



**Sharing Lessons Learnt from
Oxfam's Southern Africa
HIV & AIDS Programs with
the Pacific**

August 2006

*A Reference Tool of Lessons Learnt from
Programs Managed by Oxfam Australia*

Prepared for Oxfam Australia by Kathryn Dinh

Contents

Acronyms	3
1. Executive Summary	4
2. Introduction	7
3. Methodology	8
4. Contexts at a Glance	8
5. Sharing between Southern Africa and the Pacific – Is It Relevant?	9
6. Key Lessons Learnt from Oxfam’s HIV/AIDS Southern Africa Programs	
6.1 Integrating Prevention, Treatment, Care & Support	11
6.1.1 Management and Operation of Home-Based Prevention and Care.....	11
6.1.2 Separate Prevention and Care – the Pitfalls.....	13
6.1.3 Integrating Prevention, Care and Support.....	13
6.1.4 Preparing for Treatment.....	15
6.2 Gender Equality & Working with Men	17
6.2.1 Targeting Young Males through Schools and Recreation - South Africa.....	17
6.2.2 Male Home Based Care Volunteers - South Africa.....	19
6.2.3 Sensitising University Students to Gender and HIV Issues - Zimbabwe.....	21
6.3 Aspects of Community-Based HIV Programs	22
6.3.1 Use of Drama for Prevention.....	22
6.3.2 Peer Education and the Role of Volunteers.....	23
6.3.3 Networks & Partnerships.....	26
6.3.4 Monitoring and Evaluation.....	27
6.4 Working with Extractive Industries	27
7.0 Conclusion	30
References.....	31
Annex 1: Terms of Reference.....	32
Annex 2: Interviews for this Report.....	35
Annex 3: Lessons Learnt through Drama and Song: PNG.....	36

Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
ARV	Antiretroviral
AusAID	The Australian Agency for International Development
CBO	Community-Based Organisation
CERD	Centre for Environmental Research and Development (NGO in PNG)
CHoiCE	Comprehensive Health Care Trust (a JOHAP partner in South Africa)
COGENHA	Combined Oxfam Gender and HIV and AIDS Program (Zimbabwe)
CPC	Centre for Positive Care (a JOHAP partner in South Africa)
GIPA	Greater Involvement of People Living with and Affected by HIV and AIDS
HBC	Home Based Care
HIV	Human Immunodeficiency Virus
INGO	International Non-Governmental Organisation
JOHAP	The Joint Oxfam HIV and AIDS Program in South Africa
LASC	Lamontville HIV and AIDS Support Centre (CBO in South Africa)
M&E	Monitoring and Evaluation
NGO	Non-Government Organisation
OAus	Oxfam Australia
OI	Opportunistic Infection
PLWHA	People Living with HIV and AIDS
PNG	Papua New Guinea
PT	The Palabora Foundation (a JOHAP partner in South Africa)
SHAPE	Sustainability Hope Action Participation Education (COGENHA partner organisation in Zimbabwe)
SPC	Secretariat of the Pacific Community
STI	Sexually Transmissible Infection
TAI	Targeted AIDS Interventions (JOHAP partner organisation in South Africa)
TAC	Treatment Action Campaign (South Africa)
TB	Tuberculosis
VCT	Voluntary Counselling and Testing

1. Executive Summary

Oxfam Australia has been working with community based partners in Southern Africa specifically on HIV and AIDS since the mid 1990s. Over this time considerable experience has been developed and many lessons learnt in running community-based HIV programs. The aim of this report is to document the lessons learnt from these programs that are most relevant to the Pacific, so that Oxfam's HIV and AIDS programs in the Pacific region can benefit from the experience.

The report includes the lessons learnt from Oxfam's partner programs in South Africa, Mozambique and Zimbabwe that are managed by Oxfam Australia. It aims to inform the work of Oxfam's programs in Papua New Guinea (PNG), Vanuatu, the Solomon Islands and Fiji. The report is primarily intended for Oxfam Australia's program and advocacy staff and project partners in the Pacific. Secondary audiences could include other Oxfam affiliates, the Australian Agency for International Development (AusAID), NGOs, governments and international agencies working in the region. The report is designed as a reference tool from which partners can look up information relevant to their programs, and from which further information can be sought if needed. This report is *not* intended to provide strategic programmatic advice on specific lessons learnt in Southern Africa that can be applied to strengthen particular programs in the Pacific.

To research this report, the consultant undertook an extensive literature review of Oxfam documents. The report also makes reference to external best practice documents relating to HIV and gender equality. Finally a limited number of in-depth interviews were carried out with Oxfam program staff in Australia. (*see the TOR in Annex 1 for more detail*).

Whilst key characteristics of the regions of Southern Africa and the Pacific are significantly different (ie. HIV prevalence, geography, population numbers, stage of HIV response), there are also many factors contributing to the spread of HIV that these regions have in common. These include high levels of poverty, high unemployment, mobile populations, poor health infrastructure and high levels of gender-based violence. There are also many lifestyle and behavioural factors in common, such as attitudes of young people towards sexuality and the prominent role of the church in everyday life. Moreover, whilst at different levels in their response to HIV, these regions are implementing similar programs to combat the disease, such as home-based care programs, HIV prevention programs targeting youth, awareness raising programs drama programs and programs addressing gender equality. Many programs in the Pacific are at an earlier stage of implementation than those in Southern Africa – so the sharing experiences with Southern Africa at this time could really help to enhance the efficacy of the Pacific programs.

Key Lessons Learnt from Oxfam's HIV and AIDS Programs in Southern Africa

Integrating Prevention, Treatment, Care and Support

It is widely recognised that an effective HIV program must provide a continuum of care – integrating prevention, treatment care and support. Oxfam's partners in Southern Africa have learnt the value of integrating prevention and care programs, where there is the capacity and expertise to do so. They are now grappling with how to integrate

treatment as antiretroviral therapy (ART) is rolled out by governments. This report provides specific lessons learnt in: operating and managing home based care (HBC) programs including recruiting, training and organising volunteers; the disadvantages experienced in running separate prevention and care programs; the advantages experienced in integrating prevention and care; and the initial steps being undertaken by CBOs and NGOs to prepare for the roll-out of ART.

Some lessons learnt in providing integrated care are that:

- comprehensive training and follow-up needs to be given to volunteers in HBC programs;
- provision of adequate stipends is a big issue for volunteers, who need to support themselves and their families;
- integrating prevention and care (where there is capacity and expertise) has given the community a more efficient and responsive service and empowered the HBC volunteers; and
- staff and volunteers need to be trained in treatment literacy and build strong links with government health services in order to prepare for the roll-out of ART.

Gender Equality and Working with Men

Gender roles have a significant impact in the spread of HIV and AIDS and as such, addressing gender equality forms an integral part of many HIV programs run by Oxfam partners in Southern Africa. This section of the report focuses on three initiatives: working with young men in schools and through sport; the role of male volunteers in home-based care; and challenging gender roles and HIV awareness in a university setting.

Some of the lessons learnt in this section include that:

- peer education is a key way of accessing young boys and allowing them to explore their ideas of masculinity in a 'safe' environment;
- targeting boys at an age before they engage in sex (ie primary school) is seen as the most effective in being able to influence their sexual behaviour and challenge traditional gender roles;
- it is difficult to recruit male caregivers as this is traditionally seen as a female role; male caregivers can be just as respected by the community as their female counterparts;
- female caregivers may feel threatened by their male counterparts and be unsupportive of them; and
- engaging and training men as partners in raising awareness of gender equality at university means that they can actively help to engender mutual respect among males and females on campus.

Aspects of Community-Based HIV Programs

This section includes lessons learnt in: the use of drama for raising awareness about HIV, peer education, the role of volunteers, networks and partnerships and monitoring and evaluation. Key lessons learnt in these areas include that:

- the use of drama should be part of a holistic program in HIV prevention and lifeskills development;
- drama activities are ideally undertaken for specific target audiences (eg in schools) where it is possible to ensure effective follow-up and evaluation;
- comprehensive baseline studies help to ensure that peer education programs effectively respond to the beliefs and attitudes of the target audience;
- peer educators should be vetted for their suitability and need to be strong facilitators to ensure the program's success;
- partnering with traditional leaders and the church can result in important support for a program;
- NGOs and governments must collaborate closely in the roll-out of ART to provide comprehensive support to PLWHAs; and
- it is important for NGOs/CBOs to be well trained in monitoring and evaluation skills before commencing a project to ensure that its impact can be effectively measured.

Working with Extractive Industries

Lessons learnt from working with the mining sector in South Africa could prove valuable for NGOs/CBOs working in PNG, where mining is a major contributor to the national economy, and in the Solomon Islands which has substantial untapped mineral resources. AusAID already reports significant pockets of HIV infection around mining sites in PNG. In addition, the characteristics and behaviours of mine workers are often similar in different countries, as is the impact this behaviour has on surrounding communities. This report includes an example of a collaboration between an NGO and three mining companies in South Africa, all of whom are providing ART to their workers. Some of the lessons learnt from this program include:

- mining companies can collaborate with NGOs by providing financial and infrastructure support to facilitate the NGO's work as well as access to their workers;
- NGOs can provide prevention and awareness raising programs and an accessible referral system for the miners and the surrounding communities; and
- other partners such as the government can collaborate in the provision of treatment and clinical support.

It is recommended that this report is circulated to Oxfam program staff, partners and external NGOs/CBOs in the Pacific for use as a relevant tool in programming. Whilst advocacy is not explicitly addressed in this report, there are a number of lessons learnt that can inform advocacy activities in the Pacific and Oxfam Australia's support of these activities. Finally AusAID, other government agencies and donors working in the Pacific can draw on the lessons learnt in their planning, monitoring and evaluation of community-based HIV and AIDS programs.

2. Introduction

The aim of this report is to document key lessons learnt from those HIV and AIDS programs managed by Oxfam Australia in Southern Africa that are relevant to the Pacific. The report is designed to inform Oxfam HIV and AIDS programming and advocacy in the Pacific.

The report documents the lessons learnt from community-based partner programs managed by Oxfam Australia (OAus) in South Africa (funded by OAus, Novib – Oxfam Netherlands, Oxfam Ireland, Oxfam Hong Kong and Oxfam Germany), Mozambique (funded by OAus) and Zimbabwe (funded by OAus and Oxfam Ireland). It aims to inform the work of Oxfam in Papua New Guinea, the Solomon Islands, Fiji and Vanuatu (jointly managed by OAus and Oxfam New Zealand - therefore the Pacific is an Oxfam International program). It is designed as a reference tool so that Oxfam can draw on the experience of its Southern Africa programs to inform particular program work in the Pacific.

Whilst the Pacific and Southern Africa regional contexts are very different in many aspects – particularly the geography, HIV prevalence, population and stage of the HIV response, there are also many common social, economic and cultural factors that contribute to the spread of HIV which suggest that sharing lessons learnt has some relevancy. These include the high levels of poverty, gender-based violence and population mobility; limited health infrastructure; and the behaviours of young people towards issues of sexuality and sexual health.

Key topics selected for their relevancy to the Pacific include:

- integrating prevention, treatment, care and support;
- gender equality and working with men;
- working with extractive industries; and
- key aspects of community HIV programs including use of drama, peer education and the role of volunteers, networking and monitoring and evaluation.

A recent acknowledgement that documentation of the programs in Southern Africa needed to be strengthened has resulted in several evaluations and papers being produced that highlight many of the key lessons learnt from the Southern African programs. The Pacific has a lot to gain from the outcome of such a process.

This report is not designed to research or provide advice as to how these lessons can be applied in the Pacific, as this would require a more in-depth contextual analysis of programs in the Pacific and the relevancy of applying specific lessons learnt from the Southern African programs. Indeed without much more research, it is difficult to say just how transferable some activities would be between Southern Africa and the Pacific eg. if communities would react the same way to programs addressing stigma and utilising volunteer caregivers, in contexts in the Pacific where people are not directly infected or affected by HIV or AIDS.

Whilst the primary audience for this report are the relevant programs and advocacy sections of Oxfam Australia and its Pacific partners, secondary audiences include other Oxfam affiliates, AusAID, NGOs, CBOs, government, donors and international agencies working in the region.

3. Methodology

In the preparation of this report the following steps were taken:

1. A comprehensive literature review of internal and external Oxfam documents (*see references for a full list of documents reviewed*)
2. A limited literature review of external best practice documents relating to HIV and AIDS and gender equality (*see references for a full list of documents reviewed*)
3. Key in-depth interviews with a limited number of Oxfam programs staff based in Australia (*see Annex 2 for list of those interviewed*)

This report focuses on a limited number of program topics that were considered by OAus program and advocacy staff to be most relevant to the current context in the Pacific. These topics were initially outlined in the Terms of Reference (TOR), and then modified based on: further consultation with program staff, the information available from the Southern African programs and which topics were being addressed by other research carried out for OAus (eg GIPA in the Pacific). Those topics considered to be a higher priority are covered in more depth than other topic areas. Whilst recommendations were suggested under the TOR, it was decided to exclude them from the final report as this document is primarily designed as a reference tool. It is not designed to provide strategic programmatic advice on how the lessons learnt should be applied to the Pacific.

(The TOR for this report is attached in Annex 1).

Limitations

The TOR and time specified for preparing this report meant that topics were largely limited by the documents that were readily available, as there was little time for many primary interviews or sourcing further documentation from partners in-country. Due to a lack of documentation, certain topics suggested in the TOR were not explored in detail in this report, such as voluntary counselling and testing (VCT), sex worker initiatives and ideological approaches to prevention.

4. Contexts at a Glance

Africa

Mozambique

Mozambique has an estimated population of 19.8 million people. It has 1.8 million people living with HIV. 16.1% of adults aged 15-49 are living with HIV. Gross national income per capita is \$1,160^{1,2}.

South Africa

South Africa has an estimated population of 47.4 million people. It has 5.5 million people living with HIV. 18.8% of adults aged 15-49 are living with HIV. Gross national income per capita is \$10,960³.

Zimbabwe

Zimbabwe has an estimated population of 13 million people. It has 1.7 million people living with HIV. 20.1% of adults aged 15-49 are living with HIV. Gross national income per capita is \$2,180⁴.

Pacific

Fiji

Fiji has an estimated population of 848,000 people. According to the Secretariat of the Pacific Community (SPC), it has had 182 cumulative reported cases of HIV (including AIDS). 0.1% of adults aged 15-49 are living with HIV. Gross national income per capita is \$5,770^{5,6}.

Papua New Guinea (PNG)

Papua New Guinea has an estimated population of 5.9 million people. It has 60,000 people living with HIV. 1.8% of adults aged 15-49 are living with HIV. Gross national income per capita is \$2,300⁷.

Solomon Islands

The Solomon Islands has an estimated population of 478,000 people. According to the SPC, the Solomon Islands has had five reported cumulative HIV (including AIDS) cases⁸. Gross national income per capita is \$1,760⁹.

Vanuatu

Vanuatu has an estimated population of 211,000 people. According to the SPC, Vanuatu has had two reported cumulative HIV (including AIDS) cases¹⁰. Gross national income per capita is \$2,790¹¹.

5. Sharing between Southern Africa and the Pacific – Is It Relevant?

Given the huge disparities in HIV prevalence, geography, culture, population and stages of the outbreak and response to HIV between the nominated countries in Southern Africa and the Pacific, it would seem obvious to question the relevance of sharing lessons learnt between these two regions.

However there is evidence to suggest that:

- A. There are many aspects of the lifestyle, behaviours and values that these regions have in common
- B. Rather than 're-inventing the wheel', the Pacific has much to gain in learning from the extensive experience of those working on HIV and AIDS in Southern Africa and applying these lessons earlier on in their interventions in the Pacific than their African counterparts had the opportunity to do.

A. Common Factors

Whilst the countries listed above (and areas within each country) may differ in some of the factors that have contributed to the spread of HIV and AIDS, there are other factors that *most* of the countries have in common. These include: high levels of poverty, high unemployment, high percentages of the population living in rural areas,

high levels of gender-based violence and gender inequality, mobile populations, limited health infrastructure and low levels of education^{12,13,14,15,16}.

OAus facilitated exchanges between the Pacific and Southern Africa to date have highlighted points of commonality and shown the value of such exchange of experience. There have been two face-to-face exchanges so far between partners in Southern Africa and the Pacific. In 2005, a representative from Targeted AIDS Interventions (TAI - South Africa) presented lessons learnt from their youth peer education programs to the National Youth Forum on AIDS in Vanuatu. In the same year, two staff from the Comprehensive Health Care Trust (ChoiCE - South Africa) traveled to PNG to train OAus partner Hope for Living in home-based care. Anecdotal evidence from OAus program staff suggests that out of these exchanges a degree of commonality was discovered, and thus the value of the exchange became clear. Some of the valuable points to emerge from these exchanges include:

Vanuatu

- The TAI representative realised he could share a lot more than he initially thought – the youth in Vanuatu were experiencing very similar issues to those in South Africa eg. difficulty in changing young peoples' behaviour, high levels of STIs, high levels of sexual violence, tension between the church and young people over issues to do with sex, STIs and HIV and AIDS.
- The prominent role of the church in the lives of the people from both regions was very similar.
- The youth groups from both regions had the same focus for their activities and a similar mindset
- Even though some of the specifics of the contexts in each region were different, there was much value in discussing the broader social issues affecting young people and their sexuality in both countries.

PNG

- At the time of the exchange, there was not a lot of experience within PNG in community-based HBC programs for Hope for Living to draw on, so outside input was welcomed.
- CHoiCE was able to show Hope for Living the process in establishing and developing a HBC program over a long period of time. They demonstrated that much time is needed, but that despite this, it is possible to succeed!
- The Hope for Living Coordinator and HELP Resources (OAus partner) representative who attended the training found it useful to see how the training was conducted by CHoiCE – using different materials and styles than what they had previously experienced. They found that the material was simpler and clearer than some similar materials in PNG.

B. Learning from the Experience of Others

Oxfam partners in the Pacific are running HIV-related programs in: HIV awareness and prevention (including drama); home-based care; peer education; combating gender-based violence and traditional gender roles (including working with men) and empowering women; and STI treatment and advice. Programs promoting gender equality have been running since the mid 1990s, and those related specifically to HIV and AIDS since 2000. AusAID began its first Pacific regional HIV/AIDS strategy in 1997. Whilst much of its initial work involved institutional strengthening of government

structures and systems and developing policy, it has also funded programs in: HIV prevention (including condom distribution), awareness raising (among target populations including prisoners, police and construction workers), counselling, care and the provision of clinical services¹⁷. A new AusAID strategy for HIV/AIDS in PNG for 2006-2010 is to be released shortly but was not available for consideration by this report¹⁸.

Oxfam partners in Southern Africa have been involved in delivery of the abovementioned activities addressing HIV and AIDS since the early to mid 1990s, with Oxfam beginning its support of partners in such programs since the early 1990s. Thus some programs have built experience over a 15-year period and have much to share with similar programs in other countries in terms of mistakes made and lessons learnt.

6. Key Lessons Learnt from Oxfam's HIV/AIDS Southern Africa Programs

6.1 Integrating Prevention, Treatment, Care & Support

According to UNAIDS, "prevention, treatment, care and support are mutually reinforcing elements and a continuum of an effective response to HIV/AIDS. They must be integrated into a comprehensive approach, and a multifaceted response is needed."¹⁹

The following will explore lessons learnt from programs managed by OAus in operating and integrating responses to HIV and AIDS in Southern Africa. It will describe the management of home-based prevention and care teams. It will also explore an OAus project partner's experience in first providing separate prevention and care services, integrating these services and then several partners' current preparations for integrating treatment.

6.1.1 Management and Operation of Home-Based Prevention and Care

There is no typical management structure of a home-based prevention and care program – variables depend on such things as the size of the organisation and nature of the service provided. However looking at the programs of several Oxfam project partners in Southern Africa, some common points and lessons learnt are:

- The volunteers are **recruited from within the communities** in which they will work. This alleviates the problem of transport logistics for the volunteers (thus making for a cost-effective program), but also may prove to be a barrier to accessing patients as community members may be anxious about the stigma attached to HIV and people they know 'knowing their business'. This barrier can be overcome over time - as the volunteers build trust within the community, confidentiality is demonstrated and stigma is reduced.
- It is best to **vet the volunteers** to ensure that appropriate people are selected. This can be done by consulting with key people in the community ie church or traditional leaders.
- It is preferable to have both **male and female volunteers**. Traditionally it has been easier to recruit males for prevention work but much harder to recruit them as carers as this is traditionally seen as 'a woman's role'. However, some male

patients only feel comfortable being cared for by another male. Men can also be involved in HBC without providing direct care i.e. performing house repairs, moving furniture, undertaking advocacy for increased service provision from local government (see 6.2.2 'Male Home Based Care Volunteers - South Africa' for more detail).

- The **roles and expectations** of the volunteers should be clear from the beginning. If this role changes, it should be clear what is expected as a result of this change.
- Volunteers undertake **training**. The duration of this training can vary from 2-3 weeks to 84 days training over the course of a year. The training should be carried out by qualified teachers, and ideally meet some sort of standard (eg a government's 'basic standard of care') or enable some sort of certification (eg with the government or at least if a certificate is provided by the NGO). This gives the role of the volunteers a sense of legitimacy and also holds them accountable to a definable set of skills that they have been taught.
- Initial training should be followed up with **hands-on training** in the community (ideally the volunteers should have to demonstrate their competency prior to commencing work on their own), and then **ongoing training and updates** eg during the monthly volunteer meetings. This ensures skills are current and also is a key motivator for volunteers.
- Experienced volunteers act as **supervisors** and monitor and supervise home visits to ensure a degree of **quality control**. Volunteers need to present case records and reports (in standardised formats) at monthly meetings as part of this process.
- Teams of volunteers can be made up of **3-4 people**, with a team leader or supervisor. Each volunteer may look after **3-5 patients** (small caseload) or up to **10+ patients** (large caseload). Not all patients need to be visited every day and the total workload very much depends on not only the number of patients but also on their particular needs.
- Teams should **debrief** with their team leader. In addition to this, volunteers should **meet monthly** to debrief, present case records (for quality control and collection of data), receive training and updates and discuss any emerging issues and problems. These meetings are a good source of motivation. Debriefing of volunteers is important as they may suffer psychological, emotional, physical or economic stress as a result of their work. For example, a group of volunteers in South Africa have initiated weekly meetings to 'deal with issues of anger and sadness'. Unless this stress is addressed, this can undermine the wellbeing of the caregiver, their family and/or lead to burn-out.
- Volunteers should be **involved in the planning, structuring, prioritising and agenda-setting of programs**. There should also be **regular meetings between staff and volunteers** to raise issues to be addressed by management.
- **Team leaders** often have their own meetings to debrief and discuss issues.
- Some of the team leaders/supervisors will be **trained as trainers** to conduct ongoing training of the other volunteers. They should get refresher training at least once a year.
- Some programs provide a **stipend** to volunteers, and/or provide them with a uniform, materials for work and perhaps a bicycle to get around. Some volunteers do not receive a stipend. It cannot be assumed that the living conditions of the volunteers are any better than those they care for – such an assumption can create considerable tensions. Some volunteers work 3 days per week and then have 2 days off so that they can generate some income. This is possible if the caseload is not too big, but harder if it is higher.

- Often programs will say that they deal with ‘many diseases including HIV’ so as to reduce the **stigma** of volunteers going into homes. Often the prevention and awareness work of the volunteers helps to reduce stigma in a community and this, in turn, helps them to access patients.
- If **referral networks** are effective, and there is a functioning health infrastructure, then the district hospital and local clinics can refer patients to the home-based prevention and care volunteers for follow-up. Similarly, the volunteers can refer patients to the local clinics for treatment (NB: this does not work in contexts where the health infrastructure does not exist or if there is considerable discrimination towards HIV and AIDS patients by health staff)^{20,21,22,23}.

See 6.3.2 ‘Peer Education and the Role of Volunteers’ and 6.1.3 ‘Integrating Prevention, Care and Support’ for more information on working with, and motivating, community-based volunteers.

6.1.2 Separate Prevention and Care – the Pitfalls

Prior to the introduction of antiretroviral treatment, community-based programs in southern Africa concentrated on HIV prevention, care and support. In some of the Joint Oxfam HIV/AIDS Program (JOHAP) partner programs, there was initially no integration of these programs – they were separate initiatives, with little coordination, interaction or understanding of the other’s work. Whilst it may not always be appropriate for an organisation to provide an integrated program, particularly if they do not have the capacity or expertise, there does need to be a good understanding of where a program fits into the continuum of care as well as strong links to complementary services. It may not always be appropriate to expect an organisation to extend beyond their capacity, but in situations where that capacity exists, there are distinct advantages in the integration of services.

One example of such successful integration of services is provided by a JOHAP project partner in South Africa – the Centre for Positive Care (CPC) – which began by offering separate services. The CPC has operated in Limpopo Province since 1997, first undertaking prevention work and then adding separate care and support services through community-based partners. Both were undertaken by volunteers from within the communities in which they worked. However the peer educators, who undertook AIDS awareness and distributed condoms, were not taken seriously by the care supporters. They were labeled as “AIDS People” – perceived by the community to be moving around spreading disease. As the peer educators wore t-shirts stating “Community Against AIDS”, people assumed the homes they were visiting contained people with the disease, and as such, these homes were stigmatised. The role of the peer educators was limited – they were unable to refer people to medical or social services, even though they came across many people in need. By contrast, the care supporters, who provided a range of services to ill clients, were more respected in the community. However their role was not well understood by the peer educators.

6.1.3 Integrating Prevention, Care and Support

In mid-2001, CPC decided to trial the integration of its prevention and care services in four sites over three years. Volunteers were extensively trained to be able to undertake work in both prevention and care. Following the three-year period, a number of improvements in the program were noted:

The Community

- The community is receiving a better and more responsive service - with volunteers being able to instantaneously provide them with a wider range of care, information and referrals. The volunteers are even being called upon for first-aid.
- Stigma against HIV and AIDS has reduced as the community accepts the prevention role played by the volunteers as well as the care they provide, and as such, volunteers have increased their access into people's homes. Referrals to the volunteers from within the community have also increased.
- Ill people, including those with HIV and AIDS, vulnerable children and orphans, were previously often hidden from the volunteers when they did home visits. Now with the reduced stigma surrounding AIDS, and the dual role of the volunteers, they are able to access more of these patients, although HIV status is often still not disclosed.
- Primary care-givers have been able to learn from the volunteers how to better look after their family members.
- Clinic workers have a better working relationship with the volunteers – referring patients to them for home-based care and even asking for prevention resources. Volunteers' working relationship with social workers has also improved.
- The volunteers have engendered a greater community awareness of STIs and TB, enabling more people to recognise symptoms and go to the clinic for treatment; as well as adhere to these treatments.
- The volunteers have increased the community's awareness of their eligibility for social support and grants, as well as their ability to apply for them.
- The limited number of male volunteers have earned the respect of their clients and have helped to challenge the traditional perception that carers should be female (see 6.2.2 'Male Home Based Care Volunteers - South Africa' for more detail).
- The work of the volunteers seems to have strengthened the communities' sense of *ubuntu*²⁴ and collective responsibility for that community's problems.

The Volunteers

- The volunteers now better understand the roles of both prevention and care.
- The volunteers have experienced improved confidence and self-esteem. They feel more empowered, as they have increased their skills-base and therefore their ability to be able to serve the community.
- There is a strong sense of commitment and project ownership among volunteers – a positive indicator for the sustainability of the program.
- 'Respectable' but 'conservative' women recruited from churches who had previously worked as volunteer carers only, now feel comfortable to discuss HIV and AIDS and even demonstrate condom use.
- Sex workers who had worked as peer educators, have now learnt how to provide care and support to patients and, as with all former peer educators, can now see the visible improvements that they are making to people's lives through their work as caregivers.
- Due to the respect that they have earned from the community, ongoing training and their exposure to the real life situations of clients, the volunteers have adopted exemplary health and social behaviours and have become role-models in the community.

It is interesting to note that there were initial concerns that volunteers would 'burn-out' with the extra demands on them in providing both prevention and care services.

However this has not occurred. The retention rate of volunteers who were present at the beginning of the program is 60%. Some of the initial volunteers have died of AIDS-related illnesses. As well as providing an invaluable service to the community and gaining their respect, the volunteers do receive a stipend for their work and gain skills and a certificate which may help with their employment in the future

(see 6.3.2 'Peer Education and the Role of Volunteers' for more detail about volunteers).

The program in general has experienced some limitations, including:

- The limited number of male volunteers has meant limited access to male patients, some of whom do not wish to be cared for by a female volunteer.
- A lack of monitoring and evaluation of the program - behavioural change assessments and client satisfaction surveys have not yet been done (as of Feb 2005)
- Some duplication of home-based care services has occurred with other local CBOs.
- A lack of reliable transport for volunteers has limited their coverage of the project area.
- A lack of educational materials available in local languages is hindering community access to information.
- Inadequate allowances for volunteers has hampered service delivery.
- Lack of decentralised project management and fundraising may limit the program's ability to be sustainable.
- A growing desire by volunteers to be trained in treatment preparedness needs to be addressed, particularly as the South African Government's national antiretroviral (ARV) program is rolled out^{25,26}.

6.1.4 Preparing for Treatment

In Zimbabwe, the Government's initiative to supply ARVs through the public health system began in 2004. However, the roll-out has been hampered by many factors, so that access to ARVs is still limited to a fraction of those who need it. 8% of all reported cases of HIV-infected men and women are receiving treatment²⁷. Partners of the Combined Oxfam Gender and HIV/AIDS Program (COGENHA) have recognised that the focus of their projects may change, new elements may need to be introduced and new partnerships formed as access to ARVs increases. The partners have identified the following ways in which they may be able to respond to the roll-out of ART:

- Recruit and train staff to counsel, care, monitor and assist with treatment adherence
- Investigate how to improve access to voluntary counselling and testing (VCT) facilities
- Conduct treatment awareness and literacy campaigns for health workers and those needing ART
- Encourage health authorities to provide integrated services
- Address issues of stigma and discrimination
- Look at innovative ways to secure funding and other resources

Mozambique's previous government introduced its ART program in 2004, but the roll-out has also been severely hampered and few have treatment access. 9% of all reported cases of HIV-infected men and women are receiving ART²⁸. Oxfam's partners in Mozambique are starting to prepare for ART by:

- Training staff in treatment literacy and treatment access
- Increasing organisational capacity in: counselling, referrals, access to treatment for opportunistic infections (OIs), HBC and caring for AIDS orphans and vulnerable children.
- Increasing the integration of food and income generation activities into the continuum of HIV and AIDS services.
- Encouraging the Government to develop a strategy for ART in the public service (most ART delivery is currently subcontracted to international non-governmental organisations (INGOs)).
- Encouraging INGOs to work more closely in partnership with local NGOs in providing the continuum of care, as many local NGOs already have established effective home-based care and prevention programs.
- Developing a campaign similar to the one being run by the Treatment Action Campaign in South Africa – to promote health and human rights issues associated with access to treatment
- Ensuring good support systems for people on ART by establishing effective partnerships with other CBOs and the health sector. The support could be in the form of treatment information or income-generating projects to help pay for transport and good nutrition.
- Putting measures in place so that programs are sustainable even when key people die of AIDS.

Meanwhile the Government of South Africa began ART roll-out in early 2004. Whilst 21% of all reported cases of HIV-infected men and women are receiving treatment²⁹, hundreds of thousands of people are unable to access it, particularly in rural and semi-rural areas. Oxfam program partners in South Africa are already supporting people on ART and are preparing for ART roll-out in the following ways:

- Home-based carers are providing support with taking treatment and adherence.
- Helping to form support groups for those on ART.
- Where a partner organisation is providing ART, they are working on linking with government health services to set up a referral system.
- Working with communities to plant vegetables and fruit to be able to assist with the nutrition of those living with HIV. This is particularly an issue for some treatment eg for tuberculosis, where certain drugs should not be taken on an empty stomach. Having money to buy the seeds is an issue*.
- Providing pre and post test counselling, and ongoing counselling for those who test positive.
- Increasing links with treatment centres
- Assisting people with HIV to access disability and other grants.
- Increasing treatment literacy within their own organisations as well as within the communities where they work (some staff recently participated in a week-long course run by the well-known Southern Africa HIV and AIDS Information Dissemination Service)

- Advocating for access to treatment in their communities (according to South African law, people can only access the ARV service in the province where they live)

* Oxfam partners in Zimbabwe have been trying to integrate food security/income generation into their prevention, treatment and care programs. Whilst 50% of partners have incorporated a livelihoods component into their programs, they are finding it a challenge. This is due to the fact that they do not have the right expertise to implement the livelihoods component themselves, but are feeling compelled to modify their core business to become 'food security organisations'. Similarly whilst trying to work in partnership with organisations involved in food production/agriculture, these organisations feel that they, in turn, have to take on HIV as a core focus.

There is not one 'model' of how such a program should operate – each partner needs to understand the mutual impacts of HIV and food security and then decide how best to address them. This may be by either adding a food security/income generation component to an existing program or partnering with an organisation that can provide such a service. In Mozambique, a PLWHA organisation, Kindlimuka ("Wake Up!"), is exploring different ways that their members can use their skills and capacity to generate income rather than focusing solely on growing food (see 6.3.3 'Networks and Partnerships' for more details on Kindlimuka).^{30,31}

6.2 Gender Equality & Working with Men

According to UNAIDS, "Gender roles and relations have a significant influence on the course and impact of the HIV/AIDS epidemic in every region of the world. Understanding the influence of gender roles and relations on individuals' and communities' ability to protect themselves from HIV and effectively cope with the impact of AIDS is crucial for expanding the response to the epidemic"³²

Based on the recognition of this important role that gender relations plays in the spread of HIV and AIDS, a number of Oxfam partners in Southern Africa have both explicitly or implicitly addressed traditional gender relations in their programs. The following outlines three different programs from Southern Africa targeting gender equality and looks at the lessons learnt to date in each program.

6.2.1 Targeting Young Males through Schools and Recreation - South Africa

The following program run by Targeted AIDS Interventions (TAI), a JOHAP partner in Pietermaritzburg, KwaZulu-Natal, South Africa, provides a good model of how to involve males in community-based HIV and AIDS programs. The lack of male involvement in such programs is a key problem in South Africa – especially as it is the males who often exhibit lower rates of condom use and accessing VCT, and have a more limited knowledge of HIV. It is also the men who most often perpetrate violence against women and children.

The TAI program started by empowering women with knowledge and lifeskills to prevent HIV infection, but quickly realised that the gendered nature of female-male relations was undermining their efforts. When the trained women tried to put their knowledge into practice, their efforts were often met with resistance and abuse. This

caused TAI to switch their focus to men and to programs that aimed to educate boys and men about HIV risk behaviour as well as to explore notions of masculinity.

TAI targets males through the amateur football league. It contacted the South African Football Association and through them was given access to many local football clubs and young players aged 16-24 years. Sport is recognised as an important setting where ideas of masculinity are constructed and maintained. In TAI's experience, it is a setting which often legitimises sexual abuse of women – such as the taking of multiple female partners and the acceptance of this by women. Targeting the area of sport is in line with UNAIDS recommendations in working with males – to take interventions to where males are and to use contexts where large numbers of men can be reached at little cost, such as football associations³³.

However in 2000, knowing that many of the young men in the football clubs were already sexually active, TAI decided to also target younger boys in primary school. This program aims to educate and provide positive role models to boys before they are sexually active and come in contact with older boys who exhibit higher levels of HIV risk-taking behaviour. This sort of strategic thinking is in line with UNAIDS recommendations in working with men: "Greater attention should be given to identifying and utilising what might be described as 'critical moments' for education and change"³⁴. Life-skills and health training was already part of the primary school curriculum so the TAI program was easily incorporated.

In both programs, TAI uses peer educators to conduct focus group discussions, workshops and debates on HIV and AIDS. The boys themselves have suggested further ways to reach their peers with HIV education.

The TAI program is now being used as a model and is being shared both nationally and internationally. Similar programs will be set up across South Africa and soccer bodies in Nigeria, Botswana and Ghana are interested in TAI's program. TAI has also been approached to collaborate on a TV campaign for the 2010 Soccer World Cup (to be held in South Africa) as well as to be involved in the event itself³⁵.

A number of lessons have been learnt from both these programs run by TAI:

- The TAI programs have given young males an alternative space for exploring the meaning of masculinity. Violence towards women and children, what is acceptable and unacceptable behaviour for men, and responsibility for violence and the spread of HIV are all issues that form part of the discussion.
- Men maintain commonly held notions of masculinity but are also victims of it. They must all pretend publicly to 'know everything' (thus preventing them from seeking information), have many girlfriends and wide sexual experience, even though privately the reality may be very different.
- Using existing, respected structures to implement an HIV education program gives access to, and facilitates greater acceptance and participation by, the target audience.
- It is more effective to target younger adolescent boys before they are sexually active and before they come in contact with peer pressure from older boys who exhibit higher levels of HIV risk-taking behaviour.

- Adolescents do not necessarily identify with adults and have their own sub-culture, so the use of peer educators is a successful way in engaging these groups and having immediate access to them.
- Stand-alone prevention programs are important as well as those that are directly integrated with care. In this case, the selection criteria for the TAI peer educators may be substantially different to those needed for carers, so that it may not be appropriate for the peer educators to also be providing care services. There is not one 'successful formula' for running a program – each program must respond to local needs. However all programs must have strong links to complementary services in order to provide an effective continuum of care.
- Focus groups prior to program implementation helped TAI to identify issues relevant to the boys and to learn the language and metaphor used by the boys in order to incorporate this into their programs.
- TAI spent a year first working with the peer educators to build their knowledge, resilience and self-esteem before working with them to develop ways to reach their peers. Now the TAI coordinators meet with the peer educators monthly to continue to motivate and guide them.
- The 'bottom-up' approach of using peer educators was participative and collaborative – the boys often developed and implemented their own strategies (with minimal TAI guidance) and this gave them a feeling of empowerment and ownership of the program. The process of being listened to by adults and listening to each other's stories was an important intervention in itself, with benefits to those involved.
- There was some opposition to the TAI programs from girls whose boyfriends were leaving them after being educated in HIV, as these girls recognised that they were losing a source of income (being given gifts, taken on outings by their boyfriends etc). Both males and females contribute to the maintenance of gender norms, and thus it is important to have separate interventions targeting both females and males.
- Whilst the TAI program has resulted in some change in behaviour, this change has mainly been motivated by the desire to reduce HIV risk. There isn't much evidence to suggest that the young men are exhibiting different patterns of masculine behaviour. TAI faces the challenge of developing strategies to foster gender behavioural change without undermining the security and identity of the young men³⁶.

6.2.2 Male Home Based Care Volunteers - South Africa

The following will outline some of the lessons learnt from the work of male home-based care volunteers working in South Africa, with specific reference to the Centre for Positive Care (CPC) program (*for general information about the CPC's programs, see 6.1 'Linking Prevention, Treatment, Care and Support' earlier in this report*).

Male community volunteers working in prevention and care in South Africa, including those who work for CPC, have been able to challenge the traditional belief that caring is a 'woman's job'. The male volunteers have been able to earn the respect and acceptance of their families, clients and community, just as the female volunteers have done. They have become role models in the community.

However, there are very few men who have come forward to be volunteers. More than 95% of CPC's volunteers are women ie. there are only 5 men involved. Whilst

unemployment rates are high in some of the communities where CPC's projects operate, according to one male volunteer, men prefer to sit at home rather than be paid the small amounts of money that volunteers earn. However this volunteer says that no amount of money would persuade some of these men to become volunteers. This low number of male volunteers is an issue common to many of the Southern African programs – and is an issue that the partners are actively trying to address.

Some of the lessons learnt from the male volunteers who do work in CPC and other projects include:

- The male volunteers are motivated by: the prospect of employment; personal experience of illness including HIV and AIDS; the desire to serve the community and to act out of a sense of compassion; and to gain some recognition and status (backed by the credibility of the organisation running the HBC program).
- Whilst male volunteers may be initially ridiculed by friends, and even their wives and mothers (ie. it's not a 'proper job'), they are eventually respected for what they do, and sometimes even asked for advice by the same people who initially mocked them.
- It is not easy for some men (and women) to understand the concept of 'volunteerism'. Men are expected to be the breadwinners and support the household during their time spent away from home, and this role is very much tied up with their sense of 'manhood' and self-esteem. It is important for men not to lose face, so that in some situations they would rather be unemployed than perform a role that would result in ridicule and scorn.
- Male volunteers have adopted more exemplary health and lifestyle behaviours and act as positive male role models in the community.
- Male volunteers enable a program to reach male patients at home who may not wish to be cared for, or have contact with, female volunteers.
- The teams of volunteers have built strong relationships. One partner says, "The fact that they are all HIV positive means that they are equals". The female volunteers really support and encourage the male volunteers – urging them forward.
- However, female caregivers are not always supportive of their male counterparts. They can assume that the males are encroaching on a role that has traditionally been theirs and that the males intend to 'take over' and command the women. Some female caregivers also think that the men lack the affection, compassion and patience necessary to do the job. As a result, the female caregivers can try to sideline the males eg by asking them to leave from female support group sessions etc. Therefore it is important to reinforce that male volunteers are recruited to work in partnership with the females and this is in no way a negative reflection of the work of the females.
- It is a challenge for many male volunteers to provide care to female clients – especially those who are bed-bound and need assistance with washing, changing clothes and using the toilet. Sometimes a female observer is requested by the patient, or a female caregiver must work alongside the male, which is not always feasible.

Note: Oxfam Australia is now researching the role of men in home-based care in Zimbabwe and South Africa, including the impact on female patients. For example, if female patients are incapacitated, does it increase their vulnerability or their perceived feelings of vulnerability by having a male caregiver? Do the female patients feel supported or rather that their privacy is being invaded? Oxfam Australia is also

exploring if male caregivers should perform the same roles as women – is this the best way to utilise their time?

: One Oxfam partner in Zimbabwe (Batsiranai) has been successful in recruiting a significant number of male caregivers. Anecdotal evidence points to the following strategies that have assisted this recruitment of males: making a conscious effort to recruit men at all community forums attended by Batsiranai (ie discussing the role of men in supporting PLWHAs); utilising community members/leaders to identify suitable male volunteers; and targeting men motivated by compassion³⁷.

6.2.3 Sensitising University Students to Gender and HIV Issues – Zimbabwe

At Midlands State University, Midlands Province, Zimbabwe, it was common for older male students to initiate relationships with first year female students. This would often create a situation of power imbalance, placing the female students in a position where they were at risk of contracting HIV or becoming the subject of gender-based violence. There was also a male dominance of student leadership positions and student structures.

SHAPE Zimbabwe Trust (Sustainability Hope Action Participation Education) began working at the university in mid-2004 to try to sensitise first-year students to gender and HIV issues – including aspects of female assertiveness, ideas of ‘positive masculinity’ and ways to prevent HIV. It also aimed to promote female students in roles of leadership.

To do this SHAPE trained male and female students as peer educators to informally talk to students; organised dialogue sessions or ‘talk shows’ in residence halls; published a newsletter; organised a gala; and established a ‘cell group’ network where peer educators lead small, mixed-sex discussions. To support their work, SHAPE has established collaborative relationships with: university residences, sports clubs, health services (for VCT and treatment of STIs and OIs), culture centres, the disabled students’ service, faculties and AIDS service organisations. The AIDS organisations are providing training, information and act as referral centres for the students (for further information and for those uncomfortable with using services on campus).

Some of the lessons learnt from this program to date are:

- The talk shows have been very popular – they are relevant to the students, lively, very open and youth-friendly. Women in the audience are very vocal in expressing their views and there is a dynamic engagement between women and men. Part of the success lies in the fact that the content can be tailored to meet the needs of a fairly homogeneous audience.
- The program, and in particular the talk shows, have reportedly influenced the attitude and behaviours of students on campus. Discussion is more open and non-discriminatory, more students are accessing the university health services, there has been a rise in condom distribution, peer educators have exhibited positive behaviour change, female students are increasing their participation in previously male-dominated activities/positions, and couples report more equality in their relationships.
- Talk shows need to be organised on a regular basis to reinforce messages.

- According to Oxfam program staff, there could be improved facilitation of the talk shows – ensuring that there is not just debate, but an exploration of strategies to promote positive change.
- Students have been involved in all stages of the project – helping to ensure activities are engaging and relevant to the students.
- Male students are seen as ‘partners’ rather than ‘enemies’ in the project – helping to engender mutual respect between males and females on campus. Male peer educators are striving towards a redefined sense of masculinity.
- The male and female peer educators are trained separately so that they can comfortably address gender issues and subsequently work effectively together.
- The peer educators have found that they need training in counselling and reproductive health – this is planned.
- The project is exploring how to integrate HIV/AIDS care into their project to be able to better support students who have HIV and AIDS. Links have already been made with external organisations that can assist with this.
- University staff members need to be trained in gender and HIV issues so that they can effectively support the project.
- A challenge acknowledged by the program is that when students finish university, they no longer have access to this supportive environment.
- There needs to be increased monitoring and evaluation of the program to confirm that increased awareness has in fact lead to positive behavioural change.

SHAPE Zimbabwe Trust is now sharing the experiences and lessons learnt from this program with other universities.

6.3 Aspects of Community-Based HIV Programs

6.3.1 Use of Drama for Prevention

Drama and role-playing can be useful tools to ensure that HIV prevention and other messages are accessible (especially for illiterate audiences) and to raise taboo subjects in a non-confrontational way. Given that 35% of the population of PNG and 26% of the population of Vanuatu are illiterate (in contrast with Fiji where only 6% of the population are illiterate), this may be one way of reaching many people with prevention messages and is already being used by NGOs in the region for this purpose³⁸. Drama has also proven to be particularly effective for engaging young people.

Several of Oxfam’s partners in Southern Africa utilise drama to raise awareness of HIV and AIDS, and to talk about issues such as use of condoms, negotiating safe sex, violence against women and children and the situation of AIDS orphans. Different formats of drama are used for different purposes, from a “two-minute snapshot” (a brief depiction of one typical issue within the community to get people’s attention and introduce a topic) to a longer play which explores an issue in more detail followed by questions and discussion with the audience. In most cases the drama is carried out by members of a CBO who are from the community in which they are performing.

Whilst there is little documented on the methodology of dramas in the Southern Africa programs, anecdotal evidence from Oxfam’s program staff indicate that the following has been learnt from experience in carrying out dramas:

- Peer educators are often not trained well enough to be able to skillfully facilitate debate and discussion after the drama. They need to be able to draw out the lessons learnt from the drama, and explore positive responses and strategies to the scenario presented in the drama.
- Sometimes there is an over-reliance on drama where other prevention activities are also necessary. According to staff in South Africa, simple HIV prevention messages are not enough to bring about behavioural change. Such messages need to be delivered within a more holistic approach which addresses sexual health, STIs, gender equality and communication and conflict resolution skills.
- Follow-up after a drama is crucial. If you perform to a random audience eg in a marketplace, you can have a discussion and hand out some condoms after a drama, but there is no sense of how effective the drama has been – has it changed attitudes? Behaviours? Did people use the condoms? Did you reach the key people in the community who can help to enact change? How can you find these people to do follow-up?
- Dramas often work better when directed to a specific audience eg school children in school. In this way the drama can be tailored to be relevant to this group, structured questions can be asked afterwards and strategic and ongoing follow-up and evaluation can be done. It is possible to start with a drama in the general community to raise general awareness and then follow-up with more dramas presented to targeted audiences.
- Part of the follow-up after a drama needs to be the provision of information about accessible and trustworthy services that people can use.
- A mistake of some drama is that it tries to include too many scenarios and too many messages. A good drama should have one or two clear messages.
- A lot of thought needs to go into developing a drama to ensure that it is an effective tool. Many organisations put on dramas but rarely question their efficacy. In one case, NGOs in South Africa have hired a drama and education organisation to help them to make their dramas more effective.
- Dramas tend to follow traditional gender roles, but can be used to challenge them instead eg a man can show emotion or be the carer; women and men can take equal roles in decision-making etc^{39,40,41}.

Whilst not from Southern Africa, the Oxfam draft report *The East Sepik Provincial Response to HIV and AIDS* contains a comprehensive set of lessons learnt from drama carried out by the Baua Baua Popular Education Troupe in PNG. These lessons particularly highlight the value of comprehensive follow-up. As these lessons are particularly instructive and relevant to the Pacific region, they have been included in Annex 3.

6.3.2 Peer Education and the Role of Volunteers

Peer educators have played an important role in reducing the stigma and discrimination surrounding HIV and AIDS in several projects in Southern Africa. Most of the peer educators in the partner projects are women – often living with HIV and/or in some cases former sex workers. The peer educators have targeted groups such as sex workers, farm workers, truck drivers, young people and the unemployed; and have themselves been recruited from these groups⁴².

The following section will look at one program with youth peer educators in South Africa and then explore the lessons learnt from working with volunteers in home-based prevention and care programs.

Working with Youth in Taverns – South Africa

The Lamontville HIV and AIDS Support Centre (LASC) in KwaZulu-Natal, began a peer education project in shebeens (unlicensed bars) and taverns in April 2004. Shebeens and taverns are a major recreational site (and one of the only available) for young people in Lamontville and a place where sex is accessed relatively easily. The project involves volunteer peer educators who conduct workshops involving discussions and simulations, videos, charts and case studies. The project targets young people aged 18-30 years.

To encourage the tavern owners and young people to participate, a company selling a well-known alcohol brand was approached by LASC to conduct a promotional event (with prizes) in the tavern prior to the HIV and AIDS education session. NB: There is no available analysis to show how this activity has impacted on the messages the young people have taken away from the tavern after the education session about positive behaviour.

Key lessons learnt from this project are:

- An extensive baseline study (conducted by the young community volunteers) was useful in first understanding the perceptions and knowledge of HIV and gender roles among the young people in the taverns.
- Projects of this nature need to take activities to where young people gather, address gender issues and take into account literacy levels.
- The project was initially presented to each local shebeen and tavern owner. Those who expressed interest were given a more detailed description of the project before agreeing to participate. These initial discussions were important as the tavern owners were initially ignorant of the health and socio-economic rights of young people. They were also concerned that knowledge of these rights might make young people disrespectful and that they would lose business as a result. The tavern owners are important 'gatekeepers' of information that young people have access to whilst using the taverns.
- The peer educators need to be locals, familiar with their audience and strong facilitators.
- Involvement of local volunteers as peer educators keeps project costs low and encourages young people within the community to share responsibility for issues of health in their community.
- The peer educators need to be vetted to ensure their commitment to the project and their suitability.
- Anecdotal evidence suggests that following this peer education campaign, the incidence of STIs in the community has decreased and the numbers requesting VCT have increased.
- The workshops that run in taverns and shebeens have to be conducted in a way that ensures minimal disruption to the young people's leisure time, and this can be a challenge. Consulting with young people in advance helps to overcome this problem^{43,44}.

A number of elements of this project reflect some internationally agreed key aspects of peer education programs, namely: mobilising the main stakeholders, active participation of youth, identifying needs of the target audience, sharing responsibility with the peer educators and implementing a baseline assessment. While the LASC project appears to have a referral system to local health services and links to its care and support program, effective peer education should also be linked with other prevention and awareness raising activities. It is unclear from the documentation whether this is the case in the LASC project (eg many beneficiaries said that this was their first HIV educational experience)⁴⁵.

The Role of Community-Based Volunteers

Community-based volunteers play a crucial role in the treatment, care and support of people with HIV and AIDS as well as the education of communities about HIV and AIDS in Southern Africa. Many of the community HIV and AIDS programs run by Oxfam partners in Southern Africa rely heavily on volunteers and as such, they have gathered significant experience on this issue. Whilst several other areas of this report discuss the involvement of volunteers, there are some additional lessons learnt worth noting:

- *Stipends:* There is a heavy reliance on HBC volunteers in South Africa and as such the nature of 'volunteering' and expectations of such work are changing. The South African Government gives care givers working in its programs much more than what the Oxfam program partners pay (sometimes 80% more) – and this is an issue. Oxfam partners are now paying more than they used to. However, there is pressure from volunteers for partners to apply for income grants from government funding schemes so that their stipends can be increased. In many of its Southern Africa programs, Oxfam partner volunteers cite the amount of the stipend (or lack thereof) as a key source of discontent – as the stipends are often too low to sustain the volunteers and their dependants⁴⁶. This may prove to be an increasingly important factor in the retention of volunteers. Oxfam plans to study policies and practices of volunteerism in South Africa later this year.
- *Recruitment:* Much recruitment of volunteers is done through church networks and this appears to be working. This is based on a universal belief that 'the church represents what is compassionate and caring'. Other people consulted in the recruitment of volunteers include: community/traditional leaders, local health clinic staff, local government representatives as well as general announcements in the community asking people to come forward. Many volunteers have previously received services (ie were beneficiaries) and then are recruited to do voluntary work. Often a set of selection criteria are used – this helps to ensure that the right people are chosen and makes the process transparent and accountable
- *Community Education:* Communities need educating about the work of caregivers. This assists with acceptance and respect of caregivers by the community and may help in more male volunteers coming forward.
- *Community Leadership:* As community caregivers are respected in the community, they feel compelled to exhibit positive behaviours themselves. Many caregivers are infected or directly affected by HIV. These people become positive role models and an important source of community leadership in fighting the stigma and discrimination associated with HIV and AIDS.
- *Other motivations:* Additional motivations for people to volunteer apart from those already mentioned in this report include: the learning of new skills and knowledge

which may help them to find a job in the future (including the certification of their skills either by the NGO or by the government), the prospect of long-term career advancement within the same organisation and access to further education and personal guidance.

- *Volunteer Ownership:* Organisations encourage ownership of programs by volunteers. As many volunteers are HIV positive or were former beneficiaries of the program, they often demand a high level of commitment from the partner organisations towards the communities they serve. In this way, they keep the partners accountable to their beneficiaries.
- *Other Challenges:* As well as needing to overcome community stigma and discrimination towards HIV and AIDS, volunteers often need to deal with: domestic violence and gender-based violence; ignorance and complacency around HIV and AIDS (especially among young people); demand for them to see more patients than the volunteers have the capacity to do; limited means of transport to reach patients; lack of resources to care for patients; and lack of services to refer patients to, particularly in rural areas⁴⁷. To begin to address one of these problems - excessive demand - volunteers can train family members (where present) to do the bulk of the caregiving. This gives the volunteers more time to see other patients⁴⁸.

6.3.3 Networks and Partnerships

Oxfam partners in Southern Africa are experiencing rising demand for their community-based services and are looking at the best ways to work alongside government in delivering comprehensive programs in prevention, treatment, care and support. As such, they are increasingly developing networks with others in order to be able to retain their core business, provide referrals and ensure that beneficiaries have access to an effective and comprehensive set of services. This includes challenging governments to provide more effective services in HIV and AIDS.

Some of the lessons learnt in building networks and partnerships are:

- Involving church groups and traditional leaders from the outset of a project can lead to their valuable support. They can often contribute with such things as: recruitment of volunteers, providing a venue for volunteer training, encouraging community acceptance of a program, promoting an activity and providing assistance with legal requirements such as drawing up wills or obtaining identification documents.
- However in some areas in South Africa, PLWHAs are not welcome by the church and are even allocated separate seating areas or chased out of services. In these cases it is recognised that NGOs must work more closely with church leaders to educate them about HIV and AIDS and to mobilise young people to encourage greater sensitivity among their community leaders.
- There needs to be better collaboration and integration of NGO and government services. This is important for example, in the roll-out of ART, where NGOs could provide valuable support in providing information and referrals to government services⁴⁹.
- CBOs/NGOs often work in partnership with other organisations and national bodies with strong credentials in advocacy to help expand their influence on issues at a local and national level.
- An Oxfam partner in Mozambique, Kindlimuka, has set up income generation projects to assist AIDS widowers to make money. One such project involves tailoring, which at first struggled to succeed. Kindlimuka then partnered up with a

multinational petrol company who have made the project the preferred supplier of uniforms for their petrol-station workers around the country. This partnership has ensured that the project now really benefits those affected by AIDS⁵⁰.

6.3.4 Monitoring and Evaluation

A key issue for many Oxfam partners in Southern Africa is that they have been running programs without comprehensive systems for measuring efficacy. A lack of information about a program's impact and outcomes can limit an organisation's ability to: detect and address problems in a program, provide early evidence of a program's efficacy, establish performance incentives for staff and partners, seek and justify further sources of funding and engage in communication and advocacy activities⁵¹.

Other organisations can learn from the areas of weakness in Oxfam partners' M&E systems and how they are starting to address these weaknesses:

- An external evaluation of the JOHAP partners in South Africa found that the peer education and awareness campaigns lacked tools for measuring their impact - focusing more on data collection on numbers of people reached. There is also little documented on the quality of messages, the extent to which they reach target audiences and their impact on attitudes and behaviours. A considerable amount of the documented evidence is anecdotal (ie 'there has been a reduction in community stigma') or based on unproven assumptions of cause and effect (eg 'after the prevention programs there was a reduction in reported STI cases at the local clinic').
- The same external evaluation found that organisations needed better systems to track clients once they have been referred to other organisations. This is necessary in order to measure the impact of their programs when working collaboratively with other NGOs/CBOs and to measure the efficacy of these collaborations.
- M&E tools currently being used by partners in South Africa include: monthly activity reports, client satisfaction surveys, pre and post workshop evaluations, daily diaries of program staff, site visits, support group family profiles, personal profiles, monthly activity reports, logframes, personal stories and testimonies, video recordings of events, and reports from partners' participation in community and advocacy meetings⁵².
- Some Oxfam partners in South Africa and all in Zimbabwe have recently received training in M&E and follow-up in the form of a mentoring process by consultants and Oxfam staff. In Zimbabwe, all partners have developed and are implementing M&E plans.
- In South Africa, Oxfam has conducted a training session in M&E during an orientation workshop for potential Oxfam partners – introducing the idea and expectation that effective M&E processes are needed right from the initiation of a project^{53,54}.

6.4 Working with Extractive Industries

Mineworkers in Southern Africa are one group vulnerable to HIV infection. These workers are highly mobile, and live away from their families to pursue work. Many have little education and little access to recreational services except those provided by the informal sector (brothels, gambling etc) that often springs up around mine sites. These services are in turn conducive to high risk sexual behaviour – including casual

sex with multiple partners (including sex workers) and sex without condoms. Males who contract HIV then often travel on to different areas seeking work and continue to practice unsafe sex, further promoting the spread of HIV⁵⁵.

The lessons learnt from HIV initiatives in the mining industry in Southern Africa are relevant to countries such as PNG, where mineral deposits account for almost two-thirds of export earnings. According to AusAID, areas of high HIV prevalence can be found in rural areas of PNG around primary industry sites⁵⁶. The lessons may also become increasingly relevant in the Solomon Islands which has substantial untapped mineral resources⁵⁷. At least one OAus partner (HELP Resources) is working in promoting gender equality (including education in sexual health and HIV) in a community which may be impacted by a proposed large copper mine (Ambunti, PNG) and an OAus partner in PNG (Centre for Environmental Research and Development) and the OAus Solomon Islands country office are working on improving mining sector policy and the impact the sector has at a community level^{58,59}. OAus has also supported some work carried out in relation to a mine in Fiji by the Citizens' Constitutional Forum (CCF) and the Fiji Women's Rights Movement⁶⁰.

Whilst there is little documentation of the lessons learnt in working with the mining sector in Southern Africa, Oxfam Australia's program staff described one particular public-private partnership in South Africa and the key elements which have made it effective.

The Palabora Foundation

The JOHAP partner the Palabora Foundation (PT) has been working alongside three mining companies and a large armed forces base in Palabora in Limpopo Province, north-eastern South Africa. It services both the mineworkers and those in the army – many of whom go on peace-keeping missions in other African countries and come back HIV positive.

Whilst the mines all have HIV policies and access to VCT and ART for their workers, many miners choose not to use this service because of fear of stigma and discrimination (due to a perceived lack of confidentiality). Instead they choose to access the PT to talk about their options and then receive follow-up through the public health system.

The mines cooperate with PT by providing:

- Access to their mine sites
- A building for PT to operate from and a car
- Logistical support eg funding for organising workshops

The Department of Health provides:

- A nurse situated within the PT premises (for 3 years)
- An ART treatment site in the area (after extensive lobbying by PT)

PT provides the following to workers in the area and their families:

- Home-based care
- An "HIV Ambassador" program where PLWHAs undertake awareness raising activities in the local communities (including in churches, schools, local

organisations and villages) as well as providing counselling, care and support for community members infected or affected by HIV and AIDS

- VCT
- Prevention campaigns – including a program of peer education among the miners
- A referral service

According to Oxfam program staff, all the parties essentially have a good working relationship. There is wide representation on the PT Board – including members of the mines, armed forces, traditional leaders, members of the local hospital and a school and local government representative^{61,62}.

8. Conclusion

Oxfam program staff and partners working in the Pacific have much to gain by increasing their awareness of the experiences of their Southern African colleagues. Whilst several of Oxfam's Pacific partners have also built up experience in HIV programming and have been sharing this with their colleagues in the region, many similar Southern African programs have the benefit of longer-term experience and the insight gained through a repeated process of learning from mistakes and subsequent program adaptation.

Whilst the Pacific and Southern African contexts are very different in some respects, there are also many similarities in the social, economic and cultural characteristics that are contributing towards the spread of HIV in both regions as well as the types of programs that are being planned or implemented in response.

Specific lessons can be learnt from the organisation of home-based care programs; the integration of prevention, treatment, care and support; programs that address gender roles and gender-based violence; the use of volunteers; and specific components of prevention programs that are popular in both regions such as the use of drama. Whilst many lessons are fairly program specific, general lessons can also be drawn from them and applied to other programs. It is hoped that this document provides an outline of Southern African experiences that can be applied to programs in the Pacific, and that awareness of such programs will prompt further information sharing and face-to-face exchanges between the two regions.

As the governments of many Southern African countries begin to rollout ART, many CBOs and NGOs are grappling with how to integrate treatment support into their existing programs or debating whether to re-orientate their programs in order to provide more treatment support services. The Pacific's response in the provision of HIV treatment is generally at an earlier stage than that of Southern Africa, so community-based organisations in this region should continue to benefit from the experiences of their Southern Africa colleagues in treatment preparedness. The Southern Africa experience in ART rollout can also inform AusAID, given its recent White Paper commitment to expanded access to HIV treatment in the Pacific and the 2005 UN World Summit goal of working towards universal access to HIV treatment by 2010⁶³. Sharing these experiences will hopefully ensure that all working in HIV and AIDS in the Pacific will be better equipped and ready to provide an effective and comprehensive continuum of care to people living with HIV and AIDS.

Queries or further information on specific projects and programs mentioned in this report can be referred to:

Kathryn Dinh - HIV & AIDS Advocacy Coordinator, Oxfam Australia

Andrew Hartwich - Acting Southern Africa Regional Manager, Oxfam Australia

Bridgette Thorold- Southern Africa Program Coordinator, Oxfam Australia

References

- AusAID. *HIV/AIDS in Papua New Guinea*. Available at: www.ausaid.gov.au/country/png/hivaids
- AusAID. *PNG HIV/AIDS Update*. May 2006
- Oxfam. *An External Evaluation of the Joint Oxfam HIV and AIDS Programme (JOHAP) in South Africa*. Centre for the Study of AIDS, University of Pretoria. Pretoria, Mar 2005. A summary version is available at: http://www.oxfam.org.au/world/africa/south_africa/johapeval.pdf
- Oxfam. *Joint Oxfam HIV/AIDS Program, South Africa: 6 Month Report July - Dec 2005*. 2005.
- Oxfam Australia. *A Gender Analysis of Targeted AIDS Interventions (TAI): Gender Analysis Number One*. Melbourne 2005. Available at: http://www.oxfam.org.au/world/africa/south_africa/AIDSGenderAnalysis.pdf
- Oxfam Australia. *Combined Oxfam Gender and HIV/AIDS Program, Zimbabwe. 6 Month Report. July-Dec 2005*. 2005.
- Oxfam Australia. *Integrating Prevention and Care: Including Men in Care. Case Study 2*. Melbourne 2005. Available at: http://www.oxfam.org.au/world/africa/south_africa/positivecare.pdf
- Oxfam Australia. *Men as Carers: A Case Study*. May 2006. Available at: http://www.oxfam.org.au/world/africa/south_africa/Oxfam_Men_as_Carers_Report-FINAL.pdf
- Oxfam Australia. *Mid Term Review Report on the Combined Oxfam Gender and HIV/AIDS Program (COGENHA) in Zimbabwe*. May 2005.
- Oxfam Australia. *Pacific Regional Strategy*. Nov 2002.
- Oxfam Australia. *Southern Africa Annual Reflection: HIV/AIDS Prevention and Care Services*. Pretoria, February 2005.
- Oxfam Australia – Mozambique. *Country Strategy 2005-2010 (July – June)*. 2005.
- Oxfam Australia. *The East Sepik Provincial Response to HIV and AIDS – Draft Report*. 2005.
- Oxfam Australia. *Youth in Shebeens & Taverns – An HIV and AIDS Prevention Opportunity: Case Study Number One*. Melbourne, 2005. Available at: http://www.oxfam.org.au/world/africa/south_africa/lasc.pdf
- Oxfam International. *PNG Planning Meeting: Meeting Agenda & Pre-Reading*. Auckland, 18-19 January, 2006.
- Oxfam International. *2006 Pacific Partner Workshop & Annual Reflection Report*. Melbourne/Auckland, May 2006.
- Secretariat of the Pacific Community. *Cumulative Reported HIV, AIDS and AIDS Death Cases, crude incidence rates, gender, & cases with missing details: All Pacific Island Countries and Territories, New Zealand and Australia: 31 December 2004*. Noumea, Dec 2004. Available at: www.spc.int/hiv [Accessed July 6 2006].
- Targeted AIDS Interventions. *Annual Report – Sibamihqaha Community Project: July 2005 – June 2006*.
- UNAIDS. *Gender and HIV/AIDS: UNAIDS Technical Update*. UNAIDS Best Practice Collection. Geneva 1998. pp 3. Available at: www.unaids.org [Accessed July 6 2006].
- UNAIDS. *HIV/AIDS and Human Rights: International Guidelines. Revised Guideline 6. Access to Prevention, Treatment, Care and Support*. UNAIDS Best Practice Collection. Geneva, March 2003. Available at: www.unaids.org [Accessed July 6 2006].
- UNAIDS. *2006 Report on the Global AIDS Epidemic*. Geneva, 2006. Available at www.unaids.org/en/HIV_data [Accessed July 6 2006].
- UNAIDS. *Working with Men for HIV Prevention and Care*. UNAIDS Best Practice Collection. Geneva, 2001. Available at: www.unaids.org [Accessed July 7 2006].
- Youth Peer Education Network (UNFPA). *Standards for Peer Education Programs: Youth Peer Education Toolkit*. New York, 2005. Available at: www.unfpa.org/adolescents/docs [Accessed July 10 2006].

Annexes

Annex 1

TERMS OF REFERENCE

CONSULTANCY ON LESSONS LEARNED FROM THE HIV RESPONSE IN SOUTHERN AFRICA

Purpose of consultancy

To research and document key lessons learned from Oxfam Australia's Southern Africa program's experience of responding to HIV and AIDS, with a focus on lessons that are relevant to the Pacific context, in order to inform and strengthen both Oxfam Australia's HIV programming in the Pacific and Oxfam Australia's HIV advocacy with AusAID's Pacific program and HIV Taskforce.

Organisational Context

Oxfam Australia has prioritised a response to HIV and AIDS within its Pacific program with the rationale that HIV is probably more prevalent in the region that the statistics suggest, and that Pacific populations are becoming increasingly vulnerable to HIV. The Pacific program has adopted two approaches to HIV and AIDS work in the region, one for lower prevalence settings (Solomon Islands, Vanuatu, and Fiji), and one for higher prevalence settings (Papua New Guinea).

The lower prevalence approach seeks to:

1. Encourage recognition of HIV and AIDS as serious issues requiring a specific response;
2. Supporting development and implementation of programs which address vulnerability to HIV;
3. Facilitate mainstreaming of HIV, by working with partner organisations over time to identify where HIV response fits in with the work they are already doing, and the problems they have identified.

The higher prevalence approach will adopt the same strategies as the lower prevalence response, in addition to aiming to:

1. Support the development, implementation and documentation of HIV activities which can be used to demonstrate appropriate and effective strategies;
2. Support research into links between extractive industries and vulnerability to HIV.¹

OAus aims to apply the One Program approach to work in the Pacific, where program, advocacy and emergency work all have a role to play in the organisation's HIV and AIDS response in the region.

OAus' HIV advocacy work in the Pacific region seeks to achieve the following policy and practice change objectives:

¹ See OAus Pacific HIV Strategy 2004 for more details.

- The effectiveness of the HIV and AIDS response in PNG (including the level of resources available to NGOs and CBOs for HIV programming) is increased through influencing AusAID's policy and practice with regard to its HIV and AIDS program in PNG, and through building the capacity of NGOs and CBOs in PNG to advocate for improvements in the national, provincial and district HIV and AIDS response;
- AusAID is promoting a culture of learning on HIV and AIDS within the Pacific through increased dialogue between NGOs, CBOs, provincial and national AIDS councils, governments and donors on lessons learned, at the national and local levels and within Australia, to enable HIV policy and practice to be strengthened.

In 2006-7, AusAID will be developing initiatives to implement the HIV priorities outlined in the Australian Government's White Paper on the Overseas Aid Program, "Australian Aid: Promoting Growth and Stability", as well as developing initiatives to implement the new PNG HIV country strategy.² The AusAID HIV Taskforce will also be reviewing the Australian Government's current International HIV/AIDS Strategy, "Meeting the Challenge" in 2007. It is aimed that the findings of this research will help inform OAus' input into these processes, as well as OAus' HIV program work.

Methodology

The consultancy involves desk based research only and no travel. The consultant is expected to review relevant documents and websites regarding Oxfam Australia's Southern Africa program's response to HIV and AIDS and undertake further research/queries via email or telephone if/as necessary. A written report must be provided on the findings and analysis. It may be necessary or helpful to review some selected external materials relevant to the key lessons highlighted, to back up the findings and analysis and ensure recommendations made are consistent with broader understanding of best practice.

The consultant will report to the HIV & AIDS Advocacy Coordinator, with additional support to be provided by Pacific program as necessary.

Scope of the consultancy

Research should focus on, but not be limited to, lessons learned in the key areas of:

- linking prevention and care
- working with men
- gender based violence
- HIV prevention, including consideration of ideological approaches to prevention (eg abstinence and faithfulness), voluntary counselling and testing (VCT), peer education, funding of grassroots behaviour change programs at the community level etc
- mobilising and involvement of traditional leaders in the response
- sex worker initiatives
- key elements of successful use of theatre, music, song, and dance in HIV response

² This document has not been made public yet.

The report should highlight the key lessons learned on topic areas (these can be written up as dot points), and include any particularly relevant case studies of successful interventions, effective alternative approaches, or examples with significant relevant learning (as short summaries with sources).

Of these key lessons, the report should then highlight and provide brief rationale for the lessons of greatest relevance to the Pacific, taking into account knowledge of current AusAID and Oxfam Australia PNG and Pacific HIV programming practice and make recommendations for how this could be strengthened or improved. This should include recommendations and/or priorities for OAus HIV advocacy.

Report

A draft report (of approximately 20 pages) is to be produced with the following sections included:

- A table of contents
- An executive summary
- A list of acronyms
- Introduction and methodology
- Key lessons learned from Southern Africa in relation to the key topics, including any relevant case studies/specific examples
- Key lessons, rationale and recommendations for PNG and the Pacific:
 - for AusAID's program
 - for Oxfam Australia's HIV program
- Implications and recommendations for OAus HIV advocacy work
- Conclusion
- Annexes containing;
 - a bibliography of relevant materials sourced, including hyperlinks where resources are available online
 - names and contact details of all people/organisations sourced/ interviewed.

The report should also include detailed references as footnotes, as appropriate.

Background Information

Documents to be provided to the consultant:

- Current Oxfam Program in PNG
- OAus Pacific HIV Strategy
- Joint Oxfam HIV/AIDS Program in South Africa – 2005 Evaluation
- AusAID PNG HIV/AIDS Update May 2006

Annex 2: Interviews for this Report

- Andrew Hartwich
Acting Southern Africa Regional Manager
Oxfam Australia
- Anne Lockley
Regional Manager for the Pacific
Oxfam Australia
- Bridgette Thorold
Southern Africa Program Coordinator
Oxfam Australia

-
- The terms of reference for this project were developed by Oxfam Australia's HIV & AIDS Advocacy Coordinator in consultation with Pacific program staff and the Acting Southern Africa Regional Manager.
 - Input on aspects of the lessons learnt of interest to AusAID was provided by Peter Lockett, Acting First Secretary, AusAID, Papua New Guinea.

Annex 3: Lessons Learnt from Community Education through Drama & Song (Baua Baua Popular Education Troupe, East Sepik Province, PNG)

- To make sure the right information is in the plays, get information from NACS, ask NACS to check scripts for accuracy, and ask HIV experts to come and comment on a rehearsal performance to check its content and accuracy before it is performed in public.
- If an external script is used, make sure the language is appropriate or adapted to ensure the best comprehension by local people.
- All group members should sign an agreement about behaviour, so that they practice what they preach in workshops and performances. This includes respecting the culture and dress of the communities being worked with.
- Assess what each village is like before performing there, and then choose the kind of drama technique that will work best in that context, eg playback theatre or a musical. Playback works best in towns, for example in high schools, colleges and prisons. It involves getting stories from the community about what is happening there and what is relevant to them, and then creating a drama about it. Straight drama or musicals work best in rural areas so that people can easily follow the storyline.
- Talk about feelings in plays, for example, how a person living with HIV feels.
- Perform plays on how you can become infected with HIV as well as on stigma and discrimination.
- Invite PLWHA to work with you and give their testimony, especially at big events. Be willing to learn from them.
- Plan to stay in each village for 3 days so that there is time to talk with community members as well as do performances.
- Before doing a trip to a village, 3 or 4 group members should visit to talk to village elders, and gain their support before recruiting 2 or 3 people in each village to prepare for the group's visit (eg finding accommodation, setting up a stage, preparing food etc).
- Run separate workshops for men and women so that they feel more comfortable to ask questions.
- Screen a video if possible at the end of the day to summarise learning from the day's program.
- Use theatre to evaluate what people have learned from awareness activities. Ask villagers to do a play to show what they have learned.
- Run workshops as well as doing performances as this improves people's understanding of the issues. In workshops, talk about how people can be infected with HIV, show posters and allow people to ask questions. Check that people understand what you are saying and have understood your answer to their question.
- Have a tape recorder to record comments about performances. Then discuss the feedback as a group after each performance and make any necessary changes. Be willing to accept negative comments as well as the positive ones, as you may learn more from the negative comments.
- Before leaving a village, set up a Community Action Committee (if there isn't one already) to do continue awareness work through distributing information and undertaking more awareness activities, including with nearby villages. Support these committees by supplying more information or materials as needed.
- Use church leaders or others who are travelling to remote villages to take any materials requested for you.

-
- ¹ UNAIDS. 2006 Report on the Global AIDS Epidemic. Geneva, 2006. Available at www.unaids.org/en/HIV_data [Accessed 7 July 2006].
- ² Gross national income per capita expressed in international dollars – the amounts have been calculated in terms of purchasing power parity, or what the equivalent quantity of goods and services is that can be bought for one (hypothetical) international dollar.
- ³ Ibid. (UNAIDS)
- ⁴ Ibid. (UNAIDS)
- ⁵ Secretariat of the Pacific Community. Cumulative Reported HIV, AIDS and AIDS Death Cases, crude incidence rates, gender, & cases with missing details: All Pacific Island Countries and Territories, New Zealand and Australia: 31 December 2004. Noumea, 2004. Available at: www.spc.int/hiv [Accessed 7 July 2006].
- ⁶ Ibid. (UNAIDS)
- ⁷ Ibid. (UNAIDS)
- ⁸ Ibid. (SPC)
- ⁹ Ibid. (UNAIDS)
- ¹⁰ Ibid. (SPC)
- ¹¹ Ibid. (UNAIDS)
- ¹² Oxfam Australia. The East Sepik Provincial Response to HIV and AIDS – Draft Report. 2005.
- ¹³ Oxfam Australia – Mozambique. Country Strategy 2005-2010 (July – June). 2005.
- ¹⁴ Oxfam. An External Evaluation of the Joint Oxfam HIV and AIDS Programme (JOHAP) in South Africa. Centre for the Study of AIDS, University of Pretoria. Pretoria, Mar 2005.
- ¹⁵ Oxfam Australia. Pacific Regional Strategy. Nov 2002
- ¹⁶ Oxfam Australia. Combined Oxfam Gender and HIV/AIDS Program, Zimbabwe. 6 Month Report. July-Dec 2005. 2005.
- ¹⁷ AusAID. HIV/AIDS in Papua New Guinea. Available at: www.ausaid.gov.au/country/png/hiv/aids [Accessed 16 July 2006]
- ¹⁸ AusAID. PNG HIV/AIDS Update. May 2006.
- ¹⁹ UNAIDS. HIV/AIDS and Human Rights: International Guidelines. Revised Guideline 6. Access to Prevention, Treatment, Care and Support. UNAIDS. March 2003. Available at: www.unaids.org [Accessed July 4 2006].
- ²⁰ Oxfam Ibid. [Oxfam External Evaluation of JOHAP]. pp 54, 55
- ²¹ Oxfam Australia. Interview with Acting Southern Africa Regional Manager, Andrew Hartwich. 12 July 2006.
- ²² Oxfam Australia. Interview with Southern Africa Program Coordinator., Bridgette Thorold. 12 July 2006.
- ²³ Oxfam Australia. Men as Carers: A Case Study. May 2006.
- ²⁴ The holistic African conception of personhood that emphasises respectful relationships with other people. It also embraces the values of truth, honesty, justice, respect for property, compassion, tolerance, empathy and enthusiasm for life.
- ²⁵ Oxfam Australia. Integrating Prevention and Care: Including Men in Care. Case Study 2. Melbourne 2005. Available at: www.oxfam.org.au/world/Africa/south_africa/articles.html
- ²⁶ Oxfam Australia. Southern Africa Annual Reflection: HIV/AIDS Prevention and Care Services. Pretoria, February 2005.
- ²⁷ Ibid. (UNAIDS)
- ²⁸ Ibid. (UNAIDS)
- ²⁹ Ibid. (UNAIDS)
- ³⁰ Ibid. Interview with Bridgette Thorold.
- ³¹ Ibid. (COGENHA 6-Month Report Jul-Dec 2005) pp 10.
- ³² UNAIDS. Gender and HIV/AIDS: UNAIDS Technical Update. Geneva 1998. pp 3. Available at: www.unaids.org [Accessed July 6 2006].
- ³³ UNAIDS. Working with Men for HIV Prevention and Care. UNAIDS Best Practice Collection. Geneva ,2001. pp 38. Available at: www.unaids.org [Accessed July 6 2006]
- ³⁴ Op. Cit. Pp 38.
- ³⁵ Ibid. [Oxfam External Evaluation of JOHAP]. Pp 56.
- ³⁶ Oxfam Australia. A Gender Analysis of Targeted AIDS Interventions (TAI): Gender Analysis Number One. Melbourne 2005.
- ³⁷ Oxfam Australia. Mid Term Review Report on the Combined Oxfam Gender and HIV/AIDS Program (COGENHA) in Zimbabwe. May 2005 Pp 18
- ³⁸ Central Intelligence Agency. The World Factbook. US, last updated 11 July 2006. Available at: www.cia.gov/cia/publications/factbook [Accessed 16 July 2006].
- ³⁹ Ibid. Interview with Andrew Hartwich.
- ⁴⁰ Ibid. Interview with Bridgette Thorold.
- ⁴¹ Oxfam Australia. HIV and AIDS Input to Oxfam Australia Submission to White Paper Process. Melbourne, 2005.
- ⁴² Ibid. [Oxfam External Evaluation of JOHAP]. Pp 12.
- ⁴³ Oxfam Australia. Youth in shebeens & taverns – An HIV and AIDS Prevention Opportunity: Case Study Number One. Melbourne, 2005. Available at: www.oxfam.org.au/world/africa/south_africa/articles.html
- ⁴⁴ Ibid. [Oxfam Australia Southern Africa Annual Reflection] pp 37-41.
- ⁴⁵ Youth Peer Education Network (UNFPA). Standards for Peer Education Programs: Youth Peer Education Toolkit. New York, 2005. Pp 15-24. Available at: www.unfpa.org/adolescents/docs [Accessed 21 July 2006]
- ⁴⁶ Ibid. Interview with Andrew Hartwich.
- ⁴⁷ Ibid. [Oxfam External Evaluation of JOHAP]. Pp 53, 54, 85.
- ⁴⁸ Ibid. [Oxfam Australia Mid Term Review of COGENHA, Zimbabwe] Pp 22.
- ⁴⁹ Ibid. [Oxfam External Evaluation of JOHAP]. Pp 42.
- ⁵⁰ Ibid. [Oxfam Australia Southern Africa Annual Reflection] pp 22.
- ⁵¹ Ibid. [Oxfam Australia Mid Term Review of COGENHA, Zimbabwe] Pp 25.
- ⁵² Ibid. [Oxfam External Evaluation of JOHAP]. Pp 14, 63.

-
- ⁵³ Oxfam. Joint Oxfam HIV/AIDS Program, South Africa: 6 Month Report July – Dec 2005. 2005.
- ⁵⁴ Oxfam Australia. Combined Oxfam Gender and HIV/AIDS Program, Zimbabwe. 6 Month Report. July-Dec 2005. 2005. Pp 9.
- ⁵⁵ The Mining, Minerals and Sustainable Development Project. HIV/AIDS, The Mining and Minerals Sector & Sustainable Development in South Africa. Elias.R, Taylor I. London, May 2002. Available at: www.iiied.org/mmsd.wp [Accessed 16 July 2006].
- ⁵⁶ Ibid. [AusAID. www.ausaid.gov.au/country/png/hiv/AIDS]
- ⁵⁷ Ibid. [CIA The World Factbook].
- ⁵⁸ Oxfam International. 2006 Pacific Partner Workshop & Annual Reflection Report. Melbourne/Auckland, May 2006.
- ⁵⁹ Oxfam International. PNG Planning Meeting: Meeting Agenda & Pre-Reading. Auckland, 18-19 January, 2006.
- ⁶⁰ Oxfam Australia. Email input from Regional Manager for the Pacific, Anne Lockley. 20 July 2006.
- ⁶¹ Ibid. Interview with Andrew Hartwich.
- ⁶² Ibid. [Oxfam Australia HIV and AIDS input into the Australian Government's White Paper] pp 2.
- ⁶³ AusAID. Australian Aid: Promoting Growth and Stability-A White Paper on the Australian Government's Overseas Aid Program. Canberra, Apr 2006. Pp 50. Available at: www.ausaid.gov.au [Accessed 16 July 2006].