The ‘DMT Good Practice Guidelines’ provide practical guidance on how to implement, what Tearfund Disaster Management Team consider to be, good practice on a range of cross cutting and sectoral topics. The guidelines are internally designed for Tearfund DMT field staff but may also be a useful reference for Tearfund UK staff. They do not give in-depth information on the issue, but are intended to be simple and user friendly guides that provide practical information for practitioners in the field. They are freely available for use or adaptation by Tearfund partners and other organisations committed to good practice in disaster management.

For Tearfund staff this document can be found in:
Briefing & Ref Docs/04 Good Practices (GP)/04.3 GP Cross Cutting Issues/04.3.2 Beneficiary Accountability

For external downloads go to:
http://tilz.tearfund.org/Topics/Disaster+Management/Cross+cutting+issues+good+practice.htm
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Introduction

The AIDS pandemic has devastated communities and increased the burden of poor and marginalised people. It has destroyed hope and stability, orphaning vast numbers of children.

About 40 million people are living with HIV and AIDS around the world and over 3 million people die due to AIDS each year (UNAIDS 2003). The impact of HIV and AIDS is greatest on poor people. While Sub-Saharan Africa remains by far the region most affected by HIV and AIDS, other regions, such as South and South East Asia, Eastern Europe, Central Asia and the Caribbean have increasingly worrying trends.

The dramatic spread of the disease cannot be explained solely by individual risky behaviour. In developing countries individual risk is influenced by socio-cultural, political and economic factors including economic underdevelopment and poverty, political instability and population mobility, gender inequalities and unfavourable policies and legislation. These factors increase people’s vulnerability towards the disease by limiting individuals’ options to reduce their risk. Poverty and gender inequalities which drive the epidemic are at the same time exacerbated by the impact of HIV and AIDS. HIV particularly affects young people, children and women. Children affected by HIV and AIDS not only suffer the loss of their parents, but can in addition have inadequate nutrition, can be marginalised and lack access to education. Physiological factors, the social status of women, their lack of power and economic dependency, gender based violence and certain cultural clauses and practices increase women’s vulnerability and risk of contracting HIV.

HIV and AIDS cannot be considered in isolation as it not only impacts on the physical and mental health of individuals and population, but it also affects sociocultural structures and traditions and impacts on economies, education, food security and many other issues. HIV and AIDS needs a multi sectoral approach as it is a cross cutting issue. Prevention, treatment and care and impact mitigation need to go hand in hand.

HIV and AIDS is a strategic priority for Tearfund for several reasons:

- It is a cause of poverty
- Poor people are more vulnerable to HIV and AIDS and are less able to cope in times of disaster
- Development progress is being halted or even reversed by HIV and AIDS
- It can be considered a disaster

Tearfund and its partners:

Aim to mobilise and strengthen churches’ response to HIV and AIDS and will concentrate on and invest building expertise in the following five niche areas:

1. Prevention of mother to child transmission (PMTCT)
2. Impact mitigation through support services
3. Promoting access to treatment for opportunistic infections and Anti-Retroviral Therapy (ART)
4. Ending stigma and discrimination of people living with or affected by HIV and AIDS
5. Behaviour change among children and young people

**Within Tearfund DMT we aim to do the following:**

- to gain understanding of the epidemic and the vulnerabilities towards HIV in each specific country and community context where DMT is operational
- to mainstream HIV and AIDS within all its programmes
- to advocate and lobby for other organisations, UN, and government to address the critical gaps that DMT cannot fill due to its operational capacity and strategy
- to help reduce the impact of HIV and AIDS by implementing culturally adapted and research based HIV awareness messages to target communities
- to implement an HIV and AIDS workplace policy to ensure all staff are protected and supported
- to consider other HIV specific activities within Tearfund’s five niche areas as specified above, according to community needs and DMT programme strategy
Section 1

Background and justification for addressing HIV in relief settings

1.1 Biblical and developmental justification

Tearfund’s response to HIV and AIDS is shaped by biblical principles of compassion, justice, accountability, leadership and participation. The good news of Jesus Christ brings hope of sustainable solutions to the spread of HIV because it impacts the way that people behave with one another. Jesus Christ showed compassion and justice, especially towards those that were broken and rejected. People living with, and affected by, HIV and AIDS are often marginalised in society. It is our Christian privilege to serve such people so that they may discover their value to God in Christ and be able to live meaningful lives despite their suffering.

HIV and AIDS and poverty are inextricably linked. Poverty and income inequality, gender inequality, poor public services (health care and education), crises and disasters make people more vulnerable. HIV and AIDS affect the most productive age group (15-50 years) and as a result economic growth has plummeted in many countries. The AIDS pandemic has reversed developmental gains, increased levels of poverty in communities, and heightened the vulnerability of women and children. AIDS has claimed more lives than any conflict.

Millennium Development Goal 6 target 7 commits the international community to halt and begin to reverse the spread of HIV and AIDS by 2015.

DMT works in many disaster-prone countries that are also affected or have the potential to be affected by HIV and AIDS. DMT recognises that HIV and AIDS can affect the achievement of its disaster response by reducing the impact of its nutrition, food security, water and sanitation and health activities and cannot be ignored as a growing disaster in its own right.

1.2 Role of the church

In many communities churches have been at the frontline in responding to HIV and AIDS by providing care and support. The church is caring for hundreds of thousands of orphans, especially in Africa. Often churches have been forced to respond to the AIDS crisis simply because of the devastating impact on their own members. Although providing care and support has been the natural first step, many churches are beginning to engage with the complex areas of prevention and education.

Strategies and policies of governments, donors and bilateral agencies are increasingly recognising the capacity and potential of churches in responding to HIV and AIDS because of their access to the local community, and the work they are already doing in caring for people affected by HIV and AIDS. Our task is to build the capacity of churches so that their vital contribution is recognised and supported.
1.3 HIV in disasters
The spread of HIV doesn’t stop during a conflict, in fact in post emergency situations, people’s vulnerabilities increase and the impact of HIV and AIDS can worsen.
1 Background and justification for addressing HIV in relief settings

The very nature of a disaster encourages risky behaviour through the break down of society increasing power struggles and gender violence as well as stress and boredom. In addition the lack of resources can exacerbate the need to `buy’ or obtain food through sex. Therefore people’s vulnerability towards HIV can increase at this time due to the potential rise in the infection rate. In addition people who are already infected or affected by HIV will find it harder to cope. During and after an emergency, gender inequalities can increase, lack of infrastructure can worsen, family and community structures can breakdown, access to safe water and sanitation facilities are denied and food security is affected.

1.4 Definitions
‘HIV’ is the acronym for Human Immunodeficiency Virus. The virus is transmitted from one person to another through exchange of bodily fluids during sexual intercourse, sharing of needles, blood transfusion and breastfeeding. This virus leads to a condition called ‘AIDS’, Acquired Immune Deficiency Syndrome. AIDS is a collection of infections that the body is unable to fight. It takes between two to ten years for a person infected with HIV to develop AIDS, with large variations depending on the prevailing local health situation. The condition can be treated but there is no cure.

Risk is determined by individual behaviour and situations such as having multiple partners, having unprotected sex, sharing needles when injecting drugs or having an untreated sexually transmitted disease.

Vulnerability stands for an individual’s or community’s inability to control their risk of infection due to factors that are beyond the individual’s control. Such factors could be poverty, illiteracy, gender and living in a rural area or being a refugee.

Impact is about the long-term changes that HIV and AIDS cause at an individual, a community or a society level.

Internal is inward looking, focusing on the organisation, staff, policies and strategies. Internal activities should ensure all staff are well educated about HIV and AIDS and that those who are infected or affected are supported.

External is outward looking focusing on project beneficiaries and project design. It is about refocusing work to ensure those infected and affected are able to benefit from the programme, by ensuring the programme does not increase vulnerability or undermine coping strategies.
Section 2
Context

2.1 Understanding the context – what are the vulnerabilities?
Even though HIV prevalence is low in some of the disaster affected countries DMT work in, people’s vulnerability towards HIV may be high; therefore it is essential that HIV and AIDS is addressed. Many of the vulnerabilities that are present in relief settings can fuel the epidemic as can be seen below;

Vulnerabilities that could fuel the HIV and AIDS epidemic
- Political upheaval with high numbers of refugees and displaced people
- Deepening poverty
- Gender inequality and low status of women
- High levels of illiteracy
- Lack of infrastructure and timely response by health system
- Prevalence of & lack of access to treatment of STDs
- Injecting drug use
- Competing health priorities
- Traditional patterns of sexual union
- Lack of culturally appropriate preventative tools

In countries with low HIV prevalence the response will mainly have to focus on addressing risk and vulnerability. At the same time these countries should start to plan the mitigation of impact.

2.2 Needs of those individuals and communities affected by HIV and AIDS in disaster prone countries
In those countries with higher prevalence it is essential to understand the needs of individuals and communities who are infected or affected by HIV. The following table highlights some of these needs

<table>
<thead>
<tr>
<th>Human</th>
<th>Physical</th>
<th>Economic</th>
<th>Natural</th>
<th>Social/Spiritual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Education</td>
<td>Infrastructure</td>
<td>Income – purchasing power</td>
<td>Land</td>
<td>Cohesion</td>
</tr>
<tr>
<td></td>
<td>- schools, hospitals, clinics,</td>
<td>- Savings</td>
<td>- Water</td>
<td>- Spiritual support</td>
</tr>
<tr>
<td></td>
<td>financial institutions</td>
<td>- Ability to mobilise</td>
<td>- Livestock</td>
<td>- Acceptance</td>
</tr>
<tr>
<td></td>
<td>- Shelter</td>
<td>resources</td>
<td>- Environment (conducive)</td>
<td>- Feel valued</td>
</tr>
<tr>
<td></td>
<td>- Community assets</td>
<td>- Investment</td>
<td>- Food</td>
<td>- Leadership</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Transport</td>
<td>- Resources - minerals etc</td>
<td>- Cultural heritage,</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>- grounding</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>- Legal support</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>- Advocacy for rights</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>- Good governance</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>- Supportive policies</td>
</tr>
<tr>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

Written by Fiona Perry
May 2007
The following story illustrates the impact that HIV and AIDS has on a family in a disaster prone country.

Samuel and Elizabeth were married with two daughters, Hannah and Sarah. Samuel was a farmer and the family had a small vegetable garden and some land where they grew fruit trees and maize. Elizabeth was the only teacher at the local school in the village where they lived. Hannah and Sarah attended the same school. Samuel was a prominent member of the community and was on the environmental committee.

Unfortunately two years ago there was a drought that affected the whole of the country. Samuel’s crops failed and his vegetable garden dried up. Elizabeth continued at the school but got very little money to take care of the family. So Samuel travelled to the city to find work. He was gone for a year, visiting the village occasionally to bring back some money for his family. When he did eventually come home he was very sick. Elizabeth gave up her job to look after him. The little crops they had left got neglected. Hannah the oldest daughter stopped going to school so that she could help out with the chores at home. After some months Samuel died and Elizabeth also became sick. Sarah stopped going to school to help out with the chores at home while her sister went out to look for work. The house started to fall apart and Samuels’s relatives started talking about what to do with the land and the children. The neighbours didn’t visit very much as they were afraid of what diseases the parents had. Elizabeth died a few weeks ago and the relatives are still discussing who will look after Hannah and Sarah. The land has already been taken over by Samuels’s brother.

This story illustrates the impact of HIV and AIDS at a family level:
- **Education** – both Hannah and Sarah had to leave school so they could help out at home
- **Income** – the family lost the ability to farm and when Elizabeth gave up her job they also lost this income
- **Social support** – the family lost the support of the community and eventually Hannah and Sarah became orphans

This story illustrates the impact of HIV and AIDS at a community level:
- HIV prevalence increased in the community due to drought induced migration
- Social cohesion has fragmented in the community as suspicion and fear of those who are infected or affected increased
- Increased number of widows and orphans
- The school lost it’s only teacher
- Land was not farmed and the environment not cared for as it had been prior to the epidemic
3

What activities can DMT carry out to address HIV and AIDS?

3.1 HIV and AIDS mainstreaming
Mainstreaming is a process that enables relief workers to strengthen the way in which they address the causes and consequences of HIV through adapting and improving both their existing work and their workplace practices. This is done by considering the vulnerabilities and needs of those affected by HIV and AIDS and redesigning and reshaping core sector activities to address those issues. These activities do not target those infected with HIV. They also should not need extra funding or extra personnel as they concentrate on reshaping what is currently implemented.

As DMT we will continue to do what we are good at and what we have the skills and personnel to do - but we should also reshape our activities to reduce people’s vulnerability to HIV and to help people to cope with the affects of AIDS. DMT core projects are usually nutrition, food security and livelihoods, water and sanitation, community health education, and shelter.

Essential principles of good practice in mainstreaming HIV and AIDS
There is no standard approach or universal recipe to mainstreaming HIV and AIDS:
- Approaches need to be designed according to the stage and nature of the epidemic in a particular country or community and adapted to the specific context.
- Consider cultural context
- Consider mainstreaming in all stages of the epidemic.
- Mainstream in an integrated way throughout the project cycle.
- Base your mainstreaming strategy on the findings of repeated analyses.
- Use a gender sensitive approach
- Use a participatory approach
- Advocacy is important in low prevalence countries.
- All mainstreaming activities should be in line with national AIDS policies and international standards (Sphere, Red Cross Code of Conduct).
- Delegate practical coordination for the mainstreaming process to one person in the programme who can be a focal point.

3.2 HIV and AIDS specific activities
HIV and AIDS specific activities are those that target HIV infected or affected people. Specific AIDS-focused interventions are those whose primary objective (core business) is to fight HIV and AIDS.

3.4 Integrated HIV and AIDS activities
Integrated HIV and AIDS activities are those that are added into a project such as creating awareness about HIV and AIDS. An example of this would be creating HIV and AIDS awareness during agricultural training with farmers. This is different mainstreaming.
### 3.5 Advocacy

Advocacy is a niche of Tearfund. It is essential for DMT to use advocacy in HIV where programme strategies limit the operational capacity DMT has to implement certain HIV specific activities. As vulnerabilities are highlighted and needs identified, Tearfund can lobby and advocate for other NGOs, partners or UN to address those critical gaps.

### 3.6 Examples of HIV activities that can be implemented

<table>
<thead>
<tr>
<th>Examples of activities</th>
<th>Specific AIDS focused interventions</th>
<th>Mainstreamed interventions</th>
<th>Integrated HIV activity</th>
<th>Advocacy</th>
</tr>
</thead>
<tbody>
<tr>
<td>A water project evaluating the impact of introducing user fees for water on families with chronically sick members</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Introducing ART in the health care system</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A project introducing HIV as a module into the school curriculum</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Advocate NGOs doing watsan as water pumps are too far away from the target community</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>A transport project analysing the effect of increased mobility on sex work</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A social marketing campaign for condoms</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Introducing a code of conduct to prevent sexual violence in refugee camps</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lobby WFP to fortify some food products distributed</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>A TB programme offering an entry point to VCT</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Comprehensive Approach – Practical Steps
Steps for analysing and addressing vulnerability towards HIV and communities ability to cope with AIDS in DMT programmes

- Understand target community/beneficiary context
- Analyse programme for vulnerability/risk vs. community need (Every six months)
- Understand epidemic
- Integrate HIV and AIDS awareness with staff and beneficiaries
- Implement specific HIV and AIDS activities
- Monitor and Evaluate (Focal Person)
- Assess extra funding if required
- Action plan to address critical gaps (Proposal Stage)
  - Analyse programme for vulnerability/risk vs. community need (Every six months)
- Reshape and redesign core sector activities (Mainstreaming)
- Advocate and Lobby other NGOs, UN government etc to address gaps
  - Integrate HIV and AIDS awareness with staff and beneficiaries
- Assess extra funding if required
- Implement specific HIV and AIDS activities
- Monitor and Evaluate (Focal Person)
- Reshape and redesign core sector activities (Mainstreaming)

Written by Fiona Perry
May 2007
Section

4 Understanding the practical steps for addressing HIV in DMT programmes

4.1 Understand epidemic
Ensure good understanding of the epidemic. Make sure you have a good understanding of the basic facts about HIV and AIDS. What is HIV and AIDS? What is the cause? How is it transmitted? How does it spread? What are the prevalence rates globally and for your country of work? What support is there within our team/organisation for people who are infected or affected by HIV and AIDS? How do you personally feel about people who are HIV positive?

4.2 Understand context (Tool 1 - Vulnerabilities, Tool 2 - Problem Tree)
1. Consider the vulnerabilities in the country/community
Understand your community and context. Discuss the capacities and vulnerabilities of the community with the team and beneficiaries
Consider:
- gender issues,
- poverty - infrastructure, economy,
- political instability,
- population mobility, changes in family structure
- cultural practices and beliefs
- environment – natural disaster

2. Understand the underlying causes and consequences of the vulnerabilities that can be seen in the community
You can use a ‘problem tree’ as a tool to help you understand the epidemic in your context further.

4.3 Analyse programme (Tool 3 – Spider Graph)
Analyse your programme using the spider diagram. HIV and AIDS project analysis should ideally be part of a new project design phase however it can also be done if the programme is already running.

Some examples of key questions to ask:

Are our project activities making people more vulnerable towards HIV?
- Will the programme interventions create income which is likely to be spent on purchasing sexual services?
- Will the programme activities encourage increased mobility of staff which could result in husbands or wives being away from their spouses?
- Are the accommodation arrangements appropriate when there are mixed gender groups in trainings that are full board?
4 Understanding the practical steps for addressing HIV in DMT programmes

- Could relief activities increase the vulnerability of women by creating risky situations for sexual violence and rape at water or food distributing points, badly illuminated paths, or unprotected firewood collection areas?

Are our projects making it more difficult for people living with or affected by HIV and AIDS?

- Will the programme activities exclude people living with or affected by HIV and AIDS?
- Will the programme activities lead to further inequality or stigma?
- Does our vulnerability criteria include those affected by HIV and AIDS?

It is important that this step is done every six months to ensure vulnerabilities are reassessed and the programme is evaluated and monitored for progress. Activities may also be short term or be part of a number of activities that need to be put in place in order to address the need identified.

4.4 Plan activities (Tool 4 – Action Plan)

Once the analysis has been done and the critical gaps highlighted an action plan can be written of what needs to be implemented in order for the gaps to be met. The activities could include mainstreaming, HIV specific, integration and advocacy. All programmes can mainstream and conduct awareness; however which HIV specific activities can be done would need to be dependent on the context and the situation in each particular country.

The Inter-agency standing committee (IASC) guidelines for HIV and AIDS interventions in emergency settings can help to address common issues that may have been highlighted. Topics include; responding to sexual violence and exploitation, food aid and distribution, water and sanitation, health care, nutrition and children’s access to education.

4.5 Mainstreaming - reshape and redesign activities

Based on the context/problem analysis and the assessment implications, redesign the core interventions to integrate relevant activities that address risk, vulnerability and impact mitigation related to HIV and AIDS.

4.6 Advocate and lobby

The problem analysis exercise may have highlighted vulnerabilities and needs that cannot be addressed through mainstreaming by the core Tearfund DMT projects. In addition it may not be possible to implement more specific HIV activities in the current country strategy. Some of the activities highlighted may also be more developmental longer term issues such as access to education or health care. It is important therefore to advocate for other key players who have skills and experience in those issues identified.

Advocacy will also be a key instrument in lobbying for changes in local laws, policies and legislation to assist those affected by HIV and AIDS. Therefore in-country policy makers should be targeted in addition to Tearfund UK, other NGO’s and the UN.
4.7 Implement Specific HIV and AIDS activities

There may be specific HIV activities that can be implemented to address the highlighted critical gaps. It is essential that operational capacities and exit strategies are considered in any decisions. In addition Tearfund’s DMT strategy should be used to ensure the activities are within the guidelines and involve Tearfund’s five niche areas.

4.8 Integrating HIV and AIDS awareness

DMT is in a unique position of being able to target many different types of communities in relief settings resulting in a greater impact amongst vulnerable and marginalised groups such as refugees, displaced communities, malnourished beneficiaries, food insecure and women and children. One of DMTs core specialities is health education and therefore DMT can help reduce the impact of HIV and AIDS by implementing culturally adapted and research based HIV awareness to those communities most at risk to HIV. HIV awareness sessions can also be integrated into other core sectors that do training such as agricultural lessons to farmers, community mobilisation with church leaders and nutritional education with mothers from feeding centres.

HIV awareness with staff is an important part of the work place policy. Each field site should have trained champions whose role it is to pass on HIV awareness messages, advice on locally available resources and give confidential support.

4.9 Assess funds

Whatever activities are planned for, funding may be an issue if the programme has already started.

A mainstreaming approach needs relatively few financial and material resources; however it is wise to plan and incorporate extra funding needs into future proposals if necessary.

If the programme has identified HIV specific activities that can be implemented then there is a need to access funds and even personnel for this as it will be an extra project over and above what it has currently been planned for.

4.10 Monitor and evaluate (Tool 5 – Monitoring Form, Tool 6 – Reporting Form, Tool 7 – Evaluation Form)

It is essential that HIV is incorporated into DMT programmes using ongoing methodology. Vulnerabilities in the community and programme design need to be re-assessed and re-evaluated as the community and context changes. Therefore it is expected that the problem analysis spider graph tool should be used every six months. This will ensure the action plans are re-evaluated with activities added and removed as the process moves forward. It is essential these analytical tools are used at the beginning of a proposal so that justification for the design and activities of a programme can be included in the proposal.

As the mainstreaming process is a cross cutting issue and not the responsibility of any one person in the programme, there is a need for a focal person to monitor this process and ensure the activities are being implemented and the tools are being used. The focal person may be encouraged to use a monitoring form whenever they visit the
field to assess people’s knowledge of the mainstreaming process as well as the activities being implemented. In addition there should also be a reporting system, whereby the activities are evaluated in a monthly or quarterly report. Both the work place policy (internal) and the external activities can be reported on using the same table.

To assist with the evaluation of the mainstreaming process, there is an evaluation form with questions that can be asked in each sector. This form can assist with the analysis of the process and encourage a checklist approach to ensure the design of the projects are addressing the vulnerabilities highlighted.

Monitoring and evaluation is also important for all activities not just mainstreaming and therefore those more specific HIV activities should also be evaluated using Tearfund’s DMT strategy and the ISAC Guidelines.
Section 5

5.1 Tool One: What are the vulnerabilities in the country/community?

Think of your country of work and consider what are the current cultural, gender and conflict issues that could increase the spread of HIV and AIDS?

5.2 Tool Two: Problem Tree

A problem tree will help you address:

- What are the root causes of HIV in the area you are working?
- What are the effects that have resulted from this problem?
- What is the most important issue for our group to address?
How to use this tool

- Draw a picture of a tree, including roots, trunk and branches, on a large sheet of paper, a chalkboard, a flip chart, on the side of a building or, on the ground
- Write down a summary of the current situation (core problem) that is observed in your area, i.e. displaced people, refugees, child headed households etc
- Give each person several index cards or similar paper and encourage them to think of the reasons why the core problem is there and what the affects of the problem is and/or could be, then invite each person to attach the cards to the tree:
  - On the roots, if they think it is a root cause, or
  - On the branches, if they think it is an effect
- After everyone has placed their cards on the tree, someone will need to facilitate a discussion so that they group can come to some agreement about the placement of issues, particularly for the core problem.
- Assuming that some agreement is reached, people may want to decide which issues they wish to address first in dealing with HIV/AIDS.

This process will lead into the analysis of the programmes (spider graph) to assess whether the projects address any of these vulnerabilities.

Afghan DMT team creating a problem tree
5.3 Tool Three: Spider Graph

A spider graph is a tool that can be used to analyse the affects our projects have on reducing or increasing vulnerability to HIV and AIDS. Below is an example of a spider graph with a nutrition project as the programme being analysed.

**How do our project activities and project design help reduce vulnerability towards HIV and help people better cope with the affects of AIDS?**

- HIV and AIDS messages are given to mothers at feeding centres
- Education on balanced diet is given to mothers at feeding mothers centres
- Local project staff stay together in mixed accommodation for long periods of time
- Stabilisation centres do not involved household recovery of child in the community which may mean when they return home they will become malnourished again

**How do our project activities and project design not help reduce vulnerability towards HIV and make it more difficult for people to cope with AIDS?**

5.4 Tool Four: Action Plans

It might be good to write two action plans, one for mainstreaming activities and one for HIV and AIDS specific activities. Both action plans could involve advocacy and lobbying as part of the activities.

<table>
<thead>
<tr>
<th>Sector</th>
<th>What is the vulnerability/need identified</th>
<th>What is the activity that will address the need/vulnerability</th>
<th>How can progress in this area be measured</th>
<th>What is the timeframe for the activity</th>
<th>Who is responsible</th>
</tr>
</thead>
</table>
5.6 Tool Five: Monitoring Form

Knowledge on mainstreaming process:

<table>
<thead>
<tr>
<th>Date of Visit</th>
<th>Person asked</th>
<th>Questions asked</th>
<th>Answers correct or not and/or level of knowledge of mainstreaming 0-10</th>
</tr>
</thead>
</table>
|               |              | What is mainstreaming?  
What is vulnerability  
What are some of the ways that the project design currently could potentially increase people’s vulnerability towards HIV and AIDS? |                                                                         |
### 5.7 Tool Six: Reporting form

**Monthly Reporting of HIV and AIDS mainstreaming activities in DMT programmes by Programme Directors**

#### Internal

<table>
<thead>
<tr>
<th>Objective</th>
<th>Specific Objective</th>
<th>Activities</th>
<th>Indicator</th>
<th>How are you doing?</th>
</tr>
</thead>
</table>
| Ensure awareness and protection of Tearfund staff about HIV & AIDS | 1. All staff have good understanding of HIV & AIDS, confidentiality, discrimination and accommodation in relation to the WPP  
2. All staff have access to information about VCT, ART and condoms  
3. All Tearfund health workers are taught and are using universal precautions  
4. All staff have access to appropriate medical care that includes PEP | 1. Champions have adequate knowledge on HIV & AIDS and pass on messages to all staff  
2. All champions have researched and are aware of local availability of ART, VCT and condoms  
3. Health workers undergo universal precautions training and are standards are monitored  
4. HRM to ensure an appropriate medical scheme is known by all staff and is operational | 1. Baseline and evaluation surveys of staff knowledge  
2. Research and information available in all locations  
3. Database of all who are trained available  
4. Medical scheme is in place and outworking | |
| Ensure staff infected or affected by HIV & AIDS are supported | 1. HIV & AIDS WPP in place and is culturally relevant for programme | 1. Research conducted and information collected and compiled into Local Knowledge of Resources document  
2. HRM uses Local Knowledge of Resources document to write WPP programme guidelines | 1. All staff aware of policy provided by Tearfund and those infected or affected receive adequate support | |
## External

<table>
<thead>
<tr>
<th>Objective</th>
<th>Specific Objective</th>
<th>Activities</th>
<th>Indicator</th>
<th>How are you doing?</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV &amp; AIDS and gender is mainstreamed in all external activities</td>
<td>1. All projects are assessed and reshaped/redesigned accordingly for impact on vulnerability towards HIV and ability to help those affected by AIDS cope.</td>
<td>1. Project analysis is conducted using vulnerability and coping flow chart. Action plans are designed to address the gaps identified in project analysis.</td>
<td>1. Evidence of project analysis in each project area every 6 months during the project lifetime.</td>
<td>1. Evidence of mainstreaming in design.</td>
</tr>
<tr>
<td></td>
<td>2. All new project proposals are assessed for vulnerability and coping during design stage</td>
<td>2. Analysis of initial design conducted using vulnerability and coping flow chart and reshaping of activities implemented.</td>
<td>2. Inclusion of project analysis summary in all new proposals to show evidence of mainstreaming in design.</td>
<td>2. Evidence of training from workshops, DMDP or infield training.</td>
</tr>
<tr>
<td></td>
<td>3. All project staff have a good understanding of mainstreaming</td>
<td>3. ACs and/or focal HIV mainstreaming person ensure all staff are trained on HIV &amp; AIDS and gender mainstreaming and can use project analysis tools.</td>
<td>3. Evidence of training from workshops, DMDP or infield training.</td>
<td>3. Evidence of training from workshops, DMDP or infield training.</td>
</tr>
<tr>
<td></td>
<td>4. All HIV &amp; AIDS and gender mainstreaming action plans are evaluated</td>
<td>4. ACs to report against action plans activities on a monthly basis using a log frame type of reporting tool.</td>
<td>4. PDs receive a monthly evaluation of action plan activities from each project site.</td>
<td>4. PDs receive a monthly evaluation of action plan activities from each project site.</td>
</tr>
</tbody>
</table>
5.8 Tool Seven: Evaluation check list form for mainstreaming HIV

**General Questions**

*Are our project activities making people more vulnerable towards HIV?*

- Will the programme interventions create income which is likely to be spent on purchasing sexual services?
- Will the programme activities encourage increased mobility of staff which could result in husbands or wives being away from their spouses?
- By having mixed gender groups in trainings that are full board could we be encouraging promiscuity?
- Could relief activities increase the vulnerability of women by creating risky situations for sexual violence and rape at water or food distribution points, badly illuminated paths, or unprotected firewood collection areas?
- By increasing access to facilities and resources will the programme increase mobility and therefore potentially increase people’s vulnerability towards HIV?

*Are our projects making it more difficult for people to cope with AIDS?*

- Will the programme activities exclude people living with or affected by HIV and AIDS?
- Will the programme activities lead to further inequality or stigma?
- Does our vulnerability criteria include those affected by HIV and AIDS?
- Are our projects addressing the nutritional needs or water and sanitation needs of those infected by HIV?

**Specific questions for sectors:**

**Water and Sanitation**

*Are our project activities making people more vulnerable towards HIV?*

- Do women have a voice as to where water points are positioned?
- Are public latrines within safe walking distance for women and children?
- Are the water points safely accessible for women?

*Are our projects making it more difficult for people to cope with AIDS?*

- Are water committees represented by both men and women?
- Are water pumps suitable to be used by the chronically sick or children?

**Food Security**

*Are our projects making it more difficult for people to cope with AIDS?*

- Does the distribution criteria include vulnerabilities such as child headed households, female headed households and chronically sick?
- If the community is choosing the distribution criteria could it discriminate towards households that have people living with AIDS (PLWA)?
- Is the harvest length and management of crops suitable for chronically sick people?
- Are crops with high nutritious value such as vitamin A, iron and protein being encouraged to be planted?
- Do your project activities specifically assist those members of the community with chronically sick headed households?
- Are agricultural techniques being taught suitable for chronically sick or children to implement?
5 Tools

• Are agricultural tools distributed suitable for children or chronically sick people to use?

Health

Are our project activities making people more vulnerable towards HIV?
• Will universal precautions be taught to all staff? Is there a system of monitoring and evaluating health staff practice?
• Is there a system of safe and hygienic waste disposal, particularly needles, blades and syringes? Is there a system of monitoring and evaluation to ensure there is continued good practice?
• Is the access to the health facility safe for women and children?
• Does training involve in house mixed accommodation?

Are our projects making it more difficult for people to cope with AIDS?
• Are all patients taught about good hygiene and balanced diet in the health units?
• Are those chronically sick patients particularly targeted with nutrition and hygiene education?
• Can chronically sick members of the community access the health facilities?
• Could child headed or female headed households access the health facilities?
• Is there prophylaxis antibiotic treatment for PLWA offered?
• Are there hand washing facilities and hygienic & safe sanitation facilities provided at the health centres?

Nutrition

Are our project activities making people more vulnerable towards HIV?
• Is the access to the feeding centres safe for women and children?
• Could the design of the feeding centre programme increase vulnerability for mothers and their family by them being away from their household for long periods?

Are our projects making it more difficult for people to cope with AIDS?
• Is the food distributed suitable for chronically sick members of the community who may not be able to digest certain foods?
• Is the food distributed fortified with additional vitamins and minerals?
• Is nutrition education particularly targeted at those who are chronically sick?
• Is there follow up for those children, adults who do not gain weight in the feeding programme?
• Can all members of the community access the feeding centres?

Health Education

Are our project activities making people more vulnerable towards HIV?
• Does the training involve long distances for participants to travel? Is the access safe?
• Does the design of the programme involve mixed accommodation if there is in house training?

Are our projects making it more difficult for people to cope with AIDS?
• Are there both men and women participating in the training?
• Is hygiene and balanced diet being taught?
• Is natural medicine discussed as a way to treat some symptoms for those who are chronically sick?
Community Mobilisation

Are our project activities making people more vulnerable towards HIV?
- Does the programme encourage community leaders to understand the importance of equal and safe accessibility to facilities and resources for all in the community?

Are our projects making it more difficult for people to cope with AIDS?
- Are stigma and discrimination issues discussed?
- Do community meetings have representatives from both men and women?
Section 6

Case studies illustrating reshaping & redesigning projects & activities to mainstream HIV and AIDS

DMT case study 1:

Tearfund DMT in Kirundo, Burundi were carrying out a doing a goat distribution project within their food security sector. After analysing their activities and thinking of the needs of people coping with HIV and AIDS it was decided that some chronically sick people may be unable to care for their goats and may need to sell them. As the distribution was conducted using a farming association it was realised that this would break the terms and conditions of the distributions. Therefore the team decided that one of their activities would be to develop a self-regulatory criteria for association members who break the goat distribution cycle. It is worth noting that this activity is not targeting AIDS affected beneficiaries but rather is mainstreaming as it incorporates all chronically sick people therefore reducing the potential stigma of targeting HIV and AIDS affected families but still addressing their needs.

DMT case study 2:

Tearfund DMT in Ed Daein, North Sudan were carrying out a nutrition programme targeting malnourished children. During a project analysis session they realised that some of the centres were more than 3 hours walk for the mothers and children. They considered there could be a potential risk of attack for the mothers which could increase their chance of being infected with the HIV virus. In addition if there were any mothers who were chronically sick with illnesses that could include AIDS, then the distance for them to travel could make their condition worse. Uncertain of the risks that might be involved in the walk; they decided that one of the activities they should do was a vulnerability assessment of the route. In addition they reconsidered moving their centre or setting up a mobile centre closer to the mothers. Again these activities are not targeting only those who are HIV positive but incorporate all mothers who use the centre.
Case studies illustrating DMT reshaping & redesigning projects & activities to mainstream HIV & AIDS

DMT case study 3:
Tearfund DMT partners in Liberia were doing a community health programme and realised that they had no standardised vulnerability assessment criteria. This meant they didn't know if they were universally including vulnerable groups in all their activities such as chronically sick, female headed households and child headed households. They therefore decided to analyse their current vulnerability surveys and develop a standardised criteria.

DMT case study 4:
Tearfund DMT in Kabul, Afghanistan were designing their disaster risk mitigation workshops and realised that they had not considered the locations and distances that the women and men had to travel to. In addition they hadn’t investigated the appropriateness of men and women training together, their different learning needs or the fact that there would be more time for them to be mixing and spending time together socially. They also had not got any female trainers employed. It was decided therefore that they would hire a female trainer as soon as possible and that they would investigate the appropriateness of their training locations and facilities during the workshops and if there were any other potential vulnerabilities that would put their participants at risk of HIV. They also ensured that both men and women participants were catered for in regards to their learning needs to ensure the messages of disaster risk mitigation were disseminated.
Section 7

Useful publications and reports

Fiona Perry, July 2006, Training of Trainers Guideline manual for HIV and Gender External Mainstreaming

'The Truth About AIDS' (Patrick Dixon)
'AIDS and You' (Patrick Dixon)
'AIDS and the 21st Century' (Tony Barnett and Alan Whiteside)

Tearfund Resources: PILLARS, Roots and Footsteps focusing on HIV and AIDS

UNAIDS (www.unaids.org) – the UN body responsible for tackling HIV & AIDS. The site provides the most comprehensive information on HIV & AIDS for every country in the world.

WHO (www.who.int/en/) – the World Health Organisation

HIV/AIDS Alliance (www.aidsalliance.org)

The Core Initiative partners with community and faith-based groups to advance multi-sectoral responses to HIV and AIDS. (www.coreinitiative.org)


World AIDS Day (www.worldaidsday.org) – World AIDS Day is an international day of action, 1st of December every year. Each year there is a focus on a different aspect of tackling the pandemic e.g. 2004 is focusing on women & children

Mainstreaming HIV and AIDS in development and emergency situations can be found in Sue Holdens book called ‘AIDS on the Agenda’. Sections of the book can be found at http://www.oxfam.org.uk/what_we_do/resources/aidsontheagenda.html

160 NGOs world wide have now signed up to ‘Renewing Our Voice: Code of Good Practice for NGOs Responding to HIV/AIDS’ which can be found at: http://www.ifrc.org/what/health/hiv/aids/code/

'Humanitarian Programmes and HIV and AIDS - a practical approach to mainstreaming – Oxfam (Vivien Walden)

Guidelines for HIV/AIDS interventions in emergency settings - Inter-Agency Standing Committee

Resource people within Tearfund and useful organisations

- Veena O’Sullivan, HIV and AIDS advisor (venna.o'sullivan@tearfund.org)
- Fiona Perry, HIV and AIDS Coordinator, DMT (fiona.perry@tearfund.org)