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This publication comes at a landmark in time when the global discourse is shifting to an international development paradigm that looks beyond the Millennium Development Goals (MDGs) to a post-2015 era. It is a time when the world is charting a sustainable pathway to conquer universal issues that affect all countries within and across their borders including poverty and inequality, health and education, climate change, food security and many others. It is also a historic moment when evidence shows that the sum of our collective efforts has begun to successfully bend the trajectory of the global HIV epidemic. While this is cause for celebration, we also know that the challenge persists in ensuring that no one is left behind. People and communities who are most marginalized, who experience multiple and intersecting forms of stigma, and who are most affected by HIV, continue to remain at the heart of today’s epidemic. This is true in Canada as it is in other countries around the world. As we strive for continuous improvement and push to scale-up our response, program insights and lessons learned from partners across the globe offer us invaluable opportunity to reflect on our own triumphs and tribulations, build capacity, and spur innovations in policy, programming, and practice.

Much of the core programming at the Interagency Coalition on AIDS and Development (ICAD) focuses on helping Canadians contribute to the international HIV response while also ensuring that the lessons learned from efforts at the global level are accessible to Canadian organizations to inform strategies to strengthen prevention, treatment, care and support work across regions and communities in Canada.

Building on ICAD’s extensive history of twinning, knowledge exchange and skills building, we are pleased to share this newest addition to our series of lessons learned resources. Each of the five case studies presented in this document describes an innovative project that has been implemented in the South, and in sub-Saharan Africa in particular, by an ICAD member organization. While the focus of these case studies often speaks to HIV programming, the lessons presented here in this resource can easily be applied to other sexually transmitted and blood borne infections (STBBIs). The approaches, strategies, and the lessons gleaned through these initiatives offer transferrable insights and ideas for other settings, including in the Canadian context.

\cite{UNAIDS}
These five case studies are diverse in their subject matter and in the populations that they address; however, they share several crosscutting themes and lessons. The case studies highlight the importance of addressing HIV through the wider lens of the social determinants of health. Addressing complex and often intersecting issues of poverty, housing, disability, gender and other determinants of health is critical to responding to the root drivers of the epidemic in Canada and internationally. Similarly, working with key affected populations that experience increased vulnerability to HIV because of social inequality, stigma and discrimination, and the social determinants of health, is core to creating effective solutions.

The projects highlighted in this resource are grounded in a strength-based approach that places positive emphasis on resilience, empowerment, and community engagement. They share a focus on capacity building, whether at an organizational, community, or individual level, and present variations to models of peer education, training of trainers, and organizational self-assessments. Each case example hones in on issues that are of domestic and international priority for Canada – healthy communities, gender equality, and maternal, newborn and child health.

Though ICAD is based in Canada, we firmly believe this resource will be a useful tool for organizations addressing HIV and other sexually transmitted and blood borne infections in local contexts and countries around the world, including Canada. It is our hope that the lessons shared here will be useful. We look forward to receiving your comments on this resource, and to hearing your lessons from the field.
Building Capacity of Civil Society Organizations for Improved HIV Prevention Outcomes: The Botswana National AIDS Prevention Support (BNAPS) Project

Executed through World University Service Canada (WUSC)

This is a unique case study that highlights a model for technical support for organizational development and management for civil society organizations working in the HIV sector in Botswana. Operational and administrative aspects of organizational support in international development tend to get overlooked, having negative consequences on program delivery. This model can be adapted to improve the efficiency and effectiveness of organizations, particularly around governance and self-assessments. This sustainable approach will result in increased opportunities for civil society to contribute to other national development agenda issues beyond HIV and AIDS. The approach can be applied by international development organizations in their work overseas but can also be brought to the Canadian context to support emerging organizations. This case study describes the components of the model and highlights some of the achievements and key lessons. With the appropriate support and training, it is possible to transition emerging organizations to become functional entities with improved governance and management.

Context and Background

This project supported civil society organizations (CSOs) to better deliver HIV prevention programs in 9 districts in Botswana. Support provided to small organizations tends to be for a specific project, technical in nature, and ignores the daily operational and administrative functions. As funding cycles end and project activities cease, the efforts are not sustained and organizations fail to blossom. Working through an on-demand model and supporting some nascent community organizations, the project supported 54 CSOs in the areas of organizational development (OD), financial management (FM) and project management (PM) to successfully execute their financial management and reporting, governance, and monitoring and reporting, to ultimately achieve improved HIV prevention outcomes. This was achieved through proactive training and mentorship which was tailored to the established and emerging needs of the organizations, provision of customized and user-friendly tools and overall role-modeling of good project management including coordination and communication, and finally through one-to-one support visits. Ultimately the project ensured that the Botswana National AIDS Prevention Support (BNAPS) grantees effectively contributed to increased prioritized prevention services that reduce the risk of HIV transmission.
Approach

The following is a graphic representation of the process for building capacity with the various civil society organizations. A narrative description is provided below.

Diagram 1: Process for Building CSO Capacity in Botswana

1. Rapid Organizational Capacity Assessments (ROCA)\(^2\). WUSC administered the ROCA at inception and at the end of the project. This self-assessment tool was utilized to collect baseline information at the start of the project among each of the 54 organizations. As an assessment tool, it was designed to inform and evaluate WUSC’s training and support strategies, and to help BNAPS-funded CSOs measure their capacity against established standards in a participatory manner. The ROCA tool has seven key capacity strengthening domains including Strategic Leadership, Organizational Structure, Human Resources, Financial Management, Infrastructure, Program & Service Management and Process Management. The assessment tool takes approximately 3 hours to execute, and requires follow-up discussions for verification (where necessary) as well as analysis and feedback.

\(^2\)http://assets.wusc.ca/Website/Resources/BNAPSassessmentTool.xlsx
2. **Targeted Training.** The first training afforded WUSC with an opportunity to present Organisational Development (OD), Governance, Financial Management (FM) and Monitoring and Evaluation (M&E) tools for CSOs to appreciate what was required for efficiency and effectiveness. The ROCA findings were used to inform the results framework and training program. The second training took place after a 4 month period following the one-to-one support and was designed to be even more targeted to address any key issues that had been encountered thus far. The training program was designed not only to focus on lessons learned during the support but also to include a broader spectrum of topics on Leadership and Management, Governance, Conflict Management and Resolution, Human Resources, Communication, Results-based Management, Resource Mobilization and Time Management.

3. **On Demand One-to-One Support.** WUSC provided On Demand One-to-One Support to organizations in core management areas including OD, M&E and FM. These were based on the needs of the organizations who were encouraged to utilize this service. The one-to-one support was provided by the same specialists who conducted the training and this support was provided after hours during training sessions as well as at the organizations themselves. This training took various forms, including one-to-one coaching over several days, telephone coaching, and e-review of documents and proposals. Organizations learned how to complete the on-demand request forms which taught them how to convert needs into action plans and how to source support and assistance to fill gaps within their organizations. In some cases, stronger organizations were enlisted to share their learnings with other organizations and in some cases they even did some of the training during the second round of targeted training.

**Achievements/Results**

“This project allowed grassroots organizations with ad hoc processes to become functional organizations. It meshed a model of community and cultural governance with business governance through an organic process. WUSC has observed improvements at all levels of management capacity in all 54 organizations. With such a wide spectrum of capacity levels and a short intervention time of nine months, the methodology of joint trainings and one-to-one intensive support sessions has proven a successful method of increasing management capacities in FM, OD and PM. According to the CSOs self-evaluation, their capacity to manage and govern their organizations has improved (14% and 9% respectively), their capacity in HR has increased by 20%, their capacities to manage and account for finances has increased by 12%, their organizational infrastructure has improved by 10%, their ability to serve their communities through effective program management has improved by 7% and their process management capacity has improved by 12%. The change has been felt by the CSOs themselves and has been felt and observed by the WUSC team. It has also been anecdotally reported by District Grant Officers and National AIDS Coordinating Agency. The attribution of this project is critical to the
contribution to mitigating the impact of HIV/AIDS in Botswana. Programmatic leaders became strategic thinkers and leaders.

Lessons Learned

- **Holistic approach to develop effective civil society organizations.** Professional functioning organizations should consider organizational development, financial management and project management as key interlinked and integral pieces for success. Skills, capacity and resources need to be dedicated to all three components.

- **Assessment tools can be effective for change.** Self-assessments (such as the ROCA tool) are beneficial in making participants and organizations aware of their strengths and weaknesses and can lead to change. More importantly, these tools inspire self-awareness, opportunities for learning and a desire for improvement. Tools such as the ROCA can be utilized as a baseline and end-of-project tool, and their administration in a participatory manner installs ownership and accountability within an organization.

- **Staff participation and engagement.** Participation of all staff in training irrespective of their professional background/domain

“Since we worked with WUSC we have realized the many things that need to be done to develop our organization in order to operate in a professional way. At first we thought we were in the right track, but we were running our organization without proper policies which made it difficult for us to move forward.” [House of Men Theatre Group]
is important. This interdisciplinary approach not only ensures that everyone understands the different organizational aspects, but also mitigates against brain-drain, encourages opportunities for professional growth, and ensures continuity. A people-centric approach is really important for CSOs as individuals are the collective make up of organizations and key drivers of change.

- **Support and motivation.** Peer support or motivation works to inspire organizations. Sharing experiences of what works and success stories can help inspire other organizations. This could potentially create a sense of competition; however, it also motivates organizations to improve their performance, and provides opportunities for learning. The On-Demand One-to-One Support provided a mechanism for CSOs to initially troubleshoot their own problems and then be provided with the relevant support to ensure their issues were resolved. One-to-One support can be very effective as a coaching technique, and can help to reinforce learnings, as opposed to just a one-off training. Having this kind of mixed methodology approach to adult learning is much more effective than a singular approach. Further, having this external on-going support based on demand/needs built confidence among the various organizations.

- **Linking capacity building to funding is critical for supporting organizations.** Tying the capacity building to the provision of funding for operations and implementation resulted in more robust organizations that were able to deliver on the results. Participation in capacity building activities was a requirement of the donor and organizations had to participate in the training and then request the financial support afterwards. The donor was very interested in seeing the results and improvements to each of the organizations, which were visible particularly through better quality financial and M&E reporting.

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EMPOWERING YOUNG MOTHERS IN RURAL LESOTHO: 
THE YOUNG MOTHERS PROGRAM

Executed through Help Lesotho

This case study examines a unique approach to addressing the needs of a particularly vulnerable population, namely young mothers. The Young Mothers Program addresses some of the challenges young mothers face and provides them with options to build resiliency. This case study is relevant to many high HIV-prevalence countries in Africa, and some lessons can also be brought to many other contexts including Canada, where teenage pregnancy is an issue. The fundamentals of this approach are based on best practices in cognitive development, child and developmental psychology and psychosocial support, which are universally applicable. The program utilizes education for young women to better manage their health, leadership skills to help others, and psychosocial support to build their resilience. A similar approach could be adapted in other contexts, utilizing Young Mother Leads and providing the necessary training and support to address the needs of young women throughout the cycle of motherhood, from pre-conception to child rearing.

Context and Background

The social fabric in Lesotho has been greatly challenged by the country’s high HIV prevalence (23%). It has rendered young women increasingly vulnerable to teenage pregnancy and early marriages. Many orphaned children and youth who lack formal education, have been abandoned, and lack family and community support are now of child bearing age. The increase in teenage pregnancy and early marriages leaves young mothers to raise their children without adequate knowledge of parenting, maternal health and nutrition. Many of these young mothers feel alone and depressed trying to cope not only with motherhood responsibilities, but also with parenting in the absence of adequate resources, supports and skills to live healthy lives with their children. Furthermore, while young people are considered a population at higher risk of HIV infection, providing information on HIV prevention is insufficient to address the broader social determinants of health, especially for young mothers.

This project seeks to support young mothers in mitigating these social issues and health impacts by strengthening skills and building resiliency with and among women as mothers. The overall program objective is to improve the health and well-being of young mothers living in poverty and their children through psychosocial support, maternal health and nutrition education. Ultimately the program seeks to create supportive environments that facilitate the empowerment of women as young mothers and build skills to secure healthier lives and greater opportunities for their children.
Approach

The project targets unemployed, out-of-school pregnant and nursing young mothers between 12 to 30 years of age in three rural districts—Pitseng, Hlotse and Leribe. Several program components work together to maximize impact:

1. **One-day monthly contact sessions.** In a six month cycle, these sessions focus on such topics as: HIV and AIDS, maternal and reproductive health education; rights of women and children; strategies to handle depression, shame, sexual violence; the importance of antenatal visits and issues around labour; cleanliness and hygiene after delivery; infant and child care support; gender equity; nutrition including seasonal options, gardening and vegetable production, food preparation and preservation. Examples used during training and demonstrations are age-appropriate and contextually applicable. Ministry of Health personnel are invited to present on various health related topics. While the young mothers are in training sessions, their children attend early childhood education days provided by Help Lesotho to provide developmental stimulation and a caring environment. Help Lesotho invites the young women’s partners to two sessions in the six month cycle both to help them to feel included and to realize the advantages to them when they treat their partners and children with respect and support. Engagement of men not only increases awareness on health issues, including HIV prevention, treatment and support, but can also potentially reduce violence in homes.

2. **Young Mother Leads.** Young Mother Leads are mothers between 24-30 years of years who have experienced teenage pregnancy and have completed Help Lesotho’s four months intensive leadership training program. The Young Mother Leads receive additional multi-day training, including a project orientation, and training on psychosocial support, facilitation skills, and HIV and AIDS.

3. **Home visits.** Young Mother Leads conduct weekly home visits to provide the participants with an opportunity to talk about themselves and their family situations with someone they trust and for the Lead to observe the young mothers’ home situations and provide necessary support where possible.

4. **Formation of Village Support Groups.** The program participants form village networks in their vicinity under the guidance of a trained ‘Young Mother Lead’. These support groups meet for peer support and assistance coping with family problems.

5. **Awareness Campaigns.** Young mothers participate in advocacy events in their villages organized by the Young Mother Lead on topics such as the prevention of vertical transmission of HIV. This participation not only builds their confidence but also helps increase understanding of health and other social issues in their communities.
6. **Linking and referrals to services.** Young mothers receive information and support on how to access and link to essential service providers in their areas, such as the Hospital Adolescent Health Corner, reproductive health services, the Child and Gender Protection Unit in cases of abuse, and other pertinent local and national organizations. Help Lesotho brings representatives of the local services to the young mothers but, at this time, is unable to provide transport, childcare or other financial services for individual visits.

**Achievement/Results**

Since the inception of the project in 2011, over 230 young mothers have seen direct benefit. Several young mothers have become Leads in the community and have organized awareness campaigns on issues such as vertical transmission that benefit the wider community. Over eight young mothers support groups have been formed which provide emotional and psychosocial support.

The program increases resiliency and self-esteem among young mothers; raises awareness on HIV and AIDS prevention, transmission and treatment, and prevention of vertical transmission; reduces depression through connections with other women; promotes healthy lifestyles; develops support networks; and increases linkages with local service providers. This approach demonstrates that providing opportunities and empowering young women can lead to improved health outcomes for pregnant and nursing women, young mothers and their partners and communities.

The monthly program reports on village support groups reveal that the young mothers feel supported and loved in their groups and are better able to cope with their family problems. Respondents said they are able to share family challenges with the group and leave feeling better, more optimistic and better prepared to meet the challenges as they arise. One said that the group members guided her on what to take to the hospital for herself and the baby. She said with a shy smile: “Now that I do not have parents and nobody would have told me about this because my husband would not know either.” Young mothers’ self-perception has changed and they no longer see themselves as merely girls with children, but now as young, responsible adults.

“It seemed to me that being a young mother nobody loves you any more, your family, friends and even the father of your child whom you thought loved you so dearly. The pain of seeing him with other girls living as if I never existed nor even his child, tears my heart apart. I felt like the whole world had turned against me. With this training, the pain is going away and I am getting rejuvenated.”

A young mother who is also a double orphan shared her feelings during the discussion on pre and post-natal depression.
Lessons Learned

Understanding the beneficiary for effective responses

To be responsive and effective, a program needs to understand the groups it aims to engage and to develop responses accordingly. In this program several specific issues and needs have had to be addressed:

• **Shame:** The program revealed the significant extent of shame these young mothers carried. Compounded by their lack of formal education and a lack of self-esteem and knowledge, overcoming shame was a huge challenge for young women in Lesotho and required several one-on-one meetings and effective support groups in order to build trust.

• **Stigma and discrimination:** Many young women who bear children at a young age, particularly outside of wedlock, face significant stigma and discrimination not only from their communities but also from service providers and institutions. This is an issue that needs to be tackled. Institutions such as schools and health facilities need to be sensitive and responsive to the needs of young mothers.

• **Literacy:** Literacy levels among the young women were very low and had to be taken into consideration when designing interventions and providing support. For instance, while the benefits of a support group are critical, for these to be successful, participants needed training on cooperative learning and group dynamics. Many had only a few years of school and had not been socialized in these skills. Further training on group dynamics, cooperative learning, and peer support would increase the success of the women individually and collectively.

Addressing essential needs to enhance outcomes

• Nutrition is a significant issue among young mothers. Many do not have the food needed to take their HIV medications. Many were drawn to the training because they received food and seeds to grow food. There is a need to raise awareness about maternal nutrition and provide supports to address gender and food insecurity.

• Childcare services during training are essential for the mothers to focus on the material. Mothers need time to be with other mothers in a space where they feel safe and comfortable to speak about their concerns. Childcare allows them a small window of time to focus on themselves without worrying about the immediate needs of their children.

Engaging broader beneficiaries is important

• While training fosters hope and optimism for young mothers shunned by their communities, and a significant increase in self-esteem, they are sometimes subject to emotional and physical abuse when they return home to family members and partners. Recognizing the role of partners or husbands and engaging them in targeted activities help them to feel included, raise awareness on health issues such as HIV prevention, treatment and support, and work to reduce violence against women. Through community mobilization, the project also tackled issues around stigma and discrimination.
Follow-up and linkages are critical

- Follow-up mechanisms are critical to ensure that young women do not relapse into depression, isolation and situations that can harm their health. The support groups and Young Mother Lead home visits were useful for this purpose. Peer support works very well with young mothers, as they can relate to each other and are able to build trust and confide in others.

- Links to other services such as child protection are important as are access to family planning services and contraceptives. This program works closely with various other organizations providing these necessary services to young women.

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HIV PREVENTION IN RWANDA: THE INVOLVEMENT OF PERSONS WITH DISABILITIES IN PEER EDUCATION

Executed through Handicap International

This case study looks at HIV prevention through the involvement of persons with disabilities in peer education in Rwanda. Persons with disabilities are at increased risk of HIV infection and sexual violence. While mass media and education campaigns for HIV prevention may be available to the general public they often do not reach the most vulnerable and marginalized populations. This peer education approach has proven effective in reaching persons with disabilities in Rwanda and has had a multitude of remarkable ripple effects on a national scale. The key lesson learned is that vulnerable populations need specific and targeted interventions that address their needs and that they can be empowered to be their own effective champions of change. Lessons from this case can be applied to peer education programming in other countries and settings when working with persons with disabilities, including in Canada.

Context and Background

Persons with disabilities\(^3\) have an equal or heightened risk of HIV infection compared to non-disabled persons.\(^4\) They may be at increased risk because of additional vulnerabilities such as poverty, limited access to education and health care, stigma and discrimination, lack of information and resources to facilitate ‘safer sex,’ lack of legal protection, and increased risk of violence and rape.\(^5\) In Rwanda many projects were already routinely using peer education to engage and support people living with HIV (PLHIV); however, these programs did not include persons with disabilities among their priority populations. Few persons with disabilities sought these services and when they did, barriers to these services were very high, including limited or no access to information because of communication barriers and low levels of literacy; caregivers and community prejudice regarding persons with disabilities; physical inaccessibility of prevention activities and health, police and judicial services; and, service providers’ attitudes. Persons with disabilities were only reached by chance when they happened to fall in the catchment area of an HIV program. Since mainstream HIV messages are unlikely to reach the majority of persons with disabilities, a targeted outreach approach, such as peer education, was deemed best to sensitize persons with disabilities, their families and communities. This project was the first large-scale attempt to train and sensitize large numbers of persons with disabilities through peers, supported by disabled people’s organizations (DPOs) and community-based organizations (CBOs). The project

\(^3\) Disability is defined as “an involving concept... Disability 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 2007/WHO ICF 2011).


was implemented in 18 out of 30 districts by Handicap International and nine partnering civil society organizations (CSOs), and utilized peer education as its HIV prevention strategy.

**Approach**

Peer educators in this project were unpaid volunteers, persons with disabilities—or in some cases, especially for persons with intellectual disabilities, family members of persons with disabilities. Many of the peers were HIV-positive and reached out to other persons with disabilities, their families and the wider community. The following is a graphic representation of the approach utilized for peer education, followed by a narrative description.

Each CSO was asked to select individuals to attend five days of HIV and disability training of trainers (ToT). Sexual violence was later added as a component to this training. A total of 202 persons were trained to become disability and HIV trainers of which 98 were persons with disabilities. These trainees then trained the selected peer educators.

Each CSO was asked to select their own peer educators based on specific criteria (being a community member, type of disability, primary school level literacy, and...
caring attitude). Other peer educators were selected among DPOs, CBOs, association members and some family members of persons with disabilities. Peer educators were brought together, usually at the district level, per organization, so that peer educator trainings could be adapted to their types of disability. For instance, some peer educators were women with a hearing and/or speech disability so trainings were conducted in sign language and with the help of image boxes and visual aids. All trainings consisted of theory and practice, during which the peer educator was asked to conduct peer education exercises and was tested. The ToT-trained individuals trained 2085 peer educators. Some CSOs combined the functions of peer education with home based care, community health volunteers or women entrepreneurs.

The trained peer educators organized discussion groups with the communities who were mobilized through various means, including announcements at churches. Each peer educator met with a group of 30 people and had at least three interactive discussions on various topics such as condom use, sexually transmitted infections (STIs), transmission, care and treatment of HIV and AIDS, and myths and misconceptions about HIV. Discussion groups were held in a manner adapted to the groups’ needs, for instance using recorded messages to support discussion groups of people with low vision and/or are blind, or sign language for groups of people who are hard of hearing or deaf. Eventually a session was organized in collaboration with the health facility where community members had an opportunity to take a voluntary HIV test. For those who tested positive, referrals were made to the nearest health facilities offering treatment services. The peer educators served as role models; educated peers in a structured manner; recommended the peers to voluntary counseling and testing (VCT) services; and, referred those in need of additional help for assistance. Peer education was always done in combination with other activities such as Umuganda (the monthly communal activities celebration days) and outreach activities at schools.

Achievements

Involvement of persons with disabilities in national prevention efforts

For the first time in Rwanda, persons with disabilities were deliberately included in large scale HIV and sexual violence prevention efforts. The involvement of persons with disabilities—especially persons with disabilities living with HIV—in prevention activities that included personal contact, exchanges and testimonies affected change at the individual level. The inclusion of a variety of DPOs made it possible to involve persons with diverse disabilities in an appropriate way. The use of existing networks of DPOs and CBOs resulted in a high coverage in selected districts, even in difficult to reach areas.

Creating tailored and appropriate materials for persons with disabilities

Information, Education, Communication (IEC), Behaviour Change Communication (BCC) and training materials on HIV and AIDS and sexual violence were produced

“HIV and disability is now in our Plan of Action; it is now one of our priorities. We are moving from HIV prevention in the general population to HIV prevention in key groups, so that has changed. Because disability is included our plan of action, we have budget for persons with disabilities, for mobile VCT, for tools, for training, for supervision. It is now considered a priority.”
Anita Ahayo, responsible for Volunteer Counselling and Testing, HIV division Ministry of Health, Rwanda
or where possible, existing materials were adapted in order to include persons with disabilities and to make the materials accessible to them. Many of these materials, such as image boxes for usage during ToTs, tapes, CDs and DVDs with messages targeting people with sensory disabilities and people with intellectual disabilities, were disseminated early on during the project. A number of these have been revised and adopted by the Ministry of Health, used routinely, and will be disseminated in larger quantities in the near future.

**Building capacity and knowledge among a vulnerable group**

A sense of ownership emerged because persons with disabilities from the area were sent to be trained as peer educators, came back to sensitize others, and were accountable to their community members. Furthermore, persons with disabilities participated at all levels of the project; not only as beneficiaries, but also as actors. Persons with disabilities gained practical knowledge, such as how to apply and properly use condoms and how access to volunteer counseling, testing (VCT) and treatment services is a fundamental right. Knowledge of HIV also increased and many common misconceptions were addressed. For instance, some of the peer educators trained thought HIV had diminished or was even cured, while others confused HIV with a type of book or school. Education and awareness on HIV and AIDS has enabled persons with disabilities to make informed decisions in relation to living positively. Many of the peer educators took up leadership roles in community organizations and later found their way into positions at DPOs, NGOs, CBOs, the Umbrella, or Government.

**Increasing empowerment on rights and demand for services**

Through peer education, persons with disabilities were made aware of their rights and they were empowered to speak out about their rights. For instance, many persons with disabilities will now ask to be included in development activities and are vocal on cases of sexual violence. Many participants interviewed mentioned increased recognition by local authorities and inclusion in community meetings, as well as increased self-esteem and confidence. Furthermore, peer education amongst persons with disabilities has increased the demand for inclusive health services, especially for services that address HIV and AIDS and sexual violence. The inclusion of community health workers (CHWs) among peer educators, home-based care activities and discussion groups improved access for persons with disabilities to health services at the village level, the lowest level of health services in the Rwandan Health System.

**Decreasing stigma and discrimination**

The inclusion of family and community members in the discussion groups led to a decrease in stigma and discrimination against persons with disabilities. The good relationship and interaction with local authorities meant an increase in awareness among stakeholders such as the social affairs officers on the needs of persons with

"I found the training wonderful. After the trainings we had a kit, so we started going out, to reach out to our fellow persons with disabilities. We had an artificial penis model, condoms and radio. We also mobilized our fellow people with disabilities and they came. We educated them on HIV and AIDS and then they went to the health centre for Volunteer Counselling and Testing."

Epifania is in charge of law and justice on the executive council of Gisagara district in Rwanda. She is blind and became a peer educator during the project.
disabilities in their catchment areas. This also influenced national policy for the inclusion of persons with disabilities.

**Addressing other social issues**

Through the discussion groups, persons with disabilities met their peers and got the chance to exchange on a multitude of topics beyond health seeking, HIV and AIDS and sexual violence, including strengthening of the social fabric/network and decreasing isolation. This project inspired discussion groups to evolve into community-based organizations, support groups, and cooperative associations to decrease poverty. Other problems that persons with disabilities face are being raised and as a result persons with disabilities are now increasingly included in development programs.

**Lessons Learned**

**HIV prevention needs to be tailored to the needs of vulnerable populations**

While mass media and education campaigns for HIV prevention are important, they tend not to reach the most vulnerable populations; sometimes targeted interventions are necessary to reach them. The needs of specific vulnerable populations such as persons with disabilities are unique and interventions need to be tailored accordingly.

**Addressing HIV among women requires the integration of HIV services with sexual and reproductive health and sexual violence programming**

HIV prevention programs need to incorporate the broader social determinants and take an integrated approach. The majority of HIV infections are sexually transmitted or attributed to vertical transmission. Women and girls with or without disabilities and those who experience sexual violence are more likely to experience sexually transmitted infections including HIV, genital tract infections, unintended pregnancies and unsafe abortion.

**Behaviour change interventions take time and need a diversity of approaches to ensure effectiveness**

Whilst peer education is effective in raising awareness it requires some repetition and follow up to change attitudes and behaviours in the long term. When dealing with vulnerable populations it is essential to ensure that follow-up takes place and hence it may be necessary to have peer educators adopt a door-to-door approach to make sure that the most vulnerable individuals are identified and reached. While the discussion groups were participatory in nature, it may be necessary to diversify approaches and maybe include other elements such as drama or sketches. Messages should be reinforced through different activities and intervention channels. Peer education can also be coupled with other services such as home-based care.

**Peer education and community mobilization can be used to improve access and availability of services**

Through this project, awareness of HIV increased, as did willingness to test for HIV, and the demand for services and referrals. As a result, there were improvements in health-seeking behaviour. Responsive services should be available if demand for services increases. Structural barriers to HIV prevention should be reduced by integrating or linking peer education with community development initiatives (e.g., literacy, vocational or livelihood skills training, entrepreneurship trainings, microenterprise and
When peer education programs are integrated with other interventions, often peer educators serve as links with these program activities and services.

**Peer education empowers communities**

Through this project the ToT-trained individuals and the peer educators were empowered in areas beyond HIV. A sense of confidence was built and participants were able to demonstrate leadership and further their aspirations in helping their communities and engage in CSOs and other vocations. Several support groups and community associations groups were formed which may need further institutional strengthening and capacity building in different areas in order to serve their communities.

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Secure and affordable housing is a strong determinant of health. Inadequate shelter increases the vulnerability of the urban poor to HIV and AIDS, especially among women and children. Rooftops Canada, the international development program of cooperative and social housing organizations in Canada, has been working with housing cooperatives and associations in the South to integrate responses to HIV for over a decade. This programming was established in response to the desire to address the impacts of HIV and AIDS on their members, beneficiaries and clients. Rooftops Canada has supported the cooperative housing movement in Zimbabwe since the 1980s through a combination of technical assistance, training and resources. Rooftops Canada’s focus is to increase the Zimbabwe National Association of Housing Cooperatives (ZINAHCO)’s capacity to assist member organizations, and to help local women and families gain access to land, services and small loans for cement, bricks and other construction materials to build houses. These loans are then paid back and reinvested in the community so that the construction process can continue. This case study highlights how ZINAHCO was able to integrate HIV within its programming and to provide guidance to housing cooperatives to ensure the needs of vulnerable populations were met and their rights protected. ZINAHCO focuses on helping its members secure land and build housing while promoting social sustainability, enhancing operational capacity and improving financial sustainability. Its community-based responses focus on issues of stigma and discrimination, reducing the impact of housing rights violations, and responding to the specific vulnerability of children, women and youth. The lessons learned from this experience can be transferred to social and cooperative housing in other countries where PLHIV face similar vulnerabilities, including in Canada.

“I am now an empowered woman and a proud land owner. My house is taking shape. I am very grateful to ZINAHCO and its partners for transforming my life.”
Nduzani Beselemu, a member of the Kumboyedza Housing Cooperative in Zimbabwe, who was able to secure a plot of land to build a house and also received assistance to start a small business.

6 Kjellstrom et al. 2007, Our Cities, Our Health, Our Future: Acting on Social Determinants for Health Equity in Urban Settings, Report of the WHO Commission on Social Determinants of Health from the Knowledge Network on Urban Settings, Kobe, Japan.
Context and Background

The immense human settlement challenges in urban slums—overcrowding, tenure insecurity, inadequate water, sanitation and basic services—are intensified by the impact of HIV and AIDS on poverty and vulnerability. Poor living conditions, including homelessness, undermine safety, privacy and efforts to promote self-respect, human dignity and safer sex practices. They also disrupt medical regimes, access to nutrition, and home-based care for those affected. For persons living with HIV and AIDS, improved housing status is directly related to reduced risk behaviours, improved access to health care, higher levels of antiretroviral treatment adherence, lowered viral loads, and reduced mortality. When individuals die from AIDS-related illness, surviving family members and orphans may lose their homes because they cannot afford housing payments. Women in particular are blamed, dis-housed and denied their property/inheritance rights. Children, particularly girls, drop out of school to care for parents and siblings and more children end up living on the street in order to survive. Housing and human settlement actors and agencies have been forced to re-think their strategies for achieving adequate housing, which serves as an important element of cross-sectoral HIV and AIDS responses and health promotion in general.

In Zimbabwe, many interventions by government, the international community and local players have yielded positive results and decreased the HIV prevalence rate to 14.7% (UNAIDS, 2012). However, the housing cooperative sector remains very vulnerable to HIV and AIDS despite the recorded positive trends. This is especially the case for housing cooperatives that are still struggling to secure land and build housing. Members suffer from many of the above issues related to poor living conditions and high levels of poverty. The integration strategy (Appendix A) within ZINAHCO addresses many of these drivers.

Approach

ZINAHCO supports its members, namely affiliated housing cooperatives and District Unions (DUs), through its Management Committee, which supports HIV and AIDS Working Groups. The Working Groups are established to ensure smooth and proper implementation, functioning, supervision and monitoring of HIV and AIDS interventions for the housing cooperatives. In collaboration with existing national HIV and AIDS coordinating structures, the HIV and AIDS Working Groups are responsible for coordinating local level interventions. ZINAHCO assists with the identification of key drivers for HIV and AIDS within each sub-sector and finds ways of dealing with them. It facilitates training and awareness of members and their spouses so that interventions are owned more and more by beneficiaries and are sustainable. ZINAHCO also facilitates access to ARVs for its members.

Achievements

Despite numerous successes, ZINAHCO faces considerable organizational and financial constraints in fully implementing its comprehensive and ambitious HIV and AIDS integration strategy (Appendix A). The organization’s first success was to develop the strategy and have it accepted by both leadership and its members. The following are some of the further results achieved to date:

<table>
<thead>
<tr>
<th>Factors that facilitate successful integration</th>
<th>Challenges and barriers to integration</th>
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<tbody>
<tr>
<td>• Partnerships, collaboration with relevant institutions that can provide required services.</td>
<td>• Leadership and organizational commitment</td>
</tr>
<tr>
<td>• Leadership and buy-in at all levels of organization on the need for integration.</td>
<td>• Lack of clear understanding on why integration is necessary and how to do it. Fears it might overwhelm the core business.</td>
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<tr>
<td>• Internal integration precedes external integration.</td>
<td>• How to integrate HIV and AIDS without taking on the role of AIDS service organizations.</td>
</tr>
<tr>
<td>• Giving HIV and AIDS a human face – need to encourage open and positive living; PHAs leading programs.</td>
<td>• Lack of understanding amongst both HIV and housing sectors – what each is responsible for, why it is relevant to the other sector, funding competition.</td>
</tr>
<tr>
<td>• Exchange experiences, mentoring and learning from others who are also engaging in integration.</td>
<td>• Limited capacity and resources (and fear) – human, financial, information, relationships</td>
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<tr>
<td>• Encourage policy cross-over between national HIV and housing strategies.</td>
<td>• Historic silos – health, housing, food – of working in civil society. Constituencies also look at NGOs in that way. Need to see HIV and housing as social issues that are multidimensional.</td>
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<tr>
<td>• Integration tools should align closely with existing strategies e.g. choice of training method, gender, HIV and Habitat.</td>
<td>• HIV and AIDS is a politically charged issue – there is stigma of being an “AIDS organization” or “not being AIDS organization”</td>
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<tr>
<td>• Resources – particularly information, knowledge and tools.</td>
<td>• Politicization of AIDS – political will, overload of information.</td>
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### Training on gender issues and reducing stigma and discrimination

ZINAHCO provides gender and HIV and AIDS training for its members. The training is focused on “positive masculinity”, reducing gender-based violence, promoting women’s inheritance rights, creating safe spaces for PLHIV, and understanding disabilities all through an HIV and AIDS lens. Since 2011, a total of 340 females and 84 males from housing coops have received gender, HIV, AIDS and housing training. Several DUs have also set up committees to take leadership on responding to HIV and AIDS issues. Hundreds of women from various DUs participated in International Women’s Day events in 2013, which helped raise awareness of issues related to HIV and AIDS. ZINAHCO training also targets greater involvement of youth and PLHIV. In 2012 and 2013, ZINAHCO held national youth workshops that included the topic of HIV and AIDS. The workshops were attended by 26 young women and 42 young men. Besides
creating safe space for PLHIV in housing cooperatives, members (both women and men) learn about positive living, wellness and health. Despite the drop in prevalence rate of HIV in Zimbabwe, stigma is still rife and more HIV and AIDS training programs are needed within all structures of the housing movement.

**Income Generating Activities (IGA)**

ZINAHCO emphasizes income-earning opportunities for people living with HIV and offers related training. Musha Wedu Coop, which has 200 members with special needs, is operating a brick making enterprise with a loan from ZINAHCO’s Revolving Loan Fund. Youth also have been trained in brick making. Chido Coop, which has an HIV and AIDS support group, has also received training in brick making and accessed income generating project loans. Pepukai Coop in Masvingo is constructing a community hall as an IGA. In 2013, ZINAHCO conducted two IGA trainings that were attended by 23 women and 4 men whose lives are impacted by HIV and AIDS. The training focused on providing basic information on small businesses such as cost estimation and where to get small business information. ZINAHCO will continue to hold training on more advanced aspects of small businesses.

**Home Loans**

The Kumboyedza Housing Coop is one of the first coops to benefit from Rooftops Canada’s partnership with ZINAHCO’s new loan program and so far 58 homes have been built. ZINAHCO has helped Coop members to build 4,000 low-income houses in the past ten years. Families impacted by HIV and AIDS own many of them. ZINAHCO supports a total of 199 housing cooperatives with a total membership of 6,038 males and 4,549 females.

**Establishment of Support Groups for PLHIV**

ZINAHCO continues to provide guidance and assistance to PLHIV support groups which were previously established. Rooftops Canada supported these groups to secure funding to improve nutrition through herb gardens and urban agriculture. Currently each DU has support groups and a total of seven support groups are in existence.
Lessons Learned

Integrating HIV and AIDS within the organizational culture is a pre-requisite for success

The internal integration of HIV with the organization’s core business helps the organization better conceptualize, understand and relate to key HIV and AIDS issues within their personal lives and how it fits with the mandate of the organization. Staff, management and board members are sensitized on issues of HIV before advocating externally. Developing clear organizational policies, procedures and program strategies creates a solid platform and enables the organization to support its cooperative members.

Integrating HIV and AIDS addresses broader social determinants of health

HIV and AIDS accentuate the issues related to access to housing and living conditions in informal settlements. The integration of HIV and AIDS supports and advances linkages with broader issues such as inheritance rights, child welfare programs, and workplace programs, which are embedded within the broader context of poverty. Issues raised in the process of integration are relevant to other social determinants of health and have an important impact on improving broader health and social outcomes.

Strategic partnerships are necessary in providing integrated care and support

Where HIV and AIDS are not the organization’s core business, it becomes even more imperative to invest in building networks and partnerships to encourage a social determinants of health approach across service delivery, policy domains, and advocacy efforts. Integration should not necessarily mean adding HIV and AIDS to the ‘core business’ of a housing cooperative especially in contexts where there are quite a number of other actors directly addressing HIV and AIDS issues. Rather, housing cooperatives should integrate the perspective in their work and collaborate with other organizations that have the expertise and are better placed to address HIV and AIDS related issues. For instance, the housing cooperative can be located within an integrated network of NGOs that provide housing, health care, child welfare, assistance with legal issues, food gardens, etc. In effect, integrating HIV and AIDS offers valuable opportunity for capacity building and growth for staff, its network members and partner organizations, and for the people who use its services.

Involving key populations in the integration process creates sustainability

Involving PLHIV, women and vulnerable groups such as youth and orphans is key to integrating HIV. Not only does their leadership work to reduce stigma, but it gives HIV and AIDS a human face and makes programs better able to address the complex and often intersecting determinants of health.

Monitoring and evaluation is key to integration

Monitoring and evaluation systems are required to assess the impact of programs on reducing vulnerability and improving access to care and services. Documenting good practices and lessons learned are critical aids to program improvements, staff learning, accountability and monitoring.

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<table>
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<tr>
<th>Objective</th>
<th>Strategies</th>
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| 1. Forge strategic partnerships in taking action against HIV and AIDS     | • Design programs aligned with comprehensive HIV and AIDS interventions for ZINAHCO affiliated housing cooperatives, taking into account ZINAHCO’s core business of delivering low cost housing for members.  
  • Cover HIV and AIDS issues within the ZINAHCO strategic plans. Have focal persons who lead on issues related to HIV AIDS at District Unions, through to the housing coop and support group levels. |
| 2. Promote open dialogue and transparency within housing cooperatives      | • Housing cooperatives and members of the ZINAHCO management committee to be active and take ownership of the process and in the implementation of the policy and programs.  
  • HIV and AIDS Working Groups made up of members of the DUs, support groups and people living with HIV.                                                                                                                                                                           |
| 3. Prevent HIV infection and reduce AIDS related deaths                   | • Identify the drivers of HIV and AIDS in the housing cooperative context. Reinforce prevention and education through effective awareness campaigns and outreach programs.  
  • Working with other stakeholders who work in HIV and health, provide a variety of innovative choices for preventive methods based on known best practices.  
  • Make deliberate effort to reach out to all cooperators and their spouses with education and awareness material within their working environment and homes. Align prevention programs for the housing cooperators to other relevant prevention programs e.g. male circumcision.  
  • Address the issues of gender equality as well as poverty.  
  • Establish programs that target married couples  
  • Involve HIV and AIDS support groups in program implementation.  
  • Working with other stakeholders who work in HIV and health, facilitate access to treatment and continued treatment by lobbying for easy access to antiretroviral treatment.  
  • Improve supply of Home Based Care (HBC) kits to families and PLHIV.  
  • Lobby for the availability of drugs for opportunistic infections at designated places.  
  • Provide land to families with PLHIV to improve food security and facilitate availability and access to nutritious food.  
  • Improve economic empowerment and livelihood strategies for infected and affected people so that they can sustain themselves.  
  • Working with other stakeholders who work in HIV and health, promote voluntary counseling and testing.                                                                                                                                                                                                 |
| 4. Promote non-discrimination and non-stigmatization of cooperators or workers on the basis of imagined and real HIV status | • Design and implement programs to provide information and education on HIV and AIDS to all interested parties. Provide continued counseling services to the infected cooperators.  
  • Launch awareness campaigns.  
  • Adopt sound advocacy strategies and disseminate information on HIV and AIDS aggressively, involving Support Groups.                                                                                                                                                                                                 |
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| 5. Maintain confidentiality where HIV and AIDS issues are concerned | • Educate all interested parties, including the most vulnerable about their rights and obligations with respect to management of confidential health information.  
• Provide information and education on existing labor laws.  
• Where skills are available, counsel infected and affected persons, regardless of status, including the more vulnerable informal sector members. |   |
| 6. Facilitate the continued engagement and employment of HIV-positive persons as long as they are medically certified fit for appropriate employment; and in the case of housing cooperators as long as they are willing and able to participate in the activities of housing cooperatives in accordance with set rules | • Implement an aggressive lobbying and advocacy strategy with employment groups to reduce incidences of human rights abuses and discrimination at work, unfair dismissals from work for members. Provide education and information to all levels within the work places of coop members. |   |
| 7. Achieve gender equality and sensitivity in the workplace | • Create equal opportunities for both men and women, irrespective of HIV status.  
• Provide education on gender awareness and gender dimensions of HIV and AIDS to management, employees, regardless of status of grade.  
• Integrate gender in all HIV and AIDS preventive and care programs in all housing coops and DUs. |   |
| 8. Provide a caring and supportive environment for HIV-positive employees or cooperators, including their families | • Encourage uptake of voluntary counseling and testing services and openness on HIV and AIDS minimizing stigma.  
• Facilitate formation of vibrant informal social clubs and HIV and AIDS support groups, in the case of housing cooperatives.  
• Create structures within established ZINAHCO District Unions and existing housing cooperatives to address the needs of orphans and vulnerable children (OVCs) in a sustainable manner - need to review the by-laws of housing cooperatives in keeping with the challenges posed by OVCs.  
• Develop an affirmative policy to co-opt youth at all levels of the ZINAHCO structures, from primary level, to DU and National Management Committee. |   |
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<td><strong>9. Strengthen livelihood improvement and access to viable economic opportunities for members by facilitating engagement in diversified productive activities</strong></td>
<td>Of fer viable economic opportunities to members (largely engaged in the informal sector) through which they can generate income and savings to contribute towards building projects.</td>
</tr>
<tr>
<td><strong>10. Strengthen the financial health of members with a view to making building projects more feasible and viable for both women and men, thus reducing their vulnerability</strong></td>
<td>Establish a decentralized housing cooperative fund, with chapters managed at District Union level, principally focused on the needs of the poorest and the most disadvantaged of ZINAHCO members (e.g., widows/widowers, PLHIV), and on addressing the needs of families of deceased members. The fund should have a clearly defined purpose, be professionally administered, and be subjected to regular external audits to ensure transparency.</td>
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<tr>
<td><strong>11. Monitor, evaluate and assess impact of HIV and AIDS policy and programs</strong></td>
<td>Ensure establishment of monitoring and evaluation systems for regular review of the policy and program implementation. Conduct joint reviews of the policy and program implementation. Generate monitoring data on a regular and predictable basis which will be used to assess the impact of HIV and AIDS on housing coop.</td>
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SOCIAL ANALYSIS AND ACTION AS A PLATFORM
FOR ADDRESSING GENDER, HIV AND SEXUAL AND
REPRODUCTIVE HEALTH IN RWANDA

Executed through CARE Canada

Village Savings and Loans Associations (VSLA) are an approach whereby women are socially and economically empowered and other social issues such as sexual and reproductive health and HIV and AIDS can be addressed. An approach to behaviour change called Social Analysis and Action (SAA) can be incorporated into VSLA to address social and health issues as they evolve. Empowering women through VSLA and then engaging them through SAA can address pertinent health issues and over time develop resiliency to mitigate health-related risks. This case study highlights how the SAA approach used within the VSLA context in Rwanda has improved family planning outcomes. This model can and has been adapted to other contexts globally and can be used to address broader health issues, including HIV. This VSLA-plus model could support community-based efforts to reach vulnerable populations in Canada, such as newcomer populations and Aboriginal communities. SAA can be adapted to the Canadian context to address sensitive health issues and can open up forums for discussing sexual and reproductive health issues including HIV and AIDS.

Context and Background

In Rwanda, CARE Canada implemented the Social Change for Family Planning Results Initiative (RI) in four sectors of Gatsibo District, Eastern Province with the goals of increasing economic opportunities, reducing poverty, and improving gender equity and sexual, reproductive, and maternal health. The RI was designed to improve access to, and quality of, health services and information while also addressing deeply entrenched social, cultural, gender, and power norms that inhibit uptake of family planning. The RI was implemented through the existing micro-finance structure of VSLA, which engaged women who did not have access to financial services. The project utilized SAA, an approach which uses recurring reflection and dialogue of social barriers to analyze social issues and develop solutions to address these. Some of the most powerful social barriers to optimal health were inequitable gender attitudes and behaviours in the community and in the household. Through this process, the communities were able to address these barriers and improve health outcomes, particularly related to family planning.

Village Savings and Loans Associations (VSLAs) are self-managed groups that do not receive any external capital and provide people with a safe place to save their money, access small loans, and obtain emergency insurance. The approach is characterized by a focus on savings, asset building, and the provision of credit proportionate to the needs and repayment capacities of the borrowers. Groups are low-cost, simple to manage and can be seen as a first step for people to reach a more formal and wider array of financial services. VSLAs can dramatically raise the self-respect of individual members and help to build up social capital within communities, particularly among women who represent approximately 70 percent of members. The model was developed by CARE International in Niger in 1991 and has spread to at least 61 countries in Africa, Asia and Latin America, with over 6 million participants worldwide.
Approach

CARE pioneered the Social Analysis and Action (SAA) approach to assist communities to use regularly recurring dialogue to address how their social norms, beliefs and culture may perpetuate health challenges. SAA can be integrated into the traditional community-based program cycle or in this case a VSLA project. SAA utilizes a variety of participatory tools in an ongoing process of reflection, challenge, exploration, and learning. The goal of the process is to build the capacity of communities to challenge social norms. Some key elements of the Social Action process include:

- Exploring the social dimensions of health (including HIV and AIDS)
- Empowering communities to understand the connections between health and socio-cultural factors
- Engaging communities to take action to improve their health and well-being

The Diagram A explains each of the stages on the Social Analysis and Action approach.

Box 1: A Peer Educator is a VSLA and community member trained to conduct discussions related to family planning, gender and violence in an engaging and participatory way. Equipped with these skills and through mentorship by CARE staff, the Peer Educators create a safe space to engage their peers within the VSLA in conversations about the benefits of family planning and how to prevent gender-based violence. As a trusted member of the VSLA, providing locally-relevant and meaningful suggestions, in the local language and taking account of the local context, CARE and the Peer Educators aim to promote health-enhancing behavior change and discussions on sensitive social and gender norms to catalyze positive changes within the VSLA group and their households.
Diagram A: The Process of Integrating Social Analysis and Action into the Family Planning Results Initiative

**Staff Orientation**
- An important first step is creating a shared understanding of SAA approaches and how they can be used to initiate critical reflection and dialogue about gender, family planning and gender-based violence (GBV). A series of trainings and reflection sessions were held for staff to reflect on how their own assumptions, beliefs, and attitudes about gender, power and sexuality, influence their decisions and behaviour and ultimately, their work. Staff also reflected on how those same social and gender norms related to a woman’s ability to participate in making sound economic decisions for her family. This process was conducted in 8 days over the course of 2 months and included building a shared understanding of key concepts related to gender, sex and social barriers to services.

**Identification of Peer Educators**
- A peer educator (PE) needs to be identified (see Box 1 for definition of PE). VSLA members were first led in a discussion of the characteristics of a peer educator, such as the ability to conduct discussions within the VSLA groups, after which interested VSLA members self-identified. It was important for the peer educator to have adequate literacy skills and to be willing to work as a volunteer. The peer educator identified by the group was sent for training.

**Training Peer Educators**
- The identified peer educators were trained in basic family planning, GBV and how to use locally adapted SAA tools to address issues around gender (e.g., using a bead game). The peer educators gained knowledge on different family planning methods, which enabled them to understand how to address and challenge related community rumors and misconceptions. The training offered a safe space for peer educators and CARE staff to speak openly about topics usually not discussed in public settings. The peer educators were trained on women’s rights and how different forms of violence affect household wellbeing and family planning. The facilitators enabled the peer educators to discuss the various forms of abuse common in the community and to learn about corresponding laws that prohibit and penalize these abuses. Trainers from Rwanda Men’s Resource Center focused on male engagement strategies, led discussions on how men’s support to women and men’s involvement in family planning was crucial to the improved economic status of households and the prevention of violence.

**Identification of Change Agents**
- In order to extend the reach of the conversations being held within VSLA groups, community change agents were identified among the peer educators. These change agents were trained and mentored by CARE in advanced facilitation skills to conduct discussions outside the VSLA group and with the community-at-large. These discussions were held after celebrations or in-community gatherings in the villages. They addressed some of the issues such as child preference, gender-based violence, and family planning options.

**Training of Change Agents**
- Change agents underwent a more in-depth training, specifically on leading community reflections. Change agents were trained on how to use SAA tools to stimulate community reflections on social norms, such as preference for sons or male children, or the sharing of household chores between husbands and wives. They were also trained in advanced facilitation skills to conduct community discussions, including managing discussions on taboo subjects and coaching others in decision-making and problem solving. The change agents held discussions both within and outside VSLA groups on topics such as how the sex of the child is determined, and provided information on family planning methods available at nearby health centres. They also worked with local leaders to garner their public support for family planning. Change agents developed an activity report on their work.

**Supervision and Mentorship**
- Meetings with peer educators, change agents and religious leaders were conducted on a regular basis with CARE staff to support them in reaching the project objectives. During the meetings, progress on their implementation plans, challenges encountered, and possible solutions were discussed. Refresher exercises on various tools used for community or VSLA group reflection were provided. CARE staff also reviewed the community activity reports which provided follow-up information on the people attending the community discussion and topics discussed. These reports were reviewed and relevant feedback was provided. Plans for the next quarter or month were designed together to ensure coordination.
Achievements

Women’s lives have positively changed from their participation in a VSLA group—from feeling a sense of confidence and solidarity with others, to their ability to contribute to the improvements of their households through savings and loans. Men are more involved in the sharing of household chores and are able to have discussions on family planning. Through this project, 129 peer educators and 44 community change agents were trained and improved their knowledge and skills on various topics and in group facilitation.

CARE Canada brought together religious leaders to listen to participants’ concerns and engage them in discussions on the social factors affecting their community, such as high rates of unintended pregnancies, inequitable gender and sexual norms, and high levels of gender-based violence. This led to the training of 30 religious leaders who conduct discussions on the benefits of family planning with their communities and even use religious scripture in support of family planning and gender equity. Religious leaders also work with youth groups and counsel couples on how to work together to end violence and share household responsibilities, including decision-making and childcare.

Family planning and other health services are now available to communities previously unable to access quality services. Due to increased knowledge and demand for family planning, the project supported the establishment of a family planning auxiliary post in a new area. In collaboration with the local Ministry of Health, the family planning post in Kigasha serves a population of 9,100 people and has expanded to include other health services such as immunization, prevention of vertical transmission of HIV, and antenatal care. Not only was the establishment of the post an important milestone in the health of the community, but it also complements the VSLA and community level activities aimed to increase knowledge about and demand for family planning services.

Lessons Learned

SAA can challenge social norms

Integrating SAA includes identifying actions at various levels to promote changes that directly influence the wellbeing of communities. For instance, a participatory community mapping activity revealed that a potential source of rumors and misconceptions around family planning came from religious leaders opposed to modern family planning methods such as birth control pills, condoms, implants, and sterilization. This led to the action of training religious leaders on modern family planning to help reduce their biases. Furthermore, through participation in VSLA groups’ discussions on sensitive topics like family planning, some women also reported greater comfort discussing sexual and reproductive health with their husbands.
Addressing gender inequality and empowering women

There is a need to address the inequitable gender dynamics that act as barriers to women’s ability to participate and benefit more fully from their membership in a VSLA group. This impedes their overall economic empowerment. As demonstrated above, this can be done through peer educators who can lead these discussions in VSLA groups. Integrating SAA into VSLA activities has helped to increase women’s decision-making and ‘voice’ at the household level and has increased the support that men give to women in various household chores, creating an environment where women can increase their contribution to the household income and feel less overburdened and more valued in their households.

SAA can be used to address other health and social issues in the community

SAA can be integrated into VSLA through peer educators and change agents who will help continue and extend transformative critical reflection, dialogue, and action deeper into the community for sustainable change. SAA brings behavior change to scale and can have lasting impacts in the community. HIV and AIDS can be introduced alongside family planning and information on HIV prevention, including vertical transmission, and testing can be provided. Furthermore, VSLA groups can support people living with HIV and help mitigate stigma and discrimination, as well as provide an economic and social support system.

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LIST OF ACRONYMS

BCC: Behaviour Change Communication
BNAPS: Botswana National AIDS Prevention Support
CBO: Community-based organization
CHW: Community health worker
CSO: Civil society organization
DPO: Disabled people’s organizations
DU: District Union
FM: Financial management
GBV: Gender-based violence
IEC: Information, Education, Communication
IGA: Income Generating Activity
M&E: Monitoring and Evaluation
OD: Organizational development
OVC: Orphans and vulnerable children
PE: Peer educator
PLHIV: Person living with HIV
PM: Project management
RI: Results Initiative
ROCA: Rapid Organizational Capacity Assessments
SAA: Social Analysis and Action
ToT: Training of trainers
VCT: Voluntary counseling and testing
VSLA: Village Savings and Loans Associations
WUSC: World University Service Canada
ZINAHCO: Zimbabwe National Association of Housing Cooperatives
The Interagency Coalition on AIDS and Development (ICAD) is a Coalition of over 100 AIDS service organizations (ASOs), international development non-governmental organizations (INGOs), faith-based organizations, educational institutions, labour unions and individuals. It began in 1989 as a working group of the Canadian Council for International Cooperation (CCIC) bringing together AIDS service organizations and international development organizations to address the HIV and AIDS crisis. ICAD helps Canadians contribute to international HIV and AIDS work and ensures that the lessons learned from the global response to HIV and AIDS are accessible to Canadian organizations to inform and strengthen prevention, care, treatment and support efforts in Canada. ICAD does this through improving public policy, providing information and analysis, and sharing lessons learned.