



Policy Paper

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# Inclusive and integrated HIV and AIDS programming

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Technical Resources Division  
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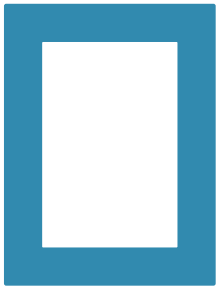
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## Policy Paper

# Inclusive and integrated HIV and AIDS programming

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the 1990s, the number of people in the UK who are employed in the public sector has increased from 10.5 million to 12.5 million (12.5% of the population).

There are a number of reasons for this increase. One is that the public sector has become a more attractive place to work. This is due to a number of factors, including the fact that the public sector is now seen as a more secure place to work, and that it offers a better work-life balance than the private sector.

Another reason for the increase is that the public sector has become a more important part of the economy. This is due to the fact that the public sector now provides a large number of services that are essential to the well-being of the population, such as health care, education, and social care.

Finally, the increase in public sector employment is also due to the fact that the public sector has become a more important part of the government's budget. This is due to the fact that the public sector now accounts for a large proportion of government spending, and that the government has been able to increase its spending on public services in recent years.

There are a number of challenges facing the public sector in the future. One is that the public sector will need to continue to provide a high quality of services, while also being able to manage its costs effectively. This will require a number of reforms, including the introduction of competition and the restructuring of public services.

Another challenge is that the public sector will need to continue to attract and retain a high quality of staff. This will require a number of reforms, including the introduction of a more flexible and attractive pay and benefits system, and the improvement of working conditions.

Finally, the public sector will need to continue to be a more important part of the government's budget. This will require a number of reforms, including the introduction of a more efficient and effective way of raising revenue, and the reduction of government spending on other areas.

There are a number of ways in which the public sector can be reformed. One way is to introduce competition, which will help to reduce costs and improve the quality of services. Another way is to restructure public services, which will help to reduce duplication and improve efficiency.

Finally, the public sector can be reformed by introducing a more flexible and attractive pay and benefits system, and by improving working conditions. This will help to attract and retain a high quality of staff, which is essential for the public sector to provide a high quality of services.

There are a number of reasons why the public sector is important. One is that it provides a number of essential services that are essential to the well-being of the population. Another reason is that it is a major part of the government's budget, and that it has the potential to make a significant contribution to the economy.

Finally, the public sector is a major employer, and that it has the potential to create a large number of jobs. This is why it is important to ensure that the public sector is able to continue to provide a high quality of services, while also being able to manage its costs effectively.

There are a number of ways in which the public sector can be reformed. One way is to introduce competition, which will help to reduce costs and improve the quality of services. Another way is to restructure public services, which will help to reduce duplication and improve efficiency.

Finally, the public sector can be reformed by introducing a more flexible and attractive pay and benefits system, and by improving working conditions. This will help to attract and retain a high quality of staff, which is essential for the public sector to provide a high quality of services.

**“When social support and other programmes for people with disabilities are delivered in an HIV-sensitive manner, they contribute to overcoming the historic neglect of HIV prevention and support for people with disabilities.”**

**UNAIDS Strategy 2011–2015**

Page 26–27.

## Foreword

## Preface

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In recent years there has been increasing global understanding about HIV and the intersection between HIV and AIDS and disability. This is a result of increased programmatic attention, publications and research on (a) the vulnerability and risk factors of persons with disabilities to HIV (b) the impacts of the HIV epidemic regarding episodic/chronic impairments leading to disability and (c) advocacy by Disabled People’s Organizations and disability organizations to promote the inclusion of disability in HIV programming at international and national levels.

However, there is still a long way to go and Handicap International has a key role to play, having undertaken some dynamic and innovative work in this field, in particular: developing and supporting national platforms on HIV and disability, strategically pairing Disabled People’s Organizations and Voluntary Testing Centres, working with peer educators with different impairments in HIV awareness-raising, and ensuring treatment and care are accessible to all. The aim of this policy document is to lay the foundations for Handicap International’s consistent and dynamic programming on HIV and AIDS for the years to come and in particular, to respond to growing international evidence of the need to intricately link HIV programming with sexual and reproductive health as well as gender-based violence.

The author is extremely grateful to both internal and external reviewers for their support in producing this document. This policy and programming framework is intended to be dynamic and evolving. As such, all feedback, reflections and strategic comments for improvement are always welcome.

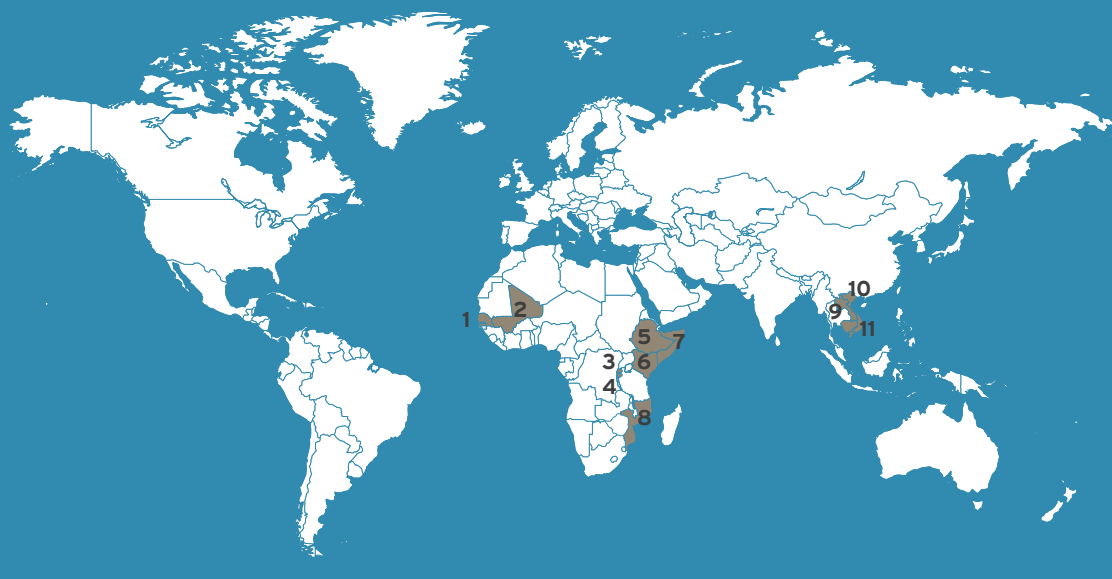
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## About Handicap International

Handicap International is an independent and impartial international aid organization working in situations of poverty and exclusion, conflict and disaster. Working alongside persons with disabilities and other vulnerable groups, its actions and testimony are focused on responding to their essential needs, improving their living conditions and promoting respect for their dignity and their fundamental rights<sup>1</sup>.

Handicap International is active in approximately 60 countries worldwide, working in the fields of Disability Rights and Policy, Rehabilitation, Prevention and Health, Inclusion, Anti-Mine Operations and Emergency. In the field of HIV and AIDS, Handicap International is currently present in 11 countries: eight in Africa<sup>2</sup> and three in South East Asia<sup>3</sup>, as shown in the following map.



**Map 1: Countries where HIV projects are implemented by Handicap International**

- |                    |                                   |
|--------------------|-----------------------------------|
| <b>1: Senegal</b>  | <b>7: Somaliland and Puntland</b> |
| <b>2: Mali</b>     | <b>8: Mozambique</b>              |
| <b>3: Rwanda</b>   | <b>9: Cambodia</b>                |
| <b>4: Burundi</b>  | <b>10: Vietnam</b>                |
| <b>5: Ethiopia</b> | <b>11: Laos</b>                   |
| <b>6: Kenya</b>    |                                   |

## About this policy document

This policy document is a strategic follow-up to Handicap International's HIV/AIDS Position and Strategy document of 2007 and builds on the recommendations of the Access to HIV services among persons with disabilities document of 2009. In order to promote a consistent and comprehensive approach at all levels, it complements other key documents by Handicap International, namely the *Inclusive Local Development Policy Paper* (2009), *Accessibility Policy Paper* (2009), *Personalized Social Support Practical Guide* (2009), *Capacity Development Guide* (2008), *Economic Inclusion* (under finalization, 2011) and *Gender-based Violence at Glance Paper* (2011).

This document revisits Handicap International's strategy and technical positioning with regards to HIV and AIDS, responding to recent international trends, emerging evidence and lessons learned from practical experience. Though it is not a guideline on HIV and AIDS per se, this document provides sufficient direction for Handicap International programmes to strategically develop, implement, monitor and evaluate HIV and AIDS projects, based on thorough situational analysis and needs assessment.

### The specific objectives of this document are to:

- Provide Handicap International with an integrated and inclusive HIV policy document that will shape the scope of project activities;
- Provide technical guidance to Handicap International programmes and projects which are implementing and/or intending to implement HIV and AIDS projects;
- Contribute to quality and coherence of Handicap International's work on HIV and AIDS;
- Promote results-based management in all Handicap International's projects on HIV and AIDS.

The document is divided into three sections. **"Principles and Benchmarks"** comprises the introduction, definitions, rationale for intervening in the field of HIV and AIDS, target populations and cross-cutting approaches for interventions. **"Intervention Methods"** outlines main modalities for interventions. **"Appendices"** provides additional documents such as practical tools, checklists and recommended readings.

This document is primarily intended for internal use by Handicap International, specifically: Project Managers, Coordinators and Country Advisors who are, or will be, directly involved in HIV project implementation; Programme Directors; Desks Officers and their Deputies; and other Technical Advisors of the Technical Resources Department (DRT). However, it can also be disseminated externally for use by project partners and relevant stakeholders.





Rwanda, 2011



# Principles and Benchmarks

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# Rationale for intervening in the field of HIV and AIDS

## A

### Definitions<sup>4</sup>

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“The human immunodeficiency virus (HIV) is a retrovirus that infects cells of the immune system, destroying or impairing their function. As the infection progresses, the immune system becomes weaker, and the person becomes more susceptible to infections. The most advanced stage of HIV infection is acquired immunodeficiency syndrome (AIDS). It can take 10–15 years for an HIV-infected person to develop AIDS. Though there is no cure for HIV, antiretroviral (ARV) drugs can slow down the process even further.

HIV is transmitted through unprotected sexual intercourse (vaginal and anal), transfusion of contaminated blood, sharing of contaminated needles, and between a mother to her infant during pregnancy, childbirth and breastfeeding.”<sup>5</sup>

## B

### HIV epidemic

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According to the 2010 Global Report of UNAIDS<sup>6</sup>, there are 33.3 million adults and children living with HIV in the world, with the heaviest account in Sub-Saharan Africa (22.5 million), followed by 4.1 million in South and South East Asia. To date, women living with HIV represent approximately 52% of all cases. In Sub-Saharan Africa, around 60% of people living with HIV are women, thus confirming the alarming feminization of the epidemic.

Global statistics demonstrate that HIV and AIDS is not only mostly affecting women (including pregnant women), but also youth (especially females), sex workers (SW), uniformed personnel, injecting drug users (IDU), men who have sex with men (MSM) and other vulnerable populations, such as persons with disabilities. HIV and AIDS is primarily a result of the key drivers of poverty, gender disparity and human rights abuses which increase vulnerability and exposure to HIV. According to several reports<sup>7, 8, 9, 10</sup>, the socioeconomic impact of HIV and AIDS are profound and have severe human costs affecting family structures and the social fabric of communities, disturbing demography, affecting existing health care systems, reducing labour productivity and food security, and engendering more poverty and inequality.

Despite the grim statistics detailed above, since 1999 (the year in which it is thought the epidemic had peaked) the number of new infections has fallen globally by 19%. Of the estimated 15 million people living with HIV in low and middle income countries who need immediate treatment, 5.2 million already have access. This means fewer AIDS-related deaths. These improvements are mainly attributed to international mobilization and national<sup>11</sup> commitments to respond to the epidemic, and increased financial resources to prevent HIV and



# C

## HIV and disability

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fight against the impact of AIDS. More specifically, a number of major international programmes and initiatives have been aimed at curbing the HIV epidemic, in particular the Millennium Development Goals (MDG) established in 2000, the WHO/UNAIDS 3x5 initiative in 2003, the establishment of the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), the World Bank Multi-Country Aids Programme and the US President's Emergency Plan for AIDS Relief (PEPFAR). More recently, the Global Health Initiative (GHI) has pledged to contribute 51 of its 63 billion USD budget to respond to AIDS, Tuberculosis and Malaria in the coming years. Needless to say, it is necessary for financial investment to match increasing demands to respond to HIV and to address the deep-seated structural issues and factors fuelling the epidemic.

As a key development issue, Handicap International has been involved in the global HIV response since 1994, with its first field interventions in Burundi. Handicap International was one of the first organisations to speak about the interrelation between HIV and disability in the context of developing countries, spearheading the Africa Campaign on Disability and HIV and AIDS<sup>12</sup>.

The primary rationale for Handicap International's operational strategy on HIV and AIDS concerns the marked vulnerabilities to HIV of persons with disabilities who constitute approximately 15.6% (11.8–18.0%) of the world's population<sup>13</sup>.

Persons with disabilities have an equal or heightened risk to HIV infection<sup>14</sup> compared to non-disabled persons. This challenges the common misconception that persons with disabilities are sexually inactive and do not require HIV or sexual reproductive health services. Indeed there is a broad range of discriminatory practices and social stigma that contribute to the vulnerability and social exclusion of persons with disabilities, such as limited access to basic services (in particular health, education, transportation.) and specifically, a lack of accessible HIV information and services.

To date, HIV and AIDS remains one of the most widespread disabling epidemics worldwide. The disease leads to impairments, activity limitations and reduced social participation. This has a severe impact on quality of life, both for people infected with HIV and AIDS and their affected families and communities<sup>15</sup>. More specifically, HIV is now considered a chronic and cyclical disease, with periods of wellness and illness. HIV is a complex and multi-systemic disease affecting the cardio-respiratory, neurological and musculoskeletal systems of the body. This, in turn, requires a multi-dimensional response to disease

prevention and rehabilitation interventions<sup>16</sup>. Indeed, any person living with HIV is likely to experience temporary and/or chronic impairments at different phases of the illness, due to acquired infections and/or side effects from taking antiretroviral drugs. Persons with disabilities who become HIV positive might also undergo similar processes of activity limitations, in addition to existing impairment(s). According to the World Health Organization's (WHO) community-based rehabilitation (CBR) guidelines<sup>17</sup>, rehabilitation becomes increasingly important for people who may be experiencing disability as a result of HIV and AIDS.

Furthermore, in light of the Convention on the Rights of Persons with Disabilities (2007), asymptomatic people living with HIV can also be considered as disabled, due to exclusion from social participation as a result of stigma and attitudinal and environmental barriers related to their health status. To this effect, the UNAIDS Disability and HIV Policy Brief (2009)<sup>18</sup> recognises the interrelations between HIV and disability and stresses the importance of addressing both sectors in an integrated fashion. The salient points of the Policy Brief include:

- HIV risk behaviours among persons with disabilities;
- High vulnerability of persons with disabilities to sexual violence;
- Low access of persons with disabilities to HIV education, information and prevention services;
- Limited access of persons with disabilities to treatment, care and support;
- Importance of addressing rehabilitation needs among people living with HIV.

Based on a review of the national AIDS strategic plans (NSP) of 18 countries<sup>19</sup> in Eastern and Southern Africa, 50% recognise disability as an issue of concern or specifically recognise the vulnerability of persons with disabilities to HIV and AIDS. Only one country, South Africa, showed extensive integration of disability into the various focus areas of its NSP<sup>20</sup>.

More recently, the UNAIDS 2011–2015 Strategy<sup>21</sup> states that “when social support and other programmes for persons with disabilities are delivered in an HIV-sensitive manner, they contribute to overcoming the historic neglect of HIV prevention and support for persons with disabilities. The significantly under-reported rates of HIV infection and related disease and death among persons with disabilities also need to be tackled directly through AIDS programming efforts.”

In summary, there has been growing international recognition of the need to address the interrelationship between disability and HIV. Handicap International has been at the forefront of promoting this change. HIV and AIDS is a core development issue and this is fully recognised in Handicap International's strategy and programming.

# D

## HIV and sexual and reproductive health

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It is acknowledged that the majority of HIV infections globally are 1) sexually transmitted or 2) attributed to vertical transmission from mother to infant during pregnancy, childbirth or breastfeeding. These are two key areas addressed by basic sexual and reproductive health (SRH) service provision, which usually comprises: family planning, maternal and infant care, management of STIs and management of other SRH problems, such as cervical cancer and fertility issues. More importantly, sexual and reproductive ill-health and HIV share pervasive root causes, namely gender inequality, poverty, stigmatization and social marginalization of the most vulnerable populations, including women and men with disabilities.

Harmful gender norms are recognised as the key drivers of the HIV epidemic<sup>22</sup>, specifically those that reinforce the submissive role of women and girls, cross-generational sex, concurrent partnerships and gender-based violence. It is proven that prevention of unplanned pregnancies remains a cost effective and economically feasible way to prevent paediatric HIV infection in the majority of African countries. In addition, the dual method approach of combining condom use for HIV and STI prevention with longer-acting more effective contraceptives for added protection against pregnancy reduces the number of AIDS orphans<sup>23</sup>.

The main advantages for the integration of HIV and SRH services are that it tends to: decrease mortality from HIV and AIDS; reduce unintended pregnancy and perinatal transmission of HIV; increase the number of people getting tested for HIV; expand the reach of programmes and services to more target groups; reduce stigma and discrimination; increase access to and use of services; and address gender-based violence that can reduce the risk for HIV<sup>24</sup>.

Also, linkages created through integrated interventions can facilitate long-term follow-up for women who require treatment. Women living with HIV, identified through integrated services, can provide an entry point for testing and counselling of others in the family, potentially increasing testing rates and follow-up for male partners and other children<sup>25</sup>. Other benefits for people living with HIV include improvement in their quality of life through improved sexual and reproductive health<sup>26</sup>.

After many years of lessons learned from programming, the interactions between SRH and HIV are now widely recognised, with integration promoted at policy level. This is exemplified by the WHO's and UNFPA's Framework for Priority Linkages<sup>27</sup>. These specific linkages work in both directions, by integrating HIV-related issues in ongoing SRH programmes and sexual and reproductive health issues in HIV programming. This mainly concerns HIV testing and counselling, prevention of parent to child transmission, promotion of safer sex, connection between HIV and AIDS and sexually transmitted infections (STI) services, and integration of HIV in maternal, neonatal and child health (MNCH).

The International Community broadly agrees that the Millennium Development Goals will not be achieved without ensuring access to SRH services and an effective global response to HIV. This approach promotes and enhances SRH, while contributing to the reversal of the AIDS epidemic and mitigating its impact among vulnerable groups.

# E

### HIV, sexual and reproductive health and gender-based violence

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“Gender-based violence (GBV) is an umbrella term for any harmful act that is perpetrated against a person’s will, and that is based on socially ascribed (gender) differences between males and females. Acts of GBV violate a number of universal human rights protected by international instruments and conventions”<sup>28</sup>. The nature and extent of specific types of GBV vary across cultures, countries, and regions, ranging from sexual violence<sup>29</sup>, including sexual exploitation/abuse and forced prostitution, to domestic violence, physical violence, human trafficking, forced/early marriage and harmful traditional practices such as female genital mutilation/cutting, honour killings and widow inheritance.

Around the world, GBV has a greater impact on women and girls than on men and boys<sup>30</sup>—be they non-disabled or disabled. GBV can impact on health, emotional and psychological status, social aspects, communities and safety issues. Furthermore, the consequences of sexual violence are numerous and costly: they increase women’s morbidity and mortality (especially as they may face unwanted pregnancies), they increase risks of STIs and HIV, unsafe abortions, pelvic inflammatory disease, psychological trauma and mental health concerns, serious physical injuries and exclusion from family and community<sup>31</sup>. In many countries, the legal system is inadequately prepared or motivated to respond fairly to GBV cases<sup>32</sup>.

Action research undertaken in Kenya<sup>33</sup> has demonstrated that physical and sexual violence within relationships often leads to repeated exposure to SRH risks, and abused women lack knowledge about the impacts of sexual violence, experience feelings of hopelessness about their health and are unable to access the health services (as well as legal, police and psychosocial support)

they need. WHO<sup>34</sup> reports that GBV is a major global health problem predisposing women and girls to numerous negative social and health outcomes, including HIV infection. The consequences of such sexual violence also affect children, and families, and also the community and society at large, as a result of stigma and marginalization.

Ideally, primary health care, SRH and HIV testing and counselling services can all be an entry point for responding to HIV and GBV. For key integration strategies, some evidence indicates that integrating multiple approaches to HIV prevention is more effective than single-approach strategies<sup>35</sup>. This includes combining the following approaches: 1) behavioural (building condom-negotiation skills); 2) biomedical (increasing access to emergency HIV prophylaxis); and 3) structural approaches (developing laws and policies that positively impact gender norms). In addition, effecting both individual and collective efficacy through methods that generate interpersonal and community dialogue are aspects of the many programmes that achieve positive results.

Hence, addressing violence against women and HIV and AIDS simultaneously can reduce incidence of both and can have a positive impact on the lives of women and their families<sup>36</sup>. Moreover, according to Campbell (2002), GBV is increasingly seen as a risk factor for a variety of conditions and diseases and not just as a health problem in, and of, itself<sup>37</sup>.

For the many reasons detailed above and also the lessons learned in the field of GBV protection services in Africa<sup>38</sup>, it makes sense to integrate GBV to SRH and HIV programming and services provision. This is also much more effective economically. Norman et al. (2010) report that cost-effectiveness analysis can demonstrate that addressing GBV in health care settings will provide net savings in terms of improved outcomes and reduced expenditures on health, social and legal services<sup>39</sup>.

This, in turn, will enable women, men and communities to better address social and gender inequalities in a more effective and efficient manner.



What about disability-based violence?

As seen in the previous section, GBV is well documented and recognised as a central problem to tackle when public health issues, including HIV and AIDS, are at stake. It is also acknowledged that consequences of violence against women and girls (as well as men and boys) stem from deep-rooted, harmful gender-related norms. However, somewhat less acknowledged are the many factors and conditions that make persons with disabilities more prone to violence, not only due to gender considerations, but also because of their disability. According to studies carried out in various countries of the European Union and in America<sup>40</sup>, data show that persons with disabilities are survivors of abuse on a far greater scale than their non-disabled counterparts, varying from two to five times more. They suggest that women with disabilities, especially those with severe physical, learning or communication impairments are at particularly high risk of suffering from different forms violence and a severe lack of social protection.

Based on the same studies, it has been reported that attitudes and structural societal barriers as well as specific barriers due to different impairments make women with disabilities more vulnerable to violence. For example:

- Reduced physical capability for self-defence ;
- Greater difficulties to be understood when reporting maltreatment due to difficulties in communication;
- Lack of accessible information and counselling services, mainly due to physical and communication barriers;
- Lower self-esteem and disregard of their image as women, due to ongoing discrimination;
- The misconception that women with

disabilities do not have the same social roles as those traditionally assigned to other women;

- A greater degree of dependence on other people for care, particularly carers providing personal support for bathing, grooming or dressing, who can abuse a position of power;
- Fear of reporting violence, as it might cause the breaking of bonds (with family and community) or the loss of a specific carer;
- Having to live in environments that favour violence; broken homes, institutions, residences and hospitals (whereby carers can exploit situations for their benefit);
- Less credibility when reporting these attacks in certain institutions (“Who would want to have sex with women with disabilities?” being a commonly entrenched negative view).

Preliminary findings of a study by Handicap International in Ethiopia<sup>41</sup> suggest that persons with disabilities are vulnerable to sexual and gender-based violence mainly because perpetrators consider them as “easy prey”. This can be attributed to the fact that there is often a general societal acceptance of violence towards persons with disabilities. Furthermore, in cases where acts of violence have been committed, persons with disabilities are less likely to disclose or report the attack because of sexual shame, fear of retribution (from family members who are often the perpetrators), and a lack of trust in services providers to offer adequate and respectful care and treatment. This latter aspect has been supported by Barile (2002)<sup>42</sup> who reports that the resources available to non-disabled women who have survived violence are often not accessible to women with disabilities.



# F

## Inclusive<sup>46</sup> and integrated<sup>47</sup> HIV programming

The International Network of Women with Disabilities<sup>43</sup> reports that one of the main factors behind the higher incidence of violence against persons with disabilities is the stigma associated with impairment whereby they are considered by society to be “not completely human and of less value” and not able to contribute to community/society development. It has further been suggested that some forms of violence against women with disabilities have not been visible as GBV because of heightened discrimination based on disability. To this effect, it is important to promote the concept that violence against women and girls with disabilities is “not just a subset of gender-based violence: it is an intersectional category dealing with gender-based violence and disability-based violence”. The combination of these two factors results in an extremely high risk of violence against women with disabilities.

According to Narvaez (2010)<sup>44</sup>, this greater vulnerability is also linked to the negative social image of women with disabilities and to the frequently irrational explanations given to justify sexual abuse against them. Thus many girls and women with disabilities experience exploitation, violence and abuse at home or elsewhere. Such violence includes rape, forced sterilization, coerced abortions and involuntary treatment. It has been further argued that actions of this type can amount to torture or inhuman or degrading treatment. To this effect, available data, though scarce, reveals that women with disabilities face a higher rate of violence than men with disabilities; and men with disabilities experience a higher rate of violence compared to non-disabled women<sup>45</sup>.

Sexual and reproductive health programmes address all three of the health MDGs:

- Child survival in prenatal care;
- Maternal health in prenatal, childbirth, post natal care, family planning and abortion services;
- HIV/STIs services, including prevention of vertical transmission.

However “the absence of persons with disabilities in the MDGs has had a consequence that plans and programmes established by many developing countries to meet the MDGs have not adequately taken into account persons with disabilities. MDG 5 on maternal health and its target of reduction of maternal mortality largely ignores the situation of women with disabilities. While disability is often cited as a result of the lack of maternal health, almost never are women with disabilities considered when addressing maternal health issues”<sup>48</sup>.

Furthermore, SRH and HIV services, especially for women with disabilities, are often inaccessible, developed without the concepts of universal design or reasonable adjustment in mind. Some reasons are as follows:

- Lack of knowledge among health professionals about disability, the rights of persons with disabilities to be sexually active, and how specific impairments may impact on HIV/SRH issues;
- Inappropriate attitudes among health professionals who often believe that women with disabilities should not have children or are incapable of having children;
- Lack of accessibility to relevant health facilities due to structural and physical barriers as well as difficulty in accessing available and affordable transportation;
- Communication barriers between the health professional and women with disabilities, for example general public

health campaigns, including those related to contraception and family planning, are often not accessible to many women with disabilities.

In addition to this, persons with disabilities, particularly women, are more at risk of GBV which can not only lead to STIs and HIV infection<sup>49</sup>, but also to physical injuries and psychological trauma. Women with disabilities are subject to higher rates of sexual assault and partner/domestic violence. Enarson (2009)<sup>50</sup> suggests the rate is as much as twice that of non-disabled women, while, a global study on disability and HIV by the World Bank and Yale University<sup>51</sup> suggests it is up to three times more. Although sexual violence is a reality for many persons with disabilities in Africa, most cases go unreported, which further increases vulnerability to economic dependency, sexual exploitation and health-related consequences<sup>52</sup>.

This view that persons with disabilities are highly vulnerable to HIV and AIDS is in keeping with the general recognition that marginalized, stigmatized communities with limited access to basic human rights are frequently at higher risk of HIV infection and feel the impact of HIV and AIDS more significantly<sup>53</sup>. In this context, women and men with different impairments (physical, sensory and particularly intellectual and mental) have often been ignored in HIV prevention, treatment, care, support and impact mitigation services, along with SRH promotion and GBV protection services.

Handicap International promotes an inclusive approach to improving quality of life and access to services for persons with disabilities. This means that basic health care and socioeconomic services are developed according to the principle of Universal Access, where all people with

impairments (whether physical, sensory, intellectual or mental), have equal access and opportunities for participation. This inclusive approach also ensures that gender considerations and disparities are acknowledged as a cross-cutting issue.

These gaps highlighted can be redressed by advocating for disability inclusive and integrated HIV policies to SRH and GBV programming; enhancing capacities of health care professionals to provide appropriate and accessible information and services; structural changes in attitudes, policies and environment through removal of barriers and promotion of facilitators at all levels to foster equal social participation; improvement in enjoyment of Human Rights by women and men with disabilities; empowerment of disabled people's and community-based organizations; developing strategic partnerships at different levels; and developing evidence-based strategies for HIV programming. More detail on these strategies and modalities of interventions are explained in the subsequent section of this document.

# G

## Target populations for HIV-related projects

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Handicap International's interventions target persons with disabilities and other vulnerable groups facing social, cultural and economic exclusion in developing countries. These populations are often disregarded in national HIV response and excluded from prevention campaigns, and therefore left highly vulnerable to the impact of the epidemic. In response to HIV, Handicap International assures equal access to HIV prevention, treatment, care and support services, breaking barriers based on gender, social, cultural, disability or economic aspects.

Particular target populations with whom Handicap International is working on HIV are:

- Marginalized women and men of reproductive age;
- Persons with disabilities (women, men, boys and girls with physical, sensory, intellectual and mental impairments) and their families;
- Children, young women and men in and out of school;
- Women, men and youth living with HIV and their families;
- Orphans and vulnerable children and their families;
- Mobile populations;
- Survivors of GBV and their families;
- Ethnic minorities;
- Sexual minorities ;
- Prisoners.

In addition, Handicap International targets various service providers directly involved in health care or indirectly influencing it. Community and traditional/religious leaders are targeted for enforcing policy changes and promoting behaviour change at local level towards more sustainable outcomes. Handicap International works closely with Disabled People's Organizations (DPOs) and other community-based organizations, AIDS organizations, associations of people living with HIV, national AIDS authorities and health facilities.

# Cross-cutting approaches for interventions

Handicap International, throughout all its projects, including those on HIV and AIDS, follows the main principles of intervention as stipulated in the Federal Strategy 2011–2015<sup>54</sup>. These principles, detailed below, reflect the essential characteristics of institutional and operational positioning for the organisation:

- Beneficiaries and level of intervention: focus on participation, emphasis on most vulnerable populations, gender, childhood and old-age issues;
- Methods of intervention: focus on emergency and a relief-rehabilitation-development continuum;
- Coordination, partnership and sustainability;
- Quality and impact: focus on situational and needs assessment combined with knowledge management;
- Conceptual frameworks, approaches, references and methodological tools;
- Use of law: in reference to universal human rights instruments, international humanitarian law and in consideration of national laws and customs;
- Testimony and advocacy;
- Impartiality;
- Responsibility and transparency: at individual and organisational levels.

These principles of intervention:

- Apply when implementing any Handicap International projects;
- Determine the practical orientation of choices and methods of intervention;
- Provide a framework for approaches and methods used to design and implement project activities.

Handicap International's HIV-related initiatives, specifically for implementing integrated and inclusive HIV prevention, treatment, care and support services must ensure:

- A disability inclusive approach, responsive to the needs of people with all types of impairments;
- A comprehensive approach;
- A gender inclusive approach;
- An approach which fully acknowledges and responds to fundamental human rights.



# A

## Human Rights and HIV

---

Approaches developed by Handicap International regarding HIV and AIDS are human rights sensitive: they consider HIV and AIDS from a broad perspective related to the dignity of human beings and their rights to access HIV/health care and services without discrimination. However this field-based, rights sensitive approach of Handicap International must be distinguished from the concept of a Human Rights-Based Approach to Development, even though some of its elements are similar.

The Human-Rights Based Approach to Development consists of applying a 'human rights lens' to development. It was developed by the UN and entails five key notions:

- A systematic reference to human rights (realisation of human rights as the objective, covering all rights as they are indivisible and interdependent, in all sectors);
- Accountability (of duty-bearers including the State, policy-makers, professionals, parents, etc. towards right-holders, i.e. in our case persons with disabilities);
- Empowerment and development of capacities is considered as a goal;
- Participation is the main methodology;
- Non-discrimination and attention to vulnerable groups (paying specific attention to the most vulnerable and marginalised).

This approach has by now been incorporated into the policies, programming and working methods of the vast majority of international development actors, as a way to bridge the gap between human rights and development, which for too long had evolved in separate spheres.

Since its creation in 1982, Handicap International has always actively promoted the human rights of people with disabilities (which includes people living with HIV), recognising this as a key reference point for defining interventions. However Handicap International's programming is not specifically guided by the five key notions outlined, but by a broader set of tools and approaches derived from practical experience over many years.

### **Human rights to health within the context of HIV and AIDS<sup>55</sup>**

The general concept of the right to health made its first appearance in Article 25.1 of the Universal Declaration of Human Rights (UDHR) in 1948. The idea of the right to health was then isolated and defined somewhat more precisely in the 1966 International Covenant on Economic, Social and Cultural Rights (ICESCR article 12). It emphasizes the "right of everyone to the enjoyment of the highest attainable standard of physical and mental health". This includes steps related to the treatment and control of epidemic diseases, such as access to affordable HIV-related medications, and the creation of conditions which would ensure access to all medical services and medical attention in the event of sickness. Additionally, the right to health is recognized in the International Convention on the Elimination of All Forms of Racial Discrimination of 1965 (article 5). The importance of the ICESCR lies in the fact it was the first human rights treaty to require states to recognize and progressively realise the right to health, and it provides key provisions for the protection of the right to health in international law. In the case of health care, governments are under an obligation to provide measures to prevent, treat and control epidemic and endemic diseases (including HIV and AIDS).

'General Comment No.14' of the Committee on Economic, Social and Cultural Rights (2000) is a groundbreaking document which greatly assists in the design of a rights-based approach to health. It underlines the links between the right to health and other human rights. It specifies the right to the highest attainable standard of health. The Committee notes that the right to health includes physical accessibility, i.e. health facilities and services should be within safe physical reach for all sections of the population, especially vulnerable or marginalized groups, such as persons with disabilities.

The UNGASS Declaration of Commitment, the Millennium Declaration and Development Goals and the establishment of the Global Fund to Fight AIDS, Tuberculosis and Malaria all reflect a commitment to an international engagement on health, and particularly HIV and AIDS. The International Guideline on HIV/AIDS and Human Rights 1996, updated in 2002 and 2006, was designed as a tool for States "to assist in the designing, coordinating and implementation of effective national HIV and AIDS policies and strategies".

In 2002, a revised 'Guideline 6: Access to Prevention, Treatment, Care and Support' was adopted, providing up-to-date policy guidance to reflect recent changes in medical treatment and international law concerning HIV and AIDS. The International Guidelines have been accorded considerable weight by the Commission on Human Rights and other U.N. human rights institutions. The guidelines cover discrimination and other issues relating to confidentiality in HIV testing and partner notification as well as criminal laws related to HIV and AIDS.

Additionally, the International Guidelines on HIV/AIDS and Human Rights and Political Declaration of the United Nations General Assembly are two frameworks that provide

stakeholders with valuable direction on how to approach HIV with respect to law and policy<sup>56</sup>.

In December 2006, the United General Assembly adopted the Convention of the Rights of Persons with Disabilities (UNCRPD) with many articles referring to the principles of universal design and reasonable accommodations for persons with disabilities. Specifically, Article 9 on Accessibility stipulates that State Parties "shall take appropriate measures to ensure to persons with disabilities access, on an equal basis with others, to the physical environment, to transportation, to information and communications, including information and communications technologies and systems, and to other facilities and services open or provided to the public, both in urban and in rural areas". Article 25 on Health recognizes that "persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability. State Parties shall take all appropriate measures to ensure access for persons with disabilities to health services that are gender-sensitive, including health-related rehabilitation". At the United Nations level, a Guidance Note<sup>57</sup> on how to specifically include the rights of persons with disabilities into UN programming at country level has been issued in August 2010 and this will provide further strength to the global implementation of the UNCRPD. Handicap International was actively involved in the elaboration of the UNCRPD and now continues to promote and support its effective implementation at all levels.

More recently, the UNAIDS Strategy for 2011-2015 reasserts its pledge on human rights as one of its three strategic directions towards ensuring Universal Access and mentions for the first time the

# B

## Adopting a comprehensive approach

need to include persons with disabilities in comprehensive HIV prevention interventions.

### Reinforcing human rights through non-discrimination and attention to the most vulnerable groups

Handicap International strives to ensure access to adequate HIV information and services for people who are highly vulnerable to infection or to the impact of the epidemic. In particular this refers to people who experience violations of their rights to move freely, work or obtain access to treatment as a result of their social, economic, geographic or cultural and sexual identity<sup>58</sup>. These highly vulnerable groups include persons with disabilities, isolated rural populations, ethnic minorities, nomadic groups, refugees, residents of post-conflict settings, seasonal labourers, migrant populations, street children, AIDS orphans, survivors of sexual violence, youth, and so on. Handicap International has a clear role to play in achieving the same human rights for people at risk and vulnerable to the impact of HIV in the communities it serves.

Handicap International is one of many emergency and development stakeholders endorsing a comprehensive approach in response to HIV and AIDS. This approach not only targets people who are already infected, but also aims to prevent or decrease transmission for high risk populations and to mitigate the impact of the epidemic for affected individuals, their families and communities. The following diagram outlines the interplay between different elements of the comprehensive approach from the community to international levels, and from prevention to rights and social participation. It is to be noted that the different components on both axes should not be viewed from a linear perspective, but rather in multidimensional and multidirectional way.

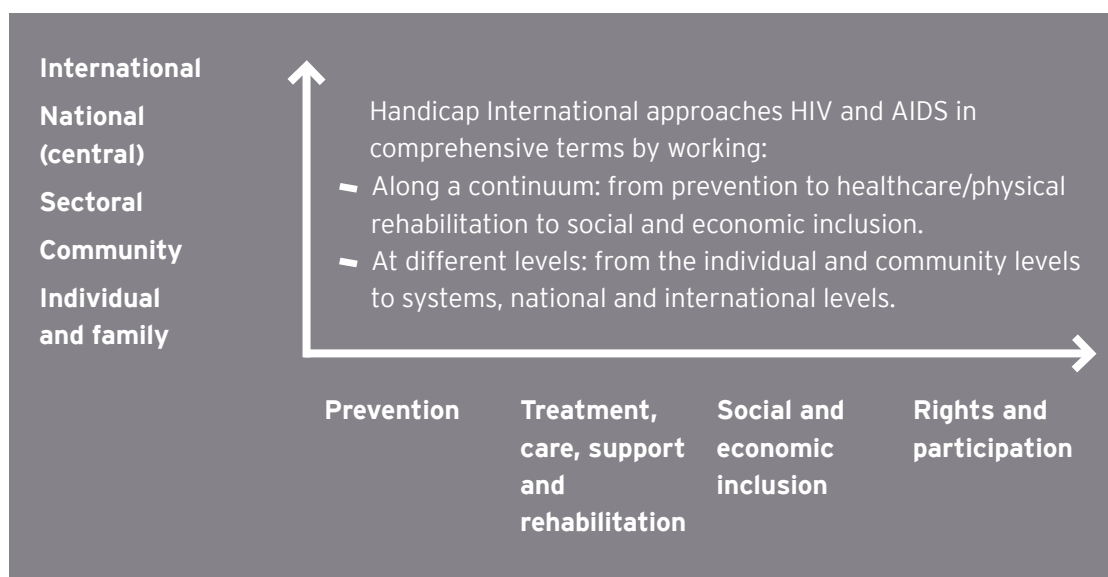


Figure 1: Comprehensive approach at Handicap International

By adopting a comprehensive approach to HIV and AIDS, Handicap International aims to complement or strengthen existing initiatives that respond to the needs of disabled and non-disabled women, men and children living with HIV and their families. This requires developing effective **partnerships**, which capitalise on the specific strengths of organisations while also linking actively with other organisations to address any gaps and thereby ensure a comprehensive response. The Appendices to this document highlight the minimum levels of partnership and related-actions at different levels that can be undertaken.

Handicap International has particular strengths derived from 29 years of working in partnership and collaboration with actors from the social, education, employment, agriculture, and other development sectors. These non-health sector partners are critical in the response to HIV and AIDS today. Handicap International therefore has a clear role to play in accompanying these non-health partners to adapt their core business to cope with the realities of HIV and AIDS.

**The goals and outcomes of a comprehensive response to HIV should not be achieved by Handicap International working alone. Rather, it is expected that they will be achieved over time by developing partnerships and building alliances with relevant organizations and working through well-established networks.**

The response to the HIV epidemic in communities where a significant proportion of the population is infected cannot be left only to the institutions and NGOs specialized in this domain. Handicap International also has an ethical and social obligation to

mainstream HIV into its own programmes with the realization that the epidemic is a challenge to development itself. This process of mainstreaming HIV in field programmes began in 2006 with the establishment of an **HIV Workplace Policy**<sup>59</sup>. This document aims to ensure that all Handicap International staff have access to HIV information, testing, care and means of prevention locally, but also that the organisation fosters an open, non-discriminatory environment where social dialogue is nurtured. For instance, with Handicap International's actions against mines and the focus on physical and functional rehabilitation, there is real opportunity to work with personnel who have received little attention from national HIV education programmes targeted at professionals. Furthermore, where partnerships are built with actors from the education, agricultural, economic, social, transportation, or urban planning sectors, Handicap International has both the opportunity and the obligation to equip these actors with the information they need to avoid transmission of HIV and reduce its impact on the lives of partners and key populations.

Through participatory planning, programming and design, systematic implementation of baseline studies, result-based management (RBM) at different levels of results, rigorous monitoring and evaluation, communication and knowledge exchange, Handicap International strives to ensure a **quality approach** for accountability to beneficiaries and partners and as a prerequisite for sustainable action.



# C

## Adopting a disability inclusive approach

---

Disability is a dynamic process that “results from the interaction between persons with impairments and attitudinal and environmental barriers that hinders their full and effective participation in society on an equal basis with others” (UNCRPD 2006). This definition of disability is further elaborated by the Disability Creation Process<sup>60</sup>, a model endorsed by Handicap International, which explains disability as the interaction between personal and environmental factors stemming from causes and consequences of disease, trauma and other disruptions to a person’s integrity and development, with a strong emphasis on social participation.

In order to better guide project development and implementation, and specifically to operationalize these broader concepts of disability, Handicap International has produced a policy paper on Inclusive Local Development<sup>61</sup>, with the following key elements:

- Inclusive Local Development is a development model that promotes equality and the widest social participation at the grassroots level;
- It allows persons with disabilities to enjoy the same rights as any other member of society and to be sources of knowledge and expertise regarding the design and implementation of policies;
- It means that development policies, programmes and projects are designed and evaluated with regard to the impact on the lives of persons with disabilities as well as others in the wider community.

Ensuring an inclusive local development approach to HIV requires:

**1) Mainstreaming disability in HIV at all levels, whereby persons with disabilities’ concerns and experiences are integral to the design, implementation, monitoring and**

evaluation of HIV policies and programmes in all political, economic and societal spheres, to ensure equal access to services.<sup>62</sup>

**2) If necessary, the creation of specific HIV services to meet the critical needs of persons with disabilities, with efforts made to incorporate these into mainstream local services where possible.**

When adopting a disability mainstreaming approach to HIV, it is crucial to assess, implement and monitor project activities through a cross-impairment lens.

Concretely this means HIV-related projects take conscious and planned steps to systematically address barriers and promote facilitators related to access to HIV services for women and men with all types of impairments: physical, sensory, intellectual and mental - and at all levels: services, community, attitudes, policy and environment.

For example, when providing HIV awareness-raising or capacity-building, service providers and stakeholders need to be cognisant of the need for accessible communication formats. Information and prevention messages should be disseminated in formats accessible to people with intellectual or sensory impairments (for example Braille, large print, sign language and plain language). For more information on disability mainstreaming, readers are referred to: (1) the Disability Mainstreaming Guideline and its annexes on disability assessment checklists<sup>63</sup> produced by Handicap International in Cambodia and (2) two training manuals on inclusive HIV and SRH services<sup>64</sup> from Handicap International in Ethiopia. These documents provide details and specifics regarding strategies and interventions to be undertaken when mainstreaming disability and particularly for specific health sectors.

# D

### Adopting a gender-inclusive approach

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Nearly 30 years into the HIV epidemic, persistent gender inequality and human rights violations that put women and girls at a greater risk of vulnerability to HIV continue to hamper progress and threaten the gains that have been made both in preventing HIV transmission and increasing access to antiretroviral therapy<sup>65</sup>. Initially discovered among men who have sex with men, today HIV infects more women than men (globally 52% of all HIV infections affect women). In Sub-Saharan Africa, the HIV epidemic affects women in 60% of new infections in adults<sup>66</sup>. A national youth survey undertaken in South Africa further highlights the disproportionate burden of HIV infection in young women aged 15 to 19 compared to young men of the same age<sup>67</sup>.

Women and girls are biologically more vulnerable to HIV transmission, which compounds differences in social factors such as economic dependence, lower levels of education, difficulties in negotiating safer sex, lack of information and means of prevention, as well as less access to HIV-specific health care compared with their male counterparts. Furthermore gender roles and power disparities limit their ability to follow the ABCCC<sup>68</sup> approach to prevention: practice abstinence; be in monogamous relationships; demand condom use; be conscious of one own HIV status; or insist that male partners be circumcised<sup>69</sup>.

Women and girls with disabilities also face vulnerabilities; they are at higher risk of sexual violence than non-disabled women and experience negative consequences of being neglected by mainstream health and social services providers, which increases risk to HIV and SRH problems. When addressing gender issues, it is important that women with disabilities are not invisible, and vice versa, addressing disability issues should not ignore gender<sup>70</sup>. Otherwise, this only will perpetuate the situation of multiple discriminations faced

by women and girls with disabilities. Although it is acknowledged that women, due to gender discrimination, often experience higher levels of marginalisation and social exclusion, this cannot be effectively addressed without taking into account the needs and interest of both women and men. All activities at Handicap International are underpinned by a commitment to equal access to fundamental rights for women and men – both disabled and non-disabled, who must be fully empowered to enjoy their economic, social, cultural, civil and political rights. According to Handicap International's Gender Policy<sup>71</sup>, three main principles are promoted:

- Non-discrimination and protection by ensuring equal treatment of women and men;
- Dual inclusion of gender and disability, with a particular focus on discrimination against women with disabilities;
- Gender mainstreaming as a project quality criterion with an attempt to systematically use gender-sensitive indicators to assess the impact of projects implementation on the situation of women and men and the relations between them.

Furthermore, Handicap International seeks to address HIV prevention, care and support in ways that take into account gender differences. This implies consideration of both male and female models of sexuality and the roles assigned to the two sexes with regard to HIV prevention and SRH promotion messages. In addition, Handicap International rejects traditional customs and practices (such as female genital cut/mutilation) which harm women or which make them even more vulnerable to the impact of HIV.

# E

## Reinforcing local capacities

---

For Handicap International, where appropriate, both male and female-specific means of protection and support to strengthen the social, economic and political roles of women in decision-making about HIV in communities will be promoted. To this effect, tailored strategies will be deployed to facilitate the engagement of men and boys in the gender discourse and challenge current harmful gender-based norms against and health-related practices towards women and girls.

Depending on the context and the needs assessment, specific activities for women may also be introduced to reduce inequalities between the sexes. Consequently, Handicap International endeavours to take into account different experiences, concerns and needs specific to both sexes, so that projects benefit both men/boys and women/girls to the same extent. This, of course, will not only require time, focused interventions and awareness-raising, but also strong and courageous leadership by all stakeholders to bring about changes.

Empowerment is commonly defined as a process by which a person, a group of individuals or a community acquires the capacities to change their situation and influence their environment. In the case of disabling illnesses such as HIV and AIDS, Handicap International projects strive to promote the integrity and dignity women, men, girls and boys at risk or living with HIV and their rights to the information and services necessary to improve their health. Handicap International also puts great emphasis on reinforcing the capacity of local groups or associations of people living with HIV and AIDS to meet their basic needs and to advocate for their fundamental rights. The ultimate goal of empowerment is to begin a process of social change whereby key political, economic or social decisions are directly shaped by those most affected.

# F

### Fostering participation

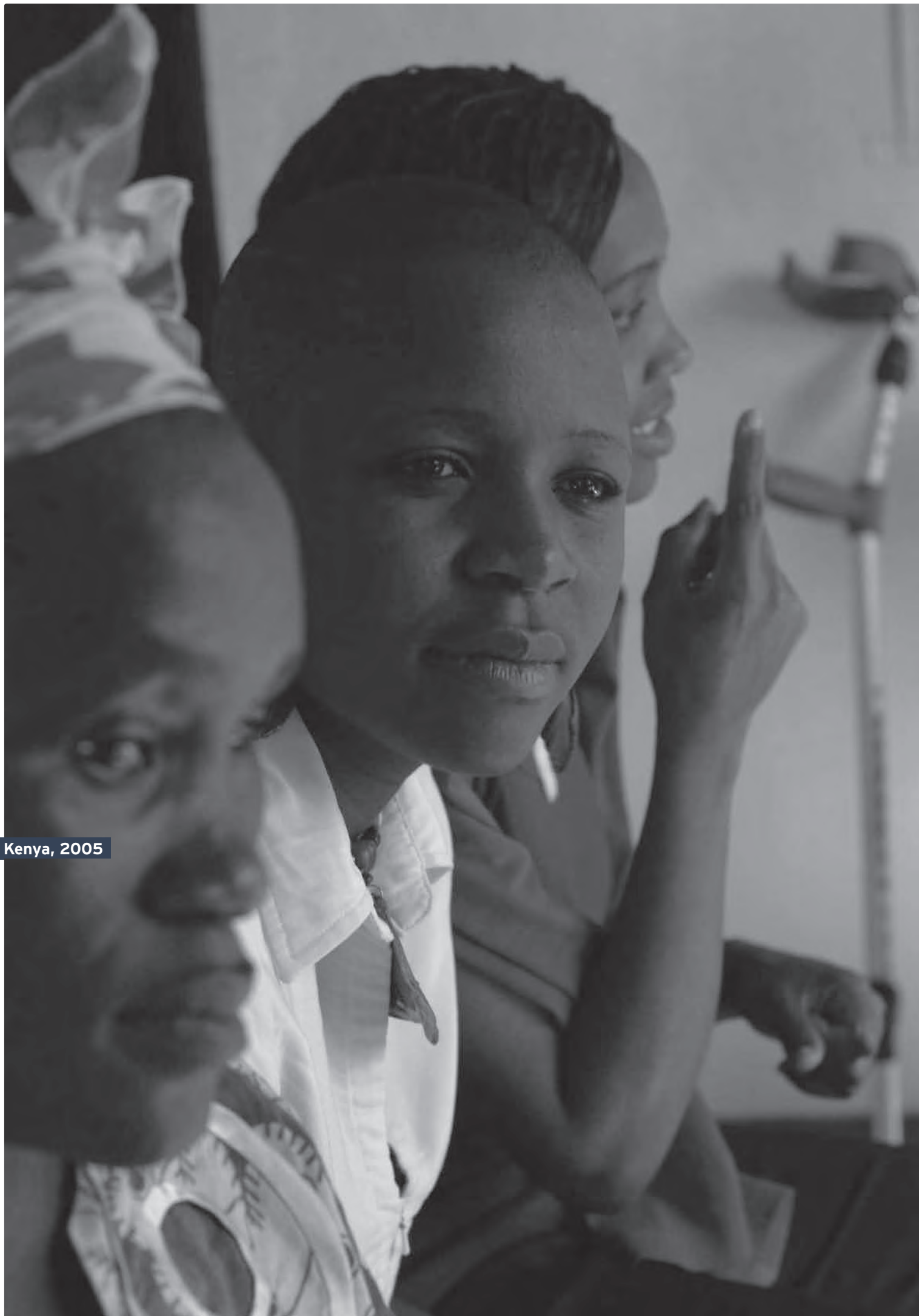
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Global experience has shown that the success of HIV prevention, care and support initiatives depends on the meaningful participation of people living with HIV themselves, as exemplified by the principle of the Greater Involvement of People Living with HIV (GIPA)<sup>72</sup>. Indeed, participation is essential to ensure the relevance and sustainability of a local response to HIV. It is also a growing preoccupation in crisis/relief contexts where issues regarding HIV and AIDS add additional complexity. Participation can be facilitated through setting up partnerships and close cooperation between people, service providers, decision-makers and other stakeholders alike at local, national and international levels.

In addition, there is a strong link between empowerment and participation whereby each component mutually reinforces the other. When an empowerment process is underway, people's capacity to participate is likely to be increased. Similarly, increased participation allows individuals and communities to enter a learning process with regard to their representation and "voice" on the issues that concern them. Participation is both a means and an outcome of the empowerment process.







Kenya, 2005

# Intervention methods

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# Intervention methods

## A

### Approaches and methodology

Based on the different rationales explained in the previous section, Handicap International's HIV programming adopts a disability-inclusive approach that is also integrated to sexual and reproductive health and sexual and gender-based violence services. More concretely, Figure 2 below illustrates an overview of the integration of HIV to SRH and GBV services by taking into account the inclusion of people with and without disabilities (including people with all types of impairments) throughout service delivery. The different components of the model and their interrelations with one another will be explained step by step in the following sections.

WOMEN/GIRLS AND MEN/BOYS  
WITH AND WITHOUT  
DISABILITIES  
MARPs



MOBILE/STATIC  
HTC SERVICES  
PPTCT

A.

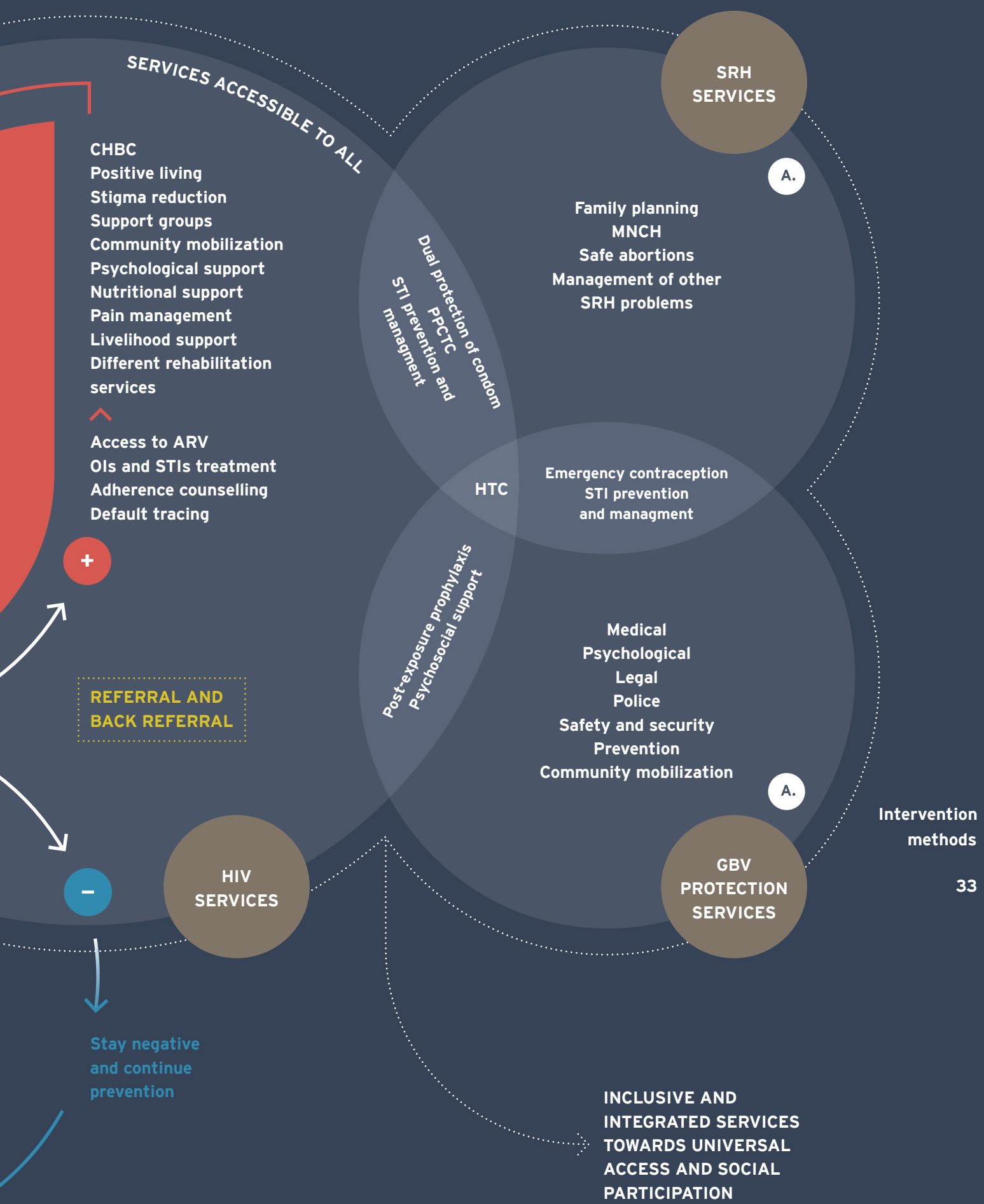
IEC  
BCC  
Awareness-raising  
Condom promotion  
Community mobilization  
Work with leaders  
Stigma reduction

**Figure 2: Disability inclusive and integrated HIV programming**

A.

Services need to be accessible to people with and without disabilities at project and organizational levels.





## Icons

If a thorough situational analysis and needs assessment has been conducted and if necessary resources are available, various actions outlined in Figure 2 can be progressively implemented over time, following a strategic and scale-up plan of action for specific target groups. Specific notes are provided in the text below to indicate the scope or limitations of Handicap International's interventions on HIV and AIDS. In particular, those

activities in the continuum of care that can be done with or without partnerships and the specific conditions and contexts which enable Handicap International to work will be explained.

Additionally, the set of icons below are used to further facilitate the understanding of readers, and specifically to guide HIV project developers and implementers throughout the document.

MP

**Minimum Package** of interventions, i.e. which need to be implemented through partnership or referral services, depending on the context.

IS

**Integrated Services** with other services, i.e. HIV services are integrated to SRH and/or GBV services, through partnership or referral services, depending on the context.

SU

**Scale-Up** of services, i.e. reinforcing activities for greater reach and impact for beneficiaries, through partnership or referral services, depending on the context.

A.

Services need to be accessible to people with and without disabilities at project and organizational levels.

Y<sup>f</sup>/  
G<sup>s</sup>

Services are **Gender Sensitive and Youth-Friendly** at project and organizational levels

# HIV prevention

## A

### Capacity building



Capacity building of human resources in various fields is central to effective project implementation and needs to take place in all of Handicap International's HIV-related projects. Training and exchange of know-how of Handicap International's staff and external organizations on integrated HIV prevention, treatment, care, support and disability inclusion is integral to HIV-related projects in order to embrace different views, instil positive behaviour changes, impart new knowledge and skills and improved service delivery by HIV-related project staff, health/HIV related professionals and authorities.

## B

### Awareness-raising



Coupled with capacity building and training of health service providers, raising awareness among target groups and beneficiaries, their families and communities is pivotal to HIV-related project implementation. Awareness-raising can be undertaken at community level through various methodologies, such as peer education, mass sensitization, utilization of radio and television programmes, Information, Education and Communication (IEC) material, magnet theatres, dialogue groups and community mobilization, all using a process of Behaviour Change and Communication (BCC). In all cases, these methodologies need to be adapted so they are accessible to all people with and without disabilities. In general, awareness-raising can be implemented in partnership with DPOs, AIDS organizations and CBOs or by referring to competent local providers.

## C

### Condom promotion



Promotion of the male and female condom is part of the minimum package in HIV prevention. It is important not only to ensure providing appropriate information on correct and consistent condom use, but also to make sure that access to condoms is facilitated. The use of condom further promotes the dual protection against HIV/STIs and undesired pregnancies. In all cases, the involvement of stakeholders (such as health and community workers, traditional and religious leaders, adolescents, sex workers) is sought for decisions on culturally acceptable delivery sites. In some countries or specific socio-cultural contexts where Handicap International implements HIV-related projects, condom distribution is not allowed. In those cases, Handicap International needs to discuss with, and build the capacity of, local/religious/traditional leaders to understand condom promotion as well as make sense of it within their particular contexts. Open space for dialogue with authorities is thus required before condom promotion begins.

## D

### HIV testing and counselling



Based on the needs of target populations, gender and socio-cultural factors and the health care system, HIV testing and counselling (HTC), (which is voluntary, confidential and comprised of pre-test counselling, testing and post-test counselling) can be provided in various formats to ensure access to all, such as through mobile, home-based or door-to-door outreach, at night (at moonlight<sup>73</sup>) or through facility-based services. This wide range of approaches enables service providers to reach population groups who can be otherwise neglected or who are often missed through static HTC services. Such groups include men, women who are not accessing SRH services, young people, rural populations with poor access to health care, marginalized groups facing stigma such as persons with disabilities, ethnic minorities and populations most at risk. Uptake of HTC services helps to break barriers, reduce stigma, promote discussion and encourage people to be tested. It is also the point of entry to an HIV continuum of care for those tested positive. In addition, HTC services can be readily integrated to perinatal care for pregnant women, SRH clinics and GBV medical management services. Based on the local context, Handicap International will have to analyse which type of HTC is best suited for target populations, and then implement this, either through partnership with local organisations, DPOs and AIDS organisations or by referring to other local public health providers and institutions.

# E

## Stigma reduction



Stigma and discrimination are perhaps the two most powerful deterrents to the effective uptake of HIV prevention, treatment and care services by vulnerable women and men and most-at-risk populations. In the case of some groups, such as persons with disabilities, MSM and sex workers, stigma and discrimination can be further exacerbated due to impairments, sexual orientation or profession. Stigma has been described as the “third epidemic” following the accelerating spread of HIV infection and the visible rise in AIDS cases<sup>74</sup>. If not addressed early on in HIV prevention strategies, projects’ actions might be counteracted or simply futile. According to seven years of data collection and research<sup>75</sup> on stigma reduction, analysis and lessons learned have revealed that there is a need to:

- 1) Increase recognition of stigma at different levels**
- 2) Decrease fear of HIV transmission through casual contact**
- 3) Decrease attitudes, values and beliefs leading to shame and blame to reduce stigma about HIV and AIDS at the individual, community and institutional levels.**

Furthermore, various studies suggest that successful strategies include: using education to correct misconceptions about the transmission of HIV, involving people living with HIV in the programmes, and engaging the community in the care and support of people living with HIV. In all its HIV and AIDS projects, Handicap International ensures close collaboration with, and high involvement of, beneficiaries, as well as partnership with key stakeholders, to devise stigma reduction strategies.

# F

## Prevention of transmission from parent to child



As much as HTC is becoming a standard in HIV prevention for different vulnerable groups and at risk populations, pregnant women should also be targeted in the scaling-up of prevention services to reduce vertical transmission of HIV to children. In order to remove and eliminate the stigma on mothers only, prevention of parent-to-child transmission (PPTCT) is preferred here to highlight the responsibilities of both parents for mother and child health. Activities under PPTCT involve<sup>76</sup>:

- HIV testing and counselling for pregnant women and their partners, as early as possible during a woman’s pregnancy;
- Clinical and immunological (CD4) assessment to determine eligibility of mothers for treatment;
- Antiretroviral therapy for eligible mothers for their own health or antiretroviral prophylaxis for mothers and their infants to prevent vertical transmission;
- Safer delivery practices;
- Counselling on, and support for, feeding infants and young children in the context of HIV.

Handicap International is not a direct PPTCT service provider. Specific PPTCT services can be provided by trained antenatal clinics, SRH facilities or family planning clinics as point of entry for counselling on safe pregnancies to reduce vertical transmission. When PPTCT are not available in project areas, either through public and/or private health facilities or project partners, referral to other competent services providers is necessary to ensure continuum of services and counter-referral for timely follow-up.

## G

### STIs prevention and management



Unprotected sex not only increases people's vulnerability to HIV infection, but also to sexually transmitted infections (STIs). These STIs, including syphilis, gonorrhoea and herpes simplex virus 2 (HSV2), may accelerate the sexual transmission of HIV<sup>77</sup>. It is therefore important to address STIs prevention and management when dealing with HIV prevention. Provision of syndromic treatment to clients presenting with STI symptoms can be provided in primary health care facilities, SRH clinics, referred from family planning facilities or provided in integrated HIV and SRH centres. In all cases, it is also important to advise STI clients to also ask their partners to seek treatment to reduce re-infection. In all cases, Handicap International needs to refer beneficiaries to relevant health/HIV and AIDS service providers.

## H

### Post-exposure prophylaxis



Post-exposure prophylaxis (PEP) is a short-term antiretroviral therapy to reduce the likelihood of HIV infection after potential exposure either occupationally or in non-occupational situations, such as in sexual violence and rape cases. WHO and UNAIDS recommend that health care settings provide PEP as part of a comprehensive universal precautions package to reduce staff exposure to infectious hazards at work and that survivors of sexual violence receive PEP in the aftermath of sexual assaults. In most countries where Handicap International is working, PEP is part of the National AIDS Strategy as well as in the clinical management of rape survivors. Hence when there are cases of sexual violence among projects' beneficiaries, Handicap International has the responsibility to refer and direct individuals and their families towards nationally recognised health facilities in order for them to receive PEP and other psychosocial and legal services, when necessary.

# I

## Male circumcision



It is estimated that male circumcision reduces risk of acquiring HIV from women to men by up to 60%, especially in sub-Saharan African countries with high rates of heterosexual HIV infection. As such, WHO and UNAIDS identify male circumcision as one of the priority HIV interventions for scaling up of services<sup>78</sup>. In many African countries where Handicap International is present, voluntary medical circumcision is promoted. In such cases, projects should foster increased awareness-raising on male circumcision, coupled with other HIV prevention measures, such as the correct and consistent use of condoms, followed by proper referral to designated health facilities, so that circumcision is done voluntarily, safely and medically.

# J

## Safe injection drug use



In many countries where Handicap International is working, the promotion of safe injection drug use still is not in place due to structural and policy barriers hindering people who inject drugs to safely access services such as HIV testing and counselling, needle and syringe programmes, condom promotion or antiretroviral therapy. In countries where policy space and dialogue can be envisaged, Handicap International's HIV projects, in partnership with other key stakeholders, can advocate for the availability of such services.

# K

## Blood safety

SU

It is unlikely that Handicap International will directly be involved, in any country, in ensuring the safety of blood supply and its rational use. However, Handicap International HIV-related projects should encourage people who donate blood or need blood transfusion to do so according to national standards of procedures to avoid introducing, and/or using, infected blood into the blood supply.

# Treatment, care and support including different types of rehabilitation

# A

## Diagnostic testing and counselling

MP A. Yf/Gs

Diagnostic testing and counselling should follow the standard operating procedures of each testing site and in accordance with national guidelines. Implementation of a quality system is crucial to ensuring reliable testing results and adequate counselling services. It is equally important that service providers only use nationally accepted procedures for HIV conventional and rapid tests. Along with internal evaluation of the performance of material/equipment and counsellors combined with technical supervision, external quality assurance exercises also need to be done on a regular basis by recognized competent bodies. Although Handicap International will not be directly involved in providing this kind of service, even when implementing HIV prevention-related projects, there remains a responsibility to contribute to ensuring that those providing the service are qualified and certified to do so.



## B

### Access to antiretroviral therapy



Wherever Handicap International's HIV-related projects are promoting the uptake of HTC among target populations, utmost efforts will be deployed to ensure that referral and access to antiretroviral therapy (ART) are locally available and that national operating guidelines are available. To this effect, a Handicap International position paper on the access to healthcare and medicine was developed in 2007<sup>79</sup>. This underscores the promotion of free access to drugs in countries where projects are implemented and that medicine purchase and/or donations should be a rare exception with stringent limitations on scope and duration. As much as possible it is recommended to adopt WHO's new ART guidelines<sup>80, 81, 82</sup> for scaling up access to treatment for adults, adolescents, pregnant mothers, infants and children. As a leitmotiv at the 18th International AIDS Conference held in Vienna (July 2010), "treatment is (also) prevention": prevention of HIV infection in sero-discordant couples, from parent to child, in occupational and non-occupational exposure, and in most-at-risk populations, such as MSM and sex workers. At this point, it is also important for clinical services providers to understand and address HIV-related impairments (found at clinical stages 3 and 4 of the progression of HIV infection and due to toxic side effects of specific ARVs), and refer clients to rehabilitation services. In cases related to ART, Handicap International will seek partnership with local health facilities and/or medical organisations/partners to ensure free delivery of ARV to clients who need treatment.

## C

### Adherence counselling



Once people living with HIV are enrolled in ART, it is of utmost importance to actively listen to their concerns, empower them to understand their treatment and adhere to the drug regimen, and to constantly provide feedback to their counsellors. It is therefore a crucial moment for therapeutic education to take place while counselling is provided<sup>83</sup>. Furthermore, this needs to be closely linked to psychosocial support system at community level and/or be linked to Handicap International projects on mental health for improved synergy and greater wellbeing of people living with HIV. Handicap International will have the responsibility to make sure that within their care, people living with HIV are referred to qualified counsellors/health staff.

## D

### Default tracing



In addition to adherence counselling, a mechanism for tracing back people that have stopped taking their medicine needs to be put in place to avoid further attrition of clients, drug resistance, stigma and exclusion. Tailored and accessible counselling should be adopted to improve quality of life of people living with HIV. This can be done in partnership with, or referral to, health facilities, AIDS associations, groups of people living with HIV, community home-based care groups and family members.

## E

### Prevention and treatment of opportunistic infections



Many people living with HIV are vulnerable to various opportunistic infections (OIs), including bacterial, fungal parasitic and viral infections, because of their depleted immune system. Prevention and proper management of these infections improves the quality and length of people's lives and may postpone the need for ART. For instance, Co-trimoxazole prophylaxis is a simple, well-tolerated and cost-effective intervention for adults and children living with HIV. It is used for the prevention of a wide range of infections, including pneumonia and toxoplasmosis<sup>84</sup>. Handicap International, in partnership with AIDS associations and health care providers, shall ensure the referral to, and access of, people living with HIV to OI treatment and services to contribute to the continuum of HIV care.

# F

## Management of co-infection (HIV/TB)



The problem of HIV-related tuberculosis (TB) remains a serious challenge for the health sector response to HIV. According to WHO/UNAIDS Progress Report (2010), revised estimates of TB cases among people living with HIV suggest that the risk for acquiring TB is 20 to 37 times greater among people living with HIV than in the general population depending on the prevalence of HIV in the population. In some countries in Sub-Saharan Africa, up to 80% of people with TB are also living with HIV. If dealing with HIV treatment and care, Handicap International will have to ensure the access of people living with HIV to HIV/TB co-infection management, through strategic alliances, partnership and/or referral to health facilities at community, district and provincial levels.

# G

## Treatment, care and support for children living with HIV



To scale up prevention, treatment, care and support services, diagnosing infants exposed to HIV during vertical transmission needs to be considered and reinforced among parents and health care providers. All HIV-exposed children should receive early virological testing at or around 4-6 weeks of age. Improved early infant diagnosis contributes to more timely coverage of treatment for infants needing ART and co-trimoxazole prophylaxis and decreased morbidity, disability and mortality. To this effect, Handicap International should be involved in direct treatment and care of children living with HIV, and should encourage parents to seek health care services and advocate health personnel to be able to provide such services along PPTCT set of activities, including addressing HIV-related disability and developmental delays.

## H

### Positive prevention



Positive prevention generally includes activities centred on four main goals<sup>85</sup>: 1) keeping HIV positive individuals physically healthy by assisting them have access to ART, OI treatment and management of co-infection; 2) keeping them mentally healthy through psychological support and counselling; 3) preventing further transmission, specifically by promoting disclosure, further HIV testing, counselling and condom use, for sero-discordant couples in particular; and 4) involving people living with HIV in prevention activities, leadership and advocacy, by fostering their social participation and a positive outlook to living with HIV. This strategy needs to take place at the community level and with the removal of as many attitudinal and environmental barriers as possible. Hence when designing HIV-related projects, Handicap International will have to consider integrating this set of activities within its implementation. This can also be done in partnership with local organisations as well as by referring to DPOs, AIDS organisations, CHBC groups, CBR members and health facilities.

## I

### Community home-based care



According to WHO<sup>86</sup>, community home-based care (CHBC) is broadly defined as any form of care given to ill people in their homes. Such care includes physical, psychosocial, palliative and spiritual activities. These can also be encompassed within rehabilitation services in the larger sense. The goal of CHBC is to provide hope through quality and appropriate care that helps people and their families maintain their independence and achieve the best possible quality of life. CHBC also includes working with the community to 1) reduce stigma and discrimination against people living with HIV, 2) prevent the further transmission of HIV and 3) mobilize the community resources for people living with HIV and their families<sup>87</sup>. Hence CHBC relies on the participation of families, communities and health facilities, as well as reinforces prevention with positives, whereby prevention of further spread of HIV infection and improvement of quality of health and wellbeing of individuals and their families are sought.

The following points, although not detailed or exhaustive, outline several possible activities for a CHBC programme:

➤ **Basic physical care**

- Basic nursing care<sup>88</sup> which includes positioning and mobility, bathing, wound cleansing, skin care, oral hygiene, adequate ventilation and guidance and support for adequate nutrition;
- Symptom (such as fever, pain and diarrhoea) management.

➤ **Psychosocial support and counselling**

- Interpersonal communication and counselling;
- Spiritual support and guidance;
- HIV testing and counselling that is both voluntary and confidential;
- Mobilizing family and community support;
- Care for the caregiver and family members involved;
- Confidentiality and autonomy;
- Mental health services when necessary as part of the continuum of care.

➤ **Care of affected and infected children**

- Basic health support;
- Nutrition and food;
- Educational support and vocational training;
- Psychosocial support;
- Shelter;
- Social protection.

➤ **Palliative care**

- Pain management;
- Spiritual and emotional support and promoting death with dignity;
- Anticipatory guidance;
- Inheritance rights;
- Bereavement counselling.

Projects/programmes that intend to implement CHBC are recommended to take into consideration national guidelines for CHBC minimum package, with the mindset that one single organisation cannot do it all and thus links should be established with locally available CBR programmes and services. It is important to implement CHBC with a broad base of committed partners and stakeholders. Given the extent of areas that can be covered, there is also a need to scale-up activities over time by putting an emphasis on strengthening community-based groups (such as support groups, DPOs and CBR groups), associations and organizations, alongside family members and caregivers. Handicap International shall select those CHBC activities that it can effectively implement in close partnership with key services providers or otherwise refer altogether to other stakeholders when solely implementing HIV prevention projects.

# J

## Different types of rehabilitation services



### Physical rehabilitation

There is a direct need to link people living with HIV to physical rehabilitation services, specifically regarding the emergence of temporary and/or chronic impairments leading to blindness, deafness and decreased mobility for example, and also the toxic side effects of specific ARV drugs still in use in first line regimen therapies in many developing countries.

Physical rehabilitation often offers various services, such as physiotherapy, occupational therapy or the provision of assistive devices to enhance mobility and functional rehabilitation (see next figure below). Specifically, they might be provided in the context of physical rehabilitation centres, CBR programmes, and outreach

services provided by professionals such as physiotherapists, occupational therapists, prosthetics, orthotics technicians and CBR workers, as well as in close collaboration with family and community members. Many of these activities are implemented by Handicap International throughout the world. Furthermore, there is also a need to include more mental health and psychosocial counselling for people living with HIV that are daily coping with their health status and changes at individual, family, community and societal levels. This has been highly supported by studies and experiences by the Canadian Working Group on HIV and Rehabilitation<sup>89</sup>.

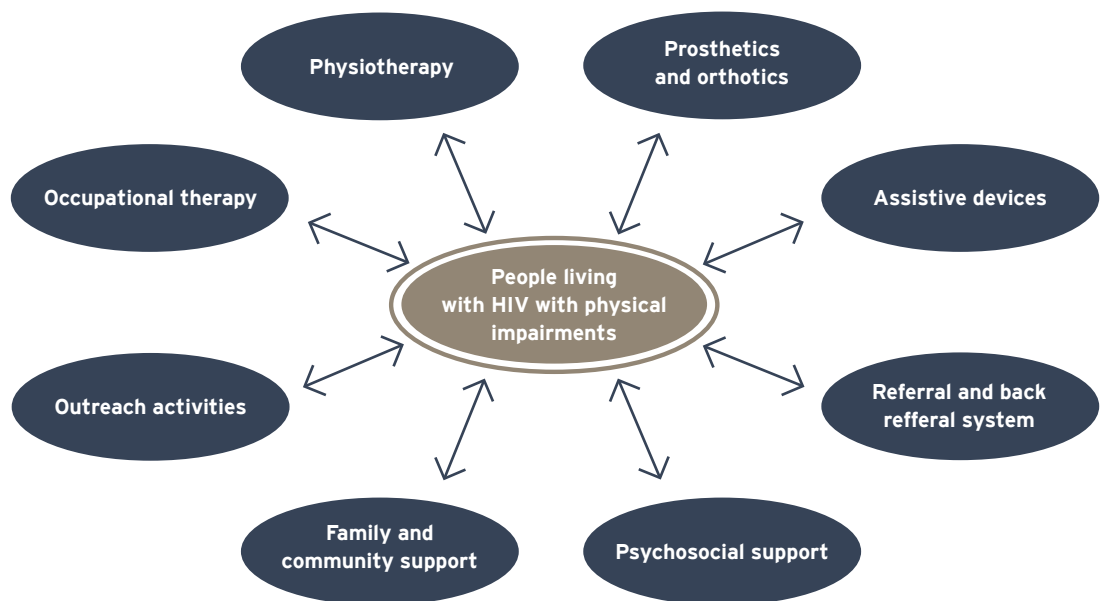


Figure 3: Linkages between services and support for people living with HIV with physical impairments

A recent in-house survey<sup>90</sup> involving 10 HIV and 34 physical rehabilitation-related projects revealed that 89% of HIV-related project staff and 74% of physical rehabilitation-related project staff were aware that people living with HIV require rehabilitation services. Services mostly mentioned were: physiotherapy, psychosocial support, followed by provision of assistive devices and outreach support. 100% of HIV project staff and 74% of physical rehabilitation project staff felt that this is an area in which Handicap International should work and strategize for future programme development. Handicap International country programmes such as Ethiopia, Kenya, Burkina Faso, Togo, Mozambique and India have shown particular interest in bringing forward more concrete steps at the programmatic level. For other programmes, it is recommended to put in place training plans of both health and physical rehabilitation staff on priority linkages between HIV and physical rehabilitation/disability, and referral mechanisms to ensure people living with HIV have access to these services.

Improving access to quality rehabilitation services means recognizing and addressing all the rehabilitation needs of people living with HIV. For example, besides physical rehabilitation, there might be a need for cognitive rehabilitation and speech therapy services for people living with HIV due to other impairments caused by HIV infection. To develop such services, there must be a thorough assessment of the local situation in terms of technical expertise and provision of existing services. In general, a comprehensive understanding and knowledge of all body function impairments related to HIV and AIDS should be guaranteed by training all rehabilitation staff and providers<sup>91</sup>.

### ➤ **Economic inclusion**

People infected or affected by HIV can experience economic strains and downturn during various periods of their life due to temporary/permanent absence from employment, loss of livelihood, decreased productivity, selling household assets and lands to support families and health care costs. Stigma and exclusion from mainstream economic activities are also major factors. Lessons learned from previous Handicap International projects<sup>92</sup> on the economic impact of HIV on households outlined the following key consequences and changes:

#### **At economic level**

- Changes in the patterns of household expenditure;
- Higher costs on health and funeral related expenditures;
- Increased medical, psychological and economic burden of care;
- Bread-winner's work capacity decreased (through reduced productivity);
- Loss of income;
- Higher time spent caring for people who are unwell, hence less time for work;
- People are too unwell to implement income generating activities.

#### **At social and cultural level**

- Stigma;
- Fear;
- Lack of respect for the dignity of people living with HIV;
- Other basic needs get priority;
- Change in household structure and composition;
- Lack of decision making power among other members of family such as women and children.

In order to contribute to restoring and rehabilitating the economic status of people living with HIV, their families and households, support for people living with HIV can be based on<sup>93</sup>:

- Enhancement of know-how and expertise, such as vocational and technical training, and apprenticeship;
- Access to capital through such activities as microfinance services and grants for vulnerable people;
- Business and entrepreneurship skills development;
- Coaching for waged and self-employment;
- Support to implement an HIV at workplace policy.

Prior to undertaking the above activities/ services and in order to ensure quality implementation, it is necessary to conduct appropriate needs and market assessments, elaborate a formal plan and deliver specific training by qualified staff. As mentioned previously, HIV projects, given their own priorities and constraints, usually cannot undertake livelihoods initiatives alone, but need to build partnerships with other organisations/stakeholders and/or refer to locally available service providers that are able to cater to the economic needs of people living with HIV and families.

### – Social support

Besides being able to have access to treatment, care, CHBC, and other rehabilitation services, people living with HIV and their families are also entitled to enjoy social roles, the same as anyone else in society. As presented in the WHO CBR Guidelines<sup>94</sup>, key elements pertaining to social support concern:

- Personal assistance;
- Relationship (social and sexual), marriage and family;
- Culture and arts;
- Recreation, leisure and sports;
- Access to rights (justice).

Again, working closely with families/ communities and in partnership with other organisations, Handicap International can contribute to working towards improved social roles amongst women, men and children living with HIV.



# K

## Referral and counter-referral mechanism

MP

In the context of HIV, referral is defined as a “process by which immediate client needs for comprehensive HIV care and supportive services are assessed and clients are helped to gain access to services, such as setting up appointments or giving directions to facilities. Referral should also include reasonable follow-up efforts to facilitate contact between service providers and to solicit clients’ feedback on satisfaction with services”<sup>95</sup>.

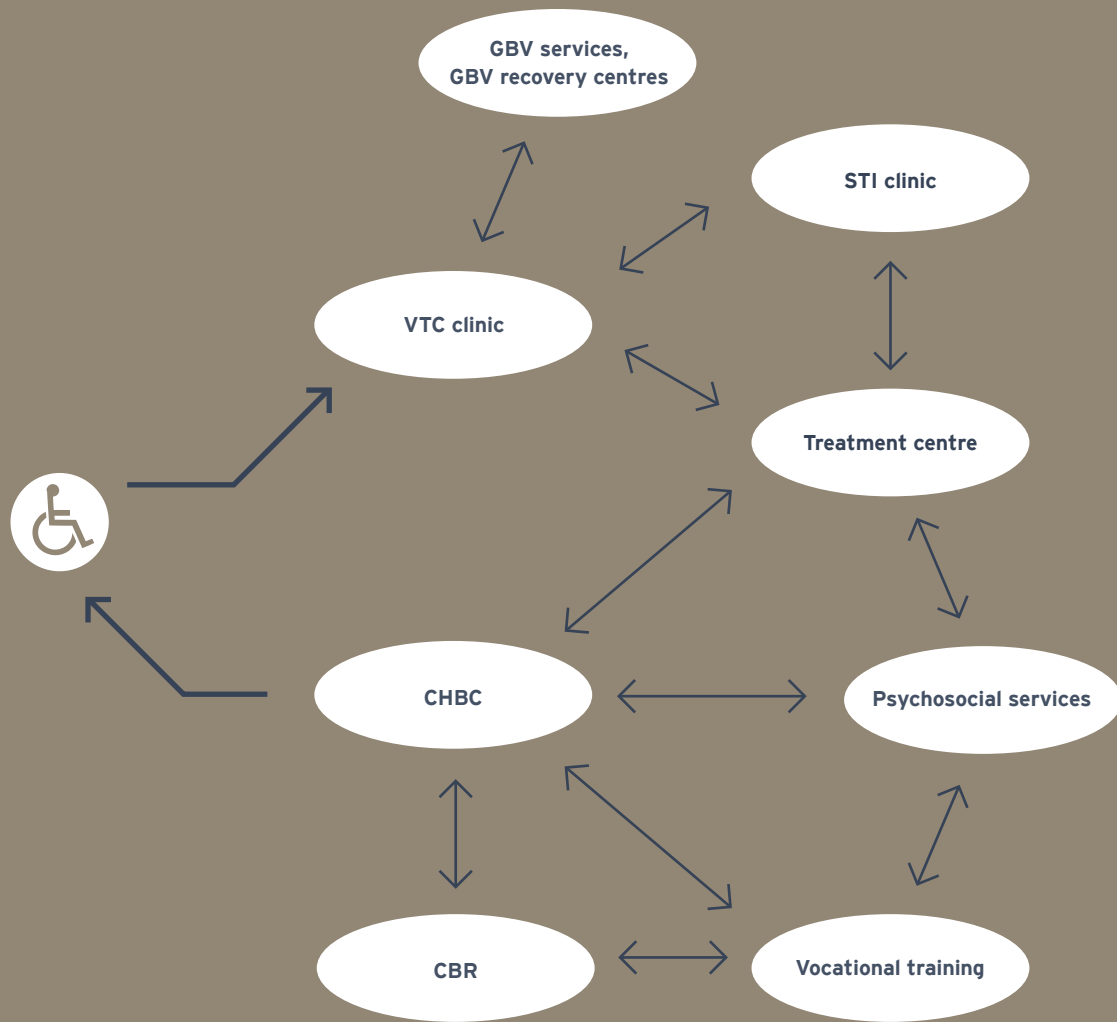
Referral works in multidirectional ways and requires different parties to be involved in the process (sending service providers, receiving service providers and the client/family) in order to ensure quality in the continuity of services and client care. Coupled with this, an inbuilt back-referral mechanism must be put in place to complete the process. Referral requires a non-discriminating and non-stigmatizing environment and approach. Furthermore, directing, re-directing or transferring a client/family to different service providers and making sure to receive feedback from them, requires an assessment of: the level of services locally available; the distance to the referral site; the costs incurred; the perceived quality of care by users; attitudes of health workers and their level of respect for the needs of people living with HIV; and socio-cultural preferences generally<sup>96</sup>. In addition, there is a need to put monitoring systems in place for the referral/back referral mechanism, to identify gaps, provide solutions and plan ahead for service delivery improvement.

It is to be noted that a referral/back-referral system concerns the interplay between any type of service, whether related to HIV

(prevention, treatment, care and support), sexual and reproductive health (mainly family planning, STI management and MNCH) or gender-based violence (mainly health, legal, police and psychosocial) programming. Handicap International cannot do this alone, but rather in close collaboration and partnership with both national health authorities and local service providers (public, private and non-governmental), through the elaboration and/or strengthening of existing referral and back-referral mechanisms and tools.

The following diagram provides some ideas for what a referral/back-referral system can look like, providing that simple, user-friendly records and communication tools are put in place and that necessary inter-agency or facility agreements (such as Memorandum of Understanding) are established to formalize the process and ensure continuity in care provided to clients/families.

Figure 4: Example of referral and back-referral links



# Integration with sexual and reproductive health

## A

### Sexuality and sexual health education



Acknowledging that sexual transmission of HIV is still the most prevalent route of transmission to date, and that power imbalance between hetero and homosexual partners often prevails on a gender inequality basis, it is imperative that HIV prevention, at its very inception, includes education on sexuality and sexual health. Given the different socio-cultural contexts (mainly traditional, religious and politically conservative), and sub-cultures of various marginalized groups and most-at-risk populations, it is necessary to tailor strategies in order to discuss these subjects in a non-judgemental and friendly manner and empower women and girls to negotiate safer sex and to access SRH and HIV services. It is to be emphasized here that women/girls and men/boys with disabilities, people living with HIV and sex workers also have the right to learn about their own sexuality and can identify with sexual health, HIV prevention messages and information. Failing to address this issue in the chain of an HIV prevention package could result in long term consequences related to ineffectiveness of interventions. Similarly, helping people learn about sexuality and sexual health is understood as a set of activities at the SRH programmatic level. Hence, not only are sexuality and sexual education part of an HIV and SRH minimum response package, they also need to be scaled-up through projects at community level. When designing HIV prevention related projects, Handicap International will also include sexuality and sexual health education that is culturally sensitive. This is best done in partnership with grass-roots organisations that are cognisant of cultural sensitivity as well as how people think and behave in the community.

## B

### Family planning



Regardless of the HIV status of women, contraception offers a number of benefits for all women. By delaying first births, lengthening birth intervals, reducing the total number of children born to a woman, preventing unintended pregnancies, and reducing the need for unsafe abortions, contraception can have a major impact on improving overall maternal and infant health. For HIV-positive women who do not want to become pregnant, contraception has the added benefit of reducing HIV-positive births and, by extension, the number of children needing HIV-related services<sup>97</sup>.

Joining family planning services with HIV prevention requires breaking the vertical orientation of many current programmes, i.e. organizations or departments which do not wish to collaborate or share information with one another. This can be achieved by addressing the ongoing needs of all women, including women living with HIV, to family planning and improved access to contraceptive methods, as well as the public health impact of HIV programmes. In the same way, Handicap international will also have to take into account this issue when designing SRH and/or HIV projects, by working closely with primary health care providers, women's and family planning clinics and AIDS associations and service providers. Moreover, there is a need to scale-up implementation of national guidelines in that regard, to reach set targets by developing partnerships with specific health service providers and facilities.

## C

### STI prevention and management



STI prevention and management is a key component to SRH services. The linkages between STI prevention and management with HIV prevention have been clarified and so this is not repeated again here. However, in general, there is an urgent need to build the capacity of primary health care providers and staff in STI and SRH clinics to systematically address incoming clients' needs (particularly people living with HIV, sex workers, MSM, youth, people with disabilities and other vulnerable groups) to HIV testing and counselling, treatment and care using a more holistic approach. Although Handicap International should not directly implement services on HIV and SRH, it can however advocate for the implementation of national guidelines, strengthen the capacities of health providers to take advantage of opportunities to communicate prevention messages, promote behaviour changes regarding sexual risk practices, and strategically partner with locally available providers and organisations to reduce both STIs and HIV infection.

## D

### Dual protection of condom use



The use of condoms (male and female) provides protection against HIV, STIs and unintended pregnancy as an effective contraceptive measure when used correctly and consistently. Emphasis should be put on increasing the condom negotiation skills of women, girls, and persons with disabilities, youth, sex workers and MSM for condom use with sexual partners. Similarly, sexual partners (including clients of sex workers) can benefit from peer education and dialogue/exchanges on condom use benefits. Specifically this includes challenging current gender beliefs/myths leading to unsafe sex, promoting methods to overcome existing barriers regarding condom use, and explaining the consequences incurred when condoms are not used during at-risk<sup>98</sup> sexual relations. Hence, making sure that condoms are locally available, accessible and distributed, along with clear condom use demonstration, combined with exchanges among target populations is necessary for more effective public health indicators. In countries where dual protection of condom use is culturally not accepted and socially not allowed, Handicap International needs first to engage in dialogue and work with local/traditional/religious leaders, as well as health authorities to promote open discussions on condom use for long-term family planning and HIV prevention strategies.

# E

## Prevention of transmission from parent to child



Research has shown that PPTCT interventions can reduce the risk of HIV transmission from parent to child from about 40 percent to less than 5 percent<sup>99</sup>. Moreover, bringing PPTCT to antenatal care services increases women's abilities to care for themselves and enhances the likelihood of positive pregnancy outcomes. Without reiterating the key elements under PPTCT described in section 6.2, the following outlines the general principles for the integration of PPTCT as essential to a SRH package:

- Provide opportunities for pregnant women and women of childbearing age for HIV testing, counselling and treatment at as many venues as possible such as: antenatal clinics, primary health care facilities, hospitals, outreach health posts, HTC facilities.
- Elicit community involvement, awareness and participation.
- Expand communication on primary prevention messages to include both PMTCT/HIV to SRH/Maternal Neonatal and Child Health education and services.
- Introduce HIV and PPTCT topics into routine SRH education;
- Offer health provider-initiated HIV testing and counselling to all pregnant women and women of childbearing age;
- Build and enhance capacities of health care providers.
- Establish collaborative and coordinated partnership with a broad base

Handicap International should not implement PPTCT alone. Rather it should do so in partnership with specific PPTCT services, such as trained antenatal clinics, SRH facilities or family planning clinics. When PPTCT are not available in project areas, either through public and/or private health facilities or project partners, referral to other competent service providers is necessary to ensure continuum of services and counter-referral for timely follow-up of women beneficiaries.

## Integration with gender-based violence

Gender-based violence protection can embrace a psychosocial approach whereby the following components are to be considered at all times when working with GBV survivors and their families:

- People's empowerment;
- Psychosocial support;
- Social participation;
- Cross-sectoral response to GBV.

More specifically, the main areas under gender-based violence with regards to HIV services will be explained in the following sections.

## A

### Health response including PEP, prophylaxis of STIs and emergency contraception



Health sector response is a core element of comprehensive GBV care. Critical health services include PEP (up to 72 hours after the event), prophylaxis of STIs, emergency contraceptive and collection (up to 120 hours after the event) and documentation of forensic evidence. Throughout the process, GBV survivors, along with families/caretakers, need to be accompanied and empowered to take informed decisions, feel safe and taken care of with professionalism and without any discrimination. Furthermore, in order to bear relevance and continuity at community level, health services need to be swiftly combined with referral to legal and police services as well as psychosocial support. When not directly involved in health service delivery through partnership with specific health organisations or health facilities, Handicap International has the responsibility to refer to dedicated service providers that are capable of providing basic medical management of rape survivors and advocate for the enforcement of national guidelines in the health response to sexual violence cases.

## B

### Voluntary counselling and testing



Voluntary counselling and testing is recommended within one week of exposure (occupational or non-occupational); however it should not be a requisite for the provision of PEP<sup>100</sup>. Counselling and testing should never be mandatory nor should the provision of PEP be delayed while waiting for the results. When involved in the GBV response Handicap International shall promote the implementation of such a guideline as well as assist services providers to be cognisant of its application and the implication for service provision. At all times, the person needs to be helped and accompanied to understand this.

## C

### Psychosocial support



Emotional consequences expressed in the “rape trauma syndrome” are often longer lasting and more difficult to deal with than physical symptoms<sup>101</sup>. Hence psychological counselling has been identified as vital for speeding the recovery process of rape survivors, as long as it is provided by experienced general counsellors who have received training<sup>102</sup>, coupled with social and community support. In addition, any service providers involved in the GBV minimum package of activities, such as nurses, counsellors, police officers and court personnel should be equipped with interpersonal and communication skills that enable their clients feel safe, attended to and protected. In terms of social support, if places where survivors are living are not secure, safe houses, temporary shelters and relocation services are critical for ensuring that they are not returned to a potentially dangerous situation<sup>103</sup>. In cases where these services are not available, for example in the many low-resource countries where Handicap International is working, community mobilization is essential to continue to ensure the safety and security of survivors. In addition, other services can include nutritional support, vocational training, and access to other economical support<sup>104</sup> towards the social rehabilitation of survivors, their families and household members.

## D

### Police and legal response



Survivors not only require healthcare and forensic evidence collection, but also require appropriate police and legal services when/if survivors or their families wish to prosecute the perpetrator or protect against further harm. In HIV and GBV projects<sup>105</sup>, Handicap International can work on advocating for synergistic response between different stakeholders, by supporting community leaders and authorities to coordinate for the protection of survivors and their families. In many cases, stigma and discrimination reduction strategies are required for building the capacity of police and legal officers as well as community/traditional leaders, to change negative attitudes and improve knowledge and enforcement of national policies and laws. Results from a study on sexual violence against children with disabilities undertaken by Handicap International<sup>106</sup> revealed that institutional discrimination within current service delivery highly contributes to the lack of support for survivors and impunity of perpetrators, hence the importance of adopting stigma-reduction strategies from the start. Coupled with this, there is also a need to analyse current barriers (attitudinal, structural and environmental) related to the enforcement of policies and laws and to design appropriate plans to overcome them using a multi-sectoral approach. In all cases, referral of survivors and their families to police and legal officers is necessary to ensure proper GBV response. In countries where free legal services are not available, Handicap International will have to seek other alternatives, such as partnering with university law faculties, legal- and/or human rights-based organisations to provide legal counselling and representation.

## E

### Community-based prevention



As part of a continuum of services, prevention work that stems from the community is recognised as equally important as other management services in the response to GBV. This involves: raising awareness and improving knowledge of human rights and laws among men, women and community/religious leaders and local service providers; empowering community-based organisations and DPOs in the promotion of the rights of women and girls; and attempting to foster environments that challenge the emergence of gender-based violence. Creating dialogue groups among men and boys, challenging harmful gender-based practices, questioning tolerance attitudes of sexual violence or reinforcement of neighbourhood protection behaviours, are just some of the strategies that can take place at the community level for building a safer environment for all women and men to live in. Alongside these activities at community level, it is important to consider strategies at the national level. For example, to increase advocacy and lobbying at policy level, Handicap International (through specific project initiatives) or other relevant organizations, can undertake an analysis of legal gaps to identify how to better integrate issues of GBV protection and human rights for all.



# F

## Referral linkages



As seen in the HIV section, referral linkages between each service provider and GBV stakeholder are not only key to the success of the survivors' wellbeing and recovery, and the success of any projects, but are also necessary to ensure that GBV-related indicators are reached and that efforts deployed to improve the quality of life of survivors are not in vain. If Handicap International decides to implement projects to respond to GBV and particularly to sexual violence, it is obligatory to ensure that an effective referral and counter-referral system is in place. Thus, simple communication and recording tools will need to be either created or reinforced to guarantee the flow of communication.

# Cross-cutting modalities for all HIV-related projects

Throughout project cycle implementation, Handicap International will strive to ensure cross-cutting modalities in addition to specific interventions, to achieve integrated and disability inclusive HIV programming. They are as follows:

## A

### Baselines

Systematic baselines should be technically and financially planned and then initiated at the inception of any HIV project. The aim is to collect key information and indicators to orientate project activities and to set targets to measure performance and results. Baseline data should not only focus on indicators that will demonstrate changes brought about by the project, but also focus on assessing barriers and facilitators regarding access to integrated and inclusive HIV services among persons with disabilities and targeted vulnerable groups. This crucial step will enable project implementers and decision-makers to appreciate the level of commitment, investment and time to be deployed in order to reach set objectives in any given context or situation. In addition, initial data collection needs to be disaggregated, at minimum by sex and impairment. Others variables such as age, ethnic group or economic status can be added, depending upon the intended beneficiaries.

## B

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### **Monitoring and evaluation**

Alongside baseline assessments, and in the framework of quality project implementation, it is necessary to develop a sound and comprehensive monitoring and evaluation (M&E) mechanism, oriented on results-based management to track the progress of project indicators as well as the number and type of beneficiaries reached at any given time. Indicators of change (at beneficiary, community, service and policy levels) must be incorporated to enable projects to better respond to the needs of beneficiaries and determine whether project activities are successful in reaching set targets. In July 2010, Handicap International issued a Monitoring and Evaluation Policy<sup>107</sup> which indicates that 5% of any project budget (direct costs) is the minimum requirement to be allocated to M&E activities.

## C

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### **Evidence-informed approach**

Though the vulnerabilities and risks faced by persons with disabilities have been widely acknowledged and documented, there remains a paucity of quality epidemiological research examining the specific situation of persons with disabilities in relation to HIV, SRH and GBV. In order to address this gap, Handicap International, across its HIV projects, will promote quantitative and qualitative research studies to both increase this knowledge base and to better inform its managers and decision-makers about the most realistic and effective strategies for benefitting target populations. Furthermore, results of such studies will help improve programme design and service provision, as well as influence policy for long-term changes aiming at reaching more equitable and inclusive environments for vulnerable populations.

## D

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### **Knowledge management**

Having collected data, generated information and formulated recommendations, there is a need to manage this new knowledge through diverse types of dissemination and appropriation. Key knowledge management activities include: organising thematic workshops, dialogue and debate platforms; participation at scientific seminars; presentations of abstracts/posters/articles at regional and international conferences; utilisation of audio-visual media; elaboration of capitalisation projects, practical guidelines or developing further knowledge through more research and studies. In all cases, information should be circulated, widely reviewed with critical attention and shared both internally and externally to feed into a continuous knowledge management cycle.

**In order to assist HIV project developers and implementers, a checklist for writing concept notes and proposals is outlined in the Appendices. An example of a logical framework is also outlined, along with more detailed readings and recommended documentation.**

# Perspectives for 2011-2015

For the period of 2011-2015, in relation to the HIV and AIDS sector, Handicap International is expected to:

- Consolidate and refocus all its projects on HIV and AIDS (ongoing and new);
- Mainstream disability in the HIV continuum of care with a cross-impairment approach;
- Develop a practical guide on the inclusion of disability in HIV prevention, treatment, care and support services;
- Promote research, studies and baselines that link HIV and AIDS to disability in target countries where Handicap International is implementing projects;
- Identify lessons learned and good practices;
- Implement inclusive and integrated HIV, sexual and reproductive health and gender-based violence projects.

SANGUINS

Senegal, 2010



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## List of acronyms and abbreviations

<b>AIDS</b>	Acquired Immunodeficiency Syndrome
<b>ARV</b>	Antiretroviral
<b>CBO</b>	Community-based Organisation
<b>CBR</b>	Community-based Rehabilitation
<b>CHBC</b>	Community Home-based Care
<b>CRPD</b>	Convention of the Rights of Persons with Disabilities
<b>DPO</b>	Disabled People's Organization
<b>DRT</b>	Technical Resources Department
<b>GBV</b>	Gender-based Violence
<b>HIV</b>	Human Immunodeficiency Virus
<b>HTC</b>	HIV Testing and Counselling
<b>IDDC</b>	International Disability and Development Consortium
<b>IDU</b>	Injecting Drug User
<b>IEC</b>	Information, Education and Communication
<b>MARP</b>	Most-at-Risk Population
<b>M&amp;E</b>	Monitoring and evaluation
<b>MDG</b>	Millennium Development Goal
<b>MNCH</b>	Maternal, Neonatal and Child Health
<b>MSM</b>	Men Who Have Sex with Men
<b>NSP</b>	National Strategic Plan
<b>OI</b>	Opportunistic Infection
<b>PEP</b>	Post-Exposure Prophylaxis
<b>PPTCT</b>	Prevention of Parent-to-Child Transmission
<b>RBM</b>	Result-based management
<b>STI</b>	Sexually Transmitted Infection
<b>SRH</b>	Sexual and Reproductive Health
<b>STI</b>	Sexually Transmitted Infection
<b>TB</b>	Tuberculosis
<b>UNAIDS</b>	Joint United Nation Programme on HIV/AIDS
<b>VCT</b>	Voluntary Counselling and Testing
<b>WHO</b>	World Health Organization

# Levels of partnership related to HIV and AIDS programming

Community	
Actors	Actions
<ul style="list-style-type: none"> <li>- Families and caregivers</li> <li>- Support groups of people living with HIV</li> <li>- Home-based care volunteers</li> <li>- CBOs and DPOs</li> <li>- Health centres</li> <li>- Voluntary counselling and testing centres</li> <li>- CBR workers</li> <li>- MNCH clinics</li> <li>- SRH clinics</li> <li>- Community health and outreach workers</li> <li>- Primary and secondary schools</li> <li>- Women's groups</li> <li>- Community and religious leaders</li> <li>- Community-based microfinance actors</li> </ul>	<ul style="list-style-type: none"> <li>- HIV, SRH and GBV prevention and awareness-raising</li> <li>- Disability awareness-raising and sensitization</li> <li>- Capacity-building of health personnel and community health workers on integrated and inclusive services</li> <li>- Accessibility measures and initiatives facilitating removal of barriers and promoting facilitators at community level</li> <li>- Financial and material support to peripheral health facilities (i.e. equipment and supplies, generic drug and test kit procurement in case of stock rupture, etc.)</li> <li>- ARV adherence support for clients at the community level</li> <li>- Community home-based care</li> <li>- Linkages with, and referral to, community-based rehabilitation</li> <li>- Stigma reduction (regarding HIV, disability and gender)</li> <li>- Pilot projects to reach excluded groups</li> <li>- Social and economic inclusion of people infected and affected by HIV and their families</li> <li>- Support for orphan care</li> <li>- Capacity development for local associations and groups</li> </ul>
Provincial or regional	
Actors	Actions
<ul style="list-style-type: none"> <li>- Provincial/regional AIDS coordination bodies</li> <li>- Provincial/regional health and rehabilitation authorities</li> <li>- Relevant platforms on HIV and disability</li> <li>- Microfinance stakeholders</li> </ul>	<ul style="list-style-type: none"> <li>- Networking</li> <li>- Capacity-building on disability inclusion</li> <li>- Accessibility measures and initiatives facilitating removal of barriers and promoting facilitators at provincial/regional level</li> <li>- Technical assistance for implementation of the National AIDS Plan</li> <li>- Technical support for inclusive services in integrated HIV, SRH and GBV services</li> <li>- Participation in the referral and counter-referral system</li> <li>- Linkages and referral to socioeconomic rehabilitation services</li> </ul>

National (central)	
Actors	Actions
<ul style="list-style-type: none"> <li>- National AIDS coordination body</li> <li>- Ministry of Health</li> <li>- Ministry of Social Affairs</li> <li>- International and national AIDS organisations</li> <li>- National DPOs and disability organisations</li> <li>- Relevant working groups on HIV and AIDS</li> <li>- Relevant platforms on HIV and disability</li> </ul>	<ul style="list-style-type: none"> <li>- Advocacy and lobbying</li> <li>- Networking</li> <li>- Technical assistance (i.e. mainstreaming of disability into AIDS policies, social and economic integration of excluded groups, rights of people living with HIV and people with disabilities)</li> <li>- Integration of impairment-disaggregated data into national health management information systems</li> <li>- Accessibility measures and initiatives facilitating removal of barriers and promoting facilitators at national/policy level</li> <li>- Advocacy for inclusion of people living with HIV in rehabilitation services policy</li> <li>- Documentation and dissemination of good practices</li> </ul>
Sectoral	
Actors	Actions
<ul style="list-style-type: none"> <li>- Physical rehabilitation</li> <li>- Economic inclusion and livelihoods</li> <li>- Inclusive education</li> <li>- Rights and policies</li> <li>- Sectoral working groups</li> </ul>	<ul style="list-style-type: none"> <li>- Advocacy and lobbying</li> <li>- Networking</li> <li>- HIV mainstreaming</li> <li>- Disability mainstreaming</li> <li>- Accessibility measures and initiatives facilitating removal of barriers and promoting facilitators at sectoral level</li> <li>- Promotion of inclusive local development</li> <li>- Research initiatives</li> <li>- Dissemination of good practices</li> </ul>
International	
Actors	Actions
<ul style="list-style-type: none"> <li>- UNAIDS</li> <li>- Donors</li> <li>- IDDC task group on HIV and Disability</li> <li>- Global Contact Group on AIDS and Disability (GCGAD)</li> <li>- Canadian Working Group on HIV and Rehabilitation (CWGHR)</li> </ul>	<ul style="list-style-type: none"> <li>- Advocacy and lobbying</li> <li>- Networking</li> <li>- Strategic alliances</li> <li>- HIV mainstreaming</li> <li>- Disability mainstreaming</li> <li>- Continuum of care within rehabilitation services</li> <li>- Accessibility measures and initiatives facilitating removal of barriers and promoting facilitators at international level</li> <li>- Promotion of inclusive local development</li> <li>- Research initiatives</li> <li>- Dissemination of good practices</li> </ul>



# Checklist for writing concept notes and proposals

The objective of the following checklist is to assist Desk officers, Programme Directors and Project Managers to plan and write concept notes and proposals related to HIV projects. It is adapted from the Handicap International BÀU tool (“Bon à Utiliser” or Good to Use) developed by the Technical Resources Department (DRT) in 2010 for quality assurance of concept notes and proposals.

This checklist is comprised of three sections: A) quality of the project (relevance, effectiveness, efficiency, sustainability and impact); B) consistency with internal documents; and C) feasibility of project in regard to required technical resources.

<b>A. Quality of the project (relevance, effectiveness, efficiency, sustainability and impact)</b>				
<b>1.1</b>	<b>RELEVANCE ANALYSIS</b>	<b>YES</b>	<b>NO</b>	<b>COMMENTS</b>
1.1	Are the target populations and beneficiaries clearly identified?	<input type="checkbox"/>	<input type="checkbox"/>	
1.2	Were the target populations and beneficiaries involved in identifying the problems?	<input type="checkbox"/>	<input type="checkbox"/>	
1.3	Are the problems related to HIV services and their causes clearly identified?	<input type="checkbox"/>	<input type="checkbox"/>	
1.4	Do the objectives defined offer a suitable response to the problems identified and HIV response in the context of your country?	<input type="checkbox"/>	<input type="checkbox"/>	
1.5	Are the expected outcomes relevant and consistent with the specific objective(s)?	<input type="checkbox"/>	<input type="checkbox"/>	
1.6	Are the objectives in line with the priorities outlined in the call for proposals and/or national priorities and HIV policies?	<input type="checkbox"/>	<input type="checkbox"/>	
1.7	Are gender issues related to the HIV epidemic taken into consideration?	<input type="checkbox"/>	<input type="checkbox"/>	
1.8	Are disability issues related to HIV taken into consideration?	<input type="checkbox"/>	<input type="checkbox"/>	

**2. POTENTIAL EFFECTIVENESS ANALYSIS**

	YES	NO	COMMENTS
<b>2.1</b> Is it possible to implement the activities and achieve the objectives in the intervention context with proposed inclusive and integrated HIV approaches?	<input type="checkbox"/>	<input type="checkbox"/>	
<b>2.2</b> Are the activities related to an inclusive and integrated HIV project consistent with expected outcomes?	<input type="checkbox"/>	<input type="checkbox"/>	
<b>2.3</b> Will the results indicators (OVI) and monitoring system effectively measure whether outcomes have been obtained?	<input type="checkbox"/>	<input type="checkbox"/>	
<b>GENERAL ASSESSMENT</b>	<input type="checkbox"/>	<input type="checkbox"/>	

**3. POTENTIAL EFFICIENCY ANALYSIS**

	YES	NO	COMMENTS
<b>3.1</b> Are the means and resources (human, financial and technical) sufficient and adapted to the HIV project as a whole and to each activity/ service?	<input type="checkbox"/>	<input type="checkbox"/>	
<b>3.2</b> Is the timeline* for the organisation of HIV activities realistic and consistent with the project's expected outcomes? <sup>108</sup>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>3.3</b> Is priority given to local material, financing and human resources (of equal competence)?	<input type="checkbox"/>	<input type="checkbox"/>	
<b>3.4</b> Are administrative costs kept to an acceptable proportion of the overall cost of the activities, in the context and for this type of project?	<input type="checkbox"/>	<input type="checkbox"/>	

<b>3.5</b>	<b>Is there a budget planned for activities such as a baseline, mid-term and end-term evaluation?</b>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>GENERAL ASSESSMENT</b>		<input type="checkbox"/>	<input type="checkbox"/>	

#### **4. POTENTIAL SUSTAINABILITY ANALYSIS**

	YES	NO	COMMENTS	
<b>4.1</b>	<input type="checkbox"/>	<input type="checkbox"/>		
<b>4.2</b>	<input type="checkbox"/>	<input type="checkbox"/>		
<b>4.3</b>	<input type="checkbox"/>	<input type="checkbox"/>		
<b>4.4</b>	<input type="checkbox"/>	<input type="checkbox"/>		
<b>4.5</b>	<input type="checkbox"/>	<input type="checkbox"/>		
<b>4.6</b>	<input type="checkbox"/>	<input type="checkbox"/>		
<b>GENERAL ASSESSMENT</b>		<input type="checkbox"/>	<input type="checkbox"/>	

<b>5. POTENTIAL IMPACT ANALYSIS</b>			
	<b>YES</b>	<b>NO</b>	<b>COMMENTS</b>
<b>5.1</b> Will the project's expected outcomes contribute towards strengthening the target public's capacities and opportunities over the long-term (for example, recognition of their rights, improved living or health conditions, increased social participation, gender and disability issues addressed, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	
<b>5.2</b> Are longer-term changes envisaged for people and/or structures that are not part of the project? (other vulnerable communities and/or public administrations for example)	<input type="checkbox"/>	<input type="checkbox"/>	
<b>5.3</b> Have there any negative impacts caused by the project that could have been avoided or mitigated during the course of the project?	<input type="checkbox"/>	<input type="checkbox"/>	
<b>5.4</b> Does the project contribute towards realising Handicap International's mission and/or strengthening its partners? (Know-how, recognition, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	
<b>GENERAL ASSESSMENT</b>	<input type="checkbox"/>	<input type="checkbox"/>	

**SUMMARY OF QUALITY CRITERIA ANALYSES**

	<b>YES</b>	<b>NO</b>	<b>COMMENTS</b>
<b>1</b> Relevance	<input type="checkbox"/>	<input type="checkbox"/>	
<b>2</b> Effectiveness	<input type="checkbox"/>	<input type="checkbox"/>	
<b>3</b> Efficiency	<input type="checkbox"/>	<input type="checkbox"/>	
<b>4</b> Sustainability	<input type="checkbox"/>	<input type="checkbox"/>	
<b>5</b> Impact	<input type="checkbox"/>	<input type="checkbox"/>	
<b>GENERAL ASSESSMENT</b>	<input type="checkbox"/>	<input type="checkbox"/>	

**B. Consistency with internal technical reference documents (HIV and AIDS policy and practical guidelines)**

ITEMS	YES	NO	COMMENTS
Consistent with internal documents validated by the DRT (on HIV, disability inclusion, accessibility, partnership, capacity building, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	
Consistent with the HIV at Workplace Policy of Handicap International	<input type="checkbox"/>	<input type="checkbox"/>	
Consistent with the policies of Handicap International relating to child protection and protection of beneficiaries from sexual exploitation and abuse	<input type="checkbox"/>	<input type="checkbox"/>	
Consistent with the Gender Policy at Handicap International	<input type="checkbox"/>	<input type="checkbox"/>	
Consistent with internationally HIV guidelines and frameworks (from UN agencies and internationally recognised institutions/leaders)	<input type="checkbox"/>	<input type="checkbox"/>	
<b>GENERAL ASSESSMENT</b>	<input type="checkbox"/>	<input type="checkbox"/>	

**C. Feasibility of the project with regard to required technical resources**

ITEMS	YES	NO	COMMENTS
Are the technical staffing requirements clearly formulated and sufficient to reach the expected results of the project? (number and technical/professional competencies required)	<input type="checkbox"/>	<input type="checkbox"/>	
Are the requirements in terms of material (technical) resources clearly formulated and sufficient?	<input type="checkbox"/>	<input type="checkbox"/>	
Are the external risks and assumptions relative to technical resources outlined in the logical framework?	<input type="checkbox"/>	<input type="checkbox"/>	
Is there a risk management plan or an alternative scenario elaborated to address identified risks?	<input type="checkbox"/>	<input type="checkbox"/>	
<b>GENERAL ASSESSMENT</b>	<input type="checkbox"/>	<input type="checkbox"/>	

## Example of a logical framework of an inclusive and integrated HIV five-year project<sup>109</sup>

INTERNAL LOGIC	OBJECTIVELY VERIFIABLE INDICATORS OF ACHIEVEMENT
<p><b>Overall objective</b> To contribute to reduced HIV and GBV prevalence; and improved quality of life of women and men with and without disabilities infected and affected by HIV and survivors of GBV in Kenya</p>	<ul style="list-style-type: none"> <li>- Decreased HIV prevalence in Kenya</li> <li>- Decreased GBV prevalence in Kenya</li> <li>- Improved quality of life of people infected by HIV and GBV survivors</li> </ul>
<p><b>Specific objective</b> To enhance access to, and utilization of, inclusive and integrated HIV prevention, treatment, care and support, SRH and GBV protection services among women and men with and without disabilities of vulnerable groups in 12 Counties of Kenya from 2011 to 2015</p>	<ul style="list-style-type: none"> <li>- Increased % of project partners/services providers who give integrated and inclusive services from baseline to end of project</li> <li>- Increased % of target population utilizing integrated services from baseline to end of project (disaggregated by sex, age and impairment)</li> <li>- Increased % of project partners/services providers with inclusive and integrated policies</li> <li>- Increase in proportion of persons with disabilities accessing HIV, SRH and GBV services from baseline to end of project</li> </ul>
<p><b>Expected results (ER)</b></p> <p><b>Expected result 1</b> Behaviour Change among target population through enhanced access to, and uptake of, integrated and inclusive HIV, SRH and SGBV services</p>	<p>Note: all data disaggregated by sex, age and impairment</p> <ul style="list-style-type: none"> <li>- Increased % of knowledge among target populations on HIV/AIDS and SRH from baseline to end of project</li> <li>- Increased % of awareness on GBV from baseline to end of project</li> <li>- Increased % of knowledge on family planning from baseline to end of project</li> <li>- Increased % of utilization of family planning commodities from baseline to end of project</li> <li>- Increased % of GBV survivors accessing medical, psychosocial, legal, police services in Trans Nzoia County from year 2 to end of project</li> <li>- Reduction in attitudes, values and beliefs leading to shame and blame towards stigma reduction from year 2 to end of project</li> <li>- Reduction in tolerance of GBV in target communities from year 3 to end of project</li> <li>- Increase in proportion of HIV positive clients receiving PPTCT services from year 2 to end of project</li> <li>- Increased % of correct and consistent condom use (dual protection) for safer practices reported over past 6 months from year 2 to end of project</li> </ul>

**SOURCES AND MEANS OF VERIFICATION    ASSUMPTIONS**

<ul style="list-style-type: none"> <li>- Kenya Demographic Health Surveys 2013-2014</li> <li>- Kenya AIDS Indicator Survey</li> <li>- National statistics on SGBV</li> <li>- UNAIDS Reports</li> </ul>	<p>The Government of Kenya’s political commitment to the declared “Total War on AIDS”, provision of integrated Sexual and Reproductive Health services, and operationalization of Sexual Offences Act will be implemented and enforced throughout the project period</p>
<ul style="list-style-type: none"> <li>- Baseline data and report</li> <li>- Mid and end term project evaluation report</li> <li>- Annual operation plans</li> <li>- Project progress and monitoring reports</li> <li>- Health Management and Information records</li> <li>- Monitoring reports (quantitative and qualitative)</li> </ul>	<p>All public and private partners will be committed to deliver universal access to HIV prevention, treatment, care and support; Sexual and Reproductive Health; Sexual and Gender Based Violence protection services in the country</p>
<ul style="list-style-type: none"> <li>- Baseline Survey Report</li> <li>- Mid Term Review Report</li> <li>- End Term Evaluation Report</li> <li>- Pre and Post Training Test results</li> <li>- Field visits</li> <li>- Monitoring reports</li> </ul>	<p>Reduction in attitudes, values and beliefs leading to stigmatization and discrimination in the community will lead to increased positive behaviour change for the community to utilize HIV, SRH and GBV protection services</p>

INTERNAL LOGIC	OBJECTIVELY VERIFIABLE INDICATORS OF ACHIEVEMENT
<p><b>Expected result 2</b> Improved capacity of project partners/stakeholders to provide quality inclusive and integrated HIV, SRH, SGBV services to target populations.</p>	<ul style="list-style-type: none"> <li>- 100% of project partners (with signed agreements) have undergone a disability accessibility audit and have developed a plan of action for disability friendly measures from year 2 to end of project</li> <li>- Increased % of women and men counselled and tested for HIV from year 1 to end of project</li> <li>- Increased % of adults and children with known HIV status on treatment for 12 months after initiation of ART from year 2 to end of project</li> <li>- 100% of project partners and service providers are technically supervised on annual basis from year 2 to end of project</li> <li>- Increased % of client/user satisfaction from baseline to end of project</li> <li>- Increased % of referral and back referrals related to VCT, SRH, STIs, family planning and GBV services from year 2 to end of project</li> </ul>
<p><b>Expected result 3</b> Enhanced socioeconomic participation among people living with HIV and survivors of GBV through mitigating initiatives</p>	<ul style="list-style-type: none"> <li>- Increased % of people living with HIV enrolled in CHBC programme and receiving care package according to National Guidelines from baseline to end of project</li> <li>- Increased % of enrolment of people living with HIV and survivors of GBV in respective support groups from baseline to end of project</li> <li>- Increased % of monthly income sustained over a period of at least 18 months among target groups receiving micro-grants</li> </ul>
<p><b>Expected result 4</b> Enhanced coordination and networking among HIV, SRH, GBV and disability implementing partners and services providers</p>	<ul style="list-style-type: none"> <li>- One project advisory committee is established and provides technical support from year 1 to the end of the project</li> <li>- Once a year coordination meeting for Project Advisory Committee from year 1 to end of project</li> <li>- Twice per year HIV/SRH/GBV/Disability/Health stakeholders' coordination meetings per project site from year 1 to end of project</li> <li>- Quarterly monitoring field visits by project implementing team from year 2 to end of project</li> <li>- Every 18 month joint monitoring field visits by the Project Advisory Committee from year 2 to end of project</li> </ul>



**SOURCES AND MEANS OF VERIFICATION    ASSUMPTIONS**

<ul style="list-style-type: none"> <li>- Baseline survey report</li> <li>- Mid term review report</li> <li>- End of project evaluation report</li> <li>- Disability accessibility audit report</li> <li>- Technical supervision reports</li> <li>- Focus group discussions</li> <li>- Client satisfaction survey report</li> <li>- Case studies</li> <li>- Testimonies</li> <li>- Referral registers at service points</li> <li>- Project progress reports</li> </ul>	<p>Partners engaged in the project will commit financial and human resources towards implementation of action plans developed</p>
<ul style="list-style-type: none"> <li>- Baseline survey report</li> <li>- Mid-term review report</li> <li>- End of project evaluation Report</li> <li>- CHBC reports</li> <li>- Project progress reports</li> <li>- Health Management and Information records</li> <li>- Support group records</li> <li>- Case studies</li> <li>- Household surveys</li> <li>- Testimonies</li> </ul>	<p>Communities will address constraints to universal access to HIV services and social transformation to reduce GBV as well as mitigate the socio-economic impact caused by HIV</p>
<ul style="list-style-type: none"> <li>- Mid-term review report</li> <li>- End of project evaluation report</li> <li>- Minutes of meetings</li> </ul>	<p>The project coordination mechanism will be aligned with the National AIDS and STIs Control Programme (NAS COP) and National AIDS Control Council (NACC) M&amp;E Framework and will be endorsed by stakeholders and partners</p>

### Preparatory activities

- Project staff recruitment;
- Development of Monitoring and Evaluation Plan/tools;
- Development of Communication Plan (internal and external);
- Consultation meetings with Government entities for endorsement on implementation mechanism;
- Stakeholders' sensitization meetings;
- Project launch.

### Partnership activities

- Planning meetings with partners;
- Signature of operational agreements;
- Organizational capacity assessment;
- Training needs assessment.

### Baseline survey of all key indicators

- Terms of Reference (TOR), consultancy, field work, analysis, reporting and dissemination of baseline data.

### Monitoring and evaluation activities

- Elaboration of beneficiaries and activities database including in a project monitoring kit;
- Monthly field monitoring visits by project staff per site;
- Quarterly technical supervision to partners and service providers;
- Joint project monitoring by Project Advisory Committee every 18 months;
- Social audit on annual basis;
- Mid term evaluation (TOR, consultancy, field work, analysis, reporting and dissemination of the results);
- Financial audit (mid and end term);
- End Term Evaluation (TOR, consultancy, field work, analysis, reporting and dissemination of the results).

### Activities related to ER 1: Behaviour change among target population through enhanced access to and uptake of integrated and inclusive HIV, SRH and GBV services

- Training of trainers (peer-led education and counselling, PPTCT, family planning and stigma reduction) in Kitale, Nairobi and Garissa in year 1 refresher in year 4;
- Training of target population by trained people to enhance their knowledge and skills (peer-led education and counselling, PPTCT, family planning and stigma reduction) in Kitale, Nairobi and Garissa starting from year 1 to year 2;
- Awareness raising through Behaviour Change and Communication (BCC) activities (mass media campaigns - radio and television; sports during World AIDS Day and International Day of Persons with Disabilities; peer-led education among people living with HIV, prisoners/MSM, sex workers, people with disabilities and youth in school, bicycle and motor bicycle taxi operators; participatory theatres; and health education days) in Kitale, Nairobi and Garissa from year 1 onwards;
- Production and distribution of adapted IEC materials (cross impairments) in Kitale, Nairobi and Garissa from year 2;
- Provision of basic SRH services (STI treatment and management, provision of FP counselling and commodities) in Kitale, Nairobi and Garissa from year 2 onwards;
- Support to access to medical, psychosocial, legal and police services among GBV survivors in Kitale from year 2 onwards;
- Community mobilization and participation (dialogue sessions, exchanges, advocacy, experience sharing, outreach by people living with HIV) in Kitale and Garissa from year 2 onwards;
- Provision of PPTCT services (training, group therapy, patient support volunteers, pediatric friendly HIV services) from year 2 onwards;
- Condom promotion and distribution for dual protection (HIV/STIs and undesired pregnancies) in Kitale, Nairobi and Garissa from year 2 onwards.

**Activities related to ER2: Improved capacity of project partners/stakeholders to provide quality inclusive and integrated HIV, SRH, GBV and rehabilitation services**

- Disability accessibility audit (physical, communication, environmental) and action for improved accessibility measures in Kitale, Nairobi and Garissa from year 1 onwards;
- Strengthen links between HIV and physical rehabilitation services (training, sensitization to people living with HIV groups, support to rehabilitation units, assessments and follow-ups by physical rehabilitation team) from year 2 onwards;
- Capacity building of service providers and partners through exposure visits, on-job training and institutional strengthening from year 2 onwards;
- Provision of HTC (static and mobile) in Kitale and Garissa;
- Provision/referral for ARVs and follow-up in Kitale, Nairobi and Garissa from year 2 onwards;
- Technical bi-annual joint supervision and monitoring visits from year 2 onwards;
- Support to linkages and referral networking for HIV, GBV, SRH and rehabilitation services from year 2 onwards.

**Activities related to ER 3: Enhanced social participation among people living with HIV, people with disabilities and survivors of GBV through mitigating initiatives/actions**

- Training people living with HIV groups on treatment literacy and adherence; and psychosocial support in Kitale and Garissa from year 2 onwards;
- Provision of CHBC services according to national guidelines (training, supervision meetings, kitchen/multi-storey garden) in Kitale and Garissa from year 2 onwards;
- Strengthen support groups of people living with HIV (Kitale and Garissa) and GBV survivors in Kitale through group therapy and supportive supervision from year 2 onwards;
- Economic support for people living with HIV, people with disabilities, and GBV

survivors (feasibility study/market survey, assessment of skills, training, skills development, meetings, micro-grants and monitoring/evaluation) in Kitale, Nairobi and Garissa from year 2 onwards.

**Activities related to ER 4: Improved (effective) coordination and networking among HIV, SRH, SGBV partners and service providers**

- Establishment of Project Coordination Mechanism (formation of Project Advisory Committee, annual meetings, joint monitoring visits every 18 months) from year 1;
- Consultation and once per year stakeholders meetings (Ministry of Health, NACC, NASCOP, health NGOs, CBOs, FBOs, DPOs, people living with HIV groups and networks, youth groups) from year 1 onwards;
- Project staff meetings(Quarterly HI staff meetings, Annual Project Implementing Team meetings) from year 1 onwards;
- Knowledge Management (documentation of lessons learnt, good practices and case studies) from year 2 onwards;
- Participate in regional, national and international HIV/AIDS, SRH, disability and GBV events/conferences from year 1 onwards;
- Sustainability and phasing out strategy elaboration from the beginning (meetings with partners, discussion with beneficiaries, handover to health facilities, action plan) from year 1 onwards.



## Bibliography

### A

#### Selected external documents and links

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##### ▾ HIV AND DISABILITY/REHABILITATION

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**The International Disability and Development Consortium (IDDC) HIV&AIDS and disability Task Group:** <http://www.iddcconsortium.net/joomla/index.php/hivaids> (Handicap International is one of the co-chairs)

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## B

### Selected internal documents and links

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#### — GBV AND DISABILITY

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Enarson, E. (2009). **Women, Gender & Disabilities: Abilities & Disabilities. Gender and Disaster Networks**, Gender Note #4. Retrieved from [www.gdnonline.org/resources/GDN\\_GenderNote4\\_Abilities.pdf](http://www.gdnonline.org/resources/GDN_GenderNote4_Abilities.pdf)

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##### **The Africa Campaign on Disability and HIV&AIDS**

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### **Capacity development:Reference documents and resources**

Zurmuehl (2010). Handicap International. [http://www.hiproweb.org/fileadmin/cdroms/Biblio\\_Renforcement/index.html](http://www.hiproweb.org/fileadmin/cdroms/Biblio_Renforcement/index.html)

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## Footnotes

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- ↪ 1. Handicap International's mission statement.
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- ↪ 30. It is important to appreciate here that though “while most of the evidence/studies point to a higher percentage of women and girls that are subjected to GBV, cultural attitudes need to be taken into consideration as boys are also survivors of sexual violence, but a lower incidence of reporting among men/boys does not indicate an absence of sexual violence against males”, personal communication May 2011, Theresa Rouger, Legal Advisor at Handicap International on the OAK project.
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- ↪ **107.** Handicap International (2010). *Handicap International project monitoring and evaluation policy*. Lyon.
- ↪ **108.** Presented in the form of a Pert diagram for example.
- ↪ **109.** This logical framework has been elaborated with the Handicap International HIV team in Kenya in 2010/2011.





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## **Inclusive and integrated HIV and AIDS programming**

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This policy paper describes Handicap International's mandate and values in operational terms as applied to the theme of inclusive and integrated HIV and AIDS programming.

It presents the approaches and references for Handicap International's actions, choices and commitments. It aims to ensure coherence in terms of practices whilst taking into account different contexts.

Essentially this is a guidance document for programme staff which defines the topic and outlines the target populations, methods of intervention (expected results, activities) and indicators for monitoring and evaluation. This policy aims to ensure that all projects carried out by Handicap International programmes are consistent with the methods of intervention presented.

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