MAINSTREAMING TOWARDS UNIVERSAL ACCESS

What international policy-makers and donors can do to increase and improve AIDS mainstreaming

A REPORT BASED ON RESEARCH IN BURKINA FASO, CAMBODIA, INDIA AND ZAMBIA
Who is the International HIV/AIDS Alliance?

Established in 1993, the International HIV/AIDS Alliance (the Alliance) is a global partnership of nationally-based organisations working to support community action on AIDS in developing countries. These national partners help community groups and other NGOs to take action on AIDS, and are supported by technical expertise, policy work and fundraising carried out across the Alliance. In addition, the Alliance has extensive regional programmes, representative offices in the USA and Brussels, and works on a range of international activities such as support for South–South co-operation, operations research, training and good practice development, as well as policy analysis and advocacy.

Our mission is to support communities to reduce the spread of HIV and meet the challenges of AIDS. To date, we have supported more than 3,000 projects in over 40 developing countries, reaching some of the poorest and most vulnerable communities with HIV prevention, care and support, and improved access to treatment.

Acknowledgements

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<td>CBO</td>
<td>Community-based organisation</td>
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<td>CSP</td>
<td>Country Strategy Paper</td>
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<td>DFID</td>
<td>Department for International Development (United Kingdom)</td>
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<td>FAO</td>
<td>Food and Agriculture Organization (United Nations)</td>
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<td>GTZ</td>
<td>German Development Cooperation</td>
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<td>IPC</td>
<td>Initiative Privée et Communautaire de lutte contre le VIH/SIDA (Burkina Faso)</td>
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<td>KHANA</td>
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<td>M&amp;E</td>
<td>Monitoring and evaluation</td>
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<td>NAC</td>
<td>National AIDS Council</td>
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<td>NACO</td>
<td>National AIDS Control Organisation</td>
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<td>NGO</td>
<td>Non-governmental organisation</td>
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<td>PRSP</td>
<td>Poverty Reduction Strategy Paper</td>
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<td>SACS</td>
<td>State AIDS Control Society</td>
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<td>UNAIDS</td>
<td>Joint United Nations Programme on AIDS</td>
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<td>UNDP</td>
<td>United Nations Development Programme</td>
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<td>USAID</td>
<td>United States Agency for International Development</td>
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<td>WFP</td>
<td>World Food Programme</td>
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Executive summary

In 2006, world leaders made a historic commitment to achieve universal access to HIV prevention, care, support and treatment by 2010.1 But many countries face significant barriers to achieving this global mandate, associated with the social, economic and political issues that increase people’s vulnerability to HIV and exacerbate the impact of AIDS.

Tackling these barriers to universal access requires a co-ordinated and wide-ranging response. This needs to involve multiple sectors and stakeholders from within the health sector and beyond. Above all, the international development community and non-health government ministries need to play a bigger part in changing the aspects of social, economic and political systems that drive HIV epidemics. One effective way to do this is AIDS mainstreaming.

We believe AIDS mainstreaming involves two key aspects:

- adapting wider health and development programmes to take into account people’s vulnerability to HIV and the impact of AIDS
- adapting AIDS programmes to take into account the wider health and development needs of the people they work with and for.

Universal access will not be achieved by relying on a standard repertoire of interventions by health programmes and AIDS organisations alone. To achieve universal access, there needs to be a wide spectrum of mainstreamed (or ‘integrated’) efforts by a diverse range of stakeholders – from ministries of social welfare to the police and agriculture non-governmental organisations (NGOs) – who may have had little or no involvement in the response to date.

This Alliance report provides evidence of how policy and funding systems at the national and international levels help or hinder mainstreaming at the community level. It is based on qualitative research conducted in Burkina Faso, Cambodia, India and Zambia, involving interviews with more than 100 people from over 80 organisations.

The findings of our research indicate that, while the policy environment in each of the four countries is increasingly receptive to AIDS mainstreaming, progress is being held back for a number of reasons. These include:

- lack of consensus on what AIDS mainstreaming is and how to do it
- limited commitment beyond the health sector to responding to AIDS
- negative impact of AIDS-related stigma and discrimination on mainstreaming
- institutional, administrative and political impediments to AIDS mainstreaming
- limitations of structures for government–civil society co-operation on AIDS mainstreaming
- limited cross-sectoral leadership and ownership of the response to AIDS
- lack of learning and training on AIDS mainstreaming
- inadequate monitoring and evaluation (M&E) systems for AIDS mainstreaming activities.

In terms of the funding environment, our research identified that, while some donors are funding AIDS mainstreaming activities, this is not occurring on a large enough scale to achieve universal access. The reasons for this include:

- inadequate funding for mainstreamed responses to AIDS
- restrictions to existing funding mechanisms for AIDS
- unsustainable, short-term or project-specific funding for AIDS mainstreaming
- inappropriate or ineffective allocation of funding for AIDS mainstreaming
- differing priorities based on unequal relationships between donors, governments and NGOs.

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Executive summary

Based on our research findings, we are making a number of recommendations to enhance the environment for AIDS mainstreaming and, in turn, achieve a greater contribution to universal access. International policy-makers and donors – particularly the Joint United Nations Programme on HIV/AIDS (UNAIDS), the United Nations Development Programme (UNDP) and the World Bank – should:

1. work together, particularly at a regional level, to promote a shared vision of AIDS mainstreaming and articulate its vital, strategic role in achieving universal access to HIV prevention, care, support and treatment.

2. use existing national health and development planning processes (such as Poverty Reduction Strategy Papers and National Health Plans) to mobilise and engage a wide range of stakeholders both within and beyond the health sector.

3. use these national planning processes – and the evidence produced by multiple stakeholders, including civil society – to assess the full and comprehensive resource needs for achieving universal access.

4. support systems – such as focal points, champions and task teams – to actively promote, co-ordinate and facilitate AIDS mainstreaming within government sectors and multisectoral bodies.

5. recognise the vital contribution of civil society to AIDS mainstreaming and ensure the meaningful participation of the sector, including people living with HIV and other key populations, in relevant national debates and multisectoral planning processes.

6. ensure that AIDS mainstreaming activities are integrated into, rather than simply added onto, a country’s harmonised national action on AIDS (that is, the ‘Three Ones’).

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2 One agreed AIDS Action Framework; One National AIDS Coordinating Authority; One agreed country level Monitoring and Evaluation System. UNAIDS (2004), ‘Three Ones’ Key Principles: Coordination of National Responses to AIDS
Introduction

The mandate of universal access

In 2006, world leaders made a historic commitment to achieve universal access to HIV prevention, care, support and treatment by 2010. As national responses are scaled up to meet this global target, many countries face significant barriers. These include inequitable access to health services, stigma and discrimination, and limited infrastructure and human capacity. While some barriers are specific to AIDS, many others are associated with the wider social, economic and political issues that increase people’s vulnerability to such epidemics and exacerbate their impact.

Tackling these major barriers to universal access requires a co-ordinated and wide-ranging response, one that involves multiple and diverse sectors, within the health sector and beyond. In particular, it requires the international development community and non-health government ministries of developing countries to play a bigger part in changing the fundamental aspects of the social, economic and political systems that drive AIDS.

Mainstreaming is an effective way to do this. Through mainstreaming, non-health sectors and non-AIDS specialists – whether community groups or government ministries – can become involved in addressing HIV epidemics by using their existing strengths and comparative advantages. As a result, multiple actors can help tackle the barriers to achieving universal access, better enabling countries to scale up prevention, care, support and treatment, and ensuring equitable access for all.

Aim of this report

This report aims to provide evidence about how national and international policy and funding processes and decisions affect the extent and quality of AIDS mainstreaming.

It calls for international policy-makers and donors to create an enabling environment for more and better mainstreaming within a range of HIV epidemics, and sets out six specific actions they can take (see ‘Recommendations’, page 16).

Research methodology

The report’s findings and recommendations are based on qualitative research carried out by the Alliance in Burkina Faso, Cambodia, India and Zambia. These countries have diverse policy and funding scenarios, and the nature of the epidemic is different in each (see box below for adult HIV prevalence). As such, they provide a snapshot of findings that are potentially applicable to stakeholders working in a range of contexts throughout the world.

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<td>Burkina Faso</td>
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<td>Adult HIV prevalence</td>
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Our research included an analysis of the relevant national and international policies and funding processes in each country. We also conducted semi-structured one-to-one interviews with more than 100 people from 80 organisations, targeting stakeholders that play a key role in developing or implementing AIDS mainstreaming strategies. Examples include representatives of governments (such as ministries and National AIDS Councils (NACs)), the United Nations, international NGOs, national NGOs and networks of people living with HIV.

The limitations of the research are that it was carried out in a short timeframe and, in some instances, lacked fully cross-sectoral representation (for example, government stakeholders largely represented health and AIDS services rather than other ministries).

Researchers co-ordinated the information-gathering process in each country. They then analysed the responses to assess the influence of international policy on national- and local-level AIDS mainstreaming and to make recommendations for improvements. More information on the specific results from Burkina Faso, Cambodia, India and Zambia is available from the Alliance secretariat.

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4 UNAIDS (2006), Epidemiological Fact Sheets on HIV/AIDS and Sexually Transmitted Infections
There are various interpretations of mainstreaming. Some development NGOs see it as an approach that enables them to maintain their ‘core business’ within an environment that is changed due to AIDS. This suggests that, through sensitisation (internal mainstreaming) and adapting existing work (external mainstreaming), organisations can adjust their approach so that they can continue to be successful.

UNAIDS has defined mainstreaming as: “A process that enables actors to address the causes and effects of AIDS as they relate to their core mandate in an effective and sustained manner, both through their usual work and within their workplace. It aims at enabling a wide range of actors to use their comparative advantage to contribute to the response to AIDS in the areas of prevention, treatment, vulnerability reduction and impact alleviation.”

At the Alliance, our approach builds on both these perspectives. We believe mainstreaming involves two complementary aspects:

- adapting wider health and development programmes to take into account people’s vulnerability to HIV and the impact of AIDS
- adapting AIDS programmes to take into account the wider health and development needs of the people they work with and for.

The first aspect requires AIDS to be analysed and addressed in all components of an organisation’s work. But it does not require an organisation to change its core function. Instead, it is about viewing the work in a different way, reviewing activities and building partnerships to ensure that the core business continues to be effective. This is vital for ensuring both an effective response to AIDS and strong, broader health and development work that continues to be relevant to the changed context.

The second aspect of mainstreaming requires AIDS programmes to recognise and respond to the holistic needs of the people they work with and for. These of course include HIV prevention and treatment, but go beyond this into areas such as nutrition, livelihoods and legal advocacy.

Both aspects of mainstreaming are especially important for reaching and supporting community members who are poor and/or marginalised. For example, a micro-credit project could provide an ‘inroad’ for HIV prevention messages for young married women who might otherwise be unable to access such information due to cultural pressures. Meanwhile, integrating food support and legal advocacy into an AIDS programme might support marginalised people living with HIV to maintain their physical health and enhance their social wellbeing.

At the Alliance, we believe that mainstreaming – alongside ‘integration’ and ‘multisectoralism’ – is not about set-piece interventions. Rather than providing narrowly defined approaches, they form a continuum of strategic options that enable organisations to adapt their work appropriately and effectively. For example, the degree to which a development organisation should continue to focus on its core business, adjust its work to the impact of AIDS and/or integrate AIDS-specific activities should be determined by a number of factors at any one time. These include its capacity, its resources, the needs of the community it is working with and the context in which it is operating.

Types of mainstreaming

AIDS can be mainstreamed into a wide variety of national and community health and development programmes. Examples include those focused on:

- general health
- poverty reduction
- micro credit
- education
- gender equity
- social protection.

Action on wider health and development issues can be mainstreamed into AIDS programmes. Examples of such issues include:

- nutrition
- income generation
- human rights
- sexual and reproductive health.

5 Holden S, Oxfam (2004), Mainstreaming AIDS in Development and Humanitarian Programmes
6 UNAIDS (2005), Mainstreaming AIDS into Development: Why and How to Do It
CASE STUDY
Mainstreaming AIDS in the agriculture sector, Zambia

In Zambia, a country with a generalised epidemic and adult HIV prevalence of 17%, AIDS and food insecurity are closely linked. The epidemic weakens and kills productive members of households, including those who grow food for the family or to sell. Hungry people are forced to adopt risky survival strategies that can accelerate the spread of HIV. Meanwhile, malnutrition makes those already infected with HIV more vulnerable to opportunistic infections, which can hasten and exacerbate HIV-related illness.

In response, Zambia’s agriculture sector has taken direct action to address the links between AIDS and food insecurity, setting up Junior Farmer Field and Life Schools. The schools promote the economic empowerment of orphans and other children made vulnerable by AIDS, as a way to improve food security. They teach traditional and modern agriculture techniques as well as life skills (including HIV prevention, gender sensitivity, nutritional education and business skills).

The schools were launched in 2004 as part of a pilot project by the United Nations’ Food and Agriculture Organization. They are also supported by the World Food Programme (which provides food to participants to encourage them to attend) and the Peace Corps (which teaches life skills).

CASE STUDY
Integrating home-based care and food security, Cambodia

In Cambodia, the Khmer HIV/AIDS NGO Alliance (KHANA), one of our linking organisations, has operated a home-based care programme for people living with HIV and orphans and vulnerable children since 1999. In 2004, to increase the programme’s impact, KHANA entered into a co-operative agreement with the World Food Programme and the Ministry of Health to integrate food support into its activities.

An evaluation of this programme found that, in the area served, households affected by AIDS spent less money (as a proportion of their total expenditure) on food and medicine and more on agriculture and schooling. They also had better overall health, better compliance with treatment programmes and took out loans less frequently than others. Households with orphans and vulnerable children were less likely to experience rice shortages, while girls who participated in the programme had better educational outcomes.

The programme continues to provide food and nutrition to poor households and families affected by AIDS. This, in turn, contributes to better health, livelihoods and more earning opportunities, as well as better access to education.

7 UNAIDS (2006), Epidemiological Fact Sheet on HIV/AIDS and Sexually Transmitted Infections: Zambia
The value of AIDS mainstreaming for universal access

Mobilising a diverse and far-reaching response

To translate the global mandate of universal access into a national and local reality requires not only commitment but also assertive, far-reaching and sustained action.

One thing is clear – universal access will not be achieved by relying on a standard repertoire of interventions provided by AIDS organisations or health-specific programmes alone. Because AIDS is as much a social and economic issue as a health problem, scaling up requires the participation, support and resources of multiple and diverse sectors.

Some of these – from ministries of social welfare to the police or agriculture NGOs – have vast experience, reach and resources to offer. Yet many have had little or no involvement in the AIDS response to date. Mainstreaming provides a crucial ‘inroad’ to such stakeholders.

Integrating AIDS into national planning for health and development

To facilitate the involvement of such a diversity of stakeholders and ensure an approach that is systematic and efficient, AIDS mainstreaming must be integrated into the recognised infrastructure and frameworks of national health and development responses. In particular, this includes the national strategic planning processes that shape policies and decisions about which programmes are implemented and how resources are allocated. Important examples of such national, multisectoral processes include those for National Health Plans, Poverty Reduction Strategy Papers (PRSPs) and Country Strategy Papers (CSPs).

Such an approach ensures that AIDS mainstreaming is seen as integral to wider national responses to health and development, rather than a ‘separate track’ of action. It also, vitally, ensures that AIDS mainstreaming is appropriately planned and budgeted, based on realistic and evidence-based assessments of the steps involved and the resources needed by all relevant stakeholders.

The role of civil society

Civil society has a critical role to play in national action on AIDS mainstreaming. Civil society includes NGOs, community-based organisations (CBOs) and groups of key populations (such as people living with HIV, injecting drug users and sex workers). Such organisations are often well placed to identify why mainstreaming is needed. They are also a vital source of information on how to do mainstreaming, particularly at the community level and within decentralised systems.

Through its everyday work with communities, civil society offers a unique perspective on the barriers to accessing services (particularly for the most marginalised groups and those most vulnerable to HIV). Most importantly, civil society groups are best placed to know what can and must be done to remove these barriers. According to Alliance country partners, the most common barriers to accessing services include insufficient funding, inadequate technical support, weak health systems and stigma and discrimination.

Many civil society stakeholders argue that families and households affected by both poverty and AIDS ask for their needs to be addressed more comprehensively. As such, it is argued that funding to mainstream AIDS into broader health and development sectors should be made more widely available, and that broader programmes would increase the capacity of individuals and households to respond to AIDS. Progress in areas such as poverty reduction and access to education will have a direct bearing on progress towards universal access to HIV prevention, care, support and treatment.

Finally, civil society also provides ‘real-life’, community-level initiatives that demonstrate how mainstreaming both reduces people’s vulnerability to HIV and mitigates the impacts of AIDS (see Zambia case study, page 7). These are models that can be promoted by international policy-makers and donors and that represent an insight into the concrete role that mainstreaming can play in making universal access happen.
The value of AIDS mainstreaming for universal access

Café Sante, one of 14 roadside kiosks run by beneficiaries of an AIDS programme by Oasis, Burkina Faso.
© 2004 Gideon Mendel for International HIV/AIDS Alliance
In terms of the policy context, our research indicated that the national policy environments of all four countries are increasingly receptive to AIDS mainstreaming. For example, in Cambodia and Zambia, the national strategic frameworks for AIDS specifically supported a multisectoral approach, while in Burkina Faso and India there were strong government advocates for mainstreaming at high levels. However, our research also indicates that the policy process for AIDS mainstreaming is being held back for a number of reasons. These include the following:

- **Lack of consensus on what AIDS mainstreaming is and how to do it**

  This issue was raised by a number of respondents in each of the four countries. As noted earlier, different stakeholders gave different meanings to mainstreaming, while the words ‘mainstreaming’, ‘integration’ and ‘multisectoralism’ were used interchangeably by many. While a fluid definition is not a problem in and of itself, the resulting confusion was felt to be a challenge to clear policy dialogue on the subject.

  In Tamil Nadu, India, the concept and scope of AIDS mainstreaming did not appear to have taken root yet due, in part, to differences in the perception of the word. Meanwhile, in Delhi, one interviewee noted that: “People are struggling to understand the meaning of mainstreaming and using this term may confuse partners, put up barriers and inhibit co-operation.” Some interviewees, particularly from development organisations, regularly used the term ‘mainstreaming’ when, in fact, describing AIDS-specific work.

  In Cambodia, some respondents felt that the government did not always provide a clear enough definition of multisectoralism or of the process needed to implement a mainstreaming strategy. Generally, respondents expressed concern that there was little knowledge either in government or non-government sectors about the practicalities of mainstreaming. While there is support for moving ahead with the mainstreaming agenda, in many instances learning has had to occur ‘on the job’, resulting in mistakes that could have been avoided.

  Overall, this indicates that governments, along with donors and civil society, need to create a shared definition, vision and roadmap for mainstreaming. High-level policy documents can have an impact on community-level programmes, and clarifying what constitutes mainstreaming at the policy level can help to prevent confusion and lead to more effective programming.

- **Limited commitment to responding to AIDS beyond the health sector**

  While there is widespread recognition that the response to AIDS must include social and economic support as well as medical care, many respondents felt that it is still dominated by the health sector, which prevents the participation of other sectors. For example, as a respondent in Cambodia said: “Often the problem is that national plans are developed by doctors whose focus is on HIV as a public health issue, without considering the broader implications for society.” Another participant sensed a “denial among development institutions about what is happening and the need to respond to HIV and AIDS. It is also that people view HIV as a health issue and absolve themselves from responsibility if this is not their field.”

  The limited involvement of other sectors in AIDS mainstreaming was also attributed to the complex challenge of assigning responsibility for it within government structures and, in particular, the fact that the department or person responsible often had limited cross-sectoral influence. This was the case in Zambia, where some interviewees felt that the NAC could be more effective if it was attached to a more senior or cross-cutting government department.

  Some respondents also felt that the uptake of mainstreaming was limited by a lack of focal points in non-health or non-AIDS specific organisations, or the lack of support for focal points where they did exist. In Zambia, some respondents felt that there was a need for trained advocates to drive the mainstreaming process. In Cambodia, the government had placed AIDS focal points in non-health ministries, though some felt that these advocates were under-supported, lacked clearly articulated roles and could become isolated within a ministry for which AIDS is not a priority. Respondents clearly expressed the need for some form of technical support for mainstreaming which, in turn, might include focal points or task teams.

  In seeking to increase multisectoral commitment to AIDS mainstreaming, our research noted the importance of determining which sectors are best placed to participate, since funding and resources are
limited. In Cambodia, for example, the government found that asking all 22 of its ministries to take part in the AIDS response was inefficient. Instead, it was taking a ‘sub-multisectoral’ response, selecting ministries that were most relevant and most able to respond.

**Negative impact of AIDS-related stigma and discrimination on mainstreaming**

Our research highlighted a perception that stakeholders outside of the health sector may avoid mainstreaming work because of the stigma and discrimination associated with AIDS and/or behaviour that increases people’s vulnerability (such as sex work, injecting drug use and male-to-male sex). In India, for example, some respondents felt that socio-cultural norms that restrict the open discussion of sex and sexuality were preventing widespread acceptance of mainstreaming. Some also felt that because vulnerability to HIV can be linked to marginalised or even criminalised groups, mainstreaming could be perceived as controversial, providing a deterrent to widespread involvement.

**Institutional, administrative and political impediments to AIDS mainstreaming**

Mainstreaming programmes and activities often operate within bureaucratic and institutional structures that may not support a multisectoral approach. This was the case in India, where a pilot project supported by the United States Agency for International Development (USAID) promoted mainstreaming within municipal corporation management. India’s National AIDS Control Organisation (NACO) required funds and activities to be routed through State AIDS Control Societies (SACSs). However, it was unclear how municipalities related to the SACSs in terms of funding flows and administration and, as a result, the project was discontinued.

Another example from India shows how the government’s actions to decentralise responsibility for some functions to the state level – a move supported by many observers – could hinder mainstreaming. Since this decentralisation of responsibility, a few states had declared opposition to sex education in schools and could even attempt to ban it. While this was unlikely to be accepted by the national government, it would complicate mainstreaming efforts in the education sector.
In Cambodia, some respondents were concerned that political differences and ambitions among government ministers and inter-departmental initiatives could shape priorities and decisions for mainstreaming – rather than technical expertise and policy implementation. As one respondent noted, this contributed to a scenario whereby any successes of the multisectoral response were more likely to be due to how individuals approached their work rather than success in integrating the work of different institutions.

Meanwhile, in Zambia, there was a suggestion from one participant that AIDS mainstreaming was not a priority for local NGOs because of confusion over where responsibility for it resided in the overall structure of the organisation. One respondent told how their organisation’s programmes were written at headquarters in Europe, which did not allow for local-level input or reallocation of resources as dictated by local needs. This highlights the need to clarify roles and responsibilities for mainstreaming as part of overall policy development.

• Limitations of structures for government–civil society co-operation on AIDS mainstreaming

Processes for co-operation between the state and civil society can be fertile ground for AIDS mainstreaming, but can just as easily work against it. For example, in Andhra Pradesh, India, there had been declarations of openness for partnerships and mainstreaming between government and CBOs. However, some interviewees suggested that government functionaries sometimes treated CBOs as outside agencies and rarely included them in the actual planning and implementation of mainstreaming. A similar situation was reported in Burkina Faso, where many NGOs were active in mainstreaming programmes funded by the government, but had limited involvement in shaping policy. Meanwhile, very few NGO networks actively sought to influence national policy.

Another manifestation of this barrier was evident in Cambodia, where the structure of the NGO platform for development agencies, known as the Co-operation Committee for Cambodia, operated through thematic-based groups. This risked limiting the type of cross-sectoral co-operation that is needed to mainstream AIDS on a wide scale.

• Limited cross-sectoral leadership and ownership of response to AIDS

Champions are vital for AIDS mainstreaming, particularly at senior levels of government. However, a lack of high-level leadership was cited as a major barrier in all four countries. There were a few good examples of high-level government leadership on AIDS mainstreaming, such as the prime minister of India and the secretariat of the NAC in Burkina Faso. However, these are not enough to scale up mainstreaming to the necessary level to achieve its potential to support universal access.

The situation in relation to civil society was similar: no single organisation emerged as the leader on mainstreaming in any one country. In Zambia, there was a consensus that local-level NGO offices were confronted with AIDS on a daily basis and thus engaged in mainstreaming out of necessity rather than taking a more strategic approach informed by policy. While it was positive that mainstreaming was occurring in these countries, it appeared to be implemented in a ‘reactive’ manner. For example, in Burkina Faso, civil society actors looked to donors for the stimulus to undertake explicit mainstreaming activities, rather than taking the initiative themselves. Meanwhile, other research indicates that when mainstreaming processes have been perceived as donor driven, they have rarely resulted in sustained action.8

• Lack of learning and training on AIDS mainstreaming

“The problem is that often there is no ‘how’ in international policy on mainstreaming, only the ‘it should be done’.” This comment from a respondent in Cambodia captures the perceptions of many interviewees that there is a lack of information on how to implement mainstreaming. Even a development organisation that received AIDS-related training commented that: “The problem is [that] people need training, as they don’t know how to introduce this [mainstreaming] into the programme... There are many people who are good at programming AIDS, but unsure how to bring AIDS and development work together.”

In fact, there are a considerable number of guidelines, toolkits and checklists to support AIDS mainstreaming at national, sectoral and local levels. However, stand-alone toolkits have rarely proven effective; facilitation

8UNAIDS (2005), Mainstreaming AIDS into Development: Why and How to Do It
and support are needed over a period of time for strategies to be fully implemented.\(^9\)

Many respondents recommended creating knowledge-sharing processes and forums to address the lack of information on mainstreaming. In Zambia, while there were various forums for sharing general AIDS information, interviewees expressed a need to bring together stakeholders specifically to share best practice on mainstreaming. The need for shared learning was also mentioned by those who were slightly removed from the health or AIDS sectors and who expressed a feeling of exclusion and being poorly informed about the activities of others. In Burkina Faso, there was a sense that many organisations were involved in mainstreaming but their actions were seldom documented, their approaches were not systematised and there was little exchange of information among practitioners.

**Inadequate monitoring and evaluation systems for AIDS mainstreaming activities**

Linked to the lack of information is the need for more and better-designed M&E systems. The development of sound policies on AIDS mainstreaming and the training and information needs of staff depend on collecting information about, and assessing, existing practices. But it seems that effective M&E for mainstreaming is rare. In Burkina Faso, for example, only one of the respondents reported that their organisation documented its mainstreaming process.

Well-designed M&E systems require templates and reporting processes that capture data specific to AIDS mainstreaming activities, while enabling programmers to respect the confidentiality and rights of community members. While many mainstreaming toolkits propose ideas for indicators, there appeared to be few examples of such indicators being adapted and used in practice. Furthermore, most indicators focus on the process of mainstreaming as opposed to the sector-specific outcomes, the latter being the more crucial measure of effectiveness.\(^{10}\)
In terms of the funding context, our research revealed that a few donors were funding AIDS mainstreaming activities in the four countries studied. Examples include the UK’s Department for International Development (DFID) in Cambodia; USAID and UNDP in India; and German Development Cooperation (GTZ) in Zambia. But the research also indicates that the funding process for AIDS mainstreaming is being held back for a number of reasons. These include the following:

- Inadequate funding for mainstreamed responses to AIDS
  In all four countries, it was clear that more funds were needed to take AIDS mainstreaming to the scale required to achieve universal access. Respondents shared examples of situations where funding from key government agencies was simply not available for implementation activities, such as in Burkina Faso. In India, apart from funding from UNDP and DFID for NACO’s Mainstreaming Cell, there was little donor support dedicated to mainstreaming and ministries were being asked to fund relevant activities themselves. In Burkina Faso, many mainstreaming activities were funded out of organisations’ regular budgets, creating competition for funds that was largely seen as a disincentive for mainstreaming. Also, many donors appeared unwilling to support mainstreaming because they viewed it as a separate field of activity from ‘traditional’ AIDS interventions.

Some respondents commented that AIDS mainstreaming would be around as long as extra funding was available. This highlights the vital need for funding specifically for mainstreaming; and donors, in particular, need to play a greater role in supporting the mainstreaming agenda. UNAIDS has found that, in spite of growing recognition of the need to mobilise many sectors and actors to address AIDS, it is still difficult for partners in non-health sectors and at the local level to access AIDS funds.

- Restrictions to existing funding mechanisms for AIDS
  In some countries, respondents raised concerns that donor funding was provided specifically for AIDS or specifically for development – a situation that could hinder mainstreaming by inhibiting implementers’ ability to secure funds for different components of the same programme.

Also, in Cambodia, there were examples of donor demands for reporting being overly restrictive for broader approaches to AIDS. For example, in one mainstreaming programme, a donor required NGO staff to count the number of HIV-positive people or orphans and vulnerable children who were supported by the programme. This required programme participants to disclose in order to benefit. But according to the representative of the NGO: “Our preference would be to work with communities and not have to count, not to force people to identify as [HIV-positive].” They added: “Equally important is that we have to reject many sick people on the grounds that they are not HIV-positive and we really don’t want to do this.”

However, funding mechanisms that have inadequate restrictions or parameters could also be ineffective. For example, respondents from Burkina Faso highlighted examples of donors that provided funding specifically for AIDS mainstreaming, but allowed for a very broad definition of it. This may not have impeded mainstreaming activities as such, but it did underscore a significant missed opportunity for donors to support the advancement of mainstreaming at the programme level.

- Unsustainable, short-term or project-specific funding for AIDS mainstreaming
  In India, the government was hesitant to rely on donor funding to support AIDS mainstreaming in the public sector, even though its ministries needed funds to implement existing policy. Similarly, among civil society actors, according to a respondent in Cambodia: “Mainstreaming and integration, and the joint programmes that they represent, can only be successful if donors are prepared to stay for the long-haul and work through these issues.”

The overall sense was that NGOs are being told to mainstream AIDS into their programming, but not being given the funding and support they need to do so. In fact, short-term funding allocations have undermined mainstreaming, particularly when donors’ commitment did not extend beyond one year and required short-term indicators. As one respondent put it: “There is a lot of good rhetoric now surrounding mainstreaming, but it is not a reality. This can be blamed upon the limits of funding streams... Decades, not years, of investment are required.”
Findings: Impact of funding context on AIDS mainstreaming

- Inappropriate or ineffective allocation of funding for AIDS mainstreaming

Where funding had been made available for AIDS mainstreaming, some interviewees reported problems with inappropriate or ineffective allocation. For example, in India, government funding for one mainstreaming programme was reported to be underspent due to a lack of absorptive capacity.

In Zambia, one participant noted: “[Current funding] incorporates all 20 ministries… Yet… the ministries should not be treated equally; some require a much more prominent position. If funding is distributed equally, you run the risk of not providing the right amount of attention to those ministries that need it most. A dilution effect occurs.” Also in Zambia, another interviewee noted: “If funding is not itemised specifically, then it becomes very difficult to enact mainstreaming in the field. If we want to mainstream, then HIV has to be factored in at the design and funding stage.”

- Differing priorities based on unequal relationships between donors, governments and NGOs

The research highlighted that while donors decided what their aid should be spent on – including in relation to AIDS mainstreaming – their decisions were not always in line with the spending priorities of governments or implementing partners. This unequal relationship was described by one respondent in Cambodia as being “like boxing… one side is too heavy”. Meanwhile, in Zambia, one NGO representative acknowledged that AIDS mainstreaming was made more difficult by having to find funding that supported both the needs of those affected by AIDS and the pre-set goals of donors.
Recommendations

Based on the findings of our research in Burkina Faso, Cambodia, India and Zambia, we are making a number of recommendations to enhance the environment for AIDS mainstreaming and, in turn, achieve a greater contribution to universal access. International policymakers and donors – particularly UNAIDS, UNDP and the World Bank – should:

1. work together, particularly at a regional level, to promote a shared vision of AIDS mainstreaming and articulate its vital, strategic role in achieving universal access to HIV prevention, care, support and treatment. This should clearly articulate the role of mainstreaming in reducing people’s vulnerability to HIV as well as the relevant role that different sectors can play. It should build on the definition provided by UNAIDS and be actively ‘marketed’ within relevant multisectoral strategies and policy-making/funding mechanisms.

2. use existing national health and development planning processes (such as PRSPs and National Health Plans) to mobilise and engage a wide range of stakeholders, both within and beyond the health sector. This should be based on an analysis of the sectors – such as police, agriculture and education – that are best placed to address the wider impacts of AIDS, but that may have had little or no involvement in the response to date.

3. use these national planning processes – and the evidence produced by multiple stakeholders, including civil society – to assess the full and comprehensive resource needs for achieving universal access to HIV prevention, care, support and treatment. In particular, non-AIDS specific resources must be managed effectively and creatively to ensure their maximum impact on the epidemic.

4. support systems – such as focal points, champions and task teams – to actively promote, co-ordinate and facilitate AIDS mainstreaming within government sectors and multisectoral bodies. These should have sufficient status and resources to be able to make decisions and to take national planning processes forward.

5. recognise the vital contribution of civil society to AIDS mainstreaming and ensure the meaningful participation of the sector, including people living with HIV and other key populations, in relevant national debates and multisectoral planning processes.

6. ensure that AIDS mainstreaming activities are integrated into, rather than simply added onto, a country’s harmonised national action on AIDS (that is, the ‘Three Ones’). In particular, indicators for mainstreaming should be developed and integrated into one agreed M&E system – with reporting making best use of the evidence from a variety of sectors, including civil society.
Who is the International HIV/AIDS Alliance?

Established in 1993, the International HIV/AIDS Alliance (the Alliance) is a global partnership of nationally-based organisations working to support community action on AIDS in developing countries. These national partners help community groups and other NGOs to take action on AIDS, and are supported by technical expertise, policy work and fundraising carried out across the Alliance. In addition, the Alliance has extensive regional programmes, representative offices in the USA and Brussels, and works on a range of international activities such as support for South–South co-operation, operations research, training and good practice development, as well as policy analysis and advocacy.

Our mission is to support communities to reduce the spread of HIV and meet the challenges of AIDS. To date, we have supported more than 3,000 projects in over 40 developing countries, reaching some of the poorest and most vulnerable communities with HIV prevention, care and support, and improved access to treatment.

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MAINSTREAMING TOWARDS UNIVERSAL ACCESS

What international policy-makers and donors can do to increase and improve AIDS mainstreaming

A REPORT BASED ON RESEARCH IN BURKINA FASO, CAMBODIA, INDIA AND ZAMBIA