CONSIDERING HIV/AIDS IN DEVELOPMENT ASSISTANCE

A TOOLKIT

CONTENTS:

This toolkit has been prepared to assist staff of the Commission of the European Communities, particularly those in DGVIII (both those in the Headquarters and Delegations), and Consultants, in considering the implications of the HIV epidemic in the provision of development assistance.

The toolkit contains the following documents:

- ***An Introduction to HIV/AIDS.*** *This explains what HIV/AIDS is and why it should be considered as a unique disease.*

- ***Assessing the National Importance of the HIV/AIDS Epidemic.*** *This sheet sets out a mechanism for assessing if HIV/AIDS is, and should be, considered as an issue in a country. Attached to this may be a* ***country profile.*** *This will be included* ***only*** *for those countries for which the profile has been completed. Where there are country profiles, they will include details of the situation in a country, and some analysis of the epidemic and its likely trends and importance.*

- ***A Sectoral Checklist.*** *Much of the support of the European Union is given to sectors. This section contains a checklist for looking at the potential impact of HIV/AIDS on a sector and of the sector on the spread of the epidemic. Specific analyses have been completed for three sectors, namely: infrastructure, education, and rural development.*

- ***Guidelines for Including HIV/AIDS in Project Cycle Management.*** *The method of Project Cycle Management is used for the management of projects. There are a number of points of entry for considering the HIV/AIDS epidemic and these are set out here.*

- ***Including HIV/AIDS in Consultants' Terms of Reference.*** *The workload of EC staff means that extensive use has to be made of consultants. This last document in the pack is available to be given to consultants to ensure that they consider the issue of HIV/AIDS.*

It should be noted that this toolkit is intended for use like any toolkit: ***only the appropriate tools need be used at the appropriate time.*** *Not all the documents will be applicable to all situations or all staff.*

Documents

1. An Introduction to HIV/AIDS
2. Assessing the National Importance
3. A Sectoral Checklist

3a. Transport
3b. Education
3c. Rural Development

4. Guidelines for Project Cycle Management
5. Including HIV / AIDS in Consultants' Terms of Reference

Acknowledgements

This toolkit was produced for the Commission of the European Communities under Contract B7.5046/94/06: Study of the Impact of HIV Epidemic on the Social and Economic Development of Developing Countries.

The toolkit has benefited from the suggestions and comments of numerous people working in the European Commission, and we should like to express our gratitude for their input.

DOCUMENT 1: AN INTRODUCTION TO HIV/AIDS

AIDS (Acquired Immune Deficiency Syndrome) is caused by the Human Immunodeficiency Virus (HIV). In order for the virus to attack a person's immune system, it has to enter the bloodstream and there are three ways in which this may occur:

1. Through sexual intercourse - this includes both heterosexual and homosexual intercourse, although most infections in the developing world are transmitted heterosexually.

2. Directly into the bloodstream through use of contaminated blood or blood products, or sharing of intravenous drug-injecting equipment.

3. From mother to child - it is estimated that about one third of infants born to infected mothers will be infected. This may occur prior to birth across the placenta, during birth, or via breast milk.

The possible responses to the epidemic are well documented. Risk of sexual transmission can be reduced by use of condoms and/or cutting down on numbers of partners and treating other sexually transmitted infections. Blood and blood products can be made safer through screening of donors and their blood. Drug users can be encouraged to sterilise or exchange needles. Work on developing means of reducing mother to child infection is underway.

One of the crucial points that has to be made about the HIV/AIDS epidemic is that it is different from most other epidemics and diseases, and consequently requires a different and much broader response - one which must encompass far more than the health sector. The factors that make it unique are:

- It is a new epidemic. AIDS was first recognised as a specific condition only in 1981 and it was not until 1984 that the cause (and a test to detect it) was identified.
- It has a long incubation period. Persons who are infected by the virus may have many years of productive normal lif
- e, although they can infect others during this period. It is not certain how long this latent period is; estimates range from five to fifteen years, with the shorter period being found in the developing world, where people are less healthy and well nourished. It is known that good health and nutrition, and early treatment of opportunistic infections, will extend the period of healthy and productive life. Unfortunately infected children will, for the most part, die before their fifth birthdays.
- The prognosis for people infected with HIV is bleak. At the end of the incubation period, a person will usually experience periods of sickness increasing in severity, duration and frequency, until he/she dies.
- The disease is found mainly in two specific age groups: children under five, and adults aged between 20-40 years. For various reasons there seem, in the developing world, to be slightly more females than males infected, and women develop the disease at a younger age.
- The scale of the epidemic is also different from most other diseases. As Table 1 shows, in some settings, up to 30 per cent of ante-natal clinic attendees are infected. This means that between 20-25 per cent of sexually active adults may be infected.
- HIV is mainly sexually transmitted, which means it is passed on through one of the most fundamental human activities, but one with which we are neither open nor comfortable.
- There are links between HIV and other diseases, most notably tuberculosis, which has further implications for public health.
- In general, the epidemic is still spreading in the developing world, although there are signs that the level of infection may have peaked in some areas.

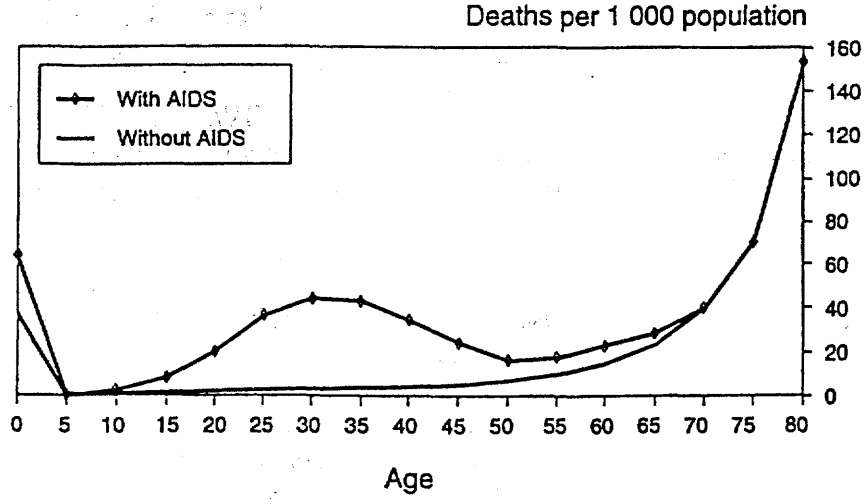
Table 1. HIV Prevalence, Selected Sites and Countries, Ante-natal Clinic Attenders (% HIV+)

	1991	*1992*	*1993*	*1994*	*1995*
Gwanda, Zimbabwe [1]	16	21	NA	25	NA
Nsambya, Uganda [2]	27.8	29.5	26.6	21.8	NA
Francistown, Botswana [3]	NA	23.7	34.2	29.7	39.6
KwaZulu-Natal, South Africa [4]	2.9	4.8	9.6	14.35	18.23

Sources:
1. Gwanda Hospital, ZIANet AIDS News, Vol. 2, No. 1 March 1994.
2. Nsambya, HIV/AIDS Surveillance Report, Ministry of Health, Kampala, March 1995.
3. AIDS Analysis Africa (Southern African Edition) 6(3), Oct/Nov. 1995.
4. AIDS Analysis Africa (Southern African Edition) 6(3). Oct/Nov. 1995.

The result of infection is an increase in morbidity (sickness) and mortality (death). There are few data on increased morbidity but the effect on mortality has been predicted (see Figure 1).

Figure 1. Impact of HIV on age-specific mortality rates of 20% adult prevalence

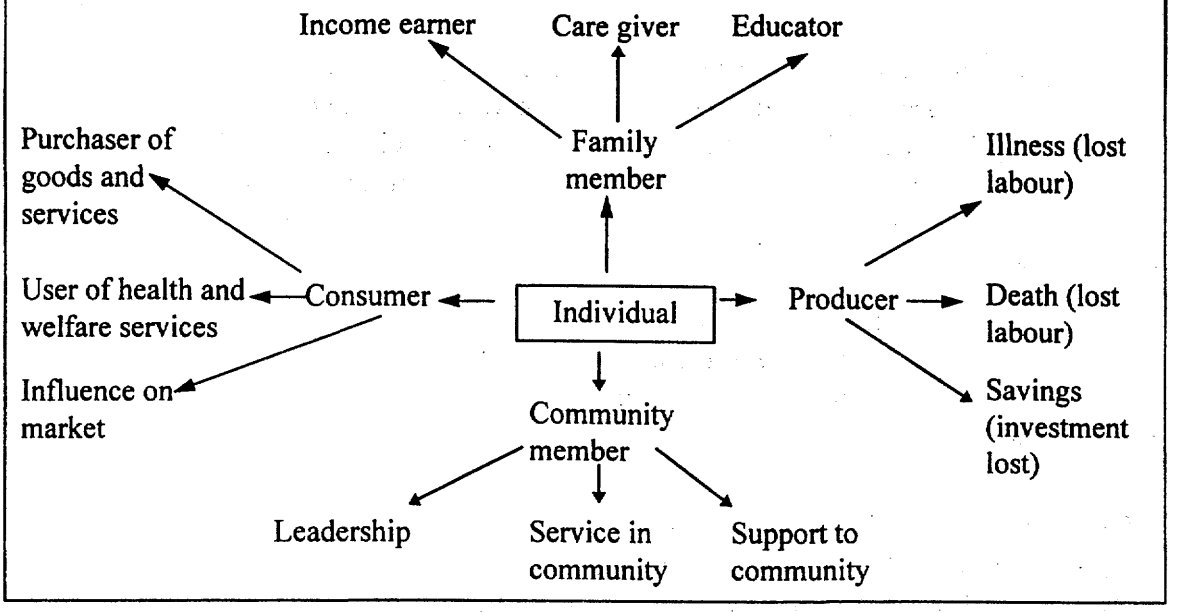


Source: Peter O Way and Karen A Stanecki, "The Impact of HIV/AIDS on World Population" US Bureau of the Census, Washington,DC, 1994.

Attempts to predict and plan for the impact of the epidemic have foundered, firstly on the fact that nowhere has it run its course, thus we do not have examples of what might happen. Secondly, there is a paucity of good primary fieldwork and data; and thirdly, like the epidemic, the response is dynamic, thus people evolve coping mechanisms and strategies. Nonetheless, some results have been observed and predictions can be made.

The effect of an infection is felt first and most immediately by the person who falls ill and their family. It then spreads like a ripple out through the household, community, and then through the country as a whole. This interaction is illustrated in Figure 2. It should be remembered that while an individual may not be a producer, he or she will always be a consumer and have social roles. Broad areas of concern for development assistance, where we expect the epidemic to have an impact, are demographic, economic and developmental.

Figure 2. The Individual as an Economic Actor



Demographic Consequences

AIDS will not stop population growth, nor cause populations to fall, thus any idea that "AIDS is the solution to the population problem" is unfounded. What it will do, in some regions, is to slow the rate of population growth and alter the structure of the population. Of particular concern is the increased mortality in the 20-40 year age group. This has the effect of reducing the working age population and increasing the dependency ratio. Most women will complete their child-bearing before falling ill so the number of orphans will rise.

Economic Effect

AIDS will have an effect on economies at various levels. The most obvious is at the household level. A household with a infected member will find that expenditure increases as the person requires medical care, a special diet and so on. If the infected person is an adult then their labour will be lost, which may affect income if the person was in paid employment or producing goods for sale, and will reduce household welfare.

At the sectoral and firm level the impact AIDS has will depend very much on how the sector or firm uses labour, what level of labour is employed, how the workers are treated in terms of benefits, and the importance of experience. In some instances the epidemic may have a significant effect on efficiency and cost, while in others the effect will be minimal.

The macro-economic impact is also uncertain. It is believed that AIDS will affect national economic growth through diversion of savings to care and consumption (thus reducing investment), and through the illness and death of productive members of the society.

There have been attempts to model the economic impact for specific countries. These models show that HIV will probably reduce the rate of economic growth; and, over a period of 20 years, this may be significant (up to 25 per cent lower than it would otherwise have been).

The Effect on Development

It is increasingly argued that development is about more than economic growth and increases in GDP per capita. It is on the development indicators that the impact of the epidemic will be felt first and worst.

Particularly vulnerable are the indicators of life expectancy; infant mortality rates; child mortality rates and the crude death rate. Infant mortality rates may nearly double in Zambia and Zimbabwe and increase by 50 per cent in Kenya and Uganda. Child mortality rates will increase even more, as many children survive beyond their first birthday. Life expectancy is predicted to fall by an estimated 9 years in Zaire to more than 25 years in the worst affected countries by the year 2010 (Way and Stanecki, 1994).

The effect of AIDS will be to reverse hard-won development gains and to make people and nations worse off. It is possible that these effects may last for decades. The people who fall ill and die are the parents and leaders in society, which means that a generation of children may grow up without the care and role models they would normally have.

Conclusion

It is clear that HIV/AIDS presents a major challenge to developing countries. The question remains as to what can be done about it. The obvious response is to reduce the number of infections. This includes 'technical solutions', such as making the blood supply safe, treating STIs, and providing condoms, but these interventions will not be successful if they are imposed without an understanding of the social and economic factors that determine both behaviour and the response to the epidemic.

The sad reality is that in many countries a significant number of people are already infected. While prevention must remain a priority: - there are those who are as yet uninfected and other who are becoming sexually active - there is a need to plan for the impact of the epidemic. The number of people falling ill and requiring care will increase. The rise in mortality and its consequences will have to be accommodated.

Thus while the first response is prevention, the second is to plan for and mitigate the impact of the epidemic. This is hard to do because: in most settings the impact is not visible; it is incremental rather than catastrophic; AIDS is only one of a number of problems facing policy makers; and there have been only a limited number of ideas as to what can be done.

References:

Lieve Fransen and Alan Whiteside, (eds.), **HIV/AIDS and Development Assistance**, Workshop Proceedings, Brussels, 13 June 1996.

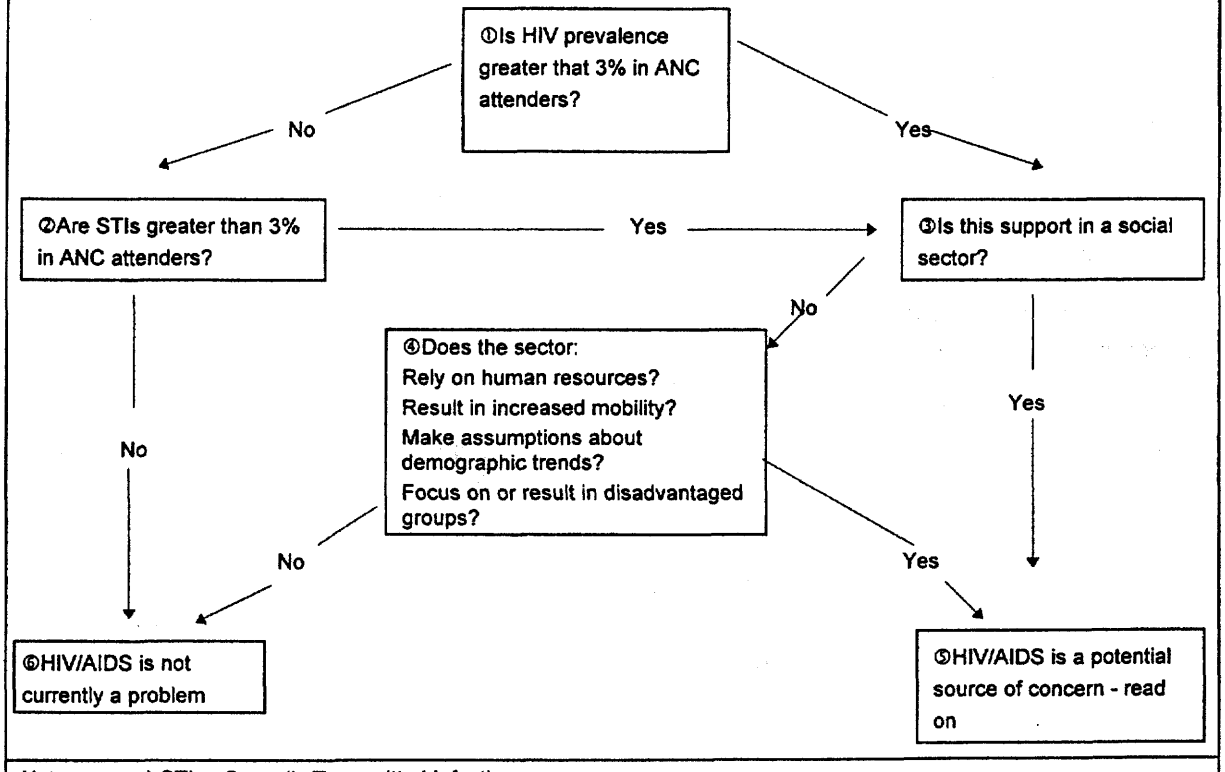
Peter O Way and Karen A Stanecki, **The Impact of HIV/AIDS on World Population**, US Bureau of the Census, Washington DC, 1994.

World Bank, **AIDS Prevention and Mitigation in Sub-Saharan Africa, An Updated World Bank Strategy,** Report No. 15569-AFR, Human Resources and Poverty Division, Technical Department, Africa Region, Washington DC, April 20, 1996.

DOCUMENT 2: ASSESSING THE NATIONAL IMPORTANCE OF THE HIV/AIDS EPIDEMIC

One of the problems with the epidemic is that most countries are experiencing an HIV rather than an AIDS epidemic, and this is not visible. The result is that people are either not aware of the potential impact of the AIDS epidemic or do not have the data to assess it. This document presents a flow chart for deciding if HIV/AIDS is a national issue. Where they have been prepared, it should be used in conjunction with country profiles. The country profiles (which have been, or are being prepared for a number of countries) set out what the position is in a country with regard to HIV/AIDS, as well as key factors of susceptibility and vulnerability.

Figure 1. Flow Chart for Asssessing if HIV/AIDS is Currently a National Problem



Notes: a) STIs - Sexually Transmitted Infections.
b) ANC - Ante-natal clinics.
c) For numbered notes see the text.

Using the flow chart:

These notes refer to the numbers in the boxes.

1. We start with available data, which in most countries are the results of surveys carried out by sampling ante-natal clinic attenders. If the level of infection is above three percent then this means that an HIV epidemic of some magnitude is likely and we need to consider HIV further.

2. If the level is below 3% in ante-natal clinic attenders, we need to look at other indicators. The prevalence of other sexually transmitted infections is a good measure, as HIV is transmitted in the same way as other STIs and there is evidence to show that these infections

increase the risk of HIV transmission. If this prevalence is above 3% then there is a risk that an HIV epidemic will be experienced.

3. If HIV/AIDS is deemed to be an actual or potential problem the next step is to look at its potential impact on the development support. The first question to ask here is: is this support in a social sector? If support is in this sector then, given that HIV increases the levels of illness and death, thus increasing and changing demand for social services, the issue of HIV is one that must be considered through the use of the other tools in this toolkit.

4. If the support is not in the social sector we turn to look at what the support actually does. Here there are a number of possibilities.

- If the sector relies on human resources (for example an agricultural project may be dependent on a supply of qualified agronomists and agricultural engineers) then HIV/AIDS needs to be considered.
- Does the support result in increased mobility (for example a road construction project might rely on a contractor taking teams of men from camp to camp)? If so we need to consider the implication of this for the epidemic.
- Does the project make assumptions about demographic trends? If a project makes assumptions about what the size and structure of the population will be then the impact of the epidemic on this must be considered.
- Does the support focus on, or result in, disadvantaged groups? Examples here might be a project that provides support for refugees- risk of HIV infection is greatly increased for such groups.

5. If, when completing the flow chart, you arrive at this box it means that HIV/AIDS should be considered in the provision of development assistance and the other tools should be applied.

6. If you arrive that this box it means that HIV/AIDS is currently not a problem and does not need further consideration. However two points should be noted.

- The flow chart looks at the national situation. There may be regional variations and these will be important for certain types of development assistance such as rural development support. For example, in Thailand the ANC prevalence is below 3 per cent yet parts of the country have a serious HIV epidemic. Obviously if data are available on a disaggregated basis the flow chart can be applied at that level.

- The chart applies to the situation at present, and this can change. There may some virtue in reviewing the position every two years. There is a trade-off between simplicity and sensitivity.

Where a country profile is available this will be appended here.

DOCUMENT 3: A SECTORAL CHECKLIST

What is a Sector?

The term sector means different things to different people. The basic economic definition of a sector is a 'homogenous group of productive economic activities'. The most common set of sectors is found in national accounts data. Economists define sectors in terms of their output. This definition of sectors is very broad, as an examination of the transport sector shows. Transport can be divided into the following sub-sectors: maritime transport (which includes shipping and ports); railways; roads; airlines. Each of these sub-sectors could be further divided between passengers and goods, and long and short haul.

The term 'sector' is used by people other than economists. The European Commission produced 24 "Fiche de Programmation Sectorielle" (sectoral notes) in 1994 and 1995 as part of the run-up to Lomé IV (bis). These included agriculture, livestock, fisheries, private sector, tourism, infrastructure and transport, research, education, public health, family planning, problems of drugs, potable water, rural development, urban development, tropical forestry sector, environment, women and development, population, regional integration, institutional reform, poverty alleviation, and social development.

As much support is given on a sectoral basis, it is both appropriate and necessary to look at the impact AIDS might have by sector. This checklist is designed to establish points of susceptibility and vulnerability to HIV and AIDS, and point to some of the actions that may be taken to reduce this. Susceptibility may be defined as the likelihood of people being infected, while vulnerability is the likelihood of the sector being more or less affected by the epidemic. For example migrant workers in the agricultural sector may be susceptible to infection, but if they are easily replaceable and have few benefits then the sector will not be vulnerable.

Addressing HIV and Sectors: a Checklist

If HIV/AIDS is deemed to be a problem in the country, the next step is to look at its effect on specific sectors. There are two points where sectors are considered. The first is in the drawing up of the Sectoral Fiches, when the main areas of concern and how they are to be addressed are established. The second point is in the National Indicative Programme (the document signed by government and the EC, which identifies focal areas in which support will be given. Typically infrastructure (especially transport), rural development and human resources development receive the bulk of the funds. Objectives are identified, along with actions and measures to be taken by government, and what EC support will be available. At both stages there is a need to consider the HIV/AIDS issues and two questions are raised:

1) Can sectors or sub-sectors be identified as being susceptible/vulnerable to HIV/AIDS?

2) Can a sector activity or intervention be put in place?

The idea of the checklist is that it should be completed as a diagnostic tool, using the notes provided. The spaces will not be completed with a simple 'yes' or 'no', but rather with a few words of explanation where necessary.

Figure 1. Assessing Sector Susceptibility/Vulnerability			
Name of sector or sub-sector			
A. LABOUR		***Type***	
A 1.	Availability	Skilled	Unskilled
(i)	Is there sufficient labour?		
(ii)	Are new recruits available?		
(iii)	Are there seasonal constraints?		
(iv)	Does the work require experience?		
(v)	Is there sick leave provision (how much)?		
(vi)	Is there compassionate leave (how much)?		
A 2.	Employee Benefits		
(i)	Are medical services or medical aid provided?		
(ii)	Is insurance provided?		
(iii)	Are death benefits provided for employees?		
(iv)	Other benefits (e.g. housing, transport)		
(v)	Is a pension provided for dependants?		
A 3.	Use of Labour (mobility)		
(i)	Does work demand travel overnight?		
(ii)	Are migrant workers employed? What % of work force?		
(iii)	Are most employees male or are they female? How are they housed?		
B. POPULATION AND WEALTH			
B1	Demographic Trends		
(i)	Is the population growth rate significant?		
(ii)	Is the population structure important?		
(iii)	Is the household size and composition important?		
B2	Income and Expenditure		
(i)	Will changes in government budgets affect the sector?		
(ii)	Will changes in taxation affect the sector?		
(iii)	Are changes in household income and expenditure significant?		
C. SECTOR SPECIFIC QUESTIONS			
(i)	Will AIDS affect demand?		
(ii)	Will AIDS affect supply?		
(iii)	Other issues		

Notes for Completing the Checklist

This checklist is designed to identify areas in which HIV/AIDS may impact on a sector or project. As it is completed areas of concern will be identified. How they are addressed falls outside the scope of the checklist. These notes assist in completing the checklist.

Section A - Labour

There are three key issues: will there be enough labour of the right type and at the right time?; what effect will increased morbidity and mortality have on the cost of employee benefits?; and how is the labour used? Skilled and unskilled labour should be assessed separately.

A1 - Labour Availability

(i) Is there sufficient labour available?

(ii) Are new recruits available? Labour may be available initially, but can it be replaced?

(iii) Are there seasonal constraints? Are there peaks in the supply of and demand for labour.

(iv) Does the work require experience? Some jobs do not require training but are learnt through experience - this type of employee will be difficult to replace.

(v) Is there sick leave provision (how much)? Although sick leave is a benefit, it will have an impact on labour availability. It is expected that employees will take all available sick leave as they fall ill - this can affect labour availability, especially if benefits are generous.

(vi) Is there any compassionate leave? Increased mortality will increase demand for compassionate leave.

A2 - Employee Benefits

(i) Are medical services or medical aid provided? The effect of AIDS will be to increase the demand for medical care whether supplied or paid for by the sector/company/project.

(ii) Are death benefits provided? If employees or their dependants receive death benefits such as ex gratia payments or coffins, increased demand will increase costs.

(iii) Is insurance provided? AIDS means claims will increase and either premiums rise or benefits decrease.

(iv) Is a pension provided for dependants? Pensions for contributors obviously cease at their death, but some schemes provide for spouses and dependents. These will continue to pay out. In the event of AIDS death, it is likely that children will be left and the contributor will not have paid enough in contributions to cover the benefits that will be paid out.

(v) Other benefits, e.g., housing and transport? Are there other benefits which might be affected by increased morbidity and mortality?

A3 - Use of Labour

(i) Does work demand travel? Workers who travel as part of their work (e.g., military, transport sector), are more likely to indulge in risky behaviour.

(ii) Are migrant workers employed? Migrants are more likely to undertake risky behaviour - as they are separated from their families.

(iii) Are male or female employees predominant? In some settings where the employees are mainly male or female, there may be more risky behaviour.

Section B - Population and Wealth

AIDS has the potential to affect both the size and the structure of a population, and the way both households and governments earn and spend money. This section sets out possible trends and asks if they are important for a sector.

B1 - Demographic Trends

(i) Is the population growth rate significant? AIDS has the potential to reduce the rate of population growth. If the sector assumes a certain level of population growth (for example

planning new schools makes certain assumptions as to the size of the school age population), then the impact of AIDS must be considered.

(ii) Is the population structure important? AIDS will have a marked impact on the structure of a population as certain cohorts will be more seriously affected than others.

(iii) Is the household size and composition important? As people in their twenties and thirties die, they will leave children who need care. This may change both the size of households and their composition.

B2 - Income and Expenditure

(i) Will changes in government budgets affect this sector? AIDS will increase demand for expenditure on health and social services and decrease resources available for other sectors.

(ii) Will changes in taxation affect this sector? It is possible that taxes may have to rise to pay for increased health and welfare while tax revenues are reduced.

(iii) Are changes in household income and expenditure significant? As households lose income-earners and/or take in orphans, both income and expenditure patterns may change.

C - Sector Specific Questions

The last part of the checklist will provide for questions that are specific to a sector. Here, the checklist would look at issues such as the inputs and outputs of a specific sector. Each sector will have its own set of questions. Three specific sector checklists have been prepared, namely education, rural development and infrastructure and are included.

DOCUMENT 3 (A) HIV/AIDS AND THE TRANSPORT SECTOR

HIV/AIDS is a new problem that the transport sector must address as better infrastructure and providing services increase the mobility of passengers and operators. There is strong evidence to show that increased mobility is linked to the spread of HIV. In addition workers involved in the construction and maintenance of infrastructure may comprise a mobile and at risk population. These issues are of particular importance to the European Commission, as its investments in the transport sector are a significant part of its development co-operation. Therefore the transport sector has to find ways to reduce the spread of HIV/AIDS when carrying out construction, maintenance, and the operation of passenger and freight services.

European Commission support to transport

Co-operation in transport is particularly aimed at fostering the movement of goods, services and people at the national, regional and international level, through "development of road transport railways, port installations and shipping, transport by domestic waterways, and air transport"[1] Transport supports development strategies by facilitating economic production and trade; helping increase production in the agricultural sector; investing in people through education; employment creation; and improving access to health. European Union investment via the European Development Fund accounted for 20 % of donor support to transport networks in the 1980s and was approximately 25 % of programmable development aid for the first half (1990-1995) of the Lomé IV Convention. Support to the roads sector dominates, and not surprisingly Sub-Saharan Africa is the largest recipient.

EC Transport Sectoral Guidelines Recognise HIV/AIDS

"While new and improved infrastructure brings economic and social benefits, it can also facilitate the spread of disease. Opening up new traffic routes and improving access and personal mobility can contribute to the rapid spread of communicable disease such as AIDS. Extra health measures must be given by health agencies and contractors during the construction stage when there might be many temporary migrants in a community. When works are complete, health agencies must cope with the greater number of travellers who can both bring and carry away infections".

Towards sustainable transport infrastructure: a sectoral approach in practice. Director-General for Development European Commission, July 1996

People at risk

There are four main areas of concern: people employed in building and maintaining infrastructure; those who work in the railways, roads, airlines and shipping services; professionals engaged in the management of the sector; and the passengers. These specific groups must be appropriately targeted if the spread of HIV and the impact of AIDS is to be reduced.

Building and maintaining transport infrastructure. These activities may involve groups of workers who are housed away from their families, often for long periods of time. For example a construction company might send a team into a remote part of the country to built a new road or carry out maintenance. The workers are usually men, housed in an all male environment, and being away from their families increases the likelihood of their having more sexual partners.

[1] Lomé IV Convention, Part Two The Areas of ACP-EC Cooperation, Title IX Development of services, Chapter 4 Transport, communications and informatics.

Furthermore their comparative wealth enables them to purchase sexual partners. Studies have shown that in Malawi road construction has been linked to the spread of HIV[2], while in Lesotho the Highland Water Project has led to an increase in sexually transmitted diseases in the remote mountain areas.[3] Thus, the extra sexual activity associated with the circumstances in which the workers find themselves increases the chance of exposure to HIV, not only for the workers but also for the communities in the areas in which they are working.

Reducing the exposure to HIV during road building and maintenance programmes (for both workers and communities) must involve several agencies and organisations. Governments and private sector firms using a mobile labour force should, through training, increase awareness of HIV/AIDS and improve the sexual health of their workers. Where on-site health services are provided they can be used for HIV/AIDS education; distribution of condoms and treatment of sexually transmitted diseases (STIs). Condoms should be provided and early treatment of STIs encouraged, even if there is no company health facility.

Employment conditions for workers should provide for movement of families where practicable, and where this is not possible, frequent leave should be encouraged. Furthermore, government should encourage the employment of local labour and require building and maintenance contract documents to cover these issues. Most countries have HIV/AIDS control programmes and people involved in the construction and maintenance of the transport infrastructure should link with the programmes in order to obtain their support.

Operating transport services. Improving transport services means more people; drivers, train crews, airline crews, and sailors spend longer away from home and their families. These people will be faced with the same likelihood of increased sexual activity as those in construction. The consequences may be regional and even international as many transport operatives cross borders. In Southern Africa transport drivers travel from the South African port of Durban to the mines of Southern Zaire, spending weeks on the road, and often having to spend days waiting to go through border formalities. Road service operators are particularly at risk. A survey of 168 bus and truck drivers in Cameroon in 1993 found that they spent, on average, 14 days away from home on each trip. Some 62% had sex during the trip and 25% had sex every night they were away. In Tanzania on the Dar-es-Salaam highway HIV prevalence was 28% for truckers and 56% for their female partners in 1991.[4] As people in the sector form a small and relatively easily reachable group the problem can be addressed. Designing awareness campaigns for the sector has been done with some success by Amref in Tanzania, where both truckers and the women serving them at truck stops have been targeted.

Companies gain by protecting their employees, as they will avoid the costs of illness and the need for eventual replacement and costly training. Companies do not need to develop their own education packages, they can draw on government or non-governmental organisations. Companies need the will to introduce programmes, including making condoms continuously and easily available.

There are other actions that might be developed in relation to working practices and conditions. For example some trucking companies in South Africa have established rest stops. The benefits are: security, and meal and rest facilities for drivers who are also less likely to have risky sexual intercourse. Although the stops were established primarily for improved security, the benefits in HIV prevention have been considerable. Government needs to be supportive of transport sector

---

[2] J M Ponninghaus & S M Oxborrow, The Lancet, 1990, 336 (Nov. 10), 1198.

[3] Dale McMurchy, HIV and The Lesotho Highlands Water Project, Summary of the Epidemiological Report on Phase 1B of the Lesotho Highland Water Project (LHWP), AIDS Analysis Africa 7.4.

[4] Data for Cameroon from AIDS Analysis Africa, Vol. 4 (5), September/October 1994, for Tanzania from AIDS Analysis Africa, Vol. 5 (2), March/April 1995.

initiatives, but actions they might also take for example, border crossing formalities, could be speeded up to reduce drivers waiting time.

Management. Transport managers, in both the government and the private sector, are drawn from a small group of educated and professional people in developing countries. They are in scarce supply, expensive to train, and take time to replace. Evidence suggests that in Africa the levels of HIV among managers and professionals are as high or higher than in the general population. Therefore management needs to identify key personnel and put in place contingency plans for increased illness and death. Moreover, continuous HIV education and training programmes are vital for this group.

Travellers. Improved transport infrastructure increases mobility generally. Mobility is associated with a greater opportunity for sexual encounters - people away from home and familiar surroundings are subject to a range of social, psychological and economic pressures. However, increasing mobility is usually a national development goal: it leads to economic growth, increases access to services, and improves quality of life.

Today vast numbers of people travel in search of work all over the world, but unlike previous generations they will return home every year, or possibly more frequently. Leisure travel is one of the most rapidly growing economic activities in the world, and again may play a role in speeding the transmission of HIV. Providing HIV education for their clients is not the responsibility of the transport sector, however it has two important roles: firstly the National AIDS Control Programme should be made aware of potential increases in movement in order that the mobile populations can be targeted; secondly the transport sector should cooperate with AIDS prevention initiatives. For example, minibus drivers might play anti-AIDS messages in their vehicles and migrant workers might be reached with special messages at departure points, and airlines might put information leaflets in seat pockets.

How to Use this Guide

For those working in the transport sector the following steps may be taken to address HIV transmission.

Step 1. Establish if it is appropriate to consider the issue of HIV/AIDS in the country. Use **"Document 2: Assessing the National Importance of the HIV/AIDS epidemic"** in this Toolkit.

Step 2. In order to establish the broad scope of the problem, apply the checklist in **"Document 3: A Sectoral Checklist"**, - Figure 1 Assessing Sector Susceptibility/Vulnerability.

Step 3. Specifically consider the issues as laid out in the Figure 1 below.

Step 4. Using the information gained from this sector study, use **"Document 4: Guidelines for Including HIV/AIDS in Project Cycle Management"** to ensure that HIV/AIDS is included in this process.

Step 5. If consultants are used by the transport sector ensure they are given **"Document 5: Including HIV/AIDS in Consultants' Terms of Reference".**

Figure1 . A Response for the Transport Sector			
Activity	**Possible Problem**	**Potential Remedy**	**Wider Action**
Building/maintenance			
Mobility of Workers.	Increase in sexual partners due to separation from family and relative wealth of labour force.	Increase use of local labour. Contract documents. i) require contractor to provide health education measures. ii) distribute condoms. iii) treat STIs. iv) include in tender documents.	Liaise with Ministry of Health and AIDS Control programme.
	Increased illness and death among workers.	Plan human resources and benefits to take account of this.	Company and government liaise on human resource requirements.
Transport Services			
Mobility of service operators.	Highly mobile group with likely increased exposure to STIs and HIV/AIDS.	Targeted health education, AIDS prevention and condoms.. Reduce time spent away from home. Provide controlled rest areas. Reduce time at border posts.	AIDS Control programmes, NGOs and operators. Operators. Operators. Governments.
Management			
Planning and running transport.	Professional and skilled cadres also experience HIV-related mortality and morbidity hard to replace. Govt. benefits allow long periods of sick leave.	Identify key personnel , human resource plans to take account of increased morbidity and mortality.	Government. Operators.
Passengers			
Increase mobility of the population for trade, employment and leisure.	People who travel away from families and home are more likely to have sexual partners.	Transport sector should monitor traffic flows (and types) of movement and inform others who will provide appropriate education.	Government. AIDS Control programme.

DOCUMENT 3(B) HIV/AIDS AND EDUCATION: A HUMAN CAPITAL ISSUE

Introduction to HIV/AIDS and Education

HIV/AIDS is of great concern to the education sector. It will affect:

- Supply - educational staff at all levels will probably experience similar increased levels of illness and death as the general population;
- Demand - the number of school entrants will be lower than would be the case in the absence of AIDS. This change in numbers will, over time, work its way up the educational system. In addition children may be kept out of school because their labour is required at home or there are no resources to send them to school;
- Provision of education. This considers the process and quality. The curriculum should include AIDS education and look at the special needs of those affected by the disease.

AIDS is, in some ACP countries, already affecting sizeable populations and has important implications for development. At the most basic level it will: increase morbidity (illness) and mortality (death), particularly among young adult populations; decrease life expectancy; and increase infant and child mortality rates. The full impact is not clear, as nowhere has the epidemic run its course.

The European Community and Education

It is increasingly acknowledged that education and training are critical for long-term development success. "Major long-term gains in development and wealth are possible only if the entire population possesses a reasonable level of education".[1] The importance of education is recognised in the Lomé Convention, which states that co-operation shall be aimed at supporting development and "back up the policies and measures adopted by those States to enhance their human resources."[2] The main provisions are found under Title XI, Cultural and Social Cooperation backed up by the policy guidelines on support to education and training laid down by the Council, and the Fiche de Programmation Sectorielle no 8, Education.

The Council Guidelines argue for a balanced approach to education and training, but accord priority to basic education; note that each receiving country is unique and must be assessed individually; highlight the need to support institutional reform; and stress the need to integrate structural adjustment support with regular EDF funding. The Education Fiche notes that only 19 of the 70 NIPs identified education and training as areas of priority, and on average less than 8% of the last 3 EDFs were committed for human resource development.

Type of Support

The sectoral fiche sets out clear guidelines of how and what support is to be given. They are:

- The ACP state must want support for the education sector.
- The state must commit itself to reforms and actions that support Community aid.
- Educational needs must be considered in structural adjustment.
- Education should get a bigger share of the budget.

---

[1] Digby Swift, EU's investments in education and training in the ACP states, **The Courier**, no. 159, September-October 1996, p65.

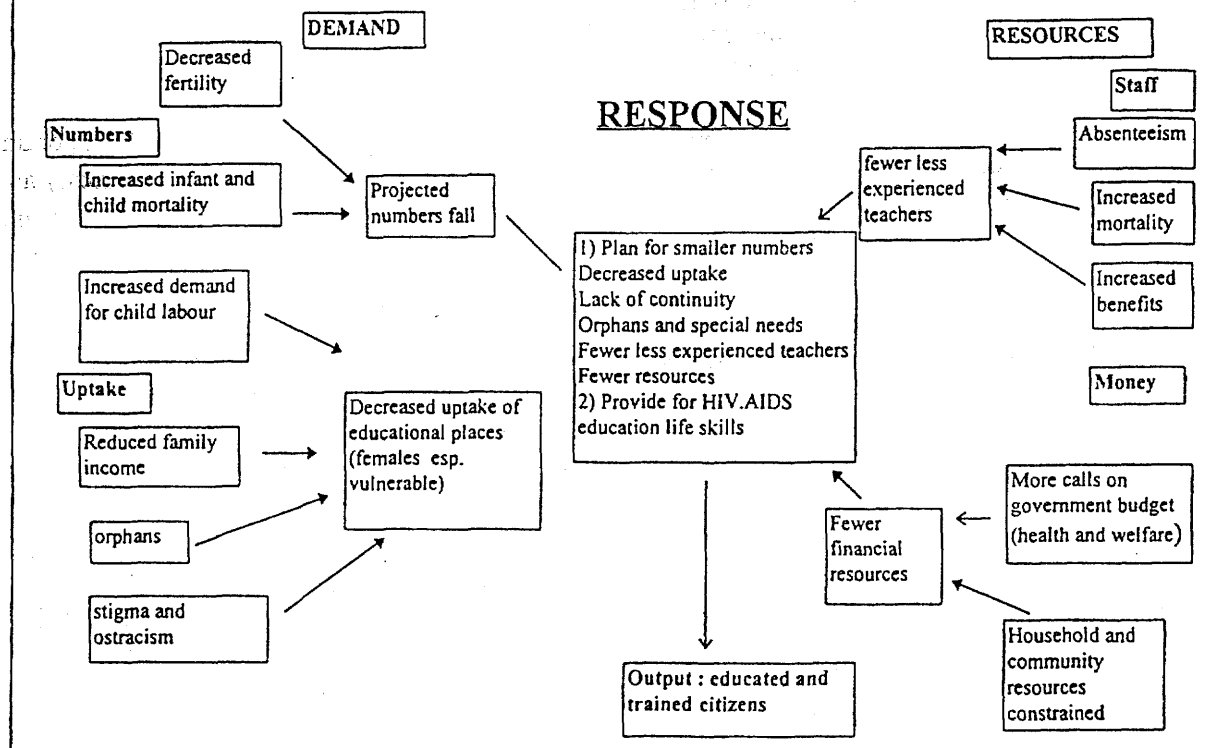
[2] Lomé IV Convention, Chapter 2 Objectives and guidelines of the Convention in the main areas of cooperation, Article 13.

The sectoral priorities are firstly: basic and primary education; improved access to education for females, through increasing enrolment of girls and the numbers of female teachers, and training of teachers and instructors. Secondly: reforming education so it addresses the needs of society and the economy and improves efficiency; ensuring strongly employment-linked professional training; supporting university education; support of economic planning and education management.

Education at Special Risk[3]

The education sector is both particularly susceptible and vulnerable to HIV and AIDS because of its nature. This is shown in Figure 1.

FIGURE 1: THE IMPACT OF HIV/AIDS ON EDUCATION



This figure shows that the challenge is to maintain and improve the output in the face of new pressures resulting from HIV/AIDS

Demand. The pattern of demand may change for the following reasons:

- Numbers. The projected number of children requiring education will decline. Firstly the birth-rate will decline, following the premature death of potential mothers and, possibly, increased use of condoms and empowerment of women. Secondly perinatal transmission and orphanhood will increase infant and child mortality. Absolute numbers in any cohort will not decline, but rather the rate of increase will be reduced.
- Availability of children for education. There is a real danger that families affected by AIDS will be forced to keep children out of school to care for the sick, work the land, or earn an income. These children may also feel discriminated against or ostracised. Orphans may be totally occupied by the struggle for survival, and education may not be an option for them. This is likely to lead to children never enrolling or dropping out.

[3] This is in part drawn from Sheldon Shaeffer, **Education Sector AIDS Brief**, Academy of Educational Development, Washington DC, (1996).

16

- Affordability of education. In some settings attendance at school requires a cash outlay for fees, uniforms and books. AIDS may result in exclusion of children from schooling because family income falls due to death and illness, or the family income per capita is reduced by taking in orphans.
- HIV infection. Children and students at the higher levels of education are becoming sexually active, which means they are not immune to infection. This is especially true of females and means that HIV-infected and ill scholars and students will appear in the educational system.

Supply. Education is a labour-intensive, service activity, and the more qualified, skilled and experienced the labour, the better the sector will serve the country. The supply of labour may be affected by the epidemic. There is some evidence to suggest that teachers may be more susceptible to infection than other groups, the reason being that their higher incomes and greater mobility are important risk factors. In many countries, teachers may be posted to areas away from their families.

The supply of teachers may be reduced by:

- Illness. This is particularly important as government employees tend to have generous sick leave packages, thus staff may be on the payroll for long periods, but not able to work or be replaced.
- Death. Teachers are likely to experience the same levels of mortality as comparable professions. Evidence suggests that this may rise from about 0.4 to 2.7 per cent of the cohort aged 20 to 40. Clearly this is a cause for concern where teachers are already in short supply.
- Absenteeism. This is likely to increase due to funerals of colleagues and family, and the need (especially for female staff) to care for family members.

It is not only teaching staff who may become scarce; these factors may affect administrators, headquarters staff, the inspectorate and so on.

There may also be a problem with financial resources. The problem of funding from parents and the community has already been raised. Governments may also face problems with the education budget line as there are increasing demands for health and welfare. In most countries all this is taking place in an environment of structural adjustment, and already restricted resources.

Process and Quality. The education process will be affected by the problems outlined above. In particular the following trends may emerge:

- Decreased uptake of education, and less continuity, as pupils' education is disrupted by illness of family members, deaths and declining resources. This will especially be the case for females.
- Increased problems of those schools facing changing demands, decreased supply of staff and funding, and growing numbers of orphans.
- Absenteeism and loss of teachers, with a move to a less well qualified and experienced teaching force, as those with experience and training are replaced by younger staff.
- A growing shortage of resources from parents, the community and the state.

At the same time the education sector has a vital role to play in prevention activities, as AIDS prevention messages and education must begin at an early age. These messages are most effective when they reach primary school children. One of the most cost effective ways is to include these messages in the curriculum, in some form. Education establishments and staff are also potential resources for outreach into broader communities.

It is clear from the above that, with the donor emphasis on basic education; access of females; educational planning and management; and training of teachers, HIV/AIDS is a issue of great concern in affected countries.

From Knowledge to Action.

How should those working in the education sector respond to the HIV epidemic? There are a number of things that can be done.

The following steps set out how HIV/AIDS should be considered:

Step 1. Establish if it is appropriate to consider the issue of HIV/AIDS in the country. Use Document 2 in this Toolkit.

Step 2. In order to establish the scope of the problem apply Figure 1 of the sectoral checklist.

Step 3. Specifically consider the issues as laid out in Figure 2 below.

Figure 2. Including HIV/AIDS in Education Sector Support

Issue	*Potential Problem*	*Response*
Demographics	Decline in projected student numbers	Revisit population projections. Revise plans to take account of changes.
	Increased staff mortality rates	Build increased mortality into human resource planning and development.
Economics	Students can't afford schooling. Student labour required. Support for poor families or their communities; flexible schedules	Support for poor students. .
	Education budget under threat.	Lobby Finance Ministry
Equity	Students with special needs because of:	
	Poverty	Poverty alleviation with special emphasis for students.
	Orphanhood	Adapting education for orphans.
	HIV infection	Respond to special needs of infected students.
	Gender - female students	Protect female students, exempt from fees?

Step 4. Using the information gained from this sector study, use document 4 to ensure that HIV/AIDS is included in the project cycle management, if consultants are used ensure they are given **Document 5- Including HIV/AIDS in Consultants' Terms of Reference.**

Finally

HIV/AIDS is a real threat to the education sector, and thus potentially to human resource-based development. The European Community recognises the importance of education (which is a basic right) for this. It also appreciates the need for basic education, planning and reform and the importance of giving disadvantaged groups access to education. The implication of the HIV/AIDS epidemic is that these goals become more difficult to achieve. Furthermore the education sector has a considerable responsibility for addressing HIV/AIDS, as it is the most appropriate and cost- effective place for education to take place.

The issues facing the education sector will occur, at all levels, from primary to tertiary, including the inspectorate, planning cadres and teacher training. The effect of HIV/AIDS on education and the role of education in responding to the epidemic has generally been ignored.

DOCUMENT 3 (C) HIV/AIDS AND RURAL DEVELOPMENT: AN ACTION PLAN

Introduction to HIV/AIDS and Rural Development

The disease AIDS, caused by the Human Immunodeficiency Virus (HIV), has been recognised since 1981. AIDS is, in some ACP countries, already affecting sizeable populations and has important implications for development. At the most basic level it will increase morbidity (illness) and mortality (death), particularly among young adult populations; decrease life expectancy, and increase infant and child mortality rates. The full impact is not clear, as nowhere has the epidemic run its course.

HIV/AIDS is of concern in the rural development sector. Evidence shows that in many countries there is currently a lower rate of HIV infection in rural areas. For example in Zambia in 1993, prevalence rates among women ranged from 33.3% in urban areas to 13.2% in rural. However, in other countries, for example Swaziland and South Africa, there is little difference in the infection rates between the rural and urban areas. The key determinant of the differential levels of infection is the amount of movement and interchange between urban and rural areas. Ironically, successful rural development will facilitate this process. It is possible that, even in rural areas with current low levels of HIV infection, these may climb, and in time approach those of the urban areas.

Even if there is a differential between rural and urban areas, the rural sector will not be immune to the impact of the epidemic. It may experience the following:

- A decline in remittances as members of the community who are employed in the urban areas fall ill and die.
- An increased demand for resources if people return home for care as they fall ill.
- Changes in the family structure and orphans returning to the (extended) family home needing care (and expenditure).
- Government budgets will face greater demands, especially social expenditure, and rural areas are usually already disadvantaged - AIDS may increase urban bias.
- Skilled labour (for example nurses and teachers) may be in short supply and less willing to accept unpopular rural postings.

The European Union and Rural Development

"Within the framework of development co-operation between the EU and developing countries, agriculture and rural development have occupied a prominent place for more than 35 years. This has been particularly true of the Lomé Conventions."[1] The agricultural/rural development sector continues to get the largest allocation within country programmes, although its overall share has declined with the growing importance of social sector support and structural adjustment.

Agricultural co-operation is aimed at food self-sufficiency and security and improving the standards, lifestyles and conditions in the rural areas.[2] Of particular importance is the emphasis on encouraging participation of women and the development of social and cultural activities (such as health, education and culture) essential for improving rural lifestyles.

---

[1] Uwe Werblow, The case for a more sector-orientated approach to agricultural development: From sector objectives and strategies to investment programmes, **The Courier**, no 156, March-April 1996, p59.

[2] Full details are in the text of the Lomé Convention, in particular Part 1 General Provisions of ACP-EC Cooperation, Chapter 2 Objectives and guidelines of the Convention in the main areas of cooperation, Article 15, and Part 2 The Areas of ACP-EC Cooperation, Title II Agricultural cooperation, food security and rural development.

Despite rapid urbanisation, the bulk of the populations in the ACP countries still live in the rural areas and depend on agriculture for their livelihoods. This ranges from 94% rural in Rwanda to 34% in Trinidad and Tobago. Globally 72% of the populations of low-income and 53% of lower-middle-income countries live in rural areas. Agriculture employs 69, and 31% of the labour forces in low-income and lower-middle-income countries respectively.[3]

Types of Support

The support provided by the EC to rural development can typically be divided into:

1. Direct support to small scale farmers through supply of inputs such as seed and fertiliser, credit and extension services.
2. Provision of infrastructural support such as roads and water.
3. Development of human resources in rural areas through education, training and health support.
4. Developing an environment conducive to rural development through support to markets and addressing policy issues.

Rural Areas at Special Risk[4]

The following features of the rural sector should be borne in mind when planning for the impact of HIV/AIDS:

1. Subsistence farming is characterised by a very close relationship between the general activities of the household (for example child care and child rearing, recreation, support relations between adult members, home maintenance, food processing) and the production of crops and care of animals to feed that household.
2. Few rural areas are entirely self-sufficient, most are in contact with the wider economy and society (for example, marketing of produce or handicrafts, purchasing inputs and consumer goods, paying taxes, and entering the labour market for various periods.
3. Rural people combine a range of activities into a livelihood strategy which enables individuals and households to "provision" themselves.
4. Rural areas rely on labour for production and given the nature of the work, good health is crucial.

Many of these points of interaction between the subsistence household and the wider economy and society may provide conduits for the spread of infection into or out of communities and the impact of HIV/AIDS-related illness or death will not only affect the quantity and quality of labour inputs to "farm" production, but will also affect the balance of labour available between the household and the farm.

Labour. Subsistence production depends very heavily on labour. Thus the impact of the epidemic on households and communities focuses on points where domestic or farm labour supply may come under pressure. Figure 1 shows some of the ways that HIV/AIDS may affect a subsistence household.

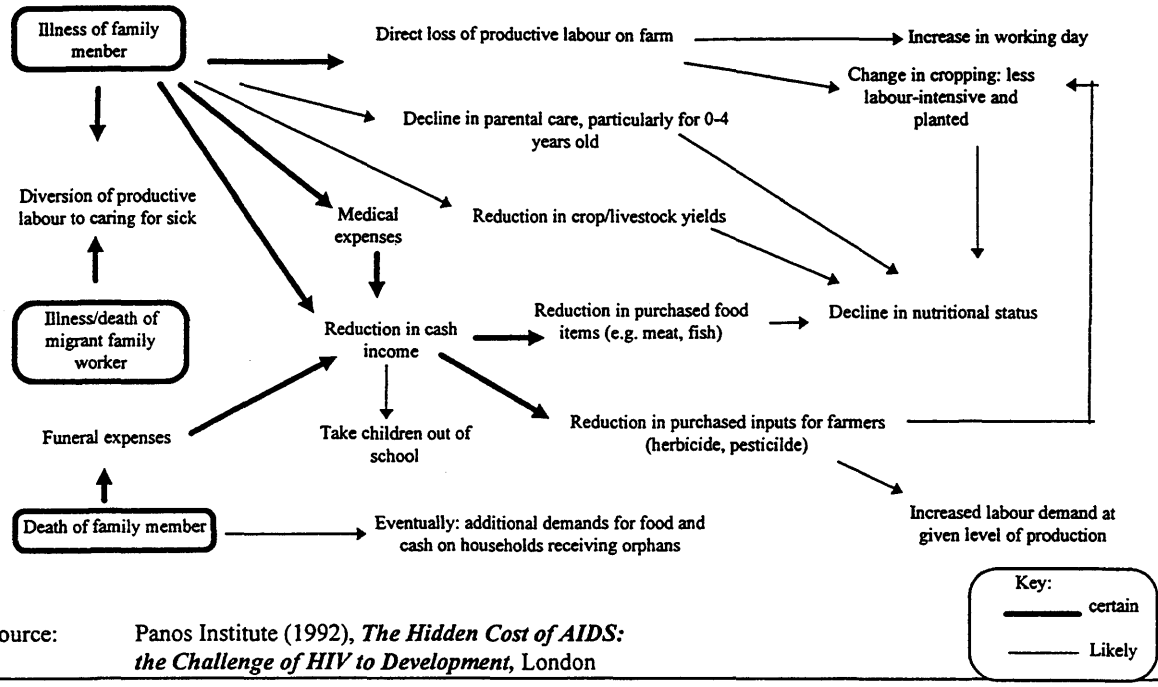
For example, the need to nurse a sick household member may force a woman to choose between bringing a bucket of clean water, washing soiled bed linen or preparing a cash crop once more. Access to clean water would have a marked effect on the amount of time women have for other activities, so a piped water supply or improvement of a closer supply, might help maintain standards of child care, crop and/or animal care, and household maintenance.

---

[3] World Bank, **World Development Report 1996**, Oxford University Press, New York and Oxford, 1996.

[4] Information in the next section is drawn from Tony Barnett, **Subsistence Agriculture, AIDS Brief**, The Academy of Educational Development, Washington DC, 1996.

Figure 1. The Impact of HIV/AIDS on the Household Domestic-Farm Labour Interface in Subsistence Communities

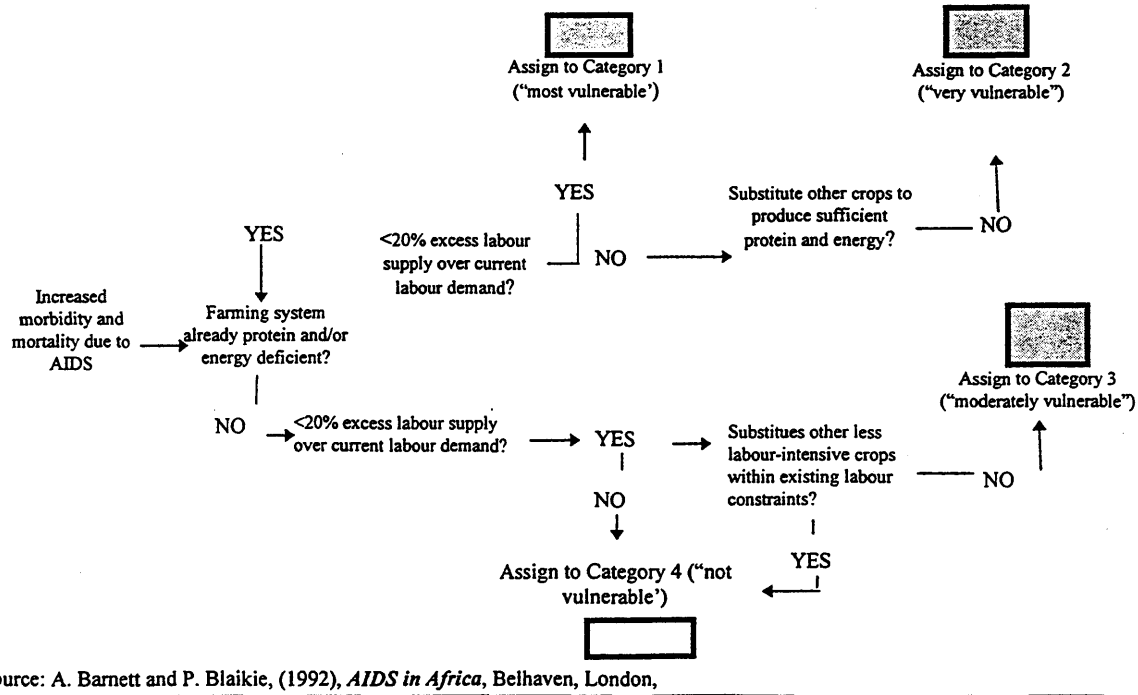


Source: Panos Institute (1992), ***The Hidden Cost of AIDS: the Challenge of HIV to Development***, London

Climate. The climate may determine the degree to which labour is a critical constraint in subsistence production. Where rainfall is seasonal, demand for labour is likely to be concentrated into short periods of a few months, or even (in very dry places) a few weeks. Death and illness reduce labour availability, both directly through affecting productive members of the household, and indirectly through diverting labour to caring for the sick.

Both of these effects mean that during the rainy period - a period of high labour demand for land preparation, sowing and weeding - labour demand for farm work may remain unmet, as urgent domestic tasks are forced to take precedence.

Figure 2. An Algorithm for classifying the vulnerability of farming systems to loss of labour



Source: A. Barnett and P. Blaikie, (1992), ***AIDS in Africa***, Belhaven, London,

21

In places where rainfall is more evenly spread through the year, demand for labour will peak so much, and it is probable that the impact of illness and death on the domestic-farm labour interface will initially be less intense, as the more even spread of labour demand over the year permits coping mechanisms (occasional assistance from relatives and neighbours, longer working hours, hiring labour) to come into operation. It is suggested that the farming system might therefore be classified in terms of its vulnerability to loss of labour. This is set out in Figure 2.

From Knowledge to Action

How should those working in the area of rural development respond to the HIV epidemic? There are a number of things that can be done depending on the type of support being offered.

Figure 3. Responding to the HIV/AIDS Epidemic : Steps For Rural Development

A. Analysis

Step	Response	Tool
1. Establish if HIV is an issue for the country.	If yes, proceed.	Document 2 of Toolkit
2. Establish if HIV is an issue for the region.	If yes, proceed	Adapt Document 2 plus local knowledge.
3. Apply general sector checklist with Figure 1 of this document to establish susceptibility and vulnerability	Having identified susceptibility and vulnerability, design interventions.	Document 3 and Figure 1 of this document.

B. Interventions

1. Improve human capital - where possible include a health component in projects.
2. Assist vulnerable groups - improve women's income earning opportunities , provide labour/time saving interventions.
3. Include HIV/AIDS education and interventions in rural development projects, for example have agricultural exterior workers trained in HIV/AIDS interventions and distribute condoms.
4. Re-orientate programmes to take account of impact of HIV/AIDS.

Clearly there can be no one blueprint for interventions in rural areas, as there is a great deal of variation from area to area depending on the country, climate, production system and culture. The above sets out some steps that can be taken. In addition rural development projects have to go through the project cycle management process, in which case document 4 can be used. Consultants may be employed and they can be given Document 5, Including HIV/AIDS in Consultants' Terms of Reference.

Finally

By considering HIV/AIDS in this systematic, but imaginative way, those working in the area of rural development may ensure that the spread of the epidemic is not facilitated by development efforts. It will also help to mitigate the effects of the disease. If it is not done then rural populations, who generally make up the bulk of the population and who are often the poorest, may bear the brunt of the consequences of the disease, although they have the fewest resources.

DOCUMENT 4: GUIDELINES FOR INCLUDING HIV/AIDS IN PROJECT CYCLE MANAGEMENT

Introduction

Project Cycle Management (PCM) is the method used by the EC's Directorate-General for Development for the management of its projects and programmes. It is based on the Logical Framework approach.

Key aspects of the basic method make it **potentially** responsive to the incorporation of HIV/AIDS issues into projects and programmes (e.g., stakeholder-beneficiary orientation in the problem analysis and definition of project objectives, assessment of assumptions, sustainability checks). Unless the entity specifically concerns HIV/AIDS, the issue is not being identified as a problem at identification, and is not being integrated into the design of interventions. Experiences of planning workshops in Africa indicate that the issue is most often raised when the sustainability of a proposed project is assessed, and in particular, when there is an assessment of the institutional and human resource capacity for project implementation; at this point, the compensatory measures may be mentioned (for example, doubling up on the appointment of personnel). Generally, however, unless HIV/AIDS is already an immediate and significant human resources problem, the issue is not addressed in any comprehensive way.

How could HIV/AIDS issues be more effectively taken into account in Project Cycle Management? In particular, **where** in the cycle should the issues be considered in order to minimise their negative impact on results and objectives and to maximise the impact of interventions on the incidence of HIV/AIDS? And who should be responsible for their inclusion?

Entry Points for HIV/AIDS in the Project Cycle

The earlier in the cycle HIV/AIDS issue are considered, the better. The identification in Programming Documents of HIV/AIDS as an existing or future problem for the development of the country or region should ensure that it is then subsequently considered when identifying the projects or programmes to be supported. The following chart suggests key entry points for HIV/AIDS issues in the various phases.

PHASES	CHARACTERISTICS	INVOLVED PARTIES	RELEVANT DOCUMENTS	ENTRY POINTS FOR HIV/AIDS ISSUES
PROGRAMMING	Macro-level socio-economic context, inter-sectoral focus, policy context	Delegation, NAO, EC-Bxl	Sectoral policy guidelines NIP/RIP documents	**- Sectoral guidelines** **- National/Regional Indicative Programming documents**
IDENTIFICATION	Establish focus and conditionalities of intervention	Delegation, NAO, beneficiary representatives, implementing agencies, line ministries, Desks-Bxl	Identification fiche Sector guides ToR pre-feasibility study	**- Preparatory studies** **- Participative planning workshops** **- ToR pre-feasibility study** **- Drafting of proposal**
FORMULATION	Establish technical design and indicators	Delegation, NAO, line ministries, consultants and Desk Bxl	ToR feasibility study	**- ToR feasibility study** **- Assessment of draft Financing Proposal**
FINANCING	Financing Proposal	EDF Committee, Desk Bxl	Financing Proposal format	**- Assessment by Reading Committee**
IMPLEMENTATION	Detailed activities and responsibilities	Implementing agencies/consultant, Delegation, Desk-Bxl	Monitoring fiches/reports	**- Operational plan** **- Monitoring, including assumptions**
EVALUATION	Assess relevance, efficiency, effectiveness, impact, sustainability and draw lessons	Evaluation Unit, geographical and technical desks, consultants, NAO and line ministries	ToR evaluations Sector guides	**- ToR evaluations**

How HIV/AIDS Issues can be Considered in Identification and Formulation

Programming, identification and formulation are, therefore, critical steps for the integration of HIV/AIDS issues into projects and programmes. While it is difficult to influence the content of the new NIPs and RIPs, there are opportunities to integrate HIV/AIDS issues into forthcoming sectoral guidelines, and into the identification and formulation of new projects and programmes. The table focuses here on project and programme identification and formulation, and suggests some ways in which HIV/AIDS issues could be taken into account.

PHASE	ENTRY POINT	HOW HIV/AIDS COULD BE TAKEN INTO ACCOUNT
IDENTIFICATION	Preparatory studies	Include in ToR for consultants undertaking preparatory and pre-feasibility studies. Questions to be investigated include: - is HIV/AIDS relevant to the proposed project? If yes: - what risks do HIV/AIDS problems pose for the project? - what potential impact might the project have on HIV/AIDS? Ensure consultation with relevant bodies.
	Participative planning workshops	Ensure that relevant studies/data are available. Ensure that participation includes knowledge of HIV/AIDS issues relating to the entity. Check that problem analysis includes attention to HIV/AIDS issues and how they pose problems. Check that intervention addresses the specific HIV/AIDS problems (in activities and assumptions). Check HIV/AIDS issues in sustainability criteria (policy, socio-cultural, institutional and management capacity, economic and financial viability).
	Drafting of proposal	Ensure that HIV/AIDS issues are mentioned where relevant in the draft Financing Proposal. Important sections could be: 2.4 problems to be addressed 2.6 documentation available 3.4 activities 4.1 assumptions 4.2 risks 6. sustainability factors
FORMULATION	ToR feasibility study	Include in ToR of consultants undertaking feasibility studies. See Document 5. Ensure reference to relevant reports/data and consultation with relevant bodies.
	Assessment of Financing Proposal	Consider HIV/AIDS issues in assessments of Financing Proposals. Check in particular if: - all relevant problems connected with HIV/AIDS are considered - the intervention takes these problems into account, either in activities or as assumptions - there are no "killer assumptions" connected with HIV/AIDS - HIV/AIDS issues have been thoroughly taken into account in the sustainability of the intervention.

DOCUMENT 5: INCLUDING HIV/AIDS IN CONSULTANTS' TERMS OF REFERENCE

Guidelines for Consultants

The Commission of the European Communities is concerned about the potential impact of the HIV/AIDS epidemic on the developing world. It was one of the first donors to recognise the potential impact of the epidemic and to see it as a development issue. The CEC has developed an AIDS Policy (Communication from the Commission to the Council and the European Parliament, AIDS Policy of the Community and the Member States in the Developing World, COM (93) 479, final Brussels, 7 January 1994.). The four strategic priorities identified are to:

- Minimise the spread of the epidemic while preventing discrimination and exclusion.
- Enable the health sector to cope with the additional burden placed on it by AIDS and efforts to contain the epidemic.
- Manage and reduce the consequences of the epidemic on social and economic development.
- Increase the scientific understanding of, and learning on, the HIV/AIDS epidemic, possible interventions and their use in implementation, monitoring and evaluation of progress.

The policy recognises the link between the epidemic and development, and that this is a circular process, with development affecting the epidemic and the epidemic affecting development. It is therefore appropriate that consultants should consider HIV/AIDS, where relevant, and these guidelines are designed to show where and how this should be done.

1. What is HIV/AIDS, and Why Does It Need Special Attention?

It is important to begin by explaining why this disease is given special consideration. It has been argued that other diseases such as malaria kill more people, and that, anyway HIV is a health problem. Unfortunately this is not the case. HIV/AIDS is unique because of:

1.1 The Location of the Epidemic. By this is meant the age groups affected. There are two groups who bear the brunt of the disease: the first are infants, who make up about 10% of cases. They are infected in the womb; during birth; or through breast-feeding. Most die before their fifth birthdays. The second group are young adults (25 to 45), who account for virtually all the other cases. Women are likely to be infected and fall ill at a slightly younger age. AIDS is unique, as most other diseases predominantly affect the young or the elderly.

1.2 The Prognosis. The prognosis for people infected with HIV is bleak. Infected adults can expect to have a number of healthy years (during which they will not know they are infected unless they have been tested). They will then experience periods of sickness increasing in severity, duration and frequency until they die. With most other diseases there is, at least, the possibility that the individual will recover.

1.3 The Magnitude. HIV is also different in scale. Data from some African urban locations show that up to 30 percent of the female childbearing adult population is infected. It is possible that, with time, similar levels of infection may be seen in rural Africa and parts of Asia. The result will be a significant increase in mortality rates and an erosion of development indicators such as infant mortality and life expectancy. The epidemic is of a different order of magnitude in the developed world, where it is either under control and declining, or spreading only very

slowly. This is hardly surprising as HIV, like most infectious diseases, spreads most rapidly in situations of poverty and deprivation.

1.4 The Transmission Mechanisms. The most common mechanism of transmission is sexual (70-80 % of global infections, and most of these are heterosexual). Mother to child infections account for 10 % of infections, and the balance are through blood and blood products (including intravenous drug abuse).

1.5 The Incubation Period. Although the disease is fatal it is characterised by a long latent period in adults. This may average about 10 years but can vary greatly. African experience suggests that in poorer populations the period is shorter (6-8 years). During this time the individual is infected and infective, but can work and function in society. Early and appropriate treatment of symptoms can extend the period of healthy life.

1.6 The Novelty. Perhaps the most important point about this disease is that it is new. The first cases of the disease were identified in the USA in 1981, but it was not until 1984 that the causal virus was identified. HIV first spread in Africa in the 1980s, and today it continues to spread there and in many parts of Asia. In no developing nation has the HIV epidemic peaked, and the long incubation period means that the number of AIDS cases, with the associated morbidity and mortality, will continue to grow even after the levels of infection have reached a plateau. This further means that we have no examples to show us what the possible effect of the epidemic might be, as nowhere has it run its course.

2. Why Consider HIV/AIDS in Planning?

The reasons why the issue of HIV/AIDS should be considered in planning of development assistance are:

(i) The viability of projects may be jeopardised by the disease and the morbidity and mortality arising from it. For example a school expansion programme would need to consider the change in the number of school-going children (both because of increased infant mortality and decreased fertility rates); the increase in mortality among education staff; and the special needs of growing numbers of orphans and children from affected households.

(ii) Projects may, unwittingly, facilitate the spread of HIV or create conditions in which it is spread. This has been documented as having occurred in a number of road construction programmes in Africa. Where road are being constructed in remote areas the contractors will frequently establish camps to house their staff (who are usually male and unaccompanied). These workers will have disposable incomes which will allow them to procure alcohol and women. Thus they may be a factor in spreading STIs and HIV.

(iii) Awareness of the potential impact can be a powerful advocacy tool in motivating policy-makers and politicians to develop and support prevention activities; and

(iv) Planning can mitigate the impact of the disease.

3. The Role of the Consultants

Consultants typically have the following roles:

- Carrying out studies designed to answer certain questions and provide policy guidelines.
- Preparing projects for funding through project identification and feasibility studies.
- Preparation of tender documents.
- Monitoring projects.
- Evaluating projects.

The methodology for preparing projects in the EC is set out in the ***Project Cycle Management Manual: Integrated Approach and Logical Framework*** (Commission of the European Communities, Directorate General for Development, Evaluation Unit, Brussels, No. 1 February 1993). In terms of these procedures, consultants can most often expect to be involved in the identification and formulation phases of the project cycle. The logical framework formulation provides for a problem analysis at the beginning of the process; consideration of assumptions, factors that are important for the success of the project, but lie outside its scope; and a sustainability check. HIV/AIDS should be considered here in most instances.

4. Putting HIV/AIDS into Consultancy Reports

HIV/AIDS will not be an issue for all consultancies or projects. This section outlines the techniques for assessing if it is, and what can be done about it. A decision tree is shown on Figure 1 and can be cross-referenced to this section.

4.1 Is HIV/AIDS a National or Regional Issue?

If reported HIV prevalence is very low nationally (<3%), or low in at-risk groups (<5% in truckers, commercial sex workers and military), and there has been no significant increase over the past few years, then HIV/AIDS is not an issue, unless the project involves large-scale international movement of people or relates directly to high-risk groups. The consultant should begin by establishing the HIV/AIDS situation in the project area to ascertain if it is an issue of concern. Sources of data include:

- DGVIII/8 Health, Family Planning and AIDS Unit and the country profiles they are producing.
- The World Health Organisation and UNAIDS. On-line data are available at www.gpa.ch.
- The US Bureau of the Census in Washington.
- In the country, data should be available from a range of sources, including the government, National AIDS Control Programme and Ministry of Health, NGOs and donor agencies.

If more than 3% of a low-risk population (women attending ante-natal clinics for example) are HIV-positive, or the numbers are doubling every two years or less, then the country can be considered to have a problem with HIV. Two tools that can be used and are available as part of this toolkit are **"Document 2: Assessing the National Importance of the HIV Epidemic"**, and, where available, the associated country profiles.

If the country does not have a serious problem there is no need to proceed further, unless the consultant or client feels that there is the potential for a problem and the data do not properly reflect this.

4.2 Is HIV/AIDS an Issue for the Sector?

HIV/AIDS is clearly not going to be an issue or need consideration in all sectors of support. For example a livestock improvement project is unlikely to be affected by HIV/AIDS, but a rural development project may need to consider it as an issue.

The consultant should establish if HIV/AIDS is an issue for the sector. This can be done by consulting **"Document 3. A Sectoral Checklist"** in this Toolkit (and, where relevant, the associated sectoral tools on Education, Infrastructure and Rural Development). Where HIV/AIDS is an issue for the sector it should be included in the sector plans and in the project associated with the sector.

4.3 Is HIV/AIDS an Issue Relevant to this Project?

This can be assessed by asking the following questions:

A. Is the HIV/AIDS Issue Relevant to the Project?

Does the project rely on a long-term input of skilled human capital?

Is the project operating in an area where labour is a constraint (Note: It is possible that labour is a constraint only at certain times of the year)?

Is the project dependent on overseas foreign direct investment (private capital)?

Is the project in social sectors affected by HIV/AIDS?

B. Will the project affect the HIV/AIDS epidemic?

Will there be increased mobility of the general population?

Will sub-groups be increasingly mobile during or as a result of the project (for example construction workers or truckers)?

Will some groups be disadvantaged by the project?

4.4 How Vulnerable is the Project?

A. Project Vulnerability to HIV/AIDS.

Skilled Labour.

Does the Project rely on skilled labour?

If yes, is there a shortage of skilled labour?

If yes, can more be trained and employed?

If no, look at ways of changing this.

Unskilled labour.

Does the project rely on unskilled labour?

If yes, are there constraints on labour availability?

Note this may only occur at peak agricultural times.

If yes, can more be recruited or mechanisation be adopted?

Project Costs (Employee benefits).

Will the project have employee benefits, for example pensions, insurance, housing and health care?

If yes, will HIV/AIDS increase these costs?

If yes, can they be controlled or reduced?

If no, can HIV spread be controlled or HIV+ people excluded from

benefits or employment?

Project Markets.

Will the project's products be vulnerable to the HIV infection through

death or loss of disposable incomes among consumers?

If yes, can alternative markets or products be developed?

Project Funding.

Is the project dependent on private sector funding that may be vulnerable to the perception of an area having a high HIV incidence?

If yes, can this be altered or the importance of private funding be reduced?

B. Project Effect on HIV/AIDS.

Mobility (Specific groups)

Will the project result in increased mobility of specific groups such as construction workers; tourists; traders; or transport workers?

If yes,

(i) can (should) this be reduced or can they be encouraged to spend less time away from home?

(ii) can they be targeted with specific prevention messages, condom promotion and STI treatment?

Mobility (General population)

Will the project result in increased mobility of the general population, e.g. for trade or pleasure?

If yes,

(i) can (should) this be reduced?

(ii) can they be targeted with specific messages?

Poverty and Disadvantaged Groups

Will the project result in specific groups being disadvantaged, for example being relocated by a dam or having income-earning opportunities taken away?

If yes, can this be prevented or alternative sources of income be found?

Health I

Will the project affect the health status of the population?

If yes, will this be beneficial and can emphasis be placed on safe blood and STI treatment?

Health II

Will the project affect the access to health care in the population?

If it reduces it, can this be addressed?

If it increases it, should this alter the way and what health care is provided?

Education

Will the project affect access to any type of education?

If yes, should this change to provide emphasis on HIV/AIDS?

4.5 Implementation

Once the project is being implemented, and if it has been identified as a project where HIV/AIDS is an issue, then the following checklist should be applied where appropriate.

Should the implementing agency be made aware of the HIV/AIDS issue?

Is there provision for targeted education?

Is there provision for condom distribution?

Have attempts be made to reduce high risk mobility?

Is health care and particularly treatment of STIs being addressed?

4.6 Evaluation

Once a project has been completed the effect it had on HIV transmission might be assessed. To do this the following checklist can be applied.

Was there a change in sero-prevalence (or number of cases of sexually transmitted infections) in the project area? Can any of the change be attributed to the project?

Were any vulnerable groups specifically targeted and empowered?

Was there any education linked to the project and did it include an HIV/AIDS component?

Figure 1. Considering HIV/AIDS in Project Design. Consultant's Decision Tree