AIDS Care, November 2005; 17(8): 988–998

Routledge
Taylor & Francis Group

Mainstreaming HIV/AIDS in development sectors: Have we learnt the lessons from gender mainstreaming?

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Abstract
Drawing on an international literature review, two international workshops and primary qualitative research in Uganda this paper reviews experiences of mainstreaming HIV/AIDS in development sectors (such as education, health and agriculture) in developing countries. The extent to which HIV/AIDS mainstreaming strategies and associated challenges are similar to or different from those of mainstreaming gender in the health sector is also explored. The paper details the rationale for HIV/AIDS mainstreaming through illustrating the wide reaching effects of the pandemic. Despite the increasing interest in mainstreaming HIV/AIDS there is little clarity on what it actually means in theory or practice. This paper presents a working definition of HIV/AIDS mainstreaming. It is argued that all too often processes of 'mainstreaming' emerge as too narrow and reductionist to be effective. The paper then considers four key challenges for mainstreaming HIV/AIDS and explores how and to what extent they have also been faced in gender mainstreaming and what can be learnt from these experiences. These are: (1) the limited evidence base upon which to build mainstreaming strategies in different country contexts; (2) the role of donors in mainstreaming and implications for sustainability; (3) who should take responsibility for mainstreaming; and (4) how to develop capacity for mainstreaming. The conclusion argues for more joined up thinking and sustainable approaches to mainstreaming both HIV/AIDS and gender.

Introduction

There is an expanding body of evidence that demonstrates the impact that HIV and AIDS are having on all development sectors, from agriculture, to education, transport and beyond (Arndt & Lewis, 2001; UNAIDS/World Bank, 2001; Dixon et al., 2002; Whiteside & Barnett, 2002). 'Mainstreaming' HIV/AIDS is increasingly seen as a process through which all sectors should respond to the crisis of HIV/AIDS, and the concept has received growing interest from governments and donors across sub-Saharan Africa and to a lesser extent, Asia.

This paper presents findings from a study of experiences of mainstreaming HIV/AIDS and gender, which included primary research in Uganda. Uganda was chosen as the case study site due to the long-standing commitment of the Government of Uganda to a multi-sectoral response to HIV/AIDS. While many countries, like Uganda, are increasingly committing themselves to mainstreaming HIV/AIDS there are many challenges in turning intention into concrete and effective policies and practice. In this paper, we explore some of the challenges facing those charged with mainstreaming HIV/AIDS and argue that these

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ISSN 0954-0121 print/ISSN 1360-0451 online
DOI: 10.1080/09540120500102250

share much in common with the experiences of gender advocates who aim to mainstream a focus on gender in the health sector. We conclude that those implementing disparate mainstreaming processes should learn from one another, and aim for more 'joined up' efforts.

The study

This one year study, based at the Liverpool School of Tropical Medicine and funded by the Department for International Development, UK, involved an initial literature review of published and unpublished experiences of gender mainstreaming within the health sector and HIV/AIDS mainstreaming within development sectors. The case study was carried out in Uganda, from April to June 2002, using qualitative interviews with employees of government sectors, donors and NGOs interested in HIV/AIDS and gender mainstreaming. A workshop was held in one district in Eastern Uganda to explore issues of gender mainstreaming, and an international workshop was held in Liverpool to share experiences among government sector workers with responsibility for mainstreaming HIV/AIDS from several countries (Uganda, Ghana and South Africa). In total 45 interviews were conducted by the first author: 28 from government ministries of agriculture, health, local government, education, gender and social development at national and district level; 10 from donor agencies; 15 from development, HIV/AIDS and women's NGOs and academic institutions. Interviewees were selected purposively to seek out 'information-rich case studies' (Patton, 2002) to illuminate experiences and interpretations of HIV/AIDS and gender mainstreaming. The interviews started with open questions relating to interpretations and experiences followed by probing questions to explore issues pertinent to the interviewee in more depth. All interviews were recorded and transcribed with the consent of the interviewee. Notes were taken during the workshops and these provided a source for triangulation with interview data. All data were analysed using a framework approach (Ritchie & Spencer in Bryman & Burgess 1994) which after a coding process, builds themes inductively from the data as well as deductively from the research objectives. During the year resource packs on gender mainstreaming within health Sector Wide Approaches (SWAps) and on HIV/AIDS mainstreaming in government sectors were produced and disseminated (this can be downloaded from: http://hivaids.users.btopenworld.com/HIVmainstreamingReport.pdf).

Rationale for mainstreaming HIV/AIDS within development sectors

In countries with high prevalence rates, the evidence of the link between AIDS and increasing poverty is clear at all levels. At the micro level of households and individuals, many studies have shown how, not only are the poor more vulnerable to HIV infection, but their level of poverty is likely to increase as they become sick (Pitayanon et al. 1994; Partnerships for Health Reform, 1999). At the meso level of institutions, the impact is felt as staff become sick and die, while those that are still healthy spend a greater proportion of their time attending funerals and supporting extended family members infected and affected by HIV/AIDS. In education, AIDS deaths are rapidly leading to shortfalls in teaching staff in many countries and declining staff numbers are reducing the quality of education available to children (Gachuhi, 1999; MoE Swaziland, 1999). In the private sector, one review reports that the annual costs associated with sickness and reduced productivity as a result of HIV/AIDS was $17 per employee in a Kenyan car manufacturing

firm; for the Ugandan Railway Corporation these costs were as high as $300 per employee per year (Dixon et al., 2002).

The macro level impacts of HIV/AIDS have received recognition from, among others, the World Bank, who have placed a strong focus on the economic impacts of the pandemic. An economic analysis of the impact of HIV/AIDS on the GDP per capita in Africa estimates a reduction of about 0.7% per year because of HIV/AIDS (World Bank, 2000 in UNAIDS, 2001). More recent estimates indicate that national growth rates have reduced by 2–4% a year across Africa due to the pandemic (Dixon et al. 2002). A country-specific econometric model of the South African economy suggests that overall GDP will be 17% lower by 2010 than it would have been without AIDS and that average per capita income will be 7–10% lower because of AIDS (Lewis and Arndt, 2000). It is not only economic indicators that are being affected at a macro level, in 1998 it was estimated that the Human Development Index (HDI) of South Africa would be 15% lower in 2010 because of HIV/AIDS (UNDP/UNAIDS, 2000).

These studies starkly illustrate the necessity for all sectors – which includes government ministries, NGOs and private providers in all areas but particularly those concerned with human development such as agriculture, education, health and social development – to take into consideration the impacts of HIV/AIDS at all levels. HIV/AIDS is changing the needs of service users, affecting the ability of the sector to respond to these needs and reducing the economic capability of the state to finance and support each sector. Furthermore, each sector must take into consideration the uncomfortable possibility that their own work may increase the vulnerability of communities and their own staff or undermine capacity to cope with the impacts of AIDS. For example road building programmes that require workers to live away from home for extended periods increase vulnerability to HIV as workers are more likely to have unprotected sex with girlfriends or sex-workers; or agricultural programmes that only provide support through farmers groups may be financially and logistically inaccessible to those who are sick because of AIDS. An increasing awareness of these interrelationships has led to a burgeoning interest in HIV/AIDS mainstreaming, particularly in sub-Saharan Africa. However, this level of interest and increasingly funding, has not been matched by a similarly high level of clarity about the exact meaning of HIV/AIDS mainstreaming, what it entails and who should carry it out. Inevitably this lack of clarity has led to confusion and uncertainty among those working within different sectors keen to mainstream HIV/AIDS.

What is 'mainstreaming'? Roots and definitions in gender and HIV mainstreaming

The concept of 'mainstreaming' appears to have originated in the late 1960s, when the term was coined to designate an approach to assimilating children with disabilities into regular classroom settings (JSA Consultants Ltd & GTZ Regional AIDS Programme, 2002). The term is now widely used across a range of different sectors and contexts. The adoption of a 'mainstreaming' approach by advocates of gender equity across all sectors seems to predate its use by HIV/AIDS activists and policy-makers. The term 'gender mainstreaming' came into widespread use with the adoption of the Beijing Platform for Action (PfA) at the 1995 UN International Conference on Women. This was in response to consistent lessons emerging from at least 20 years of experience of addressing women's needs in development work: that projects and ministries focusing on women as a separate target group generally failed to change the inequalities in power between women and men at all levels that lay at

the root of women's marginalisation in development processes (Buvinic, 1986; Rathgeber, 1990).

'Gender mainstreaming' therefore aims to ensure that women's, as well as men's concerns and priorities influence the 'mainstream' activities of development, including resource allocation, policy and legislation formulation, and programme or project planning, implementation, monitoring and evaluation. Every major section of the Beijing PfA contains the following sentence: 'Governments and other actors should promote an active and visible policy of mainstreaming a gender perspective in all policies and programmes so that, before decisions are taken, an analysis is made of the effects on women and men, respectively' (Beijing Platform for Action, 1995, cited in Derbyshire, 2002). A central principle is that: 'Gender mainstreaming is integral to all development decisions and interventions; it concerns staffing, procedures and culture of development organisations as well as their programmes; and it forms part of the responsibility of all staff' (Derbyshire, 2002, p. 12). The aim is to reframe the way in which development processes are conducted so that they work in a way that promotes gender equity. Thus, gender mainstreaming in the health sector requires attention at all stages of policy and programme cycles to women's and men's, girls' and boys' health needs and priorities as well as the constraints they face to promoting their health and accessing care for illness. Addressing these concerns requires that the culture and practice of health sector organizations promote the participation of, and equity between, women and men.

The concept of mainstreaming has appeared relatively recently in the field of HIV/AIDS policy. While initial responses to the epidemic were dominated by a bio-medical approach led by the health sector, increasing recognition of the social and economic impacts of the pandemic led to calls for a multi-sectoral response and HIV/AIDS mainstreaming (Collins & Rau, 2000; DFID, 2001; UNDP, 2002). In a number of countries AIDS Commissions have been established with a remit to work across sectors (DFID, 2001; UNDP, 2002). However, within the available documentation there are few definitions of mainstreaming and confusingly, the term is often used interchangeably with integration or a multi-sectoral response. The following definition has been developed by a working group of HIV/AIDS focal points from different ministries across sub-Saharan Africa (participating as part of this study in an international workshop held in Liverpool), and provides a clearer starting point for understanding HIV/AIDS mainstreaming. By dividing out the different components of mainstreaming, it aims to go beyond a definition to look at the processes involved in mainstreaming.

> Mainstreaming HIV/AIDS can be defined as the process of analysing how HIV and AIDS impacts on all sectors now and in the future, both internally and externally, to determine how the entire sector should respond based on their comparative advantage.

The specific organizational response may include:

- Putting in place policies and practice that protect staff from vulnerability to infection and support staff who are living with HIV/AIDS and its impacts, whilst also ensuring that training and recruitment takes into consideration future staff depletion rates, and future planning takes into consideration the disruption caused by increased morbidity and mortality.
- Refocusing the work of the organization to ensure those infected and affected by the pandemic are included and able to benefit from their activities.

- Ensuring that the sector activities do not increase the vulnerability of the communities with whom they work to HIV/Sexually Transmitted Infections, or undermine their options for coping with the affects of the pandemic.

Thus a critical element of both gender and HIV/AIDS mainstreaming is re-conceptualizing the core work of health and development organizations to pursue strategies aiming to promote gender equity and reduce the vulnerability to, and impact of HIV/AIDS respectively. As Whiteside puts it, 'in government each Ministry has to ask what HIV and AIDS means for its core business and what it should be doing differently' (Whiteside, 2002, p. 250).

Interpretations in the field: Conceptual confusion and reductionism

Recent commentators have noted 'the extraordinary changes required in the mentalities of organizations of both domestic and international actors in order for the principle of gender mainstreaming to be implemented fully' (Hafner-Burton & Pollack, 2002, p. 340). In practice, the concept is open to a wide range of interpretations by different actors and the required 'changes in mentality' are by no means realized. In Ministries of Health, gender mainstreaming has often been conceptually reduced to policies that aim to integrate women into health activities, for example through programmes addressing women's reproductive health needs (Elson & Evers, 1998). Interviewees in this study commonly interpreted gender mainstreaming within the health sector as ensuring a 'gender balance' in decision-making positions, and focusing on sexual, reproductive and maternal and child health. For example:

> Gender has been seen within the MoH as a way for women to get top positions of responsibility. (Key informant, male, donor project)

> The policy is very strong on gender, in fact I helped write it. There is a strong emphasis on sexual and reproductive health and maternal health to make sure that women and children are taken care of. (Key informant, male, Government Ministry)

While these approaches may aim for positive outcomes for women's health and participation in the health sector, experience suggests that without strategies to address gender inequities, their success is likely to be limited. As one participant commented:

> At a practical level, programmes are not addressing gender issues. For example in the malaria programme, they are promoting ITNs [insecticide treated bed-nets], but can women afford them? (Key informant, male, donor project)

The conceptual confusion and reductionist approach to gender mainstreaming in practice has its roots in the dominant bio-medical discourse found within Ministries of Health. Similar conceptual confusion and reductionism is observed in translating the rhetoric of HIV/AIDS mainstreaming into practice. Frequently, mainstreaming HIV/AIDS is interpreted as including an HIV/AIDS component in existing projects; for example, adding an element of HIV/AIDS education work to an agricultural extension programme. Haddad et al. (2001) point to a consensus that HIV/AIDS information can be imparted via agricultural service provision. However, Holden (2003) argues that while such programmes can potentially be beneficial, there is a danger that the staff involved have insufficient

capacity to both implement their own sectoral work and carry out HIV/AIDS prevention work effectively.

This interpretation of mainstreaming as an additional HIV/AIDS prevention programme also arguably has its roots in the initial bio-medical response to AIDS. The Food and Agriculture Organisation (FAO) highlighted this point with reference to the agricultural sector, 'response measures to HIV/AIDS within Ministries of Agriculture have been largely health dominated. This is partly due to the fact that in practice, HIV/AIDS is still primarily situated with a health-dominated paradigm and is perceived to be far removed from the core work of ministries of agriculture" (FAO/UNAIDS, 2001, p. 32). Interviews with sector staff at national and district level in Uganda reinforce this concern. This is illustrated by the quotation below where, even after HIV/AIDS 'mainstreaming' training, the focus is on adding a prevention component to the existing work of the extension workers rather than adapting core agricultural work to better meet the needs of those affected by HIV/AIDS:

> When training farmers, the agriculture extension workers also include messages on AIDS. At the training we were also given packets of condoms, both male and female for free and they showed us how to use them. The extension workers were supposed to go and give the condoms to the communities. (Key informant, female District Government Department)

The majority of central government sectors in Uganda now have focal points; these are existing staff within an organization who are charged with facilitating mainstreaming HIV/AIDS within their organization, most commonly in addition to their core functions. Among many of these key staff the interpretation of HIV/AIDS mainstreaming was much broader and included changes to core work:

> People are changing their crops and running away from labour intensive, so we need to find out what kind of enterprises are popular with sick people, what kind of enterprises are being left out and which ones can we popularise with different people to make sure they know how to increase their incomes so they can afford to eat well, access medical care and reduce stress. (Key Informant, female, Government Ministry)

However, this broader interpretation of HIV/AIDS mainstreaming does not generally extend to the majority of staff at either national or district level, who have interpreted HIV/AIDS mainstreaming as the addition of HIV prevention to their existing work responsibilities rather than developing new approaches as part of their core work.

Thus while the ideal of both HIV/AIDS and gender mainstreaming requires that staff consider the multiple inter-linkages of these issues within in all aspects of their work, the necessary 'mentality changes' are not yet widespread and this appears to be partly related to the dominance of bio-medical discourses. For both gender and HIV/AIDS mainstreaming there are considerable challenges to bring about these required changes in perception both at policy and process level. Some concerns and gaps within the policy approach to mainstreaming and the challenges within the adopted processes of mainstreaming, particularly the use of focal points and training are discussed below.

Policy Constraints: Limited evidence base

The lack of evidence of the complex impacts of HIV and AIDS on the work of different sectors and gender on the health sector has been cited as a fundamental problem by a

number of commentators (Dixon et al., 2001; Derbyshire, 2002). For example, while there have been several studies looking at the impact of HIV and AIDS on education and agriculture in Uganda, during this research, concern was expressed by sector staff that the studies are small scale and their findings can not be extrapolated to influence national policy. Gender disaggregated data are rarely collected as part of the routine information management systems within sectors or as part of broader research. The lack of in-depth qualitative studies of lived experiences with relation to both gender and HIV/AIDS in key sectors further deepens this gap in the evidence base.

This lack of evidence has its roots in the perception within health and development sectors that gender and HIV/AIDS are not of central concern to core areas of work. While for gender many organizations and ministries have become adept at including gender sensitive wording at some point within their policies, gendered responses tend to evaporate in more specific plans and crucially within key indicators of the sector's performance. With the increased emphasis on reaching targets, those keen to mainstream HIV/AIDS would do well to learn from experiences of gender mainstreaming and ensure that indicators of the sector's response to HIV/AIDS are included in key strategy documents. For example an indicator of mainstreaming could be the number of agricultural programmes that include extension work to advise AIDS affected households on less-labour intensive farming techniques and tools and the proportion of households reached by these activities. The inclusion of such indicators for both gender and HIV/AIDS goes some way to ensure that sectoral management information systems are established to regularly collect this information.

Policy Conundrum: The role for donors – resources or sustainable responses?

Across sub-Saharan Africa the policy and resource environment is changing. Sector wide approaches (SWAps), defined as an approach to aid where donors contribute to central government sector budgets rather than funding individual projects, have changed the landscape of donor funding. Ideally within a SWAp, mainstreamed, cross-cutting issues such as HIV/AIDS and gender should be addressed within the sector's routine budgets, and allocated resources accordingly. However, such issues are unlikely to be addressed organically and some means of 'kick-starting' the process is necessary. Capacity building processes with sector staff are intended to achieve this 'kick-start', but these strategies need not only to be resourced, but also to include in-built mechanisms for sustainability. While the majority of donors, under the new SWAp arrangements, are no longer prepared to fund specific gender mainstreaming projects, this has not been the case for HIV/AIDS mainstreaming work. For example, in Uganda the World Bank, through the Uganda AIDS Commission, has established the Uganda AIDS Control Programme with the specific aim of supporting all sectors to address HIV and AIDS. While such specific project support seems to contradict the SWAp philosophy, HIV/AIDS is seen as an emergency situation that needs a direct response, which cannot wait for the long-term capacity building that is the foundation of SWAps. While such arguments for a different and more urgent approach to HIV/AIDS are easy to accept, it is important not to overlook concerns of sustainability. Gender mainstreaming provides some pertinent lessons here. Where gender mainstreaming has been funded as a specific project within the work of sector ministry, anecdotal evidence would suggest that gender related activities rarely continue once the gender project comes to an end.

Process constraints: Who has responsibility for mainstreaming?

Attempts at mainstreaming both gender and HIV/AIDS have drawn on the strategy of establishing 'focal points' within the sectors concerned who are charged with acting as catalysts or facilitators of a response by all staff. Interviews with staff acting as gender and HIV/AIDS focal points in this study found that they face similar constraints in fulfilling their roles. Time constraints are a common problem because duties as a focal point are often added to existing responsibilities:

> Originally HIV/AIDS was not in our work-plans. For example when I was employed there was nothing in my work-plan to indicate that that is what I should be doing. So, that is an additional job and you can see it takes most of our time, so trying to balance that is very difficult. (HIV/AIDS focal point, female, Government Ministry)

Another factor raised by both gender and HIV/AIDS focal points is the lack of training and support they receive in order to carry out their new roles effectively.

> Most of those that are here are basically classroom teachers. This disease approach, we need some special training. (HIV/AIDS Focal Point, male, Government Ministry)

Without support, it is unlikely that focal points will meet the challenge posed by the conceptual confusion and multiple interpretations of HIV/AIDS and gender mainstreaming in practice. Ideally all staff take responsibility for mainstreaming, however the presence of a focal point can actually act to devolve responsibility from others, as a gender focal point within the health sector complains:

> As I am the gender focal point I just get linked up with people who are working on gender and anything to do with gender is left on my desk. (Gender Focal Point, female, Government Ministry)

Concerns have been raised from the agricultural sector that focal points are situated within 'soft' units, such as family life education, instead of within the 'hard' units of livestock, crop productions, fisheries and agricultural extension. This has made mainstreaming into these core areas more difficult and resulted in the perception of mainstreaming as an add-on project rather than of relevance to core agricultural programmes (FAO/UNAIDS, 2001).

Other discussions of gender mainstreaming have found similar challenges (Theobald et al., 2002). This suggests that, for focal points to be effective agents for mainstreaming either HIV/AIDS or gender, they need to be situated in key ministry divisions and gain support from the highest levels. Their job descriptions must also allow them the room and time to address mainstreaming. Without these prerequisites in place, focal points are likely to become frustrated, de-motivated and unable to facilitate change, whilst their presence acts as an excuse for others to ignore the issues.

Building mainstreaming capacity: The need for a sustained and responsive pedagogy

Training for staff members at national and district level has been one of the main strategies for building capacity to mainstream both gender and HIV/AIDS across sub-Saharan Africa, and have met with similar pitfalls. The content of HIV/AIDS mainstreaming training has

often been reduced to HIV/AIDS awareness training, while gender training all too often focuses on theoretical concepts of gender and is rarely applied to the realities of the areas of work of those being trained (Kilonzo et al., 2002).

Both gender and HIV/AIDS touch at the core of human relationships; they challenge us to deal with culturally entrenched relations between the genders and in addition, AIDS raises the taboo areas of sickness and death. In light of this, many gender and HIV/AIDS trainers argue that training for mainstreaming must start with participants looking within to explore personal perceptions, myths and attitudes (Mullins, 2002; Howard, 2002). It can be argued that gender mainstreaming faces additional constraints, where HIV/AIDS is a relatively new phenomenon with obvious devastating consequences, the negative impacts of gender inequity have been experienced over many years and are accepted by many in society – changing such entrenched gender norms is a great challenge. However, even though HIV/AIDS may be recognized as a serious problem, responses such as greater openness about sexuality and non-judgemental attitudes towards People Living with HIV and AIDS still challenge social norms for many. Both HIV/AIDS and gender training process must include exploring such personal perceptions and norms, but also need to provide space for staff to relate these cross-cutting issues to their area of work. Howard (2002) emphasizes the need for gender training to be responsive, participatory and grounded in the realities of different stakeholder contexts. The challenge here is to link the personal with the political and then transform this depth of understanding into practical action within core work. Training that does not link these three components has limited potential to change practice.

The lack of evidence of any impact of gender mainstreaming training is noted by Standing (2000). In a situation where rapid changes in development policy generate ever increasing training needs for staff across all sectors, there is also concern that an increasing proportion of staff time is spent on training rather than their core work. This suggests a need for reflective evaluations that can inform the development of more creative and joined-up approaches with a more lasting impact. Possible alternative approaches include mentoring systems, which provide key staff with continual technical and personal support, or working groups for staff facing similar issues to exchange ideas and experiences. In addition, it may be important to consider whether and how inputs on various mainstreaming strategies could be combined. Fundamentally, addressing both gender and HIV/AIDS is about asking the right questions – who are the most vulnerable in our communities and why, how will they be affected by our work, who might be excluded, how can we increase the benefit for the most vulnerable? Taking communities as the starting point rather than specific issues such as gender and HIV/AIDS may be a more appropriate way of supporting staff to ask the 'right questions' of their work.

Conclusions

In 2000 Cohen commented that 'the lessons of others [in gender mainstreaming] need to be captured in any attempts to mainstream HIV, for unless they are, then efforts to do for HIV what has too often failed for gender will lead to similarly disappointing and ineffective outcomes' (Cohen, 2000, p. 2). However, it would seem that the relatively recent drive for mainstreaming HIV/AIDS has learnt little from the experience of gender mainstreaming. While the substantive nature of HIV/AIDS and gender may be different – particularly considering the entrenched nature of gender norms relative to the more recent and obviously devastating impacts of HIV and AIDS – the processes of mainstreaming the

issues within development sectors have been very similar. The same strategies are being pursued and appear to be falling into similar traps; focal points are under supported and under-resourced, placed in positions lacking in influence with no allowance within their workload for the additional HIV/AIDS mainstreaming tasks; training rarely reflects the realities of participants' areas of work and little attention is given to more creative ways of supporting staff to ask questions of their work that would bring together concerns of all vulnerable groups in the communities they serve. Furthermore, the ability to devise more effective policies and strategies are undermined by the limited evidence base elucidating the realities of the lives of those infected and affected by HIV and AIDS. Underlying these constraints, there are the further challenges of sourcing funding for mainstreaming within the new environment of SWAps. These challenges can be interpreted more positively if they are seen as opportunities for strengthening national government mechanisms for planning, budgeting and monitoring systems that include HIV/AIDS and gender concerns within core sector activities.

Acknowledgements

Grateful acknowledgement must go to the HIV/AIDS Mainstreaming Working Group, established during an international workshop held at the Liverpool School of Tropical Medicine; the group developed the working definition of HIV/AIDS mainstreaming presented here. They are: Helen Elsey: HIV/AIDS Knowledge Programme/DfID; Prisca Kutengule; Ministry of Gender and Community Services, Malawi; Sue Holden: Independent consultant, UK; Dinah Kasangaki: Ministry of Agriculture, Animal Industries and Fisheries, Uganda; Rachel MacCarthy: Ministry of Local Government and Rural Development, Ghana; Akua Oforit-Asumadu: Ministry of Education, Ghana; Alfred Okema: Ministry of Finance, Planning and Economic Development/ Uganda AIDS Commission, Uganda; Rose Smart: Health Economics and HIV/AIDS Research Division, University of Natal, South Africa

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