

INTERNATIONAL FUND FOR AGRICULTURAL DEVELOPMENT

STRATEGY PAPER ON HIV/AIDS FOR EAST AND SOUTHERN AFRICA

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GLOSSARY OF TERMS AND ACRONYMS

AIDS	Acquired immune deficiency syndrome; the last and most severe stage of the clinical spectrum of HIV-related diseases
AWP/B	Annual workplan and budget
CBO	Community-based organization
CKDAP	Central Kenya Dry Area Smallholder and Community Services Development Project
COSOP	Country strategic opportunities paper
CPM	Country portfolio manager
Dependency ratio	Population aged less than 15 and over 65 (dependent population), divided by the population aged 15 to 64 (productive population)
FAL	Functional adult literacy
FAO	Food and Agriculture Organization of the United Nations
GTZ	<i>Gesellschaft für Technische Zusammenarbeit</i> (German Technical Cooperation)
HIV	Human immunodeficiency virus; a retrovirus that damages the human immune system thus permitting opportunistic infections to cause eventually fatal diseases. The causal agent for AIDS.
HIV incidence	Number of new cases of HIV occurring in a population during a given period of time, usually a year
HIV prevalence	Total number of persons living with HIV at any given moment in time
IEC	Information, education and communication
IPM	Integrated pest management
Life expectancy at birth	The average number of years a group of people born in the same year can be expected to live if mortality at each age remains constant in the future
MFI s	Microfinance institutions
NAC	National Aids commission
NGOs	Non-governmental organizations
PRA	Participatory rural appraisal
STIs	Sexually transmitted infections
UWESO	Uganda Women's Effort to Save Orphans
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDCP	United Nations International Drug Control Programme
UNOPS	United Nations Office for Project Services
USCS	UWESO Savings and Credit Scheme
VODP	Vegetable Oil Development Project
WFP	World Food Programme

EXECUTIVE SUMMARY

1. The human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS) is emerging as a key cross-sectoral issue for IFAD-supported projects in East and Southern Africa in view of three factors:

- (a) *the magnitude of the epidemic in the region.* East and Southern Africa are at the epicentre of the HIV epidemic, with the fastest-growing HIV infection rates in the world and with rural areas increasingly affected;
- (b) *the disproportionate impact of HIV/AIDS on the agricultural sector relative to other sectors.* The epidemic has caused the decimation of skilled and unskilled agricultural labour; a steep reduction in smallholder agricultural production; a decline in commercial agriculture; the loss of indigenous farming methods, inter-generational knowledge and specialized skills and practices; and capacity erosion and disruption in the service delivery of formal and informal rural institutions resulting from the scale of staff morbidity and mortality; and
- (c) the close association of HIV/AIDS with poverty, poor nutrition and household food and livelihood insecurity, thus directly impinging upon IFAD's mandate of economic empowerment of the rural poor.

2. The IFAD's poverty alleviation strategy focuses on the economic empowerment and development of the rural poor through organizational and institutional development, and through the facilitation of access to resources and their efficient use. HIV/AIDS directly undermines this strategy in East and Southern Africa. This is largely because poverty is the driving force of HIV epidemics. At the same time, HIV/AIDS increases the depth and extent of rural poverty, and changes its profile through demographic and socio-economic impacts – thus making the environment even more conducive to the spread of the epidemic. Given the strong links between rural poverty and HIV/AIDS, this strategy paper recommends that IFAD's poverty alleviation strategy and agricultural investment projects and programmes in the region address the developmental impacts of the epidemic and the ways in which these may affect the Fund's operations.

3. The paper examines four areas of HIV/AIDS relevance to IFAD-supported projects:

- (a) the vulnerability of IFAD target groups to HIV infection and to the impact of AIDS, requiring a focus on HIV prevention, with a special emphasis on addressing the co-factors of vulnerability to the infection;
- (b) the vulnerability of staff of IFAD-supported projects and of their collaborating partners, and their families, to HIV infection and to the impact of AIDS;
- (c) project implementation capacity, including diminished service delivery (in terms of reduced staff productivity; increased staff turnover, project expenditures and workload of project staff; and loss of knowledge, skills and expertise among staff); inability of project staff to address the impact of AIDS on target populations; and reduced district-level revenue base and thus IFAD counterpart funding; and
- (d) the continued relevance of IFAD-supported project objectives, strategies and interventions in view of the impact of HIV/AIDS (including not only its impact on project objectives and activities, but also the potential inadvertent impact of IFAD-supported projects on the HIV epidemic).

4. Effective responses to the epidemic require an in-depth understanding of the phases and dynamics of HIV/AIDS prevalence and impact. This strategy paper proposes an *HIV/AIDS vulnerability and mitigation matrix* as a planning tool with which to identify focus areas of response to the epidemic, using concepts from disaster management. Response measures are identified on the basis of HIV/AIDS adult prevalence rates and AIDS impact levels.

5. Four indicators are presented for measuring AIDS impact levels: (a) percentage of single orphans (children who have lost one parent) and double orphans (children who have lost both parents); (b) percentage of households fostering orphans; (c) percentage of household income spent on health-related expenditures; and (d) percentage of households with access to health care. With the assistance of the Joint United Nations Programme on HIV/AIDS (UNAIDS) and other institutions, thresholds for low and high rates of HIV/AIDS adult prevalence and impact levels can be established in order to assist project and programme staff in identifying epidemic phases and appropriate responses.

6. An analysis of the sector-specific impacts of HIV/AIDS (for instance, on crop production and livestock projects; irrigation projects; financial services programmes; area development programmes; research, extension and training projects; and post-conflict reconstruction and rehabilitation projects) shows that HIV/AIDS affects every technical area in which IFAD is involved. For this reason, an *HIV and development lens* is required and should be applied across sectors and sectoral project components within an overall multisectoral framework of response to the epidemic.

7. Five key areas of IFAD's response to the HIV epidemic are examined:

- (a) HIV/AIDS information, education and communication (IEC) programmes for HIV prevention and AIDS mitigation among IFAD target groups;
- (b) poverty alleviation and livelihood security programmes adapted to the conditions created by HIV/AIDS, including income-generating programmes, microfinance projects and functional adult literacy (FAL) programmes;
- (c) food security and nutrition-related innovations or adaptation of existing practices, such as: the introduction of high-yielding, weed/pest resistant plant varieties that require little labour; the rehabilitation of certain staple food crops; improved agricultural practices to save labour and capital; and nutritional gardens;
- (d) socio-economic safety nets, with special emphasis on support to orphans and households fostering orphans. The IFAD-supported *Uganda Women's Effort to Save Orphans (UWESO) Development Programme* is presented as a case study of how development measures, rather than relief initiatives, can effectively strengthen socio-economic safety nets; and
- (e) integrated HIV/AIDS workplace programmes for IFAD-supported projects, featuring: IEC campaigns on HIV prevention, AIDS care and support; a review and adjustment of working conditions, human resource policies and administrative procedures; and capacity-building and training in the technical aspects of the impact of AIDS.

8. The strategy paper underscores that breaking down the stigma of HIV/AIDS must be a key objective of all measures taken in response to the epidemic.

9. Further, the paper emphasizes that HIV/AIDS needs to be incorporated in the IFAD project cycle, going beyond problem analysis to the identification of concrete entry points and response measures. In project areas severely affected by HIV/AIDS, further conceptual and operational adjustments may be necessary. Such a process needs to run through the entire project cycle from

design to implementation. The paper give examples of how HIV/AIDS concerns can be integrated into each stage of design and implementation, highlighting the specific conceptual and operational adjustments required.

10. Given the magnitude of the epidemic and its far-reaching cross-sectoral impacts, the strategy paper emphasizes the need for strategic partnerships with national bodies and networks, bilateral donors, other United Nations agencies and non-governmental organizations (NGOs). It discusses the potential partnerships between IFAD and other organizations in the area of cofinancing, advocacy, operations, research and knowledge dissemination.

11. To build institutional capacity to address HIV/AIDS concerns, the strategy paper proposes a series of activities that IFAD can undertake at project, country and headquarters levels.

12. At *project level*, brief consultancies for each IFAD-supported project can help assess the impact of the epidemic on the project; enable projects to mainstream HIV/AIDS in core activities; specify operational and procedural adjustments needed to address the impact of AIDS on project staff and target groups; and identify key entry points for the integration of HIV/AIDS in ongoing project interventions.

13. At *country level*, workshops can be held bringing together staff from IFAD-supported projects to brainstorm on the impact of HIV/AIDS on their projects and to establish a networking mechanism among projects to ensure exchange of information and experience in addressing HIV/AIDS.

14. At *headquarters level*, proposed measures include:

- (a) raising awareness of IFAD staff on the links between HIV/AIDS and the technical areas of the Fund's work;
- (b) capacity development to build HIV/AIDS in project design, implementation, monitoring and evaluation;
- (c) raising awareness of the staff of cooperating institutions (the United Nations Office for Project Services (UNOPS), the African Development Bank and the World Bank) and cofinancing partners of the developmental effects of HIV/AIDS on IFAD-supported projects; and
- (d) the establishment of a database on HIV/AIDS and rural development.

I. INTRODUCTION

1. Initially, the human immunodeficiency virus (HIV) and the acquired immune deficiency syndrome (AIDS) were perceived as a **public health crisis**. Over the last decade, however, the HIV epidemic in East and Southern Africa has assumed such proportions that it poses a **threat to socio-economic development**. In 1991, it was projected that nine million people in sub-Saharan Africa would be infected with HIV by 2000, and five million would die of AIDS. This was a roughly a threefold underestimation: by late 2000, it was estimated that more than 25 million people in sub-Saharan Africa had become infected with HIV and over 17 million had died of AIDS. The magnitude of the epidemic and its systemic impact are affecting every sector (including industry, transport, tourism, education, health and agriculture). For this reason, a number of countries in the region have declared HIV/AIDS a **national disaster**.

2. Unprecedented rates of HIV morbidity and AIDS mortality among young adults are reversing hard-won gains in **life expectancy** by 20 to 40% in countries such as Botswana, Kenya, South Africa, Uganda, Zambia and Zimbabwe. Life expectancy at birth is now only 37 years in Zambia and 39 years in Botswana, whereas without AIDS it would be 59 and 70 years respectively.ⁱ **Infant mortality** is rising: in Zambia and Zimbabwe, 25% more infants are dying than would have been the case without HIV.ⁱⁱ

3. AIDS has orphaned nearly 13 million children in sub-Saharan Africa.ⁱⁱⁱ In Uganda alone, a country with a population of 21 million, 1.7 million children are orphans. The **social cost** of the epidemic in terms of human suffering, orphanhood and dislocation is incalculable. Further, HIV/AIDS is eroding the social fabric of African societies by unravelling socio-economic safety nets, exacerbating gender inequities and fragmenting or dissolving a growing number of households.

4. HIV/AIDS-induced mortality is altering **population structures**, with 'chimneys' replacing pyramids in the hardest-hit countries. A case in point is Botswana, where more than a third of the adult population is infected with HIV. The impact that AIDS is predicted to have on Botswana's population structure by 2020, as shown in Figure 1, is dramatic. The implications of this unprecedented demographic trend on socio-economic development are difficult to predict. What is clear, however, is that an increasingly smaller number of young adults (many of whom will be living with HIV/AIDS) will have to support large numbers of young and old people.

Box 1: HIV - Not Just a Virus

Hardly a home along the Kibos River in Kenya is unaffected by HIV/AIDS. Neighbours can no longer help neighbours, overwhelmed by their own misfortunes. "It isn't just the virus, or the absence of drugs," said a despondent community worker. "People are dying from hunger and poverty. This isn't some disease. It's a disaster."

Source: IFRC, 2000, p. 53.

5. In East and Southern Africa, the epidemic is no longer affecting only isolated households. Young adult morbidity and mortality have an impact on virtually all households, either directly or indirectly (Box 1). HIV/AIDS affects a household directly when: (a) a household member is living with HIV/AIDS; (b) the household has recently lost a young adult to AIDS; or (c) it is fostering an AIDS orphan. HIV/AIDS has an indirect effect when households have to assist sick relatives with labour, food, cash or other contributions on an intermittent or continuous basis; help neighbours with occasional labour; or fulfil their obligations towards the community with contributions to funerals.

6. The causes and consequences of the epidemic are closely associated with wider challenges to development, such as poverty and food and livelihood insecurity. The HIV epidemic tends to exacerbate these problems through its systemic impact (Box 2). As a long-wave disaster, HIV/AIDS

not only increases the depth and extent of rural poverty, but it also changes its profile. An alarming number of households today are headed by young widows, elderly grandmothers and orphans; and, in some countries, nearly a quarter of households are fostering orphans. For many households, HIV/AIDS triggers impoverishment and hunger. In fact, the shock that the epidemic inflicts is such that many households are unable to reverse the process of impoverishment.

Box 2: The Systemic Impact of HIV/AIDS

Agriculture and rural development do not merely consist of the total of various isolated subsectors (infrastructure, employment, education, health, etc). They are dynamic, integrated and interdependent systems of productive and other components, operating through a network of interrelated subsectors, institutions and rural households with links at every level of activity. The efficiency and effectiveness of each subsector, institution and household depends, to a large extent, on the capacity in other parts of the system. If this capacity is eroded through HIV/AIDS, then the system's ability to function will be diminished.

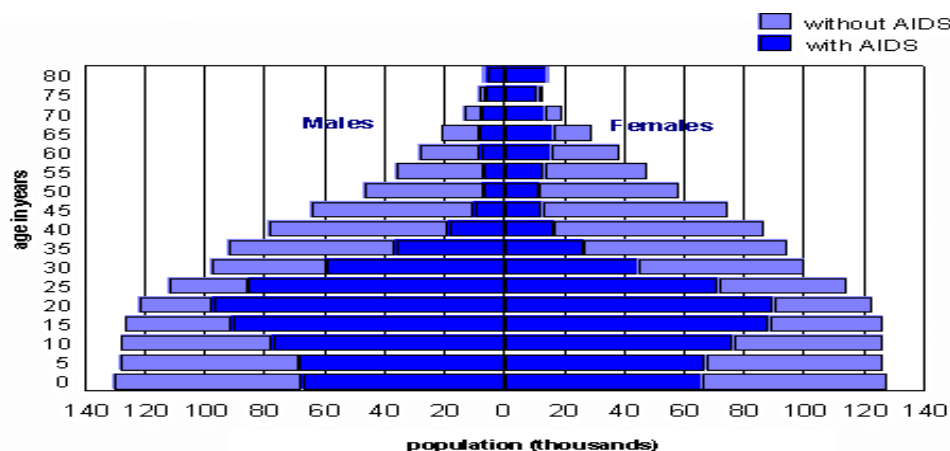
Thus, HIV/AIDS does not merely impact on certain agricultural and rural development subsectoral components leaving others unaffected. If one component of the system is affected, it is likely that others will also be affected either directly or indirectly. In other words, **the impact of HIV/AIDS is not only cross-sectoral, but, more importantly, systemic.** If the linkages between subsectors, institutions and households are not identified and addressed as such, then the analysis of the impact of HIV/AIDS will be incomplete and programme responses will be inadequate.

Source: Topouzis, 1998.

7. This strategy paper delineates IFAD's role in helping to stem the spread of the epidemic and in addressing its effects on the rural poor and on agricultural and rural development. It describes the approach the Fund will use to achieve these objectives, which consists of: (a) adapting existing agricultural and rural development strategies and programmes to the challenges posed by the epidemic, and (b) introducing new components that address HIV/AIDS-specific concerns.

8. The strategy paper is divided into six sections. **Section II** reviews in detail why IFAD should be concerned with HIV/AIDS, focusing on the linkages between HIV, poverty and gender. **Section III** proposes elements of a framework for HIV/AIDS impact analysis and for the identification of mitigation responses. This framework and suggested approach are relevant not only for IFAD but also for other donors and organizations engaged in HIV/AIDS mitigation work. Section III further highlights sector-specific impacts of HIV/AIDS and outlines their implications for IFAD-supported development projects. **Section IV** identifies key focus areas of IFAD's response to the epidemic and analyses how HIV/AIDS can be integrated into the IFAD project cycle. **Section V** outlines potential strategic partnerships with non-governmental organizations (NGOs), national bodies and networks, other United Nations (UN) agencies and bilateral donors. **Section VI** summarizes potential activities at project, country and headquarters level through which IFAD can address HIV/AIDS concerns in its work.

Figure 1: Projected Population Structure With and Without the AIDS Epidemic, Botswana, 2020



Source: U.S. Bureau of the Census, *World Population Profile, 2000*, in UNAIDS, 2000a.

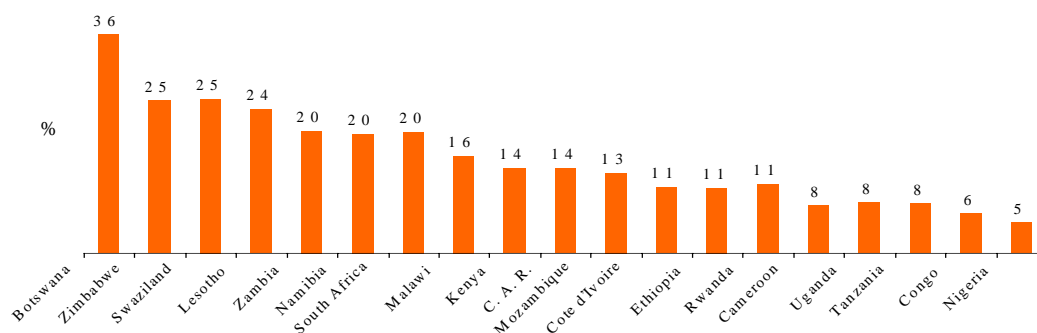
II. WHY SHOULD IFAD BE CONCERNED ABOUT HIV/AIDS?

A. Update on HIV/AIDS Prevalence in East and Southern Africa

9. With the fastest-growing HIV infection rates in the world, the East and Southern Africa region is currently at the epicentre of the HIV epidemic:

- In 14 countries of the region, **adult HIV/AIDS prevalence rates range from 11 to 36%** (Figure 2).
- In seven countries (all in the southern cone of the continent), at least one adult in five is living with HIV/AIDS.^{iv}
- South Africa, with a total of 4.2 million infected people, has the largest number of people living with HIV/AIDS in the world.^v
- In a number of countries, such as Botswana, Zambia and Zimbabwe, over one third of the people who are now aged 15 may eventually die of AIDS.^{vi}

10. **The vast majority of persons living with HIV are not aware of their serostatus**, especially in the worst-affected countries.^{vii} And since anti-retroviral drugs are prohibitively expensive, even those who have tested sero-positive are unlikely to be treated. Without treatment, infected adults in Africa have an average of 17 episodes of illness from HIV infection to death by AIDS, requiring more than 280 days of care^{viii}

Figure 2: Estimated Percent age of Adults (15-49 years) Living with HIV/AIDS, end-1999

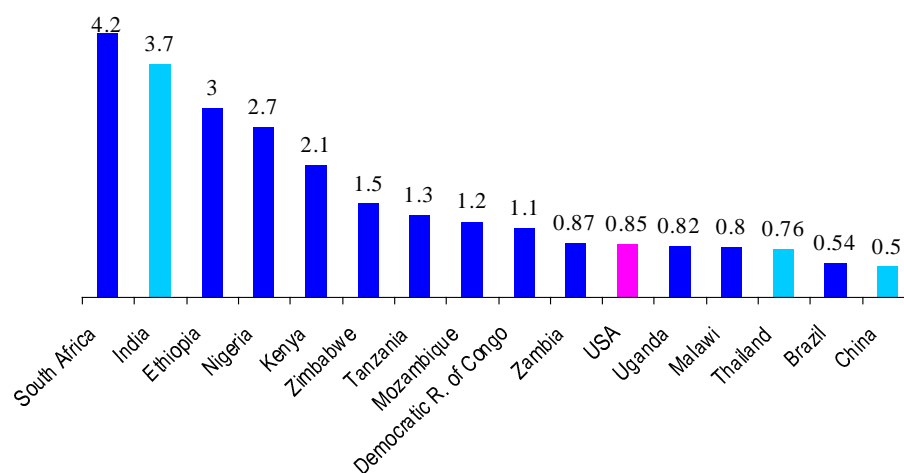
Source: Haddad and Gillespie, 2001.

11. Just as HIV/AIDS is no longer just a health issue, it is also not solely an urban phenomenon. In many countries in East and Southern Africa, **rural HIV prevalence rates are approaching the traditionally higher urban rates**. Thus, in Botswana, South Africa, Swaziland and Zimbabwe, there is little difference in HIV infection rates between rural and urban areas.^{ix} Moreover, since many countries in the region are predominantly rural, **in absolute numbers more people are living with HIV/AIDS in rural areas than in urban areas**. In addition, persons living with HIV/AIDS often return to their village of origin when they fall ill, which not only places considerable strain on their rural kin (in terms of food, patient care and medical and funeral expenses) but also increases the latter's risk of infection. Rural communities are also particularly vulnerable to the adverse effects of HIV/AIDS because of their limited access to HIV/AIDS information, and the scarcity of social support, health services and employment opportunities.

B. The Impact of HIV/AIDS on Agriculture and Rural Development

12. Given that agriculture is the largest sector in most sub-Saharan African economies, accounting for a significant portion of production and employing a majority of workers, HIV/AIDS has far-reaching implications for agricultural investment programmes. This is especially the case in a number of East and Southern Africa countries, where evidence suggests that **the HIV epidemic is disproportionately affecting agriculture relative to other sectors** (such as industry and services).^x

13. Various studies have shown that the **impact of HIV/AIDS is most severe on smallholder agriculture**, which, particularly south of the Sahara, relies almost exclusively on family labour – the most important productive resource that poor people have. HIV/AIDS-induced morbidity and mortality can constitute a serious threat to smallholder agriculture through its adverse effects on household demography, productive capacity and food and livelihood security.

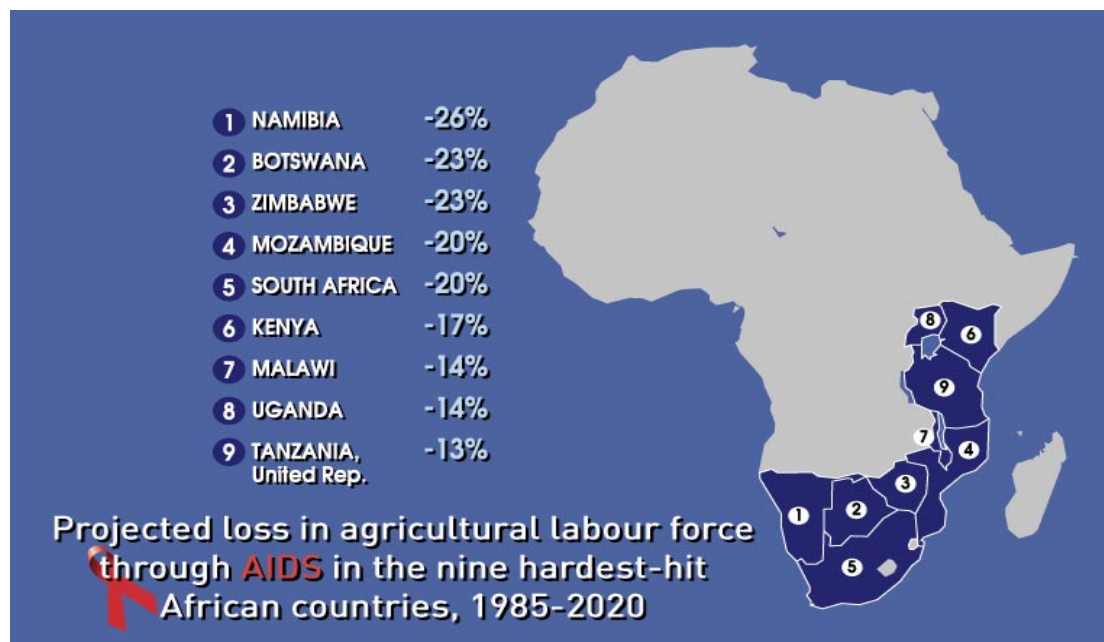
Figure 3: Estimated Millions of People Living with HIV/AIDS, end-1999

Source: Haddad and Gillespie, 2001.

14. At the household level, HIV/AIDS increases the vulnerability of rural families and communities to food and livelihood insecurity (Box 3), and pushes many of them to impoverishment through:

- **loss of young adult on- and off-farm labour**, leading to a decline in production;
- **decline in income** (and particularly disposable cash), leading to decreased food consumption, increased drop-out among schoolchildren and poorer health status;
- **erosion of the household asset base** (through depletion of savings and the forced disposal of productive assets such as land and livestock);
- **dramatic rise in expenditures** (for medical treatment and transport, funeral costs);
- **increase in the household dependency ratio** due to a higher number of dependants relying on a smaller number of productive family members;
- **loss of agricultural knowledge, practices and skills** (including farm management and marketing skills) and **social capital** (such as kinship duties and responsibilities, socio-cultural norms); and
- **disruption of traditional social security mechanisms**. A study in Zimbabwe found that nearly 25% of rural households are fostering at least one child who is not the biological child of either parent.^{xi} Similarly, in the Bukoba District of the United Republic of Tanzania, 21% of households are providing for an orphan.^{xii} There is evidence that in some instances extended families are unable to cope with this added burden.

Figure 4: AIDS Impact on the Agricultural Labour Force in East and Southern Africa, 1985-2020



Source: Slide presentation at FAO, Rome, for World AIDS Day, December 2000.

15. At the sectoral level, HIV/AIDS-induced morbidity and mortality result in:

□ **Decimation of skilled and unskilled agricultural labour.**

According to the Food and Agriculture Organization of the United Nations (FAO), AIDS has taken the lives of about seven million agricultural workers in sub-Saharan Africa to date and could claim an additional 16 million (up to 26% of the agricultural labour force) by 2020 (Figure 4). Changes in the age structure of the agricultural labour force will obviously affect the sector, but what their precise impact will be is unclear.

Box 3: What makes Rural Households Vulnerable to HIV/AIDS?

Studies in Southern Africa indicate that households will be vulnerable to HIV/AIDS if they are:

- unable to secure non-farm incomes;
- unable to meet high-peak seasonal labour demands;
- highly dependent on women and girl's labour;
- dependent on inorganic fertilizers and credit; and
- unable to substitute labour by labour-saving technologies or by switching from labour-intensive to less-labour-intensive crops.

The impact of HIV/AIDS on rural households will manifest itself in changes in food production and consumption per capita and in the amount and balance of time allocated to agricultural and non-agricultural activities.

Source: Loewenson and Whiteside, 1997.

- **Reduced smallholder crop and livestock production.** HIV/AIDS may severely undermine smallholder production and thus exacerbate food insecurity. Or it may contribute to rendering food-self-sufficient areas food-insecure. In **Zimbabwe**, for

instance, before the recent political turmoil, agricultural output from communal areas fell by a staggering 50%, largely due to HIV/AIDS, according to a 1997 report.^{xiii} Maize, cotton and sunflower yields were particularly affected. In maize production, there was a decline of 54% of the harvested quantity and a drop of 61% in marketed output. The amount of land planted to cotton decreased by about 34% and marketed output by 47%; while groundnut and sunflower production experienced an average decline of 40%.^{xiv} In **Uganda**, parts of the rural districts of Rakai and Masaka, traditionally self-sufficient in food, are now becoming food-deficit areas, mainly as a result of HIV/AIDS.^{xv}

- **Adverse effects on commercial agriculture.** In Kenya, one study found that the commercial agricultural sector is facing “a severe social and economic crisis” because of the impact of AIDS.^{xvi} In one Kenyan sugar-estate, managers reported that the cost of AIDS amounted to 8 000 labour days lost due to illness between 1995 and 1997, lower efficiency (a 50% drop in the ratio of processed sugar recovered from raw cane between 1993 and 1997) and higher overtime costs. Direct cash costs related to HIV/AIDS included a fivefold rise in spending on funerals (1989-97) and a more than tenfold rise in health costs during the same period.
- **Loss of indigenous farming methods, inter-generational knowledge, and specialized skills and practices.** In East Africa, farming practices essential to the survival of the coffee-banana farming system, such as mulching, weeding and pruning, are being neglected or abandoned in high HIV/AIDS prevalence areas.^{xvii} Evidence from two districts of Kenya further suggests that the transfer of agricultural knowledge from parents to children is being severely undermined. This is reflected in the low level of agricultural knowledge among orphan-headed households.^{xviii}
- **Capacity erosion and disruption in service delivery of formal and informal rural institutions due to the scale of staff morbidity and mortality.** For example, at least 16% of the staff in Malawi’s Ministry of Agriculture and Irrigation are living with HIV/AIDS, while 58% of all staff deaths in Kenya’s Ministry of Agriculture were reportedly due to AIDS.^{xix}

16. A distinguishing characteristic of the impact of HIV/AIDS on smallholder agriculture is that it can be so gradual that it is undetectable. As one HIV/AIDS expert has argued, “Even if [rural] families are selling cows to pay hospital bills, [one] will hardly see tens of thousands of cows being auctioned at the market....Unlike in famine situations, buying and selling of assets in the case of AIDS is very subtle, done within villages or even among relatives and the volume is small.”^{xx} Moreover, HIV infection rates in rural areas are hard to measure and are prone to under-reporting or misdiagnosis because of the poor health infrastructure, restricted access to health facilities and inadequate surveillance mechanisms. For these reasons, HIV epidemics in rural areas remain, to some extent, silent and invisible – an unknown entity for policy-makers, donors and development planners.

C. The Linkages between HIV/AIDS, Poverty and Gender

Poverty: The Driving Force of HIV Epidemics

17. Poverty alleviation has been the main focus of IFAD’s work since it began operations in 1977. This goal became even more urgent following the United Nations Millennium Summit in September 2000, where a commitment was made to halve extreme poverty by 2015. In ways that are still imperfectly understood, HIV/AIDS poses a formidable challenge to IFAD’s efforts in support of this goal in East and Southern Africa, as is summarized below.

18. **The relationship between poverty and HIV/AIDS is bi-directional:**

- Poverty is a key factor in HIV transmission. In effect, all factors that predispose people to HIV infection are aggravated by poverty, which “creates an environment of risk”.^{xxi} Poverty can also accelerate the onset of AIDS and tends to increase the impact of the epidemic.
- HIV/AIDS is likely to push some non-poor into poverty; deepen the poverty of already poor individuals, households and communities; and drive the very poor into destitution. Thus, HIV/AIDS can impoverish people in such a way as to intensify the epidemic itself.^{xxii}

19. AIDS is often characterized as a “disease of poverty” (Box 4). The World Bank notes that (a) most people with HIV/AIDS are poor; (b) HIV/AIDS has a greater economic impact on poor households than on better-off ones because it forces them to draw on their assets to cushion the shock of illness and death; and (c) households with fewer assets are likely to have more difficulty coping than households with more assets.^{xxiii}

20. Poverty and inequity combined are fuelling the epidemic further. Studies have shown the strong association between a country’s developmental status and HIV/AIDS prevalence. Countries ranked high on the Human Development Index^{xxiv} tend to have low HIV/AIDS prevalence.^{xxv}

21. To date, the response to the epidemic has been focused on ‘risk behaviour’. This focus has overshadowed the key role that poverty plays in fuelling the epidemic. In fact, **poverty is at the crux of HIV/AIDS vulnerability and impact**. Risk behaviour itself is largely determined by the socio-economic environment and by the pressures that poverty exerts on rural men and women.

22. Further, **HIV/AIDS is changing the profile and dynamics of rural poverty** through its demographic and socio-economic impacts, which may:

- **create inter-generational poverty** by impoverishing surviving orphans (often forcing them out of school, thus limiting their livelihood options), fragmenting or dissolving households and depleting the fragile asset base of the poor;

Box 4: HIV/AIDS and Poverty

Poverty directly exacerbates HIV transmission through ‘survival sex’ (sex on an occasional basis in exchange for money, food, consumption goods or favours) and inferior health care, particularly the lack of treatment for sexually transmitted infections (STIs).

It indirectly exacerbates HIV transmission by increasing migrant labour, family break-up, landlessness, overcrowding and homelessness. This places people at greater risk of having multiple casual partners.

Poor people, particularly if they are struggling with daily survival, are less likely to take seriously an infection that is fatal years hence.

The incubation period of AIDS is likely to be shortened by poor standards of nutrition, repeated infections and lack of access to medical care. Therefore, AIDS victims who are poor are likely to die faster than those who are better off. Poverty tends to affect women the most, with girls the first to be withdrawn from school and women increasingly marginalized from formal employment. Women’s economic dependence on men in marriage or in less formal commercial sexual relations is thereby increased. Educating and empowering women is strongly linked with effective family planning, improved primary health care and consequently lower rates of HIV transmission.

Poverty makes HIV/AIDS education difficult because of high levels of illiteracy and poor access to mass media and to health and education services. Poorly educated women are unlikely to be able to protect themselves from infected husbands. They tend to have little health information and little power to control any aspect of sexual relations. Even if they know they are at risk from their husbands, economic necessity may force them to acquiesce in an unsafe sexual relationship.

Source: Adapted from Jackson, 1992.

- ❑ **alter the age structure and composition of the poor**, by decimating the young adult population while impoverishing an increasing number of children and elderly people;
- ❑ **result in irreversible coping mechanisms for the poorest**. What is unique about AIDS is that it inflicts a shock from which many households are unable to recover. In particular, the erosion of the household asset base tends to be permanent;
- ❑ **intensify discrimination and marginalization of poor people living with HIV/AIDS and of their families**. This is especially the case with women, often perceived as being responsible for transmitting the HIV virus;
- ❑ **increase the prevalence of poor woman-headed households** (young widows with small children and grandmothers looking after grandchildren) and thus the feminization of poverty and agriculture;
- ❑ **exacerbate unequal asset distribution** (land, livestock, etc.), leading to **landlessness and destocking**. Once land and livestock are sold, the recovery potential of these households is severely diminished. Destitution is the culmination of this process of asset depletion; and
- ❑ **intensify poverty-driven labour migration** as a coping strategy, thereby increasing the risk of HIV infection among the survivors.^{xxvi}

23. These impacts are of direct relevance to IFAD's work as they may undermine the Fund's poverty alleviation strategies and agricultural investment projects. Given that smallholder agriculture is the subsector most severely affected by HIV/AIDS, the Fund's contribution to the international goal of halving extreme poverty by 2015 through improvements in smallholder production is under serious threat. For this reason, an analysis of the interface between HIV/AIDS and poverty (with emphasis on smallholders) and its implications for IFAD's work should be an integral part of IFAD's poverty situation analyses, and an important design and implementation consideration in its agricultural investment projects.

Gender: A Key Determinant of Vulnerability to HIV/AIDS and Coping Capacity

24. Gender determines vulnerability to HIV infection and to the impact of AIDS, and it is also likely that it is instrumental in determining the coping capacity of the survivors. This has important implications for IFAD's mandate, which is to seek to empower poor rural men *and* women. For, as argued in IFAD's 2001 *Regional Assessment and Strategy for East and Southern Africa*: "Any drive to include the poor in the development process that fails to address the specific problems of inclusion of poor women is likely to have a limited impact: addressing gender relations is an essential aspect of all development activities."^{xxvii}

25. **Women are biologically more vulnerable to HIV infection than men are and are infected at a younger age**. The risk of becoming infected with HIV during unprotected vaginal intercourse is between two and four times higher for women than for men. Women are also more vulnerable to other sexually transmitted infections, and an untreated STI in either partner multiplies the risk of HIV transmission by 300-400%.^{xxviii} With regard to age of infection, average prevalence rates of HIV infection in teenage girls can be up to five times higher than those in teenage boys. This discrepancy is due both to their biological vulnerability and to age-mixing between young women and older men (who have more sexual experience and are thus more likely to expose girls to HIV). This partly explains why more women than men are infected with the HIV virus in sub-Saharan Africa, with an estimated 12 women living with HIV for every ten men according to the Joint United Nations Programme on HIV/AIDS (UNAIDS).^{xxix} This trend has far-reaching implications, first, because young age groups account for a larger proportion of the population and, second, because persons infected with HIV at a young age tend to survive longer than they would have had they been older.

26. **HIV/AIDS exacerbates the social, economic and cultural inequalities that define women's status in society.** Inequalities, such as economic need, lack of employment opportunities and poor access to education, health services and information, make women more vulnerable to HIV infection and the impact of AIDS than men. “Low income, income inequality, and low status of women are all fairly highly associated with high levels of HIV infection”, the World Bank has argued.^{xxx} In rural areas, women tend to be even more disadvantaged because of their reduced access to productive resources and support services. Further, as mentioned, women are often blamed for transmitting HIV.

27. **AIDS has a disproportionate impact on the lives of women survivors in relation to men survivors.** Upon the death of their spouse, women often lose their house, land, livestock, plough and other resources. In Zambia, for example, IFAD found: “Not only did the death of a spouse reduce household productivity and livelihood options, but also the impact was exacerbated when associated with property grabbing by the deceased's relatives. Relatives typically dismantled the home, taking bricks, iron sheets and furniture, as well as productive assets, such as a husband's sewing machine, a gun used for killing bushmeat, hoes and cattle.”^{xxxii}

28. Further, **the burden of caring for people living with HIV/AIDS and for orphans falls largely on women.** Yet, little information is available on the quantitative impact of AIDS on women's work time, entitlements, income and savings, and especially on how this affects women within households and woman-headed households in terms of their economic security and social status.^{xxxii}

29. **The gender of the ill or deceased person can determine both quantitatively and qualitatively the loss a household suffers.** Thus, it has been argued that the illness and/or death of a woman has “a particularly dramatic impact on the family”^{xxxiii} in that it threatens household food security, especially when households depend primarily on women's labour for food production, animal tending, crop planting and harvesting. According to the same source, when women fall ill while their husbands are working in urban areas, the overall socialization and education of their children and the management of the household may be seriously affected.^{xxxiv} Moreover, studies have shown that children's nutritional status is more closely related to the mother's work and income than to the father's.^{xxxv} A survey conducted in 2000 in two districts in Zimbabwe found that 65% of households where a woman had died had ceased to exist.^{xxxvi}

30. **Gender also influences the ability of survivors to cope with the shock inflicted by AIDS** (Box 5). Although our understanding of the influence of gender on the coping processes of survivors is currently inadequate, male survivors may be in a better position to cope with HIV/AIDS than are women survivors. A World Bank study in Kagera, the United Republic of Tanzania, where more women than men had died of AIDS,^{xxxvii} found that a significant proportion of men survivors coped adequately with the impact of AIDS. A FAO study in Uganda found that men survivors tended to remarry within one year of their spouses' death.^{xxxviii} Another FAO study underscored the difficulties women survivors and their families had coping with the loss of a breadwinner, parent and household head. They had, for instance, been forced to shift from a *matooke* (banana) and groundnut farming system to a cassava/sweet potato farming system. The result was a less nutritious and varied diet and a reduction in the area cultivated.^{xxxix}

31. **Socio-cultural norms also increase women's vulnerability to HIV,** particularly norms that condone men's preference for unprotected sex and deny women (unmarried as well as married) the power to decide on sexual practice.^{xl} For example, among the Shona people in Zimbabwe, as in many other societies of sub-Saharan Africa, a woman is considered a ‘minor’, and as long as she is unmarried, her father has full rights over her. When she marries, these rights are transferred to her husband through the bride price. This payment is meant to compensate for the loss of labour the woman's father sustains when she marries. The bride also gives the husband full rights over all the children from the marriage. Consequently, once a wife and mother, a woman may be reluctant to

divorce her husband — even if he is unfaithful to her and she runs the risk of contracting HIV — as this could mean losing her children.^{xii}

Box 5: HIV/AIDS, Gender and Food Insecurity

Josephine, a widow in her late 30s and mother of seven children, lives with her 19-year-old daughter and 12-year-old son in a village in Eastern Uganda. Her husband died of AIDS and she also has AIDS. She is bedridden and incoherent at times and severely malnourished. Unable to grow enough food, she and her children eat boiled cassava, millet and a few greens every day (without sauce since they cannot afford the oil with which to make it). Josephine's daughter tries to prepare two meals a day, but they often have only one. Eating the same food every day has made Josephine lose her appetite, she claims. She has not eaten fruit for a month.

Josephine has received no moral or material support from her late husband's family or from the community. No one ever comes to see her. Attitudes towards her and her family are very negative, she says. She is reluctant to ask for help from her husband's male relatives because she fears that their wives will suspect that she is sexually involved with them.

When she is not bedridden, Josephine works as a casual labourer from 05.00 to 21.00 hours for about 1 000 Ugandan shillings (about USD .80). This long workday exhausts her, but she cannot afford to rest because then she and her children would starve. She described this as a vicious circle: on the one hand, she cannot grow enough food to feed herself and her family because she is too weak and hungry; on the other hand, she needs to eat properly to be strong enough to work.

Source: Topouzis with Hemrich, 1995

32. **Cultural and sexual practices similarly increase women's vulnerability to HIV infection.** Some practices likely to facilitate HIV transmission are: (a) ritual cleansing (where the surviving spouse is 'cleansed' and freed of the dead person's spirit through sexual intercourse with a family member of the deceased); (b) widow inheritance (a practice, which traditionally was a social safety net for women, that allows a brother or close male relative to inherit the widow); and (c) heirship for chieftaincy (where a woman from each family in the community has sexual intercourse with the chief, thus giving all families the opportunity to produce his heir).^{xiii}

33. To conclude, women's predominant role and presence in most rural areas in East and Southern Africa, combined with their disproportionate vulnerability to HIV infection and to the impact of AIDS, make it even more urgent that IFAD step up its support to address gender relations as a source of marginalization, poverty and development underperformance. In particular, the Fund can enhance rural men and women's understanding of the gender-differentiated vulnerability and burden of HIV/AIDS and address their implications through its projects.

III. TOWARDS A FRAMEWORK FOR HIV/AIDS IMPACT ANALYSIS AND RESPONSE

A. *Assessing the Impact of HIV/AIDS on IFAD-Supported Projects*

34. This section looks at the relevance of HIV/AIDS to agricultural and rural development projects, considering the vulnerability of project target groups and IFAD project staff and their families to HIV/AIDS; the reduced project implementation capacity resulting from the epidemic; and the continued relevance of IFAD-funded project objectives, strategies and interventions. It also proposes a *Framework on the Relevance of HIV/AIDS to Agricultural and Rural Development Projects* (Table 1), which can be used as a tool for analysing impact in a given project area and deciding on appropriate responses.

Vulnerability of IFAD Target Groups to HIV Infection and the Impact of AIDS

35. In addition to the impact of HIV/AIDS on households as outlined in the previous section, IFAD field work in Uganda and Zambia revealed its specific impact on project beneficiaries including: (a) **inability of contact farmers and community leaders to attend training activities due to caring responsibilities**. As an agricultural extensionist in Zambia asked: “Who do you train when farmers spend all their time attending funerals or looking after sick people?”; (b) **loss of trained beneficiaries**, which is also the loss of their knowledge, experience and labour, undermining the adoption of agricultural technologies and innovations; and (c) **exploitation of destitute children**, often AIDS orphans, as child labourers in tea plantations or as child domestic workers (Box 6).

Box 6: The Effects of HIV/AIDS on the Work of District Development Support Programme in Rural Uganda

From the perspective of department heads in charge of extension in the Kabarole District, Uganda, HIV/AIDS has two levels of impact:

Effects on households and productivity:

- Household’s ability to sustain on- and off-farm production levels is undermined through illness, death or care giving.
- Household food security and primary sources of income are threatened.
- Household production inputs, yields and hence income are depleted.
- The trauma of looking after non-recovering patients further reduces household production potential.
- The household is forced to put children to work, as child domestic workers or out-of-home labour.
- Affected households become destitute and eventually dissolve.

Effects on staff and work:

- The increase in land and property insecurity for orphans and widows adds to the workload of community courts and probation/welfare offices.
- Staff’s household food security is threatened as meagre incomes are divided between their own needs and those of orphans and sick relatives, and further depleted to meet funeral expenses.
- Staff suffer psychological trauma resulting from the loss of colleagues, relatives and friends.
- Survivors’ production capacity is reduced as they spend their income and time managing the sick and caring for the needs of extended families. This in turn causes the district tax base to dwindle.

36. IFAD-funded projects target the resource-poor, who are also likely to be vulnerable to HIV/AIDS. Poverty (and particularly food and livelihood insecurity), migration, gender inequality, and poor health are co-factors of vulnerability to HIV/AIDS. Addressing target groups’ vulnerability, therefore, is a question not only of preventing the spread of HIV and changing risk behaviour, but also

of addressing the co-factors of vulnerability to HIV infection. This is precisely where IFAD's comparative advantage lies: by focusing on enhancing livelihoods and empowering poor rural families, IFAD-supported projects can effectively reduce their vulnerability to HIV/AIDS.

Vulnerability of IFAD/Counterpart Staff (and Their Families) to HIV Infection and the Impact of AIDS

37. IFAD project staff, counterparts and their families are at least as vulnerable to HIV infection as the average adult population in a given country. Levels of knowledge of HIV/AIDS may vary considerably among IFAD project staff. Professionals are likely to be better informed than support staff, but **often assumptions about HIV/AIDS awareness are wrong**.^{xliii} Moreover, project staff directly affected by HIV/AIDS may lack access to essential services such as testing, counselling and treatment, and may be discriminated against.

38. **Some project staff are exposed to high-risk situations by virtue of their work.** Mobile professional and support staff who need to travel to carry out their duties (such as managers and professionals who frequently attend seminars, workshops and in-service training, and drivers who spend much of their time travelling to project areas) are often separated from their families. In addition, project staff may have their duty stations away from their home base and live apart from their families over a prolonged period of time.

39. Fieldwork undertaken in connection with this paper confirmed staff vulnerability to the impact of AIDS. For instance, some 95% of the district officers responsible for the implementation of a district development support programme in three districts of Uganda, and about 70% of the district agricultural extension staff of a programme in Zambia, were looking after orphans. These added responsibilities weigh heavily on government project staff, whose salaries are generally low compared to the cost of living.

Reduced Project Implementation Capacity

40. HIV/AIDS can affect project implementation capacity on three levels:

(a) **Service delivery may diminish as sickness and death increase.** Contributing factors include:

- ❑ **reduced staff productivity** (loss of human resources, absenteeism due to illness and funeral attendance, staff demoralization and HIV/AIDS-related on-the-job fatigue). In one Ugandan agricultural extension office, four out of 22 staff had died in the last 12 months, three of these from AIDS;
- ❑ **increased staff turnover;**
- ❑ **increased project expenditures** due to costs related to HIV/AIDS absenteeism, medical and burial costs, recruitment and training costs, among others. In some Ugandan districts, the administration has a budget component for staff medical and burial expenses, including the purchase of coffins. However, given the increased demand, the budget is grossly insufficient and cannot be accessed by extension staff in the sub-counties;

Table 1: Framework on the Relevance of HIV/AIDS to Agricultural and Rural Development Projects

Category of Relevance	Implications	Potential Response	Example
<p>(a) Vulnerability of the target group to HIV infection and the impact of AIDS Stigmatization, poverty, migration, gender disparities and lack of HIV/AIDS information render a project's target group vulnerable to HIV/AIDS.</p>	<p>Contact farmers and community leaders may be unable to attend training activities due to caring responsibilities. Project likely to lose trained beneficiaries and their knowledge, experience and labour. Some destitute children, often AIDS orphans, are forced into child labour.</p>	<p>Agricultural/rural development projects actively address in their regular activities the factors that increase vulnerability to HIV/AIDS.</p>	<p>Community development workers of a food security project assist in overcoming stigmatization of people living with HIV/AIDS and of AIDS orphans in a community.</p>
<p>(b) Vulnerability of IFAD project staff, counterparts and staff of collaborating partners (and/or their families) to HIV infection and the impact of AIDS.</p>	<p>Project staff may be vulnerable to HIV infection and the impact of AIDS, but few projects offer HIV/AIDS-related workplace programmes.</p>	<p>Projects establish HIV/AIDS-related workplace programmes (staff training on HIV prevention; review of working conditions, benefits and procedures; appointment of HIV/AIDS focal points, etc.).</p>	<p>A local NGO is contracted to design and implement an HIV/AIDS workplace programme for the staff of an IFAD-supported project (jointly for various projects).</p>
<p>(c) Reduced project implementation capacity because of :</p> <ul style="list-style-type: none"> • diminished capability of project staff to address their mandate due to AIDS; • diminished service delivery; • lack of knowledge and skills among project staff to address impact HIV/AIDS has on their work; • reduced district revenue base and thus IFAD counterpart funding. 	<p>Additional costs involved in increased absenteeism and loss of staff and the diversion of project resources for medical care, burials, etc., may lead to reduced quality of work. Erosion of human resources capacity is likely to disrupt project operations and delay implementation. Staff may be unable to address technical issues related to HIV/AIDS.</p>	<p>Capacity-development efforts in all project activities are intensified. Additional staff are trained, task-sharing among staff is introduced, contingencies in project budgets are increased, administrative procedures are adjusted. Project staff and staff of partner agencies are trained so that they can address the implications of HIV/AIDS for their work.</p>	<p>IFAD project managers participate in a training programme on how to address the impact of HIV/AIDS at the project management level.</p>
<p>(d) Diminished relevance of project objectives, strategies and activities</p>	<p>HIV/AIDS can compromise the achievement of targets set for a project. Project activities may inadvertently contribute to the spread of the epidemic.</p>	<p>HIV/AIDS is taken into account when analysing a project and when setting project objectives. IFAD project coordinators are made aware of the relevance of HIV/AIDS to their work and trained to integrate response measures.</p>	<p>Representatives of HIV/AIDS control programmes or NGOs working on HIV/AIDS are invited to project planning workshops. Terms of reference for project review and evaluation missions address HIV/AIDS issues.</p>

Source: Adapted from Hemrich, 1997.

- ❑ **increased workloads of project staff.** Project staff in Uganda reported that AIDS had increased their workloads since they now needed to train new community workers and contact farmers: the ones they had already trained were either ill or dead; and
- ❑ **lost knowledge, skills and expertise among staff:**^{xliv} The loss of well-trained and experienced staff can have a significant impact on project implementation capacity as junior staff may not have the expertise needed to meet the demands of the project.

(b) Project staff may not be able to address the impact of HIV/AIDS in their professional capacity. For instance, agricultural extension workers may need to deal with problems related to the impact of AIDS on the farm household economy that falls outside their technical expertise (e.g. abandonment of key agricultural practices and changes in cropping patterns). Or they may not know how to confront problems such as labour shortages among previously labour-abundant communities, land tenure problems and child-headed households.

(c) HIV/AIDS may reduce district revenue bases and thus IFAD counterpart funding. In Uganda, it is reported that the scale of HIV/AIDS-related deaths among the male population has led to a reduction in both the number of taxpayers and the taxes paid by survivors (who have a lower production capacity because of income and time spent caring for the sick). This is threatening the district tax base and IFAD counterpart funding.

41. These effects erode human capacity, disrupt project operations, delay implementation and undermine targets. As an agricultural extensionist in Zambia summed up, “The loss of any key person in the farm extension chain leaves a vacuum in project activities. These often have to come to a standstill until replacements are made, which is usually not easy.” In the long term, HIV/AIDS may even undermine the sustainability of IFAD-supported projects.

Are IFAD Project Objectives, Strategies and Interventions Still Relevant?

42. Project objectives are defined on the basis of target group problem analysis. In areas heavily affected by HIV/AIDS, the constraints of some of the target groups may be changing. For example, as mentioned above, following the death of their husbands, many women are dispossessed of their land and other property, which reverts to the male relatives of the deceased. These women and their dependent children are often left without any means to support themselves – in addition to the AIDS stigma that they often bear. Thus, as a result of the impact of AIDS, **land tenure** may emerge as a key problem, even though it may not have been addressed as such during project design.

43. Similarly, in areas heavily affected by AIDS mortality, project objectives based on long-held assumptions about labour abundance or about the profitability of certain crops may need to be carefully reviewed. Project objectives should reflect the changing needs and interests of the poor, including the ultra-poor (a growing number of whom are now affected by HIV/AIDS), and particularly women, orphans and the elderly.

44. While HIV/AIDS can impact on IFAD-supported projects directly and indirectly, the reverse can also be the case: projects can inadvertently increase the risk of HIV infection and exacerbate the impact of AIDS by, for example:

- ❑ displacing farmers and stimulating labour migration through the construction of large-scale infrastructure (dams, roads, irrigation schemes) and the stimulation of trade, tourism and employment opportunities;
- ❑ inadvertently encouraging migration, by increasing the economic potential of a particular area;

- increasing cash incomes, part of which may then be spent on alcohol, casual sex or drugs; and
- exacerbating gender disparities.

45. Thus, a project objective, such as increasing the economic potential of a particular area, if pursued in isolation from the socio-cultural and socio-economic environment, can become a co-factor of vulnerability to HIV/AIDS. To give one example, the IFAD-supported *Vegetable Oil Development Project* (VODP) in Uganda includes a component for road improvement and a regular ferry service to Bugala Island. These measures are expected to “bring much-needed economic opportunities to the people of the island, including trade, tourism and job/employment opportunities.”^{xlv} However, these very factors may also contribute to the spread of the HIV epidemic unless HIV prevention measures are built into project activities.

46. In conclusion, the fact that IFAD-supported projects may inadvertently contribute to fuelling the epidemic demonstrates the need to factor into project design the potential adverse demographic and socio-economic effects brought about by economic development and build in appropriate HIV prevention mechanisms.

B. Identifying Mitigation Responses to HIV/AIDS

47. Effective responses to HIV/AIDS require an in-depth understanding of the phases and dynamics of HIV/AIDS prevalence and impact. This section proposes an *HIV/AIDS vulnerability and mitigation matrix* (Table 2) and provides a detailed commentary on the factors underlying it. The matrix is intended to help identify project areas vulnerable to HIV/AIDS and determine the focus of response required at each epidemic stage. The tool has purposely been kept simple for easy use and needs to be refined. Moreover, parameters to the proposed indicators need to be established and agreed upon. At this stage, the purpose of the matrix is to underscore the need for dynamic, rather than static, responses to HIV epidemics and to link responses to epidemic dynamics.

48. Since HIV/AIDS is a long-wave disaster, measures to reduce its spread and impact are required before, during and after the peak of the epidemic. **Before an HIV epidemic makes its impact felt**, response measures need to focus on:

- (a) **HIV prevention.** A two-pronged approach can be adopted to reduce the risk of HIV infection among project staff, partner institutions and target groups: (i) information, education and communication (IEC); and (ii) measures designed to reduce vulnerability to HIV infection, such as poverty alleviation programmes, including support to livelihoods, food security and nutrition. Since IEC HIV prevention measures have always been sharply distinguished from other mitigation measures, this paper will use the term distinctly from mitigation.
- (b) **preparedness.** Measures taken in advance to develop operational capabilities that will facilitate a rapid response to the crisis could include: (i) projecting future epidemic impact in a project area; (ii) planning for the future impact of AIDS; (iii) building the capacity of governments, NGOs and communities to deal with current impact, and project and plan for future impact; (iv) preparing operational response action plans; and (v) earmarking funds. In the case of agriculture and rural development, measures may also include the development of an early warning system, using farming systems vulnerability mapping to plan for labour shortages and livelihood systems vulnerability; and mapping to identify vulnerable livelihoods and livelihood options appropriate in the context of HIV/AIDS.^{xlvi}

49. **During the course of an HIV epidemic**, response measures will need to focus on:

- (a) **Reducing vulnerability to the impact of AIDS.** Measures could include, in addition to the poverty alleviation programmes mentioned above, nutrition monitoring, education and nutrition programmes.
- (b) **Alleviating impact.** Immediate measures to alleviate suffering and reduce economic losses in HIV/AIDS-affected areas could include: (i) access to financial services adapted to the conditions imposed by young adult morbidity and mortality; (ii) provision of agricultural inputs (such as seeds and tools); (iii) formal or informal education for orphans; (iv) temporary relief for needy foster families; and (v) promotion of labour-saving agricultural and household technologies to offset labour shortages and facilitate food production. Measures could also include care and support for persons living with HIV/AIDS, and for their families, through nutrition education, counselling, the provision of essential drugs for target groups in collaboration with health ministries,^{xlvii} and, in some cases, the provision of food assistance to the very ill through partnerships with other organizations such as the World Food Programme (WFP).

50. **After an HIV epidemic has peaked**, measures will need to focus on **rehabilitation** to help restore livelihoods and rebuild or re-establish basic services in the medium term. Socio-economic safety nets stretched to the breaking point may need to be substituted with other mechanisms. Rehabilitation measures could include credit and training programmes for households fostering orphans; apprenticeship programmes for adolescent orphans; training in agricultural skills for orphans; and the rehabilitation of agricultural extension services to address the felt needs of farmers, including those directly affected by the epidemic. As discussed later, IFAD has been engaged in such rehabilitation work through its Uganda Women's Effort to Save Orphans (UWESO) project.

51. To measure vulnerability to HIV/AIDS and define the focus of AIDS mitigation responses, project staff and others need to understand the five stages of the epidemic from initial HIV infection to AIDS, as summarized in Box 7.

52. Households with persons living with the first, second or third stage of HIV infection will not be affected by labour shortages since infected members will be able to work and should be encouraged to do so. However, plans should be made at this time for the loss of labour, income and knowledge that households will inevitably face in the future. Nutrition interventions are as critical in these early stages as they are later on to help prolong life and avert the most severe impact of the disease on families. Households with members in the fourth or fifth stages of the disease will divert much of their labour to caring for and supporting these persons, who will only be able to undertake light work intermittently. Care and support measures are of critical importance at this stage. Household expenditures on medical treatment and related expenses will be high, and measures to alleviate the impact of AIDS on households will be needed. After AIDS victims die, impact alleviation measures will still be required in the short term and rehabilitation support in the medium term.

53. The spatial and temporal specificities of the HIV epidemic are key dimensions of impact dynamics and are reflected in what may be called the '**leopard skin**' effect. **In terms of spatial specificity, HIV prevalence rates can vary significantly not only from country to country but also from district to district, and sometimes even within districts.** Some examples of factors contributing to the patchiness of HIV infection are the distance of a community from a major road network, a port or an urban centre; population displacement; and labour migration.

Box 7: From HIV Infection to AIDS

- **Stage 1: Acute infection.** HIV causes symptoms of acute infection (such as fever and body ache) that clear up spontaneously, generally within one to six weeks after infection. Concentration of the virus in the blood, also known as viral load, is high at this time. If a woman is pregnant or breastfeeding at the time of infection, the risk of mother-to-child transmission of HIV is greater due to the high viral load. This phase of infection usually lasts between one and three weeks.
- **Stage 2: Seroconversion.** An individual undergoes seroconversion when the body begins to produce antibodies to HIV. Seroconversion generally takes place from six to 12 weeks after HIV infection. HIV antibodies can be measured through a blood test; a positive antibody test confirms that adults are HIV-infected. However, infants born to HIV-infected mothers still carry their mothers' antibodies, even if the infants themselves are not infected. These maternal antibodies may remain in their bodies for 12 to 15 months. For this reason, standard HIV antibody tests cannot confirm HIV infection in infants younger than 12 to 15 months of age.
- **Stage 3: Asymptomatic period.** In most cases there is a prolonged period (several years) when an infected person feels well and has no symptoms of infection. During this period, the disease gradually affects the infected individual's immune system. The effect of HIV on nutrition begins during this asymptomatic period.
- **Stage 4: Early symptomatic infection.** The first symptoms of a weakened immune system occur during this period. Common conditions include fungal infections of the mouth and other mucosal surfaces (e.g. oral thrush), shingles, excessive bruising and bleeding, bacterial (pneumococcal) pneumonia, tuberculosis, chronic fatigue, fever, weight loss and chronic diarrhoea. These conditions tend to persist for several weeks or months in people living with HIV.
- **Stage five: Late symptomatic infection.** This stage officially constitutes the condition called AIDS, and it is defined by a blood test that confirms a low number of immune cells or by the presence of various other severe complications. The HIV viral load and the risk of transmission is high during this stage because the immune system is not able to control the infection.

In industrialized countries, the average length of time between HIV infection and AIDS diagnosis is from eight to ten years. In developing countries, this time period and the time between AIDS diagnosis and death may be shortened considerably as a result of exposure to pathogens and infectious diseases, poor health care and malnutrition.

Source: Piwoz and Preble, 2000.

54. **In terms of the temporal specificity of the epidemic, HIV/AIDS prevalence rates and impact levels may not always overlap.** As shown in Table 2, countries with high HIV/AIDS prevalence rates can have low or high impact levels depending on the phase of the epidemic. For example, Ethiopia has high HIV/AIDS prevalence (large numbers of people in the first to third stages of the disease) and a low impact level. Zambia, on the other hand, has both high HIV/AIDS prevalence and a high impact level. Most of Angola currently has low HIV/AIDS adult prevalence rates and low impact levels and will thus require a different set of responses from that needed in many areas of Uganda and the United Republic of Tanzania, which have declining HIV/AIDS prevalence but face great challenges rebuilding their societies after two decades of severe AIDS impact levels. Countries and areas within countries with high HIV/AIDS prevalence will experience high impact with time, unless a concerted effort is made to stem the spread and mitigate the impact of the epidemic.

Table 2: HIV/AIDS Vulnerability and Mitigation Matrix

AIDS Impact Level	HIV/AIDS Adult Prevalence Rates	
	LOW	HIGH
LOW	<p><i>Phase 1: Low HIV/AIDS adult prevalence, very low impact level</i></p> <p>Focus on REDUCTION OF VULNERABILITY TO HIV INFECTION</p> <p>National-level examples: Angola, Comoros, Eritrea and Madagascar.</p>	<p><i>Phase 2: High HIV/AIDS adult prevalence, still low impact level</i></p> <p>Focus on REDUCTION OF VULNERABILITY TO AIDS IMPACT and PREPAREDNESS</p> <p>National-level examples: Ethiopia and Mozambique.</p>
HIGH	<p><i>Phase 4: Declining HIV/AIDS adult prevalence, high impact level</i></p> <p>Focus on REHABILITATION</p> <p>National-level examples: the United Republic of Tanzania and Uganda.</p>	<p><i>Phase 3: High HIV/AIDS adult prevalence, high impact level</i></p> <p>Focus on IMPACT ALLEVIATION</p> <p>National-level examples: Lesotho, Malawi, South Africa, Swaziland, Zambia and Zimbabwe.</p>

55. **Even within a single country, HIV epidemics may be at different levels of maturity in different areas.** For example, in Kenya, adult HIV/AIDS prevalence rates range from 6 to 35%,^{xlviii} while impact levels also differ significantly. Differences in prevalence and impact levels need to be taken into account when designing response measures.

56. The ‘leopard skin’ effect has important implications for policy and programming: strategies and initiatives aimed at addressing HIV/AIDS cannot be designed at national level, nor can they be based on national averages of adult HIV/AIDS prevalence. **Decentralization** processes currently under way in some East and Southern African countries may greatly facilitate district-specific HIV/AIDS-related interventions and are thus good entry points for the identification of response categories.

57. The prevalence of HIV/AIDS among adults is a key factor of vulnerability to the epidemic. HIV/AIDS adult prevalence estimates are available for each country in East and Southern Africa, and in some cases estimates are also available by district and by urban versus non-urban area from UNAIDS, the United States Bureau of the Census, and sometimes from donors (for example, in Kabarole, Uganda, a sentinel surveillance site was set up with German Technical Cooperation (GTZ) assistance to measure adult HIV/AIDS prevalence rates for urban and rural areas in the district).

58. Although an essential indicator, adult HIV/AIDS prevalence alone cannot determine the vulnerability of a given area, whereas **the epidemic impact level is critical in determining vulnerability levels and response priorities.** The matrix defines **epidemic impact level** on the basis of four indicators:

- (a) **Percentage of single and double orphans.** Data for single orphans (children who have lost one parent) are available for most countries, but, in many instances, data are

also available for double orphans (children who have lost both parents) by district or province.^{xlix} For Uganda, such figures have been available by district for more than a decade: in Masaka, for instance, the total number of orphans according to the 1991 census was 70 800 (8.2% of the population), of which 8 800 were double orphans.¹ Kumi District had the highest proportion of orphans in Uganda, with 19 900 single and 1 600 double orphans.^{li} This indicator captures possibly the most devastating impact of the epidemic on current and future generations (unless other factors, such as civil strife and war, have substantially increased the number of orphans).

- (b) **Percentage of households fostering orphans.** In Zambia and Uganda, according to some estimates, more than 20% of households are fostering at least one orphan. This indicator can help identify the scale of the burden that HIV/AIDS places on social safety nets and help focus responses on strengthening such safety nets.
- (c) **Percentage of household income spent on health-related expenditures.** A survey in Rakai District, Uganda, in 1995 showed that medical expenditures for the terminally ill AIDS patient were USD 40 per month, when average monthly household income was only USD 18.^{lii} Given the unprecedented costs created by HIV/AIDS, this indicator is a good measure of the cost burden borne by households.
- (d) **Percentage of households with access to health care.** This indicator can help identify both the extent of vulnerability of households and communities to disease, and the status of health services in a given area.

59. The availability of data on the above indicators varies considerably among and within countries. Where such data are not available, participatory rural appraisal (PRA) exercises, baseline surveys, household surveys and other such tools can generate this information, which can then feed directly into project design. However, a concerted effort is also needed to define thresholds for these indicators (low/high HIV/AIDS adult prevalence rates and low/high AIDS impact levels). UNAIDS, the United States Bureau of the Census and the UNAIDS Reference Group on Epidemiology can help standardize these indicators.

60. It should be underscored that the matrix presented in Table 2 only highlights the focus of potential project activities. In practice, a mix of different activities will be necessary for each epidemic phase, depending on other social, cultural, economic and livelihood-related factors. Further, although the distinction among various response phases (HIV prevention, preparedness, impact vulnerability reduction, impact alleviation and rehabilitation) is artificial, it can be useful for conceptual and programming purposes. Finally, while this matrix can be used for comparative purposes at national level, it is more relevant at district level, given the spatial and temporal specificity of HIV epidemics within countries.

C. Sector-Specific HIV/AIDS Impact and Implications for Response

61. This section^{liii} provides examples of the impact of HIV/AIDS on the agriculture sector and explores implications for IFAD-supported projects. The examples show that HIV/AIDS affects every technical area that IFAD is involved in and that a 'HIV and development lens' needs to be applied across sectors. It should be emphasized, however, that a multisectoral approach is essential for arresting the spread and mitigating the impact of the epidemic and that sector-specific responses can only be effective within a multisectoral framework of response.

Crop Production and Post-Harvest Protection Projects/Components

62. AIDS mortality and morbidity trigger labour shortages that may force farm households to shift from cash to subsistence crops when food security is being threatened. Cash crops

requiring an extended investment period may not be suitable for families who need quick returns to cover immediate medical, funeral or orphan-related expenses. Similarly, labour-intensive crops or those needing purchased inputs may be unsuitable given labour and/or cash shortages. Thus, projects with crop production components will need to factor into their strategies both labour shortages and the need for low-input, low-risk, early-maturing and disease-resistant crop varieties. This may require, among other things, an evaluation of the appropriateness of the crops being promoted for households experiencing severe labour shortages and income loss.

63. The VODP in Uganda, for instance, is promoting some crops that are more suitable in the HIV context than others. Sunflower production is particularly suitable, as it is not labour-intensive, requires little weeding and is early maturing (3.3 months). Palm oil, instead, is likely to be unsuitable given that it is, at least initially, labour-intensive, and no income can be derived from it until four years after planting.^{liv} When projects operate in high HIV/AIDS prevalence areas, they will need to review whether and how they can accommodate the constraints encountered by households affected by HIV/AIDS and work with them to find appropriate solutions.

64. Post-harvest components of agricultural projects may also be adversely affected by the epidemic. In areas where it is the men who usually construct storage for the crops, the women may not know how to carry out the task when their husbands die, thereby leaving the crops unprotected and losing a substantial part of their production. Similarly, when a woman farmer switches from cash crops to subsistence crops after the death of her husband, she may be unable to determine what type of storage is needed for the new crops. Projects with post-harvest components should monitor such trends and offer training in post-harvest skills as needed.

Livestock Projects/Components

65. HIV/AIDS can compromise the viability of livestock projects or components in a number of ways: (a) family members may have to sell their animals to finance medical care for AIDS patients; (b) families may not be able to afford veterinary care for their livestock; (c) if the person in charge of the livestock dies, family members may be unable to manage due to the loss of skills and experience; (d) in some areas of heavily affected countries, the price of livestock has fallen steeply either because of animal diseases or because animals are being sold off to meet HIV/AIDS-related expenses. Livestock projects or components may therefore need to monitor HIV/AIDS impact levels, addressing in particular the following key issues: What are the effects of increased human medical/funeral costs on livestock production? How are livestock management and production affected by the reduced capacity of the rural workforce? What are the impacts of the inheritance system on livestock? How is livestock production affected by the loss of skills in the sector?^{lv}

Irrigation Projects/Components

66. While HIV/AIDS affects irrigation projects through its impact on labour for civil works programmes or on the staffing of water users' associations, what is perhaps more important to point out is how such projects can increase vulnerability to HIV infection. IFAD's new *Lower Usuthu Smallholder Irrigation Project* (LUSIP) in Swaziland recognizes that the increase in the incidence of HIV and other STIs is often associated with the construction process of infrastructure such as dams, where large number of workers are isolated from their families for long periods of time, creating a market for commercial sex workers. To avert this situation, the project has adopted a community-based approach with an intensive and targeted information, education and behavioural modification component, together with condom distribution. To the extent possible, it intends to identify and target special at-risk groups in the host area *before* the influx of construction workers from outside and reach construction workers *before* they arrive on site.^{lvi} In addition, the project will promote nutrition activities (e.g. nutritional gardens and nutrition education) to improve the nutritional status of rural households and enhance their resilience to disease.

Financial Services Programmes/Components

67. The viability of agricultural credit schemes may be at risk as a result of HIV/AIDS. First, increased mortality may raise the number of defaults. Second, AIDS-affected families may be forced to liquidate their assets in order to repay the loans; or they may have their assets seized, thereby ending up worse off than before they incurred the loan. Third, families may have to spend part or all of their credit to finance medical care for family members suffering from AIDS. One way to find out whether HIV/AIDS has affected credit schemes in a particular area is to inquire if the demand for loans is increasing; and if so, why. An example of a potential response^{lvii} to increased young mortality can be found in the IFAD-supported *Rural Financial Services Programme* (RFSP) in the United Republic of Tanzania, which will offer its clients insurance coverage through a fund. This fund will cover loan defaulting for a variety of reasons, including non-repayment due to AIDS-related incapacitation or death. Insured clients will pay 50% of insurance premiums, and RFSP the other 50%.

Area Development Programmes

68. In Africa, people develop AIDS faster than in other parts of the world as a result of poor overall health conditions and health care, both in terms of dispensaries and extension services. The World Health Organization estimates that between 30 and 50% of adults in developing countries have latent tuberculosis infection, and HIV infection is the strongest known factor for the development of active tuberculosis. In addition, STIs greatly facilitate both the acquisition and transmission of HIV. STI and AIDS control rely heavily on the extent and quality of health care provision and health care systems in individual countries. Supporting **primary health care** can thus be an effective measure for HIV prevention, AIDS care and vulnerability reduction.

69. IFAD area development programmes are usually multisectoral and have primary health care components or health, nutrition and sanitation programmes. Its recently completed *Nyeri Dry Area Smallholder and Community Services Development Project* (NDAP), which aimed at reducing morbidity and mortality and improving the well-being of the rural poor in Kieni District in Kenya, had a health, nutrition and sanitation component. Through this component, district and community health workers were trained in home-based care and counselling of people living with HIV/AIDS. Such components could be further expanded to include STI control, tuberculosis treatment and HIV prevention.

Research, Extension and Training Projects/Components

70. Agricultural research projects/components may need to investigate the effects of AIDS on farmers' supply response to changes in labour inputs. They may also need to identify the special needs of farm households with high dependency ratios, particularly those headed by young widows with small children, by the elderly or by orphans. Strategies for labour substitution should be devised; situation-specific technical advice on farming and home economics issues is also likely to be needed. Further, agricultural extension staff may need to advise households on the importance of good nutrition in delaying the onset of AIDS and on improving the quality of life of AIDS patients. Ministries of agriculture in a number of countries in the region have prepared field manuals that can be used for this purpose. Nutrition education and communication strategies should have specific dietary recommendations (e.g. the need for increased protein intake, caloric intake and micronutrients) and take into account local food sources and production systems.^{lviii}

71. The growing demands on extension services arise at a time of increased illness and death among agricultural extension staff and some disruption of extension services. Project training components should take account of both the higher demand for training of skilled labour and the need to train more individuals than required to compensate for increased mortality. The cost-effectiveness of training programmes may decline substantially due to higher turnover. In addition to adaptations to

replacement and retraining strategies, training curricula may also need to be revised to include IEC components on HIV prevention, care and support, and technical training on the implications of HIV/AIDS for specific project activities.

Post-Conflict Reconstruction and Rehabilitation Projects

72. These are projects supporting returnee populations that have been exposed to high-risk situations (insecurity, camp life and separation from family, for example). In some countries, such as the United Republic of Tanzania, it has been estimated that 33% of young adults in refugee camps are HIV-positive.^{ix} Therefore, refugee populations may require both impact alleviation and rehabilitation measures. Projects supporting returnees in high HIV/AIDS prevalence areas will need to place greater emphasis on primary health care (including STI control and tuberculosis treatment, etc.), on awareness-raising of the target group using communication strategies specifically designed for returnees, and on restoring livelihoods.

IV. OPERATIONALIZING IFAD’S RESPONSE TO HIV/AIDS

73. One factor that sets HIV/AIDS apart from other illnesses and should be mentioned at the start of any discussion of measures responding to the epidemic is the **HIV/AIDS stigma**. Contrary to what is often claimed, HIV epidemics, particularly in rural areas, continue to be shrouded in stigma. Negative attitudes mainly affect persons with HIV/AIDS and their families (and especially their children), but also have implications for workplaces and communities. In most countries, death from AIDS is considered a disgrace and is seldom openly acknowledged out of respect for the deceased and concern for the survivors. Stigma can therefore be a formidable barrier not only to identifying HIV/AIDS as a problem in a community but also to defining prevention, care and mitigation responses. For this reason, **breaking down the HIV/AIDS stigma must constitute a key objective of any response to the epidemic**.

74. Further, there is a need to shift attention from the direct effects and costs of HIV/AIDS morbidity and mortality to the broader impacts of the epidemic on the entire development process. This will require new ways of thinking and operating (Box 8). To operationalize a response to HIV/AIDS, IFAD and its partners will need to use an ‘HIV and development lens’ to understand the potential and actual effects of the epidemic; and then alert project staff and others to the need to make adjustments in design and implementation procedures in order to avert or address

Box 8: “Business as Usual?”

“... the focus is still on the direct effects of HIV and AIDS. The talk is all of prevention, caring for the sick and orphans, as though no one has realized how the virus impacts upon everything we do. It is time for governments, UN agencies, international organizations and NGOs to stop and ask: ‘What were we planning to do, and are we still able to do it?’ Or do we have to make adjustments, not only in our objectives but in our approach? People are calling HIV/AIDS a disaster but we are still trying to do business as usual.”

Arjan de Wagt, UNICEF Nutrition Officer, cited in IFRC, 2000.

the impact of AIDS. In some cases, this will require changes in the project design process to ensure that it reflects the needs, interests and constraints of HIV/AIDS-affected households.

A. Focus Areas of Response to HIV/AIDS

75. This section reviews five focus areas of response to HIV infection and the impact of AIDS: (a) target group IEC programmes for HIV prevention and AIDS mitigation; (b) poverty alleviation and livelihood security; (c) food security and nutrition; (d) socio-economic safety nets, especially for orphans and foster families; and (e) integrated HIV/AIDS workplace programmes for IFAD-supported projects.

Target Group IEC for HIV Prevention and AIDS Mitigation

76. In most of East and Southern Africa, it is widely believed that rural populations are 'aware' of HIV/AIDS and that this knowledge is enough to initiate behaviour changes and prevent the spread of the epidemic. While most rural men and women in the region have indeed heard of HIV/AIDS, it cannot be assumed that all are adequately informed about the epidemic and able to act upon this knowledge. Information in rural areas is often very limited; and social, economic and cultural barriers, particularly gender barriers, are formidable obstacles to behaviour change.

77. Further, information, education and communication campaigns often do not reach poor illiterate young women and out-of-school girls, particularly in rural areas, or they are not tailored to the realities of their lives. For example, a young woman who knows that her husband could be HIV-positive will not act on, or even voice, her concern because she is economically dependent on her husband, fears losing her children or is inhibited by socio-cultural norms. An IEC campaign on HIV prevention can do little to protect this woman against HIV infection. Broader measures are needed to improve her economic status and empower her socially and within her marriage. Measures are also needed to raise her husband's awareness of the ways in which his behaviour can place him and his family at risk of HIV infection, and to inform him of the dangers of such traditional practices as ritual cleansing and wife inheritance.

78. Given its reach into remote rural areas, IFAD is well placed to deliver, through partnerships with NGOs, targeted IEC to its rural beneficiaries on **HIV prevention**, including special measures for HIV/AIDS-affected households (hygiene, sanitation, nutrition, treatment of opportunistic infections, psycho-social support), and information on HIV testing and counselling.

79. One promising methodology for awareness-raising on HIV prevention among IFAD target groups has been developed by the Global Integrated Pest Management (IPM) Facility in Asia and tested by the FAO/Community IPM Programme in Cambodia (Box 9). The Programme took the methodology used in **farmer field schools** and extended it to **farmer life schools (FLS)**. While the former use agro-ecosystem analysis to further farmer's understanding of crop cycles and pest management, the latter use human ecosystem analysis to identify factors that influence household and community economy, health, education, social relations, culture and the environment. HIV/AIDS is one of the topics covered.^{ix}

Box 9: From Rice Field Ecology to Human Ecology and HIV

Farmer life schools are based on the learning cycle and training methodology of the IPM farmers field schools. Like the field schools, which meet once a week, farmers life schools also meet regularly. Their activities include visits to families, presentations, discussions on special topics and group dynamics. These activities help farmers to recognize and analyse the interrelated elements of their lives, in much the same way as they apply their mastery of ecological concepts to their fields.

In farmers life schools, farmers examine problems that threaten their livelihoods, weigh available options and make decisions about what action they should take. The issues they address range from poverty, loss of land and occupational health issues (e.g. the hazards of pesticide use); to family planning, alcoholism, domestic violence and their children's schooling; to specific health concerns such as dengue, malaria and HIV/AIDS.

Source: FAO, 2000.

80. The FLS approach seeks to raise awareness among farmers through a dynamic learning process rather than by a top-down teaching exercise. Instead of being taught what their problems are, farmers learn how to identify and analyse their problems themselves. This learning process empowers rural men and women and can be instrumental in encouraging behaviour change. Similarly, IPM training methodology focuses on training trainers in facilitation skills and problem-solving analysis rather than on fixed messages to be delivered to the farmers. This methodology can be tested in

IFAD-supported projects in Kenya, the United Republic Tanzania, and Uganda, which are currently working through farmer field schools, and then be extended to other projects

81. Building target group awareness can extend beyond IEC HIV prevention campaigns. Rural communities need to have a central role in developing an understanding of the mechanisms fuelling HIV epidemics in order to mobilize efforts for the mitigation of AIDS impact. The urgency that surrounds IEC HIV prevention campaigns needs to extend to mitigation through complementary IEC AIDS mitigation campaigns. These can include IEC on:

- (a) **sustaining household productive capacity and productivity** in the context of the impact of AIDS;
- (b) **planning within the family for young adult mortality** (drawing up wills to ensure that widows and their children, regardless of sex, can inherit property; keeping children in school, etc.); and
- (c) **planning with the community for the impact of AIDS** (capacity-building to help communities and community-based organizations (CBOs)/NGOs to conduct HIV/AIDS impact assessments and prepare microproject proposals for submission to IFAD-supported projects).

82. IFAD is well placed to undertake such IEC AIDS mitigation campaigns through its partnerships with NGOs. IFAD projects can carry out IEC campaigns on AIDS mitigation within the framework of their community development components. Using PRA, communities can assess current impact, anticipate future impact and identify potential interventions. Capacity-building to enable communities to prepare microproject proposals should accompany AIDS mitigation campaigns so that awareness-raising becomes part of a more comprehensive package of community response to HIV/AIDS. The involvement of communities, to the greatest extent possible, in the design and conduct of AIDS mitigation campaigns is essential and cannot be stressed enough.

Poverty Alleviation and Livelihood Security

83. Through its projects in rural areas, IFAD is also in a good position to engage in HIV prevention that goes beyond IEC campaigns to address the co-factors of vulnerability to HIV infection, and particularly poverty and livelihood insecurity. As argued earlier, poverty makes people vulnerable to HIV infection and the impact of AIDS by stimulating distress labour migration, threatening people's livelihoods, pushing some women into survival or commercial sex, and reducing access to health services. Poverty alleviation and livelihood security interventions can thus play a catalytic role in stemming the spread of HIV and reducing the impact of AIDS.

84. Recent IFAD field diagnostic work in Zambia identified HIV/AIDS as the principal threat to rural livelihoods in the Northwestern Province. In the Southern Province, HIV/AIDS-induced morbidity and mortality ranked fourth among threats to rural livelihood systems, after livestock disease, repeated drought and the decimation of assets in response to drought.^{lxii}

85. IFAD-supported projects offer a range of poverty alleviation components that can help to mitigate the impact of AIDS, including income-generating activities, microfinance projects and functional literacy (FAL) programmes for adults.

- (a) **Income-generating microprojects** can improve the livelihood security of households with chronically ill adults, provide income-earning opportunities for asymptomatic persons living with HIV so that they can support their families, and strengthen socio-economic safety nets.

86. To date, income-generating projects designed to mitigate the impact of AIDS have mostly targeted persons living with HIV/AIDS. The record of such projects has been relatively poor. In Uganda, for instance, a goat-rearing scheme for this group brought no benefits since it took at least two years before they could sell the goats, by which time many farmers had fallen sick or had died. A revolving fund for income-generating microprojects also performed poorly because the loans were too thinly spread among too many members.^{lxii}

87. One reason these projects have not been effective is that they fail to reflect the needs and constraints of the lowest stratum of the poor and the dynamics of the impact of AIDS. In particular, the poorest groups, often disproportionately affected by the epidemic, do not take part in the design of the projects and are least able to participate in and benefit from their activities.

88. Income-generating microprojects can even exacerbate the vulnerability of HIV/AIDS-affected households. One example is a zero grazing heifer project in Uganda, which provided families with an expectant cow so that they could benefit from milk production. The family was given full ownership of the cow once it had given birth to a female calf, which was subsequently taken away to continue the cycle. “While the project was a success under loan circumstances,” an evaluation report argues, “an indivisible item such as a cow may actually increase vulnerability if the recipients are forced to make a distress sale when faced with calamity.”^{lxiii} The conclusion was that “the running costs, the need for veterinary services, and the need for water in a largely dry area, combined with the overall labour-intensiveness of this activity, all make it an impossible project for the poor”.^{lxiv}

89. In view of these experiences, IFAD-supported income-generating projects may need to define criteria for activities aimed at families directly or indirectly affected by HIV/AIDS so as to ensure that the intended beneficiaries can reap benefits from these projects relatively quickly (in less than six months) and that the projects do not inadvertently increase their vulnerability. The projects should also target households that have recently suffered from young adult mortality and households fostering orphans. Working in partnership with NGOs that have some experience in income-generating projects for affected households, such as the Agency for Cooperation and Research in Development (ACORD) in Uganda and UWESO, is likely to be the most effective way of incorporating such components in IFAD-supported projects.

(b) **Microfinance projects** can strengthen the coping strategies of households with persons in the asymptomatic stage of HIV infection by helping to ‘buy time’; and to a lesser extent, they can alleviate impact in households with persons in the last stages of the disease. They are also critical for rehabilitation purposes, for instance, to provide medium-term support to households fostering orphans (Box 10), as will be seen through the example of UWESO below. Thus, IFAD, which works closely with microfinance institutions (MFIs) in various East and Southern Africa countries, can help tailor MFI services and products in view of the impact of AIDS.

90. In fact, there is a growing consensus that MFIs need to adjust their services and products to the changing conditions of an increasing number of their clients. Initial survey findings on microfinance and HIV/AIDS carried out by the United States Agency for International Development (USAID) in 2000 (based on the responses of 22 MFIs from across Africa) show that MFI clients are under extreme economic stress due to the HIV epidemic. Medical expenses are their greatest economic stress (95%), followed by feeding the family (86%), paying for funerals (77%) and caring for orphaned children (50%). In response to these challenges, MFIs reported the following trends over the last 12 months: (a) increased difficulty in loan repayments (57% of MFIs); (b) increased requests for access to compulsory savings (47%); (c) higher client absenteeism at meetings (45%); and (d) increased requests for smaller loan sizes (29%). Defaults were also reported to be on the rise due to HIV/AIDS.^{lxv}

91. In view of the above, MFIs may need to go beyond their traditional role and offer additional services to their clients, including health services (such as information on HIV prevention), legal

advice to women on inheritance and children's rights; counselling; and training in caring for sick family members. If provided through strategic partnerships, these services may be channelled to clients at minimal or no additional burden to the MFI. MFIs can also improve the fit of financial products to meet the needs of HIV/AIDS-affected households more effectively. This may involve reducing compulsory savings requirements (often required as collateral for microcredit), which may be out of reach for households with chronically ill young adults; relaxing the conditions under which clients may make withdrawals from compulsory savings accounts for health emergencies; and showing greater flexibility on loan sizes and payment schedules. As clients become sick, MFIs could

Box 10: Microfinance in the Fight Against HIV/AIDS

Microfinance is most useful to households before they are deeply affected by AIDS, when they can still make use of the loans and can still save money. Microfinance services can help HIV-affected households to strengthen economic safety nets that they will need to draw upon later. By focusing on women, moreover, microfinance can also play a role in reducing vulnerability to HIV/AIDS by keeping women and their daughters away from high-risk behaviours created by economic necessity.

Once AIDS gains a foothold in a household, the role of microfinance changes to primarily one supporting the productive activities of healthy family members: those who care for the sick and for any orphans living with the family. In this situation, as long as the household undertakes income-earning activities, there may be a role for loan services to help these activities along. The greater the ability of the household to maintain an income stream during this period, the more likely they are to withstand the economic devastation of the disease without selling land or other assets, taking children from school, or breaking up the family.

Finally, after AIDS sweeps through a family, survivors (often grandparents and older children) must rebuild the economic base of the remaining household. As these individuals prepare households to take on the tasks and risks of entrepreneurship, microfinance may be able to play a role in supporting their efforts.

Source: Parker et al., 2000.

also consider allowing adolescents to take over the business and the loan for a sick parent—under the guidance of an extended family member.^{lxvi}

92. Further, MFIs could add new financial services to their portfolio, brokering relationships with burial societies, creating trust funds or linking clients to insurance. It should be stated, however, that health and life insurance is rare in the context of HIV/AIDS as the necessary premiums are generally too costly for poor households to bear.^{lxvii}

93. A number of MFIs in East and Southern Africa are pilot-testing or implementing innovations — both financial and non-financial. One is the Foundation for International Community Assistance (FINCA) in Uganda. FINCA has developed various products in response to the health concerns of its clients, including health insurance, savings plans, life insurance and AIDS prevention education. Another is Opportunity International, an MFI operating across Africa, which has developed four financial products and two non-financial services in response to HIV/AIDS: mandatory loan insurance, mandatory death benefit insurance, emergency loans, education trusts for minors, HIV-prevention programmes and legal services (Box 11). IFAD could further test these innovations, and adopt successful ones in projects it supports.

Box 11: MFI Innovations to Mitigate the Effects of HIV/AIDS

Opportunity International (OI), a microfinance institution which involved in microfinance in Africa since 1992, currently serves more than 30 000 clients. In response to HIV/AIDS, it offers the following products and services to address the health concerns of its clients:

Mandatory loan insurance: OI charges clients a one-time fee of approximately USD 0.30 that covers loans outstanding in the case of client death. This fee mitigates the impact on affected households, since the MFI assumes responsibility if a client dies.

Mandatory death benefit insurance: One OI partner, a local insurance company, offers clients death benefit insurance that covers burial and related costs for clients and up to five dependents. OI earns commission income on each of the insurance policies purchased by clients, which covers processing costs. The insurance will be offered to solidarity groups and will cover participating members and five dependents for a maximum benefit of USD 167 per household. Clients will pay a monthly premium of USD 1.50. Purchase of insurance will be mandatory for clients, although the MFI is trying to find ways to provide it on a voluntary basis. There are no exclusions for clients with AIDS.

Emergency loans: OI is now considering ways to offer loans to clients to deal with health-related and other emergencies.

Education trusts for minors: OI is examining ways to establish an education trust to allow clients to make payments into a trust fund that could be accessed as an annuity at a later date for educational purposes.

HIV/AIDS prevention programmes: In 1999, OI initiated efforts to disseminate AIDS prevention information to its clients through partnerships with NGOs such as the AIDS Information Centre in Uganda and the Society for Family Health in Zambia. These NGOs raise awareness on health issues through peer education at weekly meetings, which clients are required to attend.

Legal services: OI works with organizations that provide legal advice on issues such as wills and inheritance laws for women, to ensure that women and children will have full legal protection after a husband/father dies. OI offers these services through strategic partnerships with groups such as the National Society for Advancement of Rural Women in Uganda, the Legal Resources Foundation of Zimbabwe and the Zambian Legal Aid Foundation.

Source: Parker et al., 2000, p. 5.

- (c) **Functional adult literacy programmes:** IFAD participatory rural appraisals in Uganda have shown that FAL classes are “one of the most effective means of empowering women to learn and to acquire self-confidence”.^{lxviii} They also have a very positive impact on women’s lives. “Women acknowledge that functional adult literacy classes have an important role in empowering women and reducing ignorance and poverty. They identified the following benefits: they gain new knowledge, learn how to read and write, generate income through modern farming methods, improve agricultural techniques and methodologies, control crop pests, improve sanitation and hygiene at household level, learn about care and nutrition of children, improve food planning and preparation, get to know each other, creating networks and forming groups, learn to work together and establish poverty reduction strategies.”^{lxix}

94. Thus, literacy has empowering effects that go beyond merely learning to read and write: it can foster self-esteem and self-confidence, which are necessary to introduce lifestyle changes and cope with stress more effectively. In view of these findings, FAL programmes – if linked with productive activities such as access to credit, income-generating activities and nutritional gardens – are potentially suitable entry points for HIV prevention and mitigation education. This is because such

IEC activities are unlikely to be effective where women are illiterate: illiteracy tends to be accompanied by lack of self-confidence, fear of learning and fear of change. These qualities are key obstacles to behaviour change among women.

95. Illiterate women are also more likely to fear confrontation with their husbands or partners and shy away from negotiating safe sex. In addition, women whose spouses are living with HIV/AIDS can greatly benefit from the social support of a FAL group, which can also prepare them to face the impact of their spouse's death.

Food Security and Nutrition

96. Food insecurity and malnutrition significantly contribute to people's vulnerability to HIV infection and the impact of AIDS. Because most people with HIV in Africa are unable to get adequate nutrition, their illness progresses faster than it normally would. For persons living with HIV/AIDS, food is the single most pressing need (Box 12). Foster families with orphans often find it difficult to provide enough food for all the children they care for, and studies have shown that orphans tend to receive food of inferior nutritional value, and they are often stunted. Women in food-insecure families may engage in 'survival sex' to obtain a meal for their children.

97. The challenge for IFAD-supported projects is to find ways of breaking the vicious cycle linking food insecurity, malnutrition and vulnerability to HIV/AIDS. In certain contexts, this can be achieved through innovations or adaptations in the area of food production, food security and nutrition, rather than through HIV/AIDS-specific measures. Innovations can include:

- ❑ *Increased agricultural productivity through better crop management and the introduction of high-yielding, weed/pest-resistant plant varieties that require less labour.* One example is IFAD's recent introduction of a cassava variety in Uganda that is resistant to mould disease.
- ❑ *The rehabilitation of certain staple food crops, such as sweet potato and cassava, from 'hunger crops' to main subsistence crops* These crops, which are often not in the mainstream of agricultural research programmes, have been found to be indispensable for the food security of households affected by HIV/AIDS. They require resources for research and extension, which IFAD-supported projects can provide.^{lxx}
- ❑ *Improved agricultural practices to save labour and capital,* including intercropping to reduce weeding time, and zero or minimum tillage to reduce the need for high-cost ploughs and oxen.
- ❑ *Labour- and time-saving agricultural and household technologies.* These may include lighter ploughs that can be used by youths, women and the elderly; and cultivators and other tractional implements adapted to donkeys or other animals. Access to potable water and fuel-efficient stoves, for instance, can free women with an added caring burden for agricultural and other productive activities and greatly alleviate their workload. Experience with such innovations has been mixed, however. For example, in Uganda, the use of donkeys has been successful in some areas (including Rakai District), but socio-cultural norms have inhibited their effectiveness in others (such as Mbarara District), and the stony

Box 12: Not care, not drugs, but food

Some weeks ago I was in Malawi and met with a group of women living with HIV. As I always do when I meet people with HIV/AIDS and other community groups, I asked them what their highest priority was. Their answer was clear and unanimous: food. Not care, not drugs for treatment, not stigma, but food.

Source: Piot, 2001.

terrain has also precluded their use for cultivation.^{lxxi} Similarly, ACORD's experience with using fuel-efficient stoves in Uganda has been mixed. The type of stove promoted (twin fireplace fitted into a brick platform) proved to be unsuitable (it required a well-roofed and spacious kitchen and was costly).^{lxxii} Thus, improved technologies need to be context-specific and should be tested for their physical, agro-ecological and cultural relevance before being introduced.

- ❑ *The promotion of small ruminants for consumption, sale and manure.* Animal protein is an important element of any healthy diet, but is nutritionally essential for people living with HIV/AIDS. Alternatively, small ruminants can be raised for sale. Moreover, studies in the Bukoba District of the United Republic of Tanzania have found that the declining role of cattle in farming systems (resulting in part from AIDS-induced destocking) has created a severe problem for farmers: the loss of manure, which is vital in combating acidic soils. Less labour-demanding small ruminants or an enhanced availability of bio-fertilizers can help overcome problems arising from lack of manure.^{lxxiii}
- ❑ *Nutritional gardens.* These have been found to be effective in increasing household food security. Furthermore, because of their proximity to the homestead, they are a feasible activity for women with an added caring burden. They also yield quick benefits.
- ❑ *Nutrition education.* Nutrition education conducted by community-based workers, agricultural extension staff and NGOs is needed to inform households of the importance of nutrition in prolonging lives of chronically ill adults and promoting the healthy development of the entire household.
- ❑ *Improved labour exchange arrangements through community mobilization and organization.* Experience in Rakai and Masaka Districts in Uganda shows that labour-sharing clubs have been effective in relieving labour shortages and in alleviating the impact of AIDS.
- ❑ *Improved access to demand-driven agricultural extension services* that address the felt needs of men and women farmers, including those affected by HIV/AIDS. Priorities must be: (a) to improve access to agricultural extension services for young widows, the elderly and child-headed households; and (b) to adjust these services to factor in the effects of young adult morbidity and mortality (including labour shortage, lack of cash for agricultural inputs and decimation of the asset base). This may require a review of existing approaches, typologies of farm households, and communication strategies and materials.
- ❑ *Small changes in gender roles and in resource allocation among households and communities* can have a positive impact on food security in HIV-affected households. Since the burden of caring for HIV/AIDS patients usually falls on women, such details as whether women are allowed to ride bicycles and whether bicycles are available can be important determinants of the marketing capacity of an affected household or community. Gender roles also influence the continuation or adoption of labour-saving responses (for example, the use of oxen or access to land and/or credit).^{lxxiv}

98. It is often mistakenly assumed that projects supporting staple food crops, small ruminants, nutritional gardens and labour-saving technologies are self-targeting both to HIV/AIDS-affected households and to women. Households headed by young widows with many young, dependent children or households headed by elderly grandmothers often face severe labour constraints and may not have the time or the opportunity to participate in project activities. Projects need to reach out to them, creating an enabling environment that takes account of their needs and constraints. Moreover, since men control resources in most parts of Africa, the actual division of labour and pattern of access

and control over resources need to be verified when designing a project.^{lxxv} This is particularly important in that the impact of AIDS disproportionately affects women's access to resources.

Socio-Economic Safety Nets

99. Although orphan support is not a traditional concern of agricultural investment projects, the magnitude and tragedy of orphanhood in East and Southern Africa have far-reaching implications for the socio-economic development of every country in the region. As seen earlier, in some countries, one in four households is affected by orphanhood directly, while many others are affected indirectly. Development and poverty alleviation strategies, which so far have largely ignore this trend, therefore need to transcend traditional boundaries and address this most urgent crisis.

100. The following section focuses on IFAD's most effective mitigation intervention to date: its support to orphans and foster families through the Uganda Women's Effort to Save Orphans. What is unique about UWESO is that it began as a relief operation assisting war orphans and evolved into a development programme aimed at strengthening the extended family, which is bearing the brunt of the HIV epidemic in general and orphan care in particular. The UWESO experience is thus valuable as a model for other IFAD-funded projects concerned with supporting socio-economic safety nets, and could also be replicated in other countries with high orphan tolls.

Case Study: IFAD Support To Orphans and Foster Families

101. The Uganda Women's Effort to Save Orphans is a non-profit NGO concerned with improving the lives of orphans by empowering local communities to meet the social, economic and psychological needs of these children. It was started in 1986 by Janet Museveni, wife of President Yoweri Museveni, to provide food, clothing and blankets to orphans in war-torn areas and return children to their extended families. Under the severe impact of HIV/AIDS, however, UWESO's focus was widened to include direct welfare to AIDS orphans.

102. The task of orphan support in Uganda is formidable: there are currently 1.7 million orphans due to war and HIV/AIDS, while about a quarter of all households in the country are fostering orphans. In view of the magnitude of the orphan crisis, UWESO's direct support in the form of school fees and the provision of basic needs was proving to be limited, expensive and unsustainable. For this reason, UWESO shifted to strengthening the social safety net that has traditionally supported orphans of war, disease and natural calamity: the extended family.

103. With financial and technical support from the Belgian Survival Fund and IFAD, the UWESO Development Project was designed in 1994. The project provides training to both foster families and adolescent orphans, giving them the knowledge needed to run small-scale income-generating projects. It also provides the required resources through a loan scheme, known as the UWESO Savings and Credit Scheme (USCS).

104. Most of UWESO's 10 000 volunteers are middle-aged women (grandmothers, aunts and older sisters) who are widowed. On average, each woman cares for seven orphans. To ensure the elimination of stigma and promote positive living and respectability, UWESO offers support to caregivers without singling out AIDS orphans. Yet, over 90% of USCS clients are caregivers of AIDS orphans.

105. USCS clients generally run small businesses: buying and selling produce, fish mongering, baking and selling bread, retailing essential commodities (charcoal, salt, sugar, soap, match boxes, paraffin), selling bicycle spare parts, operating small restaurants, brewing beer or managing bicycle taxis.

106. One of the project's main pillars is its comprehensive training programme. After the initial selection of a sub-county, training commences through public rallies in different parishes.^{lxxvi} The rallies give UWESO staff the opportunity to identify parishes committed to the programme (determined through attendance).

107. During the training period, clients are encouraged to start saving money, which will be deposited in group savings accounts. The next stage of training involves group formation and the use of the group as guarantor or security for individual loans. Groups of five to seven persons are formed, and the leaders (chairperson, treasurer and secretary) are elected.

108. In pre- and post-loan training periods, other additional components are usually added to micro-savings operations, including: (a) agricultural modernization, improvement of farm output, nutrition, bee-keeping and zero-grazing; (b) women's rights and legal aid (legal status of women and children with regard to property and inheritance); (c) family planning; (d) management of adolescent orphans; and (e) treatment of malaria among pregnant women; and (f) child immunization.

109. USCS has led to: (a) improved nutrition; better access to health care, clothing and children's education; and improved living and housing conditions (with many homes being upgraded from temporary to permanent in some districts); (b) a sounder economic base for USCS clients, including a culture of savings; (c) empowerment through knowledge, self-confidence and leadership skills; (d) income diversification among USCS clients; (e) a reduction in dependency on handouts.

110. **For out-of-school orphans, UWESO has set up an apprenticeship programme through community artisans.** The programme is designed for orphans who are unable to complete elementary school, usually because they are needed at home to care for their younger siblings. Through the UWESO Savings and Credit Scheme for Orphan Entrepreneurs, village artisans (near the orphan's homes) teach skills such as carpentry, bricklaying, concrete-mixing, metal-works, tailoring, catering, hairdressing, and bicycle, radio and TV repair. Orphans receive on-the-job training and earn as they learn. After this training, they are introduced to micro-business management and subsequently become eligible to take out loans to start their own micro-businesses. These small businesses are of critical importance to child-headed households, as they often become their sole source of income.^{lxxvii}

Box 13: Restoring Livelihoods with the Help of the USCS

When Mary was 15, her father died after a long illness. Two years later, she and her brothers dropped out of school for lack of school fees. Six months after that, in 1993, she married and now has four children.

Mary joined USCS in 1997 to help support her ageing mother and pay school fees for her brothers, three of whom had not yet started school even though they were over-aged. With hard work and group savings, Mary is now operating a number of interlinked small businesses. She and her husband have expanded their shop, once near collapse, and are now running a restaurant from their living-room. In addition, they rent two spare rooms, which are occupied on average four times a week. In the evenings, they sell roasted goat meat.

Together with her husband, Mary also bought two acres of land to add to the 1.5 acres they already own. Since they have recently acquired five head of cattle from the UWESO savings and credit scheme, they use the new land for cattle grazing. On their original plot, instead, they cultivate groundnuts, potatoes, millet, peas and *matooke* (occupying about one acre). All the *matooke* they produce has a ready market – her restaurant. Mary also has a contract to cook lunch for six teachers in a nearby school.

Due to a water shortage in the area, Mary and her husband built a brick and concrete water tank, from which they sell the surplus water harvested from the roof of their shop.

Mary is able to meet the financial demands of her mother, her siblings (all of whom are now in school) and her children. She is also a member of the Ngarama People's Trust a local micro-savings operation started by UWESO clients a year ago. She has six shares in the trust and has savings amounting to Uganda Shilling 250 000 (USD 168) with UWESO.

111. Micro-savings operations, which yield quick benefits for households fostering orphans, contribute to the success of UWESO. “It is **microfinance with a difference**,” says UWESO Executive Director Pelucy Ntambirweki. “Banks do not deal with grandmothers and widows. They bombard them with paperwork and want them to write and sign things. We designed savings and credit programmes that work for families in these situations, and we have taught them how to manage, how to use a loan, how to save.”^{lxviii}

112. UWESO now has 36 branches working in 15 districts throughout Uganda and has reached about 100 000 orphans. However, as Ntambirweki argues: “We have helped 100 000 children, but despite all our efforts, that is still only 5% of those in need.”^{lxix} Given that community-based care is the only sustainable response to orphanhood (as opposed to institutional orphan care), initiatives such as UWESO are vital and in urgent need of replication across East and Southern Africa to mitigate the impact of AIDS on the millions of children orphaned by the epidemic. Using the UWESO model and its experience, IFAD projects can introduce activities aimed at supporting socio-economic safety nets (savings and credit schemes for foster families, and training and artisan programmes for orphans).

Integrated HIV/AIDS Workplace Programmes for IFAD-Supported Projects

113. HIV/AIDS workplace programmes for IFAD-supported project staff should aim to address: the vulnerability of project staff to HIV infection and the impact of AIDS (in terms of access to information on HIV/AIDS and to safe working conditions); the relevance of existing workplace benefits and human resource procedures; and the technical capacity of staff to deal with HIV/AIDS concerns in their work.^{lxxx} The following aspects thus need to be included in HIV/AIDS workplace programmes:

- (a) **IEC on HIV prevention, care and support.** Although it is recognized that development project staff are as vulnerable as other people to HIV infection, it is often assumed that they are sufficiently informed about HIV prevention, care and support. Such assumptions can be misleading. Misconceptions about the disease abound, stigmatization may be pronounced and prejudices strong, while on-the-job discrimination is a reality for a number of project staff and their families living with HIV/AIDS. This tends to be the case particularly for support staff (drivers, messengers, guards and secretaries) who are often excluded from IEC campaigns and are more vulnerable socio-economically.
- (b) **Review and adjustment of project staff working conditions.** Certain working conditions may inadvertently expose project staff to high-risk situations. For example, project staff members who are required to travel extensively for their work and are often separated from their families are at high risk of HIV infection. This includes not only professional managers and technical staff but also some support staff, such as drivers.
- (c) **Review and adjustment of administrative procedures and human resource policies.** Terms for sick leave, unofficial leave, emergency advances and other procedures may need to be reviewed, and recruitment and replacement procedures adjusted.
- (d) **Capacity-building and training in the technical aspects of the impact of HIV/AIDS.** Staff members may not have the capacity or know-how to respond to the technical implications of HIV/AIDS for their area of expertise (e.g. the implications of labour shortages for agricultural research and extension).

114. This strategy paper, therefore, extends the usual definition of HIV/AIDS workplace programmes to encompass more than IEC for HIV-prevention initiatives and programmes to combat

discrimination. HIV/AIDS workplace programmes provide an opportunity to address the cross-sectoral impacts of the epidemic in a single 'package', which could include:

- ❑ Raising awareness of project staff (at all levels) and their families of HIV prevention, care and support;
- ❑ adopting policies to break down stigmatization, promote acceptance and support project staff living with HIV/AIDS, protect their rights and prevent discrimination in the workplace;
- ❑ ensuring staff access to HIV testing and counselling;
- ❑ making provisions for the care and support of project staff living with HIV/AIDS, and their families;
- ❑ adjusting working conditions of project staff exposed to high-risk situations (e.g. trying to ensure that project staff's families live with them at their duty stations; and limiting the number of overnight stays for project employees, including the number of seminars, workshops and training courses requiring absence from their home bases);
- ❑ multi-skilling at all levels supported by training strategies;
- ❑ adjusting benefits and/or administrative procedures (e.g. recruitment and replacement, sick leave, unofficial leave) to take account of the impact of AIDS, in collaboration with public service commissions or equivalent bodies;
- ❑ providing alternative social security options (such as health care schemes and welfare funds to assist HIV/AIDS-affected staff members and their families);
- ❑ arranging for staff training on the impact of HIV/AIDS on rural households; and on the linkages between HIV/AIDS and the core technical areas of project work and their implications for project implementation (e.g. how to help households sustain their productive capacity despite labour shortages, asset depletion and the increased need for food and income);
- ❑ appointing an HIV/AIDS focal point from the project staff with precise and agreed upon terms of reference and informing staff about his or her role and responsibilities;
- ❑ carrying out advocacy campaigns to elicit political commitment for HIV/AIDS at the highest ministerial levels;
- ❑ preparing an action plan for the integration of HIV/AIDS concerns into the project workplan and budget;
- ❑ formulating communication strategies for project staff, partners and target groups to ensure that appropriate HIV/AIDS messages are delivered to each stakeholder; and
- ❑ carrying out action research on specific the impact of HIV/AIDS and relevant mitigation measures, as identified by project beneficiaries.

115. The choice of appropriate interventions from this range of activities will vary considerably from project to project and from country to country. The list above provides a broad framework on the basis of which individual projects can design HIV/AIDS workplace programmes tailored to their needs.

B. Incorporating HIV/AIDS in the IFAD Project Cycle

116. During fieldwork conducted for the preparation of this strategy in Uganda and Zambia, it became apparent that **HIV/AIDS concerns and response measures need to be explicitly spelled out in the project design phase and incorporated in the project document** in order to address the spread and impact of the epidemic effectively.

117. For example, staff of VODP in Uganda were very much aware that, either directly or indirectly, HIV/AIDS is affecting “each and every household in the country”, in the words of the acting project manager. They recognized the importance of incorporating HIV/AIDS mitigation activities into project work, even if this meant adding onto the existing workload. They had not thought of HIV/AIDS in terms of how it related to project work, however, because, they argued “it is not in the project document”. The underlying assumption is that since projects aim to reduce poverty, they *de facto* target households affected by the HIV epidemic, and no deliberate efforts are therefore needed to do so.

118. A major constraint to integrating HIV/AIDS concerns in project work is the absence of implementation guidelines. As one IFAD-supported project manager in Zambia admitted: “We don’t know how to [address HIV/AIDS]—show us [how] and we will do it.”

119. These observations point to the need for a **systematic integration of HIV/AIDS concerns into the IFAD project cycle**, which extends beyond problem analysis to the identification of concrete entry points and response measures. In project areas severely affected by HIV/AIDS, further conceptual and operational adjustments may also be necessary. Such a process needs to run through the entire project cycle **from the country strategic opportunities paper (COSOP) to project completion**. Some examples of how HIV/AIDS concerns can be integrated into each stage of the project cycle are provided below.

Project Design

120. HIV/AIDS concerns should start at project formulation. **Key stakeholders need to be involved** in the identification and planning of measures responding to the impact of AIDS on livelihoods, communities and socio-economic safety nets, and on proposed project activities.

121. Further, **project design should clearly specify institutional responsibilities for incorporating HIV/AIDS in the project cycle**. Experience shows that only when there is commitment at the highest levels of government, project management, etc., will HIV/AIDS concerns be taken seriously. Thus, while an HIV/AIDS focal point within projects in areas heavily affected by the epidemic can help coordinate HIV/AIDS response measures, overall responsibility for integrating HIV/AIDS concerns in project work should rest with the project manager or coordinator. Otherwise, there is a risk that HIV/AIDS will be perceived as a separate component and that it will not become an integral part of all aspects and phases of project work.

Country Strategic Opportunities Paper

122. The COSOP, prepared by IFAD in close consultation with governments, provides an analysis of the overall country situation, with emphasis on the rural poverty context. It is the basis on which IFAD delineates short and medium-term investment strategies for the country. Since the COSOP is the framework for the identification of investment priorities, it is important that the implications of HIV/AIDS for agricultural and rural investment projects feature prominently in this document. In particular, as pointed out in Box 14, rural poverty analyses will need to take into account the burden of disease, as the characteristics of rural poverty may change considerably under the impact of AIDS. Proposed poverty alleviation strategies may need to be adjusted accordingly. In some cases, IFAD’s strategic thrust in highly affected countries may also need to be reviewed. Finally, the COSOP can also serve to elicit political commitment for HIV/AIDS at the highest levels of government.

Box 14: Integrating HIV/AIDS in the Uganda COSOP

In its analysis of the poverty situation, the 1998 Uganda COSOP identifies **AIDS as a contributing factor to rural poverty**: “The AIDS epidemic has depleted the supply of able-bodied persons between the ages of 18-45 years and this problem continues to affect individual families and overall agricultural productivity.” This analysis needs to be taken further: the impact of the depleted rural labour supply on households and on agricultural productivity, and their implications for IFAD project design and implementation, need to be explicitly spelled out to ensure that HIV/AIDS concerns are incorporated in each phase of the project cycle.

Further, assumptions about **the characteristics of rural poverty** based on ten- or even five-year-old data may no longer be relevant in countries heavily affected by HIV/AIDS. For instance, this COSOP does not explicitly take into account how the impact of HIV/AIDS may have modified the main characteristics of rural poverty in Uganda, which are identified as follows:

“(a) the rural poor grow proportionately the same amount of cash crops as the non-poor and proportionately more coffee in the central region; b) over 80% of households spend two thirds of their total expenditure on food; c) over 20% of non-food expenditure is spent on education and health; and d) for the bottom 25% of households, over 20% of total income is provided by remittances.” In the context of HIV/AIDS in Uganda, where epidemic impact peaked in the early 1990s, and given labour shortages and income declines, it is unlikely that households headed by women, the elderly and youths have been growing the same amount of cash crops as the non-poor. Moreover, many households with chronically ill adults spend most of their income on medical expenses rather than on food. In brief, the profile of rural poverty in Uganda has changed considerably as a result of the impact of AIDS, and these changes need to be reflected in poverty situation analyses. In addition, these changes may warrant adjustments in IFAD’s overall poverty alleviation strategy in the country.

In terms of entry points for HIV/AIDS concerns, the COSOSP indicates that “there is a need to develop extension approaches and methods suitable to the changed economic and institutional framework of the country”. Since one of the factors contributing to the changed framework is HIV/AIDS, this is particularly relevant. AIDS-induced changes in the clientele of agricultural extension (the elderly, women and youths), and their needs (technology, knowledge, etc.), interests and constraints, need to be taken into account.

Specific guidelines generated from IFAD’s experience in Uganda are also relevant in the context of HIV/AIDS. For instance, the COSOP mentions that “project design should allow sufficient flexibility for the project to adapt to changing circumstances during implementation; mechanisms should be introduced to recognize and address newly emerging problems”. If HIV/AIDS is recognized as such a problem, then the need for flexibility in project design can help management introduce appropriate response measures.

Source: IFAD, 1998, pp. 8-12.

Inception Phase

123. The inception paper enters the proposed project into the IFAD programme pipeline. Building on the strategic thrusts outlined in the COSOP, it defines the scope of the planned project. In the event of changes in the political, economic or social situation as originally defined in the COSOP, the inception paper will address these changes and their implications for the proposed investment. This paper should also include the HIV/AIDS strategy to be adopted within the framework of the proposed project. In particular, HIV/AIDS concerns should be factored into the poverty alleviation strategy pursued in highly affected countries, and AIDS should be specified as a contributing factor to food and livelihood insecurity, with appropriate response measures clearly defined.

Project Identification Phase: Socio-Economic Production Systems Studies

124. For socio-economic production systems studies, IFAD missions carry out participatory needs identification and analysis with potential project beneficiaries, during which contacts are also made

with possible NGO and donor partners. At this time, they also assess the socio-economic and cultural environment. During the project preparation cycle, IFAD routinely carries out baseline surveys or similar activities, but generally does not pay much attention to HIV/AIDS in these exercises. Baseline assessments should include an analysis of the potential effects of HIV/AIDS on the proposed project (and vice versa), ongoing HIV prevention and mitigation activities in the proposed project area and potential partners.

Box 15: Factoring HIV/AIDS in Inception Papers

The inception paper of the *Central Kenya Dry Area Smallholder and Community Services Development Project (CKDAP)* illustrates why HIV/AIDS needs to be included in the poverty profile, in potential project components and in project design issues. In the mid-1980s, IFAD made a “concerted effort to establish the location of the poor in Kenya, understand the root causes of their poverty and target IFAD assistance accordingly”. The main finding of this exercise was that poor smallholders exist in both high and medium-potential agricultural regions and in the arid and semi-arid areas of the country. In the high and medium potential areas, poverty was found to be largely a result of high population density and an associated lack of agricultural land. While these findings may have been valid in the 1980s when this poverty analysis was undertaken, many areas of Kenya have since been severely affected by the HIV epidemic. Thus, there may be a need to re-examine some of these findings, especially considering that they are being used as the basis of important design decisions.

Further, the analysis of the project’s probable impact on health does not mention HIV/AIDS, even though improving the health status of the population is a project objective and key component. This is a fairly common but major omission, as it cannot be assumed that projects addressing health issues are in fact taking HIV/AIDS into account.

Source: IFAD 2000a.

125. Such preparatory activities should also determine the policy environment as it relates to HIV/AIDS and community perceptions of the effects of the epidemic on their livelihoods, including current and potential community HIV prevention and AIDS mitigation strategies. The participation of NGOs could be initiated at this stage, drawing on their experience in HIV/AIDS and community development. Participatory methodologies that involve the beneficiaries in carrying out HIV/AIDS risk assessment and HIV prevention are also likely to serve as prevention and mitigation activities.

126. In order to assess vulnerability to HIV/AIDS and determine where the focus of response should lie, the vulnerability and mitigation matrix proposed in Section III.B can be used during baseline work. Further, in highly affected areas, an exercise akin to environmental assessments could be carried out as part of the socio-economic and production systems survey (SEPSS) in order to classify the project and its various components as they relate to HIV/AIDS risk. Risk would be measured in terms of HIV/AIDS prevalence in the project area, the epidemic impact level and an assessment of the effects that proposed project activities could have in this situation (e.g. road rehabilitation involves high risk; health initiatives involve low risk).

Formulation Phase

127. During formulation, a comprehensive project design is produced based on the findings of the SEPSS. Details of the project’s technical, financial, implementation and management activities are developed during this phase. Formulation reports must clearly detail how the proposed HIV/AIDS-related activities will be implemented, including training and other capacity-building requirements, to ensure that these activities will effectively be carried out. Financial and human resource requirements should be an essential part of this exercise. Performance indicators should also be identified and incorporated into the project formulation document.

Box 16: Participatory Rural Appraisal and HIV/AIDS

PRA exercises aiming at capturing HIV/AIDS impact need to take into account the following: (a) HIV/AIDS may not be an appropriate entry point for discussion and can be too sensitive an issue to raise directly in many communities. Poverty, household food insecurity, constraints in agricultural production and ill-health are likely to be more suitable entry points; (b) project staff trying to obtain data and information on HIV/AIDS may find it more appropriate to inquire about *chronic young adult illness* rather than about HIV/AIDS specifically, given the stigma surrounding the disease; (c) HIV/AIDS is unlikely to emerge as an issue from a PRA exercise unless it specifically probes into issues related to the epidemic. This has been found to be the case not only for agricultural and rural development projects but even for health projects or health components of projects.

PRAs conducted in countries with high HIV/AIDS prevalence and high epidemic impact should include *daily activity calendars, time-use exercises, gender division of labour* by crop, and/or *asset ownership* for households affected by young adult morbidity and mortality and possibly for orphans. These exercises will help identify changes in division of labour, time labour allocation, farming systems, and the roles and responsibilities of different age groups within households. Such exercises (disaggregated by gender) will also be critical in identifying, with the communities, suitable prevention and mitigation initiatives.

128. Programme formulation teams are composed of country portfolio managers (CPMs), technical consultants hired to formulate specific project components, IFAD technical divisions and cooperating institutions. These teams would greatly benefit from training on the policy and programming implications; of (a) the impact of HIV/AIDS on the various social and productive sectors that IFAD finances; (b) the relevance of HIV/AIDS for agricultural/rural development projects; and (c) ways of integrating HIV/AIDS prevention and mitigation activities in IFAD-financed projects.

129. As part of the formulation process, the project development team (composed mainly of selected IFAD staff) reviews the formulation report and gives technical guidance to the formulation team. Once the formulation report is complete, a technical review committee, (composed of advisors from IFAD's technical division) and the strategic operations committee (chaired by the Fund's President) provide technical and policy guidance. Issues arising from the technical review and strategic operations committees are addressed during the appraisal phase. To ensure that HIV/AIDS is integrated in the project formulation phase, it is essential that members of both committees are fully aware of HIV/AIDS policy issues and recognize the need for their integration in project implementation modalities and budgets.

130. The following recommendations, based on a review of the *Central Kenya Dry Area Smallholder and Community Services Development Project* (CKDAP) illustrate how formulation reports can incorporate HIV/AIDS concerns.^{lxxxix}

131. **HIV/AIDS adult prevalence maps** can be added on to the usual repertoire of base maps, agro-ecological zone maps, rainfall maps and project division maps. Such a map will give a quick overview of the severity of adult HIV/AIDS prevalence in the project area.

132. Project **logical frameworks** (logframes) **can include vulnerability to HIV infection and the impact of AIDS** with corresponding indicators. Some logframes already include HIV/AIDS, but primarily or exclusively in a health or HIV IEC prevention capacity. The CKDAP formulation report includes a logframe where the management of STIs and HIV/AIDS is among the project activities, and a corresponding indicator is listed (number of STI/HIV prevention plans and programmes and number of activities).^{lxxxix} HIV/AIDS could, however, also feature among the core project activities (such as training, improvement of crop and livestock production, verification of agricultural technologies, safe motherhood and child survival).

133. **Households affected by young adult mortality should be included in the target group.** IFAD formulation reports often define target groups as “households that are most vulnerable to household food insecurity and to absolute poverty.”^{lxxxiii} In countries with high HIV/AIDS prevalence rates and high epidemic impact, the poorest segments of the population are likely to include many households affected by HIV/AIDS. Targeting criteria for IFAD projects may therefore need to be adjusted to ensure that households affected by young adult morbidity and mortality are specified in the target group.

134. In the case of the CKDAP, selection criteria for households developed during the design workshop included:

- ❑ *Woman-headed households*
- ❑ *Households with children under five years*
- ❑ Households with small plots
- ❑ *Poor income level*
- ❑ Recipient of famine relief
- ❑ Squatter families
- ❑ Reliance on irregular casual labour
- ❑ *Orphans*
- ❑ Young unemployed household members
- ❑ Distance to health and water supply facilities

135. Orphans aside, the criteria highlighted in italics could also have included households affected by HIV/AIDS if the formulation document had explicitly stated that young adult morbidity and mortality is a priority targeting criterion. Therefore, in addition to the **criteria** identified during the workshop, the following could be added to **capture households affected by HIV/AIDS**:

- ❑ Households fostering orphans
- ❑ Households with chronically ill young adults
- ❑ Households that have suffered from young adult mortality in the last two years.

136. **Build mechanisms in the design process to facilitate the participation of HIV/AIDS-affected households in project activities.** Targeting households affected by young adult morbidity and mortality may not be enough. The project formulation process may need to consider operational adjustments that will enable such households to overcome the labour and other constraints they face. The objective of such mechanisms should be to create an enabling environment in which households can participate in and benefit from project activities.

137. **Include HIV/AIDS as a factor of vulnerability to food insecurity and coping strategies.** In the case of **vulnerability to food insecurity**, the CKDAP refers to: (a) seasonal household food insecurity (caused by frequent drought and insufficient land); (b) inefficient social services (such as water supply, health facilities and education); (c) absence of support structures (extension services and rural finance services); and (d) insecure land tenure (for squatters).^{lxxxiv} HIV/AIDS should also be included as an important factor of vulnerability. In terms of **coping strategies**, the formulation report mentions women and girls being forced into commercial sex. What is far more significant and common, however, is ‘survival sex’ (see Box 4), which many more women engage in to support their families through periods of food insecurity. More generally, the inclusion of HIV/AIDS in the context

of coping strategies may help piece together a more comprehensive profile of poverty and vulnerability.

138. **Define the potential adverse effects of the project under preparation and particularly on households with chronically ill adults.** Projects in areas with severe AIDS impact levels may need to address the following issues, including in formulation reports:

- (a) Could project activities inadvertently obstruct the provision of care to the sick, to infants and young children and to orphans, and if so how? What types of safeguards are needed to prevent this?
- (b) Are project activities suitable for young people and the elderly in terms of their physical, legal and skills requirements? Could safeguards be built in to ensure that these groups can benefit from project activities given the constraints they face?
- (c) Could project activities inadvertently increase the risk of HIV infection, and if so what prevention and mitigation activities need to be put in place to prevent this from happening?

139. **Extend beyond health-related HIV/AIDS components.** Formulation reports often incorporate IEC programmes, usually in the context of primary health care sub-components. These tend to consist exclusively of STI/HIV/AIDS control activities (assisting district health teams to plan and implement strategies to monitor and control the spread of HIV, providing training in STI management, counselling and promoting condom use).^{lxxxv} These components should be supplemented with HIV prevention measures in the project's core technical areas as this is where IFAD's comparative advantage lies.

140. **Address HIV/AIDS as a cross-sectoral issue.** HIV/AIDS may feature in the analysis of health problems in a given project area, and may be dealt with in some detail in working papers in the annexes of formulation reports, The findings often get lost, however, within the health component of project documentation. In the case of the CKDAP, the formulation report (May 2000) included as an appendix a working paper on health, nutrition and sanitation, which clearly indicates that HIV/AIDS is a major public health *and* development challenge. It also reports that the five districts where the proposed CKDAP-II project will be operating have ongoing STI/HIV/AIDS-control activities and annual action plans and budgets, but that the financial resources they receive are so meagre that there are no activities at community level in any of the districts.^{lxxxvi}

141. The working paper cites the following problems associated with the epidemic in Kenya:

- HIV infection and AIDS are rapidly increasing everywhere in the country.
- Knowledge about the transmission and prevention of HIV is inadequate.
- Communities do not know how to live with and support people living with HIV/AIDS.
- Men are reluctant to use condoms.
- Health workers are not adequately trained to counsel those living with HIV/AIDS.
- There is inadequate empowerment of women, who are often unable to make decisions regarding their sex life.
- Unemployment and poverty are increasing, leading to commercial sex, and the brewing and sale of illicit brews.^{lxxxvii}

If these important findings had been systematically incorporated in the main formulation report, they could have led to the identification of comprehensive HIV prevention and AIDS mitigation measures.

142. A provision should be made in the formulation report to appoint an **HIV/AIDS focal point** – a technical officer appointed from the staff to coordinate the integration of HIV/AIDS concerns in project work and operationalize related activities.

Appraisal Phase

143. At appraisal, issues raised at the technical review and operational strategic committees are addressed and integrated into the formulation report, which then becomes the appraisal report. This entails field missions aimed at filling in policy, implementation and technical gaps. To include HIV/AIDS concerns, cooperating institutions may need to approve annual workplans and budgets (AWP/Bs). In some instances, objections have been raised to the implementation of HIV/AIDS-related activities proposed by projects and programmes. In an IFAD-financed programme in Zambia, for instance, staff were advised by the cooperating institution not to address HIV/AIDS issues specifically but to concentrate on agriculture and other investments as detailed in the appraisal report. This highlights the fact that many of IFAD's cooperating institutions do not operationally link HIV/AIDS with development activities.

144. The appraisal report supersedes the formulation report and is the basis of loan negotiations and eventually of project implementation.^{lxxxviii} It is therefore of paramount importance that appraisal reports specify the identified HIV/AIDS-related interventions to be undertaken by the project, including how and through what human and financial resource facilities they will be implemented.

Approval by the IFAD Executive Board

145. Following appraisal and loan negotiations, the programme is presented to the IFAD Executive Board, which approves the programme and the loan. The responsible country portfolio manager presents the programme to the board.

146. President's reports could briefly review the HIV/AIDS situation in the project area, link it with the project's objectives and rationale, specify how households directly and indirectly affected by the epidemic will be targeted and reached, and specify how response measures can feature in the proposed project components (e.g. extension, research, community development, feeder roads, and rural water supplies). In heavily affected areas, sections on the **impact of HIV/AIDS** could be introduced along the lines of environmental impact sections. In addition, the following elements could be added to President's reports:

- ❑ HIV/AIDS adult prevalence rates and number of orphans in the country data annex of the reports.
- ❑ HIV/AIDS concerns in the logical framework of the project.
- ❑ HIV/AIDS response measures in the various project components.

Project Implementation

147. An important lesson learned from IFAD's gender mainstreaming work is that better linkages are needed between project design and implementation in IFAD-supported projects. A wide gap often exists between what is argued in project appraisal reports and what actually happens on the ground.^{lxxxix} Thus, project formulation and appraisal teams need to work closely with implementing agencies to build local ownership and a common understanding of a project's approach to preventing the spread of HIV and mitigating the impact of HIV/AIDS.

148. Within the project implementation cycle, HIV/AIDS will need to feature in the following processes:

- (a) **Start-up workshops:** Held in-country, project start-up workshops bring together government officials, IFAD staff, cooperating institutions, donors, NGOs, and key project stakeholders, including representatives of the target beneficiaries. During the workshops, projects are officially introduced and implementation is reviewed in detail. Discussions are based on implementation manuals developed for the project and dealing with the implementation of project components; finance and accounting; procurement; and training. As such, these workshops can also serve as an entry point for discussion with stakeholders on HIV/AIDS and its implications for the project, based on the presentation of a brief paper on the implications of HIV/AIDS for project staff, operations and beneficiaries, and for operational modalities of implementation activities.
- (b) **Project implementation committees:** To ensure that HIV is on the agenda, project implementation committees should include at least the project's HIV/AIDS focal point and, where possible, a member from the district AIDS planning committee or equivalent body.
- (c) **Supervision missions:** The supervision of IFAD-financed projects in the region is carried out once or twice a year by cooperating institutions (World Bank, UNOPS or the African Development Bank) contracted by IFAD. In a few cases, the IFAD country portfolio manager directly supervises some projects. Supervision missions provide technical guidance to projects and make sure that project activities and procurement are in line with the appraisal reports and with AWP/Bs. IFAD has to make sure that HIV/AIDS is on the agenda of supervision missions, and that mission members have the technical capacity to address HIV/AIDS-related issues or know whom they can call upon to provide specialized technical services. Communicating the IFAD HIV/AIDS strategy to the cooperating institutions, establishing a regular exchange with them on HIV/AIDS-related issues and underscoring the need to incorporate HIV/AIDS in ongoing and future projects and in project supervision are all therefore critical.
- (d) **Monitoring and evaluation:** To ensure that IFAD-supported projects are reaching households affected by HIV/AIDS, many of which are likely to be among the lowest stratum of the poor, beneficiary contact monitoring should be built into management information systems and complemented by participatory evaluation.
- (e) **IFAD's gender-strengthening programme** in East and Southern Africa recently recommended, on the basis of its Zambia Field Diagnostic Study, that project planners and implementing agencies gather empirical information on gender roles in a particular locality, ethnic group and farming system, given the differences in gender roles and responsibilities among different ethnic populations and in different geographical areas and farming systems.^{xc} This is particularly relevant for the design and monitoring of AIDS mitigation measures in the area of household food and nutrition security. It may also be useful to complement such data collection exercises with data that capture AIDS impact levels.
- (f) **Mid-term reviews:** Mid-term reviews are carried out by governments or by IFAD's Evaluation Office to assess project implementation progress and performance. The mid-term review is an important stage in which to take stock of HIV/AIDS initiatives. In some cases, mid-term reviews recommend alternative directions for the project, including reallocation of funds in order to facilitate the project's eventual positive

impact. This could be an entry point for HIV/AIDS-related activities in cases where these were not originally included.

- (g) **Programme termination:** At programme termination, governments prepare completion reports. An evaluation could be made of how HIV/AIDS has been taken into account in project activities and of the project's impact on the spread and impact of the epidemic in the project area and on poor households affected by young adult mortality. Completion reports could then become an important mechanism through which to document experiences, opportunities and constraints in this area.

V. BUILDING STRATEGIC PARTNERSHIPS

149. Most development organizations (UN organizations, bilateral donors, NGOs/CBOs) recognize that HIV/AIDS is a multisectoral issue, and this is reflected in their development policies and strategies. However, the operationalization of multisectoral responses has been slow. While many organizations, and particularly NGOs, have developed capacity in HIV prevention and in the care and support of people living with HIV/AIDS, AIDS mitigation activities in agriculture and rural development programmes are relatively scarce.

150. Yet, given the magnitude of the HIV epidemic, no single actor can effectively address its cross-sectoral effects. Strategic partnerships are required with bilateral agencies, other UN organizations, NGOs and the private sector. IFAD usually collaborates with bilateral agencies on the basis of cofinancing partnerships where the donor agency finances project-specific activities and/or project components. In some cases, a donor may also finance and/or provide technical assistance. Key donors involved in IFAD projects at this level include the Belgian Survival Fund, GTZ and Ireland Aid. Partnerships with NGOs are an integral part of IFAD field operations, with NGOs participating on a contractual basis as service providers to the borrowing governments. In most IFAD-supported projects, NGOs provide services principally in the area of community mobilization and development.

151. Types of partnerships that can be established with other organizations for HIV/AIDS prevention and mitigation include:

- (a) **cofinancing partnerships** primarily with bilateral and multilateral donor agencies and UN agencies, and, to a limited extent, NGOs;
- (b) **advocacy partnerships** primarily with NGOs and UN agencies;
- (c) **operational partnerships** mainly with NGOs for the provision of services in:
 - (i) institutional development and capacity-building for stakeholders in IFAD-financed projects (i.e. implementing partners such as ministry staff, CBOs and NGOs); and
 - (ii) implementation of HIV prevention and AIDS mitigation activities;
- (d) **research and knowledge dissemination partnerships** (research, data and information dissemination) with UN agencies (e.g. FAO, UNAIDS), technical organizations, universities and research institutions.

152. The remainder of this section examines the potential of such partnerships with four categories of organizations: NGOs; national bodies and networks; other United Nations agencies; and bilateral donors. Possible partnerships are discussed below but should only be considered as examples and are not exhaustive.

A. Partnerships with NGOs

153. Partnerships with NGOs will be an integral part of the implementation of HIV prevention and AIDS mitigation activities for IFAD-financed projects. From a strategic point of view, and in relation

to IFAD-financed projects, the strength of NGOs is in participatory programme development and implementation at community level. Therefore, NGOs can play a leading role in:

- (a) **participatory needs assessments for socio-economic and production system studies**, to identify with the communities the constraints posed by vulnerability to HIV/AIDS and its impact on livelihoods, and to define mitigation options;
- (b) **the implementation of HIV/AIDS-related initiatives**. Depending on the project, NGO involvement would focus on community mobilization to ensure the inclusion of households affected by young adult mortality in project activities. They could also help identify community coping strategies and mitigation activities that could be supported, scaled up and/or replicated;
- (c) **the implementation of AIDS-specific community components**, including pilot and expansion/replication activities of existing programmes, focused on enabling communities to mitigate livelihood shocks, including HIV/AIDS (e.g. a replication of the UWESO Development Project or of the Africare Zambia initiative, Box 17);
- (d) **advocacy** for issues such as access to productive resources (particularly land) for the poor and inheritance rights for women and children. Through IFAD-funded community development and mobilization components, various actors can be called upon to interact with the communities on these issues. An example is land tenure access, which is one of the priority action areas for IFAD in East and Southern Africa. Rural women are disadvantaged in terms of land ownership. HIV/AIDS has exacerbated their situation in both patrilineal and matrilineal communities. Legal literacy on property rights could thus become an integral part of functional adult literacy or other project activities.^{xci} NGOs such as the International Federation of Women's Lawyers and the Legal Aid Project are potential partners in this area; and
- (e) **health care activities**: To cover health, including community needs for care and support, NGO collaboration in the water, health and nutrition components of IFAD-supported projects may be appropriate. Partnerships could be formed with NGOs specialized in areas such as training of community health workers in AIDS care, support and counselling, nutritional monitoring and raising community awareness of the need for improved hygiene and nutritional practices. In these partnerships, it will be important to ensure that NGO partners also understand the implications of HIV/AIDS for development.

Box 17: Africare’s Integrated Approach to Community Empowerment in Strengthening Community Coping Strategies to AIDS Impact in Zambia

In response to increasing household food insecurity (largely due to AIDS), Africare, a private American NGO, has launched the *Small-Scale Agricultural Mechanization Promotions Project (SAMEP)* in Zambia. The project promotes the following:

- Short-maturing seeds, e.g. *katumani* maize, sunflower, sorghum and sesame;
- nutritious leguminous crops, e.g. cowpeas and mung beans;
- conservation farming;
- seed multiplication initiatives as income-generating projects (surplus seed is sold to other organizations e.g. World Vision and Oxfam);
- labour-saving technologies, e.g. oil presses, groundnut lifters;
- livestock credit in-kind activities;
- HIV/AIDS IEC initiatives using drama and radio;
- income-generating projects for rural youth, e.g. vegetable production, dairy farming and bakeries, together with training in requisite business skills;
- youth information centres, where information on various issues is provided, including reproductive health and STIs.

Possible IFAD-Africare partnership areas could include: (a) IFAD financial support for scaling up current initiatives; (b) replicating and adapting successful initiatives in IFAD-financed projects; and (c) documenting best practices.

Source: Information leaflet produced by Africare, Zambia, 2000.

154. Financing could include: (a) direct IFAD financing for initiatives to be implemented by NGOs, e.g. UWESO-type activities and NGO activities identified for scaling up; and (b) financing through the government for activities that are integrated as part of IFAD-financed projects (either loan- or grant-based).

155. Partnerships with NGOs (and other organizations) have to be governed by memoranda of understanding, defining the mandate and commitment of each party. Procedural requirements need to be flexible to allow projects the possibility of establishing collaborative partnerships with other actors as the need arises. This flexibility needs to be integrated into project appraisal documents.

B. Partnerships with National Bodies and Networks

National AIDS Commissions

156. The mandate of national AIDS commissions (NACs) is to coordinate national HIV/AIDS programmes, establish partnerships with stakeholders and support multisectoral approaches for HIV/AIDS prevention and mitigation. NACs are also mandated to develop, in participatory partnerships with other stakeholders, country strategic frameworks for HIV/AIDS interventions. In practice, however, few multisectoral mitigation activities are implemented, even though the effects of the epidemic on each sector are well defined.

157. As a first step towards establishing partnerships with NACs, IFAD should present its HIV/AIDS strategy to create ownership and foster a process of information-sharing and coordination. Further, NACs can be instrumental in integrating AIDS mitigation for the rural poor into National strategic frameworks for HIV/AIDS activities and poverty reduction strategy papers, thereby ensuring that these initiatives are part of the overall country policy and planning process. NACs can also facilitate the dissemination of information on IFAD-supported initiatives and share with IFAD-

financed projects best practices from the field. To this effect, IFAD-supported projects should provide NACs with project implementation summaries reviewing components that address HIV/AIDS.

Networks of People Living with HIV/AIDS

158. Networks of people living with HIV/AIDS can play a key role in advocacy and IEC activities, especially HIV prevention, the strengthening of coping mechanisms for directly affected households, and the dissemination of best practices on health and nutrition. One such example is the publication “Food for People Living with HIV/AIDS”, researched and produced by the Network of African People Living with HIV/AIDS. Adapted for Zambian conditions and reprinted, this publication is a nutritional guide that can be disseminated through community structures, e.g. community health workers and NGOs.

C. Partnerships with United Nations Agencies

Food and Agriculture Organization of the United Nations

159. As a technical assistance agency whose mandate is to increase food production and security while conserving and managing natural resources, FAO is a key partner for IFAD. IFAD is already working with FAO through farmer field schools various countries in East and Southern Africa. Potential areas of cooperation on HIV/AIDS include:

- (a) strategies to adapt agricultural extension and investment services to the changing needs of target groups in view of the impact of HIV/AIDS;
- (b) capturing, analysing and disseminating information on knowledge systems adversely affected by HIV/AIDS (in particular, the loss of intergenerational knowledge of agricultural skills and practices; farm management and marketing skills, gender-specific skills and institutional knowledge);
- (c) scaling up of HIV/AIDS-related activities in projects using farmer field schools; and
- (d) at country level, FAO could be called upon to represent IFAD in policy discussions in the areas of HIV/AIDS and development, to ensure that these are integrated into poverty reduction strategy papers.

Joint United Nations Programme on HIV/AIDS

160. UNAIDS^{xcii} was formed in 1996 to mobilize a broad-based response to the global health and development challenges posed by HIV/AIDS. It is also the overall UN coordinating body for HIV/AIDS-related initiatives. The goal of UNAIDS is to catalyse, strengthen and orchestrate the unique expertise, resources and networks of influence that each of its co-sponsors offers. Working together through UNAIDS, the co-sponsors expand their outreach through strategic alliances with other UN agencies, national governments, CBOs, corporations, the media, religious organizations, regional and country networks of people living with HIV/AIDS, and other NGOs.^{xciii} IFAD and the UNAIDS Secretariat have already established a cooperation framework, the text of which is attached as Annex 1.

161. Areas of possible partnerships with UNAIDS include:

- (a) the further development and testing of the HIV/AIDS vulnerability and mitigation matrix proposed in this strategy paper, and in particular, the designation of thresholds for the proposed indicators of AIDS impact levels and low/high HIV/AIDS prevalence;

- (b) the development of sector-specific mitigation strategies and monitoring of the impact of interventions;
- (c) the development of comprehensive HIV/AIDS workplace programmes; and
- (d) the exchange, documentation and dissemination of best practices in the form of workshops, in-service training and publications. The UWESO project could be one such example of a best practice case study that can be documented and developed further in terms of its replication potential.

United Nations Population Fund

162. About a quarter of all population assistance from donor nations to developing countries is channelled through the United Nations Population Fund. UNFPA has three main programme areas: reproductive health (including family planning and sexual health), population and development, strategy and advocacy. UNFPA's comparative advantage as a co-sponsor of UNAIDS is in reproductive health, gender equality, women's empowerment and socio-cultural concerns. Like IFAD, UNFPA is primarily a funding agency and does not implement programmes, unless the recipient government has difficulties in carrying out implementation. In addition, country programme plans cover a five-year period and programme financing is released annually.

163. Possible areas of collaboration with IFAD include IEC on HIV/AIDS and reproductive health issues and the provision of condoms. IFAD-supported projects with health and nutrition components and community health worker training could greatly benefit from UNFPA's expertise in reproductive health. Community awareness-raising on gender and HIV/AIDS issues using peer educators is another potential partnership area.

United Nations Office for Project Services

164. The United Nations Office for Project Services (UNOPS) is an independent arm of the United Nations that provides project management services in every area where the UN has a mandate. It also offers services to bilateral donors, international financial institutions, developing country governments and others. At their request, UNOPS manages development projects or provides specialized services, as needed. These services include selecting and hiring project personnel, procuring goods, organizing training, managing financial resources and administering loans.^{xciiv}

165. IFAD already works in partnership with UNOPS, which is contracted to supervise IFAD-financed projects. This entails the provision of technical guidance, undertaking technical reviews and clearing project AWP/Bs. In view of the above, IFAD needs to establish with UNOPS the adverse impacts of HIV/AIDS on both the target groups of IFAD-supported projects and project staff and operations, and define mechanisms to ensure that HIV/AIDS concerns are integrated into the tasks and terms of reference of supervision missions.

United Nations Volunteers Programme

166. The United Nations Volunteers (UNV) programme was created in 1970 to serve as an operational partner in development cooperation at the request of UN member states. It reports to the United Nations Development Programme (UNDP) and works through UNDP country offices around the world. Volunteers work in programmes of technical cooperation; community-based initiatives for self-reliance; humanitarian relief; rehabilitation in agriculture; health; education; information and communication technology; community development; and vocational training.^{xcv}

167. Under the UNV/UNAIDS Greater Involvement of People Living with HIV/AIDS programme (GIPA), people affected by HIV/AIDS are recruited as UNVs to work in various projects. They bring

their technical expertise with the added advantage of a personal perspective and commitment. Pilot projects have been implemented in Malawi and Zambia. Partnerships with UNV/UNAIDS may be suitable for the provision of assistance to HIV/AIDS focal points in IFAD-supported projects.

World Food Programme

168. WFP, the food aid agency of the United Nations, aims at saving the lives of people caught up in humanitarian crises through food-for-life; supporting the most vulnerable people at the most critical times of their lives through food-for-growth; and helping the poor to become self-reliant and build assets through food-for-work.

169. Possible areas of collaboration between WFP and IFAD include:

- (a) partnerships in rural infrastructure development where food-for-work could be provided to facilitate community participation, especially in regions experiencing labour shortages and/or where communities may be too food-insecure to participate in project activities;
- (b) in post-conflict countries where IFAD finances reconstruction and rehabilitation programmes, WFP food-for-work programmes could be used to attract labour and also to help households rebuild their asset base; and
- (c) where vocational training programmes for orphans are supported by IFAD (e.g. such as the UWESO project), WFP could provide a food-for-training nutritional component. This could enable more orphans to be targeted for skills transfer and training, which would prevent them from selling their unskilled labour for food and/or assets.

D. Partnerships with Bilateral Donors

DANIDA

170. Poverty reduction is the primary objective of the Danish International Development Agency (DANIDA). Within this objective, the main cross-cutting themes are gender, the environment and good governance. In addition to these, HIV/AIDS is now a priority area. Denmark intends to support HIV/AIDS initiatives based on four principles: (a) political mobilization through the promotion of commitment of national leaders and opinion makers; (b) HIV prevention by empowering, through access to various services, women and men to protect themselves against HIV infection; (c) care and support of people living with HIV/AIDS, and their families; and (d) reducing the long-term effects of HIV/AIDS through the development of sector-specific strategies and capacity.^{xvii}

171. Denmark is an important potential IFAD partner in the area of HIV/AIDS. Possible areas of collaboration under thematic funding include support for:

- (a) initiatives aimed at mitigating the effects of HIV/AIDS on the livelihoods of the rural poor;
- (b) the development of methodological tools and modules for guiding work aimed at the integration of mitigation initiatives into rural and agricultural investment projects; and
- (c) workplace HIV/AIDS programmes.

Department for International Development

172. In response to the HIV epidemic, the United Kingdom's Department for International Development (DFID) is focusing on six main areas of response: (a) building political leadership; (b) building national institutional capacity; (c) tackling the underlying causes of vulnerability, which includes addressing stigma, gender inequalities and poverty; (d) maximizing the contribution of all sectors; (e) supporting a comprehensive HIV/AIDS prevention and care programme; and (f) supporting the development of knowledge generation.^{xcvii}

173. Potential areas of collaboration between DFID and IFAD include:

- (a) action-research on the impact of HIV/AIDS on rural livelihoods, including on access to assets such as land, and technology;
- (b) the development of a livelihoods perspective of HIV prevention and AIDS mitigation responses; and
- (c) exchange, documentation and dissemination of lessons learned and best practices.

German Technical Cooperation

174. GTZ has prioritized the mainstreaming of HIV/AIDS into their activities by allowing projects to use up to 3% of their budgets for HIV/AIDS-related activities. A technical advisory service for GTZ structures (offices, projects and staff) has also been set up, which focuses on HIV/AIDS. Key focus areas for GTZ are decentralization, privatization and commercialization; HIV/AIDS and rural livelihoods; support for the Debt Initiative for Heavily Indebted Poor Countries (HIPC) and poverty reduction strategies (PRSP) processes; and land issues. As GTZ's priority areas are similar to IFAD's, there is considerable scope for complementarity. In the field of HIV/AIDS, GTZ focuses on supporting HIV prevention and coping mechanisms; promoting the incorporation of HIV/AIDS into participatory rural extension services; and promoting community approaches for the alleviation of the impact of AIDS on socio-economic livelihood support systems.

175. Potential areas of collaboration between GTZ and IFAD include:

- (a) research on HIV/AIDS and rural livelihoods, with a focus on coping strategies;
- (b) the development of methodological tools for the integration of mitigation initiatives into agricultural investment projects;
- (c) the development of a monitoring system to measure the impact of HIV/AIDS on agricultural and rural development projects; and
- (d) cofinancing of HIV/AIDS-related development initiatives.

Ireland Aid

176. The main priority areas of Ireland's HIV/AIDS strategy include: (a) improving awareness, responsiveness and effectiveness of its aid to HIV/AIDS as a development issue; (b) protecting existing social and economic development gains from the adverse effects of HIV/AIDS; (c) promoting further development in these areas; and (d) supporting sectoral policies, programmes and activities that impact on the pandemic at national, community and individual levels.^{xcviii}

177. Potential areas of collaboration between Ireland Aid and IFAD exist and should be explored further. These could include cofinancing of HIV/AIDS prevention and mitigation initiatives, and the exchange, documentation and dissemination of lessons learned and best practices.

Japan

178. Japan's mid-term policy on official development recognizes HIV/AIDS as a serious obstacle to development in developing countries. Specific areas of action include supporting: (a) the sharing of knowledge among developing countries through South-South cooperation; (b) HIV prevention measures, including the distribution of contraceptives, safe syringes, and assistance related to the delivery of drugs; (c) IEC programmes for young people on HIV/AIDS, linked with reproductive health; and (d) care and counselling for AIDS orphans. These are areas that Japan and IFAD can further explore in order to establish areas of collaboration.

NORAD

179. In 1996, the Norwegian Agency for Development Co-operation (NORAD) established policies to integrate HIV/AIDS into its overall development assistance (planning, implementation and evaluation of all activities, including agriculture and infrastructure) within a multisectoral framework.^{xix} NORAD is currently an important financing partner of IFAD's women and gender equality programmes. Areas of potential partnership between NORAD and IFAD include:

- (a) the identification and scaling up of social safety net programmes, such as the provision of life skills to orphans and foster families of orphans. An example of this could be the replication/scaling up of programmes such as the UWESO Development Programme;
- (b) developing and supporting HIV/AIDS workplace programmes; and
- (c) cofinancing of HIV/AIDS-related prevention and mitigation initiatives.

VI. BUILDING IFAD CAPACITY TO ADDRESS HIV/AIDS: A SUMMARY OF POTENTIAL ACTIVITIES

A. At Project Level

180. To begin addressing HIV/AIDS at project level and identifying appropriate HIV/AIDS prevention and mitigation activities, it is proposed that each IFAD-supported project organize a **one-month consultancy** to systematically assess: (a) the impact of the epidemic on the project (and its partners where necessary); (b) how to mainstream HIV/AIDS concerns in core project activities; (c) operational and procedural adjustments needed to address the impact of AIDS on project staff and target groups; and (d) key entry points for the integration of HIV/AIDS in ongoing project interventions. Measures to be taken at project level will depend on the degree of HIV/AIDS prevalence and the level of impact in the project area. Therefore, the choice of tasks will vary from project to project.

The following tasks should be undertaken during the consultancy:

- (a) Conduct an **internal HIV/AIDS impact assessment** to determine: the direct/indirect costs of the epidemic on the project; the level of staff awareness of HIV prevention and AIDS mitigation (who has been reached by IEC campaigns, how and when?); and the mechanisms adopted by the project to cope with staff morbidity and mortality.^c
- (b) Conduct an **assessment of potential project impact on HIV/AIDS** to assess whether and how the project could inadvertently exacerbate the spread of HIV and increase the impact of AIDS. Issues to be addressed in such assessments would include some of the following:

- Will the project break up family structures and add to HIV risk?
 - Will the project require the displacement of people?
 - Will the project increase inequality?
 - If new transport routes are created, are there plans to address HIV risk?
 - What is the potential impact of HIV/AIDS on cash cropping versus food security?
- (c) Conduct a **community HIV/AIDS impact assessment** with project target groups using PRA to identify the level of impact in the project area (using the HIV/AIDS vulnerability and mitigation matrix), the livelihood-specific vulnerabilities of the target groups, coping mechanisms, and corresponding prevention and mitigation priorities that are location- and context-specific.^{ci}
- (d) Assess the appropriateness of establishing an **HIV/AIDS focal point** among the project staff (to be selected from among volunteers) and prepare his or her terms of reference, in collaboration with project staff. Explore what training and other incentives can be offered to the HIV/AIDS focal point.
- (e) Identify potential NGOs to undertake awareness-raising and capacity-building of project staff on HIV/AIDS, and work on a draft outline of the areas to be covered in training courses.
- (f) Explore whether and how the project coordinator or deputy coordinator can be entrusted with the overall responsibility of integrating HIV/AIDS in project operations.
- (g) Explore the financial, human resource and organizational requirements that will be needed to establish an integrated AIDS workplace programme.
- (h) Prepare a detailed action plan for the integration of HIV/AIDS in the core technical work of the project.
- (i) Define monitoring, evaluation and reporting requirements to accompany each proposed activity.

B. At Country Level

181. The following activities are proposed for IFAD-supported projects at country level, to be held at about the same time as or after the activities proposed at project level:

- (a) Organize a workshop bringing together all IFAD-supported projects to brainstorm on the relevance of HIV/AIDS for projects supported by the Fund. The aim of the workshop should be to: (a) provide topical technical information on the status of HIV/AIDS in the country and, where possible, in project areas; (b) discuss the relevance of the epidemic for IFAD-supported projects (and identify common problems resulting from the impact of HIV/AIDS, explore ways of reaching households affected by HIV/AIDS, share information on ongoing prevention and mitigation activities and experiences); and (c) propose practical steps that address the implications of the epidemic for project work.^{ci}

- (b) Set up a networking mechanism among projects to ensure easy exchange of information and experience with HIV/AIDS initiatives (including bottlenecks, gaps and, eventually, lessons learned and best practices); and organize project exchange visits to stimulate interaction and dialogue among project staff. Depending on the country and the IFAD project portfolio in that country, it may be appropriate to have one project lead the process of integrating HIV/AIDS. In Uganda, for instance, UWESO would have a clear lead role in assisting other projects in identifying entry points for HIV/AIDS activities.

C. At Headquarters Level

182. The following initiatives are proposed at Headquarters level to initiate a programme of activities on HIV/AIDS and facilitate the integration of HIV/AIDS concerns within IFAD:

- (a) **Awareness-raising** of IFAD headquarters staff of the links between HIV/AIDS and the technical areas of the Fund's work.
- (b) **Capacity development** to build HIV/AIDS in project design, implementation, monitoring and evaluation (M&E) and particularly in project documents, missions, baseline surveys, etc. Explore with staff whether and how the project design process needs to change to accommodate the conditions being created by HIV/AIDS.
- (c) **Awareness-raising of staff of cooperating institutions** (UNOPS, the African Development Bank and the World Bank) and of cofinancing partners to the developmental effects of HIV/AIDS on IFAD-supported projects;
- (d) Establishment of a **database on HIV/AIDS and rural development** to facilitate access by IFAD staff, and particularly CPMs and consultants, to essential information on HIV/AIDS, resource persons for IFAD missions, and potential partners. Essential information that can be made easily available to IFAD staff would include:
 - ❑ adult HIV/AIDS prevalence rates by district (where available) to enable CPMs to identify at a glance whether HIV/AIDS is a serious problem in current or planned IFAD-supported project areas;
 - ❑ UNAIDS and the Futures Group International's HIV/AIDS economic impact profiles by country and by sector for information on the effects of the epidemic on agriculture and rural development, industry and other key economic sectors, including existing studies in each sector;
 - ❑ national consultants and NGOs with expertise on HIV prevention, AIDS mitigation, etc.;
- (e) Incorporation of **HIV/AIDS concerns in the IFAD website**, with up-to-date information on IFAD's current and planned activities on HIV/AIDS, case studies of successful initiatives and related IFAD-supported project reports from the field.

MEMORANDUM OF UNDERSTANDING
FOR A
COOPERATION FRAMEWORK
BETWEEN THE
INTERNATIONAL FUND FOR AGRICULTURAL DEVELOPMENT (IFAD) AND
THE SECRETARIAT OF THE JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS (UNAIDS)

Whereas the objective and functions of the International Fund for Agricultural Development (IFAD) are to mobilize additional resources to be made available on concessional terms for agricultural development in developing Member States. In fulfilling this objective, the Fund provides financing primarily for projects and programmes specifically designed to introduce, expand or improve food production systems and to strengthen related policies and institutions within the framework of national priorities and strategies, taking into consideration: the need to increase food production in the poorest food-deficit countries; the potential for increasing food production in other developing countries; the importance of improving the nutritional level of the poorest populations in developing countries and the conditions of their lives;

Whereas the Secretariat of the Joint United Nations Programme on HIV/AIDS (UNAIDS) supports, promotes and documents the role of UNAIDS as the leading advocate for an urgent, coordinated and comprehensive response to the epidemic; seeks to fulfil its role by providing high-level leadership and coordination, urging rapid political and social mobilization, related to the epidemic and providing high-quality information in pursuit of these objectives; and as the response to the epidemic expands, it seeks to support a growing range of partners with a strong emphasis on country-led processes; and

Whereas IFAD and the UNAIDS Secretariat recognize that it is in their mutual interests to establish cooperation between themselves, including appropriate working procedures to that effect;

Now, therefore, IFAD and the UNAIDS Secretariat have agreed as follows:

1. The purpose of the Cooperation Framework is to establish cooperation between IFAD and the UNAIDS Secretariat. This Cooperation Framework recognizes the expertise of each institution and seeks to establish operational and practical modalities of cooperation in order to alleviate the impact of HIV/AIDS on rural poverty and livelihood insecurity and to reduce vulnerability to HIV/AIDS through sustainable rural development.
2. IFAD and the UNAIDS Secretariat recognize the need to take advantage of their respective comparative advantages in order to develop cooperation under the terms of this Cooperation Framework. In this regard, the two institutions are committed to mobilizing and carrying out a broad-based response to the problem of HIV/AIDS in relation to rural development and in the context of the Global Strategy Framework and the United Nations (UN) strategic plan for HIV/AIDS.
3. In the interest of promoting smooth and productive collaboration between the UNAIDS Secretariat and IFAD, the following principles will govern their relationship in order to define specific mechanisms that will facilitate collaboration and cooperation. Since the UNAIDS Secretariat and IFAD constitute centres of excellence for the UN system in their respective fields of endeavour, specialists of the two organizations will collaborate directly, both at their respective headquarters and at country level.

4. At the country level, the UNAIDS Secretariat works through UN theme groups on HIV/AIDS, country programme advisers, and inter-country teams. In its effort to lead the expanded response to the HIV epidemic, the UNAIDS Secretariat works in partnership with governments, NGOs and the business sector as well as its seven co-sponsors (United Nations Children's Fund - UNICEF; United Nations Development Programme - UNDP; United Nations International Drug Control Programme – UNDCP; United Nations Population Fund – UNFPA; United Nations Educational, Scientific and Cultural Organization – UNESCO; the World Health Organization – WHO; and the World Bank) and other regional and international bodies. In its efforts to fight poverty and increase agricultural production, IFAD works in partnership with governments, regional organizations, international organizations, NGOs and, where appropriate, with the private sector. All these partners constitute vital links for the facilitation and development of an effective cooperation network.
5. The UNAIDS Secretariat and IFAD will formally inform their respective staff and collaborating partners of this Cooperation Framework and will provide appropriate additional guidance for cooperation at the country level. Both IFAD and the UNAIDS Secretariat are fully committed to collaborating and working with the UN country teams, which offer opportunities to conduct in a systematic manner exchange of expertise and to develop joint initiatives and strategic planning where possible.
6. IFAD and the UNAIDS Secretariat will seek to collaborate on the following:
 - ❑ The formulation of development-oriented activities aimed at addressing the HIV epidemic through IFAD-supported field projects and programmes in order to mitigate the effects of the epidemic on IFAD beneficiaries and stakeholders, and to reduce their vulnerability to HIV infection and to the impact of AIDS ;
 - ❑ The identification and promotion of best practices for mitigation strategies and activities which may then be integrated in IFAD's ongoing and future development projects and programmes in order to reduce the impact of HIV/AIDS on the rural poor and promote sustainable rural livelihoods;
 - ❑ The systematic exchange and documentation of information and experiences of IFAD-supported HIV/AIDS initiatives and activities under the development projects it finances, and HIV/AIDS projects in the agricultural sector supported by the UNAIDS Secretariat; and
 - ❑ The provision of technical assistance by the UNAIDS Secretariat, as and when requested, in the area of impact alleviation and reduction of vulnerability to HIV/AIDS.
7. The UNAIDS Secretariat and IFAD will regularly attend the meetings of each other's governing bodies, inter-agency coordination meetings and working-level technical meetings in areas of mutual concern.
8. On an annual basis, the UNAIDS Secretariat and IFAD will jointly review the implementation of this Cooperation Framework. In order to permit such review and to encourage a regular consultation process, a one-day meeting will be convened once a year, alternating between the headquarters of IFAD and the Secretariat of UNAIDS.

This Cooperation Framework will take effect on the date of signature indicated below. It may be modified at the request of either of the parties by mutual agreement.

The parties hereto, acting through their duly authorized representatives, have signed this Memorandum of Understanding, as of 27 September 2001.

JOINT UNITED NATIONS
PROGRAMME ON HIV/AIDS

INTERNATIONAL FUND FOR
AGRICULTURAL DEVELOPMENT

Executive Director

President

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ENDNOTES

- ⁱ U.S. Bureau of the Census, *Zambia and Botswana Country Profiles, 2000*, at <http://www.census.gov>.
- ⁱⁱ UNAIDS cited in World Bank, 1999.
- ⁱⁱⁱ According to UNAIDS, an orphan is a child under 15 years of age who has lost his or her mother or both parents to AIDS.
- ^{iv} UNAIDS, 2000a.
- ^v *Ibid.*
- ^{vi} *Ibid.*
- ^{vii} *Ibid.*
- ^{viii} World Bank estimate, cited in DFID, 1998.
- ^{ix} See Fransen and Whiteside, 1997.
- ^x See, for example, Forsythe and Rau , 1996.
- ^{xi} G. Foster and C. Makufa, “The Families, Orphans and Children Under Stress Programme”, 1998; cited in Mutangadura, 2000.
- ^{xii} Rugalema, 1999a.
- ^{xiii} Karamba, 1997.
- ^{xiv} *Ibid.*
- ^{xv} Topouzis, forthcoming.
- ^{xvi} Rugalema, 1999b.
- ^{xvii} Barnett, 1994b.
- ^{xviii} Ayieko, 1998.
- ^{xix} Malindi et al., 1998.
- ^{xx} Personal communication, Gabriel Rugalema, Institute for Social Studies, 16 July 2000, cited in Topouzis, 2000..
- ^{xxi} Paul Farmer cited in Collins and Rau, 2000.
- ^{xxii} Collins and. Rau, 2000 , p. 7.
- ^{xxiii} World Bank, 1999a, Chapter 4.
- ^{xxiv} The HDI, published by the United Nations Development Programme (UNDP), is a composite index constructed from four variables: life expectancy at birth, adult literacy rate, mean years of schooling, and an adjusted measure of per capita economic production.
- ^{xxv} Decosas, 1996.
- ^{xxvi} Topouzis, 1998. Migration and mobility are often associated with increased risk of HIV infection.
- ^{xxvii} IFAD 2001, p. 31.
- ^{xxviii} See UNAIDS, 1997.
- ^{xxix} UNAIDS, 2000a.
- ^{xxx} Ainsworth, 1997.
- ^{xxxi} IFAD, 2000b, p. 28.
- ^{xxxii} Loewenson and Whiteside, 1997, p. 34.
- ^{xxxiii} Forsythe and Rau , 1996, p. 29.
- ^{xxxiv} *Ibid.*
- ^{xxxv} Devereux and Eele, 1991, cited in *ibid.*
- ^{xxxvi} Mutangadura, 2000.
- ^{xxxvii} Personal communication, Mead Over, World Bank, at the UNAIDS Reference Group on Economics Meeting, held in February 2001 in Cuernavaca, Mexico.
- ^{xxxviii} Topouzis with Hemrich, 1996; Mutangadura, 2000.
- ^{xxxix} Tony Barnett, 1994b.
- ^{xl} Topouzis, 1999, p. 5.
- ^{xli} Page, 1999.
- ^{xlii} World Bank, 1996.
- ^{xliii} See Bota, Malindi, and Nyekanyeka, 1998; and Hemrich, 1997.
- ^{xliv} See Topouzis, forthcoming.

- ^{xlv} IFAD, 1997, Vol. I, p. 57.
- ^{xlvi} For farming systems vulnerability mapping, see Barnett and Blaikie, 1992; for livelihood systems vulnerability mapping, see Topouzis, 2000 and World Bank, 2001.
- ^{xlvii} In projects with a health and nutrition component (a type of project generally cofinanced by the Belgian Survival Fund), IFAD sometimes supports essential drug supplies (through ‘seed money’) on a cost-recovery basis and in line with government policies. Under this type of project, IFAD and the government concerned could negotiate with the World Health Organization to agree on the provision of essential drugs to health centres at a subsidized price, provided that access by project beneficiaries is on a cost-recovery basis.
- ^{xlviii} UNAIDS, 2000b.
- ^{xlix} These data are available from the United States Bureau of the Census.
- ^l IFAD, 1999, p. 22.
- ^{li} In Kumi, HIV/AIDS adult prevalence rates were low, and the large number of orphans was linked to prolonged civil unrest in the area; see IFAD, 1999.
- ^{lii} Konde Lule et al., 1996.
- ^{liii} This section draws on Topouzis, 1995 and Hemrich, 1997.
- ^{liv} IFAD, 1997, p. 53.
- ^{lv} Engh et al., 1999.
- ^{lvi} Background support and issues for LUSIP Appraisal on Health Impact, prepared as input to Swaziland LUSIP PDT by the Household Food Security and Gender Desk, PT/IFAD, p. 3.
- ^{lvii} See also section IV.A that deals with microfinance in detail.
- ^{lviii} FAO, 2001.
- ^{lix} CARE estimates, cited *in* World Bank, 1996.
- ^{lx} FAO, 2000.
- ^{lxi} IFAD 2000b, p. 27.
- ^{lxii} UNAIDS, 1999.
- ^{lxiii} *Ibid.*
- ^{lxiv} Muhangi and Turinde-Kabali, 1998, p. 5.
- ^{lxv} Parker et al. in UNAIDS 2001c, Appendix D.
- ^{lxvi} *Ibid.*, p. 2.
- ^{lxvii} *Ibid.*, pp. 2-3.
- ^{lxviii} IFAD, 2000c, p. 28.
- ^{lxix} *Ibid.*, p. 22.
- ^{lxx} See, for instance, Rugalema, 1999a.
- ^{lxxi} Personal communication, Frederick Joel Wajje, Agriculture and Environment Programme Manager, World Vision, Kampala, April 2000; and Muhangi and Turinde-Kabali, 1998, p. 7.
- ^{lxxii} The Lorena stove promoted by CARE has proved more successful as it is easier and cheaper to construct and is user friendly.
- ^{lxxiii} Rugalema, 1999a, p. 199.
- ^{lxxiv} Barnett, 1994a.
- ^{lxxv} IFAD, 2000b, p. xi.
- ^{lxxvi} A parish is one of the smallest administrative groupings within the Ugandan local government system.
- ^{lxxvii} UWESO, 2001.
- ^{lxxviii} UWESO Executive Director Pelucy Ntambirweki, quoted in IFAD 2001, p. 39.
- ^{lxxix} *Ibid.*
- ^{lxxx} Topouzis, forthcoming.
- ^{lxxxi} The CKDAP operates in five districts, one of which, Thika District, has the highest HIV/AIDS adult prevalence in the country at 34% (1998 data). See IFAD, 2000a, Annex 1, p. 32.
- ^{lxxxii} *Ibid.*, p. xii.
- ^{lxxxiii} *Ibid.*, p. 16.
- ^{lxxxiv} *Ibid.*, p. 14.
- ^{lxxxv} *Ibid.*, pp. 24-25.

^{lxxxvi} Throughout the working paper, there is important information, such as “No aggressive HIV/AIDS control activities are in place [in Maragua]. No counsellors have been trained to offer services to those infected or affected and no home-based care support services are in place”, but the implications of these findings are not incorporated among project design issues. IFAD, 2000a, Appendix 1, p. 28.

^{lxxxvii} IFAD, 2000a.

^{lxxxviii} Sometimes appraisal reports may have changed considerably from the original formulation reports and some of the technical components may have been watered down. Checks and balances need to be put in place to ensure that HIV/AIDS initiatives are not watered down.

^{lxxxix} IFAD, 2000b, p. xi.

^{xc} *Ibid.*

^{xcⁱ} UWESO, for instance, raises awareness on land tenure issues.

^{xcⁱⁱ} The original co-sponsors of UNAIDS were the United Nations Children’s Fund; the United Nations Development Programme; the United Nations Population Fund; the United Nations Educational, Scientific and Cultural Organization; the World Health Organization; and the World Bank. The United Nations International Drug Control Programme joined UNAIDS in April 1999.

^{xcⁱⁱⁱ} UNAIDS website, <<http://www.unaids.org>>.

^{xc^{iv}} United Nations Office for Project Services (UNOPS) website: <www.unops.org>.

^{xc^v} United Nations Volunteers (UNV). website: <<http://www.unv.org>>.

^{xc^{vi}} Denmark’s International Programme of Action against HIV/AIDS, May 2001.

^{xc^{vii}} DFID, 2000.

^{xc^{viii}} www.irlgov.ie.

^{xc^{ix}} Royal Norwegian Ministry of Foreign Affairs, 2000.

^c For more information on Internal HIV/AIDS Impact Assessments, see Topouzis, 2001.

^{ci} For further information on Community HIV/AIDS Impact Assessments, see *ibid.*

^{cⁱⁱ} Similar exercises have been held by GTZ for its projects in Kenya, See Hemrich, 1998.