

Mainstreaming HIV/AIDS
looking beyond awareness



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and Dolar Vasani*

VSO *Experience in Focus* Papers are published on www.vso.org.uk/publications

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The cover photo shows primary school children in Zambia looking through classroom windows where older children are learning about HIV/AIDS from peer educators

Printed in South Africa by Essential Media - sawyer@mweb.co.za

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glossary, acronyms, note on terminology, treatment of quotes

<i>Activista</i>	<i>Activistas</i> are Mozambican volunteers who are trained in community service
AIDS	Acquired Immune Deficiency Syndrome
CBO	Community-based organisation
Colleagues	The people working alongside VSO volunteers (see also: partners)
DFID	Department for International Development of the UK government
HBC	Home-based care
HIV	Human Immuno-Deficiency Virus
HIV+	Status when HIV is present in the body
HIV-	Status when HIV is not present in the body
In-country training	VSO training received by a volunteer while in a host country
Integration	The actual concrete activities within individual projects which tackle HIV/AIDS
Mainstreaming	The overall concept of responding to HIV/AIDS in development sectors where the pandemic may not ordinarily be addressed
M&E	Monitoring and evaluation
NGO	Non-government organisation
Participants	People involved in an HIV/AIDS integration project, used in preference to 'beneficiaries'
Partners	Organisations or institutions working with VSO (see also: colleagues)
PEA	Provincial English Adviser in Mozambique
Placement	VSO volunteer's period of time and role in an organisation, usually for two years
PLWHA's	People living with HIV/AIDS
Programme office	VSO office in each country which manages the VSO country programme
PSI	Population Services International
RAISA	Regional AIDS Initiative of Southern Africa
RAISA-NET	Web-based information and networking forum for VSO volunteers and others working in HIV/AIDS
SHARPER	Soltech HIV Awareness Resource Project Evaluated and Revised
SIDA	AIDS in Portuguese
STEP	Secondary and Technical English Project
STIs	Sexually transmitted infections
Sugar daddies	Men who have sex with young girls in exchange for favours
TB	Tuberculosis
UDAC	Uniao Distrital de Associações de Camponeses. District Union of Farmers' Associations and Co-operatives
UNAIDS	United Nations Programme on HIV/AIDS
VCT	Voluntary counselling and testing
VSO volunteers	Men and women with skills, qualifications or background in a professional area, recruited by VSO (see also: placements)
VSO	Voluntary Service Overseas, an international development charity that works through volunteers to fight poverty and tackle disadvantage

Note on terminology

In this publication, we use 'southern Africa' to mean those countries in the region in which VSO works: Malawi, Mozambique, Namibia, South Africa, Zambia and Zimbabwe.

Non-judgemental terminology is vital to help fight prejudice and counter stereotypes. People who are HIV+ or who have AIDS are often, particularly by the mass media, referred to by negative phrases such as 'AIDS victim' or 'AIDS sufferer.' In this publication, we use non-judgemental phrases including 'people living positively with HIV/AIDS', 'people who have AIDS' or 'people who are HIV+' which help to counter negative stereotypes.

The term 'beneficiary' is not used in this publication. While it is commonly understood, it suggests a top-down and non-participatory framework in projects. Instead the term 'participants' is used.

Treatment of quotes

Some quotes have been left anonymous but all quotes are placed in an appropriate context.

acknowledgements

This publication has become a reality because of the invaluable support we have gratefully received from numerous partners, friends, colleagues, staff and volunteers. VSO-RAISA would like to extend a special thanks to the 128 inspirational educators, farmers, country co-ordinators, carpenters, planners, trainers, social workers, programme officers, managers, administrators, lecturers, campaigners, lab technicians, treasurers, mothers, programme directors, finance managers, writers and students who were willing to give up their time to be interviewed. You have shared a wealth of experiences, knowledge and concerns with us and without your input, the production of this publication would not have been possible. We wish you success in your continued efforts to integrate HIV/AIDS in the future.

VSO would also like to thank the following VSO partners for hosting this research:

Direcção Provincial da Mulher e Coordenação da Acção Social	Mozambique
Fair Trade In Tourism	South Africa
Forum Juvenil de Dondo	Mozambique
Kasempa Boys' High School	Zambia
Kasempa Day School	Zambia
Kavaya Secondary School	Zimbabwe
Ministry of Land, Resettlement and Rehabilitation	Namibia
Mothers of Disabled Children	Zimbabwe
Namibian Women's Network	Namibia
National Arts Council	Zimbabwe
Natural Farming Network	Zimbabwe
Okakarara Vocational Training Centre	Namibia
Pedagogic University	Mozambique
Samora Machel Secondary School	Mozambique
Solwezi Technical Training School	Zambia
Solwezi Teacher Training College	Zambia
UDAC	Mozambique
University of Fort Hare	South Africa

- VSO programme staff in Malawi, Mozambique, Namibia, South Africa, Zambia and Zimbabwe
- VSO-RAISA country co-ordinators for organising and facilitating the research tour
- Manuel Nhabanga for his interpretation services in Mozambique
- Heather Branton and Dr Sunanda Ray for critical analysis and comment
- Naseem Noormahomed for providing a solid administrative and logistical backbone
- Silke Bernau for editing
- Alan Smith and Michael Hoffmann for their ongoing moral support

foreword

I welcome this publication from VSO as a practical explanation of how volunteers supported partners and colleagues in mainstreaming HIV into their development work. I like the emphasis on facilitation and sustainability rather than doing, taking over and dependency.

HIV is a development issue. What does that mean? The social and environmental circumstances that lead vulnerable people to have unprotected sex, exposing themselves to possible infections, have to be resolved through addressing the causes of poverty, gender discrimination and the use of sex as a commodity. People can change when they have more control of their lives, a confidence that things can be different. Facilitating this process means supporting people to have that confidence in ways that are not patronising, but based on solidarity.

The VSO volunteers in these examples accomplish this by helping partners identify resources, whether funding or training opportunities. They work together to understand the ways that HIV has an impact on the areas of their work and impedes social development, the cycles of deprivation causing vulnerability to HIV, and HIV making poverty worse. These processes depend on people working as catalysts and cannot be created from manuals and guidelines alone. The commitment of individuals and communities to the principle of dealing with HIV/AIDS is essential and cannot be imposed from the outside, but will be enhanced through support and encouragement from those who have been sensitised to the issues.

This publication also emphasises the role of stigma and fear of discrimination as barriers to effective intervention and care of people living with HIV. AIDS is a disease we all know about but will not call by name. To call it by name, to personalise it, is to take on the stigma, the label and all that goes with it. But until we call it out, we cannot trigger the intensity of action that is needed to deal with it. From the examples given here, we can see how crucial the role of mainstreaming is: it shows how we are all involved and all affected by HIV. From that standpoint, we can then identify the key activities we must all undertake to address prevention, care and impact mitigation of the HIV epidemic.

By addressing the influence of HIV in all our lives without prejudice, by taking a human rights stand on equity of access to treatment, care and non-discrimination, we can succeed in reducing the pain and fear caused by HIV and work towards social justice for all.



Dr Sunanda Ray
Director
Southern Africa AIDS Information Dissemination Service (SAfAIDS)
Zimbabwe

executive summary

Southern Africa is one of the regions worst affected by HIV/AIDS in the world. Countries in the region each face similar cultural antagonisms between tradition and the behaviour changes needed to prevent HIV transmission. Social and economic factors as well as over-stretched or insufficient infrastructure hinder attempts to control the devastating impact of HIV/AIDS on individuals and society. Throughout southern Africa, HIV/AIDS continues to be highly stigmatised and this is exacerbated by widespread denial. Although awareness is now believed to be high in some areas, most people do not have in-depth knowledge of HIV/AIDS. This in turn fuels misinformation and fear about the pandemic.

Programme planning is therefore influenced by a distinction between 'awareness', which may be superficial, and 'knowledge', which is more in-depth and so more likely to lead to the behaviour changes required to stop the spread of HIV. It is clear from the experiences gathered thus far in southern Africa that there is a need to develop effective responses to HIV/AIDS which look beyond awareness and which also help to prevent 'fatigue' on the issue.

As the pandemic evolves, people are learning about appropriate responses. Good practise is continually being developed and it is therefore vital to share this information so that communities, including people living with HIV/AIDS everywhere, can learn from these experiences. This VSO *Experience in Focus* publication shares lessons from the early stages of experience of mainstreaming HIV/AIDS as part of VSO's Regional AIDS Initiative of Southern Africa, known as RAISA.

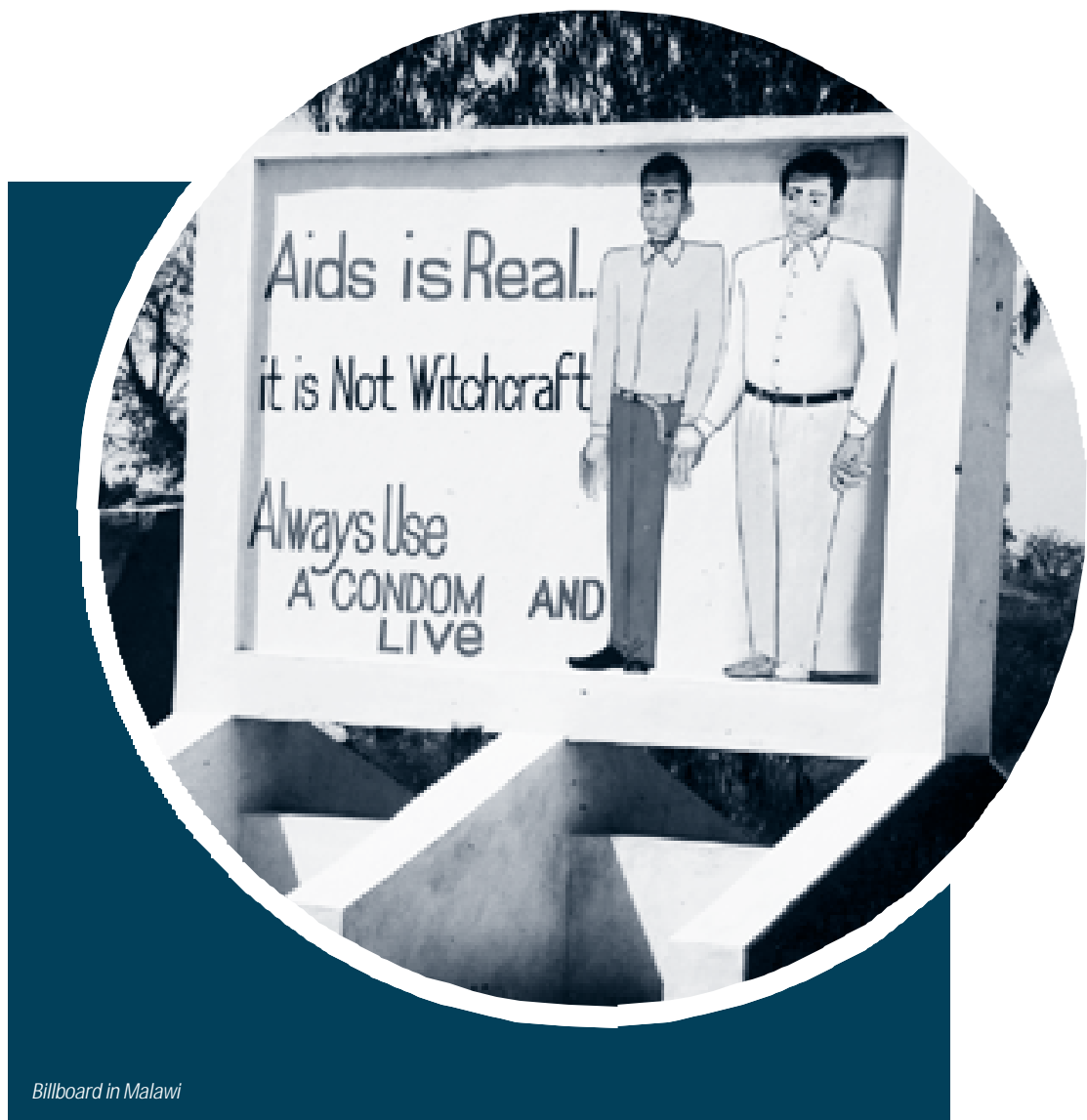
A common understanding of what mainstreaming HIV/AIDS means is evolving amongst leading practitioners in this field, including UNAIDS, Oxfam and USAID. Mainstreaming describes the overall **concept** of responding to HIV/AIDS in development sectors where the pandemic may not ordinarily be addressed, for example, teachers tackling prevention issues in classrooms or community extension workers raising awareness of good nutrition for people living with HIV as part of a rural livelihoods programme. Integration describes the concrete **activities** within individual projects which tackle HIV/AIDS.

This publication contributes to the evolving pool of knowledge by presenting case studies from a major piece of research that involved interviewing more than 100 people. (See Methodology, page 64). The case studies describe the activities and outcomes of community- or provincial-level HIV/AIDS activities supported by VSO-RAISA. The lessons and recommendations will be of interest to practitioners in this field in southern Africa as well as worldwide.

The findings reinforce the importance of using basic developmental methodologies, in particular participatory approaches, to integrate HIV/AIDS. The case studies clearly show that a participatory, facilitative approach increases sustainability and impact.

Lessons from VSO's early experience of mainstreaming HIV/AIDS are:

1. Appropriate HIV/AIDS responses can be integrated into a variety of sectors using basic developmental approaches.
2. Integrated HIV/AIDS responses should plan beyond the goal of increasing awareness to more practical, people- or community-centred solutions.
3. No HIV/AIDS integration efforts are too small or informal to document and share. A broad range of personal perspectives can highlight valuable lessons and can motivate others.
4. Training and support for facilitators (whether VSO volunteers or not) in practical development methodologies are critical components in a mainstreaming programme. Training motivates and empowers individuals to personalise information about HIV/AIDS and therefore to become a catalyst in integrating HIV/AIDS into their workplace or community.



Billboard in Malawi

Challenges for VSO relate to four main areas. These are also relevant to non-VSO practitioners.

- 1. Appropriate responses:** The primary challenge for VSO is that although newly recruited volunteers are qualified and experienced in a specific professional field, they do not necessarily have direct experience of using developmental approaches or facilitating community-based activities. As a development agency, VSO recognises the impact that consistently applied developmental approaches have on the sustainability of HIV/AIDS integration. VSO's training therefore needs to equip VSO volunteers with the skills to take on the role of a facilitator using developmental methodologies.
- 2. Communication:** The concept of mainstreaming is still evolving and sharing experiences is a valuable source of motivation and learning. The highly-inclusive research undertaken for this publication has shown a clear need for greater emphasis on qualitative, people-centred documentation. The interviews gave individuals a platform for sharing their experiences of HIV/AIDS and their response to it in face-to-face conversation. Removing the boundaries of the written word has encouraged people to talk more freely in a personal context.
- 3. Training:** VSO-RAISA's training for volunteers and partners has made an important contribution to the success of mainstreaming. However, this training needs to be planned in a more participatory way. It needs to focus more on giving volunteers and partners practical skills in basic developmental approaches such as planning, community facilitation and participation. From experience, most agree that they do not need an in-depth understanding of medical aspects of the virus or detailed statistics. Training should give volunteers and partners a networking opportunity and encourage partnerships.
- 4. Project resources:** VSO's Small Grant Fund has been an integral part of integrating HIV/AIDS. The provision of small sums of money can have a high impact in a given context. There is, however, a need to challenge applicants to take a more developmental approach to ensure that the impact is sustainable.

These lessons and challenges are part of an internal process to learn from experience and strengthen the mainstreaming work undertaken by RAISA. Since RAISA took shape in 1999, VSO has worked towards what is now almost seamless mainstreaming of HIV/AIDS into existing programmes. This publication shares these experiences with others working in the field to inform further mainstreaming efforts elsewhere.

This VSO *Experience in Focus* publication shares lessons from the early stages of VSO's experience of mainstreaming HIV/AIDS as part of the Regional AIDS Initiative of Southern Africa, RAISA. As the AIDS pandemic evolves, people are learning about appropriate responses. Good practice is continually being developed and it is therefore vital to share this information so that communities, including people living with HIV/AIDS everywhere, can learn from these experiences.

This publication is a practical resource for anyone, including VSO volunteers and partners, who are starting or adapting an HIV/AIDS integration project.

- This Introduction provides a brief overview of the VSO-RAISA programme, explains the purpose of this Publication and defines the terms used.
- Chapter 2 presents interviewees' experience of the pandemic in a framework which emerged strongly during the research. The framework (presented in Table 1) helps us to analyse the different stages or social conditions created by the AIDS pandemic and possible individual and community responses.
- Chapter 3 documents nine case studies selected to represent a range of activities, sectors and countries. They are intended to stimulate ideas for responses to HIV/AIDS and to present the methodologies used.
- Chapter 4 takes examples from the case studies and analyses the activities and methodologies applied, highlighting achievements and challenges, and distilling valuable lessons for all practitioners.
- Chapter 5 records achievements and challenges, presenting the lessons learned from these experiences as action points to share good practice with all those working in HIV/AIDS.

VSO and RAISA

VSO is a development charity that works through volunteers to fight poverty and tackle disadvantage. Founded in 1958 in the UK, VSO is now an international organisation with about 2,000 professional volunteers working in over 70 developing countries at any time. VSO volunteers are skilled, qualified and experienced professionals who normally work on two-year placements with local partner organisations in rural and urban development, education, health, business and social development.

VSO's approach is based upon mutual sharing of skills and strengthening capacity in partner organisations and communities. VSO volunteers receive a modest living allowance and work alongside their national colleagues. Volunteers, colleagues and communities develop together and learn from each other.

VSO has over 300 volunteers working in southern Africa at any time, in all skill areas, in Malawi, Mozambique, Namibia, South Africa, Zambia, and Zimbabwe. These countries are among the worst affected by HIV/AIDS and sexually transmitted infections in the world.

This situation is exacerbated by widespread denial, pervasive stigma and discrimination, poverty and insufficient infrastructure to control the impact.

VSO has responded to the AIDS pandemic in southern Africa through RAISA, a four-year programme (2000-2003) which supports the responses to HIV/AIDS by civil society, and government institutions. RAISA focuses upon effective prevention, treatment, care, and advocacy for those infected and affected by HIV/AIDS to mitigate the personal, social, and economic impact of the pandemic.

Coming as outsiders into a community places VSO volunteers in a unique situation. On the one hand, their initial unfamiliarity with the local context may make some contributions inappropriate, particularly if volunteers seek to create solutions without full consultation. But on the other hand, an external facilitator has a powerful role to play in enabling insiders to analyse their situation in new ways, opening up new opportunities and approaches. An external facilitator, in this case a VSO volunteer, can bring a new dimension to how insiders see their context. VSO asks volunteers to integrate HIV/AIDS not because they are 'experts' with all the answers, but because of the facilitation role they can play in their community.

RAISA volunteers work in two main ways:

1. VSO volunteers working directly on HIV/AIDS: they are placed with local AIDS organisations, whether in prevention, awareness-raising, capacity-building, advocacy, reducing stigma, campaigning or in care for people with HIV and AIDS.
2. VSO volunteers in all other professional fields are asked to include a response to HIV/AIDS alongside their main area of work in order to reach an even bigger community in the education, health, social development or rural livelihoods sectors.

Mainstreaming is one of the key objectives for VSO-RAISA. This publication shares the experiences of mainstreaming HIV/AIDS by the second group: VSO-RAISA partner organisations whose core work area is **not** HIV/AIDS. This publication also forms part of RAISA's monitoring and evaluation (M&E) process.

What does VSO-RAISA mean by the terms 'mainstreaming' and 'integration'?

A common understanding of what 'mainstreaming HIV/AIDS' means is evolving amongst leading practitioners in this field. The concept of mainstreaming is based upon the development approach used to bring gender issues into all areas of work, and has been applied to HIV/AIDS in a similar way.

VSO-RAISA and this publication use 'mainstreaming' to describe the overall concept of responding to HIV/AIDS in development sectors where the pandemic may not ordinarily be addressed, for example, teachers tackling prevention issues in classrooms (education) or community extension workers raising awareness of good nutrition for HIV+ people as part of a rural livelihoods programme. VSO-RAISA and this publication use 'integration' to describe the concrete activities of individual projects.

HIV/AIDS affects all sectors of society. If a development programme does not recognise that fact it will be, as a volunteer in Namibia put it, 'mopping with the tap running': treating the symptoms while leaving the cause unaddressed. A multi-sectoral mainstreaming approach gives rise to responses to the pandemic which can address the needs of individuals in a more appropriate and focused way.

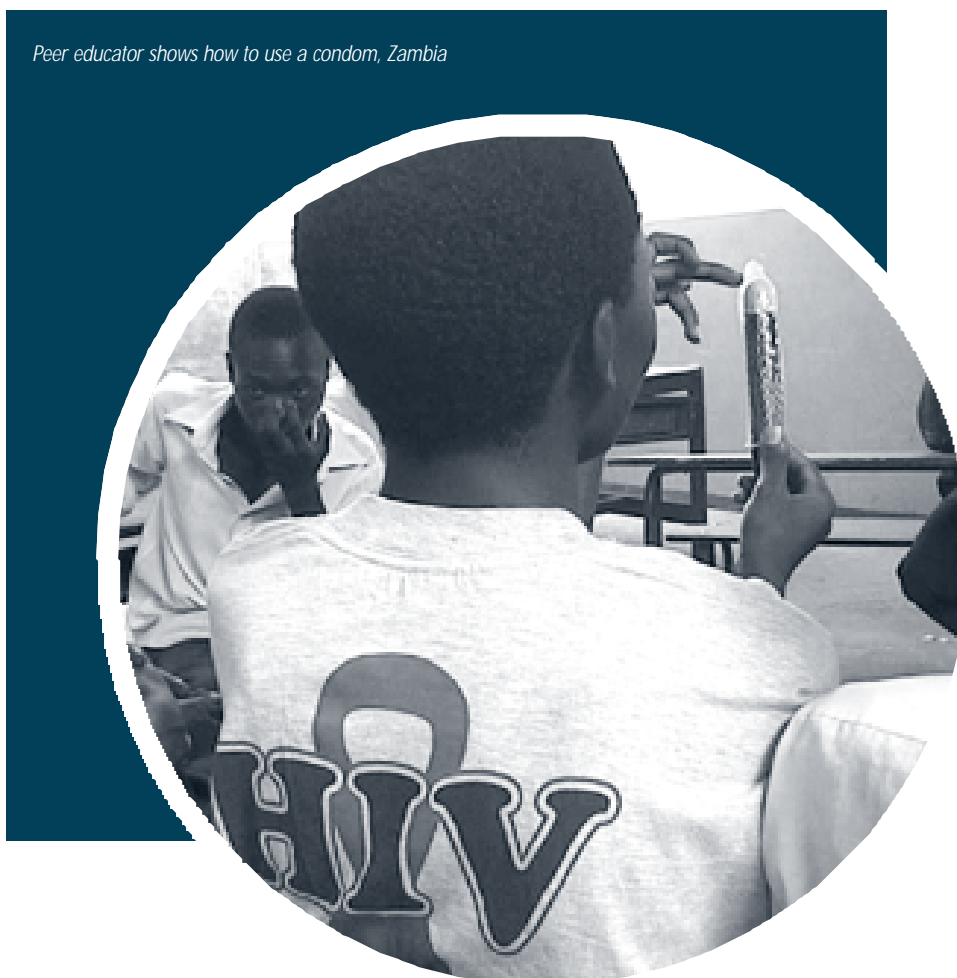
Purpose of this publication

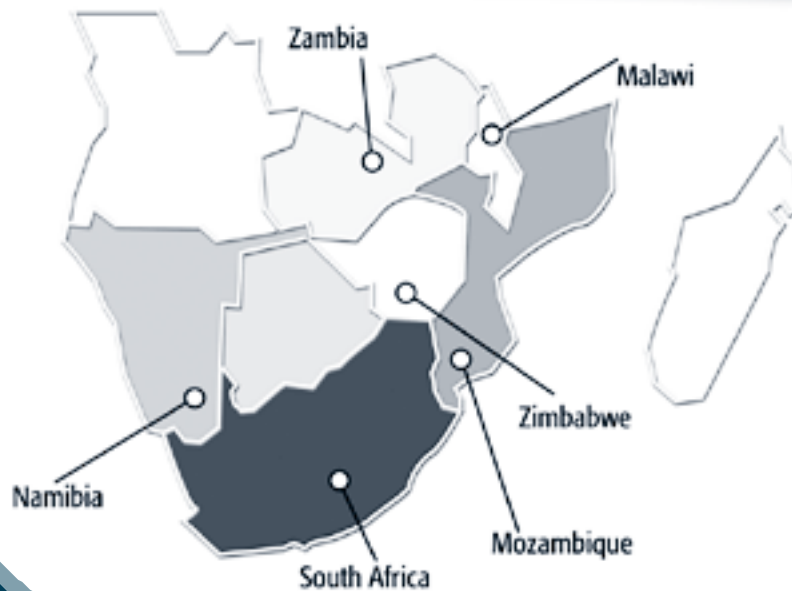
This publication contributes to the evolving pool of knowledge by sharing examples and early lessons from VSO-RAISA's work. It presents case studies from a major piece of research at the micro-level, as part of which more than 100 people were interviewed in six countries. The case studies describe the activities and outcomes of community-level HIV/AIDS projects in which VSO volunteers were working. The publication suggests lessons and recommendations which will be of interest to other practitioners in this field worldwide.

Sharing these HIV/AIDS integration experiences is intended to show what can be achieved in one organisation or community. Eight of the nine case studies involve VSO volunteers, but the models they offer can be adapted to other project contexts where one person or a small group acts as a catalyst to identify appropriate responses to HIV/AIDS. This principle can be applied to a wide variety of situations or professional backgrounds globally.

In each case study, interviewees reported signs of attitude or behaviour change. The achievements and challenges in each context can be directly attributed to the methodology used to implement the responses. We hope that this publication will enable practitioners elsewhere to adapt the responses and approaches to their own situation in order to broaden the potential that mainstreaming offers in the fight against the AIDS pandemic. HIV/AIDS is a development issue and this research shows that approaching it as such results in more appropriate and sustainable responses.

Peer educator shows how to use a condom, Zambia





A map of southern Africa, with a billboard from Malawi

the state of the pandemic

2

a southern african perspective

This chapter gives a voice to people living in southern Africa. Their experiences and perspectives are a mosaic image of the pandemic and reflect the diversity of understanding and beliefs. They give a vivid picture of the current state of the AIDS pandemic in southern Africa. What emerged from the interviews was a clear framework of stages of the pandemic, and some typical individual and community responses (see Table 1).

Introduction

Statistics about the growth of the HIV/AIDS pandemic in southern Africa have hit news headlines across the world. A traveller through the region, however, might easily believe HIV/AIDS to be a myth, as it seems almost invisible. This is not because the situation has been exaggerated but because HIV/AIDS kills behind closed doors. A myriad of social conditions and cultural practices contribute to the state of the pandemic in the region today. Generally, people are not accustomed to talking openly about sex, condom use is low, and polygamy or multiple sexual partners are common. High unemployment, poverty, alcohol misuse and gender imbalances put an economic and social strain on vulnerable groups such as women and young people. Individual knowledge of the virus is limited. For most people, adequate medical care is not available, so the presence of HIV often goes undetected until AIDS-related symptoms are severe. This can take several years, during which time the HIV+ person may infect others. There is little incentive to be tested, as treatment for HIV-related illnesses is not widely available and stigma of an HIV+ status is widespread.

So, although southern Africans experience the devastating effects of HIV/AIDS almost every day and awareness campaigns advise condom use or abstinence, the illness and death of loved ones and friends has not brought widespread individual acceptance of the risk of HIV infection. As a result, behaviour change has been slow to develop and confusion, misinformation and conflicting opinions from public bodies have resulted in widespread fear, stigma, rejection and denial.

The framework

The interviews from all six countries indicated similar stages and processes of how individuals and communities experience and react to the AIDS pandemic. Table 1 summarises this framework, which helps to analyse the development of the pandemic and which forms the structure of this chapter.

People who have personal experience of the pandemic become motivated to learn and understand more about HIV/AIDS if they have access to appropriate opportunities. With this knowledge comes a desire for practical solutions and an assessment of personal risk. When a large number of people have gained this personal acceptance, what follows is community acceptance and solidarity, leading to more effective responses in support and care of people living with HIV.

Sophie's story stands as a representative testimony for the untold stories of so many people in southern Africa. It is a moving and human account of what people and communities affected by the AIDS pandemic are facing, and places the discussion in this chapter of the different stages and responses into an overall context.

Sophie is a community participant in a suburban HIV/AIDS integration project run by the Namibian Women's Network. English is not Sophie's first language, but she has shared her thoughts and experiences openly and honestly to benefit others. Her story is told here in her own words.

Sophie's story



Sophie shows off her AIDS awareness ribbon

In Namibia in this community in Okahandja, AIDS is very high. Most of the young people, women and men, are HIV+. My little sister and my elder sister died of AIDS. I saw it with my own eyes. I saw them lying in their beds with pain because of AIDS.

I grew up here, I know the people with AIDS in this community. Most of them are my friends. Most of the people don't want to hear about HIV and AIDS. Some of them are stressed, they know they are HIV+ but can't talk about it. You know yourself, but you don't tell them straight.

One of my friends is HIV+, she told me when the doctor told her. I told her she should not sleep around and that she should use condoms, but she gets angry and she doesn't want to hear anything I say. 'I shall

not die alone,' she says. She wants to take that sickness to the person who gave it to her. She is frustrated. She doesn't want to listen to anyone. She drinks too much. I talk to her and care for her but she doesn't want to hear.

Some people reject her. They don't worry about her. The people she lives with don't want her there anymore. She says it is good to drink too much because then she doesn't have to think about it. She has a family but she sleeps alone outside the house. The family says they don't know what to do.

Sometimes she says she feels better when I come to talk to her but other times she says she wants to die. She has said to me that I must look after her child. The family doesn't want her. They say they will also get sick. I was angry with those people but I have visited them and told them how to care for her. They listened, but some said they have no time for people with AIDS. They want to know where she got it.

There are lots of children with AIDS. The rape cases in Okahandja are high. If the men know they have AIDS, they rape the children. I know two of them who have AIDS because men raped them. Some are born HIV+. Two of my friends who have died had children who died soon after. If the babies are HIV+, they die after two years. I have seen it.

There is a man I know, his girlfriend died of AIDS and he knew. He was also infected and his body got smaller and smaller. One day he asked me why. He asked me why his body was getting smaller. He wasn't feeling good since his girlfriend died. He told me he thought he had AIDS. When he told me, I was shocked. I asked him how he knew and he said that he had heard on the radio that if you feel weak, it is AIDS. I told him to get a test to be sure. He did have AIDS.

Afterwards he developed sores in his mouth and throat. There were warts around his penis and warts all over his body. I have seen it with my own eyes. I

visited him often. He lay in the house and nobody came to him. I brought him food and I would wash him. Every day, the sickness was worse. Sometimes he spoke, sometimes he couldn't, he just lay there. Sometimes he got diarrhoea and people never came to that house. I would come and I would make a mask over my nose because of the smell. I didn't know I shouldn't do that because it makes the person feel dirty. He died in the house. It was always closed. He just died and they took him to the grave. There was no meat left on his body and his eyes were deep inside. He looked like a baby.

The people don't want to go for a test. If they go, they will know. I went to test in 1999, but now I don't want to know. I can't go for the test. It is better not to know. You will think too much and [get] stressed if you know. It is better not to know. After this training¹, I think I must go and get tested. I think I am healthy but I should go and hear so that I cannot infect other people. Now I am with one partner anyway but it is good to know.

I said to my partner [that] he should go and be tested. He said no, he is fat and healthy and he won't go. I told him that if you have the virus, you won't know. Even if you are fat you can have the virus. He ignores me. He doesn't want to hear about AIDS. He says that if you go for a test they gossip and tell people that you have been for a test and the whole community will know.

People don't want you around. They don't want to eat with you or to sleep with you if they know you have AIDS. It is important that people know how you can get HIV. They think that people can get AIDS by drinking from the same cup. The only way to do it is to go to people's houses, to sit with them and talk about HIV and AIDS. They don't want to come to workshops.

I had heard about the HIV workshops but I thought they were for other people and not for us. It is clear to us now. We know what we have to do. We must fight HIV and AIDS. I was very interested to go for the training, to learn more about AIDS. The first day I went to the workshop, it opened my mind. It has been very good for me. We learned about home-based care. I had always heard about HIV and AIDS, but I didn't know exactly what it was. The training has given me a lot. I know now how to help someone with AIDS and how to protect myself.

If I come to someone's house and there is someone lying there in the bed, sick with AIDS, I must put on gloves, I myself must be clean and I should help people in the house to care for the person. Some people don't care about people in their homes who are sick with AIDS, but I have to teach them how to care.

If someone has the virus I must counsel him or her, but counselling means I must help him to help himself. I must inform him that he can protect himself by using a condom and that he shouldn't sleep around and he should avoid alcohol and eat healthily so that the virus cannot grow in his body. He must care for himself and I should visit him to give him the power in himself to be strong. I must not judge. I must give him a chance to tell his story. I should listen to him and talk to him about his children and his plans.

You shouldn't sit far away from the sick person. We have learnt that we must be strong. You must not be the kind of person who wants to talk too much, because you have to keep secrets. You have to be calm with people. As a visitor to someone's house, I must introduce myself and be strong. I must behave myself and not lose my temper. Some people don't know about the diseases and they become angry when you try to help but you have to remain strong and calm. My plan is to inform the young people because they are the future. I tell my ten-year old daughter about HIV and AIDS and that we must all learn and respect our bodies.

¹Sophie participated in an HIV/AIDS and gender awareness workshop run by the NWN, see case study in Chapter 3

The table below shows the relationship between a social stage (left-hand column) and the personal and community responses that commonly occur at that stage (middle column). This does not suggest individuals or communities will experience each and every stage and response in this table, but these are the common experiences which emerged from the research. This chapter reflects the perspective of the interviewees of the pandemic, and so if a subject was not mentioned by them, it will not be discussed here. The chapter reflects the reality of HIV/AIDS as it is perceived and experienced by real people at community level, and discusses each stage and response in turn.

Table 1: Five stages of the pandemic, common responses, and examples of action

Personal or social stages in a community	Personal or community responses	Examples of action taken to address each stage
<p>1. EXPERIENCE</p> <ul style="list-style-type: none"> - Increase in the number of deaths - Awareness campaigns in clinics, on the radio, poster campaigns etc 	<p>1. AWARENESS</p> <ul style="list-style-type: none"> - Aware of HIV/AIDS but with limited understanding and no recognition of personal risk ('AIDS affects others, not me') - Confusion and misinformation 	<ul style="list-style-type: none"> - Government and civil society campaigns to disseminate information
<p>2. FEAR and STIGMA</p> <ul style="list-style-type: none"> - HIV/AIDS is associated with 'immoral' behaviour, so people living with HIV are stigmatised - Due to a lack of information, people fear transmission from associating with a person who is HIV+, leaving that person isolated and rejected - Existence of other prominent issues, such as poverty 	<p>2. DENIAL</p> <ul style="list-style-type: none"> - Individuals deny that HIV/AIDS poses a risk to them personally - Communities deny that HIV/AIDS poses a risk to them believing that 'it happens to others' - High risk sexual behaviour continues 	<ul style="list-style-type: none"> - PLWHA's addressing small groups to personalise the pandemic - Role models and public figures speaking openly about their status - Government officials publicly testing for HIV
<p>3. MOTIVATION</p> <ul style="list-style-type: none"> - Increased motivation to understand HIV/AIDS - Increase in the number of people who have personal experience of HIV/AIDS through illness or death of a loved one, friend, work colleague or neighbour 	<p>3. KNOWLEDGE</p> <ul style="list-style-type: none"> - More in-depth information about HIV/AIDS, its effects, prevention methods, and practical solutions to day-to-day living with HIV - Greater awareness of the options available to people living positively with HIV 	<ul style="list-style-type: none"> - Appropriately-designed and accessible learning opportunities - Training community educators - User-friendly materials - Advice and support for and from PLWHA's
<p>4. UNDERSTANDING AND PERSONAL RISK ASSESSMENT</p> <ul style="list-style-type: none"> - Thorough understanding of how HIV/AIDS can affect me - Belief that 'I CAN AND SHOULD DO' something' 	<p>4. ACCEPTANCE</p> <ul style="list-style-type: none"> - Community acknowledgement that HIV/AIDS poses a threat to everyone and that they can manage the effects 	<ul style="list-style-type: none"> - Workshops and learning opportunities ensure participants receive detailed appropriate information and have an opportunity to personalise that information
<p>5. COMMUNITY SOLIDARITY</p> <ul style="list-style-type: none"> - Platform for discussion - Good leadership, resources - Group and/or community support 	<p>5. COMMUNITY CARE AND ATTENTION</p> <ul style="list-style-type: none"> - Finding agreement and support - Planning appropriate action - Taking action, leading to wider acceptance and inclusion 	<ul style="list-style-type: none"> - Support sourcing resources, planning, networking, and attempts made towards growth and sustainability of the community project

Stage 1: Experience

Almost everyone in the region knows someone *affected* by HIV/AIDS, even if they do not know whether they, their friends, colleagues or relatives are *infected*. Even if they do know, few admit it openly. There seems to be no institution, organisation, community or family where the pandemic has not had an unspoken impact.

At this stage, people *experience* the pandemic in their environment, but personally have little knowledge about it. Those people affected by HIV/AIDS, for example, if a family member or a colleague is ill, do not speak of it. An increase in illness and deaths is silently accepted and arrangements made to cope, while AIDS is not officially mentioned by name.

For example, at the University of Fort Hare in South Africa, the registrar estimated that there are between one and two deaths each week in the university's community (students, staff and their families). Services are struggling to cope. The transport section cannot handle the number of people attending funerals. There are so many deaths that the theology department no longer holds a memorial service for every student who dies but has resorted to one collective service per week. A lecturer explained, 'If you take the Daily Dispatch newspaper, you will see a whole page of people who have died. Most of those people are in their twenties and naturally you associate this with the killer disease.'

High unemployment, multiple sexual partners, alcohol abuse, depression and low self-esteem induce and sustain less responsible sexual behaviour including low condom use. Commenting on the social conditions facing young people, a VSO teacher trainer in Mozambique said, 'HIV is not worth worrying about when you haven't got any food to eat. These people are young, they want to enjoy sex, what else have they got? Every week someone dies and I hear there is a funeral. A student's sister died last week. She was 27 years old. I asked what she had died of and they said nobody knew.'

Although so many people have such personal experiences, HIV/AIDS is rarely spoken about so its effects have low public visibility. For many people, the only way the HIV/AIDS pandemic can be detected is by the silent disappearance of people from their place of work or study. A VSO volunteer in South Africa explained, 'People just don't return in the new semester and we hear they died of a short illness.'

The silence is perpetuated by misconceptions, incorrect beliefs, stigma, discrimination and the low public visibility of the effects of HIV/AIDS. In the absence of affordable appropriate care, people living with AIDS 'disappear' to the rural areas where it is hoped that their extended family will care for them.

Amusa at home



In rural areas, the effects of the pandemic are more visible. Few can afford medicine or medical care, and people with AIDS quietly die in their homes. Nineteen-year-old Amusa sits on the *stoep*² of his grandparents' mud hut every day until the sun goes down. His swollen joints make it too painful for him to move. His grandmother carries him on her back to use the pit latrine. When Amusa reaches the last days of his life, his grandfather will put Amusa on their bicycle and push him on the four-hour journey to the nearest hospital. Many rural hospitals are hopelessly overcrowded: 'there are two people in every bed with one underneath,' is the experience of a VSO hospital maintenance engineer in Malawi. Drugs are in short supply and medical staff struggle as best they can with severely limited resources.

In the cities, it is possible only to read about HIV/AIDS and never really see its effects. A VSO

²Afrikaans word meaning steps or porch in the front of a house.

volunteer at the Ministry of Land, Resettlement and Rehabilitation in Namibia explained, 'Here in our office in Windhoek, HIV/AIDS only affects my work because colleagues are absent to go to funerals. When visiting the projects, you see that several project members have died. Once, I went to visit projects in the north, and of the six I visited, there were three projects where everyone had gone to a funeral.'

Response 1: Awareness

Governments' responses to HIV/AIDS have varied considerably in the region. In South Africa for instance, President Mbeki has been lukewarm in his response. By contrast, Malawi's President Muluzi is on billboards nationwide, telling people to change their behaviour and save their country. However, knowledge and understanding is not always present where it is needed most. The general feeling of interviewees is that although people working in the development sector are vocal about HIV/AIDS, governments are not proactive enough. A third-year social work student at the University of Fort Hare expressed her views: 'The government is playing a big role, but they are printing too many t-shirts. What about the people who are HIV+? The hospitals are full. The government should use resources for medicines and new hospitals.'

Awareness campaigns are one of the most common responses to the prevailing silence about HIV/AIDS. The campaigns generally focus on the promotion of condom use or abstinence, and on basic knowledge about HIV transmission. In some areas in the region, awareness of HIV/AIDS is now believed to be close to 100%, but **knowledge** and **understanding** of personal risk and practical facts such as methods of transmission, the symptoms of illness, and potential responses, remain low.

There is a clear distinction between 'awareness' of HIV/AIDS and 'understanding' HIV/AIDS. Awareness is a very general and usually superficial recognition that HIV/AIDS exists 'out there somewhere', which does not lead to personal acceptance of risk and therefore behaviour change. This is why many HIV/AIDS programmes are now focusing upon new responses which aim to disseminate more focused knowledge that enables people to understand and personalise information, and then act upon it. However, awareness remains a vital first step in the process leading to knowledge, and this is why it is common to see and hear HIV/AIDS messages on the radio, poster campaigns, TV, hospitals and at workshops.

Time and again however, people express fatigue, or boredom, with talking or hearing about HIV/AIDS.

VSO volunteers have experienced people leaving the room or switching off a radio when the subject is raised. Many people thought HIV/AIDS would be a passing phenomenon, or that a cure would come soon. 'They say awareness has been done to death and they don't want to know any more,' said a VSO lecturer in South Africa.

Awareness programmes face many challenges in trying to communicate effectively, and HIV/AIDS messages about condom use or abstinence do not offer appropriate solutions for many people.

Culturally, the importance and expected frequency of sex is often underestimated. Many men assert their masculinity by having multiple sexual partners and believe they will become ill if they do



Sign from a Namibian public awareness campaign

not have regular sexual intercourse. Monogamy is generally not the norm, nor is it seen as right by many communities. For couples in a polygamous culture wishing to have children, neither condom use nor abstinence is an appropriate solution. In some cultures, faiths or traditions, the use of contraceptive protection for either a man or a woman is seen as sinful. In Namibia, many Herero women and men proudly claim that they 'prefer meat to meat' and will not use condoms. Some say they cannot enjoy sex when they use a condom, so they prefer to 'go live'.

When people are asked to change their lives drastically, it is inevitably a difficult task and slow process, and it is even more so when 'culture' or 'tradition' serves as a protective wing under which to hide from changes.

Compounding the problem is a reluctance to use condoms. People don't feel that condoms are reliable and stories of condoms tearing are common. This may be a convenient excuse to avoid change, but there may be some truth underlying the seemingly exaggerated claims. In addition, the practice of 'dry sex' is common in the region. In order to please men, women insert special herbs into their vagina to absorb moisture and encourage greater friction. If condoms are used without sufficient lubricants, the likelihood of the condom breaking increases, leading to a higher risk of contracting sexually transmitted infections including HIV.

Messages from some traditional healers conflict with messages from the awareness campaigns, and this has added to the confusion. Some healers claim to be able to cure AIDS, with some recommending sex with a child. In Zambia, a student explained that some traditional healers are exploiting their position of power. 'Traditional healers are spreading the disease. He admires a young fit girl, he tells the girl that she has a disease and that he can cure it by having sex with her, he continues doing that with many girls.'

The fact that several years may pass between someone becoming infected with HIV and the first signs of illness is another reason for low responses to awareness campaigns. Symptoms of HIV-related opportunistic infections may be familiar, for example, weakness, diarrhoea, skin lesions, recurring malaria or TB, so initially they may not cause serious concern. It may be difficult to accept that the root cause of the symptoms is the overall decline of the immune system, and even more difficult to associate this with having been infected with HIV, possibly years earlier.

Although most people are aware of the pandemic, few understand HIV/AIDS and the risk it poses to them and their families. Awareness alone, though fundamental, is not sufficient to bring behaviour change. Low knowledge levels contribute to widespread denial, and fear and stigmatisation of people living with HIV/AIDS.

It is vital therefore not only to raise awareness of HIV/AIDS, but to focus upon responses which help people to understand HIV/AIDS and how it is transmitted, and to gain knowledge of practical issues of prevention and living with HIV.

Stage 2: *Fear and stigma*

Fear is a response to the unknown and stigma is a manifestation of fear. Fear and stigma can be found at both personal and community level. Fear reflects the low levels of knowledge and understanding of HIV/AIDS and how it is transmitted. It is manifested in stigma which isolates anyone who is HIV+ or who is even remotely associated with someone who is HIV+. The stigma surrounding HIV/AIDS has become so severe that people fear to talk about the disease. A female farmer and *activista* in Mozambique explained, 'We don't talk about AIDS. We never say when a person has died of AIDS. One reason is because if a member of that family found out that you had been saying their loved one had died of AIDS, they would get furious and defensive, they could come and kill you with a machete. They would accuse you of having given that person AIDS.'

People fear the stigma associated with HIV/AIDS. Rejection, isolation, prejudice, violence and even suicide can ensue if someone is found to be HIV+. Silence and lies therefore surround sickness and death. In the rural areas, HIV/AIDS is less easy to hide. Stigma holds back community acceptance of the pandemic. People prefer to pretend it

doesn't exist. According to interviewees, HIV+ people are seen by some as 'already dead' or 'worth nothing'. A disability rehabilitation assistant in Malawi explained the prevailing attitude: 'They say, "What use is an HIV+ person? He can't have children, he can't get a job, and he will be sick and soon die."'

In other countries severely affected by the AIDS pandemic, such as Uganda, stigma reduced as prevalence of HIV/AIDS increased. This has reportedly been due to two main reasons³: first, enabling legislation, and second, the fact that the AIDS pandemic became a part of everyone's life. In southern Africa, however, stigma appears to have remained high despite very high prevalence. There is no conclusive evidence why this is so and the debate continues.

Response 2: Denial

The stigmatisation of people living with HIV or AIDS has led to a vicious circle. Stigma leads to silence and widespread denial, which allows misinformation and hearsay to spread, which increases fear and stigma, and so on. People repeat misinformation to support their choice to deny HIV/AIDS as a personal risk.

Examples of common misinformation in the region cited by interviewees include:

- 'Women don't get HIV because they menstruate and they lose the virus.'
- 'Mosquitoes spread HIV so it doesn't matter who you sleep with.'
- 'Condoms are infected with HIV.'
- 'AIDS stands for American Idea to Discourage Sex.'
- 'The virus is in oranges.'
- 'Only the promiscuous or morally loose contract HIV.'
- 'AIDS can be cured by raping a child.'

Misinformation perpetuates denial. Denial is an active choice. In order to choose denial, some level of awareness is required. Limited understanding of HIV/AIDS and misinformation give many people a seemingly good reason to doubt that HIV is a risk. Denial manifests itself in a number of ways. Many people have convinced themselves that HIV/AIDS is a problem of other people. A VSO lecturer in South Africa explained her experience, 'White staff think that it is a black disease and all staff think that it is a young disease, and the youth think that it is only for those who are morally loose and that it doesn't apply to the students who are "good" and "religious".'

In southern Africa, HIV is predominantly transmitted heterosexually and HIV/AIDS messages are aimed accordingly at heterosexual sex. Interviewees have either not encountered homosexuality (specifically male homosexuality) or experienced zero tolerance and almost total denial of it. A VSO volunteer in Namibia explained, 'Information presently available in Namibia is purely for heterosexuals; there is no information at all about gay sex, because it is not supposed to happen in Namibia.'

There is also widespread denial of the possibility of non-homosexual men having sex with other men, as can occur in prisons, for example. A VSO vocational trainer reported, 'A minister had suggested giving condoms to prisoners and the president refused. They will not acknowledge that it happens, but the reality is that people are going in to prison [HIV] negative and coming out HIV+. When you have a society where people are used to having sex whenever they want, and they are locked up and they won't masturbate, then it is going to happen.' Denial means that transmission of HIV by same-sex relations is not being tackled at all.

For many people, the choice to deny HIV/AIDS as a personal risk is linked to poverty as well as, often, to gender-determined power relationships. A Mozambican interviewee explained, 'Because of poverty, we watch days go by without eating anything. When a child

is invited to have sex with an adult, she accepts it because he offers her something to eat or some money.' Other interviewees had similar experiences: 'It is quite common that girls sleep with their teachers to pass their school exams. For instance, I know some of the teachers have sex with the students because they have told me. A lot of teachers will expect sex from girls in order to pass the year.'

Sugar daddies, older men who have sex with young girls in exchange for make-up, cell phones, an examination pass or cash, are known throughout the region, but appear to be particularly common in Mozambique, Namibia and Zambia. A VSO vocational trainer in Namibia explained, 'There are people who stay out with men all evening and go to bed with them because otherwise they have no money to go out and have fun. It is not contractual and it is not formal prostitution as we may know it.' A group of young male Zambian students felt that this exchange is a case of supply and demand, and resent the fact that girls of their age have sugar daddies. They feel they cannot attract the girls because they have nothing to offer. A young man may find himself in a relationship with a young woman who also has a sugar daddy: 'They have sex with the sugar daddies to look nice for the boys who will become their husbands. They always say you are the only one. They insist they are still virgins.'

A VSO vocational trainer in Namibia gave some insight into what may motivate some young girls, 'They say without money, there is no love. They go for the good life. Today it is the man with the Mercedes and tomorrow it is the man with the BMW. They do it because of the money. The sugar daddies entertain young ladies. They can give them two thousand Namibian dollars (£135) in their hands. They stay in the lodge and they have nice food and drinks on room service. How can you think about the disease [AIDS] when you are going to earn that much? You are alive today, you are afraid to go for the test, you think you may be HIV+ anyway so you say "what will come will come" and you enjoy it the way it is.'

There are men who deny they are at risk of contracting HIV if they choose a young girl, because they believe her to be a virgin or 'pure', meaning uninfected. In such situations, even if condoms are affordable to women or young girls, negotiation of condom use is difficult. Men will offer a higher price (whether money or goods) not to use a condom or will threaten to go to another woman. In any relationship, suggesting the use of a condom often leads to accusations of infidelity.

When motivated by immediate rewards, HIV infection can seem remote and denial of the risk is a comfortable response. Tangible benefits stand in the way of behaviour change. What motivation is there for a young woman, faced with these circumstances, to change her behaviour and, even if she wanted to, would it be feasible? Gender imbalances are deeply rooted in culture and limit opportunities for change. Society is patriarchal and wife inheritance remains a common practice, particularly in rural areas. An interviewee at the Namibian Women's Network gave an example of just how vulnerable women are: 'In some communities, the uncle is supposed to initiate a girl into sexual activities, so the uncle can rape five or six nieces.'

In some countries, governments have been heavily influenced by the dominant religion. Zambia is principally Christian and so does not actively encourage condom use, preferring instead a message of abstinence. A teacher in Zambia explained, 'There are churches that educate people about HIV but some do not. The Jehovah's Witnesses do not believe that AIDS exists. They do not recommend the use of the condom. Some churches play an important role but some don't allow people to go for a test. If they go to hospital they are disobeying the church.'

Stage 3: Motivation

What motivates someone to move beyond denial? For some, it is the death of a loved one, for others it is knowing their own HIV status. For people who already have deeper knowledge or understanding of HIV/AIDS, a number of factors can trigger their motivation into action.

The *opportunity* to learn is a major factor. HIV/AIDS responses are being integrated into all sectors of society, expanding access to knowledge to more people. Information is no longer restricted to those who are literate, those with a TV, to church congregations or pregnant mothers at clinics. As the case studies in Chapter 3 illustrate, everyone, from farmers, school children and disabled people to English teachers and university students, can all have better access to detailed information. A member of the Namibian Women's Network explained that before, she had only heard about HIV/AIDS workshops, and recently she realised that she could participate.

For others with knowledge of HIV/AIDS, acts of irresponsibility that they experience motivate them to learn how to encourage change. In the six countries researched, many interviewees conveyed anger and frustration at other people's behaviour. A vocational trainer in Namibia explained, 'The attitude is "if someone gave me HIV, then why should I care if I give it to someone else?" They don't think about the possibility of the loss of life or of loss of income or of parents or children. They don't think about how a life will be affected. They don't think of who will care for people when they are sick. They live for today.'

Women and young girls are starting to see themselves as a vulnerable group and are coming together to learn how to take care of themselves and their families. Women report that they feel motivated by the chance to find solutions to their own problems. This solidarity and search for change is a driving force towards responding to the pandemic.

Response 3: Knowledge

With motivation to understand HIV/AIDS comes a thirst for knowledge which goes beyond simple awareness. Knowledge is beginning to deepen among the small groups of people who have access to appropriate information. Many of those who have undergone appropriate knowledge training take the time to assess their own personal risk of infection and are more likely to change aspects of their sexual behaviour⁴.

The importance of moving beyond awareness is expressed by the National Co-ordinator of Fair Trade in Tourism in South Africa: 'People are wearing AIDS ribbons and there are posters up, but I really don't know to what extent it is being internalised. It is sort of trendy to have a ribbon on and to talk about these things. When people bring it up, even government officials will start sniggering. It is not so much a stigma but I think people don't feel it is relevant to them.'

Some HIV/AIDS education programmes take a holistic approach, including but going beyond medical aspects of the virus and its transmission. This level of knowledge is required in order for someone to begin to understand why they may be at risk. The SHARPER case study, for example, shows how alcohol, HIV transmission and sugar daddies were linked, while the Natural Farming Network addresses gender inequalities.

The advantage of workshop-style learning as opposed to public awareness campaigns is that it is face to face. In smaller groups, information can be more accurately conveyed, and it is more difficult for participants to avoid the issues. There is also opportunity to ask questions. Participants are usually encouraged to find their own answers with a facilitator or an HIV+ person to assist. Myth, stigma and denial can be challenged in this safe environment, and presents an opportunity to correct misunderstood information. Some programmes are designed to build participants' confidence and to build their communication skills. These tools can empower them to change their own behaviour and negotiate with their partner, as well as to share their knowledge and encourage behaviour change in others.

Appropriately-designed learning invariably includes information about the advantages and disadvantages of HIV testing. Voluntary counselling and testing (VCT) is gradually becoming more widely available in clinics and hospitals in the region. It is widely accepted by practitioners that, properly implemented, VCT is likely to lead to positive sexual behaviour change and it is expected that the number of VCT centres will continue to

increase in the coming years. There are difficulties associated with learning one's HIV status, not least the fear stemming from the fact that even for minor HIV-related illnesses, drugs and treatment may not be available. Counselling may be inadequate or non-existent, which can cause emotional problems for someone who is HIV+.

However, most HIV/AIDS activists feel that VCT is a vital spur to behaviour change. Those who test and learn their status have a choice to create new options for themselves. Those who learn they are HIV- can decide to ensure they remain HIV- by changing sexual behaviour. Those who learn they are HIV+ may also choose to make changes in their life. Actions such as healthy nutrition by eating unrefined foods and organically-grown produce, avoiding alcohol and getting plenty of rest can help an HIV+ person to remain healthy for longer. Perhaps s/he will decide not to have more children and to make appropriate plans for the children s/he does have.

In spite of this, interviewees in all six countries agreed that people are reluctant to have a test, and that those who know they are HIV+ are often not emotionally supported. At St Luke's Hospital in Malawi for example, where a VCT programme has been established, a counsellor explained, 'People start measuring the length of their lives when they know they are HIV+. The moment they know they are HIV+, they start to die quicker because they become stressed. Everything is over for them. People can't live with the frustration. They lose hope of living. They consider themselves dead people and the disease gets worse and worse and sometimes they just commit suicide. Some go for more sex and get re-infected and they drink more alcohol or use more drugs so they accelerate the disease.'

Many interviewees felt that suicide rates will rise dramatically. As more people discover their HIV+ status and there are fewer people left to care for them or support their families, many believe the only option is suicide. Young men in Zambia explained, 'If two people are about to get married and one found out s/he was positive, the wedding would be off. It is important to have a good sex life and to have children and if you can't do that, then what is the use of the person who is HIV+? The HIV+ person may commit suicide because society will turn its back on him/her. Getting married in that situation would be like being an animal caught in a trap. If you are HIV+, you are useless for the future of the family.'

This sentiment was echoed by an interviewee from Namibia: 'A friend was going to get married and three months before the wedding, the parents of the bride asked the man to have an HIV test and show the certificate. He turned out to be HIV+ and the wedding was off. Some people prefer dying than living when they find out and sometimes they kill their partners so they don't die alone. They just take a gun or some poison.'

Access to HIV testing is still not easy. High prices, long travelling distances and a lack of both anonymity and counselling are not encouraging. In many areas, people find the concept of going for a test absurd because they see no advantages in knowing. A critical lesson to be learned is that people have come to associate obtaining a positive HIV result with imminent death, because typically people do not test until their symptoms are severe and treatment is usually not an option. Breaking this cycle is a challenge.

Greater knowledge has a direct influence on one's personal ability to consider the risk of HIV. Without adequate knowledge of HIV/AIDS, people are unlikely to see any advantage in knowing their status. Knowing one's status makes the issue tangible and personal. Personalisation of knowledge is more likely to affect an individual's behaviour, family acceptance and cultural traditions. It also provides recognition of the responsibility one has to oneself and to others. Widespread knowledge and understanding of HIV/AIDS is therefore required in order to achieve community or national acceptance and action on the pandemic.

Stage 4: Understanding and personal risk assessment

It is common to see change after people have developed a deeper understanding of HIV/AIDS and assessed the risk posed to them and their families. When enough people in society personalise HIV/AIDS information in this way, the community often begins to respond with action.

A Provincial English Adviser (PEA) in Mozambique explained that parents are beginning to see the risk HIV/AIDS poses to their children and are encouraging monogamy: 'Previously, parents used to say that if you are studying, you should not have a boy or girlfriend. Now, they are realising the reality and they ask to meet the girl or boyfriend because it encourages a monogamous relationship instead of multiple partners.'

An HIV/AIDS *activista* in Mozambique explained the change she has undergone since her training: 'In the early days, I was bored of everyone talking about AIDS, but now, since learning about AIDS, I realise people do that for a reason. We learned about the positive ways of living. Now, if we know someone is HIV+, we will not blame him or say it serves him right and we know how to take care of him. I want to act as a role model. I want everyone to see that my attitude is different and that is why I wear the red ribbon.'

The extensive work of NGOs and communities has led some traditional healers to recognise HIV/AIDS and change customary practices to reduce the risk of HIV transmission. Since receiving training, there are indications that some traditional healers who once used only one razor blade to circumcise, or make incisions in numerous people in succession, now use separate blades or sterilise a blade between uses.

Programmes are needed which encourage people to internalise knowledge and accept personal risk, as these are more likely to lead to behaviour change. Once faith-based organisations overcome the challenges, they can play a pivotal role in addressing HIV/AIDS in southern Africa. The Headmaster at Solwezi Technical Training School in Zambia explained why: 'The church has a significant role to play. It upholds the moral society and the changes in behaviour that we desire can be reinforced by the church. When they [the church] talk about issues of morality, people are more likely to listen.'

In Mozambique, where condom use is still heavily associated with prostitution, religious leaders are regularly seen on television discussing abstinence, stating that sex outside of marriage is a crime. According to a VSO teacher trainer volunteer, 'These televised discussions are the only thing that gets people talking on the subject because people think it [the discussion] is so ridiculous.'

A VSO lecturer at the University of Fort Hare in South Africa argues, 'It needs to go beyond awareness. It is not just about how to use a condom, the right to say no, and safe sex. It goes much deeper than that. It is about self-esteem and self-confidence. The students are educated but are not taught to respect themselves. I think there needs to be a dual campaign.'

Response 4: Acceptance

People are beginning to realise that they do have choices and that as individuals, families and communities, they do not have to surrender to the pandemic. This community response is born out of the personalisation of HIV/AIDS information and social action. Acceptance of people living with HIV is extending into families and in communities where HIV/AIDS education workshops are being held.

Across the region, interviewees displayed signs of attitude and behaviour change. In small ways, cultural norms are being challenged in light of HIV/AIDS. In some areas, wife inheritance is no longer occurring as a matter of course as a teacher in Zambia explained, 'Women prefer to remain widowed or choose to marry someone else. The effects of AIDS are actually bringing up a change.' A woman in Zimbabwe explained her husband's response when she arrived home after receiving HIV/AIDS training, 'My husband welcomed me. I gave him the notes from the workshop, and he said it is a good thing to learn about HIV/AIDS. After my husband read the notes, he said we have to pretend we are HIV+. Now we don't buy refined foods and we live positively even though we might not be HIV+.'

Condom use amongst young people appears to be becoming more acceptable, as a VSO teacher in South Africa found, 'Since providing a regular condom supply, the feeling amongst youth that it is "un-cool" to wear a condom is wearing off a bit.' His colleague agreed, saying that by 'placing the condoms here, the volunteer took a risk because of the taboo associated with condoms. It was a ground-breaking thing to do in our culture. Since then, students talk more comfortably about sex and HIV/AIDS.' A VSO vocational trainer in Namibia explained, 'People don't want the condoms from the ministry of health. They want to use the "Cool Riders" because they are dotted and come in different flavours and different colours.' In Zambia, a teacher said that, 'it is quite normal now to find condoms in a schoolboy's bag.'

In Mozambique, community *activistas* have been trained to share information about HIV/AIDS with communities. They claim that people are changing their behaviour and attitude. One *activista* explained, 'Before, people were negative about talking of AIDS and they wouldn't listen. I was told I shouldn't talk about it. Now that I am trained, they listen to me and respect me.'

Stage 5: Community solidarity

Those in the region who accept the reality of the AIDS pandemic are beginning to call for change. Together, their voices are getting louder. Community solidarity is born from acceptance and understanding of the pandemic. As knowledge grows, people look to the next step. A vocational trainer in Namibia explained, 'People must be encouraged to test because everything else has been done. We know about HIV and AIDS. That is all that is left.'

Although responses begin as personal, the scale of the pandemic is too great to tackle alone. People need the support of their families, communities, churches and governments. Programmes designed and run by community groups are challenging the status quo. The VSO organisational development adviser at the Namibian Women's Network explained, 'Women don't want only information. They want skills to be able to do something for the next person whether in their own house or further away.' Her colleague added, 'I think worrying, anger, shock and fear are natural, but what they need is support from their families.'



Promoting safer sex in Mozambique

This solidarity has brought recognition that young children are a particularly vulnerable group. Across the region, there are calls for younger children to receive HIV/AIDS education. A student in Mozambique said, 'The world is changing and so culture has to change. People are realising that they have to challenge culture and educate children at a younger age.' A representative from a youth NGO in Mozambique agreed it was time to take action: 'Those parents who won't discuss it with their children should realise that AIDS is killing us and that there is no time to worry about whether you have the skill to educate your son or daughter. It is time to stop being shameful about sex.'

Response 5: Community care and attention

Community solidarity leads to community care. Communities accept HIV/AIDS as a problem and find solutions as a community. The word 'community' is applied in its widest sense here to mean groups of people who have common interests or whose lives are linked, rather than specifically those who live close to each other. For example, while in rural areas, a village may be an appropriate 'community', in urban environments, communities are less likely to be people in one physical location but rather to exist in the workplace, on campuses, church groups or by association with a particular body or institution.

Bearing in mind the stages which individuals have been through before the stage of community solidarity and care can be reached, remarkable development and progress has taken place. Community solidarity and care occurs only in small pockets of the region. Those working in development see evidence of change in some sectors. For example, in the hospitality sector in South Africa, people are planning for how HIV/AIDS will affect business in ten years' time. In the Provincial Directorate of Women and Social Action in Mozambique, the AIDS Co-ordinator explained. 'People are talking about the impact of HIV and what would happen if they didn't take it seriously. It takes three years to train a social worker: what if we lose staff, how will we cope?' The big challenge, he says, is 'to see HIV/AIDS being solved not as a government problem or a department problem but as a community problem by the people themselves.'

The five stages and responses presented in this chapter are generalised: some people or groups may pass through every stage while some may jump on and others become set at a certain stage. At any one time, different people even within one family, village or community may be at different stages.

Being aware of the types of responses taking place in the region may provide ideas and models for HIV/AIDS integration projects. It is not expected that each and every VSO-RAISA supported integration project will reach the stage at which it implements a community care project. However, the intention is to collaborate with others working in HIV/AIDS and work towards a common goal. It is therefore vital that before any new action is suggested, an assessment is made of the state of the pandemic in a particular community and the existing responses.

This chapter presents nine case studies which have been chosen to represent the six countries and the range of sectors and contexts in which VSO works. They are arranged in alphabetical order by country.

Project	Sector	Country
1. Kachere Rehabilitation Centre	Disability	Malawi
2. St Luke's Hospital	Health	Malawi
3. Acção Social	Social development and rural livelihoods	Mozambique
4. STEP	Teacher training	Mozambique
5. UDAC	Rural livelihoods	Mozambique
6. The Namibian Women's Network	Gender and small business development	
7. The University of Fort Hare	Tertiary education	South Africa
8. SHARPER	Secondary education	Zambia
9. The Natural Farming Network	Rural livelihoods	Zimbabwe

1. *Kachere Rehabilitation Centre, Malawi - Disability*

Context

In Malawi, there is no training for physiotherapists or occupational therapists. VSO has for some years placed therapists at the residential Kachere Rehabilitation Centre. They work alongside Malawian colleagues to provide rehabilitation and community resettlement assistance to disabled people, who are among the most disadvantaged groups in society. Many are also living with HIV/AIDS and staff are experiencing huge levels of frustration and emotional stress at their own inability to tackle AIDS.

VSO occupational therapist Frances Cane explained, 'When I was in England at VSO training, I was told by former volunteers that I would see people dying of AIDS every day and that people would be absent attending funerals all the time. When I arrived here I thought, "where are they all?" You can't see it because you don't know what you are looking for. Gradually, over the months you begin to realise, people don't talk about HIV/AIDS and nobody "dies of HIV/AIDS", they are just "sick".'



Many clients of the Kachere Rehabilitation Centre have paraplegia⁵, some caused by trauma or the later stages of bilharzia, and some with undiagnosed paralysis. Strokes can be caused by HIV, as the virus attacks the brain⁶. Frequently, clients come to the Centre in their last weeks of life. Doctors sometimes only refer these patients when everything else has been tried. The families either have not been told or have chosen to deny the full meaning of the patient's HIV+ status.

'We had a patient who was HIV+, he knew because he had been for a test. He was educated and spoke English. He hadn't been to a doctor, only to a traditional healer. He had weakness in one of his legs and his arms were weaker than normal. After two months, he presented much more like someone who had had a stroke, very weak and stiff down one side of his body. We admitted him for a two-week period to monitor his progress. First he couldn't sit up, then he couldn't hold his head up, then he was choking on his own saliva. Day by day, there was

something different going on. At the end of the two-week period, his family wanted us to give him another chance. We let him stay a bit longer because we were trying to get him into the hospital. The family resisted putting him in hospital because they thought that would mean the end. Finally we discharged him and he died a week later. We get that kind of thing all the time. Relatives want to give their loved ones one last chance. They think that if we can just get them to sit up, the patient will improve. They put all their faith in us,' said Frances.

Mr Mafolela, centre manager, estimates that close to 60 per cent of their patients admitted are HIV+, although many do not know their status. 'The challenges,' he says, 'are like those faced by any health facility: sometimes you could be making good progress with a patient and they fall ill, and when they return you have to start again. The process of recovery takes longer, sometimes patients just can't get better and they die.'

Methodologies and activities

VSO team physiotherapist Erika Burger⁷ decided to organise an HIV/AIDS workshop for all staff at the Kachere Rehabilitation Centre to encourage recognition of HIV/AIDS and foster a response. Erika worked in the rehabilitation department but used the quarterly full staff gathering to hold a day-long HIV/AIDS workshop. There was a speaker who was HIV+ and a local group of HIV/AIDS counsellors who spoke about the different stages of counselling and presented role-plays. 'It was the first thing of its kind,' said Frances, 'and people shared things and the response was positive. I think it opened the way for people to talk about HIV/AIDS.'

⁵Stiffness on one side of the body

⁶See www.ninds.nih.gov/health_and_medical/disorders/aids.htm

⁷Erika had completed her VSO placement at the time of the interview.

Outcomes and impact

Since the workshop, one staff member has begun training to become a pre- and post-test HIV/AIDS counsellor. Previously, nobody would say the words HIV or AIDS, they would just say somebody was 'very sick'. The biggest problem faced by the rehabilitation staff is silence and denial.

Stella Mpezeni, rehabilitation assistant, explained, 'If a patient knows himself to be HIV+, he thinks he is dying tomorrow and that he is helpless. People prefer not to tell the patients. Nurses and doctors in hospitals are not trained to give people the results of their test and neither are we. Most of the staff don't want to disclose a patient's status to either the patient or to their relatives. They are afraid to tell because they don't know how. They prefer to keep the information to themselves.'

Mr Chiwaya, rehabilitation assistant, benefitted a lot from the training and has been informally talking to patients since the staff workshop. He said, 'Most people are unaware of their status. They believe that they are sick because of witchcraft. They think that people have always died and that you are born with the sickness.' Mr Chiwaya also uses the training outside work. He twice had to help people come to terms with HIV/AIDS and to show family members how to care for their ill relatives.

It is not so much a lack of awareness, we need to get people to accept the situation.

VSO physiotherapist Vincent McGuinness, just weeks into his placement and due to replace Frances, said, 'It is not so much a lack of awareness, we need to get people to accept the situation. We are at the sharp end of the situation here. We need to be able to give people the option to test and provide good counselling. I want to tackle awareness from a different angle. Maybe come at it from a stigma point of view. I don't think people know the advantages of testing and that could be where I can do something. I am not sure I know myself. The people we could really work with are the relatives. The patients are usually too sick. People need positive information. How much do posters really work? People want to know what they can do and how to accept that they may already be HIV+.'

Future direction

Erika's workshop was a critical first step in HIV/AIDS integration at Kachere Centre. It brought HIV/AIDS into the open and created an environment where staff could openly discuss HIV/AIDS. Having reached this stage of awareness, however, the Centre is not clear what responses might build on this awareness. There is little support for an ongoing programme to empower staff to take action and address the issues facing them, the patients and their families. Without this next step, patients and their relatives, continue to struggle in denial and silence, which takes its toll on the staff and ultimately on the Centre. The challenge for the Centre's staff, and VSO volunteers, is to go beyond awareness: to identify and implement appropriate responses.



Stella with a patient

2. St Luke's Hospital, Malawi - Health

Context

VSO lab technician Lameck Mwape works at St Luke's, a rural mission hospital outside Zomba in southern Malawi. The hospital laboratory is scantily equipped and usually short of medicines and of chemicals for laboratory tests. St Luke's hospital has begun offering HIV/AIDS voluntary counselling and testing (VCT) alongside routine tests for malaria, TB and anaemia. Motivated by attending a VSO national workshop on integrating HIV/AIDS, Lameck designed the programme which is delivered by hospital counsellors and community outreach teams, such as those on TB surveillance and public health care. 'I called everyone together and explained my idea,' recalled Lameck, 'and they said there was no problem but I would have to get the testing kits.' With four testing kits in the blood bank (enough for roughly 400 tests, including blood donor screening), Lameck and his colleagues decided to make a start.

Methodology and activities



Lameck with some community members

They placed posters in and around the hospital to advertise the new VCT service. On the first day, one client came from very far away, the following day, there were two clients. On the third day, there were seven and so it went on. Lameck and his colleagues extended the idea to two rural clinics and they received an overwhelming response. The programme received a RAISA small grant and a contribution from the hospital, which provided ten more testing kits. 'In the seven-month period since then, a total of 859 people have been tested. Of those, 263 (30.6%) tested HIV+.'

Lameck is hoping to find a donor for the testing kits to sustain their supply. In addition to the VCT programme, the lab runs a blood-screening programme and Lameck also recently started a prevention programme to inform HIV-negative blood donors about condom use and HIV/AIDS.

The big concern surrounding the VCT programme is that the counsellors have not yet received training in appropriate pre- and post-HIV test counselling. Hospital counsellor Nelly Njowe explained, 'We don't know where to start talking to them [the clients]. We talk about HIV and how we bring it into our families and how we can prevent that. If the result is positive, we do spiritual counselling, we read from the Bible.'

Outcomes and impact

It is becoming common for couples to test before marriage. But the counsellors predict a rapid increase in suicides because there is no support for people who test HIV+ and who consequently will not marry. 'Some take poisons and some hang themselves. We hear it from neighbours. When a patient learns s/he is HIV+, s/he always asks, "how long am I going to stay here in this world?". We say, "we don't know, only God knows that".'

The team is worried about the future of the VCT programme when Lameck leaves. 'I have spoken to the senior medical officer to find out if there will be anyone who can take over when I leave. It seems nobody is ready. When you look at most HIV/AIDS activities in Malawi, even in the communities, most of them are linked to some remuneration as an incentive. I am just integrating [HIV/AIDS] and I have no funding and it is difficult for them to understand that,' said Lameck sadly. Alice Liwewe, acting VCT co-ordinator added, 'Lameck is working alongside us as colleagues but without financial support it [the VCT programme] will die down.'

Future directions

The VCT programme at St Luke's and the surrounding clinics is clearly meeting a need, but it faces some important decisions. Without appropriate counselling, the programme cannot operate responsibly and without a Malawian staff member to drive it forward, its future is uncertain.

It was a challenge for Lameck and the hospital team to work in an area where cultural practices such as wife inheritance and 'dry sex' are common. They faced the dilemma of whether to begin a much-needed VCT programme in poorly-resourced conditions and without adequate counselling to offer emotional support for clients, or to do nothing at all and waste an opportunity to address HIV/AIDS in a way which is believed to induce sexual behaviour change and thus reduce the risk of HIV transmission.

3: *Direcção Provincial da Mulher e Coordenação da Acção Social, Mozambique - Social development and rural livelihoods*

Context

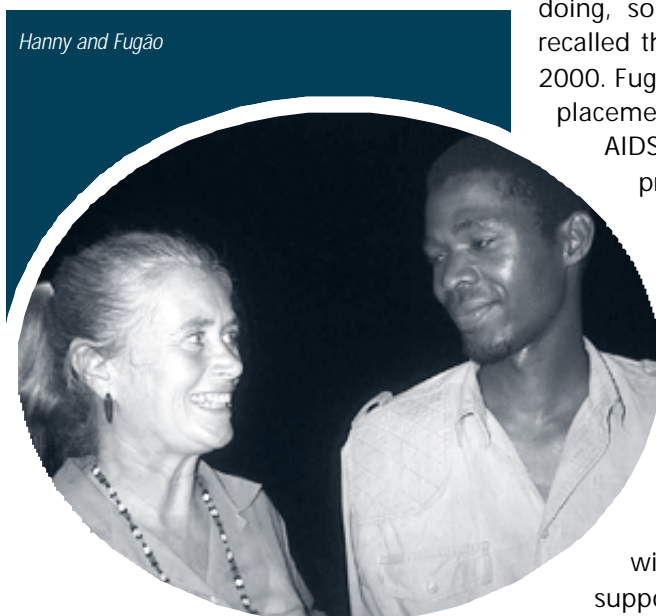
Fugão Alfonso and VSO management adviser Hanny Rennen work in the Provincial Directorate of Women and Social Action in Sofala Province, one of the poorest in Mozambique's central region. The directorate is responsible for the recovery of street children, prisoners, people with mental health problems or with learning difficulties, drug users and, more recently, people affected by HIV/AIDS. Acção Social is based in Beira, but supports many NGOs in the province to carry out this work. Fugão is a social worker specialising in psycho-social matters and Hanny is based in the planning department. Together they have developed and begun to implement an HIV/AIDS plan for the directorate.

Activities and methodologies

A conference organised by VSO Mozambique motivated Hanny to consider what she could do to integrate HIV/AIDS into her work. 'There was no activity in the department and no SIDA [AIDS in Portuguese] co-ordinator at all. I started drafting an HIV/AIDS plan in my

own time. Fugão was very interested in what I was doing, so we developed the plan together,' Hanny recalled the beginnings some 18 months ago in early 2000. Fugão adds: 'In the past, I had undertaken a job placement at MONASO (Mozambique Network of AIDS Service Organisations) where I worked in prisons on HIV and STI prevention, so I had a personal interest and felt I could contribute.'

Describing the source of her motivation, Hanny explained, 'Mozambique has a polygamous culture, condom use is very low and people don't talk openly about sex. We came together to write the plan because we had inner conviction. There was nothing at all happening about HIV/AIDS (in the directorate).' Fugão previously tried to start an HIV/AIDS project with the Red Cross, but, 'there wasn't big support,' he recalls.



The Provincial Director of Acção Social took the first draft of the plan to a national conference of all provincial directorates, organised by the Ministry of Women and Social Action, where she received huge applause for being the only directorate to bring an HIV/AIDS plan. Although there was a national strategic plan, this outlined general areas to be tackled at ministry level, there was no action plan for the provincial directorates. 'We were the first in the country,' explained Hanny with excitement.

'I remember, before the plan was in place, a man from another province was admitted into the hospital with TB and skin lesions. He ran away from the hospital to our offices and the Provincial Director brought him to me and said, "you are now responsible for AIDS." So I became the SIDA Co-ordinator,' remembered Fugão with a smile of residual disbelief.

Hanny and Fugão gained confidence, but also recognised their growing responsibility. Undaunted, they wrote a three-year plan, stating clear objectives and target groups, using the Mozambique national strategic plan as a guide. The target groups were identified as children under the age of 18, orphans and women.

'I worked on the computer to elaborate the objectives and the structure because Fugão doesn't have computer skills. I had initiated the idea and was there to keep momentum and give motivation. There is always a lot of talking and this was actually sitting down and doing,' remarked Hanny. At the next provincial conference, Fugão and Hanny were asked to present the plan. 'We presented three action points: first, awareness, second, training for all social workers and all staff in the directorate, and third, direct assistance,' explained Hanny. 'We also went on the radio together and this was the first experience Hanny had of talking Portuguese to a lot of people,' said Fugão.

Outcomes and impact

Using a RAISA small grant, Acção Social organised an HIV/AIDS workshop for staff in the directorate and for staff from the organisations they work with, an institute for blind people, a home for the elderly, a school for deaf children, a land mine survivors' organisation, and an orphanage - including the drivers. They trained 50 people in AIDS awareness over five days. 'Things changed after the seminars, people understood. They asked questions and were more professional in their thinking,' recalled Fugão.

After the workshop, Fugão's and Hanny's colleagues encouraged them to approach journalists and to promote the plan. They realised Hanny and Fugão were serious and were inspired by what they were doing. The next step was to find a donor. Hanny and Fugão also knew that at the next provincial meeting, they would be asked to present their progress.

'The small grant was the first of others [funding]. It got everything started so that people could see our ideas,' explained Hanny. Fugão and Hanny submitted many proposals to donors and Acção Social's initiative became a focus for donor attention: international donors visited often and UNICEF became interested. After a long process, UNICEF agreed to fund the plans, as well as provide two cars, two computers and eight motorbikes to deliver the activities.

In collaboration with ADDP (Ajuda do povo para povo), a local NGO with an HIV/AIDS programme, a manual was developed which included topics such as sexuality and gender in relation to HIV/AIDS. Administrative staff in the office are still using the manual as a reference, a sign of continuing awareness following the initial workshop training. Hanny and Fugão are very pleased they managed to include all staff in the workshop.

The small grant was the first of others [funding]. It got everything started so that people could see our ideas.

Future directions

Part of the Acção Social plan is to create a register of families willing to take in children without parents. 'We won't make a distinction between orphans who lost their parents because of AIDS and those who lost their parents for other reasons. We don't want to further stigmatise. The register will be implemented by local NGOs. We expect there to be 300,000 orphans this year alone in this province. We only have two staff in each district, so it is critical that we work with local groups to provide the monitoring and support,' explained Hanny.

Hanny and Fugão discussed their working relationship like two old friends. Fugão felt that, 'I probably could have done it without Hanny but not now, [not yet]. I needed someone to work with and I needed the right person. Because of the social mandate [of my job], I would have been forced [to do this] sooner or later. It was like I only had one leg and couldn't walk and Hanny was my other leg.' Hanny has come to the end of her placement and Fugão is a little concerned about continuing the work alone. However, he has been planning World AIDS Day activities and hopes that their success will be a goodbye celebration for Hanny.

4. STEP, Mozambique - Teacher training

Context

In Mozambique, 16 VSO teacher trainers have been working with the in-service English language teacher-training programme, the Secondary and Technical English Project called STEP for short. Run in partnership with the Ministry of Education, the British Council, and funded by DFID, the VSO volunteers have supported the programme in all ten provinces since 1997. Many have incorporated HIV/AIDS into their courses and have encouraged their trainee teachers to develop English language teaching materials with an HIV/AIDS theme.

One such volunteer is Neil Murray who for the last four years has been based in the Northern Province of Cabo Delgado responsible for the STEP certificate course. Neil and fellow volunteers across the region looked at ways of integrating HIV/AIDS into their classrooms.

Methodology and activities

'VSO teacher trainers in the STEP programme have the freedom to design the course,' commented Neil. The English proficiency module, the listening comprehension and the note-taking and discussion skills modules use videos, quizzes, role-plays and texts with an HIV/AIDS theme. 'The students responded really well to the video *Emma's Story*⁸. There is an oral culture here and they like someone talking about their own experiences.' Although a taboo subject for many, teachers have designed materials for use in the classroom and VSO volunteers have collated them and distributed them across the country.

Although a taboo subject for many, teachers have designed materials for use in the classroom and VSO volunteers have collated them and distributed them across the country.

In each province, volunteers work alongside Provincial English Advisers (PEA's). Volunteers have experienced varied levels of participation from PEAs when it comes to HIV/AIDS integration, some showing no interest at all while others have found interesting entry points for involvement. Simon Militão, PEA in Beira in the central region, is also the general secretary of MELTA (Mozambique English Language Teachers' Association). Each year, MELTA organises a provincial drama competition which is open to all English teachers and their students. In 2001, the committee agreed that the plays should have the theme of HIV/AIDS. Kim Greig is a VSO teacher working with the STEP programme at Samora Machel Secondary School in Beira. Lacking HIV/AIDS materials in Portuguese, Kim trained teachers in HIV/AIDS using English-language materials in order to prepare them to direct the plays.

Thirteen schools attended, bringing over 300 pupils together, and some schools sent two groups of students. 'AIDS is a big problem and the response has been good,' commented Harry Assane, English teacher at Samora Machel Secondary School, treasurer of MELTA and founder of the provincial drama competition.

Outcomes and impact

'The teachers were excited by the HIV/AIDS theme in the drama competition this year because it gave them a chance to reflect on what they had learned and display it. They did a lot of preparation and they communicated with Kim a lot during that time,' said Mr Militão. 'At the beginning,' he adds, 'it was difficult for the teachers to talk about HIV/AIDS. I think they thought it was something light. As time went by, they began to see that HIV and AIDS is a reality in the region. They started to see it was helping them to be aware that they could do something with their students and also within their families.'

Introducing HIV/AIDS into English language training hasn't been easy, as VSO teacher

Neil Murray explains, 'There was very little awareness of HIV/AIDS from the teachers I have trained and they were quite self-conscious as well. I opened myself up although I too was not confident. Together we found the answers.'

Neil believes his students do consider themselves at risk but is aware that he is working in an environment where there is a widespread association between condoms and prostitution, a belief that condoms contain HIV and that mosquitoes carry and transmit HIV. 'Some volunteers become frustrated by the shocking lack of awareness and the fact that people still doubt the existence of HIV/AIDS,' commented Neil. Neil believes it is important to have realistic expectations about integrating HIV/AIDS into the workplace. He says, 'The challenge has been getting people involved. It has been VSO-led, which is the downside. We were not the first to do HIV/AIDS work. The Red Cross and UNAIDS had trained HIV/AIDS *activistas* before. They had given them caps and t-shirts and nothing has been done since,' Similarly, he recalls a situation where a volunteer staged a week-long awareness campaign only to face the most basic questions at the end.

VSO volunteers seem to fear that HIV/AIDS may fall off the agenda when they leave their placements, but are comforted by the fact that the lesson plans and materials that have been developed will remain and may motivate future teachers to continue.

Future direction

The potential impact of VSO teacher trainers on dissemination of accurate HIV/AIDS information is phenomenal. If only a small percentage of the newly-trained teachers use the materials they have developed in their classrooms, a huge number of students will be exposed to HIV/AIDS messages. One drama group student offered, 'Now that I have learned about HIV and AIDS, I have told my brothers and sisters and my boyfriend. They listen and ask questions about how you contract HIV and how you protect yourself.'



5. UDAC, Mozambique - Rural livelihoods

Context

União Distrital de Associações de Camponeses (District Union of Farmers' Associations and Co-operatives, UDAC) is a non-profit union in the village of Dondo in Sofala Province. UDAC represents small farmers at a district, provincial and national level, unifying to have a greater voice and larger purse. Some 575 farmers, 350 of whom are women, make up the district's UDAC membership.

Although the government and local NGOs are working hard to raise HIV/AIDS awareness levels on TV, radio and billboards, many people in rural areas do not have access to information, so UDAC has become an important communication vehicle. Mozambique appears to be lagging behind the rest of the southern African region in awareness levels. This is highlighted by the quite common belief that condoms and oranges contain HIV.

Methodology and activities

With the help of VSO small business adviser Janet Richardson, UDAC joined with the District Directorate of Social Action in Dondo and a local NGO to train 30 *activistas*. *Activistas* are well-respected in the community and can be found in roles as varied as assisting with traffic control or as community nurses. Over the last few years, *activistas* have been trained to disseminate information about HIV and AIDS in their communities.

Domingo Buramo, Secretary of UDAC, explained, 'Janet had the idea, but she wanted UDAC to own the project. She pressured us to come together and see if it would be feasible. We wrote project objectives and received a small grant from RAISA.' A two-week training programme was arranged and three representatives from each of the ten farmer's groups attended. Three days of intensive training covered information about HIV/AIDS and the role of an *activista*. 'Janet's role,' explained Domingo, 'was to get people together and to support us. When she came, there was nothing happening about HIV/AIDS but she didn't want to do things only for UDAC. She visited other organisations and asked how HIV/AIDS was affecting them. Together, people decided something had to be done.'

Janet had the idea, but she wanted UDAC to own the project. She pressured us to come together and see if it would be feasible.

Outcomes and impact

'There were positive results,' said Julio Sozinho, treasurer of UDAC. 'People welcomed the idea of disseminating the information themselves.' The *activistas* show great enthusiasm for their role and take the responsibility seriously. *Activista* Anita Capece explained, 'Before, people were negative talking about HIV/AIDS, they wouldn't listen and they said I shouldn't talk about it. Now that I am trained, they listen and I am prepared for the challenge.'

The *activistas* visit people's homes and talk about HIV/AIDS to the head of the family, whether it is a woman or a man. Sometimes, the whole household wants to listen, making talking about such a sensitive subject challenging. Anita said, 'I explain at the beginning that I am going to talk about a sensitive subject. Many of the children never say anything and the women say less than the men in a group situation. Few have the courage to ask questions but they always find a way of asking me afterwards as they walk with me. Women are the most vulnerable group in my opinion. The only way to help them is to convince them to use a condom but women think only prostitutes use condoms.' Since they were trained, the 30 *activistas* have visited 871 families and have big plans to move into the more rural areas if they can find money to buy bicycles.

The *activistas* also arrange community meetings, speak to church groups and train traditional healers about HIV/AIDS. 'Most people go to a traditional healer first and only when they are not getting better do they go to the hospital. People only have an HIV test when they are sick. We tell the traditional healers not to use the same razor blade for many

people during traditional ceremonies and we tell them to bury the blades after use,' commented Anita.

The *activistas* explained that although people are not declaring their status, they find sick people in the homes. They work closely with the health department, which can arrange home visits. 'People don't talk about AIDS. They never say when a person has died of AIDS. They are frightened because if the family finds out you said their loved one died of AIDS, they will get furious and defensive and kill you with a machete. They will accuse you of giving that person AIDS because that can be the only reason why you know it was AIDS. What would happen to the wife and the children if everyone knew that her husband had died of AIDS?' Stigma stands in the way of many HIV/AIDS awareness and care projects, making the work of the *activistas* all the more critical.

Gender imbalances also make it difficult to turn awareness into sexual behaviour change, as *activista* António Luacioa explained, 'Men are high above women, so negotiating condom use is very hard in the home. If one partner is HIV+ then being married to that person is like an animal caught in a trap, like suicide.'

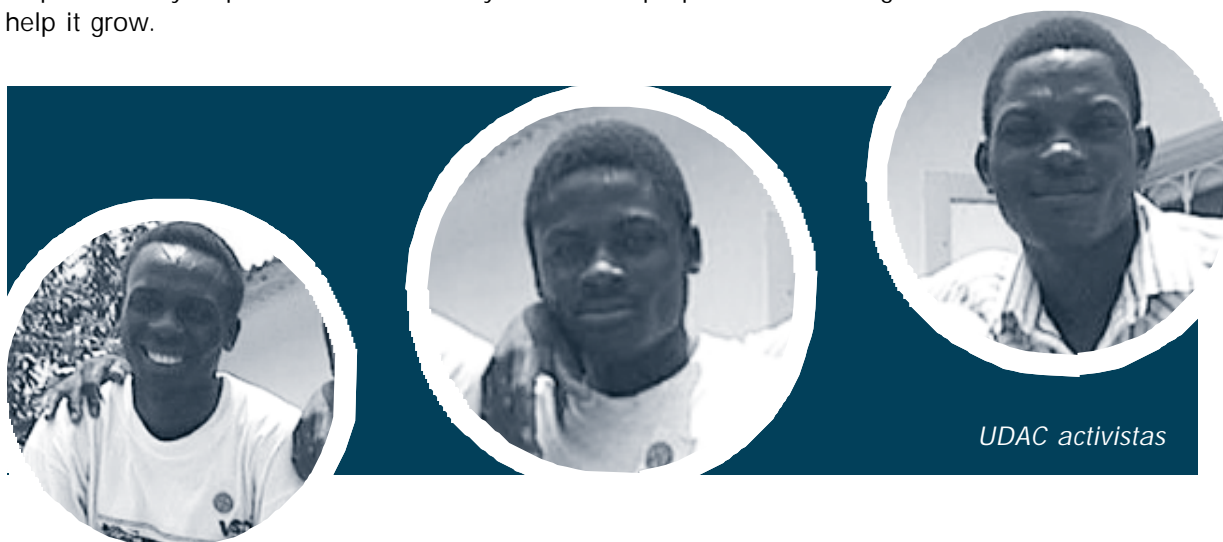
Young people too are considered to be at high risk because they go to the bars. 'Sex is big business,' said *activista* José Filipe. 'There is a very important link between alcohol and HIV transmission. When people are drunk, they want to have sex. When they are drunk, they don't think about using a condom.'

Since the programme began, there have been some changes around town. There is now a minimum age in the bars. One *activista* claimed, 'Some of my family and friends used to have a lot of sex with a lot of partners and they have listened to me and have stopped and they want to tell others.' Another offered, 'In the past, women believed it showed a lack of respect to ask to wear a condom. Now they are starting to understand it is the opposite. It means there is total respect because it means you want to protect yourself and your partner.'

Commenting on levels of education amongst young people, *activistas* agreed that children from the age of ten should learn about sex and HIV/AIDS in a responsible way. They believe that boys and especially girls are already sexually active or experimenting, and a big problem is that condoms are one size and therefore useless for younger boys.

Future directions

UDAC plans to train a second group of *activistas* in the near future. The *activistas* feel held back by their lack of transport. They want to find a donor who can provide bicycles so they can reach rural areas. The *activistas* and UDAC alike have no doubt that the programme will continue. Other programmes are coming to the area and making use of the *activistas*' skills and experience. Acção Social has begun an orphan project and the *activistas* plan to assist. VSO volunteer Janet appears to have helped these farmers to plant a very important seed and they seem well prepared and willing to help it grow.



UDAC *activistas*

6. *The Namibian Women's Network, Namibia - Gender and small business development*

Context

In the busy high-density urban suburb of Okahandja, the Namibian Women's Network (NWN) supports women with income-generating activities. In late 2000, when VSO organisational development adviser Christine Nganga arrived, the NWN office was disorganised with very few resources.

Today the NWN is a vibrant, well-respected organisation where prominent community leaders come to offer their services. Christine's incessant hard work and dedication has won the respect and co-operation of many. Women welcomed her into their lives and together, they identified a need to respond to HIV and AIDS.

Christine explained, 'My colleagues said to me that HIV/AIDS is real here and nobody is talking about it. The women were realising just how vulnerable they were. They didn't want only information but also needed skills to do something for the next person, whether that is in their own house or further away.' With a new and very competent staff, Christine felt re-motivated to move forward. It was agreed that an HIV/AIDS workshop would be arranged for young people in the community of Okahandja.

Methodology and activities

Grace Hindinua, NWN programme officer, explained that NWN works mainly within existing community structures, such as church groups and youth groups, to increase networks, encourage local support, raise their profile and build on what has come before. With a RAISA small grant and support to find a trainer able to speak the local language and understand Okahandja life, the workshop was a great success. Christine said, 'The young people were very excited: for once, someone was addressing an issue that was relevant to them and they could start internalising the message of HIV/AIDS.'

Twenty-four-year-old Belinda Owoses spoke about her motivation for taking part in the workshop: 'There are teenagers who are dying. Every weekend, we have a funeral. There is always a money problem and we women use our bodies to sell and that helps to spread the disease. In a night, you can get N\$500 (£33) and it is already enough to support your family when your parents are not educated or they are sick. Most teenagers sell their bodies to men so they can get money. Sometimes the man would say the money is less if you use a condom so you have to think, but you also have to think about your life.'

'The youth are most vulnerable,' added Michael Inarib, also aged 24. 'People are mostly unemployed, around 80%, and there are no leisure activities, so they tend to use alcohol. Whether you are young or not, alcohol is the most contributing factor to HIV transmission. Each and every weekend you see the youth drunk and it is killing us softly.'

Outcomes and impact

Following the success of the youth HIV/AIDS workshop, the NWN decided to run a second workshop. 'Mothers were urging their mothers and sisters and aunties to take part and understand about HIV/AIDS,' recalled Christine. Again, the workshop was a huge success but people wanted more than just awareness. 'People want to feel there is hope, that they are supported. That there is something they can do at a community level,' explained Christine.

NWN has started training a group of fifteen members of the local community on intensive home-based care under the supervision of a qualified counsellor. Although a qualified counsellor and trainer herself, Christine felt handicapped by not knowing the local language and culture. 'I was getting depressed because I am here and I have the knowledge, but I can't do anything.' Instead, Christine identified a Namibian trainer. 'I noticed the [participants'] enthusiasm and the way they responded and it was promising.

The women were realising just how vulnerable they were. They didn't want only information but also needed skills to do something for the next person, whether that is in their own house or further away.

People want to feel there is hope, that they are supported. That there is something they can do at a community level

A seed has been sown and is germinating and there are a few people who are willing to water it. I do have a backstage pass but it is the Namibians in the forefront.'

Being an outsider has both helped and hindered Christine in her work. 'When I landed in this village, I realised I was on the other side. The people looked like my people [Christine is Kenyan] but they were very different in lifestyle, but somehow they started treating me like one of them. When I talk to the young people in the evenings, I tell them things the way they are. I tell them I am talking as a mother, as a professional, as an African and as someone from a developing country. They like the fact that I am an outsider so they can say "that woman said . . .".'

Christine had a great deal of personal motivation and knew the way HIV/AIDS affects all other work. 'If RAISA hadn't existed, I still would have done something. I brought materials with me. I have lost friends and I promised myself that I would do something wherever I am. I am a business counsellor and a trainer but I have found myself going into HIV/AIDS because it is so relevant in everyone's lives. If volunteers come and do whatever they are assigned to do and leave without addressing HIV/AIDS in some way, much will be lost. It is so deep into the communities. Unfortunately, it is the least measurable aspect of your work but yet it is the one where you can say much more than a local person. If you took me to my local community in Kenya I would not say these things, I couldn't.'

Future directions

NWN is looking for donors to take the HIV/AIDS training to other regions. Christine would like to see more attention focused on sexual and domestic violence, but feels this subject is too delicate at this time. Her vision is to see people battling HIV/AIDS from the house, not just in workshops.

'My advice to other volunteers,' offers Christine, 'would be to read anything you can about HIV/AIDS, whether it is positive or negative. For me, because of my background, I am totally opposed to condoms, but the reality is that I had to get into it and understand it. Try to listen to yourself. Ask yourself: what do I think about this thing? If you can, go to talk to someone who is HIV+. Do it regularly, not just once. You have to listen to the diversity of stories. Then go to the people who are affected and infected and listen to their stories. The picture will begin to take shape. Until you have listened and asked "how?" and "why?", you won't be able to ask the real question: "what can I do for you?". See where your potential is as a volunteer. Are you a supporter? Are you an activist? Sympathy alone cannot help.

There is so much you can do. Work in the schools, work with families or colleagues, write about it or make a documentary. If you discover yourself you will see that medicine is only one angle. If you feel you can't do it, train others to do it. Here I realise I can't do much but there are others who can. Find them and ask them to help. Go beyond curiosity because everyone can do something.'



A role-play of home-based care

7. The University of Fort Hare, South Africa - Tertiary education

Context

The University of Fort Hare is in the Eastern Cape, one of the most disadvantaged provinces in South Africa. Fort Hare University is classified as a 'historically disadvantaged university' (HDU) with an important history and many past and present-day leaders as alumni. Today, the university is in the shadow of more wealthy and prestigious tertiary education institutions, but makes a significant contribution to the number of black graduates emerging.

The university registrar believes that as many as two deaths per week may be attributed to AIDS among the university's students, staff and their families. Unable to avoid HIV/AIDS in this context, five VSO volunteers working with different departments of the university have integrated HIV/AIDS in their work.



Richard with his colleagues, Cheryl and Chris

VSO's strategy in South Africa places small groups of volunteers in one institution to maximise peer support, and in this case, it also widened the number of colleagues and students who were directly involved. This enabled the VSO volunteers and their colleagues and students to generate a multi-level approach to HIV/AIDS at the university and in the wider community. In the departments of social work, statistics, and sports and human movement, and in the university central administration, HIV/AIDS is now out in the open and on the agenda.

Methodologies and activities

With the full support of his colleagues, VSO lecturer Richard Lightbown has been able to raise the profile of HIV/AIDS within the Sports Development Department. HIV/AIDS is incorporated into lectures and staff, teaching in related subject areas such as anatomy and sociology of sport, have included it in their curricula.

I didn't just go into the classroom and decide that today I am going to discuss HIV and AIDS. I had to win trust, and I had to pick my moment.

'Sport has the ability to form strong relationships, it can break down social, racial and economic barriers quicker than anything else,' believes Richard. 'I didn't just go into the classroom and decide that today I am going to discuss HIV and AIDS. I had to win trust, and I had to pick my moment.'

Twenty-five per cent of the students in the department are female and Richard was keen to include everyone and get people talking. 'There are men and women in the group and both have strong personalities, making the discussions animated and suppressing the traditional Xhosa male dominance.'

There are natural entry points for HIV/AIDS discussions such as blood-to-blood contact, healthy living and anatomy, but Richard also finds talking about his own relationship helps to open up discussions, 'I lay myself open. I say this is my life and this is what I think, and they tell me their thoughts and we take it from there.'

Chris Ndezekeni, fellow lecturer in the department, said, 'By placing condoms [in the department], Richard took a risk because of the taboo associated with condoms. It was a ground-breaking thing to do in our culture. Since then our students talk more comfortably about sex and HIV/AIDS.'

The demand for condoms, averaging over 500 a week, is met by a supply from the university clinic, the only other place on campus where condoms are available free of charge. 'Originally, the ones in the entrance were just for show and I would put condoms in the toilets where it would be more discreet, but now people don't mind taking them from the display area in the foyer,' said Richard.

On a different level, VSO administrative assistant Katherine Dennison in the registrar's office and VSO social work lecturer Karen Southern have been instrumental in helping the university to develop a policy on HIV and AIDS. Katherine said, 'The Vice-Chancellor's special assistant contacted me because she knew I was interested in HIV/AIDS and said we needed an institutional policy. I came up with the draft policy drawing from other policies and then pushed it through the formal channels.'

Pindi Ndungane, Special Assistant to the Vice-Chancellor, worked closely with the VSO volunteers on the HIV/AIDS policy. Pindi said, 'The volunteers brought in the community element to the policy because they have worked with the community. HIV has no culture and knows no boundaries. The objectivity the volunteers have brought and their keenness has been a major contribution to this institution.'

Outcomes and impact

Staff awareness workshops were held but according to Pindi, the response was 'not exciting'. Not discouraged, Pindi would like to see interested staff forming a committee and including HIV/AIDS in every department.

Karen and Katherine looked beyond the campus and discovered a huge need within the community. 'I have a good relationship with local social workers,' said Karen, 'and they do a lot of community relations work. We have encouraged groups in the community to apply for the RAISA small grant and [so far] two groups have received funding.'

My students will be key players in spreading the HIV/AIDS message. In the same way that VSO asks us [volunteers] to integrate HIV into our work, I say that to my students.

In the social work department, VSO volunteers found that gaining staff participation has not always been easy. 'Before the policy,' according to Karen, 'it felt like nobody else was interested in HIV/AIDS. I remember a conversation we [the volunteers] had with the registrar about HIV/AIDS. He said that the university is "beyond awareness", as though everybody knows about it.'

VSO social work lecturer Brian Stout comments, 'The [HIV/AIDS] policy will help but there are issues that the policy can't address. You cannot force people to be interested. It has to come from the students first, but they are unlikely to come and ask for a module on HIV/AIDS. Potential employers need to recognise that social workers are graduating with incomplete training if they don't know how to address issues around HIV.'

Students themselves seem very enthusiastic and freely engage in debates on HIV/AIDS and its relation to culture, gender and politics, as well as discussing condom use, testing, community care and stigma. One female third-year social work student commented, 'Brian and Karen were the only ones that I know who talk about HIV/AIDS. They are giving their knowledge to us. When other lecturers saw what Brian and Karen were doing, they thought that maybe they would take part in doing it as well.'

Brian said that, 'My students will be key players in spreading the HIV/AIDS message. In the same way that VSO asks us [volunteers] to integrate HIV into our work, I say that to my students. These social workers will meet people whom government and NGO messages using TV, radio and poster campaigns will not reach. Social workers may be the only ones with access to that information and they very much buy into the idea of being role models in the community.'

Future directions

The HIV/AIDS policy appears to have given the university a strategy for responding to the pandemic and raising funds. A commitment has been made to introduce a voluntary counselling and testing facility and so far, some 50 peer educators have been trained. 'We hope that they will form part of what will be a national peer educators programme in universities,' said Pindi Ndungane.

'The next level,' says Chris Ndezekeni, sports development lecturer, 'is to internalise the issues, to achieve continuous discussion and openness and have a constant supply of new information. The younger generations can pass that information out, it is important to keep it alive in our curriculum as well.'

Poster launching the University HIV/AIDS policy



8. SHARPER, Zambia - Secondary education

Context

In 1999, VSO science teacher Sarah Tweats began looking for appropriate HIV/AIDS resources to use in her classes at Solwezi Technical Secondary School (Soltech) in north-western Zambia. Sarah wrote to her family in the UK for help and her mother identified *Stepping Stones*, a training package on HIV/AIDS, gender issues, communication and relationship skills written by Alice Welbourn⁹. *Stepping Stones* is designed for communities and aims to enable women and men of all ages to explore their social, sexual and psychological needs, to analyse the communication blocks they face, and to practise different ways of behaving in their relationships.

Methodologies and activities

Sarah and her colleagues began running the 18-session *Stepping Stones* programme with students. It soon became clear that 60 hours of sessions over 12 weeks required more time than either the students or the teachers could find in a busy term, so Sarah and her colleagues decided to adapt the programme to their secondary school situation.

Fellow VSO teacher Tom Butcher explained, 'We wanted to build something that was more accessible to the staff and students. We made the whole programme shorter to fit into a school term, and each session shorter to fit into an afternoon prep session.' Facilitators had to make some tough decisions in order to reduce the material. It was agreed that the focus should be on HIV/AIDS and should include some related social issues such as cultural expectations and alcohol misuse. The adapted version took shape and with some external support, SHARP (Soltech HIV Awareness Resource Project) was produced.

Students from grades 10 to 13, ranging in age from 16 to 22 years, have taken part in the SHARP programme. Girls and boys have separate workshops with teachers of the same sex as facilitators. 'This is specially designed to allow the pupils to be free,' explained Mr Kawilila, the headmaster. 'Our objectives are prevention. We believe that if they learn in an environment where they can freely ask questions with a facilitator present, it is better than hearing myths on the street.'

The sessions are based on the original *Stepping Stones* programme, where free and active discussion is promoted. During the sessions, the traditional teacher-pupil relationship falls away, as Mr Muntanga, facilitator at Kasempa Boys' School explained, 'We don't give lectures to them, we have an open discussion. We are there to provide guidance, but we all participate. We are equals.'

Each structured session includes an introduction to the topic, a related game and a group discussion, followed by another related game and finally time to recap on the main points of the session. 'There are lots of games in the programme that help the pupils to participate actively and not get bored. The workshop environment is conducive for discussing these issues. HIV affects people in the school. Some of us have had relatives or friends dying,' said Violet Luputa, one of the facilitators at Soltech.

At a teachers' workshop organised by VSO, the Soltech facilitators demonstrated SHARP and generated enthusiasm amongst teachers from other schools. VSO and national teachers at Kasempa Boys' School and neighbouring Kasempa Day School soon began using the sessions with their students.

Our objectives are prevention. We believe that if they learn in an environment where they can freely ask questions with a facilitator present, it is better than hearing myths on the street.

⁹*Stepping Stones* is produced by Action Aid and is part of the Strategies for Hope series. For more information, see www.actionaid.org/stratshope

Outcomes and impact

'We received a lot of feedback at the end of last term from the staff and the pupils in all the schools,' explained Tom. This was used to refine the sessions and what followed was the birth of SHARPER (Soltech HIV Awareness Resource Project Evaluated and Revised).

At Kasempa Boys' School, pupils have decided to share their knowledge using drama. SHARPER graduates formed small Anti-AIDS Clubs outside school time, where they write and rehearse plays to perform at schools and to community groups in the area. After each performance, discussion groups facilitated by the cast offer audiences an opportunity to see a condom demonstration and to ask questions.

VSO teachers at Kasempa Day School, on the other hand, have struggled to motivate female colleagues to take part in the programme, although this is compensated for by the bounding energy that Chris Kamocha, a teacher at the school, brings as a facilitator. 'It is my vision that the programme should continue even if the VSO volunteers should leave. I don't need resources or transport. I can cycle and I have the knowledge.' Support from teachers and headteachers in the schools has been strong, although the VSO teachers in all participating schools were unsure how long the programme would continue once there were no more VSO volunteers at the schools.

VSO has placed volunteer teachers in these schools for some years, and teachers have come to know their presence as the norm. 'There will never be a situation when there will be no volunteers in this school,' said one teacher¹⁰. While this highlights the long-term nature of development in an overstretched education system, the teachers also stress the benefits: 'The partnership [with the volunteers] is very important. We share ideas. We are good at some things and they are good at other things. We complement each other and learn from each other.'

Most Zambians are Christians from a variety of denominations, and many struggle with the SHARPER discussions on condom use. A Provincial Education Officer recently sent a directive preventing condoms from being distributed to pupils. Mr Kawilila, headmaster at Soltech, commented, 'We do not encourage people to use condoms or to have sex outside of marriage. We have advised pupils that if they cannot restrain themselves, they can consult someone who may be able to provide them with a condom.' SHARPER facilitators are quick to point out the reality that many students are sexually active and have been for

Tom Butcher with some pupils



some years.

Even if abstinence may be a solution for now, these young people soon expect to leave school and marry. Many churches expect couples to take an HIV test before marriage, creating a huge challenge. Students and facilitators both predict an increase in the number of suicides as a result.

Volunteers agree that SHARPER does not prepare young people for decisions they may have to face outside school, issues around marriage, HIV testing, family planning and the reality of gender imbalances. However, the SHARPER programme does develop young people's understanding of HIV/AIDS to a level rarely achieved in mass awareness programmes. SHARPER graduates are passionate about the knowledge they have gained, they debate with confidence, and they want to share what they know with others, indicating that they have acquired much more than facts but also confidence and the motivation to act. This confidence in discussing HIV/AIDS may begin to break down the stigma surrounding HIV and AIDS in the community, and gives the students an informed position from which they can make important decisions.

Future directions

Identifying and adapting the *Stepping Stones* manual has been a catalyst to achieve greater awareness in and around these participating schools. In Malawi and Mozambique, VSO teachers have also begun to use SHARPER in some schools. The SHARPER manual is a simple but practical tool for VSO volunteers wishing to integrate HIV/AIDS into their workplace in the future. The challenge as with all resources is to use the manual only if it is appropriate in a particular setting.

9. *The Natural Farming Network, Zimbabwe - Rural livelihoods*

For comparison, a case study has been included which did not involve a VSO volunteer in the project, but which benefited from a small grant from VSO-RAISA.

Context

Jekesa Phumwa (JP) means 'open your mind'. It is the name of a national NGO with a membership of thousands of women in Zimbabwe and is one of 12 member organisations belonging to the Natural Farming Network (NFN). NFN seeks to strengthen and link its members in order to promote sustainable communities. At the beginning of 2001, NFN began to integrate HIV/AIDS into its work, believing that a nutritious organic diet is key to managing life with HIV and AIDS. Elsie Chabata, director of NFN, says, 'Mainstreaming HIV/AIDS into other areas of our work is important nowadays. If you are making any plans, you have to recognise that. A lot of the staff within our member organisations and staff at NFN have been affected. Many of the project officers that were hard-working and knowledgeable have died as a result of HIV/AIDS.'

With a RAISA small grant of ZIM\$76 000 (£1000), a group of women has been helped by NFN and JP to establish an organic vegetable and herb garden to assist people living with HIV/AIDS in their village. The garden is 55 kilometres outside Harare and the women grow vegetables and herbs to boost the immune system and treat opportunistic infections.

Methodologies and activities

NFN trains the farmers in organic farming methods and encourages the women to feed their families first and to sell the extra produce. Previously, women would grow vegetables to sell, leaving little for their own families. They spent the money they earned on supermarket foods, which in some cases was of a lower nutritional value than the foods they grew. Although NFN supports women gardeners, they have worked with both men and women in a series of workshops to promote a better understanding of the nutritional value of the foods they grow, as well as to increase HIV/AIDS and gender awareness. 'The moment you hold a gender workshop, it is easier to work with that community, because the men and women appreciate from which angle each are coming from,' remarked Elsie. At the start of the project, NFN and JP approached the local headman to discuss the advantages of an organic garden. He called the community together so that everyone could be involved, and NFN and JP were welcomed. Apart from a need for affordable nutritional food, the community identified a need to care for ill people in their own homes and a need for medicines.

Outcomes and impact

Most women involved in the garden cannot afford medicines, so they often hid their infections because they could not afford to treat them. The project gave them the confidence and the knowledge to use the herbs they grow, many of which have medicinal value. In fact, many women already had knowledge of the uses of these herbs but they had been too frightened to apply or share that knowledge. The use of herbs has long been associated with traditional healers, whom some people believe to be witches or to use herbs in negative ways. Showing knowledge of the use of herbs might link that person to witchcraft, leading some people to keep their knowledge secret. The women overcame this fear by recognising that the knowledge gave them the ability to help others.

Growing vegetables organically has changed the lives of these women. Before, unable to afford fertilisers and pesticides, the women were seldom able to harvest enough for their family's needs, let alone to sell. This led some women to seek other sources of income, with most facing prostitution as their only option. Using fermented nettles is just

one organic fertiliser about which the women have learned. Simple methods of organic farming can increase the yield of a crop and retain the crop's nutritional value, therefore making it more likely to boost the weakened immune system of someone infected with HIV.



Lucia Kaseke, organic farmer

The women feel empowered by their knowledge. Having the garden and knowing how to use the herbs has helped them talk about HIV/AIDS more easily. They feel they can go into someone's home and discuss a person's health because they have some solutions, something to offer. Before the programme, people with AIDS were often left to die, because people feared contracting HIV if they cared for someone with AIDS. Now, they know how to look after someone with HIV and which food is appropriate. The women also realise that they have to stay healthy, because they don't know their HIV status.

While the community knew about HIV/AIDS before the project began, talking about it was difficult because, in their words, 'they were shy'. Now, NFN holds workshops where women and men come

together and discuss openly. In each village, a number of people are chosen to be community home-based carers. They are responsible for visiting people with HIV/AIDS at home, distributing free condoms and talking about their use in their community.

NFN has helped these farmers as a pilot project and they hope that it will be an example to their members elsewhere of what can be achieved. Due to the uncertain economic climate in Zimbabwe, the RAISA grant did not stretch as far as they had initially budgeted: at the beginning of the project in early 2001, a nursery plant cost ZIM\$10 and by May 2001, the price had increased by 30 or 40 per cent.

NFN and the women feel that the programme has not been running for long enough to assess impact properly. More time is needed to determine how the garden is helping HIV+ people. Small but significant indications of impact mentioned by the women are:

- One woman said that when she recently visited a homestead where an AIDS patient complained of mouth sores, she recommended wormwood herb and after a few days, the sores had improved.
- The women explained that they had discovered the aphrodisiac properties of some of the herbs, which has enabled them to strengthen their relationships with their husbands.
- Another woman said her husband was so pleased with the improvement of her cooking since she started using basil that he gives her more money.

The women continue to share their stories and NFN hopes to attract more donor money to extend this programme by documenting their experiences.

Future directions

The most immediate problem the women face is a lack of a sustainable water supply for the garden. The borehole is not deep enough and the group is trying to find funds for a watering system using an existing hosepipe.

For the gardeners, they see HIV/AIDS as more manageable. Previously, they felt helpless and resigned to their fate, whereas now, they feel rejuvenated by their sense of empowerment. The challenge is to ensure that the whole community benefits from this project, not just a select few. The women have become protective of their garden and their knowledge, and it is important to curtail the sense of jealousy that has begun to build up in the village. One response has been to harness the jealousy as a healthy dose of competition, and the challenge has been made to other women's groups to see who will have the best garden.



Susan Mushango, a farmer with the NFN

experiences and challenges

4

lessons from the case studies

Introduction

The case studies in chapter 3 illustrate the variety of HIV/AIDS integration activities taking place and highlight some of the challenges faced in different settings. This chapter analyses the activities in the case studies and the methodologies used, and draws out some of the achievements, challenges and lessons that can be learned from this experience.

Integration activities

Awareness activities were a natural starting point in every HIV/AIDS integration project discussed in the case studies. In contexts where awareness of HIV/AIDS is very low, awareness-raising is a useful starting point. However, in order to tackle the AIDS pandemic, people must move beyond awareness. The case studies show that this action is most likely to be achieved when communities or other existing structures are involved in planning from the outset. The following examples illustrate some of the reasons why this approach is effective.

In the UDAC case study, farmers in Mozambique, who were part of a network of existing farmers' groups, were trained as *activistas* to disseminate HIV/AIDS information in their communities. *Activistas* address a wide range of other social issues so their role is already well-known in Mozambican society. The farmers who were trained were members of existing community-based groups. So the farmer HIV/AIDS *activistas* are respected and remain motivated.

One of the main challenges faced by awareness programmes is the need to take into account other development issues which affect HIV/AIDS. Promoting abstinence or condom use is not always appropriate due to gender inequalities and other cultural factors. Community involvement enables an appropriate response that is acceptable to local people. For example, the Natural Farming Network (NFN) in Zimbabwe included a gender workshop in its HIV/AIDS integration programme as a longer-term approach to arrest the spread of HIV. Empowering women can help fight HIV/AIDS by, for example, overcoming traditional gender inequalities which may hinder condom use. Including men in the workshop helped to overcome potential opposition, and paved the way for addressing the problems the whole community faced because of the pandemic.

By involving people, the facilitators can be clear about the needs of the group. For example, Jekesa Phumwa and NFN helped women in Zimbabwe to identify a practical solution that would help them to care for people living with HIV/AIDS in their community. Awareness about HIV/AIDS was raised in gender workshops for women and men. The practical response was the organic herb and vegetable garden, which benefits HIV+ people nutritionally and generates income for the women. Similarly, participants at the awareness workshop run by the Namibian Women's Network specifically identified a need to train counsellors in the community. The awareness activities in both these case studies empowered participants with knowledge which enabled them to identify their own needs and find appropriate responses.

The VSO volunteers had been catalysts by making it clear that they were interested in integrating HIV/AIDS, and were able to respond when the university realised the need and asked for their input.

At Fort Hare University in South Africa, several VSO lecturers had each begun to promote HIV/AIDS awareness at an individual level, but it was a request from the Vice-Chancellor that motivated them to help a university committee develop an institutional HIV/AIDS policy. As part of that process, a student awareness booklet was developed and HIV/AIDS began to become visible at events on campus. This case study highlights the importance of working within existing structures. The VSO volunteers had been catalysts by making it clear that they were interested in integrating HIV/AIDS, and were able to respond when the university realised the need and asked for their input.

In Acção Social in Mozambique, all staff underwent HIV/AIDS training to ensure that everyone felt involved, motivated and confident about the integration project. Awareness was the first step in an ongoing programme that went on to establish links with various NGOs to address HIV/AIDS according to agreed objectives.

The Namibian Women's Network began by inviting the local community to an awareness workshop at which participants identified a need for more practical training for people living at home with HIV in their community. What followed was specifically-tailored training programmes in home-based care and counselling.

In contrast, integration activities which focused solely on awareness saw motivation and participation levels decrease after initial training in the absence of practical follow-up. At the Kachere Rehabilitation Centre in Malawi, staff found it difficult to use the knowledge that they gained from their training in their work without an ongoing programme of support. Although the staff felt that HIV/AIDS was very much a part of their day-to-day work, they felt that as a team they had not yet identified how they could tackle HIV/AIDS practically in their work.

Lessons on integration activities

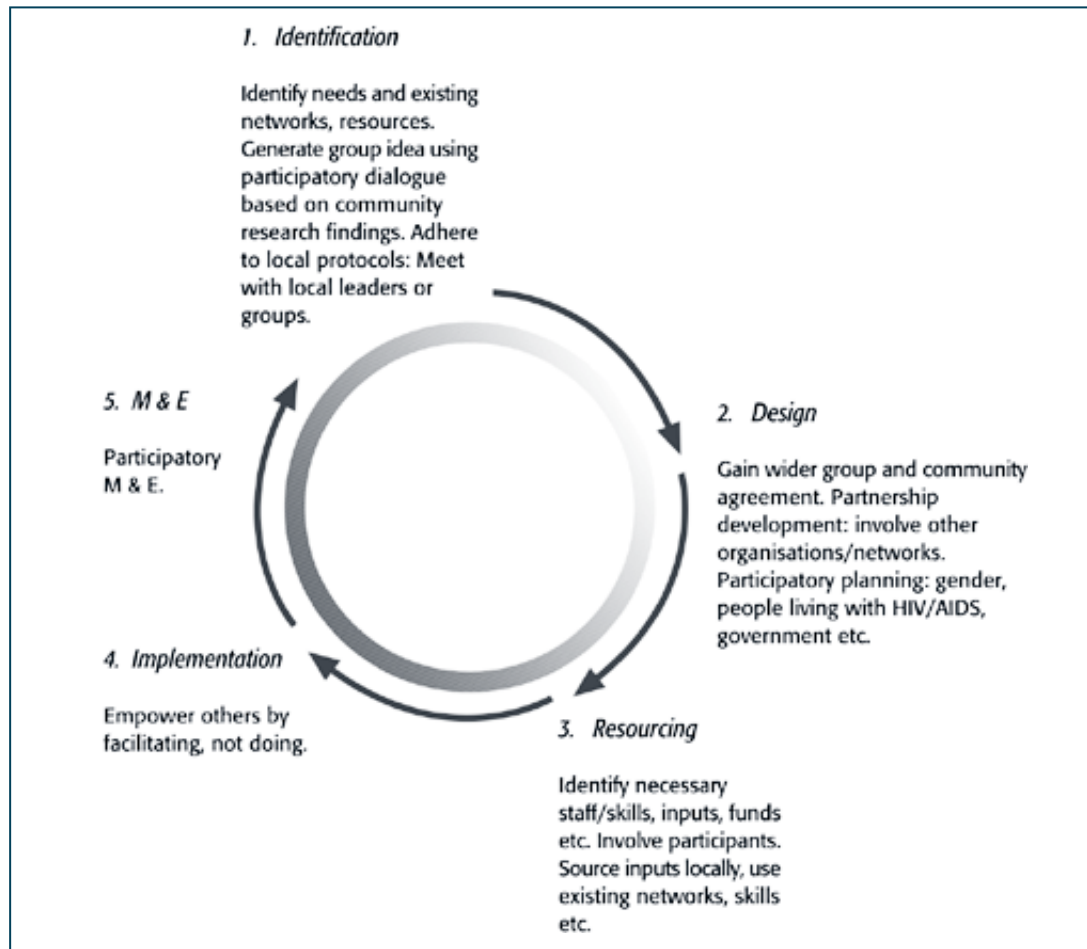
- Involving existing groups, structures or even a whole community in the planning phase is critical if awareness projects are to generate practical action on HIV/AIDS.
- Communities should be encouraged to identify an appropriate integration project in response to the ways HIV/AIDS affects them.
- In order to maintain interest and ensure the usefulness of integration, facilitators (VSO volunteers and others), their colleagues and project participants should plan beyond an awareness project.

Integration methodology

The methodology that VSO volunteers and their colleagues used to integrate HIV/AIDS has varied in every situation. In order to find patterns from which to learn, it is helpful to identify the motivation for the initial integration idea and trace the planning processes used to take it forward, including the role of the facilitator (in eight of the nine case studies, this was a VSO volunteer). It is also useful to examine how the idea responds to the needs of the community.

Valuable lessons can be drawn from looking at who participated at each stage of the project cycle, and noting the networks and support relationships established outside the project. Every stage of the process has an impact on the likelihood of the integration project achieving organisational and financial sustainability, and community ownership (see figure 1 on page 47).

Figure 1: Stages of a project cycle



Project motivation

The initial motivation to begin integrating HIV/AIDS has sometimes been the role of the VSO volunteers, but it has also originated from collaboration between VSO volunteers and their colleagues. In some instances, it came from the partner organisation or its participants. Wherever it came from, motivation is a key ingredient in the integration process and should be nurtured and harnessed.

Most VSO volunteers and their colleagues reported that they began thinking about how to integrate HIV/AIDS following VSO-RAISA training. During these mainstreaming workshops, VSO volunteers and their colleagues hear numerous experiences of integration and are asked to think about what they believe could be achieved in their workplace or local community. Volunteers and colleagues alike have cited these workshops to be the main stimulus for their mainstreaming project.

In the SHARPER case study in Zambia, it was the personal motivation of one VSO teacher to find an appropriate resource to use in her secondary-school classroom that began the integration process. At Acção Social in Mozambique, the VSO management adviser began by writing a draft HIV/AIDS plan, which attracted the interest of a colleague who had experience of working with HIV/AIDS, and the process took off. The team at the Namibian Women's Network began by asking their members to prioritise their development needs. HIV/AIDS was identified as something the women wanted to address in a practical way. Like the SHARPER case study, VSO lecturers at Fort Hare University in South Africa each took the individual initiative to incorporate HIV/AIDS within the context of their own work. In this case, however, their initiative sparked an institutional response from the university, resulting in the expansion of their work into an institutional HIV/AIDS policy.

Some of those motivated by a workshop or challenged by the HIV/AIDS objective in their job description commented that they began by feeling that they 'had to do it' in order to meet expectations, and only later realised how important their efforts had been. VSO volunteers with previous development experience stated that before arriving at their placement, they had already planned to identify a participatory way to address HIV/AIDS if this was appropriate. For these volunteers, previous experience and the need for addressing HIV/AIDS was motivation enough.

Colleagues of VSO volunteers have been motivated to integrate HIV/AIDS into their workplace for two main reasons: either they became interested in ideas presented by the VSO volunteer, or they had already identified HIV/AIDS to be an issue but had been struggling with how to address it and were looking for support. It appears that in many contexts, both colleagues and community participants may already realise that HIV/AIDS is an issue, but that facilitation is needed in order to spark a process of identifying needs and planning responses. VSO volunteers can play this role, but it is clear that in projects initiated by VSO volunteers without adequate and consistent participation from their colleagues, motivation was limited and/or dwindled over time.

For example, in SHARPER in Zambia, after the VSO teacher's initial work in identifying and adapting the *Stepping Stones* manual, a small group of Zambian teachers at the first school were trained as facilitators. These teachers now receive a small financial sum to maintain their motivation. When VSO teachers took the SHARPER model to a neighbouring school, only one teacher wanted to be involved and no female teachers were willing to support the project. It seems that the methodology of bringing in a programme from another school did not give teachers at this new school ownership and they did not feel motivated to become involved.

It is interesting to compare this with the Natural Farming Network case study from Zimbabwe, where no VSO volunteers worked, but which benefited from a small VSO-RAISA grant. The workshops on farming and nutrition (which met an identified need for information on food crops) also addressed HIV/AIDS and gender. This enabled participants to see a link between nutrition and problems related to HIV/AIDS which the community faced, such as home-based care for people who have HIV-related illnesses. This motivated the women farmers to take action in spreading HIV/AIDS messages and advising on home-based care. VSO's input was a small grant for plants and fencing for the garden. The women say this grant was a further motivation for them, but it is clear that their involvement in the workshops and in identifying their needs was the primary motivator.

Lessons on motivation:

- Involvement of partners, colleagues and communities develops a sense of ownership which makes sustainability more likely. Sound development principles such as participation should be implemented to encourage motivation. In VSO placements, this process should begin before the VSO volunteer arrives, in dialogue between VSO and the local partners.
- Colleagues and communities should be enabled by VSO volunteers or other facilitators to identify the integration project appropriate to their needs.

Project planning

Very few interviewees spoke about project planning. It is widespread to see planning as little more than a prerequisite for funding, in which case the plans may exist only on paper and bear little relation to what actually happens. When planning does happen, it is often only one person or occasionally a management team which conducts it, so there is little or no awareness, involvement or ownership of the planned activities by staff, facilitators and participants.

In the case of Acção Social in Mozambique, the planning stage generated interest and encouraged people to believe integration was important.

Yet proper planning has many benefits. Planning makes us challenge our ideas and assumptions, and should entail a consideration of how sustainability will be achieved. The planning phase is also an ideal and natural stage to bring potential partners into the discussion and gain their support and involvement. In the case of Acção Social in Mozambique, the planning stage generated interest and encouraged people to believe integration was important. The Natural Farming Network in Zimbabwe worked with the community to plan how to address HIV/AIDS. The community members attending a workshop run by the Namibian Women's Network planned a series of further specifically-designed workshops involving church groups and health professionals.

Project planning and participation should go hand in hand. Examples of good planning in the case studies have been participatory. A cross-section of opinions were represented, crucially including not only potential project participants but also people living with HIV/AIDS and professionals with relevant skills in the local community.

Lessons on project planning

- Project planning helps to ensure that sustainability is built into the project.
- Participation is an integral part of project planning, to encourage motivation, project ownership and therefore sustainability.

Project participation

Participation is an important development principle for project sustainability. When a community participates in planning, implementation, in financial management and reporting, it becomes empowered and has ownership of their project. Each context has different challenges, so it is important to find ways of encouraging widespread participation that are appropriate to the situation.

VSO volunteers sometimes found participation difficult to achieve, and many felt low motivation of colleagues to be the biggest barrier. This may be due to low salaries or poor working conditions. However, while some volunteers were surprised at the length of time it took to win the confidence of colleagues and participants, for others it happened almost effortlessly. Each context is different, and while it may be an attractive option to work with those who are motivated and eager to participate, it is important to ensure wider participation and to continue to work within local protocol. Where VSO volunteers have encouraged wide participatory dialogue from the point where an idea develops, they have found that the community or colleagues do respond, and identify their own problems and thus own them.

At UDAC in Mozambique, the *activistas* reported that the VSO volunteer spent a great deal of time and effort meeting representatives from NGOs and the district directorate of social action to learn about their work and to discuss how HIV/AIDS affects what they do. The *activistas* also all independently reported that the volunteer would leave them to do things alone because it was their project. This investment in widespread participation paid off because staff and the community now support the project at many different levels.

A delicate part of encouraging participation is to recognise the importance of local protocols. When the Natural Farming Network in Zimbabwe was asked to help a group of women to set up an organic garden, they first approached the local headman to discuss the idea. It was the headman who called the community together for the Natural Farming Network to make a presentation.

Gender participation should also be considered. In the SHARPER case study in Zambia, men and women are separated to encourage free and open discussion. This methodology is drawn from *Stepping Stones*, the original manual which was adapted to create SHARP and then SHARPER. *Stepping Stones* separates the men and women for part of each

Where VSO volunteers have encouraged wide participatory dialogue from the point where an idea develops, they have found that the community or colleagues do respond, and identify their own problems and thus own them.

session and brings them together at the end to discuss what they have learned in their single-sex groups. Female-only groups give women confidence to talk about their problems and to practise dialogue around culturally sensitive issues. In the male groups, men are encouraged to talk about their feelings, providing an opportunity to practise a new skill. Ensuring equal participation by women and men must be planned carefully and carried out with tact. At Fort Hare University in South Africa, sports development students were confident and comfortable in a mixed-sex discussion, but in other contexts, forcing a mixed group to discuss issues around sex may be inappropriate. Beginning a programme with a gender workshop, as the Natural Farming Network in Zimbabwe did, allows both men and women to understand each other better.

It is clear from the interviews that VSO volunteers have a natural desire to achieve unwritten goals during their time-bound placement. In addition, as part of its monitoring and evaluation process, VSO's placement documentation asks both volunteers and partners to record activities and outcomes. It is possible to see a potential tension between vital reporting requirements and a project's natural momentum, which, if pushed, may exclude some people.

This tension is faced by many development projects. There is nothing in the case studies that suggests that the interviewees experienced this tension, but it is worth noting that facilitators coming from outside the local community (such as VSO volunteers), may be unaware of the natural momentum, because the speed of life is likely to be different from that in their home countries. This applies to volunteers from the developed world as well as those coming from other developing countries. The timing of key events, for example in the agricultural cycle, may be overlooked. Finding out who could potentially participate can be a time-consuming exercise, and it can easily be forgotten in the excitement of getting to the implementation stage.

Participation needs to happen at all stages of a project. VSO volunteers commented that everyone was invited at the planning stage and after that, only a few remained involved. It is natural to expect that some people do not want to or may be unable to stay involved. However, it is also important to remember that the concept of participation may be new to many people, particularly to groups who are not accustomed to being asked for their opinions, for example, women may feel intimidated in the presence of men, or poor farmers may feel reluctant to speak openly to well-educated facilitators from the local town. This is why participation always needs encouragement. The seed of the initial idea should come from the potential participants and all planning stages (including accessing resources) should involve as many people as is possible and feasible.

Lessons on participation

- By using appropriate developmental approaches and participatory methods, facilitators and volunteers can ensure that the project progresses at its natural momentum.
- Participation is more important for effectiveness and sustainability than achieving set goals within a limited timeframe. Taking time to include participants and enabling them to determine the pace of a project is critical in nurturing a project that has a chance to be sustainable.
- Ensure participation of both women and men.

Community partnerships and volunteer facilitation

The case studies show that even in very rural or remote areas, there is a wide range of organisations including church organisations, small local NGOs, unions and community structures, all of which have the potential to be involved in integrating HIV/AIDS. Most of

these are already taking some form of action on HIV/AIDS and a good facilitator will tap into these community-level partnerships to support a programme within their own context.

Community partnerships were an integral part of some of the cases studies. For example, in Mozambique, the UDAC *activista*-farmers work hand-in-hand with the district directorate of social action. They provide training and the *activistas* refer people to community health workers. The Namibian Women's Network works with local youth groups and AIDS service organisations in the community. The voluntary counselling and testing facility at St Luke's Hospital in Malawi works closely with outreach teams from the hospital and with neighbouring health facilities.

Good facilitation is more likely to lead to a successful sustainable programme. Facilitation has, for many, come to mean working in groups or networks so that everyone can contribute in order to reach an objective. A facilitator guides and supports others through a process: s/he may do little more than bring people together and enable them to set their agenda. But facilitation can go well beyond the limits of a group situation. A good facilitator may introduce people working in the same field or connect two related organisations. The role may require little more than a few telephone calls or a visit to local government offices.

Facilitation and participation can enable VSO volunteers to approach integration in a more inclusive and sustainable way and help them avoid becoming the sole instigator and implementer of HIV/AIDS integration activities. Facilitators, including VSO volunteers, do need to be motivated and hard-working, but it is important to allow participants and projects to develop at their own speed. Only then can the community feel ownership and become empowered in the long run.

Lessons on partnerships and facilitation

- Facilitation links organisations and networks. It goes beyond a group situation and extends into every stage of HIV/AIDS integration.
- Facilitation may take longer, but it is more effective and empowering in the long term than working in isolation.

Project sustainability

Sustainability is the ultimate goal for development practitioners, but it is frequently omitted from both planning and reporting stages. When participants of HIV/AIDS integration projects were asked of their plans beyond the volunteer placement, there were mixed responses. At Acção Social, the HIV/AIDS co-ordinator recognised he would struggle initially, but retained his motivation and had extensive plans, while in the schools of the SHARPER case study in Zambia, many interviewees had never considered that there might come a time when there were no VSO teachers at their school.

The headmaster at Soltech is very supportive but although the Zambian teachers appeared enthusiastic about HIV/AIDS, most looked to the VSO teachers for direction and resources. HIV/AIDS is not a curriculum or examination subject, relying very much on the motivation of individual teachers. On a positive note, the students taught are benefiting from increased AIDS awareness and some are motivated to share this with their families and in their communities, via anti-AIDS clubs and touring drama presentations.

At UDAC in Mozambique, the situation is rather more positive. The VSO volunteer in the case study had left at the time of this research, and the *activistas* and UDAC had plans to extend the project into more rural areas. The challenge now is to find additional funds to continue planned activities.

It seems that in education contexts, sustainability may be more difficult to achieve. There is a natural turnover of learners and an increasingly high turnover of staff. A

significant portion of the loss of teachers, according to anecdotal evidence in each country, is related to HIV/AIDS. Teachers are also being poached into other professions offering higher pay and better conditions. However, the SHARPER case study also suggests that the ongoing nature of VSO's support, where successive VSO teachers have worked in some remote and disadvantaged rural schools, has created expectations of continuing future placements of VSO teachers, and HIV/AIDS integration activities have become associated with the VSO volunteers. This creates an additional challenge to sustainability of HIV/AIDS integration in education.

Clustering, where several VSO teachers are placed in schools close to each other, can also have an impact upon sustainability. Clustering enables the VSO teachers to support each other professionally (which is particularly valuable to support newly or recently qualified VSO teachers). However, if ownership of HIV/AIDS activities is already closely associated with VSO volunteers, clustering can encourage the volunteers to seek each other's support rather than involving national teachers.

In education, it may not be possible or appropriate to measure sustainability in the same way as in a community. A community tends to have an overlap between people moving into it and away, so that there is a core of continuity over time. In schools, by contrast, this continuity is increasingly lacking. There is high staff turnover due partly to HIV/AIDS and to teachers moving into other professions. In the absence of HIV/AIDS as an examination or curriculum subject, teaching about HIV/AIDS depends upon the individual teacher's motivation. Each year, pupils come, learn about HIV/AIDS in the classroom, and go. Some may be motivated to take action outside the classroom. But within a school, although integration is relatively easy to achieve through classroom teaching, increased awareness by pupils should perhaps be seen as an appropriate goal in itself. One opportunity which should always be explored is to look beyond the school to local groups, programmes or initiatives in the surrounding communities, where sustainable partnerships may evolve.

In the interviews, some volunteers focused less on the sustainability of a project than on individual accomplishments: their achievements, successes and the challenges they have overcome. There is less clarity about how their work fits into the development framework. Many volunteers see themselves primarily as professionals rather than as development workers, and they may not be familiar with developmental approaches. They expressed their struggle to move from their known professional environment into a development context. Though many volunteers do not have a development background they are asked to perform and report using developmental terms and principles. For a teacher from the UK, a pharmacist from the Netherlands or a lab technician from Kenya, this may seem inappropriate. Without training in these areas, volunteers will be less effective which can affect the sustainability of their integration activities.

This point was emphasised in interviews throughout the region and clearly has implications for the sustainability of volunteers' input. As a development agency, VSO recognises the impact of consistently-applied developmental approaches on sustainability of HIV/AIDS integration and the challenge for VSO-RAISA is to provide training which equips volunteers from all professional backgrounds with the skills to take on the role of facilitator using developmental approaches. Encouraging volunteers and partners to look for an existing support network may increase sustainability. Although the VSO-RAISA small grant is a useful resource to initiate HIV/AIDS integration, volunteers and partners alike should be encouraged to identify resources locally, whether in the form of staff, skills, information, existing programmes or other inputs.

All the case studies presented have sustainable elements that can act as a guide for future HIV/AIDS interventions. The SHARPER volunteers created materials that will undoubtedly remain valuable. The UDAC *activistas* in Mozambique are trained and the programme is supported by the community. The women involved in the organic farming project in Zimbabwe intend to expand the garden, which will help them, their families and

the wider community to better manage living with HIV/AIDS. At Acção Social in Mozambique, the programme has funding for the next three years and the plan is to establish a financially-sustainable testing facility in partnership with another organisation.

Lessons on sustainability

- Planning should include extensive participation for a project to have a chance of becoming organisationally sustainable.
- Sharing skills is the approach around which VSO turns. Sharing skills means between everyone involved, not a one-way exchange from volunteer to local people. Volunteers need training and support to find practical ways to do this in their placement.
- HIV/AIDS should be addressed as a development issue.
- It is important that volunteers understand the importance of developmental approaches and can see their role in the development process. This includes the need to look at local partnerships and resources.
- Motivation + planning + participation + partnership + facilitation = sustainability

Training and support

VSO-RAISA has been designed to work within the existing programme framework of VSO. HIV/AIDS training opportunities for volunteers and their colleagues are available at various stages during a volunteer's placement: some training and self-briefing information is available before their departure to their country of placement, with more extensive and country-specific training and workshops in-country.

Before departure to their country of placement, volunteers have had limited experience of HIV/AIDS, but most volunteers felt that additional HIV/AIDS-specific training before departure is not needed. Country-specific information is what they want. The RAISA self-briefing pack, also given to volunteers before departure, received mixed feedback, more due to the timing than to its quality of content. Most volunteers agreed that when they are preparing to leave, their time is limited and the self-briefing pack falls to the bottom of the 'to do' list.

Volunteers' opinions of RAISA in-country training varied across the region. For many, the in-country workshops on integration acted as the impetus to begin identifying integration possibilities within their own workplace. For others, the training brought on a bout of HIV/AIDS fatigue. The VSO-RAISA video 'Global Challenge, Local Response', which is used during in-country training for newly-arrived volunteers, generally received positive feedback. It meets volunteers' need for practical ideas, but some felt it was too awareness-focused, encouraging repetition of similar projects rather than networking with existing services, facilities and organisations. In addition, most examples in the video are of volunteers delivering training, as opposed to facilitating a partnership with local trainers.

Most volunteers would like to see more interactive sessions and practical resources. Generally speaking, volunteers did not feel they gained a grasp of the range of HIV/AIDS interventions in existence and what their role in these kinds of interventions might be. It appears that a delicate balance of information and practice is needed and the timing of the training is critical.¹¹

HIV/AIDS training organised by VSO-RAISA has included partners as much as possible to achieve greater participation. Inviting colleagues to attend the workshops with the volunteers enables networking and establishes personal contact with other volunteers, organisations, agencies and government officials. In addition, training directed at partners has a greater sustainable impact and takes the pressure off volunteers to act as HIV/AIDS 'experts'.

¹¹See www.vso.org.uk/raisa for on-line resources developed for VSO volunteers and partners.

Finally, volunteers are finding the emotional challenges presented by HIV/AIDS a heavy burden. Volunteers sometimes experience loss and suffering of friends and colleagues. Some volunteers feel they want to provide emotional support to friends or colleagues who have lost relatives. In order to support volunteers, VSO must recognise these difficult situations and find appropriate solutions.

Lessons on training and support

- Volunteers and facilitators need practical information and examples of the impact HIV/AIDS has on development, and practical information about existing HIV/AIDS responses in their region.
- Training sessions should include developmental approaches such as planning, facilitation and participation as practical tools in HIV/AIDS integration. There should be less emphasis on statistics of the global pandemic and the medical aspects of HIV/AIDS and more on what can realistically be achieved working with local individuals or communities.
- Training sessions should encourage greater networking, particularly with partner organisations where an HIV/AIDS volunteer is based. HIV/AIDS volunteers should facilitate a process where their colleagues, as experts, develop relationships with VSO partners in sectors not directly related to HIV/AIDS.
- Volunteers and partners may experience huge emotional strain linked to HIV/AIDS and should therefore be supported and prepared to manage this.
- Volunteers should set realistic personal objectives and understand the importance of their role in a development context.
- VSO pre-departure training should have practical sessions on developmental approaches as a core component. Volunteers should be clear about their role in learning and using development methodology.

Financial resources

Access to financial resources has proven to be fundamental in the start-up and continuance of most HIV/AIDS integration projects. Eight of the nine case studies used money from VSO-RAISA's small grant fund. Project participants felt that even small sums made a project more formal, gave it credibility and created excitement, which in turn was motivational. Setting broad criteria for the fund has encouraged creativity in the type of activities submitted for support, but it has not pushed projects far enough in considering important issues such as participation, partnerships, sustainability and planning sufficiently and it has not focussed the process to take into account programme issues around geographical and time constraints.

The amount of money available per project is £1000, which has proved ample for some projects and insufficient for others. In an attempt to encourage project ownership, the small grant is only given to projects making their own contribution in addition to the amount requested. In most cases, recipients have contributed in kind with time and labour. While these contributions should not go unrecognised, projects would have benefited from attempting to source additional funding themselves. This is intrinsically linked to project sustainability and deserves stricter attention: the UDAC case study shows that a sole focus upon the VSO-RAISA fund can hinder an organisation's initiative to look elsewhere. Some volunteers have expressed caution about being associated with access to funds. However, a grant application does not depend upon having a VSO volunteer precisely to overcome this problem (see the case study of the Natural Farming Network). This has raised the profile of VSO-RAISA. The small grant fund has enabled organisations or groups who do not need or perhaps are too small to afford a VSO volunteer to increase

their impact.

Lessons on financial resources

- The small grant fund is an important catalyst for HIV/AIDS integration projects and has raised the profile and impact of VSO's work. Relatively small sums of money, available at the right time to an appropriate project, can have a meaningful impact.
- The small grant fund criteria need to be adapted to suit the VSO country programme objectives and effectively communicated to applicants.
- Small grant fund monitoring methods should include both volunteers and partners. This process would ask volunteers and partners to visit other VSO-supported integration projects so they can be inspired to adapt successful methodologies and learn from the challenges. This would create an information-sharing opportunity and encourage good practice as outcomes can be shared.
- Greater emphasis should be placed on the organisational and financial sustainability plans of projects to be funded. This will reduce re-applications.
- Small grant applications should focus on the role of all project partners and participants, as well as that of the volunteer. This will encourage partners and volunteers to recognise VSO and the role the volunteer plays as that of a facilitator.

Non-financial resources

Each VSO programme office helps volunteers and partners identify sources of information, supplies or donor support. This has happened with varying degrees of success across the region. In Namibia, a 'tour box' system is being developed: a box of resources which each programme officer takes on tour will be used to help meet the resource needs of volunteers and partners. Similarly in Zambia, the programme office has established an active resource centre, managed by a full-time staff member who is responsible for information management and dissemination.

Programme offices have understood the function of resource management differently in each country. In some cases, volunteers and their colleagues have come to depend on the programme office for supplies of condoms or leaflets. Integration projects in rural areas naturally find it more challenging to source local supplies but this should be encouraged where possible in order to reduce the dependence on VSO.

The SHARPER case study was specifically chosen to highlight how existing resources can be adapted and shared within a sector. Existing HIV/AIDS resources may be difficult to find or inappropriate. In Mozambique, for example, volunteers struggle to find good HIV/AIDS resources in Portuguese. Organisations such as UNAIDS and PSI are focusing their efforts into this area so the situation is improving. Volunteers and partners should continue to share their experiences of resources locally, nationally and regionally. It is vital to share examples or initiatives, learning and good practice - no project is too small to be recorded and shared.

Lessons on non-financial resources:

- Adapting existing resources can be highly effective for integration because appropriate resources are not always easy to find.
- Greater regional sharing of information is to be encouraged but local and national sharing should be a priority. VSO should make available a list of AIDS service organisations to volunteers and partners. Placements should be

encouraged to arrange relevant national exchanges within financial parameters.

- All volunteers should be invited to contribute a case study of their HIV/AIDS integration project to be posted on the web and distributed via the programme newsletter or by email using RAISA-NET. This should include references to appropriate resources.

The South-South volunteer experience

Two case studies show the experience of VSO volunteers recruited from countries in the developing world: a Kenyan volunteer at the Namibian Women's Network and a Zambian volunteer at a rural hospital in Malawi. It might be assumed that their experience of life in a developing country may offer them advantages in working in other developing countries, but the Namibian Women's Network case study indicates that in fact, previous experience of developmental methodologies may be a bigger advantage.

Like most volunteers, both experienced a culture shock and are making attempts to gain acceptance in their host community by learning the local language(s) and demonstrating their professional skills. Both volunteers have integrated HIV/AIDS into their work, using their skills and experience. And both felt that coming from a developing country gave people confidence in them and that they could speak as someone who understood some of the problems people face.

At St Luke's hospital in Malawi, a VCT facility was established as an integration project but co-operation from colleagues has not always been forthcoming. It is feared that the project will cease to continue without the presence of the volunteer. The volunteer initiated the VCT programme and it was he who had the principal skills the project required. As a laboratory technician, he was able to transfer his skills to his colleagues but the volunteer may have overlooked key developmental stages because his colleagues have not developed complete ownership of the project. Although partnerships have been established and there is co-operation from the hospital, to some extent, the VCT programme is considered a volunteer initiative.

At the Namibian Women's Network however, the volunteer and her colleagues are convinced that the NWN will continue to offer HIV/AIDS programmes to their members. This sustainability may be due to the volunteer's career-long experience of working in the development sector. She applied community mobilisation principles and methodologies at every stage in the process. She believes that her colleagues have developed sufficient confidence, skills and contacts to maintain the integration projects.

Lessons from the South-South volunteer experience

- Regardless of where a volunteer comes from, it is the application of simple development methodologies that determines the sustainability of a project and thus the impact of a volunteer's role.
- Volunteers are outsiders no matter where they come from, and they have to overcome challenges related to this.

Regional dimension

The AIDS pandemic affects the six countries in southern Africa where VSO works in many similar ways. Regional learning could be stronger, and there is great potential to take advantage of this opportunity. There is, however, consensus among VSO programme staff that each of the country programmes needs to be strengthened before they can look beyond their borders to share at a regional level.

Staff, volunteers and colleagues feel they have identified both strengths and weaknesses of RAISA and are ready to learn from their neighbours. The email discussion

The regional use of resources has proved to be the thread that is beginning to sew the countries in this programme together. The Stepping Stones adaptation SHARPER was developed in Zambia and is now reportedly being used in Malawi and Mozambique.

group RAISA-NET¹² was intended to facilitate more communication and information-sharing, but it has not had the support it had hoped for. In a recent review¹³, 70% of respondents found RAISA-NET to be useful, although only 23% of subscribers responded. RAISA-NET is a means and not an end and local situations can hinder the use of the tool. In some parts of the region, email contact is not regular and where it exists, it can be expensive and difficult to access, which may explain these response statistics.

The regional use of resources has proved to be the thread that is beginning to sew the countries in this programme together. The *Stepping Stones* adaptation SHARPER was developed in Zambia and is now reportedly being used in Malawi and Mozambique. The Namibian video *Emma's Story* is also being used extensively throughout the region.

VSO staff, volunteers and partners suggested there would be value in inter-regional exchanges of experience. As an alternative, one or two individuals could traverse the region sharing their own and other project experiences in a practical workshop format.

Lessons on regional dimension

- Staff, volunteers and partners would like to explore regional integration beyond the web or email, perhaps circulating country newsletters in which a monthly HIV/AIDS case study is included.
- The sharing of resources regionally has been taking place and this should be further encouraged.

The impact of integration

What difference have these efforts made? What has been the impact? How can this impact be measured? After an awareness programme, how do participants change?

Impact assessment is often used rigidly to mean measuring an end result. For example, in the case of an awareness programme, conducting an impact assessment might lead to a search for evidence of knowledge acquisition and behaviour change in participants immediately after the programme. Impact assessment however should also include more subtle marks of change.

In many of the awareness programmes in the case studies, HIV/AIDS debates have been encouraged, which has achieved greater confidence levels among participants. This greater confidence may give participants the courage to challenge difficult situations relating to HIV/AIDS that may arise in the future. Most project participants described situations where they had used the knowledge gained to help others.

Interviewees spoke of pressure to quantify impact, which in many cases, has proved difficult. Partly, this is because during the planning stages, HIV/AIDS placement objectives were not specific enough. At the reporting stage, therefore it proves difficult to demonstrate progress against the initial objectives. However, at the same time, objectives which are too tightly defined can force a project along a pre-determined route which may not reflect local needs. This is one of the challenges of true participation: if a project is to be truly responsive, it becomes more difficult to set specific, measurable objectives at the outset. Interviewees also felt that partners and volunteers were not benefitting from potential lessons since the current VSO reporting system, which is under review, is more focused upon reporting upwards, and less upon recording lessons for the placement.

The important information to be gleaned and that is most difficult to measure is how far participants have internalised information and whether this has led to behaviour change. Interviewees cited a need to find a way of capturing and sharing project participants' experiences as anecdotal evidence. In the case of the Natural Farming

¹³Report available at www.vso.org.uk/raisa

Network, it is easy to point to concrete achievements, such as the harvest of organically-grown vegetables from the garden, but it is less easy to show the impact of their use. The farmers themselves anecdotally claim almost miracle results from administering herbs to patients with symptoms of AIDS-related infections. Subtler still is the degree of empowerment of the women involved.

Change has taken place in each and every project researched. The extent of the change in each of those examples is best assessed within its own context. At Kachere Rehabilitation Centre in Malawi, the training workshop may not have achieved dramatic change, but staff report that they have absorbed the information and they now feel free to discuss HIV/AIDS amongst colleagues. Although the momentum decreased after the departure of the volunteer and the impact seems limited, the lessons are important.

In the SHARPER case study in Zambia, graduates of the awareness programme at Kasempa Boys' School formed a drama group to take HIV/AIDS messages to the wider community. The potential impact of their project has therefore extended beyond that of its original participants, which is a significant achievement in a school context.

Volunteers, colleagues and anyone working in HIV/AIDS should be encouraged to share their experiences so others can learn and find motivation from them. Sharing this information need not be a set document. Project participants, including volunteers, may prefer to speak at an in-country training session, write an article, take photos or record an interview. Recounting experiences of HIV/AIDS can convey emotions that deserve to be heard in an appropriate format which allows that expression. Because many newly-arrived volunteers have had little exposure to HIV/AIDS before their placement, these stories are critical sensitising tools.

Lessons on impact assessment:

- There is immense value in sharing experiences, however small or informal. Critically, the experiences of project participants other than the volunteer should be recorded in order to gather evidence of change.
- Longer-term partnerships will allow VSO staff to assess whether follow-up activities are taking place and gather further evidence of this. It will also enable VSO to assess whether further support is required.
- Realistic, organisation-specific HIV/AIDS objectives should be encouraged so volunteers and partners feel more comfortable reporting on the differences that have taken place.
- Volunteers and partners should be encouraged to document their use of development principles in their methodology to support assessments of expected sustainability.

Table 2: Ten practical action points towards HIV/AIDS integration

1. **Map the situation:** Take time to build a picture of how different people perceive HIV/AIDS, how it affects them and what local services exist. Include as many people as possible in planning, facilitate appropriate gender inclusion and adhere to local protocol.
2. **Develop community facilitation skills:** Ask for help in and outside the workplace and support existing or dormant programmes rather than start new ones. At every stage of a project, including preparing grant applications, participants will become empowered if they are supported by a facilitator rather than led by a doer. This process will not only share skills among everyone but also create project ownership.
3. **Encourage a natural momentum:** Aim to work in partnership with existing bodies such as youth groups or church groups and understand the importance of a project's natural momentum. Have realistic expectations of a placement and plan for project growth beyond a placement.
4. **Get people on board:** Make it a challenge to include those who do not immediately show interest in HIV/AIDS integration. Often, the participation of a key person or someone who showed initial resistance can make all the difference.
5. **Support greater involvement:** Go out into the community with a colleague and meet local NGOs, CBOs, faith-based organisations or donors. Find out what they are doing and discuss ways of working together. Is there a local resource that your project could use?
6. **Have realistic expectations:** Recognise that different groups need different solutions. Have realistic expectations of change. For example, the constraints facing women may be different from those facing men.
7. **Stand back:** Don't do too much. Have patience. Your role could be little more than to bring people together or help a group to plan. Avoid presenting yourself as an HIV/AIDS expert. Work with people living with HIV and AIDS locally, with NGOs or medics.
8. **Use experience as a springboard:** Facilitate a session to capture opinions about the strengths and weaknesses of other HIV/AIDS responses. Invite volunteers and their colleagues from neighbouring placements to visit, or find out if you can visit them.
9. **Recognise your contributions:** Document your experiences in a way others can learn from and encourage colleagues to do the same. However informal, value it as a lesson and record it for others.
10. **Take stock:** If you feel like you are pushing against the flow, perhaps it is time to change direction!



Young girl looking curiously into a classroom

Denial of the personal risk posed by HIV/AIDS is widespread. The stigmatisation and isolation of people living with HIV/AIDS prevents effective care and reinforces the widespread denial of the pandemic. These factors combine to prevent a rapid reduction in HIV transmission rates.

Although awareness levels are now thought to be high in the region, in some areas, there is a high level of 'fatigue' with the topic of HIV/AIDS, which may grow out of the perceived hopelessness of the situation. It is feared that this fatigue with hearing about HIV/AIDS may lead to apathy, where people and communities will not be motivated to take action against the pandemic.

It has become clear that awareness alone does not lead to behaviour change. New responses to the pandemic, such as mainstreaming, now focus on providing practical tools, appropriate knowledge and support to all those affected by HIV/AIDS.

VSO-RAISA has mainstreamed HIV/AIDS by integrating it into the workplaces and community structures of everyday life and supporting locally-designed, practical responses to the pandemic. The practical mainstreaming responses undertaken to date have taken participants beyond denial and awareness. Mainstreaming appears to have encouraged changes at a personal level, both in attitude and behaviour, as well as addressing some of the pressing needs of people living with HIV/AIDS. There are grounds for optimism that mainstreaming may be the first step towards more effective tackling of the AIDS pandemic.

Practical 'beyond awareness' interventions discussed in the case studies:

- A voluntary counselling and testing facility
- Counselling training for medical staff to inform patients of their HIV status
- An organic herb and vegetable garden with herb use workshop
- Home-based care programme in partnership with a hospital
- HIV/AIDS policy development and programme planning
- Peer educator drama programme in schools
- Integrating HIV/AIDS into teaching and learning materials
- Gender workshops in the community
- Adapting an HIV/AIDS resource for use in a secondary school
- Training and support of community HIV/AIDS trainers and peer educators
- Resource sharing with other integration projects

The nine case studies in this Publication have provided a brief overview of the activities and processes being undertaken by VSO volunteers, their colleagues and community members to address HIV/AIDS in their context. In each case, the VSO volunteer has helped people in their workplace or local environment to identify an appropriate way of addressing the way HIV/AIDS affects them and their families. No two activities are the same, yet there are a number of recurring methodologies and challenges.

Appropriate responses

In all of the integration projects, the successes and the challenges stem back to the methodologies used in the response. Simple developmental principles applied

Simple developmental principles applied consistently have led to greater motivation and sustainability. Motivational problems and fears that the project will not continue beyond a volunteer placement, point to gaps in the application of proper planning, facilitation, participation and the development of community partnerships.

consistently have led to greater motivation and sustainability. Motivational problems and fears that the project will not continue beyond a volunteer placement, point to gaps in the application of proper planning, facilitation, participation and the development of community partnerships.

The most appropriate role for a VSO volunteer in integrating HIV/AIDS is that of a facilitator. In this way, the volunteer will empower others and will not be in danger of either feeling like or being thought of as an HIV/AIDS expert. Greater involvement of partners and greater networking with HIV/AIDS specialists, including people living with HIV/AIDS, will take emphasis away from volunteer involvement and improve the sustainability of a project. The research showed a large proportion of volunteers in the region struggled in these areas because they had no previous experience of employing these approaches when sharing their professional skills. For this critical aspect of an HIV/AIDS integration project to take place, facilitation training should be made available to volunteers. VSO-RAISA recognises this challenge.

In responding to HIV/AIDS as a multi-sectoral challenge, great efforts should be made to recognise that a volunteer's professional skills remain valued. Though the term mainstreaming is applied to the process, individual integration projects are not expected to dominate the time of a volunteer. Not all volunteers will be comfortable using developmental methodologies and so it is not realistic for VSO-RAISA to expect HIV/AIDS integration within all placements in southern Africa.

Mother with child



Communication

Improved documentation and better sharing of personal experiences of HIV/AIDS is essential to share the good practice emerging. Without personal accounts to bring it to reality, the pandemic remains a series of remote statistics. Volunteers and partners should be encouraged to record their experiences of HIV/AIDS and the processes they used in their response to it. Sharing these experiences with other volunteers can act as an important sensitisation process. As part of a documentation process, volunteers and partners should be encouraged to comment on more subtle signs of behaviour change, such as the building of confidence levels, community networking with AIDS service organisations, greater gender awareness or improved communication skills.

Interviewees felt that VSO's current placement reporting style is too rigid and does not allow for emotional expression, informal experiences or sufficient inclusion of colleagues opinions. As the research for this publication showed, written reports are not always the most appropriate medium.

Training

Training and support must recognise the importance of volunteers' understanding of development methodologies. Many of these methodologies come with practise or experience and training alone will not for instance make a good community facilitator. Training has been key in the integration of HIV/AIDS into projects for VSO. Mainstreaming workshops in particular have been critical in motivating volunteers and their colleagues. This feature of VSO-RAISA training should be extended to include practical tools to integrate responses by volunteers and their colleagues. Building capacity to respond to HIV/AIDS will stimulate motivation and assist volunteers and partners to find creative ideas for integration projects.

VSO staff noticed a difference in volunteers' attitude to integration between those who had and had not received training. Volunteers and staff alike have in some cases developed AIDS fatigue, particularly when it comes to training. HIV/AIDS training requires better planning in terms of both content and timing.

HIV/AIDS training can sometimes put too much emphasis on global or national statistics and the medical aspects of the virus. Volunteers are calling for more practical information and skills to help them and their colleagues address HIV/AIDS. In each country volunteers valued an opportunity at in-country training to hear the personal experiences of a person with HIV or AIDS. Greater involvement of volunteers and their colleagues already integrating HIV/AIDS responses should be encouraged. In the same way, volunteers directly involved in HIV/AIDS should encourage their colleagues to network with partners in other sectors to increase awareness of progress being made nationally and the potential support available.

Training sessions should pay specific attention to project planning, participation, facilitation and community partnerships. When volunteers and partners feel comfortable using these principles at every stage of a project cycle, the project has a good chance of being sustainable. By using these principles, the project will respond to HIV/AIDS in a way that addresses participants' needs. With participatory planning, projects will more likely be designed to look beyond the awareness stage to practical activities incorporated into and owned by local communities.

Certain sectors may require specific training on HIV/AIDS. Volunteers in the education sector for instance, where the turnover of learners and teachers is high, may need practical tools to look beyond the classroom at community involvement. This will extend a project outside of the classroom, which may help it to be more sustainable. Peer educators could develop tools among students to record and pass on information from year to year.

Training should not be confined to workshops or conferences. By way of finding practical training opportunities, volunteers and partners could help to monitor recipients

of small grants. This aspect of the small grant fund management is time-consuming for VSO country programme staff. In being asked to look for examples of facilitation or participation, volunteer and partners will be exposed to successes and challenges. This process will increase the learning potential within a project and helps partners to network.

Project resources

Integrating HIV/AIDS extends as a principle into the VSO programme office. Programme staff should see their role in HIV/AIDS resource management as that of facilitators. VSO should avoid, where possible, becoming a supplier of condoms or information to placements but instead assist to identify local resource people. In providing this support, a relationship can be developed with a representative from the partner organisation as opposed to a volunteer as a more sustainable approach.

The small grant fund has proved to be a catalyst for HIV/AIDS integration. It has become a motivational factor to volunteers and communities and raised the profile of the work of VSO.

The small grant fund has proved to be a catalyst for HIV/AIDS integration. It has become a motivational factor to volunteers and communities and raised the profile of the work of VSO. Tighter management, monitoring and greater communication would improve the value of the facility to both VSO-RAISA and applicants. In the grant application form, particular attention should be paid to methodologies applied in the project and future financial and organisational sustainability plans to reduce a project's dependency.

As the SHARPER case study shows, the adaptation of existing resources is one way to address the limited availability of appropriate resources. In addition, sharing resources in this way has brought the region closer together during the last two years and this is to be further encouraged - but not at the expense of looking closer to home first.

Mainstreaming projects have achieved wider access to HIV/AIDS information and brought about personal change for many individuals. The past two years have been a steep learning curve for staff, volunteers and partners and their lessons will stimulate others to integrate HIV/AIDS. The key lesson drawn from the mainstreaming experiences to date is that HIV/AIDS is a development issue and therefore must be addressed as such. The capacity of facilitators and volunteers to do that depends on the strength of the context and the consistency of development methodologies s/he applies. VSO volunteers must not only have professional skills but also the development skills needed to facilitate HIV/AIDS integration. The importance of the use of these development principles must also therefore be reflected in the placement description. The placement objective should be specific about methodologies required in order to integrate HIV/AIDS as opposed to activities to undertake.

Appendix 1: Methodology and Interviewee Information

This publication is based upon a major piece of research at the micro-level in six countries between October and December 2001. In order to learn from the mainstreaming responses underway in the region, interviews were conducted with a range of project participants at a selection of VSO partner organisations (see graphs on page 65).

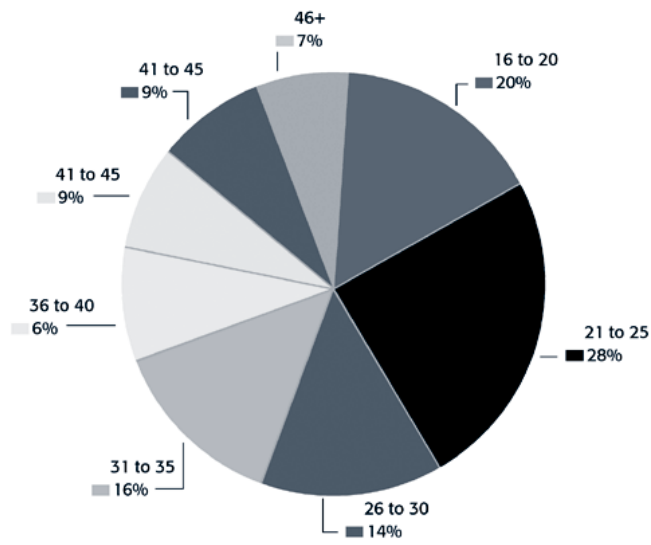
Of these partners, nine have been chosen as case studies for this publication to represent the countries, sectors and organisational structures where HIV/AIDS has been integrated. They either received support from a VSO volunteer or have received a small grant from VSO.

This publication presents the first-hand views of VSO volunteers, their colleagues and project participants. It is neither an academic piece of research nor is it a methodologically rigorous survey with randomised samples. Instead, it gives a voice to people at community level who are working in and are affected by the projects, a point of view which is so often missing from more academic research. Interviews were conducted either in small groups or on a one-to-one basis. VSO programme staff, in conjunction with VSO volunteers and partners, arranged the research tour programmes in each country. Where appropriate, individuals of both sexes and from different age groups and organisational functions were interviewed at each project.

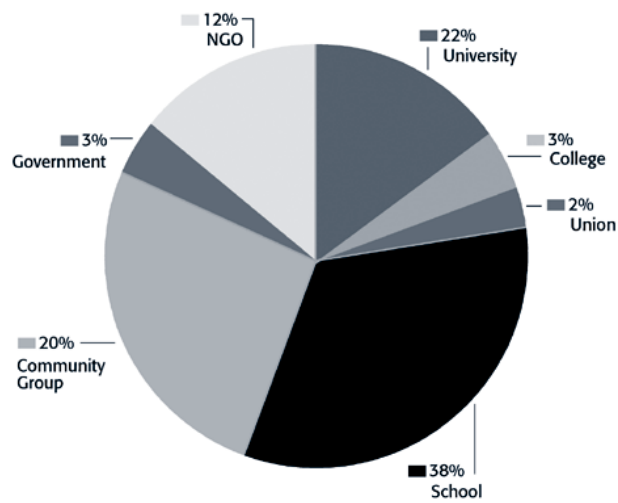
Interviews usually lasted approximately 90 minutes and captured personal experiences of the pandemic, their response to it and future plans. All interviews were recorded and transcribed and in Mozambique, most interviews were conducted in Portuguese and translated into English.

Interviewees' responses have been quoted verbatim. Comments by interviewees represent their own opinions and may not represent the views of VSO-RAISA. This publication only presents information gathered from the interviews and for this reason, it may not present a representative overall picture of the pandemic and society's response to it.

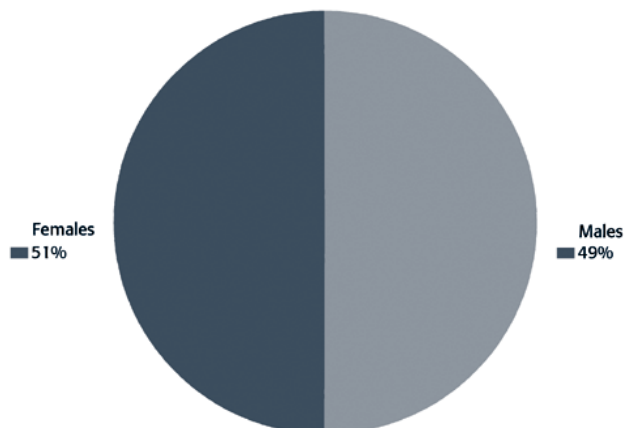
Age Group



Location of Projects



Gender



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