Addressing HIV/AIDS through Agriculture and Natural Resource Sectors:

a guide for extension workers

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CONTENTS

ANNEXES

ABBREVIATIONS

ARV	Anti-retroviral
BCC	Behaviour change communication
CKC	Community knowledge centre
FFS	Farmer field school
FHH	Female-headed household
GHH	Grandparent-headed household
HH	Household
IEC	Information, communication and education
JFFLS	Junior farmer field and life school
MTCT	Mother to child transmission
OHH	Orphan-headed household
PLWHA	People living with HIV/AIDS
STI	Sexually transmitted infection
VCT	Voluntary counselling and testing

GLOSSARY

Assets: the resources used by a household to make a living including human (household members), natural (land, trees and livestock), physical (seeds, fertilizer, tools and equipment), financial (savings, credit and remittances) and social assets (membership of groups and associations).

Adaptive strategy: adjusting livelihood activities in the medium to long term to overcome shocks and changes to the livelihood system, such as a reduction in the asset base.

Coping or response strategy: responding to changes in the livelihood system in the short term, which may or may not be sustainable.

Household: a group of people who live in the same house, provide for each other and often share meals together.

Livelihood: describes how households use their asset base to make a living through farming, non-farm activities or other strategies.

Natural resource sector: includes fisheries, forestry and other livelihood activities using the natural environment.

Non-farm: livelihood activities other than agriculture.

Social cohesion: the extent to which a community shares common values and belief systems.

Sustainable livelihood: a livelihood system that can cope with, and recover from, shocks and changes in the medium term.

Introduction

HIV/AIDS Epidemic: The potential contribution of extension services

The agriculture and natural resource sectors present a unique opportunity to combat the HIV/AIDS epidemic in predominantly rural economies. Up to 80 percent of the population in some African countries depend on subsistence agriculture; crops, livestock and other natural resource products are the mainstay of economy and export earnings; and agriculture, forestry and fisheries provide vital safety nets. In other regions of the world, the sectors still account for the livelihoods of a sizable proportion of the population, ranging from 50 – 60% in Asia to 15 – 30% in Latin America and the Caribbean.

The impact of HIV/AIDS erodes the asset base of rural households, depletes their labour force, reduces their range of knowledge and skills, restricts their ability to earn cash from farming and non-farm activities, and undermines their ability to feed themselves and maintain adequate levels of nutrition. At the national level, the epidemic is seriously undermining efforts to reduce poverty and, in some countries, is reversing the development gains made during recent decades. At present, the scale of the problem is most severe in sub-Saharan Africa: 70% of people with HIV/AIDS at present live in Africa and it is likely that at least one quarter of economically productive adults in Southern Africa will die within next five to 10 years. However, the worst impact of the epidemic is still expected to come. So far, few countries have taken measures sufficient to see a decrease in their national infection rates and data suggest that within the next 10 years, the largest number of infections is likely to be in India or China.

Rationale for the guide

It is only recently that the rural dimension of the epidemic has being fully appreciated, as prevalence rates in rural communities gradually rise towards the urban thresholds. Many of the lead agencies addressing the disease have limited experience in working with rural communities. Hence extension services, with their unrivalled experience of working to improve nutrition and food security and strengthen rural livelihoods, have a major opportunity to contribute to addressing the rural epidemic. However, in order to realise this contribution, the work of extension services has to be adapted. The epidemic is changing the face of rural communities. New client groups with different needs and priorities are emerging. The relevance and effectiveness of many conventional extension messages is being diminished. There is an urgency to adopt new approaches which will achieve significant change in resource-poor settings at scale.

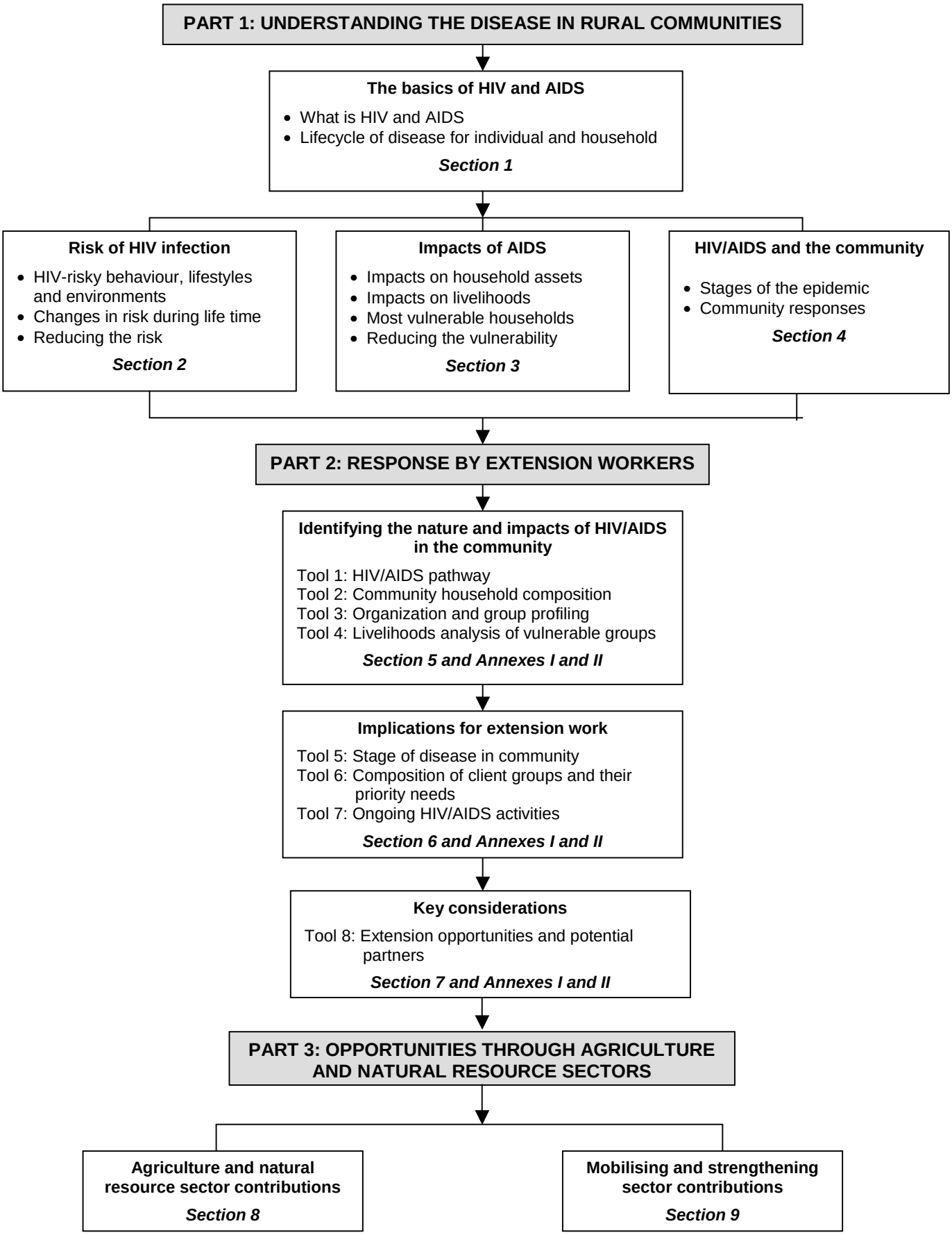
Purpose and structure of guide

The purpose of the guide is to enable extension workers and development agents to contribute to addressing the rural epidemic through agriculture and natural resource sector initiatives. Part 1 provides basic facts about the disease, sources of risk of HIV infection and vulnerability to the impacts of AIDS in the context of rural communities.

Part 2 identifies participatory tools which enable extension workers to understand the disease in their rural communities prior to responding to the epidemic in their work activities. The contribution of the agriculture and natural resource sectors to addressing HIV/AIDS, and actions by the extension service to mobilise and strengthen these initiatives are described in Part 3.

An overview of the structure of the guide is presented in Figure 1. In addition to the main text, there are three supporting annexes: Annex I provides guidance on the use of the participatory tools; Annex II presents examples of completed templates; and Annex III provides links to other relevant FAO manuals and guides.

Figure 1: Implications of HIV/AIDS for an Extension Worker



PART 1

UNDERSTANDING THE DISEASE IN RURAL COMMUNITIES

The first part of the guide provides an overview of HIV/AIDS in the context of rural communities. Section 1 covers key basic facts about the disease, distinguishing between HIV infection and AIDS-related illnesses, and the timeframe in which these events occur. The different sources of risk of HIV infection facing an individual are identified in section 2. Section 3 explores why and how the impacts of AIDS differ between households and their livelihood systems. The different stages of the epidemic experienced in communities, coupled with typical community responses, are described in section 4.

Further reading material prepared by FAO describing the impacts of HIV/AIDS on rural communities, particularly in east and southern Africa, are noted in the bibliography in Annex III.

Section 1

Understanding the Disease: The basics of HIV and AIDS

This section introduces the basic facts about the HIV/AIDS epidemic by explaining the relationship between HIV and AIDS, identifying sources of infection and ways in which the disease is not transmitted, and describing the lifecycle of the disease for an individual and his or her family.

What is HIV and how do people become infected?

HIV causes AIDS, a disease that destroys a person's immune system. There are no clear symptoms of HIV infection but an infected person can pass on the virus to others.

The main sources of infection are through:

- unprotected sex with an infected person;
- contact with contaminated blood or other bodily fluids (such as semen and vaginal secretions) (for example, by sharing contaminated skin piercing instruments such as injecting needles, razor blades and safety pins, or open cuts and wounds, or by transfusion with infected blood); or
- from mother to child (during pregnancy, at delivery or during breast-feeding).

The meaning of HIV

Human: human beings

Immuno-deficiency: a weakening in the body's immune system - the white blood cells – to fight diseases and other infections

Virus: an infectious organism that multiplies and destroys human body cells

The meaning of AIDS

Acquired: the virus is passed on from an infected person

Immune Deficiency: a weakening in the body's immune system to fight off diseases

Syndrome: a group of health problems that occur together or one after another but are all part of the same underlying medical condition

What is AIDS?

AIDS is the final stage of the infection. As HIV slowly damages the immune system, the body's ability to fight off diseases and other infections is weakened. Eventually an infected person suffers from a combination of illnesses which results in their death.

AIDS symptoms typically include rapid weight loss, dry cough, diarrhoea lasting more than a week, recurring fever, swollen lymph glands, skin rashes, memory loss, depression, dementia and severe chronic fatigue. *Take note*: these symptoms are similar to those associated with other illnesses so it not possible to rely on these alone to determine whether someone has AIDS.

Who can be infected with HIV?

Everyone is potentially at risk from HIV infection and the disease is found in all races, nationalities and age groups. People are especially at risk if they practice high-risk behaviour, have risky-lifestyles or live in potentially risky environments which may expose them to the virus through unprotected sex, or infected blood and bodily fluids. However, HIV infection is preventable and a few precautions reduce the risk of infection even for those in high-risk groups. Sources of risk of infection and measures to reduce them are discussed in section 2.

The ABC of prevention

Abstain: stop having sex

Be faithful: keep to one uninfected partner who should also be faithful

Condoms: use condoms correctly every time during sexual intercourse

Absence of cure

There is no traditional or scientific cure for HIV and AIDS. However, there are steps which HIV-infected people can take to delay the onset of full-blown AIDS and reduce the vulnerability of themselves and their families to the impacts of AIDS. These are discussed in section 3.

Ways in which HIV is NOT transmitted

HIV is a very fragile virus. People living with HIV/AIDS (PLWHA) do not pose a threat to others in the community during casual, day-to-day activities and contacts. The virus is not spread through casual contact with infected people such as: shaking hands, hugging, sitting together or playing; sharing toilet or bathroom facilities; sharing dishes, utensils or food; eating food bought at the market from someone who is HIV-positive; wearing clean clothes which have been worn by a person living with HIV; through sneezing, coughing or insect bites; or witchcraft.

How can people act responsibly in the era of HIV/AIDS?

Responsibility to one's self: Since there are no clear symptoms of HIV infection, it is only by having an HIV test that someone knows his or her HIV status. Early detection not only enables an infected person to safeguard others from infection but also improve the quality of his or her own life. People with HIV can help themselves stay healthy by avoiding stress, resting and taking exercise, improving their diet, avoiding cigarettes, drugs and alcohol, and following good hygiene practices. They should avoid re-infecting themselves by always practice safer sex even with another HIV-positive person (since re-infection may accelerate the onset of AIDS).

Responsibility to others: HIV-positive people should ensure that other people do not come into contact with their blood or other bodily fluids and should always practice safer sex. Those living or working closely with HIV-positive people should take care not to expose PLWHA to infections (such as colds, 'flu or other viruses) which their weakened immune systems are less able to withstand. PLWHA need support, encouragement and respect; they should not be marginalised or discriminated by their community.

Voluntary counselling and testing (VCT) services

The only way to be sure if one has HIV is to be tested. The test should be accompanied by counselling, to provide (i) information about the test; (ii) advice about how individuals may protect themselves from infection if they have negative test results; and (iii) for those with positive test results, advice about how an infected person may protect others from infection, and their own care and treatment options.

Why is stigma so harmful?

Stigma is very common, particularly in rural communities where there are many misconceptions and misunderstandings about how the disease is transmitted. Many people fear all forms of contact with PLWHA even though normal daily activities are not a source of infection. Stigma has devastating consequences not just for the infected but also for their families and the wider community. People who may be infected are reluctant to have a HIV test and to tell others of their status. As a result, the disease continues to spread and PLWHA delay in seeking appropriate health care. It is essential to end the silence and secrecy surrounding the disease by creating more openness, less stigma and a more supportive environment for HIV-infected and affected women and men.

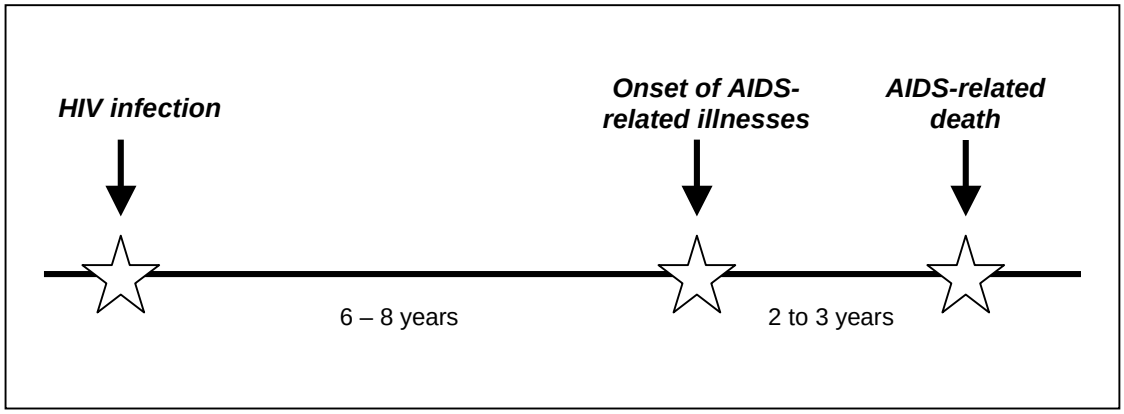
What is the lifecycle of the disease for an individual and the household?

An individual passes through three stages between infection and death and this process may spread over a period of up to eight to 10 years. The stages are described below and illustrated in Figure 2:

- **HIV-infected but not yet affected**: After a person becomes infected with HIV, he or she can spend a number of years looking and feeling healthy and strong. This stage is very risky for the spread of the disease because an infected person can pass on the virus to others without knowing they are doing so, through unprotected sex or sharing unsterilised skin piercing instruments. Good nutrition and medical treatment can slow down the rate at which HIV weakens the immune system. This stage, without any symptoms, may last between six to eight years.

- **HIV-infected and affected**: The infected person starts becoming sick with opportunistic infections, such as tuberculosis, pneumonia, viral and fungal infections, which take advantage of the body's weakened immune system. As these illnesses become more frequent and persistent, the patient suffers from chronic fatigue. Medical treatments can prevent or cure some of the illnesses associated with AIDS. Household resources are diverted into patient care, involving not only the time of other household members to tend to the sick but also financial resources for medical treatment. The ability of someone suffering from AIDS-related illnesses to carry on with their normal lives depends on the extent to which physical strength and visual appearance is important. Once the person has full-blown AIDS, life expectancy is two to three years.
- **AIDS-related death and impact on other household members**: Immediately following the death of an infected person, many households observe funeral and mourning rites. This can be a time-consuming and expensive process, further draining a household's limited resource base. If the deceased had a spouse, it is very likely that the spouse is also infected and it is only a matter of time before he or she becomes sick. A household may remain in a state of being infected and affected for several years. Many households struggle to survive the death of key household members, particularly in communities where the property inheritance system is weak or characterised by property grabbing by relatives of the deceased.

Figure 2: Individual HIV/AIDS Timeline



Section 2

Understanding the Disease: Risk of HIV infection

This section explores the factors that put people at risk of HIV infection (in terms of their behaviour and lifestyle, and the environment in which they live) and how these risks change during an individual's life. Opportunities for reducing the risk of infection are also discussed.

What is HIV-risky behaviour?

There are three main modes of behaviour which may result in individuals engaging in activities which expose them to the HIV virus:

- **HIV-risky behaviour by choice, usually for pleasure**: for example, multiple sexual partners, high alcohol or narcotic consumption which may lead to unprotected sex, injecting drug users;
- **HIV-risky behaviour by convention, culture, peer pressure or coercion**: sexual norms, physically damaging sexual practices, widow inheritance, polygamy, rape, abduction, child sexual abuse and incest, early sexual debut, early marriage, inability to negotiate for safe sex due to unbalanced power relations, harmful traditional practices with unsterilised instruments (such as circumcision, female genital mutilation, milk tooth extraction, tonsillectomy) and a reluctance to abandon breast-feeding by HIV-positive mothers;
- **HIV-risky behaviour by necessity**: exchanging sexual favours for food, cash or preferential access to limited resources (such as male labour or food items for processing) and caring for the AIDS sick without due caution.

What are HIV-risky lifestyles?

Some lifestyles place people at risk by presenting them with opportunities for unprotected sex with non-regular partners. These activities usually take place away from home, often in urban areas where prevalence rates are usually higher than rural areas. The lack of social cohesion in this setting may encourage people to do things which they would not do if they were at home. Several of these lifestyle activities are associated with the generation of cash which increases the opportunity for new sexual liaisons.

Risky lifestyles that may result in unprotected sex include:

- traders, merchants, transporters, foresters or fisherfolk who spend nights away from home in the course of their work
- seasonal migrants and daily labourers seeking employment during off-farm season
- urban migrants seeking permanent employment, often leaving their families behind in the village
- commercial sex workers and women working in bars and hotels
- secondary school and college students living away from home during term time
- extension workers, development agents, health personnel and teachers living in rural communities away from their families

These people are known as **bridging populations** since they engage in HIV-risky behaviour in high-risk environments away from home and then carry the virus back into their homes and the community. Their sexual activities bridge high and low prevalence communities.

What are HIV-risky environments?

People are more at risk if they live in environments subject to climatic variability (such as droughts or floods), conflict or weak governance which, in turn, disrupt rural livelihoods and cause poverty, migration and a lack of social cohesion. A weak infrastructure contributes to the spread of the disease if people are unable to: access information to become better informed about methods of prevention, treat other sexually transmitted infections (STIs) and opportunistic infections promptly, acquire condoms and live in adequate housing. Widespread stigma and discrimination about HIV/AIDS makes it difficult for people to disclose their status and take appropriate preventative action.

How do sources of risk change during an individual's life and according to gender?

The potential source of infection varies by age and sex of the household member. Among adults, the principal source of transmission is generally through unprotected sex with an infected person. The youth are susceptible to infection either through sexual contact or harmful traditional practices, such as circumcision, using unsterilised infected implements. Children and infants are potentially at risk from traditional practices, and infants from Mother to Child Transmission (MTCT).

Women and girls are among the high-risk group, often due to events beyond their control. For each sexual encounter, they are more biologically vulnerable to infection than men. They are also more socially vulnerable due to discriminatory social and cultural practices. In many communities women have lower rates of literacy than men, leave school earlier than boys, have limited access to sources of information, and have little opportunity to participate in decision making. They are also disadvantaged with regard to using and controlling economic resources in the household. Due their weak social position and the dominance of men, women are either unaware or unable to insist on condom use and negotiate for safe sex. Gender inequalities also affect the ability of women to disclose their HIV status and utilise treatment and care services. Moreover, their lack of economic independence makes them more likely to engage in survival sex.

How can the risk of infection be reduced?

It is possible to take steps to reduce the risk of infection, even in high-risk environments and by those with potentially high-risk lifestyles or behaviour. The effectiveness of preventative actions by individuals may be supported by actions at the community level.

Individual actions:

- being well informed about disease
- changing behaviour towards potentially risky activities (though practising abstinence, remaining faithful to one partner, delaying first sexual encounter, always using condoms and other safe sex methods, avoiding excessive alcohol and injecting drugs)
- seeking prompt treatment of STIs
- knowing one's HIV status
- following safe practices during pregnancy, birth and breast-feeding

Community actions:

- reducing poverty
- empowering women socially and economically
- changing cultural norms and behaviours
- changing stigmatising attitudes
- improving health services, VCT centres, centres for preventing MTCT, social marketing of condoms (including female condoms and microbicides), information services
- creating and maintaining stable communities

Section 3

Understanding the Disease: Vulnerability to the impacts of AIDS

The epidemic affects households in different ways in terms of its scope, intensity and duration. This section examines the differing impacts of AIDS on households, livelihood systems and communities. More literature about the impacts on AIDS on agriculture and the natural resource sectors are noted in the bibliography (Annex III).

What are the impacts of AIDS-related illnesses?

Temporary loss of labour during illness: The first sign of the presence of the disease in a household is usually its impact on the availability of labour. Labour shortages start when a patient becomes sick with AIDS-related illnesses and is unable to work during bouts of sickness. How quickly this impact is felt depends on the extent to which physical strength and visual appearance is important for their livelihood. Other household members take time away from their normal work in order to care for the sick. A shortage of labour has serious consequences in communities where many activities, such as fetching water and firewood, farming, food preparation and cooking, are very time-consuming.

Increased expenditure on medical treatment: Cash income is diverted from other uses to cover medical expenses. Crops and livestock normally used to feed the family may be sold, along with other household assets (such as draught animals, tools and implements, boat engines). In addition, household incomes decrease as a result of the loss of labour due to the illness.

Greater reliance on social networks: Households may be able to withstand some of the short-term losses of labour and income through the support of the extended family, reciprocal labour groups and welfare groups. However, some households may not have strong social networks due to time constraints or they may loose these ties due to stigmatization. Hence the social network may deteriorate just at a time when it is needed the most.

What are the impacts of AIDS-related deaths?

Permanent loss of labour, income skills and knowledge of the deceased: The disease usually strikes the most productive and economically active members of households. Their illness and ultimate death can have serious implications for the short-term struggle for survival and the long-term viability of the household. The position of the remaining household members may be seriously compromised in communities where there are marked gender roles, skills and knowledge. This may drive the remaining spouse to find another partner quickly to overcome these constraints.

Loss of assets following death: The slaughter of livestock for funerals, the absence of property rights and property grabbing by relatives undermine household survival strategies, particularly in households that become headed by women and orphans.

Increased food and nutrition insecurity: Following the loss of labour and assets, households respond by reducing the area cultivated, delaying or skipping operations, and practising poor management. As a consequence, productivity and production falls. Households cope with periods of food insecurity by reducing the number of meals, switching diets, and reducing the number of household members eating at home. Their nutritional status declines and household members become increasingly susceptible to illnesses.

Lower income: Less money is available to buy food, household goods, productive inputs (seeds, fertilizer, fishing nets, livestock medicines) and to save for the future.

Increased social exclusion: Individuals and households become increasingly marginalised and excluded from community activities as a result of stigma and discrimination by the community. Many PLWHA and their families may be driven to self-exclusion, cutting their contacts with the outside world, such as extension, markets, non-farm activities and input suppliers. Widows, in particular, become increasingly isolated especially from services and markets outside the community.

Undermined long-term viability of household: Many of the strategies adopted in the short term, such as the sale of productive assets or the withdrawal of children from school, are often irreversible in the face of persistent poverty. It becomes more difficult for households to secure a living in subsequent seasons. Horizons become very short as heavily-impacted households struggle to meet immediate needs.

Spillover effects beyond the household: The extended family becomes burdened with the care of orphans. Transactions between households (such as seeds, livestock, labour and land) and between generations (including the transfer of knowledge and decision-making responsibilities) are undermined. In heavily-impacted communities, the capacity of traditional safety nets and coping mechanisms to provide continuing support to households is overwhelmed as the HIV/AIDS crisis deepens. Ultimately, the productive capacity and the resilience of the community are eroded over time.

The impacts of AIDS on agriculture and natural resource livelihoods

Agriculture
The nature of production makes some farming systems more vulnerable to the impact of AIDS than others. Farming systems requiring high inputs of physical labour, farm power, purchased inputs and technical skills are very sensitive to the depletion of the household asset base. Systems are more vulnerable if they have limited rainfall, a critical dependence on the timeliness of operations, marked labour peaks and a limited range of crops. For example, tree-based or root crop systems are likely to be more resilient than labour-intensive irrigated vegetable production or cereal cultivation, at least in the short term. The loss of labour, draught animals, tools and equipment, and cash to purchase inputs results in a reduction in the area cultivated, increased land under fallow, switches to less labour-intensive cropping systems, and the abandonment of soil and water conservation practices.

Livestock
The livestock base is often depleted as households struggle to raise cash to buy medicines and food. They are also slaughtered during funerals and may be taken by the relatives of a deceased male. Livestock suffer if household members do not have enough time or fodder to care for them. Widows and children may not have the knowledge and skills to care for specific animals due to gender differences in the ownership and care of animals. A reduction in the draught animal base not only results in a smaller area under cultivation and increases the burden of transporting goods but also reduces opportunities to earn a rental income.

Forests and woodlands
Households in need often resort to communally owned resources such as forests and woodlands as a valuable safety net providing food, medicines and materials for household and livelihood activities. These resources may be over-exploited when whole communities are in crisis, threatening their long term viability as a safety net and reducing the agro-biodiversity of the area. Woodlands and the products and services they provide are also destroyed by uncontrolled forest fires. Fires are a common way of clearing land for farming but they are being used more frequently to overcome labour shortages and by people who lack experience in their safe use.

Fisheries
Fishing communities are among the most heavily AIDS-impacted communities due to their behaviour, lifestyle and environment. As a result of the impact of AIDS, open water fishing practices are changing from fishing in deeper waters to fishing less frequently and closer to shore in areas which are often already over exploited. With fish ponds, less time is spent on feeding fish and pond maintenance. Both systems experience small catches of fish which are of lower monetary value, less capacity to repair fishing equipment and nets, less money to replace equipment or restock ponds, and a loss of specialist knowledge.

Extension services
Extension staff and rural development workers are at risk of HIV infection if they spend extended periods working away from home. This has significant implications for the capacity of these organizations to deliver services to rural communities. Sick staff members are unable to perform their duties, they die and their colleagues have to attend their funerals. The service loses their knowledge, skills and expertise and has no spare capacity to respond to changing needs and priorities of the rural population. In some countries, the loss of staff outstrips the ability to train new replacements, leaving those remaining with heavier workloads. In addition, the financial resources of the organization are drained by the costs of treatment, funerals, compensation, early retirement, retraining and insurance.

See Bibliography in Annex III for specific impact studies

Which individuals and households are more vulnerable to the impacts of AIDS?

The epidemic is creating new patterns of poverty and livelihood insecurity. Those most vulnerable to the impact of AIDS include:

- resource-poor men and women with few resources or social networks to fall back on in times of crisis and few livelihood alternatives;
- households that have already lost at least one key family member to the disease and have had to sell household assets to care for them, and are compromised in their ability to care for another;
- orphans without anyone to care for them;
- women who have to give up their usual livelihood to care for the sick;
- widows with weak control of household resources and who risk losing them to other family members;
- the elderly who are caring for sick children or orphaned grandchildren.

Which communities are more vulnerable to the impacts of AIDS?

Factors that make communities more vulnerable to the impacts of AIDS include:

- weak social cohesion and an absence of social networks and labour exchange between households to provide support to each other in times of crisis;
- limited opportunities to substitute between labour intensive livelihood activities and activities requiring fewer labour inputs;
- limited opportunities to diversify livelihood activities into non-farm employment;
- regular experiences of food insecurity;
- insecure land tenure and weak system of property rights;
- widespread poverty;
- limited access to external support such as information, home-based care, food for work, school feeding programmes;
- weak infrastructure which makes many aspects of rural living very labour intensive, requiring household members to travel considerable distances – often on foot – to collect water, seek health treatment etc;
- advanced state of the epidemic which has exhausted any tradition of welfare assistance within the community.

How can vulnerability to the impacts of AIDS be reduced?

Reducing vulnerability to impacts during AIDS-related illnesses:

- changing attitudes towards HIV/AIDS and PLWHA by creating more openness and less stigma
- improving access to and quality of health care and medication for treatment of opportunistic infections
- increasing use of anti-retrovirals (ARVs) and treatments to prevent MTCT
- providing care and support for PLWHA and caregivers improving nutritional intake of PLWHA
- improving access to relevant labour saving technologies and practices
- strengthening social networks, inter-household linkages and community safety nets
- improving response strategies to make their long term effects less damaging
- gender empowerment
- encouraging people to know their HIV status and plan ahead, prolong life through adjusting lifestyle, avoid infecting others, succession planning

Reducing vulnerability of remaining family members after AIDS-related death:

- succession planning to ensure continued access to, and control over, resources
- gender empowerment
- inheritance and property rights
- ensuring access to services such as extension, health, legal, education
- acquiring and developing life and livelihood skills
- improving access to relevant labour saving technologies and practices
- strengthening safety nets
- providing psycho-social support for orphans and vulnerable children
- recording, storing and sharing agro-biodiversity and local knowledge
- securing and diversifying livelihoods

Section 4

Understanding the Disease: HIV/AIDS and the community

This section explores the different stages of the epidemic that a community passes through, moving from pre-infection to being heavily impacted by the effects of AIDS. The use of proxy indicators to help identify the stage of the disease is discussed. The section concludes by considering the potential scale of the problem based on the limited evidence available.

What is the stage of the disease in the community?

The presence of the disease evolves over time in a community, spanning several years if not decades. The six principal stages are:

(i) HIV/AIDS is almost non-existent with very low prevalence rates but any community is always potentially at risk from infection, especially if members of the community interact with high risk environments and, once infected, act as bridging populations (AIDS-initiating);
(ii) people are HIV infected but not yet showing any symptoms of AIDS-related illnesses (AIDS-impending);
(iii) people are sick with AIDS-related illnesses but their illness is misdiagnosed due to a lack of knowledge about the disease (AIDS-impacted but ignorant);
(iv) people are already sick and dying from AIDS but the community is in a state of denial and ignoring its presence (AIDS-impacted but denial);
(v) infected and affected households are present in the community and the disease is acknowledged as the cause of their plight (AIDS-impacted and acknowledge); and
(vi) HIV prevalence rates are declining but the community remains heavily AIDS-impacted due to the time lag between infection, illness and death.

Identifying the stage of the epidemic at community level is also complicated by the fact that, within a community at any one time, different households are at different stages of the epidemic.

What indicators can be used to estimate the stage of the disease?

If there are no local data regarding HIV prevalence rates, proxy indicators can be used to help determine the stage of disease in a particular community. These indicators reflect the impacts and changes which may be caused by the disease. In order to have some reliability, it is necessary to look a several indicators together since there are many reasons other than HIV/AIDS as to why an individual indicator may be present.

Potential indicators of the presence of the HIV/AIDS epidemic

- Increase in prolonged and recurrent bouts of sickness among adults aged 18 – 59
- Increase in death among adults aged 18 – 59
- Increase in number of young widows or widowers
- Increase in number of orphans
- Increase in number of households fostering orphans
- Increase in dissolution of households
- Increase in number of sick people returning from urban areas to stay at home
- Reduction in the area cultivated per household
- Increase in fallow land
- Change to less-labour intensive livelihood activities (eg less labour-intensive crops or livestock)
- Change in division of labour between household members, use of reciprocal labour groups and labour sharing
- Reduction in household assets
- Loss of property to relatives
- Reduction in number of meals, change in composition of diet
- Nutrition-related (underweight, stunting, wasting, adult Body Mass Index, low birth weight)
- Community response: denial, despair, acknowledgement, pro-active coping

The relevance of the indicators varies between communities. For example, the impact of the loss of labour on the area cultivated, fallow land and switch to less labour-intensive crops is not relevant in communities with large sized families, small areas cultivated per family or a tradition of supporting bereaved households by providing physical labour. Other indicators may be culturally specific, such as the incidence of grabbing property from widows. It may not always be possible to detect changes in household composition if households dissolve (with any remaining members being absorbed into new households) or move away. Changes in food insecurity and malnutrition specifically attributable to the impacts of HIV/AIDS are often difficult to identify. An analysis of who is most at risk of becoming infected and the sources of risk of HIV infection in a rural community (see section 2) provides a context in which to interpret the indicators.

Further insights about the stage of the epidemic may be gained by reviewing the community's response to the disease. The reaction generally changes as prevalence rates increase, moving from a position of denial during the early wave of infections to acceptance and assistance when the disease is well established in a community.

Community response to HIV/AIDS

- ***period of social denial***: The incidence of the disease is relatively limited. Infected persons and affected households are seen as isolated instances and are often marginalised and excluded. In many cases, the illness is attributed to witchcraft and traditional cures are sought. Due to the stigma attached to HIV/AIDS, the disease is generally not named; there is no open discussion about it and little understanding of the kinds of care that could improve the quality of life of HIV-positive persons. Support comes from the extended family, and household assets are sold to pay for medical care and compensate for lost earnings.

- ***period of growing despair***: The incidence of AIDS within the community begins to be noticeable, with the increasing loss of able-bodied adults, break-up of family units, and a growing orphan population. Extended families care for the sick, bury the dead, and arrange for the future care of orphaned children. The nature of the disease is still not openly discussed but indirect references to the epidemic as a tragic destiny become more common. There is growing fear that whole families and even communities may be wiped out. Infected widows and widowers often take new spouses as part of their survival strategy, thereby prolonging their ability to care for themselves and other family members but at the same time, further spreading the disease. The only external help comes from pre-existing rural development or safety net programmes.

- ***period of acknowledgement***: By this stage, when every household has lost at least one family member to AIDS, there is general recognition that HIV/AIDS is affecting all community members. The tendency to isolate affected households decreases. There is often a noticeable decline in food production, as the loss of able-bodied adults forces remaining household members to change their farming and livelihood strategies. Departures from the strict observance of customary practices regarding funeral rites, inheritance and the care of minor children become more frequent as communities seek practical solutions to look after those left behind. Faith-based organizations (FBOs) and other local NGOs begin to provide organised support focusing on the immediate needs of orphans and HIV/AIDS-affected families in distress. The nature of the disease and how it is spread are openly acknowledged. However, messages about the importance of safe sex as a method of prevention may not acted upon due to a lack of motivation and a fatalistic attitude.

- ***period of proactive coping***: Different behaviour patterns begin to emerge which offer some hope for dealing with the widespread presence of HIV/AIDS and its effects. There is full acceptance of the disease, it is openly discussed, and HIV-positive people are less reluctant to talk about their condition. As a result, infected people and their families are able to plan ahead for the future, including passing on knowledge and assets between generations, and making provision for the care of orphaned children. They are able to access healthcare and support services, and are more likely to know about the benefits of good nutrition and life-extending treatments. Farming and livelihood systems are adapted to the new realities. In addition to the FBOs and NGOs, community self-help groups including PLWHA and outreach programmes for orphaned youth and other vulnerable children begin to emerge. Safe sex practices become more common and rates of new infection may begin to decline.

Source: Abridged from FAO (2004)

Interactions between the stages of the disease and community responses are highlighted in the matrix below (Table 1).

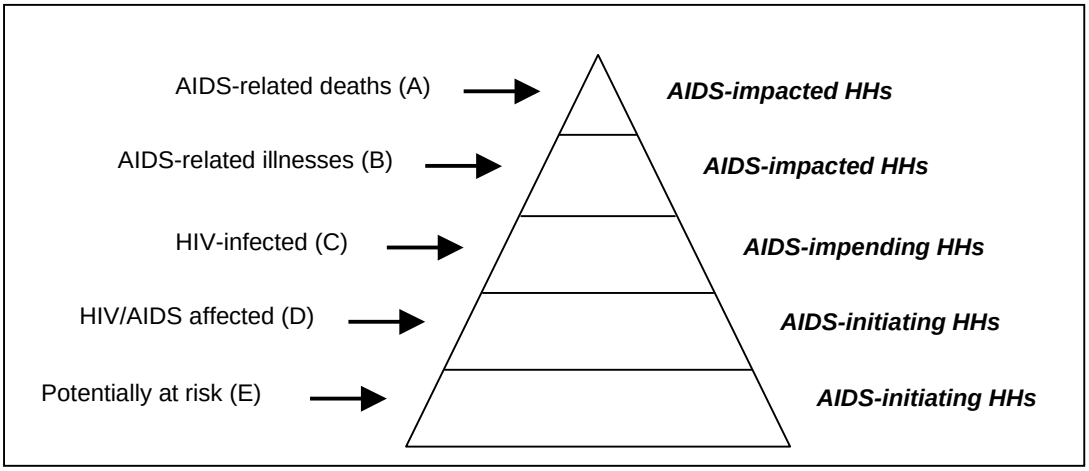
Table 1: Stage of Disease and Community Response Matrix

Stage of disease	Community responses		
	Not aware	**Denial and despair**	**Acknowledgement and pro-active coping**
1. Initiating: low rates of HIV prevalence and very few AIDS-related deaths	Community not aware of disease.	People aware of disease in other communities but do not think (or want to acknowledge) that it may infect or affect members of their community.	Community aware of disease's potential and people are being encouraged to: • avoid infection by changing their behaviour and lifestyles • prepare for potential AIDS impacts by taking precautionary measures to reduce vulnerability (such as succession planning)
2. Impending: rising rates of HIV infection and AIDS-related illnesses and deaths beginning to increase	Community not aware that some members are exposed to risk of infection and AIDS-related deaths are being misdiagnosed.	Community aware of HIV/AIDS but unwilling or unable to acknowledge scale of the risk facing members of the community. PLWHA face stigma and discrimination. AIDS-related illnesses and deaths deliberately misdiagnosed.	Community aware of disease and its impacts and people are being encouraged to: • avoid infection by changing their behaviour and lifestyles • prepare for potential AIDS impacts by taking precautionary measures to reduce vulnerability (such as succession planning)
3. Impacted: HIV infection rates high and community experiencing many AIDS-related deaths	Not relevant	Extent of HIV infection and frequency of AIDS-related deaths commonplace but community unwilling or unable to admit that people are infected with HIV and dying of AIDS.	Disease having significant impacts in community. People being encouraged to: • avoid infection by changing their behaviour and lifestyles • provide effective care and support to PLWHA • change attitudes towards households infected and affected by HIV/AIDS • take measures to overcome AIDS impacts
***4. Impacted (extended*)**: HIV infection rates high and community experiencing widespread AIDS-related deaths	Not relevant	Not relevant	Extent of HIV infection and AIDS-related deaths so high that impossible for community not to respond actively. People being encouraged to: • avoid infection by changing their behaviour and lifestyles • provide effective care and support to PLWHA • change attitudes towards households infected and affected by HIV/AIDS • take measures to overcome AIDS impacts

What is the scale of the problem?

Once a community starts experiencing AIDS-related deaths (A) and illnesses (B) this is only the tip of the problem (Figure 3). It is likely that a larger group is already infected with HIV but not yet showing any symptoms (C). Many household members are affected by the diversion of household resources to care for the sick or by fostering orphans (D). Ultimately the whole community is at risk of infection (E). Hence the scale of the problem presents a serious challenge to extension work even if prevalence rates are relatively low.

Figure 3: HIV/AIDS Pyramid



HHs = households

An estimate of the scale of the problem

Assuming an average household size of five and making allowance for the fact that in some households more than one person is infected, it is possible to estimate the proportion of the community affected by the disease. For example, if 5% of the community is either infected or dead from AIDS, an additional 10 – 20% of the community is directly affected their illness and death. If 20% of the community is either infected or dead from AIDS, over 60% of the community is affected. Once 30% of the community is either infected or dead from AIDS, almost everyone is affected.

PART 2

RESPONSE BY EXTENSION WORKERS

Part 1 has provided a broad overview of HIV/AIDS and identified some of its major implications for rural households and communities. Part 2 explores how extension workers may respond to the implications of the epidemic in their work programmes. The first task of the extension worker is to identify the nature and impacts of the disease through community dialogue (section 5). Four tools are described which may be used with community groups and representatives to structure the discussion. A detailed guide on how to use each tool and examples of completed templates are provided in Annexes I and II respectively. Extension workers should modify the tools to their own context to ensure that they are relevant and everyone understands them.

The second step for the extension worker is to draw out the implications for extension activities from these findings (section 6). Again, details about the tools used are presented in Annex I and completed templates in Annex II.

The final step for the extension worker is to identify opportunities for agriculture and the natural resource sectors (covering crops, livestock, fisheries and forestry) to contribute to HIV/AIDS prevention, care and mitigation (section 7). Details about the sector contributions are described in Part 3.

Section 5

Community Dialogue to Identify the Nature and Impacts of HIV/AIDS in the Community

This section describes how the extension worker can establish a dialogue with the community about HIV/AIDS. Four tools are used to understand the disease in the context of the community, covering sources of risk of infection and vulnerability to impacts, the impacts of AIDS on household composition and the livelihoods of vulnerable groups, and the profiles of organizations and groups active in the community.

Community dialogue as a process of empowerment

The dialogue between extension workers and rural communities about HIV/AIDS serves two purposes. First, it helps guide extension workers in how to address HIV/AIDS in their work. Second, these discussions are an opportunity for empowering the community to be better informed about the disease, increase their understanding about the risks they face, and recognise the impact it is having on their livelihoods and how those impacts differ between different types of household. The community also sees how its own attitudes, cultural norms and responses either help or hinder the community's ability to withstand the epidemic.

Inter-disciplinary approach

The extension worker may call on the services of others, such as HIV/AIDS coordinators, health workers, teachers, social workers, NGOs and district administrators, to assist with the community dialogue. Such collaboration may enable extension workers to achieve more than working alone. It also ensures that other agencies have a better understanding of the contribution of the agriculture and natural resource sectors to addressing the epidemic.

Mobilising the community

Drawing on their knowledge and experience of the community, extension workers should call a meeting of the whole community or its representatives including village elders, key informants, and leaders of CBOs, FBOs, interest groups, associations, clubs and self-help groups. It is important to ensure that the vulnerable groups, particularly women, the poor, the youth, orphans and vulnerable children, have the opportunity to participate. If it is neither possible nor culturally acceptable to call one meeting, separate meetings should be arranged for women, men and the youth. The timing and the venue should be suitable for all.

Although extension workers are very familiar with mobilising communities and their representatives to participate in meetings, the topic of HIV/AIDS is very sensitive and may require different approaches, depending on the stage of the disease in the community and how the community has responded to date. Stigma and discrimination often surrounds HIV/AIDS due to misunderstandings and misconceptions about sources of infection, in particular its association with immoral behaviour. It is easier to discuss HIV/AIDS in communities which already acknowledge the full reality of AIDS and are actively trying to cope with its impacts, than in communities which are in denial and discriminate against PLWHA and their families. Stigma also makes it difficult to reach the more vulnerable groups since targeting may draw more attention to their plight. Infected people often try and hide their status for fear of discrimination and, once the symptoms become apparent, many isolate themselves and withdraw from public space.

Tips on dealing with stigma and discrimination during community mobilisation

- Be tactful and sensitive to PLWHA and their families
- Avoid language or behaviour which will offend or hurt them
- Avoid stigmatising or discriminating actions or language with others
- Include PLWHA and their families in community discussions
- Identify opportunities to use PLWHA as a resource during discussions
- Ask local HIV/AIDS specialists to assist with the community dialogue
- Increase community understanding about the basic facts of the disease

Structuring the community dialogue

The community dialogue is a participatory process structured around four tools which are described in detail in Annex I and examples of completed templates are in Annex II. The tools are presented as a guide and should be adapted to make them relevant to the community.

- **Tool 1: HIV/AIDS Pathway**: provides a practical framework for explaining the basics of HIV/AIDS, discussing the nature of the disease in the community, identifying sources of risk of infection for individuals and exploring factors that make households more or less vulnerable to the impacts of AIDS.
- **Tool 2: Community Household Composition**: identifies changes in the distribution of households in the community between the main types of household over the last 10 years, as well as changes in household size, and the reasons underlying those changes.
- **Tool 3: Organization and Group Profiling**: identifies the different organizations and groups active in the community, their origins and current status, the socio-economic and gender composition of their membership and leadership, and their potential role as entry points for addressing HIV/AIDS.
- **Tool 4: Livelihoods Analysis of Vulnerable Households and Groups**: reviews livelihood assets, strategies and outcomes of different types of household or group in the community and identifies their strengths and weaknesses.

A tentative schedule for the community dialogue is set out in Table 2. Ideally the whole community participates in the HIV/AIDS pathway exercise (Tool 1) in order to get maximum benefit from using the community dialogue as a process of empowerment. Discussions about household composition (Tool 2) and organization and group profiles (Tool 3) may be used with community representatives or key informants. The livelihoods analysis (Tool 4) provides a structure for small groups discussions or individual interviews with representatives of different household types or vulnerable groups. If time is a constraint and several extension staff members are available, some of these sessions may be run concurrently.

Table 2: Tentative Schedule for Community Dialogue

Whole community or groups within community	Community representatives and key informants	Vulnerable groups
• Tool 1: HIV/AIDS pathway *Note: this activity takes place first. It may be completed in three long sessions, with several groups working concurrently, or in nine separate sessions of 1 – 2 hours each.*	• Tool 2: Community household composition (1 hour) • Tool 3: Organization and group profiling (1 hour) *Note: these two activities could take place concurrently with two separate groups.*	• Tool 4: Livelihoods analysis (1 – 2 hours per group) *Note: this activity takes place after Tool 2. Small group discussions or individual interviews could run concurrently.*

Outputs at the end of the community dialogue

By the end of the community dialogue (Tools 1 to 4) both the extension workers and the community have a clearer understanding about the dynamics of the disease in the community and the impacts it is having on vulnerable groups. They recognise the ways in which the community is helping infected and affected households cope with the disease, and any community attitudes and responses which are counter-productive. Opportunities to address the disease more effectively are identified. Extension workers now reflect on the implications of these findings for their future work in the community. As a result of the dialogue, communities may also be empowered to initiate their own response to the epidemic.

Section 6

Reflecting on the Findings

Following the community dialogue, the next step for extension workers is to reflect on the findings and their implications for extension activities, particularly in terms of the client groups and their priority needs. Groups conventionally targeted by extension messages, such as the more progressive farmers interested in improving their production, may no longer be relevant in high AIDS-impacted communities where most households are concerned about their basic survival and reducing the vulnerabilities of the next generation. Similarly, traditional methods of communication may no longer be appropriate. Many women and men have less time to attend meetings and demonstrations as they strive to meet their daily needs, including the care of the sick and attendance at funerals, with a reduced household labour force.

Tools for reflection

It is probably most effective if extension workers meet with other colleagues and HIV/AIDS specialists to reflect on the findings from the community dialogue. Three tools draw together key information; guidance on their use is presented in Annex I and examples of completed templates are in Annex II.

- **Tool 5: Stage of Disease and Community Response**: summarises the stage of the disease in the community and the nature of community responses.
- **Tool 6: Client Groups and Their Priority Needs**: identifies who are the priority groups for extension work, their problems and most pressing needs in the era of HIV/AIDS.
- **Tool 7: Ongoing HIV/AIDS Activities**: reviews who is currently working on HIV/AIDS activities in the community and their target groups.

Outputs at the end of the reflection

At the end of this process, extension workers have a clear understanding of the stage of the epidemic in the community, priority client groups for the extension service in the era of HIV/AIDS and their needs, and an overview of ongoing HIV/AIDS activities in the community.

Section 7

Key Considerations for Extension Responses

Focus of extension response

The principal focus of the extension response is determined by:

- What is the stage of the epidemic in the community (Tool 5)?
- Who are the priority clients and what are their needs (Tool 6)?
- Who, including the community, is doing what to address the epidemic at present (Tool 7)?
- How may the agriculture and natural resource sectors contribute to addressing the priority needs of the client groups, and which organizations can provide additional assistance (Tool 8)?

The stage of HIV/AIDS epidemic in community influences the principal thrust of activities (Table 3). In communities where few members of the community are infected, most of the emphasis is on increasing awareness and understanding about the disease with a view to reducing the risk of infection. In communities where a significant proportion of the population are already infected but not yet sick with the disease (AIDS-impending), priority is given to preparing households to reduce the impacts of AIDS. Finally, in AIDS-impacted communities, attention is focused on providing care and support to PLWHA and their families and adjusting to the impacts of the disease. However, in any community, it is likely that all stages of the disease are present in different households, so all activities are relevant, to a lesser or greater extent. Opportunities for the agriculture and natural resource sectors to contribute to realising these objectives are discussed in sections 8 and 9.

Table 3: Principal Focus of HIV/AIDS Activities According to Stage of Epidemic

Stage of epidemic	Focus	Objectives
All stages	Reducing the risk of HIV infection	• Increase awareness and understanding of HIV/AIDS • Change behaviour and attitudes at individual and community levels • Reduce risky behaviour, lifestyles and environment
AIDS-impending	Preparations to reduce vulnerability to impacts of AIDS	• Maintain and improve health and nutritional status • Secure asset base • Secure and diversify livelihoods • Record, store and share agro-biodiversity and local knowledge
AIDS-impacted	Providing care and support for PLWHA and their families	• Maintain and improve health and nutritional status • Psycho-social support • Prevent infection of others
AIDS-impacted	Adapting to overcome impacts of AIDS	• Adapt livelihoods to new resource base with less labour, fewer assets, fewer skills, lower income • Care for orphans • Provide economic and social support for severely affected households

Protecting and enhancing livelihoods

In the short-term, the urgent priority is to protect livelihoods through reducing vulnerability and ensuring the survival of households most at risk. In the medium to longer term, livelihoods need to be enhanced if members of rural communities are to enjoy an improved standard of living and well-being. How this will be achieved depends on the profitability of agriculture and the dynamism of the non-farm economy. They will influence the extent to which subsistence farmers will expand and diversify, or exit from agriculture.

Ten guiding principles for extension work in the era of HIV/AIDS

- to **understand** the implications of the disease for one's own life;
- to **mainstream HIV/AIDS** considerations into the extension work programme;
- to reduce **stigma and discrimination** associated with the disease;
- to reduce the risk of HIV infection among the **youth**;
- to encourage and support the **community** to be actively involved in addressing the disease, including reviewing their norms and behaviour which contribute to the spread of the disease;
- to promote **gender empowerment** as a means of reducing the risk of HIV infection and vulnerability to the impacts of AIDS;
- to ensure the HIV/AIDS-related needs and priorities of **vulnerable groups and households** are recognised and addressed;
- to follow a **flexible and participatory process** with the community;
- to adopt an **inter-disciplinary** and **innovative** response forming new linkages between technical services and **partnerships** with government services, NGOs and private sector; and
- to **advocate** and increase understanding among other stakeholders of the potential contribution of agriculture and the natural resource sectors in addressing HIV/AIDS.

The challenge of working with vulnerable groups

Households headed by widows, grandparents and orphans are becoming more common in the community, largely as a result of HIV/AIDS. However, it may be difficult for them to participate in meetings and training opportunities: extension staff may not know them or they may not have time to attend. Their livelihoods are often under severe stress due to a shortage of labour, limited cash, depleted assets, gaps in their knowledge and skills base, and difficulties in accessing services. Under these circumstances, they are both unwilling and unable to expose their households to risks that may threaten their very existence. Hence any activities proposed for these groups must take full account of the constraints they face.

Young **widows** are especially at risk from HIV infection which they may have acquired from their husbands or as a result of using sex as a survival strategy in exchange for food, cash or other favours. If they are already HIV-positive, they may have several years before the onset of AIDS-related illnesses. During this time, there is a window of opportunity to help them prepare for the future livelihoods of their children. Non-infected widows need to be empowered to remain free from HIV. Single married men whose wives have died are less common because many remarry quickly and others are in polygamous relationships.

Orphans and vulnerable children not only face the challenge and stress of caring for their sick parents, but also trying to survive the aftermath of their death. In addition losing family property, orphans lose the chance to learn and develop life skills from their parents. They are more likely than other children to drop out of school and suffer from malnutrition, disease, abuse, sexual exploitation and discrimination. They need care, opportunities to develop life skills and self-esteem, and, above all, the ability to avoid engaging in HIV-risky behaviour.

Grandparent-headed households provide crucial support to orphaned grandchildren but their capacity to do so may be limited by their physical strength and the emotional stress of watching their own children die. They may also have limited physical and financial resources if these have already been distributed to their children. In communities which have been severely impacted by AIDS for over a decade or so, many of the older generation has passed on, and those remaining may be overwhelmed with orphan care.

The **rural youth** are particularly vulnerable to HIV infection. After finishing their schooling, their opportunity to make a living in the rural area may be limited. If they move to town in search of employment, they may end up in HIV-risky environments and lifestyles. Nevertheless they represent the window of hope for stemming the next wave of HIV infection. By encouraging them to remain in school and strengthening and diversifying their livelihood options in the rural areas, it may be possible to change their outlook towards the future, remain in rural areas and avoid HIV-risky behaviour and environments.

Development and humanitarian activities

It is useful to differentiate between activities which are broadly humanitarian (providing immediate assistance to support livelihoods in the short term) and development activities (which develop the capacity of rural livelihoods over the medium to long term). Both are necessary and relevant, and a combination is often the most appropriate option. This distinction may also have implications for funding opportunities.

Targeting

The process of targeting is always difficult and potentially open to misuse. It can create a dependency on handouts, crowd out self-help initiatives, undermine the private sector, and attract the attention of the non-vulnerable. It works best when self-targeting interventions reach the vulnerable without distorting the market and include an exit strategy to enable individuals and households to graduate from requiring assistance. In the era of HIV/AIDS, targeting may be seen to be appropriate on humanitarian and welfare grounds. However, unless it is approached with sensitivity, households may prefer not to be targeted because of the stigma attached to being among the HIV/AIDS-affected and poorest households.

Reduction of risk associated with adopting new technologies and practices

When dealing with the devastating impacts of AIDS, there is no time to work only with tried and tested activities. In order to enable vulnerable households to participate immediately in activities which may strengthen their livelihoods, mechanisms need to be found to reduce the element of risk. For example, food, seeds or other inputs may be distributed in return for participating in a training programme to learn new skills or for adopting new technologies or practices on the farm.

Tool for identifying opportunities

One tool is used to set out the contribution of agriculture and natural resource sectors in addressing HIV/AIDS through the extension service. It is described in Annex I and an example of the completed template is in Annex II.

- **Tool 8: Extension opportunities and partners**: identifies opportunities for agriculture and natural resource based activities to address the priority needs of various target groups and potential partners.

Potential partnerships

Throughout this process, extension workers need to work closely with the community leadership. In addition, there is a wealth of expertise and a variety of resources which the extension service may draw on to assist in addressing HIV/AIDS. In many countries there is now a comprehensive network of players, ranging from other government services (particularly health, nutrition and education), local administration, international and national NGOs, CBOs, FBOs, self-help groups and the private sector. However, many are based in urban areas and have little experience in working in rural communities. Consequently it is essential for the extension service to mobilise its expertise and complement these initiatives in order to provide an effective rural response.

Some of the issues arising from the community dialogue, such as the need to improve the basic infrastructure in order to make rural life more attractive and reduce the urge to migrate, are beyond the scope of work for extension staff. However, they can voice these concerns in an appropriate forum for others to follow up.

Duration and possible sources of funding

Many countries have established funds specifically to address the challenges of HIV/AIDS. In deciding how to respond to the epidemic, extension workers need to be fully aware of potential funding opportunities and eligibility criteria. They may guide and assist communities in applying for such funds. However, the ability of communities to respond by drawing on their own resources should be recognised and care should be taken to ensure such initiatives are not undermined by external interventions.

PART 3

OPPORTUNITIES TO ADDRESS HIV/AIDS THROUGH AGRICULTURE AND NATURAL RESOURCE SECTORS

There are three principal ways in which the agriculture and natural resource sectors may contribute to addressing the HIV/AIDS epidemic in rural households through:

- **Food and nutrition security**: Food and nutrition security plays a crucial role in both preventing HIV infection and caring for the infected. Food security enables people to stay at home and cultivate their land, thereby enabling rural communities to remain intact and care for orphans, and removes the need for people to adopt HIV/AIDS-risky behaviour in order to survive. Providing nutritional care and support for PLWHA is an important part of care at all stages of the disease. Good nutritious food is often the only treatment available to the rural poor, delaying progress between infection and full-blown AIDS. Even with access to ARVs, a balanced diet is crucial for their effective utilisation. If PLWHA are able to keep active for longer, they can contribute to household activities and work, and reduce the burden of care on other household members.

- **Livelihoods security**: Secure livelihoods enable people to remain in rural areas and be less likely to resort to HIV-risky lifestyles in order to make a living. Households with secure livelihoods are also in a stronger position to cope with the impacts of the disease if household members become infected. Agriculture and the natural resource sectors can contribute to strengthening existing and diversifying the range of livelihood activities.

- **Sense of well-being and vision for the future**: In order to achieve a sense of well-being and an ability to plan for their future, household members need: a reduced burden of daily living; security over their asset base; access to services and markets; empowerment to participate in decision-making and share in the benefits of production; and the option to develop new skills and acquire knowledge. They also need the capacity and access to support to care for orphaned children in the event of the untimely death of their parents.

It must be recognised that subsistence agriculture is not a panacea. Whilst strengthening subsistence agriculture provides a short-term solution to the HIV/AIDS crisis in rural areas, it does not have the capacity to provide the long-term solution for all. By definition, livelihoods based on subsistence farming survive at the margin and are highly vulnerable to the influence of external shocks, such as drought, floods, pest attack and livestock diseases. However, considerations of longer term strategies are beyond the scope of this guide.

Part 3 provides an overview of the different ways in which the agriculture and natural resource sectors may contribute to strengthening food, nutrition and livelihoods security in the era of HIV/AIDS (section 8). Ways in this potential may be mobilised and strengthened are discussed in section 9.

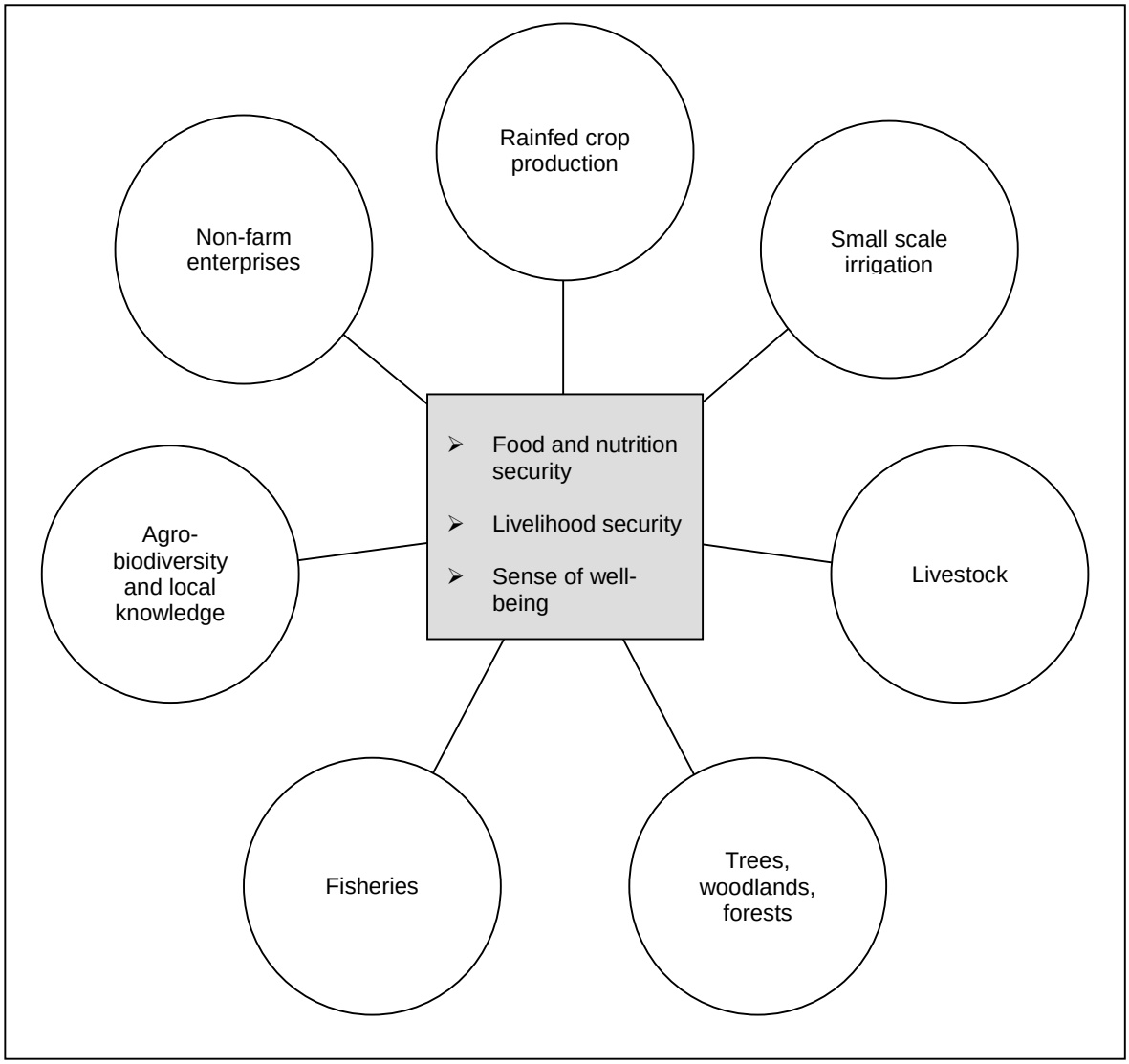
A bibliography of relevant manuals and guides prepared by FAO is presented in Annex III.

Section 8

Agriculture and Natural Resource Sector Contributions

An overview of the different ways in which the agriculture and natural resource sectors may contribute to strengthening food, nutrition and livelihoods security in the era of HIV/AIDS is presented in Figure 4 and described below. Ways in which these contributions may be mobilised and strengthened are discussed in section 9. Supporting FAO guides and manuals are presented in the bibliography in Annex III.

Figure 4: Contribution of Agriculture and Natural Resource Sectors to Addressing HIV/AIDS



(i) Rainfed crop production

The majority of rural households rely on rainfed crop production as their core livelihood activity for meeting most of their food needs and as a source of cash for other household requirements. In areas of relative land abundance, the ability to cultivate land rather than the availability of land, is a major determinant of food security. Factors that compromise the ability to cultivate sufficient land have long been recognised as a source of poverty. Hence AIDS-related sickness and death and the associated loss of assets, including farm tools, draught animals and ploughs, are having a devastating effect on rainfed crop production. Labour saving technologies and practices can assist in reducing the labour requirements of different cropping systems, for example, through the use of reduced tillage and cover crops to suppress weeds (see section 9).

Other ways in which the food production system may be made more secure include: community seed systems to enable farmers to have access to a diverse range of seed resources; soil and water conservation methods to improve soil fertility and water retention; improved handling and storage facilities to reduce post harvest losses; and village cereal banks to dampen price fluctuations throughout the season.

(ii) Small scale irrigation

Small plots of irrigated land enable households to improve their food security by growing food crops out of season and many also venture into commercial crop production. However, small scale irrigation activities are time consuming, requiring labour to construct and maintain the irrigation facilities, as well grow irrigated crops which are often more labour intensive than rainfed systems. Labour saving technologies such as treadle pumps and drip irrigation systems may enable households who are short of labour to share in the benefits of an extended growing season.

(iii) Small livestock

Small animals (such as pigs, sheep, goats, poultry and rabbits) play a vital role in many rural livelihoods, providing food, income and security. Small livestock products are rich in protein, minerals and vitamins. They are sources of income and manure for use as compost or fuel, and a store of wealth and insurance. Small livestock may enable women to have more economic independence if they control the income earned from the sale of livestock and their products. Tending to the day-to-day needs of small livestock can be integrated into the time and labour constraints facing many HIV/AIDS affected households.

Community-managed flocks of sheep, goats or poultry can play multiple roles as an AIDS-response strategy. In addition to providing income for the group managing the flock, they are a source of animals to distribute to vulnerable households in the community. The flock can be used as a basis for passing on skills and demonstrating simple low cost improvements in animal husbandry to the community.

(iv) Trees and forests

Trees, forests and woodlands fulfil multiple roles in food security and livelihood strategies. They provide materials for housing, cooking, heating, furniture, fodder and opportunities for alternative livelihood activities, such as handicrafts and bee keeping. Wild food plants, nuts, fruits, mushrooms and bush meat are nutritious sources of vitamins and minerals and can form an important part of the diet during the hungry season. Some wild plants have medicinal properties and may help boost the immune system and treat opportunistic infections that are associated with AIDS. Forests provide an essential safety net for poor and vulnerable households in times of crisis.

Trees can also play a role in longer term livelihood strategies by: assisting in securing land tenure, since trees are often taken as an indicator of tenure; improving the use of fallow land by planting multipurpose trees and shrubs to provide fruit, fodder and fuelwood and contribute to improving soil fertility; and increasing the efficiency of use of land and labour through agro-

forestry. Investments in community-managed woodlands can be used to generate income to benefit the community in the future, as well as provide a source of forest and non-timber forest products.

(v) Fisheries

Fish is an important source of nutrition: it contains large quantities of high quality proteins and fats, is easy to prepare and digest, and is tasty. Hence it can play an important role in improving nutritional intake, particularly of the sick. Fish farming, through the use of small fish ponds and fish cages, and diversifying the species cultured, provides an opportunity for livelihood diversification and income generation. It may be integrated with other activities, such as vegetable gardening, small livestock rearing, and irrigated agriculture.

(vi) Agro-biodiversity and local knowledge systems

Over time, communities have developed a diverse resource base of cultivated and wild plants, trees and livestock, and site- and gender-specific knowledge which enable them to sustain and enhance their livelihoods. Traditional crops, neglected and underutilised species, wild food and medicinal plants and livestock and local knowledge represent valuable assets for improving nutrition, food security and health care. They may also be used to overcome some of the constraints facing conventional agricultural production, such as the inability to purchase inputs or shortage of time, by utilising local seed sources and less labour intensive cultivation practices.

However, their continuing existence is threatened by the impact of HIV/AIDS. Community-owned resources, such as open water fishing and forests, and the agro-biodiversity contained therein, are at risk from over-exploitation by households with few livelihood alternatives. Similarly, knowledge systems are at risk from the untimely death of adults before they have the chance to share their skills and knowledge with the next generation. Mechanisms are required to enable communities to develop, record and share local knowledge about agro-biodiversity, both within and between communities, and between generations.

(vii) Non-farm enterprises

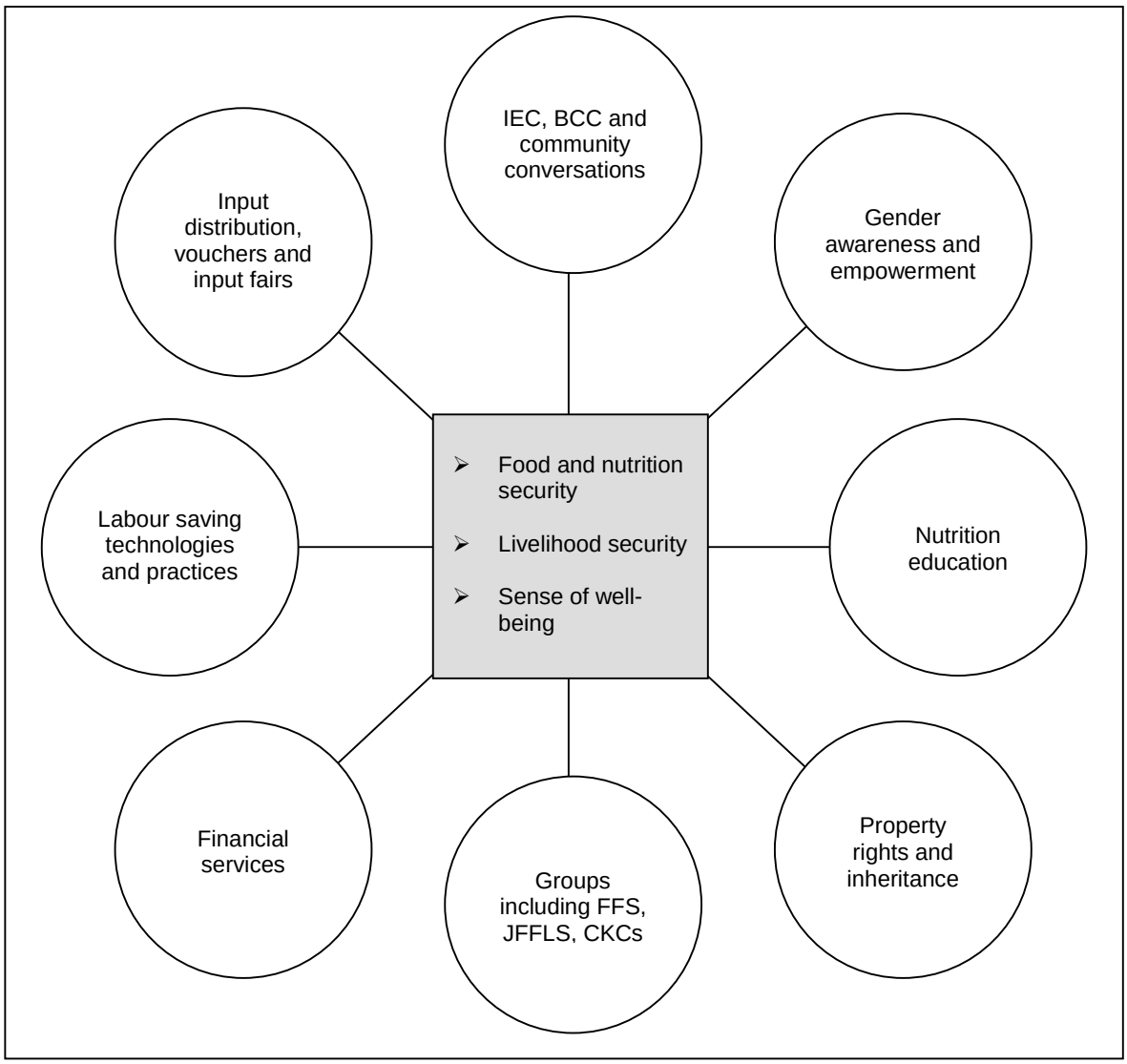
In rural areas, there are usually limited opportunities for waged non-farm employment. Self-employment in enterprises run by small groups can provide an opportunity to diversify livelihoods and develop new sources of income. Group-based activities may be more successful than individual initiatives because they combine the different abilities of their members, mobilise more resources, provide easier access to services, have more bargaining power, form a basis for saving, and members are often better motivated when working together. In addition to small-scale commercial farming ventures (such as poultry, livestock fattening or horticultural crops), non-farm opportunities include textiles, food processing and other ways of adding value to crop and livestock products, bee keeping, tree nurseries, transport services, blacksmithing and labour groups.

Section 9

Actions for Mobilising and Strengthening Sector Initiatives

There are various ways in which the potential contribution of the agriculture and natural resource sectors to address HIV/AIDS may be mobilised and strengthened (Figure 5). They are described below and supporting FAO guides and manuals are presented in the bibliography in Annex III.

Figure 5: Activities for Mobilising the Agriculture and Natural Resource Sectors to Address HIV/AIDS



IEC *Information, education and communication*
BCC *Behaviour change communication*
FFS *Farmer field school*
JFFLS *Junior farmer field and life school*
CKC *Community knowledge centre*

(i) Information, education, communication and community conversations

Rationale: A key element to addressing the HIV/AIDS epidemic is to increase understanding about the disease (through Information, Education and Communication (IEC)) and to change behaviour at individual, household and community level (through Behaviour Change Communication (BCC)). Extension workers have a unique opportunity to reach many rural households who otherwise have little contact with sources of information.

Activities: A variety of communication channels need to be used to have maximum outreach, such as rural radio programmes, audio and video cassettes, songs, drama, puppet shows, newsletters, leaflets and posters, non-formal and formal education curriculum materials. The central theme of the communication campaign is the relationship between HIV/AIDS, food and nutrition security, rural livelihoods and poverty. However, the focus is tuned to the stage of the epidemic in a community, depending on whether the disease is initiating, impending or impacting. Nevertheless, it will always be necessary to have BCC among young girls and boys before they become sexually active. Community conversations (promoted by UNDP) can be used as an entry point for encouraging behaviour change through providing a forum for community discussion about HIV/AIDS risks, paying particular attention to cultural aspects which contribute to the spread of the disease and cause stigma and discrimination.

(ii) Awareness of gender issues and gender empowerment

Rationale: Gender roles and relations contribute to the spread of HIV infection by placing women and girls in a weak position to negotiate for no or safe sex. Women are made more vulnerable to the impacts of the disease by their limited economic independence, their role as care providers in the home, and their weak legal rights to land and property.

Activities: An important element of any strategy to address HIV/AIDS is, first, to raise awareness about gender issues, in particular women's and men's differing access to and control over resources, and participation in decision-making and, second, to identify opportunities for poor rural women and men to strengthen and diversify their livelihoods.

(iii) Nutrition education

Rationale: Even at the early stages of HIV infection when no symptoms are apparent, HIV makes demands on the body's nutritional status, increasing energy requirements by 10 – 30%. The risk of malnutrition increases significantly during the course of the infection. Good nutrition helps maintain and improve the nutritional status of a person with HIV/AIDS, delays the progression from HIV to AIDS-related diseases, and complements and reinforces the effect of any medication, such as ARVs.

Activities: Nutrition education and demonstration gardens, coupled with practical experience of growing and cooking using nutritious ingredients, may be undertaken in schools (through the school curriculum and creating school gardens), at health centres, nutrition rehabilitation units, hospitals and with interest groups and self-help groups in the community.

(iv) Property rights, inheritance and succession planning

Rationale: The livelihoods of people with weak inheritance rights may be threatened if they lose a spouse (through death or divorce) or parents. Women and adolescents are the most at risk in communities where, under traditional customary practices, land and other forms of property are owned and inherited by adult male relatives.

Activities: The extension service can assist by: advocating for land tenure reform, land titles for women and the abolition of asset stripping; raising awareness and sensitising communities about the inheritance rights of women, orphans and the youth; and supporting para-legal training.

(v) Groups including Farmer Field Schools, Junior Farmer Field and Life Schools and Community Knowledge Centres

Rationale: Small groups are an effective way of mobilising skills and resources and undertaking small risks to improve livelihoods. They are also an efficient channel for delivering development services (such as extension and financial services) and they provide an entry point for raising awareness about gender and HIV/AIDS issues. Mutual self-help groups may also provide support and assistance to each other in times of need. Inter-group associations enable small groups to pursue broader objectives such as gaining access to external markets, influencing the policy process or developing community facilities. Cooperatives and cooperative associations may offer similar benefits to members. Membership criteria, particularly in terms of time and monetary contributions, should not be too onerous to enable PLWHA, their families and other vulnerable people to have the opportunity to participate and benefit from group activities.

Farmer Field Schools (FFS): FFS are set up by a group of 25 – 30 people within a community to develop their skills and knowledge in a range of topics determined by the group. One member is trained as the FFS facilitator and trials are conducted on a piece of land allocated to the school. Weekly meetings are held to identity problems in their production system, to design and carry out field experiments on the FFS land, and to interpret the results. Specialist expertise may provide technical inputs to assist with a particular problem. The lessons from FFS are replicated on the home plots. FFS also provide an entry point for other topics, such as raising awareness about HIV/AIDS and gender issues, nutrition and hygiene, marketing and non-farm enterprises. The schools are initially established for one season but may evolve into a permanent feature, possibly supported by their own income generating activities. Several FFS can be established in a community focusing on different core interests (for example, separate FFS for livestock keepers, farmers using small scale irrigation and organic farmers) or different groups of people (women, men, the youth or home-based carers).

Junior Farmer Field and Life Schools (JJFLS) are 'schools without walls' where 25 orphans and vulnerable girls and boys (aged 12 to 18 years old) are empowered through a year long educational programme covering agricultural and life skills. Extension workers, school teachers and social animators act as facilitators, meeting with the children three times per week. The JFFLS encourage children to learn by working on the JFFLS farm plot, growing staple food crops, crops with a high nutritional value, cash crops, indigenous and medicinal plants, and rearing small livestock. The schools also address broader life skills such as HIV/AIDS awareness, gender issues, child protection, psycho-social support, empowerment through the performing arts, succession planning, nutritional education, business skills and savings. Through this process, the children develop their self-esteem, share their knowledge with their families and communities, deepen their sense of social and cultural belonging, and have a more positive outlook for the future. They may also be provided with meals and take-home rations supported, for example, by the World Food Programme. JFFLS create close links with the community, faith-based organizations and formal school environment to ensure continued support for their activities. JFFLS may develop into independent rural youth groups engaged in longer-term income-generating activities.

Community Knowledge Centres (CKCs): These centres are a mechanism for developing, recording and sharing local knowledge and agro-biodiversity, both within and between communities. For example, gardens are located at primary schools and health centres as a locally-run resource for collecting, growing, storing and supplying materials. Links are established with traditional practitioners using local knowledge in their livelihoods and conserving materials either on their own land or in the natural environment.

(vi) Financial services

Rationale: Access to savings or financial services are important for improving people's lives. In the era of HIV/AIDS, the livelihoods of many rural poor are in such a precarious position that not only is their capacity to save completely undermined by the impact of AIDS but also many resort to the sale of assets in order to raise cash. Simultaneously, the viability of rural

credit programmes is threatened by HIV/AIDS affected households defaulting on loan repayments and diverting loans originally intended for productive purposes to cover medical expenses.

Activities: The ability to access short term credit to meet immediate needs, rather than resorting to selling assets, would place households in a much stronger position to recover from the impacts of AIDS. Savings and medium term finance may be used to develop group initiatives to strengthen and diversify livelihoods. Credit provisions should be sensitive to situation of vulnerable households with regards to requirements for collateral and repayment conditions, particularly for women and the youth.

(vi) Labour saving technologies and practices

Rationale: Many activities in rural communities are highly dependent on manual labour. Significant inputs of time and energy are required to clear and till the land, to harvest and process the produce, to fetch water and firewood for cooking, to make and repair homes, to create and maintain soil conservation structures, and repair rural roads. In this setting, an illness such as HIV/AIDS which is prolonged and deadly can have devastating impacts on the sustainability of rural livelihoods.

Activities: Labour saving technologies and practices can reduce the labour peaks associated with farming by, for example, reducing land preparation through reduced tillage and using cover crops to suppress weeds, or extending the use of draught animals into secondary tillage, or switching to less labour intensive crops or livestock. They can also reduce the burden of daily household tasks through promoting simple technologies such as roofwater harvesting, fuel-efficient stoves, food processing, woodlots and agro-forestry, and simple transport systems.

(vii) Input distribution, vouchers and input fairs

Rationale: During short-term emergencies, it may be necessary to provide targeted assistance to the most vulnerable rural households to enable them to continue to produce food in the following season and pave the way for longer-term food security.

Input distribution: Essential inputs, such as seeds, tools and equipment for farm and household use are distributed directly to poor and vulnerable households.

Vouchers: These are an alternative means of enabling households to gain access to such inputs. They may also be extended to service provision, such as hiring labour, draught animals or tractors; milling; water fetching; child care, laundry; or cooking. Vouchers may be issued in the form of tokens for specific, pre-determined uses; have a nominal monetary value for a restricted range of uses; or have a monetary value that is fully flexible and can be used for any purpose. Potential recipients of vouchers include people caring for the chronically sick, households fostering orphans, vulnerable households, members of bereavement or welfare groups, or people providing assistance to households under stress by helping with key household and farm tasks. They can be used to support fledgling service providers (such as labour groups) and traditional safety nets.

Input trade fairs: Fairs are organised when inputs are not readily available through the private sector and often complement voucher schemes. They strengthen local market and exchange mechanisms, and can be used to mobilise local agro-biodiversity resources (in particular, seeds). They are usually organised by a committee representing local government services, NGOs and CBOs. Fairs are attended by sellers (such as seed and tool companies, local small scale seed producers, artisans, manufacturers and other traders) and around 500 households who are issued with vouchers.

ANNEX I

TOOLS FOR IDENTIFYING THE STATUS AND IMPACTS OF HIV/AIDS IN THE COMMUNITY

Annex I provides guidance on how to use the tools outlined in Part 2. Tools 1, 2 and 3 are used with community representatives, key informants or the whole community. Tool 4 is used to guide separate discussions with different types of household in the community.

Extension workers use tools 5, 6 and 7 to reflect on the findings from the community dialogue and identify potential clients, their priority needs and the nature of ongoing activities at present. Tool 8 sets out the potential extension response, identifying activities, methods of delivery and potential partners.

Each tool is accompanied by a template that can be used to record responses. Examples of completed templates are presented in Annex II. The description of the tools should be used as a guide, and adapted and modified to suit local conditions as necessary.

Tool 1: HIV/AIDS Pathway: A Framework for Community Dialogue and Empowerment

Template 1.1: HIV/AIDS Pathway
Template 1.2: Potential Sources of HIV Infection for Different Household Members
Template 1.3: Potential Drivers of HIV Infection for Different Household Members
Template 1.4: Opportunities to Reduce Risk of HIV Infection
Template 1.5: Experiences in Addressing AIDS-related Illnesses in the Community
Template 1.6: Experiences in Addressing AIDS-related Deaths in the Community
Template 1.7: Opportunities to Reduce Vulnerability to AIDS-related Illnesses and Deaths

Tool 2: Community Household Composition

Template 2: Changes in Composition of Households in the Community

Tool 3: Organization and Group Profiling

Template 3: Organization and Group Profiles

Tool 4: Livelihoods Analysis of Vulnerable Households and Groups

Template 4.1: Description of Asset Base
Template 4.2: Description of Livelihood Strategies and Outcomes
Template 4.3: Summary of Strengths and Weaknesses

Tool 5: Stage of Disease and Community Response

Template 5: Stage of Disease and Response Matrix

Tool 6: Client Groups and Their Priority Needs

Template 6: Composition of Client Groups and Priority Needs

Tool 7: Ongoing HIV/AIDS Activities and Implementing Agents

Template 7: Ongoing HIV/AIDS Activities and Implementing Agents

Tool 8: Extension Opportunities and Potential Partnerships

Template 8: Potential Extension Activities and Partners

Tool 1

HIV/AIDS Pathway: A Framework for Community Dialogue and Empowerment

***Purpose**: to provide a practical framework for explaining the basics of HIV/AIDS, discussing the nature of the disease in the community, identifying sources of risk of infection for individuals and exploring factors that make households more or less vulnerable to the impacts of AIDS.*

METHOD

The HIV/AIDS pathway is used as a basis for community dialogue and empowerment. It helps people, first, understand their own environment and sources of risk in the era of HIV/AIDS and, second, identify opportunities which may reduce their likelihood of infection and increase their ability to withstand the impacts of AIDS. It is important to ensure that all members of a community are aware of the basics of HIV/AIDS. In some communities and cultures, it may be most appropriate for women and men, and girls and boys to meet separately whereas in other settings mixed age and sex groups would be acceptable.

Activities

The use of the pathway is based on four core activities which may be conducted over several meetings (see box below):

1. Setting out the pathway
2. Sources of risk of HIV infection
3. Progressing from HIV infection to AIDS-related sickness and death
4. Community follow-up

Suggested session structure when using HIV/AIDS pathway to guide community discussions

Session 1: Setting out the pathway (see activity 1)
Session 2: Identifying HIV-risky environment: external (activity 2.1)
Session 3: Identifying HIV-risky environment: internal (activity 2.2)
Session 4: Drivers of the epidemic (activity 2.3)
Session 5: Opportunities to reduce risk of HIV infection (activity 2.4)
Session 6: Impacts and responses to AIDS-related illnesses (activity 3.1)
Session 7: Impacts and responses to AIDS-related death (activity 3.2)
Session 8: Opportunities to reduce vulnerability to AIDS impacts (activity 3.3)
Session 9: Community follow-up

The HIV/AIDS pathway is not a one-off exercise. It should be re-run periodically to enable the community to understand the dynamics of HIV/AIDS in their own setting. It should also be used specifically with young girls and boys before they become sexually active.

Activity 1: Setting out the pathway

This introductory activity is to be completed in plenary: 1 hour.

Further details about the basic characteristics of HIV/AIDS may be found in section 1.

Step 1: The three gates (Template 1.1)

1. Draw a pathway down the middle of a sheet of flipchart paper – this is the HIV/AIDS pathway.
2. Draw three gates across the pathway:

   - Gate 1: HIV infection
   - Gate 2: AIDS-related illnesses
   - Gate 3: AIDS-related death

Step 2: Markers and timeline

1. Ask: How do we know where we are on the pathway?

   - HIV infection: do not know unless have HIV test
   - AIDS-related illnesses: start experiencing some of classic illnesses associated with AIDS (for example – chronic illness, weight loss, dry cough, skin infections)
   - AIDS-related death

2. Ask: How long does it take to move between the gates in the absence of any care and treatment including anti-retroviral therapy?

   - Gates 1 to 2: on average 6 to 8 years
   - Gates 2 to 3: on average 1 – 2 years

Step 3: Objectives

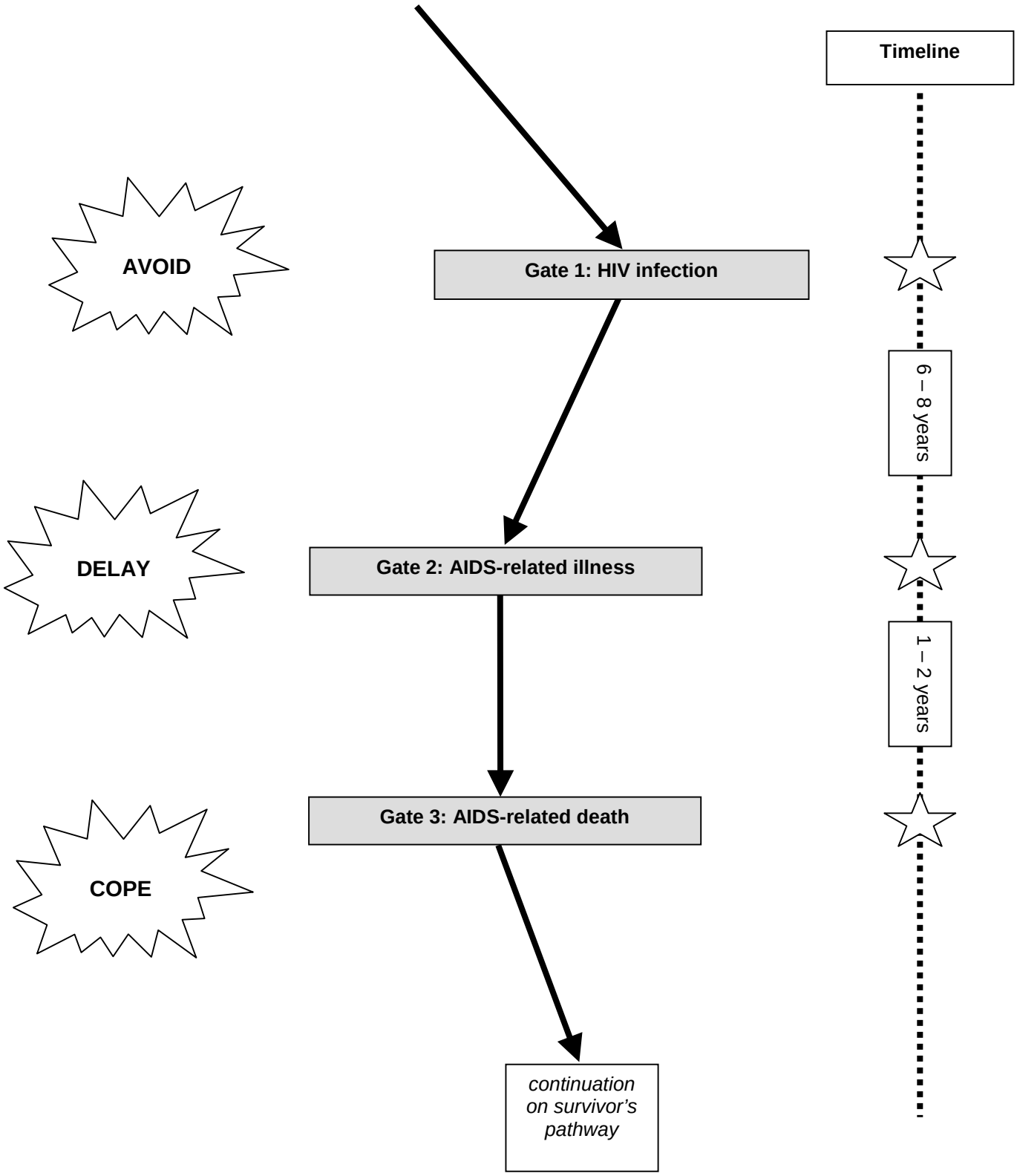
1. Ask: What do we want to achieve in this community?

   - **to avoid gate 1:** giving people life skills to enable themselves not to become infected with HIV
   - **to delay arrival at gate 2:** finding ways to delay the progression of the HIV infected person towards AIDS (and avoiding infecting others)
   - **to cope and adjust to life after gate 3:** helping other household members survive the death of key adults, such as a spouse or parents.

Step 4: Conclusion of the introductory session to the pathway

- entrance through gate 1 is an irreversible step which will inevitably lead to the second and third gates at some time in the future, even though the journey may take place over six to 10 years.
- the speed with which individuals pass along the pathway, or even commence the journey, depends on a number of factors.
- factors which help people avoid entering gate 1, slow down progress to gate 2, or improve the outlook for household members surviving gate 3 are explored in the subsequent activities.

Template 1.1: HIV/AIDS Pathway and Gates



Activity 2: Sources of risk of HIV infection

This activity may be completed in four separate sessions working in plenary. Alternatively the group may be divided into two to work separately on activities 2.1 and 2.2, before coming together in plenary to discuss activities 2.3 and 2.4.

Further details about sources of risk of infection are discussed in section 2.

Introduction to activity 2

1. Ask: How do people in the community (who share a similar socio-cultural and economic setting) become infected with HIV and pass through gate 1?

   The main sources of infection are:

   - through unprotected sex with an infected person (vast majority)
   - through contact with contaminated blood or other bodily fluids
   - through mother to child transmission

   (Prior to this session find out the main sources of infection in the study area)
2. Explain that in activity 2 we explore how people find themselves in HIV-risky environments, or adopting risky behaviours and lifestyles.
3. Divide the group into two: group A will look at interactions between the community and the external environment (activity 2.1) and group B will look at behaviour within the community (activity 2.2). The findings will be shared in plenary (activities 2.3 and 2.4). Alternatively these activities could be undertaken by the whole group over four separate sessions.
4. Ensure: during the discussions the groups consider the risks from an age and gender perspective.

Activity 2.1: Identifying HIV-risky external environment-community linkages (Group A)

Step 1: Exploring the external environment

1. Draw a sketch map setting out the major towns, market places, health centres, hospitals, schools, trading centres, administration, water points, woods, places of work etc which are visited by the community.

Step 2: Movement from the community to the external environment

1. Identify interactions between members of the community and the external environment (indicate on the map):

   - who travels outside the community? (women, men, youth, elderly, children)
   - where do they go?
   - when do they go? (daily, weekly, dry/wet season, harvest, hungry season etc)
   - why do they go? (to buy, sell, recreation, education, health, collect water/wood, earn money etc)
   - how long do they stay? (less than one day, overnight, several nights, several weeks etc)
   - where do they stay? (with friends, relatives, rented accommodation, hostel etc)
   - what do they do that might result in unprotected sex?

Step 3: Movement from the external environment into the community

1. Identify any movement of people from the external environment into the community (indicate on the map):

   - who comes to the community? (women, men, youth, elderly, children)
   - when do they come? (daily, weekly, dry/wet season, harvest, hungry season etc)
   - why do they come? (to buy, sell, recreation, education, health, administration, collect water/wood etc)
   - where do they come from?
   - how long do they stay? (less than one day, overnight, several nights, several weeks etc)
   - where do they stay? (with friends, relatives, rented accommodation, hostel etc)
   - what do they do that might result in unprotected sex?

Step 4: Opportunities to reduce the risk of infection

1. Identify what the community may do to reduce the risk of infection from the external environment.

Activity 2.2: Identifying HIV-risky internal environment (Group B)

Step 1: Exploring the internal environment

1. Draw a sketch map setting out the main places in the community where people meet (market place, bars, hotels, beach, homes, school, water points, woods, neighbours etc).

Step 2: Movement within the community

1. Identify interactions between members of the community (indicate on the map):

   - who visits these different locations? (women, men, youth, elderly, children)
   - when do they go? (daily, weekly, dry/wet season, harvest, hungry season etc)
   - why do they go? (to buy, sell, recreation, education, health, collect water/wood etc)
   - how long do they stay? (less than one day, overnight, several nights, several weeks etc)
   - where do they stay? (with friends, relatives, rented accommodation, hostel etc)
   - what do they do that might result in unprotected sex?

Step 3: Other HIV-risky behaviour

1. Identify any other events, cultural and traditional practices which put people at risk from infection:

   - what is the event? (for example, dances, weddings, rape, abduction, circumcision, widow inheritance, seasonal practices)
   - who is at risk?
   - why does this practice occur?

Step 4: Opportunities to reduce the risk of infection

1. Identify what the community may do to reduce the risk of infection within the internal environment.

Activity 2.3: Drivers of the epidemic (Groups A and B)

Step 1: Summary of risk environment (Template 1.2)

1. Groups A and B share their findings about the external and internal environments in plenary (from activities 2.1 and 2.2, steps 1 to 3).
2. Add secondary data to the map showing prevalence rates in the community and surrounding environment to demonstrate risks.

   (Note: prior to the session, find out the HIV prevalence rate in neighbouring towns and centres).
3. Use the findings to highlight the greatest risks for the community and the most potentially vulnerable groups within the community.
4. Use the matrix to explain the role of *bridging populations*, people who engage in high risk activities outside the local community but have links into groups of people with low risk behaviour which then put the general population at risk.

Step 2: Analysis of drivers of the epidemic (Template 1.3)

1. For each of the main sources of risk, identify the underlying factors which put people at risk (for example, why do people migrate to look for casual work during the hungry season?)
2. Group the underlying factors as to whether they are:

   - economic
   - socio-cultural
   - infrastructure/environmental

Activity 2.4: Opportunities to reduce risk of infection (Groups A and B)

Step 1: Identification of opportunities (Template 1.4)

1. Use the findings from step 4 of activities 2.1 and 2.2 to identify opportunities to reduce the risk of infection.
2. Group the opportunities according to whether they require a change at individual, household or community level.
3. What activities could be introduced in the community which would reduce the risk of HIV infection?

Template 1.2: Potential Sources of HIV Infection for Different Household Members

Potential source of infection	Woman	Man	Female adolescent (10 – 19 years)	Male adolescent (10 – 19 years)	Child (5 – 9 years)	Infant (under 5 years)
Unprotected sex with infected person						
Contact with infected blood						
Mother to child transmission						

Template 1.3: Potential Drivers of HIV Infection for Different Household Members

Potential driver of infection	Woman	Man	Female adolescent (10 – 19 years)	Male adolescent (10 – 19 years)	Child (5 – 9 years)	Infant (under 5 years)
Economic						
Socio-cultural						
Infrastructure/ environmental						

Template 1.4: Opportunities to Reduce Risk of HIV Infection

Level	Reduce risk of infection	
	Opportunities	Community actions
Individual		
Household		
Community		

Activity 3: Progressing from HIV infection to AIDS-related sickness and death

This activity may be completed in three separate sessions working in plenary. Alternatively the group may be divided into two to work separately on activities 3.1 and 3.2, before coming together in plenary to discuss activity 3.3.

Further details about vulnerabilities to the impacts of AIDS are discussed in section 3..

Introduction to activity 3

1. Divide the group into two: group A will look at the impacts and responses to AIDS-related illnesses (activity 3.1) and group B will look at the impacts and responses to AIDS-related deaths (activity 3.2). The findings will be shared in plenary (activities 3.3). Alternatively these activities could be undertaken by the whole group over three separate sessions.

Activity 3.1: Impacts and responses to AIDS-related illnesses (Group A)

Step 1: Household impacts (Template 1.5)

1. What usually happens when a household member is chronically sick?
   - to his/her own work?
   - to the workload of other household members?
   - to the children?
   - to participation in social networks outside of the home?
   - to household assets?
   - to household food and nutrition security?
   - to household income?
2. How do these impacts differ depending on the age or the sex of the sick person?
3. How do these impacts differ between different types of household?

Step 2: Community responses (Template 1.5)

1. How does the community respond to AIDS-related sickness in a household?
2. Are there things which the community does which possibly make things worse (for example, stigmatise and exclude PLWHA and their families from community activities)?

Step 3: Opportunities for slowing down progression to AIDS and reducing impacts of sickness

1. How can households be helped to avoid the worst impacts of AIDS-related illnesses?
2. Are there any things which the community could do to help these households during this period?

Activity 3.2: Impacts and responses to AIDS-related deaths (Group B)

Step 1: Household impacts (Template 1.6)

1. What usually happens when a household member dies from AIDS?
   - to the workload of other household members?
   - to the children?

- to household assets?
- to contacts with markets and services?
- to household food and nutrition security?
- to household income?

2. How do these impacts differ depending on the age or the sex of the deceased?
3. How do these impacts differ between different types of household?

Step 2: Community responses (Template 1.6)

1. How does the community respond to AIDS-related death in a household?
2. Are there any things which the community does which possibly make things worse (for example, stigmatise and exclude families who have lost someone to AIDS)?

Step 3: Opportunities for reducing impacts of death

1. How can households be helped to avoid the worst impacts of AIDS-related death?
2. Are there any things which the community could do to help these households during this period?

Activity 3.3: Opportunities to reduce vulnerability to AIDS impacts (Groups A and B)

Step 1: Summary of impacts

1. Groups A and B share their findings about the impacts arising from AIDS-related sickness and death at the household and community level (from activities 3.1 and 3.2).

Step 2: Identification of opportunities (Template 1.7)

1. Use the findings from step 3 of activities 3.1 and 3.2 to identify opportunities to reduce the vulnerabilities to the impacts of AIDS.
2. Group the opportunities according to whether they require a change at individual, household or community level.
3. What activities could be introduced in the community to help strengthen HIV/AIDS-affected households to withstand the impacts of AIDS-related illnesses and death?

Activity 4: Community follow-up

This activity is conducted in plenary to enable the community to reflect on the HIV/AIDS pathway in their own community and identify follow-up activities.

1. Review and discuss the dynamics of HIV/AIDS in the community, reflecting on Templates 1.1, 1.2, 1.3, 1.5 and 1.6.
2. Refer to Templates 1.4 and 1.6 to explore any follow-up activities the community may wish to undertake.

Final message

The journey down the HIV/AIDS pathway is not inevitable and there are lifestyle choices, even within the context of poverty, that enable people to remain outside the loop of infection and vulnerability.

Template 1.5: Experiences in Addressing AIDS-related Illnesses in the Community

Impacts	Negative experiences	Positive experiences
Household impacts (note if linked to any particular type of household)		
Community response		

Template 1.6: Experiences in Addressing AIDS-related Deaths in the Community

Impacts	Negative experiences	Positive experiences
Household impacts (note if linked to any particular type of household)		
Community response		

Template 1.7: Opportunities to Reduce Vulnerability to AIDS-related Illnesses and Deaths

Level	Reduce vulnerability	
	AIDS-related illnesses	AIDS-related death
Individual		
Household		
Community		

Tool 2

Community Household Composition

Purpose: *to identify the distribution of households in the community between the main household types, and changes in the distribution during the last 10 years (with special reference to potentially vulnerable households), as well as changes in household size.*

METHOD

Step 1: Identification of main types of household

1. Ask the community to identify the different types of household that are present in the community. For example, they may include:
   - Married households – monogamous
   - Married households – polygamous
   - Female-headed households (FHHs)
   - Single male-headed households (SMHHs)
   - Grandparent-headed households (GHHs)
   - Orphan-headed households (OHHs)
   - Others (specify)

Step 2: Distribution of households (Template 2)

1. Note the total number of households in the community (approximately). Define a household to be the unit in which people eat together in the evening.
2. Use proportional piling to determine the distribution of total households across the household types. Take a large number of seeds or stones (100 or 200) and explain that this represents the total number of households in the community. Ask for a volunteer to distribute the seeds between the different household types. Give other people a chance to adjust the distribution until all are happy. Add up the number of seeds in each group and divide by the total number of seeds in order to calculate the percentage distribution.
3. Repeat the exercise in order to determine the distribution five years ago and ten years ago.

Step 3: Movement between groups (Template 2)

1. Have there been any movements between the household types?
2. Which household types are expanding in number?
3. Which household types are contracting in number?
4. What are the reasons underlying these changes?

Step 4: Changes in household size (Template 2)

1. Have there been any changes in the number of people living in a household by household type during the last five years?
2. Which household types are expanding in size?
3. Which household types are contracting in size?
4. What are the reasons underlying these changes?

Step 5: Identification of households belonging to different household types

1. At the end of this process, ask one or two of the village leaders to identify people belonging to the different types of household who would be prepared to participate in group discussions about their livelihoods (Tool 4).

Template 2: Changes in Composition of Households in the Community

	Household type *					
	Married - monogamous	**Married - polygamous**	**Female-headed HHs**	**Single male-headed MHHs**	**Orphan-headed HHs**	**Grandparent-headed HHs**
HOUSEHOLD DISTRIBUTION						
Distribution at present (total = 100%)						
Distribution 5 years ago (total = 100%)						
Distribution 10 years ago (total = 100%)						
Reasons for growth/ decline in number of households						
CHANGES IN HOUSEHOLD SIZE						
Average number of people per household today						
Average number of people per household two years ago						
Average number of people per household five years ago						
Reasons for change in household size						

The households listed here are for illustrative purposes

Tool 3

Organization and Group Profiling

Purpose: *to identify the different organizations and groups active in the community; their origins and current status; the socioeconomic and gender composition of their membership and leadership; and to establish their potential role as entry points for addressing HIV/AIDS.*

METHOD

Step 1: Organizational profiles (Template 3)

1. Identify all formal and informal groups active in the community. They may include:

   - reciprocal labour groups
   - farmers' groups
   - savings and credit associations
   - interest groups
   - Farmer Field Schools
   - welfare/bereavement groups
   - community woodlots and forest keepers
   - informal self-help groups
   - women's clubs or associations
   - youth groups
   - community based organizations
   - faith based organizations

2. For each group, gather the following information: date of formation, origins, purpose of formation, official registration (if any), external assistance, activities, operational status and, if they have stopped operating recently, the reasons why.
3. For each group, determine the membership criteria, current membership and leadership by sex (female/male) and socio-economic group. Note whether any members also belong to other organizations.
4. For informal groups, find out how they work (with respect to pooling labour, sharing implements or draught animals, saving collectively for example).

Step 2: Significance of groups

1. Which parts of the community are being served by these groups?
2. Are some members of the community being overlooked? Why?
3. Do any of these groups provide an entry point for addressing HIV/AIDS (for example, providing opportunities for IEC activities, or access to credit or skills development)?

Step 3: Follow-up

1. It may be appropriate to interview external organizations (such as NGOs) that have supported any groups if they appear to be suitable entry points for addressing HIV/AIDS.

Template 3: Organization and Group Profiles

Type of group and date formed	Status and activities	Membership			Leadership			Potential entry point for addressing HIV/AIDS
		Female	Male	Socio-economic composition	Female	Male	Socio-economic composition	

Tool 4

Livelihoods Analysis of Vulnerable Households and Groups

Purpose: *to review livelihood assets, strategies and outcomes of different types of household or group in the community and to identify their strengths and weaknesses.*

METHOD

Step 1: Review existing asset base (Template 4.1)

1. Identify the assets available to the household or group to undertake farm, non-farm, household and community activities:

   - **human assets**: sex and age of household head, average household size, skills and knowledge of household members, health of household members, and use of hired labour;
   - **natural assets**: rainfed area, irrigated area, fallow, trees and livestock;
   - **physical assets**: seed and fertilizer, farm tools and implements, post harvest equipment, other household assets (furniture and other household items, quality of house, and means of transport);
   - **financial assets**: use of credit, remittances, savings;
   - **social assets**: membership of groups and associations, leadership roles, participation in reciprocal labour groups

Step 2: Analysis of existing livelihood strategies and outcomes (Template 4.2)

1. Identify how the household or group uses its resource base to make a living, through farming, off-farm activities or other strategies (**livelihood strategies).**
2. Identify the major **shocks and changes** experienced in the household or group, and the short-term **coping strategies** and longer-term **adaptive strategies** used to overcome those shocks and changes.
3. Identify the **livelihood outcomes** of the livelihood system, be it in terms of food, income or other indicators of well-being and quality of life.
4. Identify the **outlook** for the future: does the household or group think its livelihood will improve, remain stable or deteriorate over the next five years?
5. Identify the main challenges facing these households or group.

Step 3: Summary of strengths and weaknesses (Template 4.3)

1. Review the assets, livelihood strategies and outcomes with the group to identify their strengths.
2. Review the assets, livelihood strategies and outcomes with the group to identify their weaknesses.

Template 4.1: Description of Asset Base

Group:

Characteristics	
Human assets	
Age, sex and marital status of HH head	
Number of people living in HH	
Skills, knowledge and educational levels of HH members	
Main health threats facing the HH and sources of treatment	
Does the HH hire in labour?	
Natural assets	
Rainfed area cultivated (ha)	
Irrigated area (ha)	
Fallow (ha), length of fallow, reasons for fallow	
Fruit trees, woodlots etc	
Number of livestock and draught animals	
Physical assets	
Source of seeds and fertilizer	
Inventory of farm tools and equipment	
Post harvest equipment and granaries	
Number of dwellings and construction materials	
Ownership of means of transport	
Other HH assets	
Financial assets	
Access to credit	
Remittances	
Savings	
Social assets	
Membership of groups	
Leadership positions in groups	
Participation in reciprocal labour groups	

Template 4.2: Description of Livelihood Strategies and Outcomes

Group:

Characteristics	
Farming	
List rainfed food crops grown (in declining order of importance)	
List rainfed cash crops grown (in declining order of importance)	
List irrigated crops grown (in declining order of importance)	
List livestock reared for home use/sale (in declining order of importance)	
Non-farm activities	
List non-farm activities that household members are involved in	
Livelihood strategies	
List the main ways in which the household makes a living (in declining order of importance)	
Changes and shocks	
List any positive changes and negative shocks experienced by the household in last five years	
Responses and coping strategies	
What strategies and responses has the household used to adjust to changes and shocks	
Livelihood outcomes	
What does the household achieve in terms of food security (months per year), schooling, other indicators of well-being?	
Outlook	
What does the household feel about the future?	
Major challenges facing the household	

Template 4.3: Summary of Strengths and Weaknesses

Group:

	Strengths	Weaknesses
Household asset base		
Livelihood strategies		
Livelihood outcomes		
Main challenges		

Tool 5

Stage of Disease and Community Response

Purpose: *to use the matrix to summarise the stage of the disease in the community and the nature of community responses.*

METHOD

Step 1: Estimating stage of disease (Template 5)

1. Drawing on information collected from the community (in particular, the HIV/AIDS pathway (Templates 1.2 and 1.3) and community household composition (Template 2)), estimate what stage of the disease the community is experiencing at present:

   - **Initiating:** low rates of HIV prevalence and very few AIDS-related deaths
   - **Impending:** rising rates of HIV infection and AIDS-related illnesses and deaths beginning to increase
   - **Impacted:** HIV infection rates high and community experiencing many AIDS-related deaths
   - **Impacted (extended):** HIV infection rates high and community experiencing widespread AIDS-related deaths and the majority of the households in the community are either infected or affected by the disease.

   Tip: Are any of the indicators listed in the box in Part I, section 4 present?

Step 2: Characterising community response (Template 5)

1. Drawing on information collected from the community (in particular, the HIV/AIDS pathway (Templates 1.5 and 1.6) and organization and group profiles (Template 3)), characterise the nature of community responses to date in terms of:

   - not aware
   - denial and despair
   - acknowledgement and pro-active coping

2. Use the results from Steps 1 and 2 to identify the appropriate cell on the stage of disease and community response matrix (see Table 1 in Part I, section 4).

Template 5: Stage of Disease and Community Response Matrix

Stage of disease	Community and household responses		
	Not aware	Denial and despair	Acknowledgement and pro-active coping
1. Initiating: low rates of HIV prevalence and very few AIDS-related deaths			
2. Impending: rising rates of HIV infection and AIDS-related illnesses and deaths beginning to increase			
3. Impacted: HIV infection rates high and community experiencing many AIDS-related deaths			
***4. Impacted (extended*)**: HIV infection rates high and community experiencing widespread AIDS-related deaths			

Tool 6

Client Groups and Their Priority Needs

Purpose: *to identify who are the priority groups for extension work, their problems and most pressing needs in the era of HIV/AIDS.*

METHOD

Step 1: Listing client groups, their problems and priority needs (Template 6)

1. Drawing on information collected from the community discussions (in particular, the HIV/AIDS pathway (Templates 1.2 and 1.3) and community household composition (Template 2)), list main client groups for the extension service in the era of HIV/AIDS.
2. Drawing on information collected from the community discussions (in particular, the HIV/AIDS pathway (Templates 1.2, 1.3, 1.5 and 1.6) and livelihoods analysis (Template 4.3)), list the main HIV/AIDS-related problems facing each group.
3. On the basis of this information, identify the priority needs of the different groups.

Template 6: Composition of Client Groups and Priority Needs

Client group *	Problems	Priority needs
PLWHA		
Young widows		
GHHs		
SMHHs		
Orphans and vulnerable children		
Youth		
Married men		
Married women		
Community		

** These client groups are only for illustrative purposes*

Tool 7

Ongoing HIV/AIDS Activities and Implementing Agents

***Purpose**: to review who is currently working on HIV/AIDS activities in the community and their target groups.*

METHOD

Step 1: Identifying ongoing activities and implementing agencies (Template 7)

1. Drawing on information collected from the community discussions (in particular, the HIV/AIDS pathway (Templates 1.5 and 1.6) and organization and group profiles (Template 3)), identify ongoing activities to address HIV/AIDS by target group.
2. Drawing on information collected from the community discussions (in particular, the HIV/AIDS pathway (Templates 1.5 and 1.6) and organization and group profiles (Template 3)), identify who is undertaking this work.

Template 7: Ongoing HIV/AIDS Activities and Implementing Agents

Client group *	Ongoing activities	Implementing agents
PLWHA		
Young widows		
GHHs		
SMHHs		
Orphans and vulnerable children		
Youth		
Married men		
Married women		
Community		

** These client groups are only for illustrative purposes*

Tool 8

Extension Opportunities and Potential Partners

***Purpose**: to identify opportunities for the agriculture and natural resource sectors to address HIV/AIDS through the extension service and potential partners.*

METHOD

Step 1: Identifying broad theme and activities (Template 8)

1. Determine the broad theme of extension work for each client group:

    - reducing the risk of HIV infection
    - preparations to reduce vulnerability to the impacts of AIDS
    - providing effective care and support for PLWHA and their families
    - adapting to overcome the impacts of AIDS

    Tip: refer to the stage of disease and community response matrix (Tool 5) and the client groups and their priority needs (Tool 6).

2. Identify the different activities the agriculture and natural resource sectors may contribute for each client group (review opportunities in Part I, section 8).

3. Determine whether these activities are either development or humanitarian in nature.

4. Identify how these activities may be delivered (see Part I, section 9).

Step 2: Identifying potential partners and sources of funding (Template 8)

1. Identify potential partners and possible sources of funding to assist with these activities (see HIV/AIDS pathway (Templates 1.5, 1.6), organization and group profiles (Template 3) and ongoing activities (Template 7)).

Template 8: Potential Extension Activities and Partners

Client group *	Broad theme	Potential activities (development/humanitarian)	Methods of delivery	Potential partners and funding
PLWHA				
Young widows				
GHHs				
SMHHs				
Orphans and vulnerable children				
Youth				
Married men				
Married women				
Community				

** These client groups are only for illustrative purposes*

ANNEX II

EXAMPLES OF COMPLETED TEMPLATES

Annex II presents examples of completed templates. They illustrate the types of outputs that may be generated during the community dialogue and extension worker reflection. They are not blueprints and, in practice, the findings will vary between communities, agro-ecological, socio-economic and political environments, and the stage of the epidemic.

Identifying the Nature and Impacts of HIV/AIDS in the Community

1.1 HIV/AIDS Pathway
1.2 Potential Sources of HIV Infection for Different Household Members
1.3 Potential Drives of HIV Infection for Different Household Members
1.4 Opportunities to Reduce Risk of HIV Infection
1.5 Experiences in Addressing AIDS-related Illnesses in the Community
1.6 Experiences in Addressing AIDS-related Deaths in the Community
1.7 Opportunities to Reduce Vulnerability to AIDS-related Illnesses and Deaths

2 Changes in Composition of Households in the Community

3 Organization and Group Profiles

4.1 Description of Asset Base
4.2 Description of Livelihood Strategies and Outcomes
4.3 Summary of Strengths and Weaknesses

Implications for Extension Work

5 Stage of Disease and Community Response Matrix

6 Composition of Client Groups and Priority Needs

7 Ongoing HIV/AIDS Activities and Implementing Agents

8 Potential Extension Activities and Partners

Example of Template 1: HIV/AIDS Pathway in Fishing Communities

Drivers of risk:

Community:

- Weak infrastructure
- High degree of mobility
- Lack of social cohesion

Fishing lifestyle characteristics

- Physically unpleasant, risky work
- Seasonal migration, absence from home
- Ready access to cash
- Low levels of education
- Limited livelihood alternatives
- Limited resources
- Perceptions about risky livelihood

Sources of resistance:

- Generally absent

Key markers for gate 1:

- Incidence of HIV
- Prevalence of HIV
- Morbidity

Drivers of vulnerability:

- Livelihood lifestyle: physical well-being
- Stigmatization, discrimination
- Lack of resources
- Gendered access/control over resources

Sources of resilience:

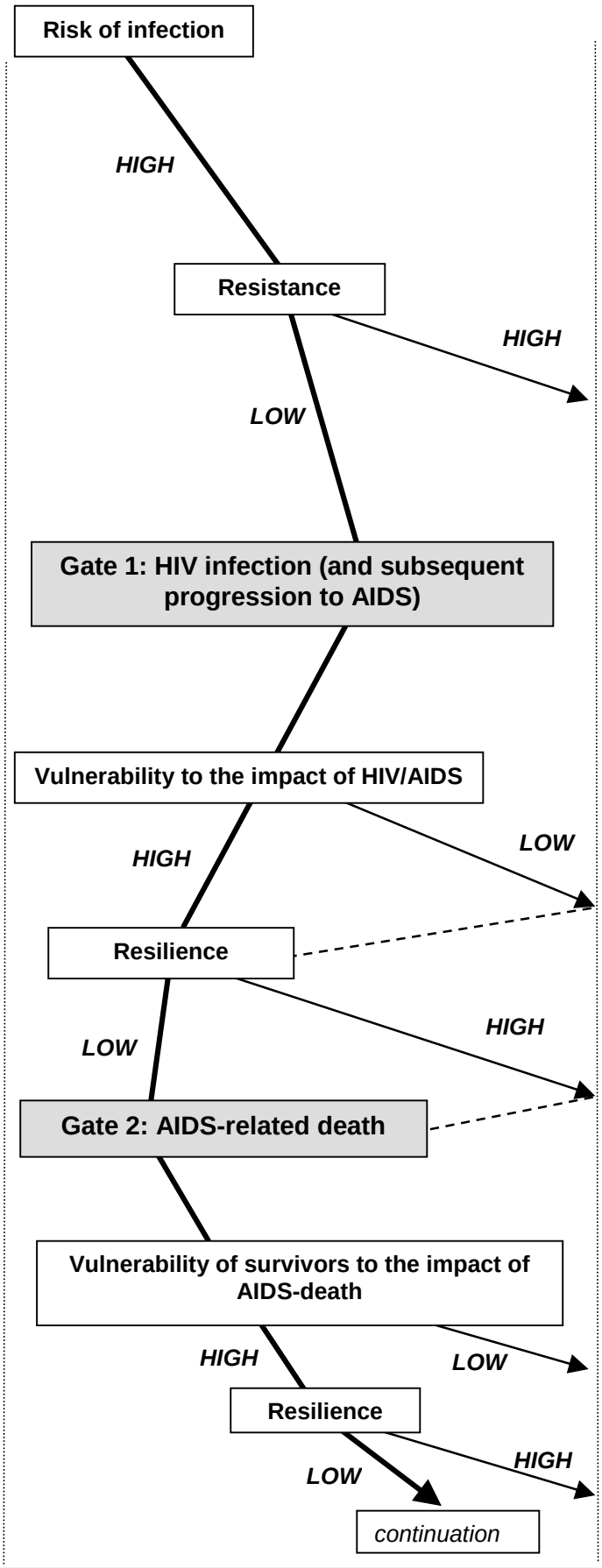
- Absence of community-based support (eg home-based care, support for orphans)
- Absence of family support

Key markers for gate 2:

- Mortality due to AIDS

Vulnerable groups:

- Orphans and vulnerable children
- Widows
- Members of extended family in home community



Opportunities for prevention and resistance:

- HIV/AIDS information, awareness
- VCT
- Health care
- Treatment for STIs
- Condoms
- Community resource management
- Livelihood diversification
- Savings and investment
- Community groups, networks
- Gender empowerment

Opportunities for mitigation and resilience:

- Savings and investment
- Livelihood diversification
- Community groups and safety nets
- Schooling for children
- Access to and control over resources
- Life and livelihood skills

Example of Template 1.2: Potential Sources of HIV Infection for Different Household Members

Potential modes of transmission	Woman	Man	Female adolescent (10 – 19 years)	Male adolescent (10 – 19 years)	Child (5 – 9 years)	Infant (under 5 years)
Unprotected sex with infected person	▪ marketing ▪ traders ▪ rape ▪ widow inheritance ▪ polygamy	▪ marketing ▪ traders ▪ daily labouring ▪ seasonal migration ▪ widow inheritance ▪ polygamy	▪ marketing ▪ urban migration ▪ abduction, rape ▪ early marriage ▪ secondary school	▪ casual labouring ▪ urban migration ▪ secondary school		
Contact with infected blood	• caring for AIDS-sick		▪ HTPs	▪ HTPs	▪ HTPs	▪ HTPs
Mother to child transmission						▪ pregnancy, birth, breast-feeding

HTPs = harmful traditional practices (they include male circumcision, female genital mutilation, removal of milk teeth, tattooing etc).

Example of Template 1.3: Potential Drivers of HIV Infection for Different Household Members

Potential driver of infection	Woman	Man	Female adolescent (10 – 19 years)	Male adolescent (10 – 19 years)	Child (5 – 9 years)	Infant (under 5 years)
Economic	• poverty • lack of economic independence • livelihood	• poverty • seeking employment • livelihood	• pursuing education • seeking employment	• pursuing education • seeking employment		
Socio-cultural	• coercion • weak negotiating power to have safe sex/no sex • cultural norms	• cultural norms • lack of social cohesion when staying away from home	• cultural norms • peer pressure to have sex • lack of social cohesion when staying away from home	• cultural norms • peer pressure to have sex • lack of social cohesion when staying away from home	• cultural norms	• cultural norms • reluctance to stop breast-feeding
Infrastructure/ environment	• lack of knowledge • poor health services	• lack of knowledge • lack of access to condoms • no health services to treat STIs	• lack of knowledge • lack of access to condoms • no health services to treat STIs	• lack of knowledge • lack of access to condoms • no health services to treat STIs		• lack of knowledge by mother • poor health services for mother

Example of Template 1.4: Opportunities to Reduce Risk of Infection

Level	Reduce risk of infection	
	Opportunities	**Potential community actions**
Individual	• increase awareness • change attitude towards unprotected sex and multiple partners • resist peer pressure and delay first sexual encounter • reduce nights away from home	• hold IEC sessions
Household	• support livelihood diversification and non-farm skills development among youth • recognise rights of women to say no to sex/unprotected sex	• form interest groups and self-help groups for skills development and livelihood diversification
Community	• gender empowerment • change attitudes towards rape, abduction, harmful traditional practices • improve access to preventative health care services including VCT and STI treatment	• hold community conversations to review socio-cultural norms which place people at risk • form youth groups and women's groups to act as discussion fora • work with FBOs to encourage community members to have HIV test

Example of Template 1.5: Experiences in Addressing AIDS-related Illnesses in the Community

Impacts	Negative experiences	Positive experiences
Household impacts (note if linked to any particular type of household)	• sale of assets to raise money to buy food, cover medical expenses (particularly in poorer households that have already experienced one death) • other family members stop doing casual work in order to care for the sick (FHHs, GHHs)	• creation of home gardens • improved nutrition for PLWHA • use of labour saving technologies (roofwater harvesting, improved stoves) to reduce burden of household tasks
Community response	• denial of existence of disease in community • discrimination and avoidance of those of who look sick • stop borrowing farm tools and cooking utensils from each other	• reciprocal labour groups assist with key farm tasks

Example of Template 1.6: Experiences in Addressing AIDS-related Deaths in the Community

Impacts	Negative experiences	Positive experiences
Household impacts (note if linked to any particular type of household)	• children drop out of school to work at home (in FHHs) • property grabbing by relatives (from widows) • Widow inheritance	• succession planning for widow and orphans to inherit property
Community response	• exclusion of widows from meetings, community groups • no assistance to help orphans continue at school	• burial group assist with funeral and mourning activities • community feeding programme for orphans

Example of Template 1.7: Opportunities to Reduce Vulnerability to AIDS-related Illnesses and Deaths

Level	Reduce vulnerability	
	AIDS-related illnesses	AIDS-related death
Individual	• become better informed about HIV/AIDS • training in home-based care	• succession planning for widow and orphans to inherit property
Household	• adopt labour saving technologies and practices to reduce the burden of household work • belong to reciprocal labour group	• diversify livelihood activities for youth and women
Community	• provide take home food packs for vulnerable children in homes with PLWA • assist with transporting PLWA to health centre for treatment	• create junior farmer field and life school for orphans and vulnerable children

Example of Template 2: Changes in Composition of Households in Community

Community: High AIDS-impacted

	Household type *					
	Married - monogamous	**Married - polygamous**	**Female-headed HHs**	**Single male-headed MHHs**	**Orphan-headed HHs**	**Grandparent-headed HHs**
HOUSEHOLD DISTRIBUTION						
Distribution at present (total = 100%)	40%	20%	25%	5%	5%	5%
Distribution 5 years ago (total = 100%)	30%	50%	10%	2%	2%	5%
Distribution 10 years ago (total = 100%)	25%	63%	5%	1%	Nil	1%
Reasons for growth/ decline in number of households	▪ increased interest in monogamous relationships among youth, partly due to economic issues, partly due to HIV/AIDS messages	▪ household heads tend to be middle-aged ▪ reduction because men can no longer afford to support several wives ▪ monogamous relationships considered to be safer in times of HIV/AIDS	▪ previously FHHs were headed by elderly widows ▪ today most widows are in their late 20s – 30s ▪ main cause of loss of husband is death (AIDS-related), occasionally divorce	▪ until recently most widowers remarried soon after the death of their wife or they were in polygamous relationships ▪ today finding it more difficult to remarry or unwilling to do so ▪ likely that this number will continue to rise	▪ households headed by orphans has begun to rise as GHHs and other relatives no longer able to care for growing number or orphans ▪ likely that this number will continue to rise	▪ grandparents who are alive and able to look after orphans are already doing so ▪ no more capacity among elderly households to care for orphans
CHANGES IN HOUSEHOLD SIZE						
Average number of people per household today	8 – 10	14 - 18	6 – 8	4 – 6	2 – 6	6 – 10
Average number of people per household two years ago	6	12 – 16	4 – 6	4 – 6	2 – 6	4 - 6
Average number of people per household five years ago	6	10 – 12	4 – 6	4 – 6	-	2 – 4
Reasons for change in household size	• estimated that 25% of these households are caring for orphans	• estimated that around 50% of these households are caring for orphans	• some capacity to care for orphans of relatives	• stable size because only caring for immediate family	• stable size because only caring for immediate family	• some capacity to care for orphans of relatives

Example of Template 3: Organization and Group Profiles

Type of group and date formed	Status and activities	Membership			Leadership			Potential entry point for addressing HIV/AIDS
		Female	Male	Socio-economic compositior	Female	Male	Socio-economic composition	
Village committee, 1980	Operational; village administration	2	8	Richer HHs	2	8	Richer HHs	• coordinates village administration • provides a forum for calling people together for HIV/AIDS discussions • knows vulnerable households
Women's irrigation group, 2000	Encouraged by Agric Extension Officer; operational and very active; members see group as very relevant, enabling women to grow cash crops, and a basis for developing skills in irrigated agriculture and new technologies	25	3	Mainly middle wealth HHs	6	2	Middle wealth HHs	• enables women to earn income and gives them some independence • opportunity to include nutrition/home garden component • basis for HIV/AIDS IEC
Youth group – bee keeping, 2000	Operational; active membership; top bar hives and training	5	20	Middle wealth HHs	1	4	Middle wealth HHs	• provides alternative employment • keeps youth gainfully employed in village • basis for HIV/AIDS IEC
Under 5s club, 1990	Operational; formed by Home Economics Officer. Focus on nutrition and home care for under 5s	50	-	Middle wealth and poorer HHs	8	-	Middle wealth HHs	• basis for HIV/AIDS IEC • nutrition education • preventative steps regarding MTCT
Reciprocal labour groups, 1980	Operate informally between mixed groups of women and men; leader is the person on whose land the group is working; assist each other at busy times of year	15	15	Poorer HHs and widows	-	-	-	• no formal structure so may be difficult to mobilise • limitation that most vulnerable households unable to participate when severely labour stressed
Bereave-ment groups, 1985	Households offer each other mutual support in times of crisis including food, cash and labour	40	20	Middle wealth and poorer HHs	5	5	Middle wealth HHs	• route to reach vulnerable HHs • group being over-stretched during times of crisis • basis for HIV/AIDS IEC • basis for HBC training and support
Savings and credit group, 1995	Group supported by micro-finance institution. Members make monthly savings. Access short term and medium term credit through group.	15	45	Middle wealth HHs	2	6	Middle wealth HHs	• source of credit for livelihoods diversification

Example of Template 4.1: Description of Asset Base

Group: Young widows

Characteristics	
Human assets	
Age, sex and marital status of household head	Young widows in their 30s. Husbands died in last five years.
Number of people living in household	On average, 3 – 4 children, most under age of 12.
Skills, knowledge and educational levels of household members	FHH attended primary school, a few started secondary school. No work experience outside community
Main health threats, sources of treatment, nutrition status	Malaria common; cannot afford medicine, use traditional remedies. Most family members malnourished during hungry season.
Use of hired labour	No – cannot afford.
Natural assets	
Rainfed area cultivated (ha)	Cultivate approximately 0.5 ha; rent out or sometimes share-crop another 0.5 ha; many lost another 1 ha to relatives after husband's death.
Irrigated area (ha)	No access to irrigated land. A very few belong to women's irrigation group but struggle to find time to attend.
Fallow (ha), length of fallow, reasons for fallow	Approximately 0.5 ha under fallow because unable to cultivate it all due to shortage of labour
Fruit trees, woodlots etc	No private trees; collect fuelwood from forests.
Number of livestock and draught animals	Keep a few poultry (chicken) and 1 – 2 goats. Many used to have a pair of oxen but often sold during husband's illness or taken by relatives.
Physical assets	
Source of seeds and fertilizer	Select and store many local seeds. Cannot afford to buy improved varieties or fertilizer.
Inventory of farm tools and equipment	Many tools worn out, no money to replace them. Try to borrow from neighbours. Many still own plough but do not know how to use it.
Post harvest equipment and granaries	Small granary store. Used to use privately-owned mill in village which recently closed. Now pound maize by hand.
Number of dwellings and construction materials	Generally have one house for living and sleeping (mud walls and floor; iron sheet roof) and small kitchen.
Ownership of means of transport	Some have bicycles which oldest sons use for errands. A few own donkeys which are used for carrying water and fuelwood.
Other household assets	Some have sewing machines but many are not in working order. Since husbands were sick unable to repair them. Others have beehives which male relatives help look after.
Financial assets	
Access to credit	Unable to secure loans.
Remittances	Some received some money from relatives in town when husbands were first sick but now money is declining.
Savings	Used up during husband's illness to buy medication.
Social assets	
Membership of groups	Belong to under 5s club but have limited time to attend meetings. Bereavement group very helpful with funeral activities.
Leadership positions in groups	None in leadership positions due to household workload.
Participation in reciprocal labour groups	Used to be active but now difficult to reciprocate due to limited time available.

Example of Template 4.2: Description of Livelihood Strategies and Outcomes

Group: Young widows

Characteristics	
Farming	
List rainfed food crops grown (in declining order of importance)	Maize, pigeon peas, beans.
List rainfed cash crops grown (in declining order of importance)	Do not grow crops specifically for cash – sell small surpluses of food crops to gain some cash to meet HH needs.
List irrigated crops grown (in declining order of importance)	None.
List livestock reared for home use/sale (in declining order of importance)	Chicken – mainly for home use although may sell some eggs. Rear goats and sell occasionally when need money.
Non-farm activities	
List non-farm activities that household members are involved in	Casual labouring – all family members able to work Handicrafts – women and daughters
Livelihood strategies	
List the main ways in which the household makes a living (in declining order of importance)	1. Producing food for home consumption 2. Selling small livestock and livestock products 3. Casual labouring 4. Other income generating activities (bee keeping, handicrafts)
Changes and shocks	
List any positive changes and negative shocks experienced by the household in last five years	Changes: free schooling and community feeding for orphans Shocks: illness and death of husband, loss of property during and after husband's death, shortage of labour and draught animal power
Responses and coping strategies	
Strategies and responses used by the household to adjust to changes and shocks	• belong to bereavement group which offers support • withdrawn children from school to help at home • reduce area cultivated, use reduced tillage methods of cultivation, grow crops that require little labour inputs • skip meals during hungry season and eat wild fruits
Livelihood outcomes	
Household achievements in terms of food security (months per year), schooling, other indicators of well-being	• food secure for 8 months a year • meet basic household needs • struggle to meet school costs (even though mainly free) • no money for health care • no money to maintain and improve home
Outlook	
Household attitudes towards the future	See livelihood continuing to deteriorate but have to carry on for the sake of the children
Major challenges facing household	• time and labour constraints in household • seasonal food insecurity • shortage of cash • shortage of fuelwood in locality • inability to send children to school which will compromise their future options

Example of Template 4.3: Summary of Strengths and Weaknesses

Group: Young widows

	Strengths	Weaknesses
Household asset base	• head of household generally young • range of farming skills with rainfed crops and small livestock • local knowledge regarding seed selection and storage, and use of wild fruits • have more land available than able to cultivate • membership of women's and other groups	• head of household widow, many may be infected with HIV, some already sick with AIDS-related illnesses • high dependency ratio • household members malnourished for part of year • limited horizons – no experience outside village • loss of property (land, farm assets and household assets) during and after death of husbands • limited time to attend groups and meetings in order to develop new skills • limited representation in group leadership • limited time to participate in reciprocal labour groups
Livelihood strategies	• have a few non-farm activities to supplement crop and livestock production	• reliance on limited range of rainfed crops • generally no experience or opportunity to grow irrigated crops for cash • tend to concentrate on low value products with limited markets
Livelihood outcomes	• food secure for 8 months a year • meet most of household basic needs	• struggle to survive • expect things to continue to deteriorate in future
Main challenges		• time and labour constraints in household • seasonal food insecurity • shortage of cash • shortage of fuelwood in locality • inability to send children to school

Example of Template 5: Stage of Disease and Community Response Matrix

Community: AIDS Impacted

Stage of disease	Community and household responses		
	Not aware	**Denial and despair**	**Acknowledgement and pro-active coping**
1. Initiating: low rates of HIV prevalence and very few AIDS-related deaths			
2. Impending: rising rates of HIV infection and AIDS-related illnesses and deaths beginning to increase			
3. Impacted: HIV infection rates high and community experiencing many AIDS-related deaths		• increase in number of households headed by widows and grandparents • many deaths among young and middle aged adults – malaria and TB • denial of disease in community • avoidance of those who look sick • exclusion of widows from meetings	
***4. Impacted (extended*)**: HIV infection rates high and community experiencing widespread AIDS-related deaths			

Example of Template 6: Composition of Client Groups and Priority Needs

Community: High AIDS-impacted (extended)

Client group	Problems	Priority needs
PLWHA	• poverty • food insecurity and malnutrition • absence of effective local medical care • absence of psycho-social support • stigmatised by community	• improved access to health care services • improved diet • increase understanding to reduce vulnerability to opportunistic diseases and infecting others • planning for future: succession planning
Young widows	• poverty • food insecurity and malnutrition • weak control over assets • limited asset base: many items sold during husband's illness • marginalised and excluded from community activities • cultural norms to be inherited	• coping with the death of their husbands: security over their assets, psycho-social support • caring for children: food security, improved nutrition, assistance with school attendance, child care • access to groups and meetings in the community • access to extension and financial services • economic and gender empowerment • planning for the future: succession planning
GHHs	• lack physical energy • limited asset base • poverty • food insecurity and malnutrition	• skills in caring for PLWA: safe care practices, food • caring for orphaned grandchildren: food security, assistance with school attendance • planning for the future
SMHHs	• food insecurity and malnutrition • limited asset base: many items sold during husband's illness • marginalised and excluded from community activities	• coping with death of their wives: psycho-social support • caring for children: food security, improved nutrition, assistance with school attendance, child care • access to groups and meetings in community • planning for the future: succession planning
Orphans and vulnerable children	• poverty • food insecurity, malnutrition • weak control over assets • limited asset base: many items sold during parents illness • marginalised and excluded from community activities	• knowledge to reduce risk of HIV infection • food security • coping with death of parents: life skills and psycho-social support, continued access to family assets • livelihood skills and knowledge • continued school attendance
Youth	• peer pressure and cultural norms to be sexually active • limited opportunities to continue education • lack of economic activities	• knowledge to reduce risk of HIV infection • diversify farming activities • non-farm employment opportunities • access to financial services • access to extension and technical advice • ability to live within a stable community with life skills support
Married men	• seasonal nature of farm employment • food insecurity and malnutrition • extra-marital affairs	• knowledge to reduce risk of HIV infection • diversify farming activities • non-farm employment opportunities • planning for the future: succession planning
Married women	• weak control over assets • cultural norms and coercion to have unprotected sex • weak bargaining position about sex • seasonal nature of farm employment • food insecurity and malnutrition	• economic and gender empowerment • knowledge to reduce risk of HIV infection • diversify farming activities • non-farm employment opportunities • planning for the future: succession planning
Community	• lack of understanding about HIV/AIDS • marginalisation and discrimination of those infected and affected • limited capacity to provide effective support	• understand disease and local drivers of the epidemic • change attitudes and cultural norms which make people more at risk of infection or vulnerable to impacts • provide effective care and support to those infected and affected

Example of Template 7: Ongoing HIV/AIDS Activities and Implementing Agents

Client group *	Ongoing activities	Implementing agents
PLWHA	IEC Home-based care	Local government NGOs
Young widows	IEC	Local government and women's groups
GHHs	Take home rations for households caring for orphans	World Food Programme
SMHHs	IEC	Local government
Orphans and vulnerable children	School feeding programme IEC	World Food Programme with school Local government and schools
Youth	IEC	Local government and youth clubs
Married men	IEC	Local government
Married women	IEC	Local government
Community	-	-

Example of Template 8: Potential Extension Activities and Partners

Client group *	Broad theme	Potential activities (development/humanitarian)	Methods of delivery	Potential partners and funding
PLWHA	• care and support • preparations to reduce vulnerability to impacts	• nutrition education and home gardens (development) • nutrition gardens at health centre (humanitarian) • labour saving technologies and practices (humanitarian) • succession planning (development)	• women's groups • welfare groups	• health service • NGOs, CBOs (national HIV/AIDS funds)
Young widows	• preparations to reduce vulnerability to impacts • adapting to overcome impacts	• livelihoods strengthening and diversification (development) • nutrition education (development) • labour saving technologies and practices (humanitarian) • succession planning and property inheritance (development) • land tenure reform (development)	• women's livelihood interest groups • para-legals	• local administration • NGOs • microfinance institutions
Orphans and vulnerable children	• adapting to overcome impacts	• IEC and BCC (development) • life skills, psycho-social support (humanitarian) • farming and livelihood skills (development) • labour saving technologies and practices (development)	• Junior Farmer Field and Life Schools	• schools • FBOs, CBOs (national HIV/AIDS funds) • World Food Programme
Youth	• reducing risk of infection	• IEC and BCC (development) • livelihoods strengthening and diversification (development)	• youth groups • rural livelihood schools • apprenticeship schemes	• private sector • microfinance institutions
Married women	• reducing risk of infection	• IEC (development) • gender empowerment (development) • labour saving technologies and practices (development)	• women's associations • Under 5s club	• home economists • NGOs (national HIV/AIDS funds)
Community	• all aspects	• IEC and BCC (development)	• community conversations	• NGOs with HIV/AIDS specialists (national HIV/AIDS funds)

Annex III

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