- produce handbooks, overhead transparencies and slides for MOPH to use in HIV/AIDS campaign;

- produce a script about 'HIV/AIDS infected people and misconceptions about AIDS', drawing on local folk-drama traditions (the script was performed and captured on video which was then distributed to the villages in the chosen areas);
- reproduce 500 copies of the PATH AIDS-education flip chart for distribution as a teaching aid;
- produce an AIDS patient video showing northern Thai AIDS patients speaking in the local dialect about how they contracted AIDS and the suffering they were going through. (This communicated that AIDS was a local reality);
- produce leaflets designed to meet the needs of five specific 'target groups': primary school students, adolescents, adult males, adult females and the general population;
- produce AIDS-education scripts for radio DJs giving accurate AIDS information;
- produce a 15-minute video for all long distance buses to and from Bangkok and north eastern routes to be shown before main movie;
- support the development and production of other AIDS educational materials, including:
  - inviting monks of high standing to participate in a workshop to develop outlines for sermons that integrated Buddhist teaching and AIDS education—these outlines were mass produced and circulated;
  - producing calendars and stickers incorporating HIV/AIDS messages;
  - producing and distributing AIDS education lesson plans developed in cooperation with the primary school provincial office;
- provide equipment to enable voluntary testing—in the year prior to the evaluation over 5000 people were voluntarily tested using the donated equipment;
- arrange a workshop promoting cooperation between government and non-government organisations in the area of HIV/AIDS education and prevention in Chiangmai;
- train district and sub-district health workers in the activities of the program.[15]

Given the cultural and personal diversity among community groups and members, it is important for projects to provide choices in prevention methods including abstinence or use of protective methods when engaging in otherwise high risk activities. The abstinence and protective-practice choice applies, among other things, to sexual intercourse, injecting drug use and blood donation.

Consistent with the policy of UNAIDS and the national HIV/AIDS plans, all WV sampled projects appear to have adopted the following three-pronged communication strategy relevant for prevention of HIV/AIDS infection during sexual intercourse:

- promoting abstinence especially among unmarried people;
- fidelity for married people;
- condom use for those who could not or would not abstain or be faithful.

However, the emphasis given to each component varied between projects. In general, many African HIV/AIDS projects appear to have been half-hearted in their promotion of condom use in the light of:

- the widely held view that promoting condoms was to promote immorality;
- the view held by some that condoms were not a reliable form of protection against HIV/AIDS given unsafe storage practices of street vendors and others. This view was particularly expressed and promoted in Nankumba.

Unfortunately, less-than-enthusiastic education concerning the use and promotion of condoms blocks potential synergies between HIV/AIDS prevention narrowly defined and broader areas and issues, for example:

- family planning;
- reduction of sexually transmitted infections;
- reproductive health;
- negotiating important life issues including terms and timing of sexual intercourse, especially for girls and women;
- female empowerment.

Most projects appeared to focus mainly on preventing transmission through sexual intercourse and, in East Africa, through changing traditional practices such as widow-inheritance and urging avoidance of the sharing of sharp objects. A few projects in Asia included a focus on promoting safe injecting drug use (Thai-Burma/Myanmar, Danang I, Kawthaung).

In general, the projects used multiple methods, media and messages to promote prevention. One evaluation that went into communication methods in detail found that the intended audiences wanted more variety, and messages and media geared more to their culture and standard of education. This is also a reminder of the desirability of designing media and messages in cooperation with the intended audiences.

Integration of prevention and care

Best-practice literature widely urges HIV/AIDS responses to integrate prevention and care as far as possible. The recent UNAIDS' Global Strategy Framework on HIV/AIDS notes: 'An expanded response creates major synergies by placing prevention strategies alongside care and support strategies'.[16] One often-mentioned way is to help promote the visibility of HIV/AIDS in the community. This helps to fight the historical tendency of many governments and dominant communities who initially deny the existence of HIV/AIDS.

Supporting people living with AIDS (PLWAs) to associate 'privately' is an early and valuable step towards creating an ideal social environment where they can *come out* publicly and be publicly accepted. Chiangmai I helped PLWAs take the first step.

While the main focus of the Chiangmai project was education for prevention, its multifaceted approach extended to establishing a support group (Thursday Club) for PLWAs towards the end of Chiangmai I in cooperation with the Chiangmai Red Cross. The club provided a forum for PLWAs to meet and share, as well as to receive counselling, medical care and enjoy social activities. Clubs were facilitated after the 1993 evaluation team recommended that the project facilitate social networks and community-based groups to increase acceptance and community care of PLWAs.

Variety is the spice of life: lessons from Mae Sai, Thailand

The final evaluation team ascertained that the project had a definite impact in the dissemination of information regarding HIV/AIDS and condom usage. However, some of the [commercial sex workers](CSWs) interviewed indicated that they were becoming a little bored with hearing the same messages over and over again and would like to have information presented in other ways such as videos, cartoons and music tapes. In an interview with one of the brothel staff, he said he would be happy for this to happen while the CSWs were not working…

It was apparent that the need for more appropriate materials remained. Literacy for many of the CSWs interviewed in their mother tongue, let alone Thai was quite low. Some of the young women interviewed stressed the need for more appropriate forms of communication such as cartoons, videos and audio tapes.

It is recommended that the project continue to research and develop more appropriate forms of communication, particularly for people with a low literacy level. There are already some materials for different language groups available and a good starting point for these would be at NAPAC [AusAID-funded Northern Thailand AIDS Prevention and Care Program] in Chiangmai.

Textbox 3.6
Source: Maesai Project Completion Report (2001), pp.10,16.

Risk reduction:
UNAIDS Strategy Framework

Decreasing the risk of infection slows the epidemic. HIV/AIDS infection is associated with specific risks, including:

- behaviours where there is a risk of HIV infection, mostly commonly unprotected sexual intercourse, and, in some parts of the world, the use of infected injecting equipment;
- situations where there is a risk of HIV infection, such as needing a blood transfusion in a setting where blood safety precautions are not implemented, or being forced to have sex.

'Risk reduction interventions have been the mainstay of HIV/AIDS prevention programs to date. They include the provision of information, the development of relevant skills and the promotion of supportive values and attitudes. As well, many specific prevention methods focus on changing risk-taking behaviours and decreasing the occurrence of risk situations.

Textbox 3.7
UNAIDS, Global Strategy Framework on HIV/AIDS, 2001, p. 9.

PLWAs were involved in prevention activities in some projects such as Kariobangi and Arumeru. However, these were exceptional. In Arumeru, the two PLWAs who were involved were themselves unique, operating in a social climate where at least some project staff and community regarded PLWAs as patients whose main role was to stop themselves from spreading infection rather than being involved in broader educative and advocacy roles. Actual and potential roles for PLWAs in our sample of HIV/AIDS projects will be discussed in more detail in chapter five.

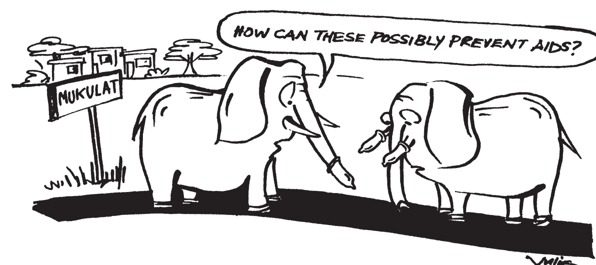
Community volunteers in most African projects and some Asian projects combined prevention with educative and advocacy roles. In Asian projects particularly, community volunteers were more likely to be involved in condom distribution as well as other prevention, and more recently PLWA-family care, activities.

Reducing risk, vulnerability and impact simultaneously

UNAIDS' recent global strategy framework urges 'an expanded response … that simultaneously acts on reducing risk, vulnerability and impact'.[17]

Risk reduction

All projects in the WV sample assisted government and community partners to help their communities to reduce risk behaviours and situations, usually through developing the capacity of government and/or community members to undertake community education on HIV/AIDS prevention.



The Kariobangi contributed to risk reduction, for example, through training various community members—∇youth, PLWA, traditional birth attendants, and community health workers—∇to educate others on prevention, including delaying first intercourse, abstinence, fidelity and condom use. Some PLWAs distributed condoms. In the next phase, the intention is to strengthen the project's support for the government's community-based distributors in order to help improve their level of condom-distribution and their role as peer educators.

Reducing vulnerability

In addition, all HIV/AIDS projects worked in one or more of the areas described in UNAIDS Strategy Framework to illustrate vulnerability reduction. All projects, for example, worked to increase participation in community activity through mobilisation of community volunteers. Most projects worked to improve or extend government health services and infrastructure, including the community network.

The UNAIDS strategy framework highlights the importance of focusing on reducing the

vulnerability of youth ∇and especially on the integration of youth into the fabric of family, community and society∇ as part of reducing societal and personal vulnerability to HIV/AIDS infection.

Eleven of the 19 sampled projects included a significant focus on youth, for example:

- Arumeru and Kariobangi successfully involved youth in HIV/AIDS prevention activities in project area;
- Chiangmai I and II, Mumbai, Songkhla I and II used peer volunteers to work with young people;
- Nankumba and Iyolwa established children's clubs in schools;
- Danang I and II helped mainstream HIV/AIDS curriculum in district schools∇those of the Arumeru community counsellors who were also teachers ensured that HIV/AIDS awareness was actually taught in their schools rather than merely specified in the national curriculum.

Reducing vulnerability: UNAIDS strategy framework

Decreasing vulnerability decreases risk of infection and the impact of the epidemic. Poverty, underdevelopment, the lack of choices and the inability to determine one's own destiny fuel the epidemic. Vulnerability to HIV/AIDS is a measure of an individual's or community's inability to control their own risk of infection. Different patterns of infection are accounted for by personal factors, access to relevant information and services, and societal factors.

[Key areas for focusing interventions to address social vulnerability include …]

Reducing vulnerability with a focus on protecting youth:

- positive relations with trusted adults;
- peer relations that model safer behaviours;
- participation in family religious and community activities;
- positive orientation to education and health;
- the development of schools as more inclusive, protective and gender sensitive community-based organisations.

Reducing vulnerability through supportive legal and social norms:

- the reduction of gender and economic disparities that fuel the epidemic;
- greater equity in educational, vocational training and employment opportunities;
- increased participation in community, religious and political activity;
- the reduction of stigma associated with sex, sexuality, sex work and drug use;
- attention to policies or programmes which have the effect of perpetuating HIV/AIDS within particular communities;
- the promotion and protection of human rights.

Reducing vulnerability through access to services:

- sexual health information, education and services including information and access to female condoms;
- schools and other organised education programs through secondary levels;
- life-skills based HIV/AIDS education to develop the knowledge, attitudes and values needed to respond to the epidemic;
- voluntary counselling and testing services;
- antenatal care that includes treatment to reduce mother-to-child transmission;
- clean needles, syringes and drug abuse treatment in communities;
- rehabilitation and legal services;
- essential protection, prevention and care services for populations in complex emergencies, especially women and girls at greatest risk.

Textbox 3.8
Source: UNAIDS, The Global Strategy Framework on HIV/AIDS, 2001, pp. 9 and 10

The ways and degrees to which the projects contributed to reducing the vulnerability of youth and other groups were not well documented in evaluations because:

- reduced vulnerability was not an objective or component in any project design;
- most evaluations concentrated on researching and documenting projects in the light of their stated objectives and components.

It is likely, however, that the main focus of most projects was on reducing risk behaviour and risk situations given that this was the main emphasis of most designs. This has also been the main focus of HIV/AIDS interventions outside WV in the past.

Reducing impact

In the light of the UNAIDS' global strategy framework on HIV/AIDS, the nine projects that were involved in building local capacity both (a) to care for PLWA and their families and (b) to prevent HIV/AIDS transmission, could be said to be working to reduce HIV/AIDS impact as well as to reduce risk behaviour and vulnerability.

Those projects involved in establishing and/or improving community care networks were also extending the reach of education, counselling and care to a very marginalised, stigmatised, hidden and often alienated risk group, PLWA. Promoting hope and joy in life helps PLWA care about others as well as taking more care of themselves in all senses of the word (see chapter five for PLWA testimony to this effect). Re-infection with HIV/AIDS is also a health risk for PLWA.

The four projects that facilitated the creation of mutual support groups for PLWA were also reducing the impact of HIV/AIDS for PLWA and community members generally. The few projects that did acknowledge and involve PLWA as active project participants in education, care or project committee roles were also reducing the impact of HIV/AIDS. Promoting *positive living* for PLWA and placing them at the centre of HIV/AIDS responses is good for PLWA, those who love them and their community as a whole for a variety of reasons. It is also good for prevention.

Six projects worked to reduce risk, vulnerability and impact in ways beyond education and PLWA care, namely Kahama II, Kariobangi, Iyolwa, Highway One, Mongla and Thanh Hoa.

Reducing the impact of HIV/AIDS: UNAIDS strategy framework

Decreasing impact decreases vulnerability

Action to reduce impact can occur within, and focus on, nation, community, family and individuals. Some actions to assist families and communities are described here …

Reducing the impact on individuals and families:

- direct support to reduce the catastrophic financial impact of HIV/AIDS on families;
- early support to children, especially those orphaned by AIDS, focusing on their health, nutrition and education;
- vocational training opportunities for young people;
- improved access to quality care for people living with HIV including peer group support, voluntary counselling and testing, essential drugs and commodities, antiretrovirals, and social support services, including appropriate supportive roles for traditional practitioners;
- improved access to legal services, and human rights protection.

Community action to reduce impact:

- empowering communities to respond to issues at local level;
- improving the capacity of community organisations to carry out their activities, including outreach, and the provision of care and social support to affected families;
- enhancing the role of schools as centres for family and community service;
- assurance that community consultation occurs in HIV/AIDS policy and program design and implementation;
- increased community and external investments in essential infrastructure in key sectors including health, education, social services and agriculture.

Textbox 3.9
Source: UNAIDS (2001), The Global Strategy Framework on HIV/AIDS, pp.11-12.

Kariobangi

Kariobangi, for example, helped integrate young people in a slum urban area with high unemployment, violence, alienation, drug taking and HIV/AIDS incidence into the community through:

- motivating youth to form self-help youth clubs and become involved in writing and presenting their own HIV/AIDS-prevention dramas;
- assisting selected youth to access vocational training by helping with fees;
- assisting foster mothers look after orphans and other marginalised children who may have otherwise become street children.

Kariobangi also supported community traditional birth attendants (TBAs) who ran a nursery that included a free, nutritious food for local children, thus supporting the development of a pre-school that was a more inclusive and protective community-based organisation. It was inclusive because all children at the nursery were fed, not just the poorest children who were in fact the main concern of the TBAs and the project. In this way, the project was 'enhancing the role of schools as centres for family and community service'. The TBAs were one of the loan groups assisted by the project. By supporting and training youth, PLWAs, TBAs and foster parents the project was 'empowering communities to respond to issues at local level'.

Kariobangi's new plan includes support to build community networks in water and sanitation, environmental improvement and income-generation and permaculture as well as HIV/AIDS prevention. This can be called a primary health care (PHC) approach designed to improve community members' immune systems to reduce vulnerability for those who were HIV negative and to improve the quality and length of lives of those who were already HIV positive.

The project helped to improve literacy and educational levels in the Kariobangi slum area by:

- helping to pay the school fees of some orphans and other marginalised children in primary and secondary school;
- contributing to vocational training fees;
- promoting and supporting home-based fostering for children who would otherwise be at risk of being street children and not attending school;
- supporting TBAs to run their nursery, attracting greater attendance through the nursery-based food program.

Low literacy and educational levels have been found to increase people's vulnerability to HIV infection. 'Poverty is often associated with lower education, which may in turn be associated with lower awareness of effective measures to prevent HIV/AIDS infection' notes a recent UNAIDS/World Bank paper on AIDS, poverty reduction and debt relief'. In this context it is worth noting that:

- Highway One included an education-scholarship program for resource-poor girls;
- five of the projects were part of broader ADPs all of which included components aimed to boost and maintain children's participation in school (Mongla, Kariobangi, Mumbai, Iyolwa, Senegal).

Evaluations did not comment on the degree of integration between activities geared towards reduction of risk, vulnerability and impact *per se,* although some evaluations did comment on integration issues (described later in chapter).

Lack of internal synergy sometimes an issue

Most evaluation reports did not specifically raise the question of degree of synergy or integration between the project components. This suggests that for these evaluations, the project's operations did not trigger internal integration as an issue. Five evaluation teams raised internal integration[19] as a concern.

The Danang II evaluation team felt that a 'relative lack of cross-fertilisation between components was a limitation of the project and a lost opportunity'. It felt that the project could have used the research findings flowing from component one (detailed research on risk behaviour conducted), component three (AIDS education campaign among out-of-school children and youth designed and conducted) and

component four (preventive medicine centre's counselling, community care and AIDS awareness activities∇further developed and implemented) to inform component-two activities (AIDS education campaigns among school children and young adults∇ designed and conducted).

The team found little evidence that research findings from component one were used to inform activities under component three (the development and implementation of out-of-school children and youth curricula). The team commented: 'Nor were there systematic efforts to ensure that out-of-school youth benefited from development of in-school materials, parts of which could probably be used with out-of-school population'.[20]

One dimension of the Kariobangi loan scheme that may not have been integrated so well into HIV/AIDS prevention and care was the targeting of some loans to mainstream older community members with the stated aim of channelling their energies towards productive, useful activity. Some of the evaluation team were sceptical of effectiveness of loans to mainstream community members in their 50s as a prevention measure given that there was always time for unprotected sex even if beneficiaries were to become busier than their pre-loan situation. The 2001 Kariobangi evaluation report recommended that the loan component in future emphasise the project's existing main direction of giving loans to activists already involved in community prevention and care.

The Iyolwa loan scheme raised the issue of integration but in a different way. Its objective was women's empowerment, that is, to assist resource-poor women to improve their economic position and thereby to reduce the economic imperative that may drive them into full-time or part-time commercial sexual activity. Around 55 per cent of loan beneficiaries were women. While the technical advisor's report supported the objective of 'empowerment of resource-poor women' it questioned whether the loan scheme was directed to the poorer women in the community and whether economic benefits would help the female beneficiaries to have safer sex in the short term. The evaluation recognised that the component was valuable and could be more so if integrated into a coherent female empowerment strategy. One effect of the loan scheme was that it assisted some of the women to care for orphans and other marginalised children.

To be fair to the project, the Iyolwa loans were also possibly a sensible community-sweetener to help raise community interest in what was otherwise a specialised HIV/AIDS prevention and care project.[21] HIV/AIDS is widely recognised to be a difficult entry-point for new organisations or programs in many localities given that HIV/AIDS may not feature among the highest expressed needs of communities even if prevalence rates are high in these areas.[22] The sweetener role of loan schemes in relation to projects in new areas otherwise having an exclusive HIV/AIDS focus is justifiable, although it is better for organisations to make a commitment to areas and integrate HIV/AIDS interventions into their development program as a whole.

As noted earlier, the Senegal 1999 evaluation team noted the low level of integration between introduced HIV/AIDS components and the remainder of the ADP activities in two ADPs. WV Senegal had planned that HIV/AIDS awareness activities would be introduced in four ADPs, but two of the four did not incorporate them at all. The HIV/AIDS components were planned and introduced by the head office.

The Senegal evaluation team touches on the difference between *mechanical integration* and *organic integration*.[23] Mechanical integration entails the addition of an HIV/AIDS component to another intervention so that it sits side-by-side with other components as a separate *silo*. Organic integration is the mainstreaming of HIV/AIDS-related dimensions through some or all of existing components so that it interacts synergistically with other components. The framework presented by the Senegal evaluation team is a tool designed to assist in planning and enhancing a project or program's organic integration. Monitoring and evaluating the kind and degree of organic integration is also assisted by such a framework.

Those planning, monitoring or evaluating HIV/AIDS responses in localities could use the simple

An integrative tool

The team brainstormed a possibly useful framework for integration of activities and projects/programs on the level of the ADPs.

We experimented a bit with the following grid, which does not intend to be more than a suggestive example of how one could conceptually and operationally link the (previous and current) independent-ly operated (and often funded) individual programs (like the STD/HIV/AIDS prevention and education project) into the overall ADP framework. We present it here, so that it can be further developed if it proves to be a useful tool.

Strategies						
ADP objectives	HIV/AIDS	Training	Sponsorship	Agric.	Vaccin.	Nutrition etc
Education						
Health/ drinking water						
Agro- environment						
Economy						
Gender & development						
Christian witness						
Program Intelligence						

In the above table, each of the individual cells could thus become a point of integration for the strategic objectives of each individual program component to be matched with the overall goals of the area development program(ADP) as a whole. Specific evaluations/reflections could be centered on each of the rows in the table, to check on horizontal integration according to overall ADP goals and across the various strategic approaches deployed.

Alternatively and complementarily, they could center on the columns to check on the integrity and synergies of the individual strategic approaches, and on whether full advantage is taken in the overall developmental orientation of the ADP.

Textbox 3.10
Source: Senegal Evaluation Report (1998), p. 29.

but powerful checklist tool (Textbox 3.10) that invites participants to discuss which actual or potential project functions should be included in which actual or potential focus area (vertical column).

Integrate with a broader development program

It is probably evident that trying to reduce risk, vulnerability and impact at the same time requires integrating HIV/AIDS interventions (narrowly defined) into broader development programs.

Mainstreaming HIV/AIDS into a broader development program now appears to be accepted as a best-practice principle. For example, the Canadian International Development Agency (CIDA) accepts the following guiding principles for HIV/AIDS programming:

Key elements of primary health care

The Alma-Ata Declaration [endorsed by all the countries attending a World Conference in Alma Ata USSR in 1978] stated the essential elements in health services included in primary health care. There are at least eight essential health elements in the provision of primary health care:

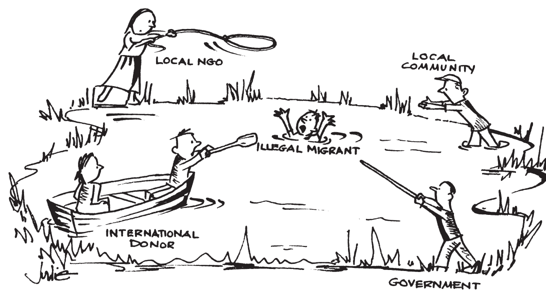
- education concerning prevailing health problems and the methods of preventing and controlling them;
- promotion of food supply and proper nutrition;
- maternal and child health care, including family planning;
- adequate safe water supply and basic sanitation;
- immunisation against major infectious diseases;
- prevention and control of local endemic diseases;
- appropriate treatment of common diseases and injuries;
- provision of essential basic household drugs for the community.

There are five basic principles identified in the PHC approach:

- equitable distribution;
- human development;[28]
- community participation;
- appropriate technology;
- multisectoral approach.

Textbox 3.11
Basavanthappa, B. (1998), *Community Health Nursing*, Jaypee Brothers Medical Publishing, Bangalore, pp. 101-102.

> [HIV/AIDS programs should…]
>
> [address] the determinants of HIV/AIDS through intersectoral strategies, including considering the potential impacts of other development programs on HIV/AIDS.
>
> [promote] sustainable development and poverty reduction through a broad development approach, including basic human needs and human rights.[24]



As noted in chapter 1, the new global framework on HIV/AIDS notes that 'achievement of the overarching aim of the global response requires leadership commitments', among other things, 'to develop policies, legislation and programs which address individual and societal vulnerability to HIV/AIDS and lessen its socio-economic impacts, by focusing on enabling strategies which operate in the context of overall poverty reduction and human development priorities, and to develop the coping strategies required to address the impact of the epidemic in productive sectors'.[25]

The global framework calls for an expanded, multi-level response to HIV/AIDS that simultaneously works to reduce risk of infection, vulnerability and impact. In this light, HIV/AIDS activists should consider adopting a primary health care approach within a broader poverty reduction program.

Integration of HIV/AIDS into primary health care approach

HIV/AIDS interventions should also be integrated into a broader primary health care (PHC) approach. For example, condom use can be promoted as a protection against a variety of sexually transmitted infections as well as contraception inside and outside of marriage. Counselling, care and education∇and those doing all the above∇are enabled to work in a less stigmatised role and context when HIV/AIDS activities are integrated into broader PHC. HIV/AIDS-specific services can stigmatise the service, providers and clients.[26]

The *Abuja Framework For Action For The Fight Against HIV/Aids, Tuberculosis and Other Related Infectious Diseases In Africa* appears to endorse an integrated PHC approach to HIV/AIDS, TB and other infectious diseases. This makes sense. In addition to HIV/AIDS, a variety of infections (TB, malaria, herpes simplex), conditions (malnutrition) and lifestyle options (drug use) can suppress the immune

system, increasing people's susceptibility to other infections and reducing their capacity to fight the infection.

Protecting and strengthening people's immune systems can help protect them from a variety of infections or reduce the length or severity of symptoms once infected.[27]

The strength of the PHC approach is its emphasis on appropriate, participatory, multisectoral, community-level prevention and accessible community-based treatment.

Five projects integrated or intended to integrate HIV/AIDS into a broader PHC approach (Kahama II, Thai-Burma\Myanmar, Thanh Hoa, Kariobangi Primary Health Care Project, Iyolwa).

Some evaluation teams recommended that volunteers' identity and roles (and/or the project's approach) be broadened from HIV/AIDS specific to (Arumeru, Kawthaung, Kariobangi, Nankumba). The Nankumba evaluation report, for example, made the following recommendations:

> The project helps to strengthen the capacity of village health committee (VHC) members to assist carers *and* people requiring home-based care.
>
> In cooperation with health staff and other relevant stakeholders, project staff find out more about the degree and type of home-based care activities that different VHCs do in relation to people not suspected of being PLWA, and what degree and kind of additional knowledge/skills are required.
>
> If supported by the research findings flowing from the recommendation above, the project help to strengthen VHCs' capacity to play broader *primary health care* roles (to be able to assist people requiring home-based care irrespective of cause).
>
> The project, in consultation with other relevant stakeholders, works out the scope and content [that needs] strengthening.
>
> Future quarterly reports list all home based care activities, not just HIV-related care.[29]

In general, the HIV/AIDS projects were not designed to work wholeheartedly in the PHC paradigm, but provided a HIV/AIDS-specific contribution. The standout exception was Kahama II with a program linking three projects using this approach. The main program activity areas were:

Broad understanding of primary health care(PHC) in Thai-Burma/Myanmar

> Output 4: Social network groups established to be involved in HIV/AIDS, PHC and community development issues with a particular focus on the support and care of PABA [people affected by AIDS]….
>
> Primary health care is provided through special FSNs [frontline social networkers] and is a strong component of community activities. PHC has been thoroughly integrated into the project via two programs in succession that were externally funded. A final evaluation of the first phase of the PHC project showed that only 45 per cent of households had access to pipe water, less than 60 per cent use sanitary latrines, and not more than 23 per cent have garbage disposal facilities. Despite some improvements from the PHC project, and cooperation of the MOPH, serious communicable diseases are still prevalent, and diarrhoea in children is a major concern. Mother and child health is a focus of the PHC initiatives.
>
> PLA [participatory learning and action] activities suggested that mothers were very concerned about the lack of education for their children. Suggestions were taken up and discussed and informal classrooms were set up. Unfortunately four of these classrooms have closed due to teachers, mothers and children moving back to Burma/Myanmar or elsewhere, and other considerations such as lack of ongoing funds. Two community schools remain supported by parents' contributions. The third is a fairly recent development where students were accepted into a Thai school. This is in accordance with new government policy but came about through advocacy by the project with support of local authorities.
>
> Savings schemes have been developed for some community members as with the fishermen, and include housewives of fishermen who were vulnerable to seeking men to support them while their husbands were away. This became quite common and acceptable among some groups. This is evidence of behavioural norms changing when living in new environs with a range of influences that can change perceptions and attitudes. The incidence of women having such relationships seems to be reducing but there is limited data to this effect.

Textbox 3.12
Thai-Burma/Myanmar Evaluation Report (1998), pp.12, 55.

- growth monitoring, oral rehydration treatment, immunisation, malaria prevention and HIV/AIDS education;
- strengthening partnerships between government and communities, providing credit for income-generating activities and addressing gender equity issues;
- food production and land use;
- water supply.

Loan schemes can be part of PHC approach

The rationale behind the addition of income-generating activities and loans directly to women and activities already running in Kahama I (called KSCSP Phase I below) was made out in PHC terms.

The KCSDP Phase II is an integrated community-based primary health care program in the context of isolated, rural and poor communities. The link between poverty and poor health is well recognised and documented. The mid-term evaluation of Phase I stressed very strongly that poverty is the basic (root) cause of child deaths. As a result of this recognition, the Phase II design incorporated a very specific component which aims to establish a credit scheme to support the income-generating activities of women.[30]

In other words, Kahama II offered loans to local women to start income-generating activities to help raise household income and ultimately to reduce infant morbidity and mortality.

The example of Kariobangi was described earlier. The Thanh Hoa project, another example, incorporated community training on HIV/AIDS prevention into a broader community health and development program to:

- improve women's and children's health;
- improve the ability of health personnel to facilitate community health care;
- strengthen the capacity of government institutions in these communities;
- increase family food production among poor families.[31]

Thanh Hoa, Iyolwa, Kariobangi and Arumeru had loan schemes of different types with different purposes. The Thanh Hoa loans were provided to resource-poor community women (1416), mainly mothers with malnourished children under five years of age and to hamlet health workers (90). The aim of the loan to mothers with small children was to increase food production through tying loans to fish-pond raising, fruit tree planting and animal rearing. The aim of no-interest loans to hamlet health workers was to contribute to the continuation of their voluntary roles given that the local government was not able to finance their salaries.

Mechanical/organic integration

Again, the issue of mechanical/organic integration between HIV/AIDS components and the broader development program arises. The existence of several components in one project does not mean that there is synergy or that HIV/AIDS is *integrated* into a broader development program. The integration between the loans scheme and other parts of the Thanh Hoa program, for example, did not start strongly but improved over time:

> During the first year of the project, the project steering committee thought that there was little integration between the loan scheme and the health promoting activities, but this integration was strengthened during the subsequent two years… An excellent feature of this project was the integration of improved health care delivery with health education, provision of water and sanitation and income generation. It is futile to teach mothers and health workers about nutrition and health when families are too poor to eat. The way in which this income generating scheme was planned and managed meant that there were important additional social community development benefits which potentiated the impact of the loans.[32]

In Kahama II, HIV/AIDS could have been integrated more tightly into the overall primary health care program. The evaluation team suggested that the HIV/AIDS education component be incorporated under the community health education component and that 'all future HIV/AIDS components should be integrated into a sexual and reproductive health model which advocates STD syndromic management, improved access to STD treatment services,

free distribution and social marketing of condoms, condom negotiation training for women, condom distribution as a means of dual protection, behaviour change strategies and mobilisation of communities infected and affected by HIV/AIDS'.[33]

There were other important exceptions and several evaluation teams encouraged projects in this direction. Kariobangi's new design has embraced the PHC paradigm.

Integration of HIV/AIDS into poverty programs

Given the increased emphasis on poverty reduction among multilateral and bilateral overseas-aid donors as well as in the HIV/AIDS best-practice literature, it makes sense for HIV/AIDS responses supported by World Vision and other international NGOs to integrate HIV/AIDS more explicitly into poverty-reduction approaches and programs. A recent review of best-practice literature on behaviour-change concluded that approaches that acknowledged the social, economic and engendered dimensions of inequality stood a higher likelihood of success.[34]

Many of the most commonly named high-risk groups in less industrialised countries (such as commercial sex workers and migrant workers) often come from resource-poor families and communities. Community-development and area-development approaches to increase social and economic opportunities for resource-poor communities and to support those most marginalised within these communities to protect the health of themselves and others are part of important

OECD's Development Assistance Committee(DAC) Poverty Guidelines

8. The OECD/DAC strategy *Shaping the 21st Century: the Contribution of Development Co-operation* set out a vision of development co-operation based on partnership around development strategies owned and led by developing country governments and civil societies. The principles underpinning this vision—partnership, ownership, country leadership, broad-based participation, development effectiveness and accountability—have far-reaching implications for the way development agencies conduct business. Development co-operation agencies now need to work in a much closer, more co-ordinated way with a wider range of development partners. They should tailor assistance to partner-country priorities and needs where the conditions for partnership exist. They are now accountable to partners and to their own publics for actions and commitments. They need to work as facilitators, rather than prime movers, of development.

9. The 21st century strategy also committed DAC members to assist developing countries to achieve the international development goals (IDGs), which address the key dimensions of poverty. The IDGs are viewed in the context of the broader set of goals including on hunger, safe water and HIV/AIDS—agreed in the Millennium Summit Declaration, and in the context of the ultimate objective of poverty eradication. These goals have been reaffirmed in emerging international frameworks for organising poverty reduction support.

10. Under the impetus of the 21st century strategy, DAC members are committing themselves to work with greater resolve to reduce poverty in solidarity with poor people and in the interests of securing universal human rights. They will be working to ensure centrality of sustainable poverty reduction in development co-operation, and to integrate economic, social, environmental and governance concerns within comprehensive approaches to development at the country level.

11. Determined to work more effectively to reduce poverty, DAC members have now developed a set of guidelines to help concert and improve their individual and collective efforts. The DAC guidelines on poverty reduction cover five major themes: poverty concepts and approaches, partnership issues, country programming, policy coherence and institutional change in development agencies. This summary highlights key guidelines' conclusions, commitments, and challenges…

Greater attention is needed to improve coherence within the aid system itself, ensuring that the policies and decisions undertaken by other ministries with responsibilities for aspects of development assistance, by implementing agencies, and by member country representatives in the governing bodies of multilateral development institutions are consistent and compatible with the poverty reduction objective.

Textbox 3.13
Extract from OECD Development Assistance Committee's *Guidelines on Poverty Reduction*, May 2001, pp. 8, 109, http://www.oecd.org/dac/htm/g-pov.htm.

Action: adapting poverty reduction efforts to the reality of HIV/AIDS

The poverty impact of AIDS demands a twin response:

- strengthening HIV prevention, treatment and mitigation within poverty reduction strategies, and
- strengthening implementation of pro-poor policies to reduce the impact of AIDS.

In countries with advanced epidemics, AIDS amplifies existing problems of household poverty to the extent of triggering structural changes and thereby creating new problems. Hence for example, AIDS produces child headed households, a breakdown of informal rural institutions and of social safety nets. This makes wider poverty reduction strategies critical to mitigating the impact of AIDS and to reducing future vulnerability. Poverty reduction strategies need to be backed by pro-poor policies to secure the educational needs of youth and orphans, ensure access to shelter and social services, enhance food security, [provide] access to safe water and provide an adequate income security to deal with the consumption needs generated by AIDS. Pro-poor policies direct resources in a more sustainable manner towards low income communities for these needs, and in so doing reduce their susceptibility and vulnerability to HIV/AIDS.

Textbox 3.14

Source: Loewenson, R. (2001), *HIV/AIDS: Implications for Poverty Reduction*, United Nations Development Program (UNDP), background paper prepared for UNDP for the UN General Assembly Special Session on HIV/AIDS, 25-27 June, 2001 available at http://www.undp.org/dpa/frontpagearchive/2001/june/22june01/hiv-aids.pdf. op.cit., p. 21.

HIV/AIDS prevention and poverty reduction at the same time.

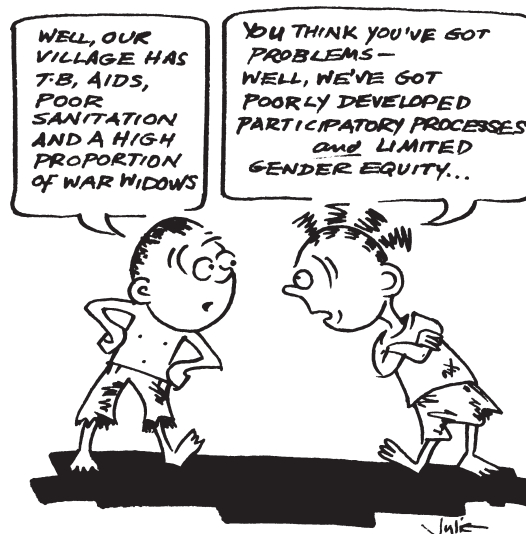
Migration and poverty are among the key HIV/AIDS vulnerabilities noted in the UNAIDS/World Bank paper on HIV/AIDS and poverty. Increasing viable social and economic integration in specific communities is a key response to poverty and the widespread out-migration that results.

Most area development programs (ADPs) assisted by WV have pro-poor policies in the sense described in the Box 3.11 above, most focusing on:

- supporting the continued participation of children, including orphans, in education;
- improving water and sanitation;
- improving the situation of women;
- community mobilisation;
- gender awareness;
- spiritual nurture;
- provision of loans for income-generating activities;
- improving agricultural productivity.

Given that all WV ADPs in more general terms are designed to maintain and enhance community solidarity, sustainability and vitality (sustainable livelihoods), it is fair to say that all are well geared to positively influence the reduction of HIV/AIDS risk, vulnerability and impact.

Five of 19 HIV/AIDS interventions in our sample were situated in ADPs and so could be said to be part of a broader poverty reduction program. Five interventions took a primary health care approach, one of these was working within an ADP (Kariobangi). So nine interventions could be said to have worked within a broader WV-assisted development program. However, no project was explicitly integrated in a broader national or international poverty reduction program as described below.



The interplay between HIV/AIDS and poverty (both feeding into each other) is increasingly recognised. The link between HIV/AIDS and poverty was a key theme in the UN Special Session on HIV/AIDS, June 23-25, 2001. Highly indebted poor countries (HIPC) are expected to prepare a debt initiative and the poverty reduction strategy paper (PRSP).[35] In this context, a joint UNAIDS and World Bank working group has developed a toolkit 'to enable country officials and their partners to prepare and negotiate effectively the inclusion of scaled-up HIV/AIDS programs in the PRSPs and instruments of debt relief under the enhanced HIPC initiative'. The rationale for the toolkit was explained as follows:

Despite increasing recognition of its negative impact on development, HIV/AIDS is only one of many problems that countries will address in their PRSPs and HIPC documents. With so many ministries, sectors and civil society groups competing for attention and funding in PRSPs and HIPC documents, the case for HIV/AIDS must be highly compelling: that HIV/AIDS jeopardises poverty reduction efforts, that by fighting AIDS, poverty will also be tackled, that money can be spent efficiently to reverse the epidemic and improve people's lives. There, any effort to mainstream HIV/AIDS in the development agenda must be well articulated to ensure buy-in from multiple sectors and the highest levels for HIV/AIDS need to demonstrate that an effective national HIV/AIDS program will contribute to the fight against poverty. They must

Table 3.1 Interventions for prevention of HIV infection

	Factors influencing transmission of HIV	Interventions
Risk-oriented strategies addressing immediate factors of transmission	Sexual transmission	Information-education-communication (IEC) campaigns for behaviour change School education Life skills Condoms (promotion of 100% condom use among the most vulnerable including CSWs and the military) Voluntary counselling and testing Counselling
	Blood transmission	Blood safety Universal precautions Safe injections/needle exchange
	Mother-to-child transmission	Prevention of mother-to-child transmission
Vulnerability-oriented strategies addressing underlying factors of transmission	Sexual behaviour Intravenous drug use Cultural and religious factors Poverty Illiteracy Discrimination Migration	Behaviour change education Life skills and education for in-school and out-of-school youth Harm reduction IEC for behaviour change Community mobilisation Poverty reduction Education Legislation Human rights Rural development etc

Source: Adeyi, O., Hecht, R., Njobvu, E. and Soucat, A. (2001),*AIDS, Poverty Reduction and Debt Relief: A Toolkit for Mainstreaming HIV/AIDS Programmes into Development Instruments,* UNAIDS and World Bank, Geneva, p. 14.

also lay out the financial case for debt relief, including how much will it cost to implement a far-reaching HIV/AIDS program.[36]

Poverty has been explored in several important WV publications including the following:

- *Working with the Poor: New Insights and Learnings from Development Practitioners* edited by Dr Bryant Myers, World Vision International's vice-president of ministry;[37] and
- *God of the Empty-Handed: Poverty, Power and the Kingdom of God* written by Dr Jayakumar Christian, World Vision International's Director of Transformational Development.

Both these books, and poverty more generally, are part of an intensive internal course preparing selected WV staff for future leadership roles. It is significant and welcome that the importance of a poverty perspective is being championed and promoted among current and future WV managers.

The relationship between poverty and HIV/AIDS was a central focus of a 1994 WV publication *Beyond the Fragments: HIV/AIDS and Poverty*.[38] The poverty focus also reflects the emphasis that WV places on a poverty reduction framework for its practice.[39] On the other hand, WV has not been using an explicit poverty reduction framework. While its overseas-aid program focuses on what are normally recognised as key areas for poverty reduction (such as improved sanitation, health, income, food security, training and education, access to water, horticulture and agriculture etc.), its programs and evaluations do not normally focus *explicitly* on poverty reduction. For example, few project proposals describe poverty reduction as an explicit project goal or purpose.

In the light of WV's vision statement and the increased international commitment to integrate HIV/AIDS into a global poverty-reduction program, it is appropriate for WV to consider more explicitly and routinely situating HIV/AIDS (and other programs) within a poverty-reduction framework. This has implications of course for project planning, proposals, designs, monitoring and evaluation.

Understanding poverty

Poverty is a complex and contested term. The UN Secretary-General's Millennium Report exemplifies the mainstream economic view of poverty in the following recommendation: 'Poverty: to halve, by 2015, the proportion of the world's people (currently 22 per cent) whose income is less than one dollar a day'.[40]

This and other examples of a single-variable analysis of poverty have been criticised as overly simple, reducing a multidimensional phenomenon to a quantifiable, single factor.

Probably the most common and influential understanding has been that poverty is a *lack of resources*. Chambers dictionary, for example, defines poverty more broadly as 'the state of being poor; need, want of necessities; a lack or deficiency; meagreness or inadequacy'.[42] Jayakumar Christian notes that the lack of resources assumption has guided policy formulations of governments and development interventions for years',[43] but that it has been criticised as being narrow, missing other important causes and dimensions of poverty.[44]

Christian presents a well-grounded, multidimensional and nuanced framework for understanding and addressing poverty. In his contribution to Bryant Myer's *Working with the Poor*, he identifies the following strategic implications flowing from his understanding of poverty:

- our response to the poor must address the whole context of poverty;

- poverty demands a response that is essentially spiritual at its core;
- transformation must include the agents of transformation.[45]

One of the better-known frameworks offering a wider notion of poverty was developed by Manfred Max-Neef, a Chilean economist. In Max-Neef's multidimensional framework, unmet economic, political, social and psychological human needs are seen as *poverties*.

Max-Neef presents key human needs according to the following *axiological categories*: subsistence, protection, affection, understanding, participation, idleness, creation, identity and freedom. He distinguishes four *existential categories* applying to each need, namely, being, having, doing and interacting. For example, subsistence needs include physical health, mental health, equilibrium, sense of humour and adaptability (being); food, shelter, work (having); feeding, procreating, resting, working (doing); and living environment, social setting (interacting).

In this framework, we can speak of :

- poverties of understanding, subsistence, protection, affection, participation etc.; and
- poverties of being, having, doing and interacting.

Manfred Max-Neef

Max-Neef won the *Right-Livelihood Award* in 1983 for his contribution to 'revitalising small and medium-sized communities, fostering self-confidence and reinforcing the roots of the people'. In the field of alternative economics, the Right-Livelihood Award is the equivalent of the Nobel prize.

'Manfred Max-Neef is a Chilean economist who has gained an international reputation for his work and writing on development alternatives. In addition to a long academic career, Max-Neef achieved an impressive minority vote when he stood as candidate in the Chilean presidential election of 1993. He was subsequently appointed Rector of the Universidad Austral de Chile in Valdivia.

After teaching economics at the University of California (Berkeley) in the 1960s, he served as a visiting professor at a number of US and Latin American universities. He has worked on development projects in Latin America for the Pan-American Union, the UN Food and Agriculture Organization and the International Labour Office.

In 1981 he wrote the book for which he is best known, *From the Outside Looking In: Experiences in Barefoot Economics*, published by the Dag Hammarskjöld Foundation, Sweden. It describes his experiences as an economist attempting to practise 'economics as if people matter' among the poor in South America. In the same year he set up in Chile the organisation CEPAUR (Centre for Development Alternatives).

CEPAUR is largely dedicated to the reorientation of development in terms of stimulating local self-reliance and satisfying fundamental human needs. More generally, it advocates a return to the human scale. CEPAUR acts as a clearing-house for information on the revitalisation and development of small and medium-sized urban and rural communities. It researches new tools, strategies and evaluative techniques for such development, assists with projects aiming at greater local self-reliance and disseminates the results of its research and experience.

In *Human Scale Development*, published in 1987 in Spanish and later in English, Max-Neef and his colleagues at CEPAUR outline a new development paradigm based on a revaluation of human needs. Needs are described as existential (having, doing, being) and as axiological (values) and the things needed to satisfy them are not necessarily dependent upon, or commensurate with, the kinds or quantities of economic goods available in any given society. The book seeks to counter the logic of economics with the ethics of well-being.

> There are two separate languages now—the language of economics and the language of ecology—and they do not converge. The language of economics is attractive, and remains so, because it is politically appealing. It offers promises. It is precise, authoritative, aesthetically pleasing. Policy-makers apply the models, and if they don't work there is a tendency to conclude that it is reality that is playing tricks. The assumption is not that the models are wrong but that they must be applied with greater rigour... While the many deficiencies and limitations of the theory that supports the old paradigm must be overcome (mechanistic interpretations and inadequate indicators of well-being, among others), a theoretical body for the new paradigm must still be constructed. - *Manfred Max-Neef*

Textbox 3.15
Source: http://www.rightlivelihood.se/recip1983_4.html

All these poverties – or dimensions of poverty, can be related to HIV/AIDS risk, vulnerability and impact.

In the language of Max-Neef, HIV/AIDS activities designed to reduce risk behaviour can be seen to address poverties of understanding (such as ignorance of how HIV/AIDS is transmitted and can be prevented). Similarly, HIV/AIDS activities designed to reduce vulnerability can be said to address poverties of:

- understanding more generally (low levels of participation of children, youth and adults in quality formal and non-formal education, including literacy education; taboos on open discussion and learning concerning sexuality, sexual behaviour, safe sex, sex roles etc.);
- protection (rape, assault, difficulty of women to negotiate safe sex with regular partners; marginalised status of PLWA, commercial sex workers, men-who-have-sex with men, injecting drug users);
- participation (unequal participation of females in social, economic and political life);
- subsistence (dearth of opportunities and viable livelihoods in marginalised localities leading to widespread urban-rural migration; poor immune systems, health, nutrition, water, sanitation).

Finally, HIV/AIDS activities designed to reduce impact can be understood as addressing poverties of:

- protection (orphan-headed households, street children; stigma towards, and human rights of PLWA, commercial sex workers, men-who-have-sex with men, injecting drug users);
- subsistence (poor health and economic situation of PLWA and families; psychological and spiritual dimensions of life for PLWA).

Suggestions for the future

Organisations supporting local HIV responses could consider the following suggestions:

- developing a strategy and detailed plans to mainstream the kind of ideas relating to synergy, integration, primary health care approach and poverty reduction described in this chapter;
- mainstreaming the following actions into appropriate phases of HIV/AIDS programs:
  - explicitly framing project proposals and designs in terms of poverty-reduction;
  - researching and documenting the kinds and degrees of poverties endured by people in the locality during the planning phase (for examples poverties of understanding concerning HIV/AIDS; poverties of participation of women in decision-making in government, work and household domains, including over sexual and reproductive areas);
  - explaining the project's location and intended population-group focus in terms of comparative poverties in project proposals. (for example, are people's needs in this area greater than elsewhere? Why this area? Why work with these people not those people? Hard but important questions);
  - exploration and documentation of comparative needs and poverties are not handled well at present in project proposals, project designs or in evaluations that generally focus on evaluating projects in terms of their specific objectives, as noted earlier.
- moving beyond a project-by-project approach to more integrated national and international poverty-reduction programs by incorporating, among other things:
  - integrated advocacy that feeds from, and into, many projects with a focus on reducing poverties increasing HIV/AIDS-related risk, vulnerability and impact for marginalised populations;
  - a gender-and-development approach;
  - strengthened links to social movements and to participatory approaches;[46]
  - attention to spiritual *and* secular poverties;
  - more synergy among projects and components;
  - monitoring and evaluating performance, effects and learning not only at project level, but at program level (What difference is our HIV/AIDS program in different parts of the world having? What have we learned across all the different projects?) and at organisational level

(How integrated are the different parts of WVA's organisational poverty-reduction program—fundraising, marketing, overseas-aid program, education, advocacy? How can the parts work better together?)

- promoting more integrated WV national and international plans on HIV/AIDS and other development dimensions.
- strengthening appraisal structures, processes and capacity, ensuring that attention to the kind and degree of synergy, integration and poverty-reduction is a key dimension of each project/program appraisal;
- ensuring that each staff member involved in project design, implementation, management and evaluation is familiar with the best-practice guidelines and knows how to apply them in practice;
- monitoring and evaluating projects' positive and negative effects on reducing poverties;
- committing to building capacity in explicit poverty-reduction design, management, monitoring and evaluation.

Summary

The following best-practice principles relating to synergy and integration were applied to a sample of WV HIV/AIDS projects:

- cooperate with other local stakeholders (government, community and private sector);
- promote synergy among WV projects;
- promote synergy among project components
  - be multifaceted—multifaceted adopt multiple methods of prevention;
  - make connections between prevention and care;
  - reduce risk, vulnerability and impact at the same time;
- integrate HIV/AIDS into a broader development program:
  - primary health care approach;
  - poverty reduction program.

The quantity and quality of cooperation between WV's HIV/AIDS projects and government stakeholders was generally regarded as strong by evaluation teams. Projects generally collaborated well with health ministry counterparts in line with their project designs. All sampled HIV/AIDS interventions were in line with national government HIV/AIDS strategy.

Project-community cooperation was generally low during the initial planning, becoming generally high in implementing project activities. Community cooperation in managing projects was generally not required by projects. Community members in some projects collaborated with project staff and/or government staff in monitoring and evaluating the project or specific project functions.

Most HIV/AIDS projects initiated some kind of collaborative relationship with private-sector stakeholders such as fishing boat owners, brothel owners and petty traders. The private sector is now being called on to play still more pervasive and influential roles in implementing and resourcing HIV/AIDS responses. Private sector relations and roles are worthy of expansion in future HIV/AIDS responses.

Six evaluative reports raised internal integration or synergy as a dimension for praise or for criticism. In a minority of projects, it was suggested that the various project components sat side-by-side with little or no synergy rather than dynamically interacting. The Senegal evaluation suggested a tool for assessing and improving synergy between components of a project and beyond.

Synergy and integration between HIV/AIDS interventions was generally low, although there were some noteworthy exceptions. Most projects were multifaceted in their approach, using different communication media and methods, and urging multiple prevention methods. On the other hand, most projects were not multisectoral in their approach but operated within the health sector. The major exceptions were HIV/AIDS projects that were part of broader area development programs (ADPs) and/or included horticultural, income-generation and youth vocational-training components.

All projects were involved in *reducing risk* through their prevention activities. All were involved in *reducing vulnerability* through their community mobilisation and capacity-building in HIV/AIDS

prevention and/or care. Nine of nineteen projects helping to build the government and/or community care infrastructure were also involved in *reducing the impact* of HIV/AIDS on PLWA and their families. Several projects extended into a range of other impact-reducing activities including loan-scheme support of PLWA and their carers, facilitation of new community-based organisations of PLWA and community counsellors, support and training for foster-parents of orphans and promotion of child/youth participation in school and vocational training.

The importance of integrating HIV/AIDS interventions with broader development programs, including primary health care and poverty reduction, is now emphasised. In general, most HIV/AIDS projects were not designed to work wholeheartedly in the primary health care (PHC) paradigm, but offered HIV/AIDS-specific assistance to government and communities. Five of the 19 HIV/AIDS interventions took a PHC approach. Five interventions worked within an ADP that could be called a poverty reduction program. Given that one project (Kariobangi) spanned both types of broader development programs, nine of the 19 HIV/AIDS interventions worked within a broader development program. None of the interventions was explicitly integrated in a broader national, international or WV poverty-reduction strategy. None of the HIV/AIDS interventions had explicit poverty-reduction objectives.

So, in terms of the best-practice principles of synergy and integration, the standout features of the HIV/AIDS program (or at least the sampled interventions) were:

- most projects worked well and closely with a range of local stakeholders;
- all projects worked to reduce risk and vulnerability and just under a half worked to reduce impact as well;
- just under half of the sampled HIV/AIDS interventions (narrowly defined as specifically education and/or PLWA care components) were integrated into a broader development program.

There was room for improvement in the internal and external integration of HIV/AIDS interventions, including their integration into broader development programs, especially poverty reduction. A number of suggestions were made. It is probably fair to give the sampled projects overall a medium rating for integration and synergy. As remarked by the UNAIDS Executive Director in June 2001, a key challenge for the new millennium is to broaden and deepen collaboration in the global HIV/AIDS response.

Notes and References

[1] Evidence of the acknowledgement of World Vision-assisted HIV/AIDS interventions as part of the government's national HIV/AIDS and health plan comes through the evaluation reports and my own experience.

[2] Thai-Burma\Myanmar Program (1998) Evaluation Report, p.5.

[3] World Vision Australia, Macfarlane Burnet Centre for Medical Research, Asian Research Centre for Migration (2000) *Inception Report: Preventing HIV/AIDS Among Mobile Populations in the GMS*, World Vision Australia, Melbourne.

[4] Ibid.

[5] Arumeru Evaluation Report (1999), p.54.

[6] Thanh Hoa Community Health and Development Project Evaluation Report (1997).

[7] Aboagye-Kwarteng, T. and Moodie, R. (1985) *Community Action on HIV/AIDS*, 1st edition, AusAID, Canberra, p. 85.

[8] Nankumba Evaluation Report (1999), p. 92.

[9] See also, for example, the Global Strategy Framework on HIV/AIDS' encouragement of leaders to 'seek out actively and support the development of partnerships required to address the epidemic among the public sector and civil society, including the private sector' (op. cit., p. 15).

[10] Http://www.uneca.org/adf2000/Abuja%20Framework%20for%20Action.htm.

[11] See earlier-cited calls for coherence, integration and synergy as well as O'Shaughnessy, T. et al. (1999) *Capacity-Building: A New Idea?* World Vision Australia, Melbourne.

[12] There was dual use of the term Kariobangi ADP to cover (a) one project funded by child sponsors in Australia and (b) all three projects.

[13] Songkhla I Evaluation Report (1993), p.28.

[14] Fowler, A. (1999)

[15] Chiangmai I Evaluation Report (1993), Appendix Nine.

[16] UNAIDS (2001) Global Strategy Framework on HIV/AIDS, UNAIDS, p. 8.

[17] UNAIDS (2000) Global Strategy Framework on HIV/AIDS, UNAIDS, p. 8.

[18] Adeyi, O., Hecht, R., Njobvu, E. and Soucat, A. (2001) *AIDS, Poverty Reduction and Debt Relief: A Toolkit for Mainstreaming HIV/AIDS Programmes into Development Instruments*, UNAIDS and World Bank, Geneva, p. 41.

[19] The third project was Kariobangi. The technical advisor questioned the project's theory linking the income-generation component to HIV/AIDS prevention via female poverty reduction and female empowerment through loans (a) given the relatively non-poor profile of male and female loan recipients and (b) the deep-seated gender relations that would take more than loans to change and more time than the initial three year project allowed. The technical advisor saw the loan scheme as a component that could be incorporated within an explicit gender-and-development strategy. See Report (2001), due to the project proposal's calim that not because the loan scheme was inappriate

[20] Danang II Evaluation Report (1998), p. 23.

[21] Iyolwa Evaluation Report, informed by conversation with Project Manager. The 'sweetener' aspect was sensible but not mentioned in either project proposal or other documents. In the view of the evaluation team, however, it is a reasonable point for non-government organisations moving into new localities for include a mix of interventions with HIV/AIDS to promote local interest in, acceptance and active support of organisation and program. The loan program was arguably the bridge for many community members to become involved with the project, including those active on various project committees.

[22] 1999 Iyolwa Evaluation Report. See also Kwarteng, T. et al. (forthcoming) (eds) *Community Action on HIV/AIDS*, AusAID, Canberra.

[23] See O'Shaughnessy, T. (1994) *Beyond the Fragments: HIV and Poverty*, WVA, Melbourne, for more detail on these terms.

[24] Canadian International Development Agency (2000), *HIV/AIDS Action Plan*, http://www.acdi-cida.gc.ca/cida_ind.nsf/0/61e4364421dcbfc685256918006292ea/$FILE/aidsactionplan2.pdf, p. 2.

[25] UNAIDS (2001) op. cit., p.14.

[26] See, for example, Kawthaung, Mumbai and Nankumba evaluation reports.

[27] This topic is too large and complex to go into here. See O'Shaughnessy, T. (1994) for description and discussion of multifactorial approach and other theoretical frameworks.

[28] The original text phrased this principle as 'manpower development' and explained it as aiming to mobilise the human potential of the entire community by making use of available resources.

[29] Nankumba Evaluation Report (1999), p. 6.

[30] Kahama II Evaluation Report (1998), p. 32.

[31] Thanh Hoa Evaluation Report (1997).

[32] Thanh Hoa Evaluation Report (1997) p. 32.

[33] Kahama II Evaluation Report (1998), p. 31.

[34] Reeves, K. (2000) *Lessons Concerning Behaviour-Change*, internal paper prepared during social work placement at World Vision Australia, mimeo.

[35] Poverty Reduction Strategy Papers 'document country-owned strategies for poverty reduction and provide the basis for a wide range of development programs to be financed from public funds and grants': Adeyi, O., Hecht, R., Njobvu, E. and Soucat., A. (2001) *AIDS, Poverty Reduction and Debt Relief: A Toolkit for Mainstreaming HIV/AIDS Programmes into Development Instruments*, UNAIDS Best Practice Collection, Geneva. p.7.

[36] Ibid., p.11.

[37] Myers, B. (ed.) (1999) *Working with the Poor: New Insights and Learnings from Development Practitioners*, World Vision, Monrovia, California. Several other poverty-focused World Vision publications are cited in this study.

[38] O'Shaughnessy, T. (1994) *HIV/AIDS and Poverty: Beyond the Fragments*, World Vision Australia, Melbourne.

[39] WVA's own vision statement refers to World Vision Australia 'working towards a world that no longer tolerates poverty'. WVA is currently reviewing its understanding and practices concerning poverty reduction, working to improve the coherence and quality of its organisational approach to poverty reduction.

[40] United Nations Secretary-General (2001) *'We the Peoples': The Role of the United Nations in the 21st Century'* also called the *New Millenium Report*, United Nations, Geneva.

[41] See Christian, J. (1999) *God of the Empty-Handed: Poverty, Power and the Kingdom of God*, MARC, World Vision International, Monrovia, California, pp. 19*ff*.

[42] Chambers Dictionary (1993), p. 1340.

[43] Ibid. p. 19.

[44] See Christian, J. (1999) op.cit. for more detail.

[45] Christian, J. (1999) 'An alternate Reading of Poverty' in Myer, B. (ed.) op.cit., pp. 21-23.

[46] See also O'Shaughnessy, T. (1995) *Seeds of Change: Food Aid, Food Security and Sustainable Livelihoods*, World Vision Australia, Melbourne for a discussion of David Korten's well-known 'generations' typology of NGO intervention strategies and choices.