

Development and disasters in a time of HIV and AIDS



*An HIV mainstreaming toolkit
for development and humanitarian response workers*

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The CAFOD HIV mainstreaming toolkit contains:

● A manual

This explains the concept and the approach used, and provides a guide to the process of HIV mainstreaming. It also has a section containing resource materials for those applying the process or training others to do so.

● A poster

This illustrates an overview of the process of HIV mainstreaming with a flowchart.

● A CD-ROM containing:

- the **HIV mainstreaming poster**, as a pdf file
- a **diagram** illustrating the causes and effects of HIV and AIDS as a problem tree, as a pdf file
- a set of **MS PowerPoint slides** to use in facilitating training on HIV mainstreaming
- **checklists for humanitarian responses** to rapid onset emergencies, as a pdf file
- the **tools** for HIV mainstreaming, in MS Word format.

Each tool consists of one or more key questions and a table for the user to fill in, with suggestions and guidance.

The tools may be:

- completed electronically
- printed and filled in by hand
- printed and photocopied for use in training sessions.

Users are strongly advised to read the explanations in the manual before attempting to use the tools.

You can offer feedback and/or order more copies of this toolkit from:

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Introduction

The HIV pandemic is growing at alarming rates in many parts of the world. It disproportionately affects the poorest countries and within them often the poorest people. Where the pandemic is more established, its impact is devastating for individuals and communities. HIV and AIDS bring sickness, death, bereavement, and social, economic and emotional losses to the people infected and affected. They also undermine the ability of communities to implement key strategies to alleviate poverty, sustain livelihoods and promote development, and to cope with other disasters. Likewise, failure to respond adequately to the challenges of poverty and humanitarian disasters exacerbates the conditions that fan the HIV pandemic. Even in countries where the pandemic is as yet less established, the potential for this damaging interplay between HIV and development exists and must be acknowledged.

Efforts to address HIV have thus far generally focused on immediate interventions to prevent infection and to preserve the health and wellbeing of those infected and affected. Such initiatives are essential, but cannot be effective on their own: they must combine with measures to address the interplay between HIV and other development or humanitarian challenges. This makes it imperative for CAFOD to mainstream HIV in all its humanitarian and development work and in its workplace policies and practices..

This toolkit provides a practical guide to the work of HIV mainstreaming. It has four parts:

Part 1 sets out CAFOD's understanding of and commitment to HIV mainstreaming and locates this within its wider response to HIV.

Part 2 offers tools and processes for applying HIV mainstreaming to development and humanitarian response programmes. It identifies implications for programme design and implementation (external or programme mainstreaming), and can also indicate some issues arising from this for the internal (organisational) policies and practices of the partner programme.

Part 3 looks at applying these HIV mainstreaming tools to internal, or organisational, policies and practices. It might also be used, with appropriate modifications, with partner organisations who want to undertake a more thorough internal HIV mainstreaming analysis.

The process of external, or programme, mainstreaming of HIV does not apply to HIV-focused programme partners. However, the challenge of mainstreaming HIV internally (ie within their management and employment policies and practices) does apply and can often be forgotten in work with these programmes. Part 3 of this toolkit provides a useful resource for facilitating an internal mainstreaming process with HIV-focused programme partners.

Part 4 contains additional resources for those who wish to find out more, or who are responsible for training others in the mainstreaming approach:

- 1** Guidelines for facilitating a workshop on HIV mainstreaming.
- 2** Case studies and scenarios from development and humanitarian response programmes, and from organisational or workplace situations.
- 3** Examples of completed tools as referred to in the text, applied to development and humanitarian response programmes.
- 4** A list of recommended further reading.
- 5** The HIV problem tree.
- 6** Tool table blanks to photocopy and fill in by hand.

Using the tools

The tools described in this toolkit are intended primarily for NGO or other programme staff to use in their own analysis of programme proposals, or in their work of internal HIV mainstreaming.

Because this resource started life as a toolkit for CAFOD staff, much of the technical language around programme development is taken from CAFOD systems and CAFOD's 'non-operational' mode of working in partnership with local programmes. However, initial work with other NGOs suggests that with appropriate adjustment, the tools can easily be applied to their organisational culture, terminology and models of working.

For CAFOD staff, it will in many cases be appropriate to use these tools, in full or abbreviated, with partner programmes; individual CAFOD staff are best placed to decide how the key questions given here can be adapted for use with their partners.

In some circumstances, talking about HIV to partner programmes engaged in other development work may be counter-productive, especially in countries where the estimated HIV prevalence is low. Even if HIV mainstreaming is not mentioned explicitly to partners, CAFOD staff should use the tools to inform their own analysis and to identify considerations they may need to explore with programme partners, albeit indirectly.

The tools are not directly applicable to work with communities, and staff will need to explore how best to take up with community members the considerations brought out by these tools.

Many of the issues raised by HIV mainstreaming are gender-related and so these tools can also facilitate an effective gender-based analysis. However, such an analysis will not always be comprehensive (i.e. gender issues go beyond HIV) and conversely, not all HIV mainstreaming issues are gender-related.

The toolkit has been developed by CAFOD's HIV team. It is an evolving resource and all contributions to improve its content, ease of use and effectiveness are welcome.¹ The toolkit format allows for updating and replacement of pages or sections, if required, in the first two years after publication. The resource will be reviewed more fully after two years of use.

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1

HIV mainstreaming

What does it mean?

1.1 A twin-track response to HIV

CAFOD programme and workplace responses to HIV fall into two types, which we regard as twin tracks:

- 1 HIV-focused responses
- 2 HIV mainstreaming

CAFOD is committed to supporting both of the twin tracks to ensure a comprehensive response to the challenges of HIV and AIDS.

1.2 HIV-focused responses

HIV-focused responses specifically address HIV. They may be stand-alone initiatives entirely dedicated to HIV work, or integrated responses, forming part of a wider programme of work.

Examples of stand-alone initiatives would be:

- A project solely concerned with providing home-based care to people with AIDS,
- A proposal to hold an HIV event in the office for World AIDS Day
- A campaign to reduce the price of HIV drugs
- A publication devoted entirely to HIV and AIDS

In an integrated HIV-focused response, although the specific HIV component forms part of a wider programme, it is still recognisable as directly addressing HIV.

Examples of an integrated response would be:

- A primary health care programme that includes home-based care for people with AIDS
- A set of workplace policies that includes one on HIV in the workplace
- A human rights programme that includes tackling discrimination against people with HIV
- A magazine on development issues that includes an article on HIV.

In HIV-focused work, HIV and AIDS are used as a filter, highlighting the needs and challenges posed directly by the pandemic in order to identify specific responses.

1.3 HIV mainstreaming

The HIV mainstreaming approach recognises that HIV and AIDS have, or will have, significant effects on the communities and programme staff where other development or humanitarian responses are located. Because of this, all development or humanitarian responses may need to be modified to remain effective and avoid doing further harm in the environment that has been changed by HIV and AIDS.

Similarly, an organisation's employment and management policies and strategies may need to be modified to ensure that their work remains relevant and that the organisation avoids doing harm to employees or others with whom they work.

In this approach, HIV and AIDS become a lens to scrutinise all development work and organisational practices, identifying the changes needed to ensure continued relevance and minimise risks of doing further harm.

CAFOD's understanding of HIV mainstreaming applies both to its programme activities and to the recruitment, management and support of staff and volunteers working for CAFOD.

HIV mainstreaming is

the process of identifying and making the necessary changes to a development or humanitarian response programme, or to workplace practices and policies, in order to ensure that these remain relevant and effective, and that they do no harm in an environment also affected by HIV and AIDS.

External mainstreaming

involves designing or modifying all programme responses to ensure that these

- remain relevant and effective when the changed capacity and needs of communities affected by HIV are taken into account
- do not increase people's vulnerability to HIV infection or the impact of AIDS.

Internal mainstreaming

involves adapting workplace policies and practices to ensure that the work of the organisation

- remains effective if the capacity of the workforce has changed because of HIV and AIDS
- does not increase the vulnerability of staff or beneficiaries to HIV or the impact of AIDS.

To understand what mainstreaming is, it can be helpful to identify what mainstreaming is not.

Mainstreaming is not:

- making everyone do HIV-focused work or become HIV experts
- diverting people away from their core work to HIV work
- inserting an HIV component into every programme response or workplace policy
- making changes to programmes or employment issues that apply only to people identified as living with or affected by HIV
- claiming to consider HIV but ignoring it in reality and continuing with 'business as usual'.

Why mainstream?

The overall purpose of mainstreaming is to ensure that the organisation or programme a) remains relevant and effective and b) does no harm in contexts also affected by HIV.

- The reality of HIV and AIDS affects, or will affect in the foreseeable future, people's ability to respond to the challenges of poverty, injustice and humanitarian crises.
- Failure to mainstream HIV will make broader development and humanitarian relief work increasingly irrelevant and ineffective in communities affected or threatened by HIV and AIDS.
- Failure to mainstream HIV will affect the longer-term sustainability of organisations because, if neglected, HIV will increasingly diminish organisational skills and experience.
- Failure to make the necessary programme and workplace changes can mean that development organisations (such as CAFOD and its partners) unwittingly exacerbate the effects of HIV and AIDS on individuals and communities, and increase people's susceptibility to HIV. They become part of the problem.

CAFOD's HIV mainstreaming commitments

CAFOD is committed to:

- 1** Ensuring that external HIV mainstreaming is applied to all CAFOD-supported development and humanitarian response programmes and projects from the outset, by linking this to core tools of Programme Cycle Management (PCM)
- 2** Ensuring that internal HIV mainstreaming is applied to policies and practices related to staff recruitment and ongoing management, support and supervision
- 3** Ensuring that internal HIV mainstreaming is applied to all HIV-focused initiatives
- 4** Providing guidelines and tools to enable programme and organisational mainstreaming, as described in points **1** and **2** above
- 5** Promoting CAFOD's understanding of HIV mainstreaming across the organisation with particular (but not exclusive) reference to staff in the following areas of work and departments: education, campaigns, communications, public policy, International Division
- 6** Ensuring that all new staff are aware of CAFOD's twin-track approach and understand the meaning and implications for CAFOD of HIV mainstreaming, and ensuring that this is a core component of the HIV induction programme for all new staff
- 7** Providing training and support to staff and managers, to enable effective implementation of these commitments, and to partner programmes to enable them to address the issues raised by this approach.

How is HIV mainstreaming taken forward?

CAFOD identifies five stages in implementing its commitments to mainstreaming. These may be referred to as 'the five As'.

The five As

Awareness	This stage establishes an initial understanding of what HIV mainstreaming is, and is not, and how it can form part of a twin-track response to HIV.
Analysis	This stage uses an approach dubbed the '4Ps tools' to examine the context of a proposed programme or of the workplace.
Adjustment	This stage aims to identify the implications for the programme or the workplace of the 4Ps analysis, and to adjust the proposed programme, or workplace policies and practices, in the light of this analysis.
Action	This stage applies and monitors the modifications identified in the adjustment stage.
Assessment of impact	This examines whether the modifications have helped ensure that the programme or organisation remains effective and that it minimises its risk of doing harm in the context in which it operates.

These stages are shown in the overview flowchart on the **poster** included in the plastic wallet at the back of this toolkit.

The knowledge required for the awareness stage has been addressed in this section of the toolkit. Some ideas for facilitating an awareness session for colleagues or partner organisations are given in **Part 4**. CAFOD develops awareness of the need for HIV mainstreaming among its own staff, through induction programmes for new staff. The relevant CAFOD staff are expected to promote a similar awareness with programme partners.

Parts 2 and **3** of this resource offer processes for implementing the analysis, adjustment, action and assessing impact stages of HIV mainstreaming. **Part 2** applies to external or programme mainstreaming, and **Part 3** to internal or organisational mainstreaming. They provide four tools for doing this. They assume that users will already have been taken through the awareness stage. The table overleaf provides an overview of how the tools fit into the remaining four A stages.

HIV mainstreaming stage	Tool used and key question addressed
<p>Analysis of context in order to identify additional points that need to be taken into account</p>	<p>Tool 1 <i>Applying the 4Ps lens</i> How does the present situation affect HIV and AIDS and how is it affected by HIV and AIDS?</p>
<p>Adjustment of the proposed programme design or workplace policy and practice</p>	<p>Tool 2 <i>Implications of the 4Ps</i> What are the implications for programme design or workplace policies and practices, of the points brought out by Tool 1? What do we need to do differently or additionally in order to remain effective and do no harm?</p>
<p>Action</p>	<p>Tool 3 <i>Making and monitoring the changes</i> Are the changes proposed in Tool 2 happening in practice?</p>
<p>Assessment of impact</p>	<p>Tool 4 <i>Assessing the impact</i> Have the changes recorded in Tool 3 helped us to remain effective and to do no harm?</p>

CAFOD systems for Programme Cycle Management (PCM) have trigger questions to refer staff to **Tools 1 to 4** at the appropriate points of programme development and management. It is hoped that this will make HIV mainstreaming an automatic part of all development and humanitarian response work, and reduce the perception that this is an additional task for already overburdened staff.

Tools 1 to 4 are described in detail in **Parts 2 and 3** of this resource. **Electronic versions** are also provided in Word format, in the CD-ROM accompanying this toolkit. They contain forms that can be filled in for computer-based records, or printed out for hand-written records or to prepare handouts for training sessions.

2

Making it happen

Mainstreaming HIV in development and humanitarian response programmes

2.1 Using the tools

Part 2 of this toolkit provides a guide to HIV mainstreaming in the work of developing and managing programmes (ie external mainstreaming) that do not focus primarily on HIV and AIDS. It will take you through the stages of analysis, adjustment, action and assessment of impact.

The tools provided take the form of a key question, or series of key questions, for each stage. For each main question, supplementary ideas are given to aid thinking. These are by no means definitive; they are intended to prompt responses to the overarching question. You may choose to include some, reject others, and add yet others, depending on the relevance to the local situation.

Forms for recording the answers, or for noting sources of information, are **supplied in Word format** on the accompanying CD-ROM. The forms may be filled in electronically or printed out and filled in by hand. Blank tables are also available at the end of this toolkit in **Part 4.6**.

In applying these tools for external HIV mainstreaming, internal (or organisational) issues may also emerge (eg staff protection, changed organisational capacity because of HIV and AIDS, and power and its potential abuse). These should also be noted and acted upon.

In many respects the analysis and adjustment stages of HIV mainstreaming are – and should be – the most demanding of time and effort. Hence the larger number of pages of guidance and tools devoted to this. If these two stages are carried out properly, the last two stages of mainstreaming – action and assessment of impact – should be relatively light.

For CAFOD staff, the tools are intended in the first instance for use in their own analysis and monitoring of programmes. In many circumstances it will also be appropriate to use them in full or abbreviated, with partner organisations. Individual staff are best placed to decide how the key questions can be adapted for use with their partners and in their turn, by programmes with community participants. In some cases, discussing HIV with partner programmes engaged in other development work may be counter-productive, especially in countries where the estimated HIV prevalence is low. Even if HIV mainstreaming is not named explicitly, CAFOD staff should use the tools to inform their own analysis and to identify considerations they may need to explore with programme partners, albeit indirectly.

HIV-focused initiatives will follow the normal process for programme cycle management. However, the organisational aspects of the programme proponents should also be subjected to mainstreaming analysis using the internal HIV mainstreaming tools (see **Part 3**).

2.2 The 4Ps approach

The 4Ps approach facilitates and makes manageable what can otherwise seem like a complicated and time-consuming analytical process.

The four Ps are:

1 Potential

Is the potential of intended programme participants to engage with the proposed initiative affected because HIV and AIDS are present? Does the current situation adversely affect communities already affected by HIV and AIDS?

2 Protection

What features of the local situation might increase people's vulnerability to sexual violence or coercion, or sex as a survival mechanism? What features might increase vulnerability to blood-borne infection? What features might stigmatise people infected or affected by HIV, or for other reasons?

3 Power

Where does power reside in the current situation? How might the distribution of power increase people's vulnerability to HIV or the harm to those already infected?

4 Priority groups

Does consideration of the first three Ps identify additional priority groups not specified in the original programme proposal?

Tool 1–e (the 4Ps tool) is used in the analysis stage of the process and is referred to subsequently in the tools used in the remaining three stages. It explores the question: *How does the present situation affect HIV and AIDS, and how is it affected by HIV and AIDS?*

The findings of the 4Ps tool have implications for how programmes are designed and point to adjustments to original thinking that might be required. **Tool 2–e**, used in the adjustment stage, addresses the question:

As a consequence of the 4Ps analysis, what should we do differently or additionally in order to:

- a** *remain effective and relevant*
- b** *do no harm*

in contexts affected or potentially affected by HIV and AIDS?

The points identified apply both to intended beneficiaries and to programme staff and volunteers. They apply not only to the present situation but also to that anticipated for the timeframe of the programme or project cycle. Thus staff will need to think of the present and also of a timeframe of at least three to five years, depending on the specific proposal.

Tool 3–e (action stage) monitors whether or not the proposed adjustments are happening in practice, and **Tool 4–e** (assessment of impact) examines whether they are achieving the purpose of mainstreaming: to ensure the programme remains effective, and that it does no harm in contexts also affected by HIV and AIDS.

Preparation

The process of developing or appraising any programme proposal usually starts with a situation analysis identifying the key factors in the context that require a programme response. Because HIV and AIDS are, or can become, the backdrop for such programmes, it is also important to do a quick mental review of the causes and effects of the virus once you have completed your initial situation analysis. (As you gain familiarity with the approach, this will become second nature and will no longer require additional time and effort).

These are the preliminary steps for the analysis stage of HIV mainstreaming. You will then be ready to apply the 4Ps analysis tool.

Remember:

- Don't spend time chasing information for a specific point that is irrelevant to the situation being considered. If it doesn't fit, move on.
- Your focus should be on achieving the proposed programme's original objectives.
- Do not divert objectives or skills into providing HIV-focused programmes or projects. These can be referred to other local groups skilled in this work.
- Ensure that any organisational issues that emerge are recorded (eg codes of conduct, support or protection policies, flexible working patterns where there are sick family members, etc).
- Women and men, girls and boys, may be affected in different ways by any of the points. Note any gender differences.
- Any changes should apply to everyone participating in the programme, not only to individual families or staff members known to be affected by HIV or AIDS because:
 - HIV and AIDS may affect only some people at present, but they may affect others in the future. What applies to one person today or this year may apply to others tomorrow or next year.
 - This reduces the risk of stigmatising certain individuals or families.
 - Measures to address protection or power issues will be effective only if applied across the board.
 - A key feature of HIV mainstreaming is the adaptation of plans to ensure the inclusion of people otherwise unable to access the proposed programme because of the impact on them of HIV and AIDS.

**Tool
1-e**

Analysis *Applying the 4Ps lens*

1 Potential: How is this changed by HIV and AIDS?

This examines whether reduced coping capacity, loss of skills, sickness and/or care duties related to HIV affect people’s potential to engage with the proposed programme and conversely, whether these HIV-related effects are exacerbated by the concerns addressed by the programme.

Thinking of the proposed timeframe for the programme, consider:

- ▶ **a** Is the potential of the intended beneficiaries or the programme staff affected by the presence of HIV and AIDS? If not now, might this happen over the proposed programme timeframe? (Information on national prevalence of HIV and AIDS may offer pointers for this.)
- ▶ **b** Does the current situation reduce people’s capacity to cope with HIV and AIDS, or with disability or chronic sickness more broadly?

Note relevant points in the table supplied on the CD-ROM or in Part 4.6

Potential: What points do we need to note for the current situation?	Who is affected by this point?

▶ **Ideas to help you address Question a**

High levels of sickness among adults may mean:

- Only children or older people are available for work proposed in the projects.
- Families are less mobile and therefore cannot flee from danger, nor can they easily access services, job opportunities or amenities, eg water, latrines.
- Local skill levels and expertise may be reduced.
- Care duties for sick family members may mean people (especially women and girl children) cannot access programme activities or training/education.
- Staff absenteeism may increase
- People’s ability to cope with and recover from setbacks (eg drought, conflict, food insecurity, other natural disasters) may be reduced
- The nutritional needs of communities with high levels of HIV infection will be different and, if these are not met, that community’s potential to undertake other development initiatives will be reduced

Note gender differences.

▶ **Ideas to help you address Question b**

- Drought might lead to a rapid drop in nutrition and consequent health deterioration.
- Poor or non-existent sanitation might increase the spread of infectious diseases that would damage the health of people who are immune-compromised.
- Lack of local markets for produce may escalate the poverty of families immobilised by disability or sickness or who have used up all cash reserves on health care

Note gender differences.

**Tool
1–e**

2 Protection

- ▶ **a** What features of the local situation might increase people’s vulnerability to sexual violence, coercion, casual consensual sex or transactional sex as a survival option or coping mechanism?
- ▶ **b** What, if any, features of the local situation might increase people’s exposure to blood-borne infections, including HIV?
- ▶ **c** What programme practices might increase people’s stigmatisation because of their HIV status, or for other reasons?

Note relevant points in the **table supplied on the CD-ROM** or in **Part 4.6**

Protection: What points do we need to note for the current situation?	Who is affected by this point?

▶ Ideas to help you address Question a

People’s vulnerability can be increased:

- when women, young girls, young boys or programme staff are working alone in isolated areas
- when carrying out certain chores or activities, eg gathering firewood, collecting water, walking long distances unaccompanied, using community latrines or washing facilities, travelling by public transport, having to stay out overnight or make overnight stops in journeys, travelling alone with male drivers etc
- in certain locations or types of accommodation used by beneficiaries or staff
- at certain times of day, week or year, eg during festivals, at evenings or weekends, after alcohol consumption, etc
- with movements of people into or out of the region (military, displaced people, NGOs)
- because of gender inequalities or legislative conditions that increase some people’s vulnerability to sexual violence or coercion (eg women may not be entitled to participate in community decision-making processes; women or children may not be entitled to give evidence in a court of law).
- in times of increased trauma, as a coping mechanism, source of intimacy or survival strategy
- if women/girls/boys are excluded from earning opportunities other than sex work
- if staff are left without appropriate organisational support to cope with emotionally or physically demanding situations

Note gender differences.

▶ Ideas to help with Question b

Exposure to risk can be increased by:

- road accidents
- ritualistic scarring practices
- traditional birthing practices
- sharing of skin-piercing implements for medical or cosmetic interventions, etc

Note gender differences.

▶ Ideas to help with Question c

Stigmatisation can be increased by:

- programme practices that single out people affected by HIV
- carelessness about written records or conversations
- core values, staff attitudes, spoken messages or written materials that come across as judgmental of certain people or behaviours, or that exclude some sectors of a community

Note gender differences.

**Tool
1-e**

3 Power

▶ Who holds power in the situation being considered and who are the powerless?

Note relevant points in the table supplied on the CD-ROM or in Part 4.6

Power: What points do we need to note for the current situation?	Who is affected by this point?

▶ **Ideas to help you address the question**

- Is there potential for abuse of power through sexual coercion (including by programme workers)? If so, identify what the potential is and by whom.
- Could the programme potentially worsen the financial situation of local women and/or men, eg by distorting local markets, bringing in a lot of outside skills or materials, flying in their own experts, etc?
- Could the programme disempower local communities by failing to include them in decision-making, by making them passive recipients of the programme's activities, and/or by ignoring local expertise and insights?
- Could the programme disempower women of local communities by failing to include them in decision-making?
- Could the timing of programme consultations and activities disrupt people's work (men or women) or prevent them looking for paid work?
- Could the timing of programme consultations and activities exclude women or schoolchildren?
- Could the programme's principles or practices reinforce existing discrimination or exclusion of some people because of eg their ethnicity, lifestyle, gender, HIV status, sexual orientation, age, health status, etc?

Note gender differences.

**Tool
1-e**

4 Priority groups

▶ Does consideration of potential, protection and power identify additional priority groups to be included in your programme?

Can you include these groups in your initial consultations?

If not, you will need to identify other reliable sources to ensure the reality of these groups is taken into account.

Note relevant points in the table supplied on the CD-ROM or in Part 4.6

Priority groups to be included in the proposed programme	Can you include these in initial consultations? Yes/No

▶ **Ideas to help you address the question**

- Women-headed households
- Child-only or child-headed households
- Families with chronically sick members
- Migrants (women only, men only, girls and boys?)
- Unaccompanied young people (girls and boys)/women
- Elderly carers
- Military/peacekeepers
- Programme staff or volunteers/ other NGOs

Note gender differences.

**Tool
2-e**

Adjustment *Implications of the four Ps*

The adjustment stage uses the information from **Tool 1-e** to identify what the programme should do differently or additionally in order to:

- ▶ **a** remain relevant and effective in achieving its original objectives in a context also affected by HIV and AIDS
- ▶ **b** do no harm.

Remember

- Your focus is still on achieving the original objectives of the proposed programme.
- Do not divert objectives or skills into providing HIV-focused programmes or projects. These can be referred to other local groups skilled in the area.
- Ensure that organisational issues that emerge are recorded (eg codes of conduct, support or protection issues, flexible working patterns where there are sick family members).
- Women and men, girls and boys, may be affected in different ways by any of the points. Note any gender differences.
- Any changes should apply to everyone participating in the programme and not only to individual families or staff members known to be affected by HIV or AIDS because:
 - HIV and AIDS may affect only some people at present, but they have the potential to affect others in the future. What applies to one person today or this year, may apply to others tomorrow or next year.
 - This reduces the risk of stigmatising certain individuals or families.
 - Measures to address protection or power issues will be effective only if applied across the board.
 - A key feature of HIV mainstreaming is the adaptation of plans to ensure the inclusion of people otherwise unable to access the proposed programme because of the impact on them of HIV and AIDS.

Note relevant points in the table supplied on the CD-ROM or in **Part 4.6**

What P concerns should be taken into account? <i>Give a summary of your points under each heading below</i>	What PRIORITY GROUPS are affected?	What can the programme do differently or additionally in order to: 1 remain relevant and effective 2 do no harm?
POTENTIAL		
PROTECTION		
POWER		

See **Part 4** for case studies and scenarios for development and humanitarian response programmes and examples of completed **Tool 2** tables for external mainstreaming.

► Ideas to help you work out modifications to the programme
 The suggested changes are not comprehensive but may provide pointers.

If the concerns identified are related to:	Make the following changes to programme design. Include gender-specific measures:
Potential (present or anticipated in future):	
<ul style="list-style-type: none"> • Loss of able-bodied and skilled adults 	Adjust tools, weights of materials, distances to walk, etc to suit women, or younger and older workers. Provide skilled people to supervise or train workers. Target activities at groups rather than individuals, so that members can help each other. Introduce labour-saving initiatives, eg drip irrigation, small livestock.
<ul style="list-style-type: none"> • Loss of mobility because of sickness or care duties 	Move programme activities closer to people's homes. Have flexible timetables for training and work projects. Adjust school timetables, etc. Engage female carers.
<ul style="list-style-type: none"> • Coping capacity reduced because of sickness among community or staff, or because of the situation the programme is addressing 	Provide a bigger, quicker or more frequent response. Provide assistance for longer than anticipated. Introduce quick-return initiatives in agriculture, eg fast-growing cash crops, small livestock. Develop contingency plans for absenteeism.
Protection	
<ul style="list-style-type: none"> • Vulnerability to sexual violence or coercion 	Adjust timing and location of activities and amenities to minimise this. Minimise travel distances and the need for overnight stops away from home. Provide secure supervision. Involve both women and men in decisions. Include gender-specific protection considerations in all plans. Have a system to record reported instances of abuse. Review staff protection and support needs (for both women and men).
<ul style="list-style-type: none"> • Vulnerability to blood-borne pathogens 	Improve control of infection standards as applicable.
<ul style="list-style-type: none"> • Vulnerability to stigma 	Ensure changes are accessible to all as required and do not further stigmatise individuals.
Power	
<ul style="list-style-type: none"> • Potential abuses of power to barter supplies, programme benefits, wider entitlements or even life itself for sexual favours 	Establish a code of conduct or professional standards, and make sure all staff and volunteers are familiar with it, and with disciplinary measures and legal implications. Monitor practices and have a system to record reports of abuses by anyone linked to the programme and by external power-holders such as military, other NGOs, etc. Label all materials provided by the programme to indicate they are free, not for re-sale or bound by any conditions.
<ul style="list-style-type: none"> • Potential of programme to distort local markets or employment opportunities 	Minimise this when sourcing supplies or engaging skilled staff.
<ul style="list-style-type: none"> • Potential to disempower local communities and to further disempower women 	Involve local communities in decision-making, and in programme implementation. Use local expertise. Involve women in decision-making and programme implementation. Ensure they also exert power over control and distribution of supplies, etc.
<ul style="list-style-type: none"> • Potential to reinforce exclusion 	Have alternative consultative routes and flexible plans to serve those excluded by more established procedures. Re-examine programme principles, attitudes, practices and literature/communications.

**Tool
3-e**

Action *Making and monitoring the changes*

The key question in the action stage is:

- ▶ Are the changes to programme design identified in the analysis and adjustment stages being implemented in its component projects and activities?

Remember

Tools 1-e and **2-e** may have identified changes needed in the priority groups or stakeholders and budgets, as well as changes to programme design and organisational practices. Monitoring should check for implementation of proposed changes to all these aspects, and not only those that apply to programme activities.

Note relevant points in the table supplied on the CD-ROM or in **Part 4.6**

Adjustment proposed in Tool 2-e	Source of information/ means of verifying that it is happening in practice	Is it happening? Yes/No

▶ **Sources of information and means of verifying this include:**

- information recorded in wider monitoring work or visits.

Records of specific activities and how they were implemented should indicate whether or not the changes proposed in the design phase have been implemented.

This question should be addressed directly or indirectly as specific circumstances dictate, in conversations with the programme partner and documentation developed in the action and impact phases of the project or programme cycle.

**Tool
4-e**

Assessment *Looking at impact*

The process of assessing impact is not concerned with such matters as demonstrating a reduction in the incidence of HIV, or increased access to HIV-specific services.

Rather, it seeks to establish whether the HIV mainstreaming analysis has enabled the programme to remain effective in achieving its original objectives and to minimise the harm that it might otherwise have done in a context also affected by HIV and AIDS.

The key questions for this stage are.

- ▶ **a** Are these changes enabling the programme to remain effective in a context affected by HIV and AIDS?
- ▶ **b** Are these changes ensuring that the programme, as far as possible, does no harm in this context?

Some of the adjustments you made will have helped the programme to remain relevant. Some will have helped it to do no harm. Some will have done both.

These questions should be addressed directly or indirectly as specific circumstances dictate, in conversations with the programme partner and through documentation developed in the action and impact assessment phases of an organisation's programme cycle management.

Note relevant points in the table supplied on the CD-ROM or in Part 4.6

Adjustment recorded in Tool 3-e	Indicators that this has helped the programme remain relevant	And/or indicators that this has helped the programme do no harm

▶ **Ideas to help you answer Question a**

- From the ongoing monitoring can you identify if:
- programme activities are taken up by all intended sectors of the target beneficiaries, including those identified by the 4Ps tool?
 - target beneficiaries have continued to engage with the programme in contexts changed by HIV or AIDS?
 - the programme has been sufficiently flexible to adapt to changing circumstances and to offer a variety of possibilities and options, depending on individual situations and preferences?
 - the programme has made any contingency plans to minimise the effects of HIV and AIDS on the capacity and skills of programme staff and/or programme participants?

Note gender differences.

▶ **Ideas to help you answer Question b**

- From the ongoing monitoring can you identify:
- whether and how protection measures have increased the ability of relevant priority groups to participate in the programme?
 - whether and how potential abuses of power have been addressed or minimised?
 - whether and how programme activities have strengthened rather than damaged the coping capacity of communities affected by HIV or AIDS?
 - whether and how the programme's mode of operating has minimised its potential to distort local markets, labour, skills, etc?
 - whether and how programme practices and attitudes have minimised risks of stigmatisation because of HIV or for wider reasons?

Note gender differences.

3

Making it happen

*Mainstreaming HIV in organisational,
management and workplace policies
and practices*

3.1 Using the tools

Part 3 of this toolkit focuses on organisational considerations and internal mainstreaming. It offers tools for applying the stages of analysis, adjustment, action and assessing impact to policies and practices for staff recruitment, working conditions, management, support and supervision.

This process is most effective if applied to specific teams or similar units within an organisation, as well as to the organisation as a whole. The tools can also be used by partner organisations implementing development and humanitarian response programmes and wishing to take forward a more thorough internal mainstreaming. They should also be used in work with HIV-focused programme partners, as these will need to apply internal mainstreaming to their own organisation – a consideration that is often overlooked.

The table below explains how the process and tools can be used for internal mainstreaming.

Who would use this process?	For what purpose?
Personnel/human resources staff	To identify, apply and monitor any changes required to organisational policies and management standards on provision of support, standards of conduct, travel and security, exploitative practices by staff/managers, and staff responsibilities To identify and apply implications for recruitment procedures: job descriptions, interview questions, potential staff turnover, skills loss and absenteeism
Managers	To identify and act on considerations that apply specifically to staff they recruit or manage, and to their particular working context. To identify points that might be included in one-to-one meetings with staff and in annual reviews
Individual staff	To identify concerns, expectations and responsibilities that fall to them or to their managers, and that they might raise in one-to-one meetings with managers, pre-trip briefings, annual reviews, etc. To facilitate an internal HIV mainstreaming process with partner organisations
Staff of partner programmes	To apply an internal (organisational) HIV mainstreaming analysis to their own organisation or to that of a collaborating organisation

The four tools provided take the form of a key question, or series of key questions, for each stage. For each main question, supplementary ideas are given to aid thinking. These are by no means definitive; they are intended to prompt responses to the overarching question. You may choose to include some, reject others, and add yet others, depending on the relevance to the local situation.

Forms for recording the answers, or for noting sources of information, are **supplied in Word format** on the accompanying CD-ROM. The forms may be filled in electronically or printed out and filled in by hand.

The analysis and adjustment stages of HIV mainstreaming are and should be the most demanding of time and effort. Hence the larger number of pages of guidance and tools devoted to this. If these two stages are carried out properly, the last two stages of mainstreaming – action and assessment of impact – should be relatively light.

3.2 Applying the 4Ps approach to internal mainstreaming

A detailed explanation of the 4Ps approach is given in **Part 2.2** and will not be repeated here. If you have not read this, you should do so before proceeding further.

The tools described in the following pages are similar to those employed for external (or programme) mainstreaming. They apply the 4Ps approach to organisational considerations and internal mainstreaming.

The table below identifies the key questions addressed in each stage.

Stage	Questions addressed by this stage
Analysis <i>Tool 1–i</i>	What additional or priority features in the context in which staff work should be taken into account because HIV and AIDS are, or will become, a significant part of this context?
Adjustment <i>Tool 2–i</i>	What should the organisation do differently or additionally in its recruitment processes and its staff and management policies, practices, responsibilities and entitlements in order to <ul style="list-style-type: none"> • remain effective and relevant • do no harm in contexts also affected by HIV and AIDS?
Action <i>Tool 3–i</i>	Are the changes identified in the analysis stage being implemented in recruitment procedures and in working conditions and management practices?
Assessment of impact <i>Tool 4–i</i>	Are these changes enabling the organisation to remain relevant and effective in a context affected by HIV and AIDS? Are these changes ensuring that the organisation, as far as possible, does no harm in this context?

Preparation

Before moving to the four Ps, you will need to take two preparatory steps.

First, recall the key features of the work situations of staff. You may wish to make a note of any relevant points.

► Ideas to help you think about work situations

- The physical and emotional demands made on staff by the nature of their work
- The amount of travel undertaken by staff away from their normal place of work and usual sources of support
- Degree to which individuals are isolated from colleagues or management support, and from friends and family support channels, perhaps because of geographic location or political, social or personal circumstances
- The core skills of actual or potential post-holders for the team or for the type of work you are considering
- The decision-making power held by staff because of the nature of their work and their position in the organisation
- Patterns, causes and degree of absenteeism

Next, recall the causes and effects of HIV and AIDS, both generally and those that apply in the places where CAFOD staff work. The **HIV problem tree** that is included in **Part 4.5** and on the CD-ROM may help.

You are now ready to use **Tools 1–i** to **4–i**. **Tool 1–i** (the 4Ps tool) analyses:

- how this work situation affects HIV and AIDS
- how HIV and AIDS might affect the work situation.

Tool 2–i will help you to identify any adjustments to recruitment processes and working conditions that emerge as a consequence of using **Tool 1–i**. Use **Tool 3–i** to establish that these are being implemented in practice and **Tool 4–i** to establish whether they are helping the organisation to remain effective and do no harm.

The next four pages set out **Tool 1–i**, followed by two pages for **Tool 2–i** and a page each for **Tools 3–i** and **4–i**. You may wish to note the relevant points emerging for each in the **tables provided on the CD-ROM**.

Remember

- Don't spend time chasing information for a specific point that is irrelevant to the type of work or the particular context being considered. If it doesn't fit, move on.
- Usually, an organisation's 'HIV in the workplace' policy covers recruitment and employment considerations specific to HIV. It is an 'HIV-focused' initiative. The workplace issues identified by this mainstreaming approach are broader, and should not be located within this type of HIV in the workplace policy. Pointers offered in the following pages take as a given that the HIV in the workplace policy is being implemented and refer instead to broader measures.
- When identifying the people affected by a particular point, identify collective groups, not individuals: eg staff who use public transport in country X, not Ann Smith in Programme Support Section.
- Women and men may be affected in different ways by any of the points. Note any gender differences.
- Any changes should apply to everyone, staff and volunteers, as relevant to their work situation or related circumstances, not only to individual volunteers or staff members known to be affected by HIV and AIDS because:
 - HIV and AIDS may affect only some people at present, but they may affect others in the future. What applies to one person today or this year may apply to others tomorrow or next year.
 - This reduces the risk of stigmatising certain individuals or families.
 - Measures to address protection or power issues will be effective only if applied across the board.

**Tool
1-i**

Analysis *Applying the 4Ps lens*

1 Potential

This examines whether reduced coping capacity, loss of skills, sickness and/or care duties related to HIV affect the potential of staff to take forward the work of the organisation and conversely, whether these HIV-related effects are exacerbated by the management practices and/or broader working conditions of the organisation. Consider the following:

- ▶ **a** Is the potential of your organisation to provide effective and relevant development and/or humanitarian responses affected by HIV and AIDS? If not now, might this happen within eg the next five years?
- ▶ **b** Is the capacity to cope with disability, or chronic sickness – including HIV-related illness, if acknowledged – hindered by the working conditions?

Note relevant points in the table supplied on the CD-ROM or in Part 4.6

Potential: What points do we need to note for the work situation?	Who is affected by this point? <i>Identify collective groups not individuals</i>

▶ **Ideas to help you think about Question a**

- Are current or potential staff skilled and competent in taking forward their core work in contexts also affected by HIV and AIDS?
- Is staff's availability for travel, for normal working hours, or for extra timetable activities affected by increased care duties at home or health care needs of other family members?
- Is staff availability affected by fear of sexual or physical violence, or by road or air safety concerns?
- Is absenteeism affected by increased sickness among staff or family members, or by frequent attendance at funerals?

Note gender differences.

▶ **Ideas to help you with Question b**

Factors that might reduce staff's coping capacity include:

- inflexible working hours
- excessive demands by managers or colleagues on staff who already have full workloads
- bullying, manipulation or other behaviours by managers or colleagues that increase stress levels for individuals
- poor standards of hygiene and sanitation in offices and other locations where staff may have to work or visit
- office layout or architecture that are difficult for people with disabilities or chronic sickness to negotiate
- lack of transparency regarding tasks and responsibilities, financial security and job tenure, and so on.

Note gender differences.

**Tool
1-i**

2 Protection

- ▶ **a** What features of the relevant work situation might increase staff's vulnerability to sexual violence, rape or sexual coercion?
- ▶ **b** What work situations might lead staff to resort to alcohol, drugs or casual sex as coping mechanisms?
- ▶ **c** What work situations might increase staff's exposure to blood-borne infections, including HIV?
- ▶ **d** What work situations might stigmatise staff, including staff affected by HIV?

Note relevant points in the table supplied on the CD-ROM or in Part 4.6

Protection: What points do we need to note for the work situation?	Who is affected by this point? <i>identify collective groups not individuals</i>

▶ Ideas to help you answer Question a

Situations that increase staff vulnerability might include:

- travelling alone and in isolated situations
- location and lack of security of the office during the day and late evening
- vulnerability of accommodation provided while travelling or relocated for business reasons, heightened by eg choice of location, pressures to take the cheapest option, etc
- accommodation, travelling or working situations that heighten vulnerability to sexual coercion by programme partners, back-donors, government, other NGO or church officials, or others on whom a staff member is dependent
- conflict situations (both ongoing and rapid onset).

Note gender differences.

▶ Ideas to help with Question b

Staff may resort to high-risk coping mechanisms if they experience:

- lack of support for dealing with emotionally traumatising programme scenarios or decision-making situations
- physically exhausting work schedules and itineraries over prolonged periods without support or recuperation.

Note gender differences.

▶ Ideas to help with Question c

Situations that increase risk of exposure might include:

- poor first aid practices
- unsafe vehicles for road travel
- unsafe local cosmetic or traditional blood-letting practices offered to staff

Note gender differences.

▶ Ideas to help with Question d

Features that might stigmatise staff include:

- workplace practices that single out people affected by HIV
- carelessness about written records or conversations
- core values, staff attitudes, spoken messages, or written materials that come across as judgmental of certain people or behaviours, or that exclude some sectors of a community

Note gender differences.

**Tool
1-i**

3 Power

▶ Who holds power over whom? Is there potential for abuse of this power through sexual coercion?

Note relevant points in the table supplied on the CD-ROM or in Part 4.6

Power: What points do we need to note for the work situation?	Who is affected by this point? <i>Identify collective groups not individuals</i>

▶ **Ideas to help you address the question**

Staff may hold power in a number of ways, including:

- decision-making powers over programme partners or beneficiaries
- decision-making powers over other staff
- power emanating from position within the organisation, location in 'head office' or in a smaller local office, age, experience, gender, ethnicity or nationality, creed, etc
- lobbying and advocacy power/influence with other NGOs, institutional donors and policy-makers.

Staff may be vulnerable to false accusations of abuse of power. They may also be victims of such abuses perpetrated by other NGOs, partner programmes, institutional donors, policy-makers, etc.

Note gender differences.

**Tool
1-i**

4 Priority groups

- ▶ Does consideration of potential, protection and power identify any priority groups in the work situation?

Note relevant points in the table supplied on the CD-ROM or in Part 4.6

What are these priority groups?

▶ Ideas to help you address the question

Some points may apply specifically to:

- female staff
- all staff who travel
- staff who are away from home for prolonged periods
- staff working, travelling, or staying alone in areas of known heightened violence or conflict
- staff carrying, storing or dealing with large amounts of cash
- staff dealing with particularly demanding situations emotionally or physically
- staff affected by their own or a family member's disability or chronic sickness and need for care
- managers
- younger staff
- male staff
- staff, whether or not they are managers, who are key decision makers regarding funding, provision of advocacy support, etc
- staff with power by virtue of their standing in the organisation, length of service, location in head or local offices, etc.

Note gender differences.

**Tool
2-i**

Adjustment *Implications of the four Ps*

The adjustment stage uses the information from **Tool 1-i** to identify what an organisation or employer should do differently or additionally in order to:

- ▶ **a** remain relevant and effective in achieving its original objectives in a context also affected by HIV and AIDS
- ▶ **b** do no harm.

Remember:

- Usually, an organisation’s ‘HIV in the workplace’ policy covers recruitment and employment considerations specific to HIV. It is an ‘HIV-focused’ initiative. The workplace issues identified by this mainstreaming approach are broader, and should not be located within this type of HIV in the workplace policy. Pointers offered in the following pages take as a given that the HIV in the workplace policy is being implemented and refer instead to broader measures to be applied.
- Any changes should apply to everyone, staff and volunteers, as relevant to their work situation or related circumstances, not only to individual volunteers or staff members known to be affected by HIV or AIDS because:
 - HIV and AIDS may affect some people at present but they have the potential to affect others in future. What applies to one person today or this year, may apply to others tomorrow or next year.
 - This reduces the risk of stigmatising certain individuals or families.
 - Measures to address protection or power issues will only be effective if applied across the board.

Note relevant points in the **table supplied on the CD-ROM** or in **Part 4.6**

What P concerns should be taken into account? <i>Give a summary of your points under each heading below</i>	What PRIORITY GROUPS are affected?	What can the organisation do differently or additionally in order to: 1 remain relevant and effective 2 do no harm?
POTENTIAL		
PROTECTION		
POWER		

See **Part 4.2 Case study 3** for a case study example of organisational mainstreaming.

► Ideas to help work out what the organisation might do differently or additionally

The suggested changes are not comprehensive but may provide pointers.

If the concerns identified are related to:	Consider the following changes or additions to workplace policies, guidelines and practice:
<p>Potential</p> <ul style="list-style-type: none"> • Changed skill requirements because HIV is a backdrop to programme work • Loss of skills because of sickness, care duties or frequent absenteeism • Effects of bullying, manipulation or lack of transparency as stressors 	<p>Include this point in job descriptions, eg ability to identify the implications of HIV mainstreaming for the post. Include it in interview questions. Identify and provide any additional training required for new staff or existing post-holders.</p> <hr/> <p>Consider alternative means of distributing responsibilities so that they are not held exclusively by one person. Consider the financial benefits of increasing the staff quota to allow for such losses. Consider implementing flexi-time arrangements generally or for any staff member with care duties or any personal health circumstances requiring this.</p> <hr/> <p>Ensure anti-bullying policy is known to all staff and can be implemented in all offices. Promote transparency as a core management standard and requirement of subsidiarity. Activate the organisation's whistle-blowing policy (if it has one).</p>
<p>Protection</p> <ul style="list-style-type: none"> • Vulnerability to sexual violence or coercion • Sex, drugs or alcohol resorted to as the only available coping mechanisms • Vulnerability to blood-borne pathogens • Vulnerability to stigma 	<p>Ensure this concern is included in pre-trip risk assessment and security briefings. Ensure travel and security policy guidelines are followed. Include this consideration in decisions on staff accommodation, location of offices and meeting venues, timing of events, means of transport, etc.</p> <hr/> <p>Identify coping resources and support channels (workplace and personal) provided for staff. Identify particular concerns (personal, family or work-related) that may need specific attention. Consider additional support required for extended trips or when staff are away from their normal work-base for prolonged periods. Identify appropriate support mechanisms for staff working in isolation or in particularly traumatic situations. Ensure staff have appropriate rest scheduled into travel and other prolonged periods away from base. Ensure staff are aware of sexual health services and wider health services available to them.</p> <hr/> <p>Implement the organisation's First Aid standards, road safety and general travel and security guidelines.</p> <hr/> <p>Apply non-discrimination/equal opportunity policies. Ensure confidentiality and disclosure of personal information only on a need to know basis and with informed consent, and apply appropriate safeguards and disciplinary measures. Challenge judgmental attitudes expressed orally, in behaviour and in any written materials of the organisation.</p>
<p>Power</p> <ul style="list-style-type: none"> • Potential abuses of power to extract sexual favours from other staff, programme partners or beneficiaries, or others similarly dependent on the organisation's decisions or influence • Potential to reinforce exclusion 	<p>Make staff aware of expected standards of behaviour when identified as representing the organisation. Have a code of conduct or professional standards in place, and make sure all staff and volunteers are familiar with this and with disciplinary measures.</p> <hr/> <p>Apply equal opportunities, bullying and gender policies. Ensure staff are aware of complaints options and procedures and of an organisation's whistle-blowing policy as a last resort.</p>

**Tool
3-i**

Action *Making and monitoring the changes*

The action stage of internal mainstreaming should form an integral part of routine processes for implementing and monitoring workplace policies, guidelines and good practice.

This stage of internal HIV mainstreaming addresses the following question:

- ▶ Are the changes identified in the adjustment stage being implemented in recruitment procedures and working and management practices?

Make sure to include any training issues and budgetary implications identified in the adjustment stage.

Note relevant points in the table supplied on the CD-ROM or in Part 4.6

Adjustment proposed in Tool 2-i	Source of information/ means of verifying that it is happening in practice	Is it happening? Yes/No

- ▶ **Sources of information and means of verifying this could include:**
- monitoring of job descriptions and interview questions
 - monitoring of implementation of travel and security guidelines and of what is included in pre-trip briefings
 - monitoring of post-trip incident reports
 - evidence that key points raised in 4Ps are covered in induction programme for all staff
 - evidence that staff competence issues raised by HIV mainstreaming are identified and addressed
 - feedback from staff, informally or through various management and review processes in place.

**Tool
4-i**

Assessment *Looking at impact*

The process of assessing the impact of organisational HIV mainstreaming should become a standard consideration with yearly monitoring of organisational procedures.

The process is not concerned with such matters as demonstrating a reduction in the incidence of HIV, or increased access to HIV-specific services. Rather, it seeks to establish whether the HIV mainstreaming analysis has enabled the organisation to remain effective in achieving its original objectives and to minimise the harm that it might otherwise have done.

The two key questions for assessing impact are:

- ▶ **a** Are the organisational changes implemented because of HIV mainstreaming enabling the organisation to remain relevant and effective in a context affected by HIV and AIDS?
- ▶ **b** Are these changes ensuring that the organisation, as far as possible, does no harm in this context?

Some of the adjustments you made will have helped the programme to remain relevant. Some will have helped it to do no harm. Some will have done both.

Note relevant points in the table supplied on the CD-ROM or in Part 4.6

Adjustment recorded in Tool 3-i	Indicators that this has helped the programme remain relevant	And/or indicators that this has helped the programme do no harm

▶ **Ideas to help you answer Question a**

Indicators that organisation's core work remains effective and relevant to the communities it aims to serve might include:

- evidence of successful outcomes against the objectives set for a given strategic period
- satisfactory completion by individuals and teams of yearly operational plans,
- sustained pattern of managing workloads within a team,
- achievements and stories of change resulting from the core work of the organisation
- sustained working relations with current partners and requests from others to enter into partnership
- ability to respond to programme partners' demands and expectations in the specified time and to the degree agreed
- ability to meet the targets agreed with institutional donors and to demonstrate continued effectiveness
- ability to attract continued or new funding on the evidence of current achievements.

▶ **Ideas to help with Question b**

Monitoring should indicate:

- how and whether protection measures have increased the ability of staff to take forward their core area of work more effectively
- how and whether potential abuses of power have been minimised
- how and whether working practices have adversely affected the coping capacity of staff affected by HIV or AIDS, or whether they have minimised any adverse effects
- how and whether workplace practices and attitudes have minimised the risks of stigmatisation because of HIV or for other reasons.

Note gender differences.

4

Resources

4.1 Guidelines for facilitating a workshop on HIV mainstreaming

These pages offer guidelines for facilitating a workshop or training session for your own organisation or for programme partners. The guidelines provide ideas for helping participants to understand the concept of HIV mainstreaming, and to apply this understanding in practice. The guidelines address each of the five As of the mainstreaming cycle (awareness, analysis, adjustment, action and assessing impact).

The guidelines for each stage are set out as self-contained modules. These modules may be delivered in four separate sessions, or in a single, all-day training event. A note at the end of this chapter describes possible variations when using these modules in a single all-day event. Whichever approach is chosen, facilitators should read through the guidelines for all stages before using any one module.

4.1.1 Awareness

Facilitators may choose to use just one or a combination of the approaches described below to promote the awareness stage of mainstreaming HIV.

The purpose of this stage is to enable people to develop an understanding of what HIV mainstreaming means for their work, and for themselves as people working for an NGO in contexts affected by HIV and AIDS. The awareness stage should also enable participants to identify HIV mainstreaming as one of the two co-equal tracks of responding to HIV. When used in CAFOD's induction programme for new staff, it should be part of a process to strengthen staff's understanding of the epidemic and CAFOD's response. It should be used to create a safe and supportive environment in which people can talk openly about issues related to HIV and AIDS, and discuss these in relation to their own lives.

The awareness stage answers the following questions:

- What is HIV mainstreaming?
- What is it not?
- Why mainstream HIV?

Approaches to promoting awareness

Stories, practical experiences, and scenarios for discussion are all useful for developing awareness among colleagues and partner organisations. In some instances participants' basic knowledge of HIV and AIDS may be poor or non-existent. In such circumstances it may be necessary to schedule a session on the basics to strengthen factual knowledge, correct misinformation, dispel myths and ensure adequate and accurate understanding of facts and issues. If this is the case, there is a risk that participants may divert their energies inappropriately into setting up HIV-focused

initiatives. It is therefore important to follow up the factual session with the awareness exercises below, to focus participants' minds on mainstreaming, and to remind them what their role is and what it is not: they are not 'HIV practitioners'.

Option 1 The ropes exercise

Time: Approximately one hour

Materials needed

- Two lengths of rope or string, each at least one metre long
- A set of A5/A6 index cards or similar
- Floor space

Preparation

Before the session prepare up to ten cards. On each card write a different activity that is an example of either an HIV-focused response or a mainstreaming response. (See examples opposite or make up your own.)

Facilitating the exercise

- 1 Place the two ropes in straight lines, parallel to each other, on the floor in a centrally cleared space, and ask participants to stand around this space. Designate (orally or with a paper label) one rope 'HIV work' and the other rope 'indirect HIV link'. Explain that the indirect HIV link is for activities that are not obviously HIV-related, but have some connection.
- 2 Place the cards, face down, on a plate. Ask participants to take one each. If there are more than ten participants, ask random volunteers to take a card.
- 3 Ask participants to look at their card and to think whether it belongs to the 'HIV work' line or to the 'indirect HIV link' line. Ask them to read their card out loud and then place it on whichever rope they decide is appropriate, with an explanation. If they think a card does not belong on either rope, ask them to place it on a nearby table or other convenient spot away from the ropes.
- 4 When all the cards are placed, ask the group to spend a few minutes saying if they agree or disagree with the placings, and why (just short comments: don't let this extend too long, especially if it is getting bogged down in a particular point)
- 5 Explain that the 'HIV work' rope contains all activities that can be described as 'overtly doing HIV work', and that this is what we call HIV-focused work. Group together along one half of the rope all activities that are solely and entirely concerned with providing an HIV response. Call these 'stand-alone' activities. Along the other half of this rope, group the activities that are HIV specific but form part of a wider initiative. Explain that these are 'HIV-integrated' activities. They come under the HIV-focused track because they can still be identified overtly as HIV work, even though they are embedded within wider initiatives.

- 6 Explain that the ‘indirect HIV link’ rope contains activities that have been modified in some way because they can affect HIV and AIDS, or because they are affected by HIV and AIDS. The changes have been made to ensure the original initiative remains effective in situations affected by HIV, or to make sure the initiative does not unwittingly do harm in this setting. Explain that this is what we mean by mainstreaming. Group the cards on this rope into two clusters along the rope, one for internal mainstreaming activities and the other for external mainstreaming.
- 7 If some cards are placed on the wrong rope, correct this.
- 8 If any cards have been discarded as irrelevant to either rope, reclaim these and place them in the appropriate place, engaging participants as you do so and explaining your decisions.
- 9 Explain that the two ropes represent a twin-tracked approach to responding to HIV and that they apply both programmatically and organisationally.
- 10 Discuss the exercise. Repeat definitions of what mainstreaming is and is not, with reference to the completed exercise.

Suggestions for activities to write on cards ¹	Type of response
Write articles on HIV projects for CAFOD magazines	HIV-focused: integrated
Support an HIV home-based care project	HIV-focused: stand-alone
Provide lighter tools because only children and elderly people can do the work	External mainstreaming
Fund HIV education materials used in a school’s sex education curriculum	HIV-focused: integrated
Ensure staff are adequately supported when dealing with traumatic work situations	Internal mainstreaming
Include liturgies and reflections on HIV and AIDS in CAFOD publications on spirituality	HIV-focused: integrated
Develop an organisational code of conduct that includes reference to exploitative or coercive sexual conduct	Internal mainstreaming
Make school or work timetables flexible to cater for care needs of sick family members	External mainstreaming
Organise World AIDS Day events	HIV-focused: stand-alone
In construction projects make sure latrines and water supplies are not located in isolated areas	External mainstreaming
Fund provision of school fees for AIDS orphans	HIV-focused: stand-alone
Give talks on CAFOD’s HIV work	HIV-focused: stand-alone
Fund HIV testing and counselling within a local health clinic	HIV-focused: integrated
Develop an HIV in the workplace policy	HIV-focused: integrated
Ensure women as well as men control programme decisions	External mainstreaming
Develop contingency plans to cope with increased levels of absenteeism and loss of skills in a workplace	Internal mainstreaming

1 Wherever ‘CAFOD’ appears in this list, substitute the name of another organisation if applicable.

A variation on this exercise

The short sentences given in the previous table are designed to be easily read out from a card, but in some instances this brevity may be counter-productive. If you believe the participants in your training session are unlikely to be familiar with the terms used or the activities mentioned, it is better to develop short scenarios instead. Examples are given in the table below.

Scenario	Type of response
<p>A micro-finance institution reviews its work in the light of how AIDS affects clients and their participation in the savings and credit clubs it supports. It discovers several ways of modifying its approach in order to meet the needs of its clients when their households are affected by AIDS, or by any chronic sickness, without compromising the sustainability of the savings and credit clubs or the micro-finance institution itself. These modifications allow clients to miss meetings without penalties and allow them a 'rest' from a cycle of the savings and credit clubs when necessary.</p>	<p>External mainstreaming</p>
<p>The Ministry of Education, Science and Technology aims to address the threats posed by AIDS to the education system and its ability to provide relevant services. Research reveals that the growing number of teachers lost to illness and deaths dwarfs the supply of new teachers. The ministry, therefore, decides to invest in voluntary counselling and testing, and in treatment and counselling for staff, so that those who are HIV positive are able to work for longer. It develops an HIV in the workplace policy and includes it in its staff policies handbook.</p>	<p>HIV-focused: integrated</p>
<p>A programme partner is increasingly concerned at the rapid increase in numbers of children orphaned by AIDS and that these children are losing out on educational opportunities as well as their legal entitlements and inheritance. It develops a programme to provide school fees and uniforms, to fight HIV-related discrimination in schools and to legalise the inheritance rights of children orphaned by AIDS.</p>	<p>HIV-focused: stand-alone</p>
<p>An NGO is aware that many of its staff work in very difficult situations that are physically exhausting and emotionally draining. It realises that staff have little access to support locally and that many of them spend their evenings in the bars and seem to be well known to local sex workers. The NGO reviews its support mechanisms, increases home leave, access to telephone calls to family or friends, closer support and accompaniment by managers and psychological support as standard for staff away for long periods and working in particularly difficult circumstances.</p>	<p>Internal mainstreaming</p>

Option 2 PowerPoint slides

It might be helpful to use slides (or flipchart pages) to supplement **Option 1**, to summarise the main points covered. **Examples of the slides** used in CAFOD staff induction are included in the CD-ROM accompanying this resource. If using flipcharts it is helpful to prepare one setting out the definition of what mainstreaming is and a second flipchart saying what mainstreaming is not.

Option 3 Case studies

It can be helpful to use case studies, stories, fictitious or reality-based scenarios from programme activities and organisational work to illustrate what mainstreaming means. You may use these instead of **Option 1**, or to set the scene for the exercise, or as a final activity after it. Some of the scenarios in the next section could serve this purpose.

For whatever scenario is chosen:

- 1 Divide participants into smaller discussion groups (maximum six people).
- 2 Provide each group with printed copies of one of the scenarios (a different one for each group).
- 3 Ask group members to comment on the following:
 - a Has HIV affected the plans of each of the NGOs in the scenario and if so how?
 - b What is the effect of this on the NGO's work?
 - c What is the effect of this on the intended beneficiaries?

Whichever method you use, at the end of the session emphasise that the purpose of mainstreaming is to remain relevant and do no harm in contexts affected by HIV and AIDS, now and in the foreseeable future.

Participants who have completed the awareness stage can proceed immediately to training on the remaining four stages: analysis, adjustment, action and assessment of impact.

These use **Tools 1 to 4**. You should take these from:

Part 2 (Tools 1–e to 4–e) if focusing on external mainstreaming

Part 3 (Tools 1–i to 4–i) if focusing on internal mainstreaming.

You may prefer to use the **tools provided on the accompanying CD-ROM**, which are in MS Word format and which can be manipulated if needed, or to copy the tool table blanks provided in **Part 4.6**. If copying the tool table blanks, ensure you always give participants the related lists of ideas provided in **Parts 2 and 3**.

4.1.2 Analysis

The following process can be applied equally effectively to both external (programme) or internal (organisational) mainstreaming. This exercise calls for **copies of Tool 1**.

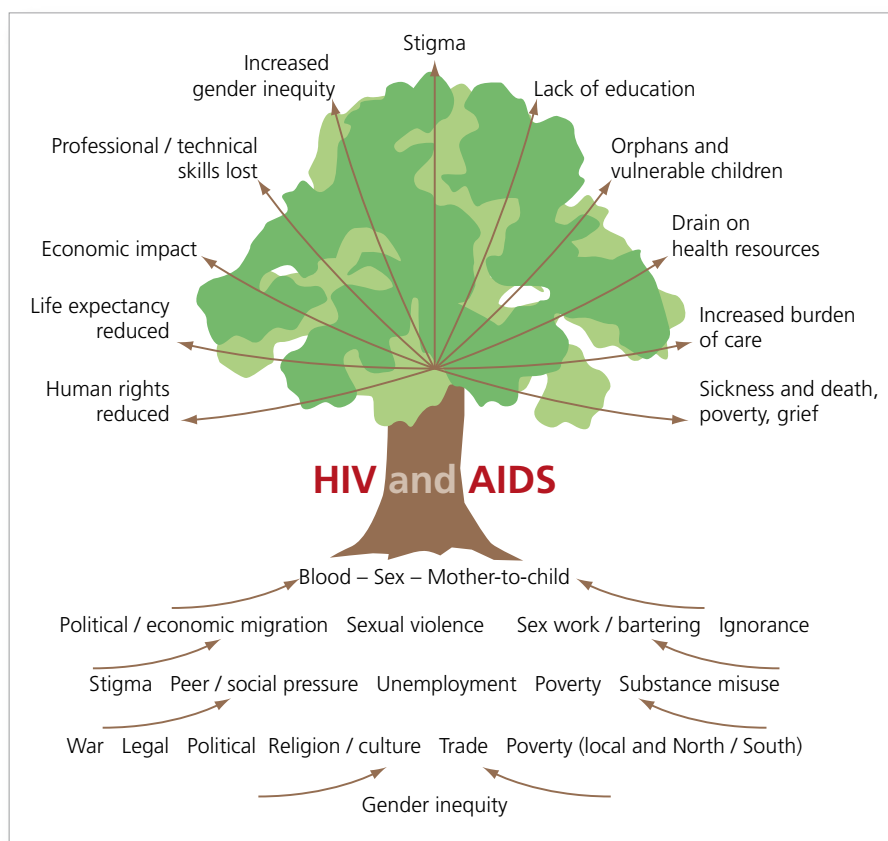
Variations on the exercise are given at the end of **Part 4.1**

Exercise Using Tool 1

Time: Approximately two hours

Materials needed

- Copies of the **HIV problem tree** (as illustrated below and provided in **Part 4.5**) at least one per group
- Copies of **Tool 1** – one set per participant
- The HIV mainstreaming poster included in the plastic wallet at the back of this toolkit, for display purposes, or a flipchart showing the key questions for each stage (see Flipchart C in **Preparation**)
- One or more case studies to allow group work by five to six people in each group, in abbreviated and full versions (see **Preparation**)
- Flipcharts (see **Preparation**)



Preparation

- 1 Decide whether to use case studies for external or internal mainstreaming, or for both, depending on the group participating and the desired focus of the training.
- 2 Prepare printed copies of two or three case studies setting out the local context, challenges requiring a programme/organisational response and the proposed programme or organisational objectives. For ideas, see the case studies in the next section. The parts enclosed in a box are the sort of material to be used. You may photocopy these on to a separate page (one copy per participant) or prepare other scenarios in a similar format.
- 3 Prepare a second, longer version of these case studies setting out the programme/organisational response. If using the samples from the next section, provide the complete text (one copy per participant). This version will be given to participants at the end of the overall training on all four tools. You may like all groups to have a copy of all case studies for later reference.
- 4 If this part of the training takes place on a different day from that covering the awareness stage, prepare two flipcharts, one summarising what mainstreaming is and the second summarising what mainstreaming is not, as set out in **Part 1**. Remind participants that the purpose of mainstreaming is to remain relevant and do no harm.
- 5 Prepare the following flipcharts:

Flipchart A with the following information.

Analysis overview

Step 1 Recall the key features of the situation for which a response is being considered.

Step 2 Recall the causes and effects of HIV and AIDS, generally and locally.

Step 3 Apply the 4Ps lens. Use the 4Ps exercise to consider:

- how the situation affects HIV and AIDS
- how HIV and AIDS affect the situation.

Flipchart B with the following information.

The four Ps

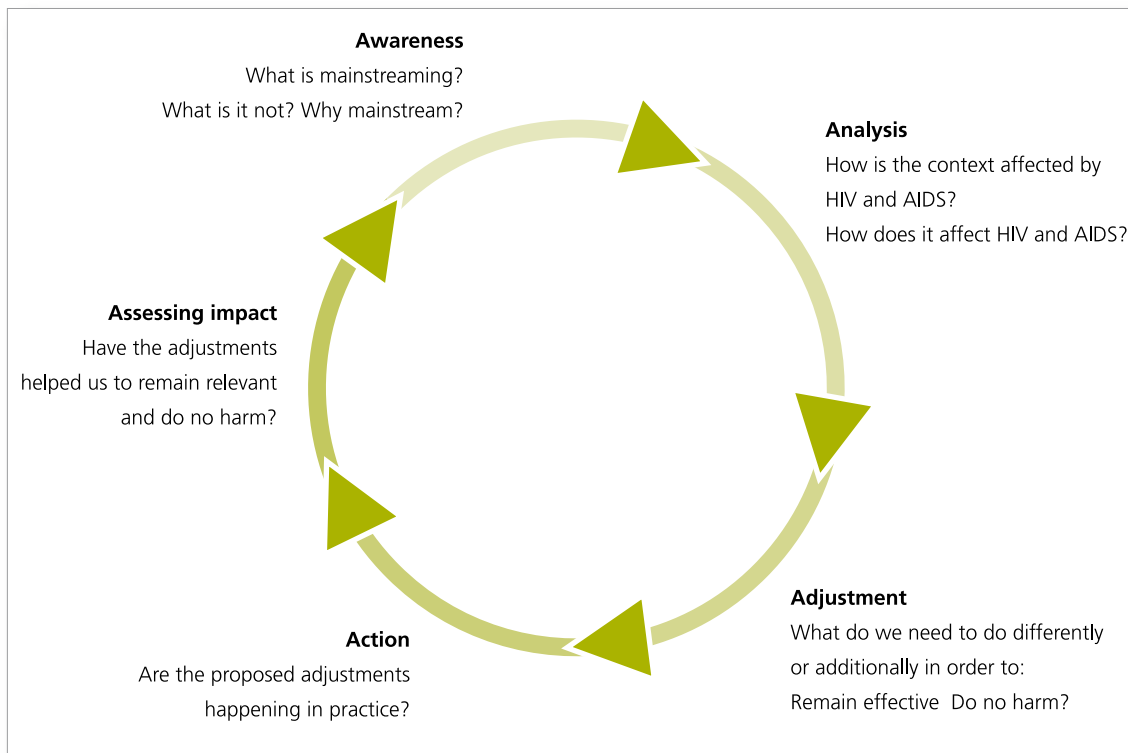
1 Potential How is the potential of programme participants/staff changed because of HIV and AIDS?

2 Protection What in this situation makes people vulnerable to HIV?
What damages the wellbeing of people with HIV?

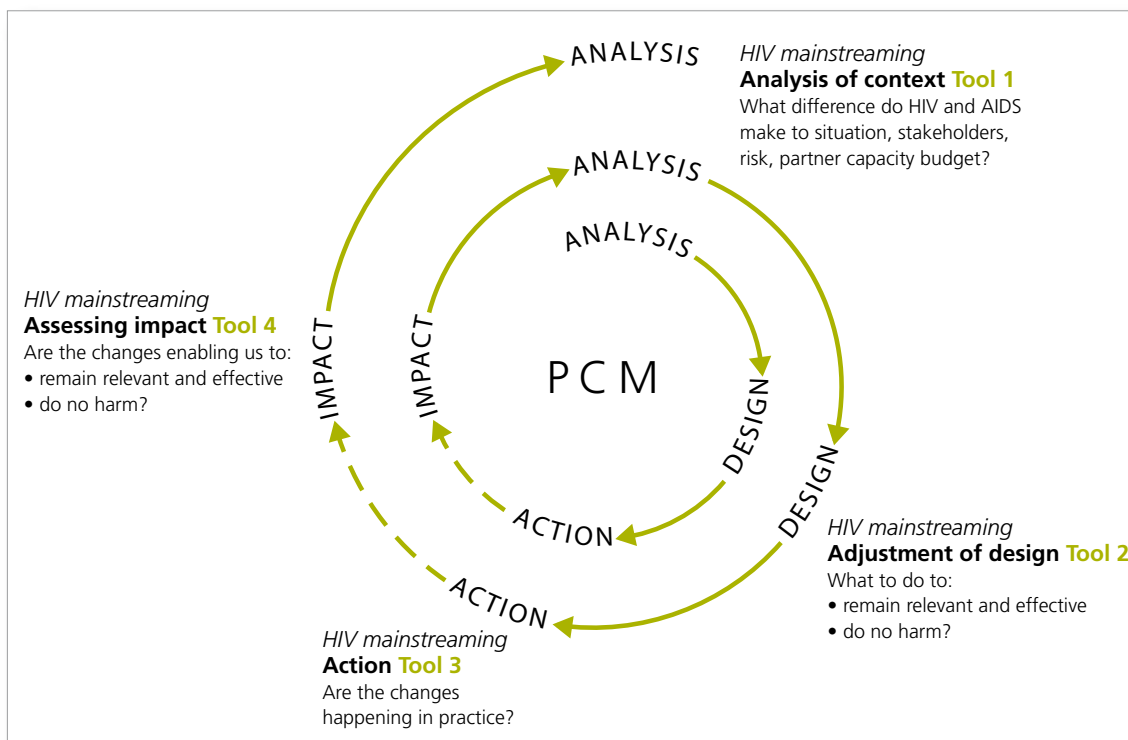
3 Power Who holds power, including sexual power, in this situation? Who are the powerless?

4 Priority groups Are there any additional priority groups because of **1** to **3**?

Flipchart C as an alternative to the HIV mainstreaming poster.



Flipchart D if facilitating this exercise with CAFOD staff.



Facilitating the analysis exercise

- 1 Display and use the **HIV mainstreaming poster** or Flipchart C to:
 - a Give participants an overview of the complete process.
 - b Explain that the previous exercises covered the awareness stage.
 - c Explain that the current exercises will cover the analysis stage, that this and the adjustment stage are the most critical and time-consuming, and that it is important to devote time to them, if HIV mainstreaming is to be successful.
 - d Highlight the two questions to be addressed in this analysis and adjustment stage, as indicated on the diagram.
- 2 Use the awareness flipcharts to remind participants of what mainstreaming is and what it is not. Emphasise again the overall purpose of mainstreaming.
- 3 Divide participants into two or three groups (of five or six per group).
- 4 Use Flipchart A to describe the four steps that participants will follow in the analysis they are about to carry out.
- 5 Give each group a set of abbreviated case studies (one copy per participant). Allocate a different case study to each group. Give each group at least one copy of the HIV problem tree.
- 6 Ask the group to read their allocated case study.
- 7 Ask them to note the key contextual features of the situation they are considering (a rough listing on a sheet of paper). Allow just a few minutes for this step; light and quick.
- 8 Ask them to recall the causes and effects of HIV and AIDS both generally and those applying to the local situation. They might refer to the HIV problem tree, mark the issues relevant to the situation they are considering, and add any others to include. Allow just a few minutes for this step; light and quick.
- 9 Display Flipchart B and explain the four Ps.
- 10 Distribute copies of **Tool 1** to each participant.
- 11 Ask participants to work in their group to complete these for the situation they are considering.
- 12 When this exercise is completed, participants will either proceed immediately to use **Tool 2**, or should save their work and bring it with them to the training session on **Tool 2**.

4.1.3 Adjustment

In this exercise, participants will use their work from the previous exercise to complete **Tool 2**.

Exercise Using Tool 2

Time: Approximately one to two hours

Materials needed

- The HIV mainstreaming poster or flipchart C from the analysis exercise
- Copies of Tool 2 – one per participant

Facilitating the exercise

- 1 Display the HIV mainstreaming poster or Flipchart C.
- 2 Distribute copies of **Tool 2**.
- 3 Ask participants to consider the key question for this step: what must we do differently or additionally in order to remain relevant and do no harm? They may like to refer to the guidance table in **Tool 2** for help. Allow time for them to read through this. Repeat the key question and remind them:
 - a to stay focused on the original objectives
 - b to include any points that apply to staffing issues as well as those applying more directly to programme practices
 - c that the modifications they propose should apply to everyone participating in the programme and not only to beneficiaries or staff members known to be affected by HIV and AIDS. It is not a question of singling out the latter for different types of service.
- 4 Ask participants to complete the table for **Tool 2**, working in the same groups as before, and using the information they documented earlier in **Tool 1**.
- 5 When this work is completed, participants will proceed to use it with **Tool 3**.

4.1.4 Action and assessment of impact

In this exercise participants will use their work from the previous exercise to complete **Tools 3** and **4**.

Time: Approximately two hours for both

Exercise Using Tools 3 and 4

Materials needed

- The **HIV mainstreaming poster** or Flipchart C from the analysis exercise
- One copy per participant of **Tools 3 and 4**

Facilitating the exercise

- 1 Return to the HIV mainstreaming poster or Flipchart C; remind participants of the key questions belonging to these last two stages.
- 2 Distribute copies of **Tool 3**. Ask participants, working in the same small groups, to identify the sources of information they will use to identify that the adjustments proposed in **Tool 2** are being made in practice. Ask them to record these in **Tool 3**.
- 3 Distribute copies of **Tool 4** and ask participants to spend a few moments reading it. Check that they understand the questions.
- 4 Remind participants that:
 - a They are not concerned with demonstrating reduction in HIV incidence, or increased uptake of HIV services.
 - b They are concerned with identifying evidence that the programme or organisation has remained effective and done no harm.
- 5 Ask participants, working in the same small groups, to consider the two questions for assessing impact. Ask them to complete **Tool 4**.
- 6 At the end of this session, each group reports on the work they have done through **Tools 1 to 4**. Ask each group to summarise their scenario before reporting on their work. For brevity's sake, ask them to select a few examples from **Tool 1** (perhaps one from each P that they have completed) and trace these through each of the other tools, reporting on the decisions they made at each stage.

4.1.5 At the end of the workshop

- 1 Remind participants of the overall process followed through **Tools 1 to 4** and the questions they addressed in each of the four As. Refer again to the HIV mainstreaming poster or Flipchart C.
- 2 Identify what needs to change in working practices to ensure that HIV mainstreaming happens automatically within their work of programme or

organisational development. This may require them to identify mechanisms in standard systems that will trigger the key questions for each stage. Emphasise that, with practice, this will be a light process, requiring only a reference to the key questions for each of the four tools.

- 3 For CAFOD staff the PCM process will ensure this happens within programme development. Display Flipchart D to illustrate this. CAFOD's Organisational Development and Personnel department is working out how to ensure that an internal mainstreaming analysis is applied routinely to recruitment and working conditions.
- 4 Review and evaluate the process followed in the workshop. Identify possibilities for follow-up and further support.
- 5 Distribute the full version of case studies (the second item in the list of **Materials** in the analysis exercise) for participants to see and for their future reference.

4.1.6 Variations on these guidelines

The steps described for introducing each tool are just one way of facilitating training in their use and facilitators are sure to develop variations that suit their style, culture, local circumstances, resources available, etc. Variations that CAFOD facilitators have introduced thus far include:

- 1 Several days before a workshop on **Tools 1 to 4** we send participants a copy of each of these tools, and ask them to read through them and familiarise themselves with the detail.
- 2 A few days later we send participants:
 - a copies of the abbreviated versions of all case studies to be used in the workshop. We ask them to read these and ponder the main contextual points for purposes of developing a response.
 - b copies of the problem tree diagram. We ask participants to refresh their awareness of the causes and effects of HIV and AIDS.

Again we stress the importance of staff reading these – and the tools sent earlier – before the workshop, to familiarise themselves with the contents.

- 3 We hold either half-day workshops or a single full-day event on using **Tools 1 to 4**, for staff who have already attended a session on the awareness stage.

We begin by recapping our understanding of mainstreaming, what it is and what it is not.

We divide participants into groups, distribute case studies and ask them to apply **Tool 1** straight away, on the assumption that they have read the tools and case studies as requested. We follow the workshop as described for all stages above.

4.2 Case studies and scenarios

The case studies below come from development and humanitarian response programmes, and from organisational or workplace situations.

Case study 1

Livelihoods and food security programme

In a country of East Africa reports are reaching NGOs of communities being badly affected by food insecurity, with millions of people threatened by worsening drought. This is resulting in increasing levels of distress migration with accompanying social disruption. Levels of sickness and mortality are increasing alarmingly. It is widely known that HIV and AIDS prevalence is also high in the area. Two NGOs respond with the following objectives:

- to set up disaster relief food distribution schemes for 10,000 people
- to establish income generating schemes that will curb distress migration through cash-for-work projects for 5,000 people
- to restore household food security by providing seeds, tools and irrigation equipment for 10,000 households
- to support people's livelihoods by promoting improved farming and animal husbandry techniques for 10,000 households.

Both NGOs have huge experience and skills in responding to similar situations. After carrying out a situation analysis, the first NGO follows its standard procedure for food distribution, setting up fixed collection points and prioritising children under five and lactating mothers. It establishes construction employment initiatives with payment based on the weight of rocks and rubble cleared, and provides daily transport to the sites. It organises for all heads of household to collect seeds and tools, and attend one-week courses on agriculture and animal husbandry techniques in local agricultural colleges. It sets up home-based care (HBC) programmes for any families with people sick with AIDS, and makes sure that its own staff are familiar with its HIV in the workplace policy.

The second NGO also carries out a situation analysis including an HIV mainstreaming analysis. In setting up activities to meet the programme objectives, it brings in the following modifications to its usual way of working:

- The NGO ensures that women-headed households, unaccompanied children and children-only households, and families with immobilised sick members are included in initial consultations and decision-making.
- Priority groups for all initiatives are adjusted to include women-headed households, groups of children or child-only households (children being anyone up to the age of 18), and households with people immobilised because of illness.

- Food distribution points are located nearer to communities affected by drought, because sick adults cannot travel long distances.
- Collection routes are supervised and the times of distribution set to minimise the possibility of sexual attacks on girls coming to collect food.
- The size and weight of food sacks are adjusted so that children and elderly people can carry them more easily.
- The NGO re-calculates the kcalorie and micronutrient requirements for all food aid recipients on the assumption that the whole community is, or could be, affected or infected by HIV.
- Cash-for-work initiatives in construction offer equal pay regardless of type of work, so as to ensure that women, adolescents, and frail but mobile family members can participate.
- Other income-generating initiatives and cooperative schemes are also set up to enable people with care duties to work from or near their homes, and to ensure that families without able-bodied skilled people are helped through community-based approaches.
- Agriculture and animal husbandry training schemes are brought into communities, so that individuals do not have to be away from home for too long.
- Less labour-intensive approaches are included for all participants, regardless of whether they identify as affected by AIDS (on the grounds that others may be affected in the future).
- The size and weight of tools are adjusted so that children and young people can use them.
- Women as well as men are involved in all decisions about and distribution of supplies.
- The support and coping mechanisms for programme staff are reviewed and increased because of the difficult situations they are handling.
- Monitoring checks are in place to ensure that staff abide by the organisation's code of conduct, and do not abuse their positions of power and control over scarce resources.
- The NGO refers anyone needing home-based care to the local Church programme, whose volunteers have been trained and have a good HBC programme.
- Because so many families are coping with a huge burden of illness and have used up their financial reserves already, the NGO estimates that recovery from the drought disaster will take longer and it budgets for a longer period of dependency on external support.

Case Study 2

Conflict – rapid onset acute emergency

Reports are coming in of conflict erupting in a country of South America. Thousands of civilians are fleeing their homes as fighting and killing between opposing factions become widespread, and they are heading for temporary safe areas where UN agencies are providing relief. Many civilians have been killed or wounded by combatants. A significant number of families have sick members, probably AIDS-related, although no-one acknowledges this. Rape of women and young girls by combatants is common. Normal life, basic services and social structures have been completely disrupted by the fighting. Two NGOs agree to respond with the following objectives:

- to provide basic needs of food, shelter, water and sanitation, and health
- to strengthen protection and security measures for displaced people.

The first NGO quickly sets up relief services after an initial situation analysis. It ships in supplies of tents, blankets and cooking utensils, and contracts a number of extra humanitarian staff from Europe to help. Having consulted with the community leaders, it sets about distributing these items to families as they arrive. The NGO sets up a food distribution programme and decides to include information on HIV and supplies of condoms with the food sacks. They make sure that people who are sick are attended to by health teams operating in the camp, while respecting people's need for confidentiality regarding HIV.

The second NGO has the same objectives but modifies its plans after conducting an initial situation analysis that incorporated HIV mainstreaming analysis:

- The NGO ensures that women-headed households, single women and unaccompanied children, and families with immobilised sick members, are included in initial consultations and decision-making.
- Priority groups for all initiatives are adjusted to include women-headed households, single women and unaccompanied children, and households with people immobilised because of illness.
- Women as well as men are involved in decision-making and in distribution of supplies.
- Nutritional needs for all are calculated to include the increased kcalories and changed micronutrient requirements for people with HIV or AIDS.
- Size of food parcels is reduced and people have to walk only short distances to collection points.
- Measures are in place to minimise the possibility of people trading food for sex, and to protect against sexual attacks on women and girls carrying away food supplies.

- Water and sanitation services are located close to living quarters, with separate amenities for women and men; families with sick members are given tent sites closest to amenities and toilet areas are well lit at night.
- Water rations take account of increased needs because of diarrhoea.
- Tents are for single family units, not for numerous families sharing.
- Protection considerations include
 - housing single women and unaccompanied young girls away from the camp periphery, ensuring that girls who go out to gather firewood and women foraging for food in nearby fields are protected from sexual attack
 - ensuring that the camp perimeter is protected by thorn bushes.
- The support and coping mechanisms for programme staff are reviewed and increased because of the difficult situations they are handling.
- Monitoring checks are in place to ensure that staff abide by the organisation's code of conduct, and do not abuse their positions of power and control over scarce resources.
- The programme sources supplies in local or in-country markets as far as possible, and recruits local skilled staff.

Case Study 3

Organisational considerations raised by HIV mainstreaming

'Livelihoods for all' is a UK-based international NGO supporting partner programmes in development and humanitarian response aimed at providing secure livelihoods for local populations in countries of the South. The NGO developed its HIV in the workplace policy some years ago and with this felt it had addressed all the HIV-related issues that might crop up. More recently the organisation adopted a mainstreaming approach to its programme support work. As a result of this a number of staff issues emerged that were not covered in the HIV policy. Staff felt that the points raised were broader than HIV and should be addressed independently of a more focused HIV policy. The points raised included:

- On field visits, staff often had to deal with emotionally difficult programme situations on their own and without any real support from base. They were often away from home for four weeks or more, with little contact with families. A few staff had become increasingly dependent on alcohol in a way that worried colleagues. For others, casual sex with locals was occasionally the only way of coping with loneliness and emotional stresses.
- There were rumours that a few staff used their hold on budgets to obtain sexual favours from partner programme staff.
- On more than one occasion staff had been sexually assaulted by a programme partner when travelling with him to remote programme areas
- Managers from country X, where the NGO has a small office, are beginning to report increased absenteeism among staff, to attend family funerals or because they themselves are sick.

Following widespread consultation the NGO introduced the following measures:

- All staff pre-trip security briefings now include:
 - Consideration of risks of sexual violence and measures to minimise these.
 - Confidential reporting systems (that could by-pass managers if desired) for any concerns experienced.
 - Appropriate health support where required. (The HIV in the workplace policy makes provision for accessing post-exposure prophylaxis¹ in case of need).
 - Discussion of support and coping mechanisms to be applied for the duration of the trip, along with appropriate de-briefing afterwards. Frequency of telephone calls to family contacts (where available) is to be increased in situations known to be particularly demanding physically and emotionally. Assured rest periods are built into trips, with funding for staff to get away from the area, eg at weekends, where this is deemed necessary.

¹ Post-exposure prophylaxis (PEP): use of short course antiretroviral drugs in cases of accidental exposure to HIV.

- Notice is now sent to partner programmes of the measures introduced and expectations of compliance, as a matter of course, in pre-trip correspondence and terms of reference.
- A code of conduct is now in place for all staff referring to the unacceptability, under penalty of disciplinary action, of any form of sexual exploitation or coercion or any form of misuse of staff's position of power over programmes, beneficiaries and others dependent on the NGO.
- A policy on absenteeism for family funerals has now been developed, in consultation with other local employers and NGOs, taking into account cultural duties and expectations, along with the need to remain effective as an NGO.
- The issue of re-distributing areas of responsibility so that no area is exclusively reliant on the presence of a single member of staff has been looked at. Budgets have been adjusted to allow for an increased staff quota to cover for absences and to maintain a secure skills base.

Case Study 4

Local income/employment generating initiative

Two NGOs in a country of South East Asia are approached by community representatives from a village in the rural part of their province. Although this area is very fertile, there is little real earning opportunity and most young people leave school early and migrate to the regional capital to look for work. With very few skills, they often end up as labourers in heavy construction work or in nearby mines where they stay for years, often without ever returning home, or in bars and hotels, many of which are a cover for the outlawed sex industry. In recent years a few young people, men and women, have returned home sick and are dying. (AIDS is suspected but nobody names it. People say AIDS does not exist in their region.) As well as the grief this causes, it makes it even more difficult for other family members to go and earn money, as they now have to care for the sick people. Medicines and funeral costs are driving families even further into debt and poverty, and with it come increased pressures to earn money by whatever means. Community representatives are appealing to the NGOs to help them set up some light industry locally that would provide employment to local people.

Both NGOs agree to set up local projects making jam, as this has become very popular among families across the country and there would be good national markets with potential to expand into neighbouring countries. Their objectives are:

- to set up a local jam factory offering employment to the majority of villagers and to all interested school-leavers
- to reverse the flow of migration by young people away from the village.

The first NGO sets about establishing a jam-making factory. It has supported a similar initiative in another province and already knows where to obtain the cheapest fruit (from a neighbouring country) and can negotiate an even better price if it buys in bulk for both enterprises. The NGO flies in its own experts to manage the factory and train locals who are recruited to work in the factory.

The second NGO agrees to the same objectives and, before developing its activities, it incorporates an HIV mainstreaming analysis into its planning process. As a result of this analysis, the NGO decides:

- to source the fruit locally, given that the area is fertile, and local people have expertise in growing methods that work in the area and good knowledge of the land. This will also provide a source of income and employment locally, will not undermine existing markets and may suit some families less inclined to work in the factory itself.
- before the factory is constructed, to recruit and send local people to other similar enterprises to give them training in the technology involved

- to send some local people who have business management or administrative experience for further management training, and arrange for them to have mentoring during the first five years of the project
- to hold community consultations to identify a good location for the factory that makes it easy to get to and safe to travel to and from, especially for night-shift workers
- to ensure women are included in the consultation
- to ensure recruitment and employment is open equally to women and men
- to use flexi-time arrangements as much as possible to suit child-care and family nursing care duties of some employees and variable health needs of others
- to calculate recruitment quotas to take account of staff turnover and absenteeism caused by sickness
- to take measures to minimise stress to all staff from work overloads, or bullying by colleagues or managers.

Case Study 5

Education programme for minority ethnic groups

Conditions for Roma communities in a country in the Balkans are a cause for great concern. They are ten times poorer than the poorest among majority ethnic groups, have no access to social benefits, and little opportunity for education or employment. They have appalling living conditions, shorter life expectancy and higher infant mortality, and lack access to even basic health care. They are a marginalised group living in social isolation and experiencing high levels of discrimination. Domestic violence, early marriages, buying and selling of Roma brides and generally poor women's rights are a feature of Roma life. Street children, women and child prostitution, drug misuse, alcoholism and human trafficking are also serious problems within this community. The Roma distrust NGOs and government officials equally, have low literacy skills and little understanding of the language of the majority. Two NGOs agree to address the situation. They decide to set up a project with the following objective:

- to increase access for local and internally displaced Roma children to the full range of quality educational opportunities available to the general population of the capital and increase the educational standards of Roma adults.

Agreed activities included:

- providing supplementary literacy classes in schools and Roma settlements
- working with parents and state institutions to improve Roma children's access to education services
- lobbying the Ministry of Education to include a module on the special needs of Roma children in its teacher training courses
- support for children living on the streets.

Both NGOs are experienced in such work. The first NGO set about establishing initiatives according to tried and tested methodologies. The second NGO recognised that, although HIV prevalence in the country is low, the conditions for Roma communities make them particularly vulnerable to infection. Thus it applied an HIV mainstreaming analysis to its planning, identified additional protection and power considerations to take into account, and decided to introduce the following modifications to its usual mode of operating:

- Prioritise women and girls, and children of both sexes living on the streets and target religious leaders as key adults influencing the community and its customs.
- Access women through the Roma settlements and offer incentives to increase their uptake of classes.
- Check if using the language of the majority as a working language prohibits uptake, particularly by women.

- Check that the timing and location of classes suit women's daily routine and their own and their children's safety and possibilities of movement.
- In work with parents, ensure that women as well as men are involved in developing the project.
- Involve parents as educators wherever possible, as a means of empowerment and cultural synergy.
- Strengthen literacy and language skills, particularly but not exclusively for Roma women, and provide interpreters so that they can more easily register for legal status and welfare benefits.
- Given the degree of family break-up, seek ways to broaden the base of community life beyond the family unit as a means of providing more role models.
- Invest in initial awareness-raising work in Roma communities to redress the effects of mistrust.
- Ensure that the NGO's own staff are aware of its code of conduct and that transactional sex with intended programme beneficiaries is not an option.
- Ensure teacher training addresses gender issues and self-esteem for women and girls, and for men and boys. Involve teachers from the Roma community.
- Link education to work-related skills where possible, particularly for women and for children living on the streets.

Case Study 6

Internal mainstreaming by an HIV-focused programme

In a country of Southern Africa, two NGOs are attending a review meeting with an institutional funder. Both NGOs provide entirely HIV-focused services.

These include:

- self-help support groups run by and for people living with the virus
- home-based care for people with AIDS-related illnesses and their families
- voluntary counselling and HIV testing
- advocacy and campaigning work on a number of HIV-related issues
- community-based HIV education and prevention.

As part of the review, the institutional funder asks both NGOs to indicate how or whether they have addressed HIV within their own organisation.

The first NGO replies that it has a policy on HIV in the workplace. This sets out the organisation's commitment:

- to provide all staff and volunteers with the HIV-related information and skills they need for their work and personal lives
- to ensure confidentiality of any HIV-related information disclosed in confidence by staff or volunteers
- not to discriminate on grounds of HIV status, sexual orientation, gender, lifestyle or ethnicity
- not to oblige staff and volunteers to disclose their HIV status
- to provide access to a confidential voluntary counselling and testing (VCT) service for all who seek it and health care and psychosocial support for any staff and volunteers, plus one family member living with HIV.

The second NGO reports that it too has an policy on HIV in the workplace, covering the same points. In addition, it has applied an internal mainstreaming analysis to its own organisation which brought out the following points:

- Many staff and volunteers reported that they found their work particularly stressful and often emotionally draining. Some admitted to having increased their consumption of alcohol since joining the NGO. Others said they often went out at night and had a good time with the girlfriends or boyfriends they met in the bars.
- Absenteeism had increased dramatically in the past year, either because of workers' own health care needs or because they stayed at home to care for sick relatives. Workloads were piling up as a result and this in turn had led to missed deadlines and increased stress for staff.
- Some potential clients had decided against using the NGO's services because they felt the attitudes of some staff were judgmental.

- Some female workers were reluctant to travel to isolated rural areas, or to distant places requiring late-night travel or overnight stays, because of the risk of physical or sexual attacks.
- High staff turnover because of chronic ill-health meant the NGO lacked skilled and experienced staff for many areas of its work.
- Clients reported that some male staff had provided extra food supplies to women who had 'agreed to be their special friends'.

In response to these findings the NGO introduced the following measures:

- Support measures for all staff and volunteers were strengthened and included regular debriefing opportunities, weekly 'caring for ourselves' meetings, monthly outings, away-days or meals together. Referral services were made available for staff or volunteers wishing to use them.
- More flexible working hours were introduced to facilitate any personal care-related needs or duties of staff and volunteers. A policy on absenteeism for family funerals was developed in consultation with staff and volunteers, taking into account the dual requirement of respecting local customs while remaining effective as an NGO.
- All workers were retrained in the NGO's commitment to non-discrimination, and in appropriate and inappropriate language, and were challenged to tackle attitudes that were stigmatising, judgmental or discriminatory. They were reminded of the disciplinary repercussions of breaches of this commitment. All of the NGO's literature and website publications were reviewed to identify any breaches of this commitment. This point was included in the induction programme for all new recruits.
- Travel and security guidelines were revised to minimise the risk of physical and sexual attacks. Additional measures included ensuring female workers travelled to rural areas in teams; reviewing the security of accommodation, meeting venues and transport options; and timing events so that journeys would be completed before nightfall.
- Workloads and areas of responsibility were redistributed to ensure services were covered when individuals were absent. Skills updating and renewal was made a regular part of all workers' annual plans. Experienced workers were paired with newer recruits to ensure sustained organisational learning. Budgets were increased to allow for this and to increase staff quotas to cover for absences and maintain a secure skills base.
- The NGO's code of practice was revised to specify the unacceptability, under penalty of disciplinary action, of any form of sexual coercion or misuse of workers' positions of power to exact sexual favours. Resources given to clients as part of the NGO's work were labelled 'not for re-sale' or 'free of charge'. Similar safeguards were applied to cash transfers in social protection initiatives. Existing workers and new recruits were made aware of these rules.

4.3 Examples of 4Ps analysis applied to development and humanitarian response programmes

This section offers an example of:

- 1 A completed **Tool 2** table using the scenario described in **Case Study 1** (livelihoods and food security programme). The objectives for this programme were:
 - a to set up disaster relief food distribution schemes for 10,000 people
 - b to establish income generating schemes that will curb distress migration through cash for work projects for 5,000 people
 - c to restore household food security by providing seeds, tools and irrigation equipment for 10,000 households
 - d to support people's livelihoods by promoting improved farming and animal husbandry techniques for 10,000 households.
- 2 Completed **Tool 2** tables illustrating how the 4Ps approach can be applied to programme responses to acute emergencies as a means of summarising in an easily accessible checklist the recommendations contained in UN and similar guidelines. This may serve as a reference for practitioners concerned to mainstream HIV into responses to providing basic needs, such as water and sanitation, shelter, food and health, in acute or rapid-onset emergencies and who, because of time pressures and the need to provide an immediate response, cannot undertake a thorough HIV mainstreaming analysis at this juncture. Many of the measures mentioned may well also apply to longer-term emergencies.

4.3.1 Sample completed Tool 2–e table

From scenario described in Case Study 1

What P concerns should be taken into account? <i>Give a summary of your points under each heading below</i>	What PRIORITY GROUPS are affected?	What can the programme do differently or additionally to: 1 remain relevant and effective 2 do no harm?
POTENTIAL		
<ul style="list-style-type: none"> ● No skills, reduced strength: care duties deprive people of education and opportunities to keep the land productive; risk of increasing poverty/HIV cycle. 	<ul style="list-style-type: none"> ● Children and child-only households 	<ul style="list-style-type: none"> ● Provide lighter and smaller tools, usable by children. Distribute smaller sized sacks of seeds delivered to each home. Include less labour-intensive options. Organise community groups for heavier work. Organise adult mentors to teach skills. Organise flexible school timetables and community carers.
<ul style="list-style-type: none"> ● Child-care and nursing duties hinder women's participation. 	<ul style="list-style-type: none"> ● Adult women 	<ul style="list-style-type: none"> ● Devise flexible training timetables and modules working around needs to go home to check sick family members. Provide child-care. Include less labour-intensive options, eg small animals in animal husbandry, drip irrigation, etc. Deliver programme supplies to or near people's homes.
<ul style="list-style-type: none"> ● Inability to undertake regular or heavy work or to walk long distances; care duties disrupt work. 	<ul style="list-style-type: none"> ● Families with chronically sick members 	<ul style="list-style-type: none"> ● Include less labour-intensive irrigation and farming methods in the general programme. Include small animals in animal husbandry options. Deliver supplies to or near programme participants' homes. Have flexible training/work timetables.
PROTECTION		
<ul style="list-style-type: none"> ● Children's lack of voice makes them vulnerable to exploitation, including sexual exploitation. 	<ul style="list-style-type: none"> ● Children and child-only households 	<ul style="list-style-type: none"> ● Include children in community interviews. Ensure they are mentored and supported by women as well as men.
<ul style="list-style-type: none"> ● Women have no markets, no earnings; vulnerability to arriving NGOs and peacekeepers; HIV stigma; women and young girls walk long distances to get to food distribution points, sometimes staying out overnight, vulnerable to sexual attack. 	<ul style="list-style-type: none"> ● Woman-headed households. Women and young girls 	<ul style="list-style-type: none"> ● Ensure women are recruited to income-earning opportunities. Label all supplies 'FREE' that are provided by the programme. Make no distinction between women who know they are HIV affected/infected and other women. Locate distribution points closer to people's homes. Ensure collection routes are supervised and set times of distribution to minimise the risk of sexual attacks.
<ul style="list-style-type: none"> ● Programme workers vulnerable to exploitation, or accusation of abuse; unsupported in difficult/traumatic situations 	<ul style="list-style-type: none"> ● Programme staff and volunteers 	<ul style="list-style-type: none"> ● Ensure programme workers have appropriate management support and rest days. Ensure working practices do not leave workers vulnerable to false accusations, or to risk of rape.

POWER		
<ul style="list-style-type: none"> ● Women in the beneficiary community have no control over programme decisions. 	<ul style="list-style-type: none"> ● Woman-headed households 	<ul style="list-style-type: none"> ● Involve women as well as men in programme planning and in distribution of supplies. Consult women separately.
<ul style="list-style-type: none"> ● Programme workers have control over decisions that will benefit community members. They set timetables, decide action plans, bring in their experts and supplies 	<ul style="list-style-type: none"> ● Programme staff and volunteers 	<ul style="list-style-type: none"> ● Schedule programme activities to suit community work, employment opportunities and family duties. Source supplies and skills locally where possible. Ensure the programme has a code of conduct or similar guidelines in place for all staff and volunteers, and that this includes consideration of sexual behaviours. Implement effective monitoring and a reporting and disciplinary system for any breaches.

4.3.2 Tool 2–e used to create checklists for humanitarian responses, by sector, to rapid onset emergencies

For humanitarian responses to rapid-onset emergencies, these checklists may offer a useful short-cut to applying an HIV mainstreaming analysis. They are compiled in sectors, with reference to IASC¹ guidelines and SPHERE standards². They follow the format used in this tool for recording the relevant points from the 4Ps and identifying implications for programme practices. They are offered as summary points to prompt thinking for **Tools 1** and **2** and not as an exhaustive, definitive list.

To recap, the key questions in **Tools 1–e** underpinning this checklist are:

Potential: How is this changed by HIV and AIDS?

Thinking of the proposed time-frame for the programme, consider:

- 1 Is the potential of the intended beneficiaries and/or the programme staff affected by the presence of HIV and AIDS? If not now, might this happen over the proposed programme timeframe? (see information on national prevalence of HIV and AIDS)
- 2 Does the current situation reduce people's capacity to cope with HIV and AIDS, or with disability or chronic sickness more broadly?

Protection

- 1 What features of the local situation might increase people's **vulnerability to sexual violence, coercion, casual consensual sex or transactional sex** as a survival option or coping mechanism?
- 2 What if any features of the local situation might increase people's **exposure to blood-borne infections**, including HIV?
- 3 What **programme practices might disclose people's HIV status** and **increase the stigmatisation** of people infected or affected by HIV?

Power

Who holds power in the situation being considered and who are the powerless?

Priority groups

Does consideration of *potential*, *protection* and *power* identify additional priority groups to be included in your programme?

The key questions in **Tool 2–e** are:

What can the programme do differently or additionally in order to:

- 1 remain relevant and effective?
- 2 do no harm?

1 UN Inter agency standing committee working group on HIV in emergencies: Guidelines for HIV/AIDS intervention in emergency settings, IASC on HIV interventions in ER settings

2 Humanitarian charter and minimum standards in disaster response. www.sphereproject.org

Water and sanitation

<p>What P concerns should be taken into account?</p> <p><i>Give a summary of your points under each heading below</i></p>	<p>What PRIORITY GROUPS are affected?</p>	<p>What can the programme do differently or additionally to:</p> <p>1 remain relevant and effective</p> <p>2 do no harm?</p>
<p>POTENTIAL</p> <ul style="list-style-type: none"> ● Reduced labour capacity ● Reduced skills ● Decreased mobility and increased care needs of chronically sick people 	<ul style="list-style-type: none"> ● Families with chronically sick members ● Child-only households ● Women-headed households 	<ul style="list-style-type: none"> ● Provide support and skills for families to dig/construct latrines. ● Ensure easy access for children, elderly and chronically ill people to toilets and bathing areas. ● Ensure water containers and pumps can be managed by children, young people, women and people whose strength is compromised by sickness. ● Wherever possible calculate increased water rations in situations with significant levels of chronic sickness/diarrhoea.
<p>PROTECTION</p> <ul style="list-style-type: none"> ● Vulnerability to sexual violence ● Increased susceptibility to water-borne pathogens ● Stigmatisation 	<ul style="list-style-type: none"> ● Single women, young girls, young boys ● Woman-headed households ● Unaccompanied children ● Female staff who are staying on site ● Communities with significant pre-existing sickness levels 	<ul style="list-style-type: none"> ● Locate water supplies, communal latrines and bathing areas close to residential quarters. ● Have separate women's and men's toilets/bathing areas. ● Provide lighting for communal toilets. ● Involve women as well as men in supervision and maintenance of water supplies, as appropriate to local culture. ● Ensure water quality; ration quantity to match increased needs. ● Ensure highest possible hygiene and sanitation standards. ● Develop practices that minimise wider disclosure of HIV status where known, or decisions based on status alone.
<p>POWER</p> <ul style="list-style-type: none"> ● Vulnerability to sexual exploitation or coercion ● Potential for distorting local markets, economies and skills 	<ul style="list-style-type: none"> ● Women, young girls ● Unaccompanied children ● Programme workers and other NGOs ● Combatants/peacekeepers 	<ul style="list-style-type: none"> ● Involve women as well as men in decision-making. ● Code of conduct and accountability for programme workers. ● Lobby for similar for community representatives, other NGOs and where possible, for combatants/peacekeepers. ● Source supplies and skills locally wherever possible. ● Time programme activities to suit care duties, and any work and education opportunities, and thus minimise disruption.

Shelter

What P concerns should be taken into account? <i>Give a summary of your points under each heading below</i>	What PRIORITY GROUPS are affected?	What can the programme do differently or additionally to: 1 remain relevant and effective 2 do no harm?
POTENTIAL		
<ul style="list-style-type: none"> ● Reduced labour capacity ● Reduced skills ● Decreased mobility and increased care needs of chronically sick people 	<ul style="list-style-type: none"> ● Families with chronically sick members ● Child-only households ● Women-headed households 	<ul style="list-style-type: none"> ● Review construction plans to provide support for families unable to undertake their own construction. Make plans community-based rather than relying on individual families. ● Allocate skilled labour to each construction undertaken. Set up rotating systems of skilled supervisors. ● Locate all housing close to shared amenities, for easy access of today's sick people and anticipating tomorrow's. ● Ensure child-only groups are included in surveys.
PROTECTION		
<ul style="list-style-type: none"> ● Vulnerability to sexual violence ● Stigmatisation 	<ul style="list-style-type: none"> ● Single women, young girls, young boys ● Woman-headed households ● Unaccompanied children ● Female staff who are staying on site 	<ul style="list-style-type: none"> ● Provide single family shelter units where possible. ● Keep families together. ● Surround the perimeter of camp accommodation with a fence or thorny shrubs. ● Keep families in or near their original property wherever possible; minimise displacement. ● Strengthen security and supervision at fuel collection points. Consider safer options for cooking and heating. ● Provide lone children with secure accommodation and supervision. ● Revise safety of staff accommodation and working conditions ● Allocate accommodation based on need and not on HIV status.
POWER		
<ul style="list-style-type: none"> ● Vulnerability to sexual exploitation or coercion ● Potential for distorting local markets, economies and skills 	<ul style="list-style-type: none"> ● Women, young girls ● Unaccompanied children ● Programme workers and other NGOs ● Combatants/ peacekeepers 	<ul style="list-style-type: none"> ● Ensure transparent decision-making. Involve women and men. ● Code of conduct and accountability for programme workers. ● Lobby for similar for community representatives, other NGOs and as possible, for combatants/ peacekeepers. ● Label distributed utensils 'free of charge / not for re-sale'. ● Source supplies & skills locally wherever possible. ● Time programme activities to suit care duties, work and education opportunities still operating and minimise disruption. ● Support and monitor families providing accommodation. ● Secure women's rights to own property/houses

Food security/nutrition

<p>What P concerns should be taken into account?</p> <p><i>Give a summary of your points under each heading below</i></p>	<p>What PRIORITY GROUPS are affected?</p>	<p>What can the programme do differently or additionally to:</p> <p>1 remain relevant and effective</p> <p>2 do no harm?</p>
<p>POTENTIAL</p>		
<ul style="list-style-type: none"> ● Rapid health deterioration because of reduced nutrition ● Reduced labour capacity ● Reduced skills ● Decreased mobility and increased care needs of chronically sick people 	<ul style="list-style-type: none"> ● Families with chronically sick members ● Child-only households ● Women-headed households 	<ul style="list-style-type: none"> ● Review kcalories and micronutrient contents of food rations in populations with high HIV prevalence. ● Seek earliest and speediest possible delivery of food supplies to populations with high HIV prevalence. ● Deliver food supplies to any less mobile families. ● Ensure child-only groups are included in surveys and have skilled support for cooking and in longer-term food production projects. ● Provide lighter/smaller utensils and farming tools where children or elderly people are the only/main workers. Provide lighter sacks of food/seeds. Minimise walking distances to collection points. ● Introduce labour saving farming and irrigation devices and quicker cash return crops for longer term projects. ● Budget for a longer recovery/aid dependency period.
<p>PROTECTION</p>		
<ul style="list-style-type: none"> ● Vulnerability to sexual violence ● Stigmatisation 	<ul style="list-style-type: none"> ● Single women, young girls, young boys ● Woman-headed households ● Unaccompanied children 	<ul style="list-style-type: none"> ● Strengthen security and supervision at food distribution points. and locate these closer to people's homes. ● Avoid the need for overnight stays at distribution points. ● Avoid locating distribution points in remote areas. ● Allocate supplies based on wider health or vulnerability needs and not on HIV status alone.
<p>POWER</p>		
<ul style="list-style-type: none"> ● Vulnerability to sexual exploitation or coercion ● Potential for distorting local markets, economies and skills 	<ul style="list-style-type: none"> ● Women, young girls ● Unaccompanied children ● Programme workers and other NGOs ● Combatants and peacekeepers 	<ul style="list-style-type: none"> ● Ensure transparent decision-making. Involve women and men. ● Involve women and men in distribution of supplies. ● Code of conduct and accountability for programme workers. ● Lobby for similar for community representatives, other NGOs and if possible for combatants and peacekeepers. ● Label distributed supplies 'free of charge / not for re-sale'. ● Source supplies and skills locally wherever possible. ● Time programme activities to suit care duties, and work and education opportunities still operating and minimise disruption

Health

This is not a comprehensive checklist of health care measures for practitioners. See SPHERE standards and other guidelines for these. Consideration of ART provision, for treatment or as a preventive measure, should be made in consultation with World Health Organisation, UNHCR and national guidelines in place before the emergency. This table signals additional challenges raised by a mainstreaming approach and possible responses.

What P concerns should be taken into account? <i>Give a summary of your points under each heading below</i>	What PRIORITY GROUPS are affected?	What can the programme do differently or additionally in order to: 1 remain relevant and effective 2 do no harm?
POTENTIAL <ul style="list-style-type: none"> ● Reduced labour capacity ● Reduced skills ● Decreased mobility and increased care needs of chronically sick people 	<ul style="list-style-type: none"> ● Local Health professionals ● Families with chronically sick members ● Child-only households ● Woman-led household 	<ul style="list-style-type: none"> ● Reassess assumptions of locally available medical and health care skills and back-up services in areas affected by HIV and AIDS. ● Consider health care approaches based on HBC models. ● Ensure child-only households are included in surveys and can access health services, including sexual health services as needed.
PROTECTION <ul style="list-style-type: none"> ● Vulnerability to sexual violence or coercion ● Sex as a coping or survival mechanism ● Vulnerability to infection with blood-borne pathogens ● Stigmatisation 	<ul style="list-style-type: none"> ● Single women, young girls, young boys ● Woman-headed households ● Unaccompanied children ● Injured and sick people 	<ul style="list-style-type: none"> ● Ensure sexual health care is a priority from the outset. ● Establish syndromic STI treatment. Provide appropriate services for injecting drug users. ● Universal precautions, equipment sterilisation, clinical waste disposal. ● Minimise the use of injections and transfusions. ● Isolate patients only to control infections and not to segregate HIV+ people. ● Prohibit mandatory HIV testing except for blood transfusions. ● Ensure HIV status is not grounds for withholding other treatments, other basic provisions, or political or financial entitlements. ● Provide psychosocial support for rape survivors. ● Provide/support women-only spaces.

POWER		
<ul style="list-style-type: none"> ● Vulnerability to sexual exploitation or coercion ● Potential for distorting local markets, economies and skills 	<ul style="list-style-type: none"> ● Women, young girls ● Unaccompanied children ● Programme workers and other NGOs ● Combatants/ peacekeepers 	<ul style="list-style-type: none"> ● Ensure transparent decision-making; involve women and men. ● Code of conduct and accountability for programme workers, other NGOs, community representatives and military as far as possible. ● Record reported abuses and instances of rape. ● Label distributed medicines 'free of charge/ not for re-sale'. ● Offer gender-specific and culturally sensitive services. ● Source supplies and skills locally wherever possible. ● Time non-urgent health care activities to suit any work and education opportunities still operating and thus minimise disruption.

4.4 Further reading

The meaning given to the term 'mainstreaming' may vary between publications and in some instances it refers to the approach that CAFOD would define as a response integrated with HIV-focused work. Bearing this in mind the resources listed are a valuable source of theory, practical tools and guidelines.

- **ACCORD**

(2005) *Generic training guide on HIV & AIDS mainstreaming* and
(October 2005) *Trainer's handbook on HIV & AIDS mainstreaming*

- **DFID and others**

(2003) *HIV/AIDS mainstreaming; A definition, some experiences and strategies*
(developed by HIV/AIDS focal points from government sectors and those working on HIV/AIDS mainstreaming)

Resource pack funded by DFID's HIV/AIDS and STI knowledge programme, Liverpool School of Tropical Medicine, Health Economics and HIV/AIDS Research Division, University of Natal and DFID Ghana office. This pack is aimed mostly at managers and decision makers in government ministries who are devising strategies to mainstream HIV and AIDS in their sectors. It assumes that mainstreaming is necessary and that this is generally accepted, but notes that the confusion on what it actually means and lack of training and resources have led to an ineffective response. The pack was developed following a workshop attended by those with experience of mainstreaming, facilitated by Sue Holden. It looks at internal and external mainstreaming. It also talks about both opportunities and constraints for mainstreaming HIV and AIDS and looks at the role of HIV and AIDS focal points in government sectors. It suggests process and impact indicators.

- **Dóchas (Irish Association of Development NGOs)**

(2005) *Mainstreaming HIV/AIDS in humanitarian action – an introduction*

Introduction to mainstreaming for humanitarian organisations. This publication notes the need to link to development literature for a longer-term perspective on humanitarian work. It stresses the need for organisational as well as programmatic mainstreaming and focuses particularly on unequal power relationships (especially in gender). It provides many examples of mainstreaming activities in different areas of humanitarian work (security, shelter, water, health).

- **GTZ/SNRD Africa**

(2004) *Mainstreaming HIV/AIDS mitigation measures in agriculture and rural development – How can institutions respond?* Workshop held July 2004.

- **Holden, Sue**

(2004) *Mainstreaming HIV/AIDS in development and humanitarian programmes*, Oxfam

(2003) *AIDS on the agenda: Adapting development and humanitarian programmes to meet the challenge of HIV/AIDS*, Oxfam

An often-cited author on mainstreaming, Sue Holden has worked with DFID, WHO, ActionAid and Oxfam. This book has good explanations of terminology and examples of mainstreaming HIV and AIDS into development, as well as the rationale behind it and some practical guidelines.

- **Humanitarian Charter and Minimum Standards in Disaster Response**

www.sphereproject.org

- **International Food Policy Research Institute**

(2005) *HIV/AIDS and food and nutrition security conference* (Durban, April 14 to 16, 2005)

A number of background papers, some specific case studies and some more general, available at <http://www.ifpri.org>. The objectives of the conference included to learn more about interactions between HIV and AIDS and food security, to develop tools and guidelines for addressing policy and programme implications of these interactions, and to forge new links between different organisations, sectors and perspectives. The ultimate expected outcome is more effective, large-scale action that addresses the link between food and nutrition insecurity and HIV and AIDS. It is planned that the papers and research will be brought together in a book.

- **Misereor**

(2005) *Responding to HIV/AIDS. A practitioner's guide to mainstreaming in rural development projects*

- **Oxfam**

(2002) *Mainstreaming HIV/AIDS into development: What it can look like and Mitigating the impact of HIV/AIDS – mainstreaming in action – Malawi case study*, from satellite session at Barcelona AIDS conference, 2002

Oxfam has quite a focus on mainstreaming – both internally and externally. Its website has these documents and various other pieces of information, including examples from Oxfam programmes.

- **Swiss Agency for Development and Cooperation**

(2004) *Mainstreaming HIV/AIDS in practice*

A user-friendly toolkit with many pictures, charts and diagrams. It provides an overview of HIV and AIDS in the world today and an explanation of mainstreaming. It then looks at ways to carry out mainstreaming and describes them step by step. It also

includes a section on monitoring (particularly important because mainstreaming is a new approach) with examples on the CD-ROM, and a section on knowledge sharing.

- **UNAIDS**

(2004) *Support to mainstreaming AIDS in development*, UNAIDS, Secretariat strategy note and action framework 2004–2005.

A short document that aims to promote a common understanding. It summarises lessons learned and outlines the UNAIDS framework to strengthen support to mainstreaming processes in partner countries.

- **UN Inter Agency Standing Committee Working Group on HIV in Emergencies**

Guidelines for HIV/AIDS intervention in emergency settings, IASC on HIV interventions in ER settings.

- **UNHCR**

(2007) *Antiretroviral medication policy for refugees* January 2007

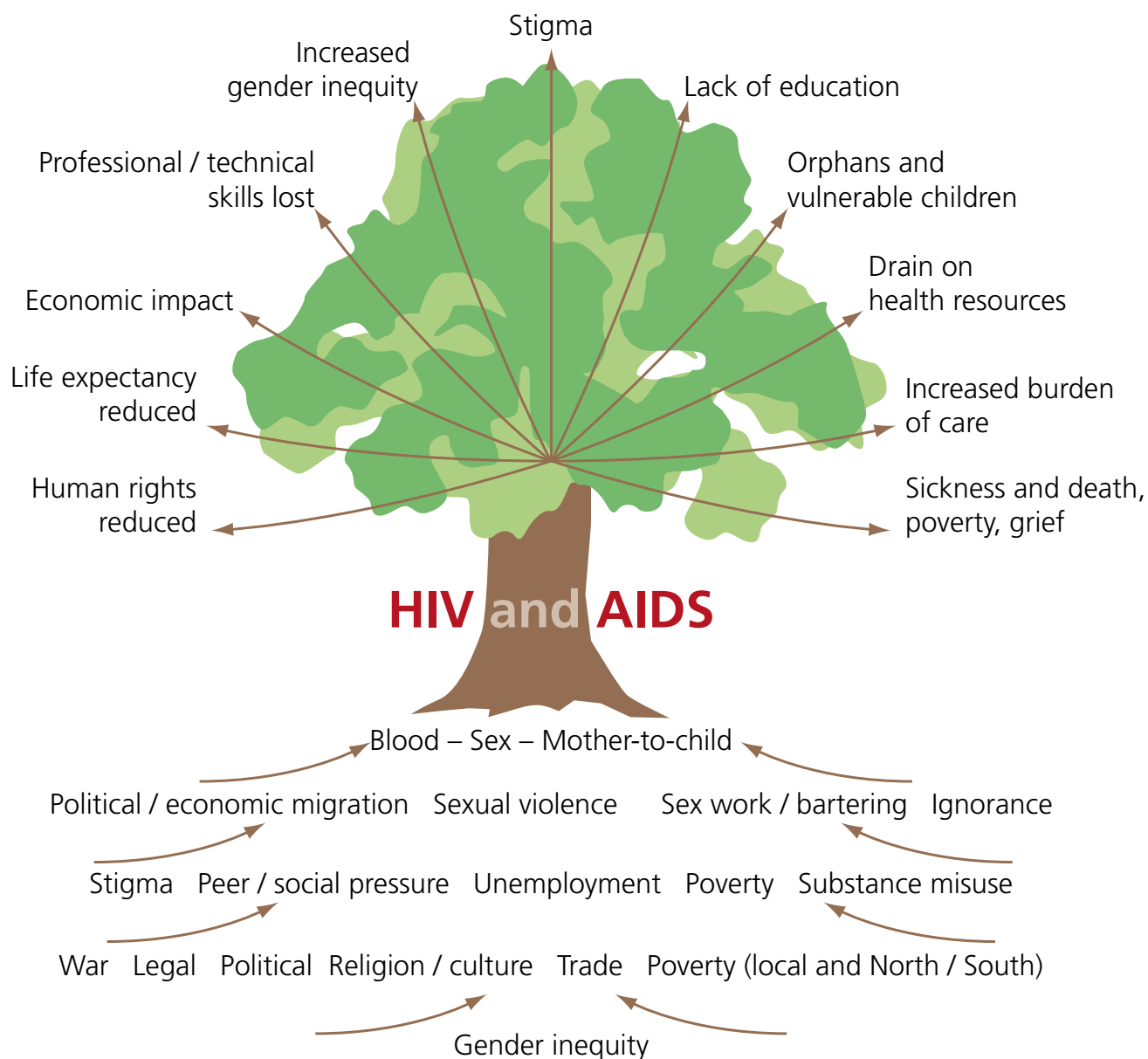
www.unhcr.org/publ/PUBL/45b479642.pdf

- **VSO**

(2002) *Mainstreaming HIV/AIDS: looking beyond awareness*

This paper focuses on case studies as part of the VSO-RAISA programme (a four-year HIV/AIDS programme in South Africa which has mainstreaming of HIV and AIDS as one of its key objectives). The purpose of the paper is to share examples and early lessons. It notes that the concept of mainstreaming is based on the development approach used to bring gender issues into all areas of work. A number of the case studies look at examples of integration rather than mainstreaming.

4.5 The HIV problem tree



4.6 Tool table blanks

The following 14 pages contain blanks of each of the tool tables, for you to copy and fill in by hand.

If you want to extend the size of the tables beyond a single page's depth, please use the **stand-alone tool files in the CD-ROM** that accompanies this toolkit.

- **Tool 1–e** Analysis *Applying the 4Ps lens*
 - 1 **Potential** *How is this changed by HIV and AIDS?*
 - 2 **Protection**
 - 3 **Power**
 - 4 **Priority groups**
- **Tool 2–e** Adjustment *Implications of the four Ps*
- **Tool 3–e** Action *Making and monitoring the changes*
- **Tool 4–e** Assessment *Looking at the impact*
- **Tool 1–i** Analysis *Applying the 4Ps lens*
 - 1 **Potential**
 - 2 **Protection**
 - 3 **Power**
 - 4 **Priority groups**
- **Tool 2–i** Adjustment *Implications of the four Ps*
- **Tool 3–i** Action *Making and monitoring the changes*
- **Tool 4–i** Assessment *Looking at impact*

