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Section 1

Introduction



Who are these guidelines for?

These guidelines are meant for all Oxfam staff who may be involved in implementing a humanitarian response or who may be collaborating with partner organisations in humanitarian situations. Knowledge of HIV and AIDS is important for Public Health Promoters, Water and Sanitation Engineers, Food and Nutrition specialists and Project Co-ordinators and Managers in order to facilitate decision-making and project formulation.

Programme managers can use these guidelines to help them in deciding on how best to mainstream HIV.

It is assumed that the complementary Oxfam resources for project design and public health promotion (i.e. the Emergency Response Manual, the Public Health Promotion Guidelines etc) will be used in conjunction with this guideline therefore only additional information required for mainstreaming HIV/AIDS has been included.

As the mainstreaming of HIV/AIDS is new for Oxfam in humanitarian responses this guideline should be seen as a ***working document*** and ***feedback is encouraged***.

No HIV/AIDS mainstreaming efforts are too small or too informal to document and share. Personal perspective can increase the value of lessons learned and make them much more useful and memorable.

Oxfam is not in a position to address all aspects of a comprehensive HIV/AIDS programme but should endeavour to establish networks and partnerships with agencies to complement their own work and ensure that the wider context is being addressed.

Many interventions will not be appropriate or possible during the acute stage of any crisis when chaos leads to the breakdown of the political, social and/or physical infrastructure. Where a certain degree of stability exists and/or the rehabilitation phase has commenced it will be possible to mainstream many issues throughout the project cycle.

What Managers Need to Do

Ensure that you understand the difference between Mainstreaming HIV and Integrating HIV (see Terms and Definitions)

Try to obtain some background information on HIV prevalence in your area (see chapter on emergency preparedness)

Consider the potential risks of transmission of HIV in your area particularly in emergency situations

Assess the extent to which previous emergency responses have taken gender and protection issues into consideration and focus on ensuring the practical application of existing guidelines in future emergency response (especially gender and protection guidelines)

Consider organising some initial training with your staff on the issue of mainstreaming HIV/AIDS (how will the potential for HIV transmission affect our programmes and what do we need to do to change our programming). Some support may be available from HD to facilitate this training.

Consider how you support Partner organisations to mainstream HIV/AIDS – training will be important

In areas of high HIV prevalence, assess the capacity of existing and potential partners to undertake focussed HIV/AIDS activities in the event of an emergency.

In areas of low HIV prevalence consider how gender and protection guidelines for emergencies can be practically incorporated into the emergency response and consider providing additional training for staff on these issues.

Incorporate gender and HIV/AIDS targets into performance objectives (to include study/reading time where necessary on mainstreaming HIV and/or gender into programmes)

Terms And Definitions

Below are the definitions that Oxfam GB has agreed to work with. Variations in the understanding of these terms is common and therefore it is important that some clarity is achieved prior to initiating work in this area.

AIDS WORK

This is work that focuses directly on AIDS prevention, care or mitigation and is undertaken as a distinct and separate programme.

INTEGRATED AIDS WORK

Integrated AIDS work is work which integrates AIDS prevention, care and mitigation alongside an existing project or within a wider programme which targets other sectors.

MAINSTREAMING AIDS

Whereas the first two approaches have traditionally looked at changing people's behaviour, mainstreaming AIDS looks at how an organisation and the programmes it delivers must change in order to take account of the changing context that has been caused by the pandemic.

MAINSTREAMING AIDS INTERNALLY

Mainstreaming internally refers to how organisational policies, procedures and practice need to change to reduce the organisation's vulnerability to AIDS and to cope with its impact. For example, policies concerning staff health or the provision of leave or the way learning is institutionalised or rules about sexual conduct.

MAINSTREAMING AIDS EXTERNALLY

Mainstreaming externally refers to how our programmes must change to remain effective in an era of AIDS. For example, recognising that people may be too sick to access the distributions they are entitled to and ensuring that another system is put in place to accommodate this fact or that the chronically ill may have increased water needs and ensuring that they are provided with extra storage containers or that tap stands are sited closer to their homes.

Section 2

HIV and Oxfam GB



Oxfam GB Strategy

Oxfam GB strategy recommends that Oxfam should work towards three outcomes, each of which, if achieved, would reinforce the others:

- Decreasing transmission of HIV.
- Increasing access for those **infected** and **affected** by the disease to high-quality treatment, care and support; in particular, promoting equality of access for women, men, and children, and ensuring that interventions are relevant to their needs and roles.
- Mitigating the impact of the epidemic on social and economic development.

Objectives

The global programme therefore has three objectives:

1. ***Mitigating the impact of the epidemic on social and economic development by:***
 - Mainstreaming Externally HIV/ AIDS, and specifically a gender perspective on HIV/AIDS, into all programme and policy work
 - Mainstreaming Internally by increasing the capacity of institutions (both Oxfam and its partners) to respond to the epidemic by analysing and adapting internal policies and procedures in order to address the impact of the epidemic on the workforce. This impact will vary depending on a range of factors, including gender, age, location, type of employment, and so on.
2. ***Increasing access, and equality of access, for women, men, and children to high-quality services in prevention, treatment, care, and support,*** in order to prevent more infections, and to improve the quality of life and productivity of those already infected/affected.
3. ***Investing in learning*** from the above to inform policy and practice and to strengthen programme quality.

Scope and timescale

The strategy will include an action plan for the next three years, but the assumption is that this will be part of a sustained 15-20 year development programme in all the regions.

Implications for programming

The strategy recommends that **objective 1 should be mandatory in all regions and departments**, at least in terms of the first stage of developing awareness and mainstreaming HIV analysis in all key programme areas (business planning, campaign planning, emergency preparedness and planning, internal policies, financial procedures, etc).

Objective 2 would apply to selected regions (currently East Asia, South Asia, and Southern Africa but expanding to HECA and other regions as appropriate) depending on the nature of the epidemic and the level of other agency activity.

Objective 3 forms part of the corporate knowledge management programme.

Stage of epidemic	Population	Countries	Policy and programme implications
Low Level/Nascent Fewer than 5% rate in the groups at high risk.	2.3 billion	Bangladesh, Indonesia, Philippines, most of Former Soviet Union, areas of China and India.	Mainstreaming in all policies and in all programmes. Some focused interventions targeted at high-risk groups.
Concentrated More than 5% of women and men in high-risk groups infected. Low rate of infection in the rest of the population.	1.6 billion	Most of Indochina, Latin America, West Africa.	Mainstreaming as above. More extensive focused interventions (public awareness; continuum of care; PTCT prevention).
Generalised High rate in groups at risk. 1% or more of women in antenatal clinics infected.	250 million	Most of East and Southern Africa; some parts of West Africa and of the Caribbean.	As above but more intensive and wider in scale.

HIV/AIDS and the SCOs

HIV/AIDS impacts across all Oxfam's SCOs:

Livelihoods

Inability to generate income once ill; productive assets may be spent on unproductive 'cures'; increase in number of dependents erodes income

Health and Education

Skilled workforce under pressure due to illness; greater demands on overstretched health services; School attendance falling especially for girls

Life and Security

Emergencies increase susceptibility to HIV infection and vulnerability to the impacts of AIDS

Right to be heard

Those infected and affected by HIV/AIDS face stigma and discrimination and can become "invisible" or excluded

Gender

Women are at increased risk of infection compared to men and are more likely to bear burden of care. An understanding of gender relations is key to addressing the issue.

Section 3

HIV and the
Humanitarian
Department

HIV/AIDS: Why get involved?

Until now HIV/AIDS has not had a high profile in Oxfam's humanitarian programming for a variety of reasons:

- It is difficult to measure
- It is difficult to prevent
- It was seen as a medical issue
- It was not seen as an emergency issue.

Humanitarian emergencies increase the susceptibility to HIV infection and increase vulnerability to the impacts of HIV and AIDS.

Mainstreaming AIDS is about how we work in a world where AIDS will be a problem for the foreseeable future and our humanitarian response cannot continue to ignore the impact of AIDS or deny our responsibility to ensure that we take account of it in designing and implementing programmes. If we do not, we may at worst be unwittingly contributing to people's susceptibility and at best failing to target appropriately those who are most vulnerable. It also seems contradictory to save lives in the short term whilst ignoring a preventable disease that will have 100% mortality in the medium to long term.

"We don't want to die with our belly full"

Male Villager-Zimbabwe assessment 2002

SPHERE explains the situation in the following terms:

"Action must be taken in the acute stage following the disaster to minimise risk of infection. The nature of the disaster and the epidemiological situation of the people affected will dictate what HIV/AIDS interventions are called for and what is feasible. A basic response to any emergency must aim to maintain respect for the individual rights of people with HIV infection or AIDS..."

Sphere Handbook: Minimum Standards in Health care, guidance notes p246

In addition to the recommendations in Sphere it is crucial to consider the rights and needs of people **affected** by AIDS i.e. carers and other family members.

In some regions in which we work there are still low prevalence rates for HIV/AIDS e.g. some parts of South and East Asia and people often question the relevance of mainstreaming AIDS in these areas especially during an emergency. However experience has shown that it is probably only a matter of time before rates increase and the emergency may increase people's susceptibility to HIV. We must therefore ensure that we make every effort to reduce this susceptibility.

It is also important that a thorough analysis of each situation is undertaken as low national prevalence rates for HIV may disguise high local rates (as is the case in India).

In some areas it may make more sense initially to focus efforts on ensuring that existing standards for the provision of services and gender equity are adhered to as these already take account of many of the issues that affect susceptibility. However, AIDS is probably with us for a long time to come and if our response is to remain effective we need to take account of its impacts in designing our response.

HIV/AIDS touches on many issues related to blood, sex and death that are considered taboo in many contexts. Before addressing these issues in programming it is worthwhile to examine your own beliefs, values, assumptions and attitudes toward HIV/AIDS.

Questions for reflection

- What fears or misunderstandings do you have?
- How might these fears or misunderstandings affect your work?
- From where do you think these fears/misunderstandings come?
- How might you overcome these fears/misunderstandings in order to provide advice in the prevention and mitigation of HIV?
- How might you be influencing other people's attitudes – in a positive or negative way?
- If a relative of yours became sick with the AIDS virus, would you be willing to care for him or her in your household?
- If a teacher has the AIDS virus but is not sick should he or she be allowed to continue teaching?
- If you knew a shopkeeper or food seller had the AIDS virus would you buy food from them?
- If a member of your family got infected with the AIDS virus, would you want it to remain a secret?

Oxfam's Approach to Humanitarian Emergencies

Introduction

Oxfam (GB) has a dual mandate, working (a) to overcome poverty and (b) to reduce suffering, where overcoming poverty refers to long-term development work and reducing suffering to responding to humanitarian emergencies.

Oxfam (GB) defines an emergency as “Any situation where there is an exceptional and widespread threat to life, health or basic subsistence, which is beyond the coping capacity of individuals and the community’.

Objectives

The Life and Security Strategic Change Objective aims that:

- 3.1 Fewer people will die, fall sick, and suffer deprivation, as a direct result of armed conflict or natural disasters.
- 3.2 Fewer people will suffer personal or communal violence, forced displacement or armed conflict.

Oxfam's primary objective in responding to an emergency is saving and protecting lives.

Building capacity and addressing gender inequalities are vital additional goals, providing it is feasible to address these simultaneously without weakening our ability to save lives.

3. Public Health Approach

All emergencies are public health emergencies. They will entail deterioration in public health conditions, which will show up, sooner or later, in a deterioration of public health indicators, such as mortality, morbidity and malnutrition, compared to the pre-emergency situation.

In addition to immediate death or injury, suffering in humanitarian emergencies will be increased by:

- The destruction of livelihoods, leading to inadequate nutrition
- The destruction of environments that can sustain health
- The emergence of unhealthy environments (e.g. floods)

Oxfam's response in humanitarian emergencies will normally concentrate on its distinctive competencies, which are key to any public health programme: **public health engineering, public health promotion, and food and nutrition.**

Section 4

What is HIV/AIDS?

HIV: The Virus

In 1983 scientists in France discovered the virus that caused AIDS and the routes of transmission were confirmed. The virus eventually became known as the human immunodeficiency virus (HIV). There are 2 different types of HIV:

HIV-1 the most common type found worldwide, and

HIV-2 found mostly in West Africa.

What is HIV?

HIV is a virus that can damage the body's defence system so that it cannot fight off certain infections.

It may take several years to damage the immune system but during this time the person is infected and is infective (i.e. can infect others). During these years the person may feel and look well. The person is infected with HIV (HIV positive) but does not have AIDS.

What is AIDS?

If someone with HIV goes on to get certain serious illnesses, this condition is called AIDS which stands for Acquired Immune Deficiency Syndrome.

AIDS is a collection of symptoms and diseases a person gets due to the damage HIV causes to the immune system.

If a person has another sexually transmitted infection (STIs) this increases the risk of HIV transmission.

Most people with HIV look and feel healthy for a long time so you can't tell who has the virus by just looking at them

There is no vaccine against HIV

There is still no cure for HIV although **anti-retroviral drugs** have been developed which means that some people can stay well for longer.

Acute HIV infection

Most people, as many as 90%, infected with HIV do not know that they have become infected. HIV infected persons develop antibodies to HIV antigens usually 6 weeks to 3 months after being infected. In some individuals, the test for the presence of these antigens may not be positive until 6 months or longer (although this would be considered unusual). This time - during which people can be highly infectious and yet unaware of their condition - is known as the "the window period".

Seroconversion is when a person recently infected with HIV first tests sero-positive for HIV antibodies. Some people have a "glandular fever" like illness

(fever, rash, joint pains and enlarged lymph nodes) at the time of seroconversion. Occasionally acute infections of the nervous system (e.g. aseptic meningitis, peripheral neuropathies, encephalitis and myelitis) may occur.

HIV infection before the onset of symptoms

In adults, there is often a long, silent period of HIV infection before the disease progresses to "full blown" AIDS. A person infected with HIV may have no symptoms for up to 10 years or more. The vast majority of HIV-infected children are infected in the peri-natal period, that is, during pregnancy and childbirth. The period without symptoms is shorter in children. Most children start to become ill before 2 years.

Progression from HIV infection to HIV-related disease and AIDS

Almost all (if not all) HIV-infected people will ultimately develop HIV-related disease and AIDS. This progression depends on the type and strain of the virus and certain characteristics of the individual infected. Factors that may cause faster progression include age less than 5 years, or over 40 years, other infections, and possibly genetic (hereditary) factors. Poverty and underdevelopment also affect the rate of progression, increasing susceptibility due to a lack of access to health care and education, exposure to opportunistic infections, poor nutrition and overwork. A person's gender may also indirectly affect the rate of progression if for example a woman has little control over household income to enable her to pay for treatment.

How is HIV passed on?

There are four main ways in which HIV can be passed on:

1. By having vaginal, anal or oral sex without a condom with someone who has HIV.
2. By using needles, syringes or other drug-injecting equipment that is infected with HIV.
3. From a woman with HIV to her baby (before or during birth) and by breastfeeding.
4. By receiving infected blood, blood products or donated organs as part of medical treatment.

You cannot get HIV through:

- Everyday social contact
- Kissing, touching, hugging, shaking hands
- Sharing crockery and cutlery
- Coughing and sneezing
- Contact with toilet seats

- Insect or animal bites
- Swimming pools
- Eating food prepared by someone with HIV

Sex and staying safe

What is safer sex?

A simple way of understanding safer sex is to see it as any sex that does not allow either partners' blood, semen, pre-ejaculatory fluid (precum) - or fluid from the vagina to get inside the other partner's body. Some kinds of sex - such as kissing or masturbation - carry no risk of HIV.

What are the riskiest kinds of sex?

Vaginal and anal sex without a condom carries the highest risk. HIV can be passed on to either partner - male or female, active or passive - during penetrative (where the penis enters the vagina, mouth or anus) sex without a condom.

- Always use a male or female condom
- Explore ways of non-penetrative sex: masturbation, kissing, touching and holding each other

How safe is oral sex?

Oral sex is where one partner uses the tongue or mouth to stimulate the partner's genitals. There is some risk from oral sex, but it is less risky than vaginal or anal sex without a condom. The risk can be further reduced by:

Avoiding getting semen or pre-ejaculatory fluid (precum) in the mouth, particularly if there are any cuts, sores or ulcers in the mouth.

Using a condom for oral sex with a man or a dental dam (latex square) for oral sex with a woman.

What is an HIV test?

The HIV test involves taking a blood sample, which is then checked for antibodies to HIV. Antibodies are your body's response to infection with a virus.

A negative result means no HIV antibodies were found

A positive result means HIV antibodies were found and that the person is infected with HIV.

What if the result is HIV negative?

This means that no antibodies to HIV were found in your blood. This usually means that you do not have HIV. It can however take the body up to three months to produce antibodies.

If you think you have been at risk less than three months ago, you might need to have a repeat test.

Remember - it is important to remember that someone who has tested negative because they are not infected with HIV can become infected the following day!

What if the result is HIV positive?

This means that you do have HIV antibodies in your blood and are HIV positive. This does not tell you whether you have AIDS.

Being HIV positive means you will need to look at ways of taking particular care of your own health in order to stay healthy. It also means that you can pass on the virus to others (but only in the ways already discussed). So:

- Always use a condom for vaginal, oral or anal sex
- If you inject drugs, do not let other people use your equipment
- Remember that you cannot pass on the virus through everyday social contact.

The benefits of taking an HIV test:

If the results of the test are negative, you can confidently manage your lifestyle to stay negative

If your results are positive, you can:

- Ensure you do not pass on the virus to someone else
- Make informed decisions about relationships and childbearing
- Keep healthy with attention to nutrition and lifestyle (increased exercise, reduced alcohol intake, reduced tobacco intake, high protein foods and vitamin supplements)
- Be treated with low cost drugs and vaccines to reduce risk of opportunistic infections, e.g. flu jab, antibiotics
- Get effective treatment of common opportunistic infections like TB (Tuberculosis) and reduce the harmful progressive damage to the immune system
- Be treated with ARVs (AntiRetroVirals) to slow down the progression to AIDS
- Gain support from other people
- Make plans for your dependents when ill

Learning you are HIV+ is traumatic

- You will experience a wide range of emotions: fear, anger, loss, denial, anxiety, depression, and grief
- Future hopes and expectations have to be adjusted
- You will need counselling and support
- Relationships with family and friends will come under pressure. They may also need counselling and support

- You may face ignorance, stigma and discrimination from some people

Informed consent and confidentiality

All people taking an HIV test must give **informed consent** prior to being tested. This means they must agree to the test and must understand exactly what the test is for and what the implications of both a positive and negative test are. Mandatory testing without consent is an abuse of human rights.

The results of the test must be kept absolutely confidential. However, shared confidentiality is encouraged. Shared confidentiality refers to confidentiality that is shared with others. These others might include family members, loved ones, care givers, and trusted friends. This shared confidentiality is at the discretion of the person who will be tested.

Although the result of the HIV test should be kept confidential, other professionals such as counsellors and health and social service workers might also need to be aware of the person's HIV status in order to provide appropriate care. This should be discussed with the person being tested.

Section 5

HIV as a Humanitarian Emergency

Overview

By the end of 2001 an estimated 60 million people had contracted HIV, some 20 million of whom had died. (www.UNAIDS.org). In 2001 alone, some five million people are believed to have been infected with HIV and there were an estimated 3 million HIV related deaths.

There are regional variations in prevalence statistics* (*number of people living with HIV and AIDS*) and variations in modes of transmission (*ways that HIV is passed on*) that will influence the priority and types of interventions.

The major concentration of HIV infections is in the developing world, mostly in countries least able to afford care for infected people. In fact, 86% of people with HIV live in sub-Saharan Africa and the developing countries of Asia, which between them account for less than 10% of global Gross National Product (GNP). Infection rates are rising rapidly in much of Asia, Eastern Europe and southern Africa.

HIV Prevalence trends: 1996-2001	
Eastern Europe	+1300%
South East Asia	+160%
Latin America	+40%
SS Africa	+30%
Western Europe	+20%

The picture in Latin America is mixed with prevalence in some countries rising rapidly. In other parts of Latin America and many industrialized countries, infection is falling or close to stable. This is also the case in Uganda, Thailand, and in some West African countries. Nevertheless, although the situation is improving among many groups, large numbers of new infections occur every year in these countries.

The global HIV epidemic actually consists of numerous overlapping epidemics within and among countries. Each epidemic has its own starting point, pattern and rate of spread not necessarily revealed by standard, national epidemiological data sets. National figures are often “best guess” extrapolated from different sub groups of the population. Methods vary from country to country so these figures should not be relied upon totally but can be used to gain a general picture of the epidemic within each country.

* Prevalence rates are often given for adults between the age of 15 to 49 years and written as a percentage. Estimates for the numbers of adults and children with HIV may also be given. As with all statistics they should be viewed with caution and especially in countries affected by complex emergencies the figures given may underestimate the size of problem.

The regional picture of AIDS

Sub-Saharan Africa: the epidemic shifts south

Over two-thirds of all the people living with HIV in the world (nearly 21 million) live in sub-Saharan Africa, accounting for 83% of the world's AIDS deaths. An even higher proportion of the children living with HIV in the world are in Africa, an estimated 87%. There are a number of reasons for this. First, more women of childbearing age are HIV-infected in Africa than elsewhere. Second, African women have more children on average than those in other continents, so one infected woman may pass the virus on to a higher than average number of children. Third, nearly all children in Africa are breastfed. Breastfeeding is thought to account for between a third and a half of all HIV transmission from mother to child. Finally, new drugs, which reduce transmission from mother to child before and around childbirth, are far less readily available in developing countries, including those in Africa, than in the industrialized world.

Asia: low infection rates but rapid spread

HIV came later to Asia, and mostly through drug injectors and sex workers. However, by 1997 HIV was well established across the continent. The countries of South East Asia, with the exception of Indonesia, the Philippines, and Laos are comparatively hard hit, as is India. While the prevalence remains low in China, they are beginning to record increasing numbers of cases. Only a few countries in the region have developed sophisticated systems for monitoring the spread of the virus, so HIV estimates in Asia often have been made on the basis of less information than in other regions. Overall, about 6.4 million people are currently believed to be living with HIV in Asia, just over 1 in 5 of the world's total.

Latin America and the Caribbean: marginalized groups

The picture is fragmented in Latin America with most infections being in marginalized groups. Men having unprotected sex with men, as well as drug injectors, who share needles, are the focal points of HIV infection in many countries in the region. Rising rates in women show that heterosexual transmission is becoming more prominent with the proportion being around one fifth.

Eastern Europe: drug injection drives HIV

Until 1994, mass screening of blood samples from people whose behaviour put them at risk for HIV showed extremely low levels of infection. But in the

last few years, the former socialist economies of Eastern Europe and Central Asia have seen infections increase around six-fold. By the end of 1997, 190,000 adults were infected. The most common form of spread is through unsafe drug injecting, and to a lesser extent through commercial sex. The rise in new cases of Sexually Transmitted Infections (STIs) may reflect a dramatic increase in unprotected sex, which indicates that the risk of HIV infection is spreading rapidly throughout the general population of Eastern Europe.

The industrialized world: AIDS is falling

In Western Europe, HIV infection rates appear to be dropping, with new infections concentrated among drug injectors in the southern countries, particularly Greece and Portugal. Antiretroviral drugs have accounted for low mother to baby transmission. In North America 44,000 new HIV infections were reported with half that number being in injecting drug users. As in Western Europe, mother to baby transmission is rare. Although cases of HIV infections continue to rise in the industrialized world, the cases of AIDS are falling. This downturn is probably due to the new antiretroviral drug therapies that postpone the development of AIDS and prolong the lives of people living with HIV. In the United States, in some disadvantaged sections of society, AIDS continues to rise.

North Africa and the Middle East: the great unknown

Less is known about HIV infection in North Africa or the Middle East than in other parts of the world. Just over 200,000 people are estimated to be living with HIV in these countries, under 1% of the world total.

Distinctive features of HIV/AIDS pandemic

- The mortality rate is 100%. Close to 40 million women, men, and children are now infected, 99% of whom live in developing countries.
- In contrast with other diseases, AIDS kills mostly members of the productive age group age 15-49 years, leaving behind the elderly and the young
- HIV leads to AIDS, which is fatal, however, early diagnosis and access to food and basic care can prolong life and keep a person healthy and productive for a longer period of time
- Women and girls are particularly susceptible to infection and to the impact of the epidemic due to their relative powerlessness and low status in society. HIV infection rates are three to five times higher in young women than in young men.
- Elderly women and men lose the traditional support of their children; grandmothers in particular also have to care for orphaned grandchildren.
- There are 12 million orphaned girls and boys as a result of HIV/AIDS. Children now head many households.
- Food consumption has been found to drop by 40 percent in homes affected by HIV/AIDS
- HIV/AIDS reduces GDP growth per capita by an estimated 1% annually in Africa.
- The disease still carries stigma and discrimination. In many places, injecting drug users, men who have sex with men, commercial sex workers, and women are subjected to a culture of fear and punishment when their HIV status is suspected.
- Targeting interventions is hindered by the fear of infected people to self-identify as well as the stigma from communities. The private nature and divergent cultural attitudes towards sex tend to lead to silence, denial, stigma, and discrimination at many levels.
- Organisations often follow a similar learning curve: initially denial, then regarding HIV as a health issue affecting specific marginalized groups, and only later recognising its wider impact.
- In the absence of routine HIV testing, infected individuals have less of an incentive to alter risky behaviour. Individuals who are unaware of their HIV status and their families cannot begin to alter livelihood strategies in response to the coming shock

As the pandemic intensifies with a parallel need for action, the actual *capacity to act* is decreasing, as individuals in the government and nongovernmental organizations continue to die.

Until recently it was thought that rural areas were relatively protected from the epidemic but it has become increasingly recognised that the populations of these areas are susceptible to high rates of infection as well as very vulnerable to the impacts of the infection.

Rural areas are at high risk¹

- More than 2/3rds of the population of the 25 most-affected African countries live in rural areas
- Access to information in rural areas is poorer
- Access to health care is poorer
- HIV infected urban dwellers tend to return to rural homes therefore care burden is higher
- HIV prevalence usually higher in mobile populations therefore HIV/AIDS disproportionately affects agriculture, transportation and mining sectors.
- Labour intensive farming systems with a low level of mechanization are worst affected

¹ UN General Assembly Special Session on HIV/AIDS

Global and Regional Statistics

Close to 40 million women and men are living with HIV/AIDS around the world, including 1.4 million children.*

Sub-Saharan Africa	28.5 million
South & South-East Asia	5.6 million
Latin America	1.5 million
East Asia/Pacific	1 million
Eastern Europe & Central Asia	1 million
Caribbean	0.42 million
Western Europe	0.55 million

These figures hide areas of concentrated epidemic and in some countries such as India the prevalence in some states is much higher than the National average:

India	3,970,000 people	0.8%
Ukraine	240,000 people	1%
Haiti	130,000 people	6.1%
DRC	1,300,000 people	4.9%
Brazil	610,000 people	0.7%
South Africa	5,000,000 people	21% (0.7% in 1990)

The global estimates of the HIV/AIDS epidemic as of the end of 2001 are:

People newly infected with HIV in 2001

Total:	5 million
Adults	4.2 million
Women	2 million
Children <15 years	800,000

Number of people living with HIV/AIDS

Total:	40 million
Adults	37.1 million
Women	18.5 million
Children < 15 years	3 million

AIDS deaths in 2001

Total:	3 million
Adults	2.4 million
Women	1.1 million
Children < 15 years	580,000

* Source: Report on the Global HIV/AIDS epidemic 2002: UNAIDS

Section 6

HIV in Humanitarian Emergencies

The two-way relationship

Emergencies increase susceptibility to infection with HIV and vulnerability to the impacts of the HIV/AIDS epidemic.

Emergencies worsen HIV/AIDS by:

- Increasing susceptibility to HIV infection due to high risk behaviour to access food and resources (commercial and transactional sex),
- Increased incidence of sexual violence and rape in conflict situations
- Increased migration of people looking for work
- Faster progression to AIDS due to decreased access to health services and good nutrition
- Dislocation from usual support structures increases vulnerability to the impacts of AIDS

HIV/AIDS worsens the impact of emergencies by

- Reducing incomes
- Depleting assets
- Decimating social networks and safety nets

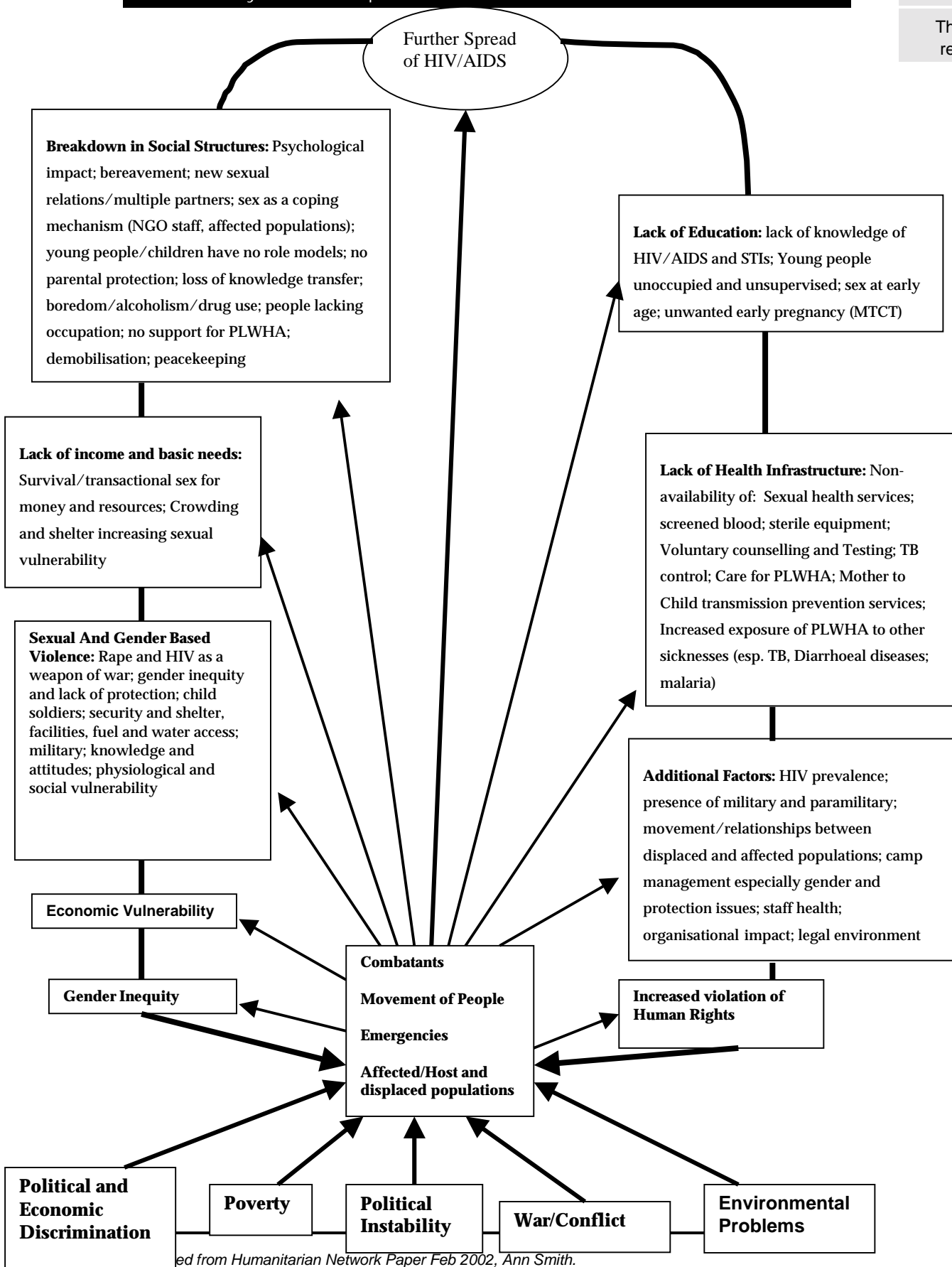
Factors fuelling the pandemic

“ Massive Population displacement, disruption of family and social structures and mores, disruption of sexual networks, sexual interaction of emergency affected people with military or paramilitary personnel, the economic vulnerability of women and unaccompanied minors, the frequency of commercial sex work, the frequency of sexual violence and coercive sex, psychological trauma, the disruption of preventative and curative health services, unsafe blood transfusions at a time of increased blood transfusion requirements, the increased use of illicit drugs, and the high prevalence of sexually transmitted infections...host refugee/IDP interaction, especially rural people with lower HIV prevalence and less HIV knowledge interacting with urban population with higher both ”²

Oxfam intervenes in many types of emergencies and it is outside the scope of this document to describe the varying contexts, however there are certain common factors within emergencies that fuel the epidemic. These are conceptualised in the following framework.

² Khaw AJ, Salama P, Burkholder B, Dondero TJ. HIV risk and prevention in emergency –affected populations: a review. *Disasters* 2000; 24 (3): 181-197

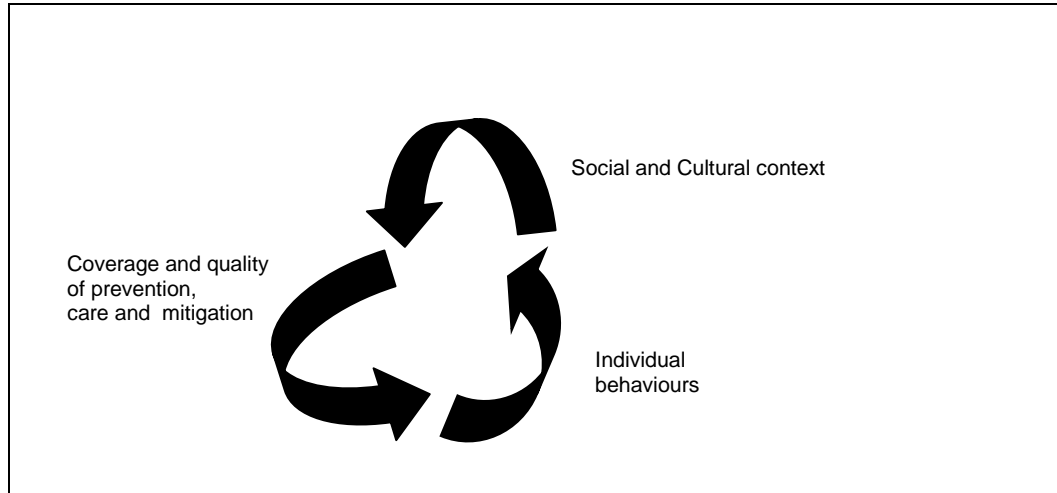
The Two Way Relationship³



Adapted from Humanitarian Network Paper Feb 2002, Ann Smith.

Ongoing Challenges

Increased susceptibility to infection depends on:



Gender

The rapid spread of HIV infection among women is alarming. Roughly 47% of the 15,000 new cases each day are in women of childbearing age. Women are physiologically more vulnerable to HIV infection and other STIs and this is often exacerbated by socio-economic and cultural factors that make it difficult for women to have control over their own sexuality and sexual relations.

Gender roles powerfully influence vulnerability to HIV infection and the impact of the epidemic and therefore will significantly shape the possible response in different communities. Both men and women can be infected but vulnerability to the impact differs.

Women bear the burden of the impact of AIDS. They may have additional care responsibilities for ill husbands, take on other orphans, engage in further work to ensure income, engage in risky sexual behaviour during transactional and commercial sex. They are also more susceptible to HIV infection and women whose husbands migrate for work are especially vulnerable as their husbands may have other sexual partners.

Children of HIV-infected mothers living in poverty are at great risk for malnutrition, growth failure and mortality, either as a result of their own HIV infection or because of the deteriorating health of one or more of their care providers. Around 15% of all HIV+ve children are taken out of school.

Factors that increase vulnerability of women and girls to HIV:

- **Physiological:** The virus is found in greater concentration in semen than in vaginal secretions. There is also evidence that women become more vulnerable to HIV infection after menopause. In addition, tearing and

bleeding during intercourse, whether from rough sex, rape, or prior genital mutilation (female circumcision), multiply the risk of HIV infection. In addition, STIs – which increase the likelihood of HIV transmission – are less visible for women than men and so are more likely to go untreated.

- **Social:** Typically, women are expected to leave the initiative and decision-making in sex to males whose needs and demands are expected to dominate. There is often a tolerance of predatory, violent sex, as well as a double standard where women are blamed or thrown out for infidelity (real or suspected) while men are expected or allowed to have multiple partners. Millions of young girls are brought up with little knowledge of their reproductive system or how HIV and STIs are transmitted and prevented.
- **Economic:** The majority of women in the world lack economic resources, and are fearful of abandonment or of violence from their male partner. Thus they have little or no control over how and when they have sex, and hence have little or no control over their risk of becoming infected with HIV.

For many women worldwide, their principal risk factor is to be married-male partners have unprotected sex with several partners putting their wife at risk.

In Sub-Saharan Africa, for every HIV+ve young male there are 4 or 5 HIV+ve young females. This is often due to the “sugar daddy” phenomenon where older men use money and power to encourage young women to have sex with them. There is also a widely held belief of “virgin cure”-that is where an HIV+ve man believes he can rid himself of the virus by having sex with a virgin.

Most HIV infection rates among women begin in the early teens, rising steeply, peaking in the early to mid-twenties while for men infections peak five to ten years later.

Factors that increase vulnerability of men, and especially young boys:

- Social norms that reinforce their lack of understanding of sexual health issues and celebrate promiscuity.
- Likelihood of engaging in substance abuse (alcohol, drugs).
- Types of work that can entail mobility and family disruption (migrant labour, military).

Sexual and Gender Based Violence (SGBV)

The prevention of sexual violence and coerced sex should already be mainstreamed within Oxfam GB’s Humanitarian programming due to the ongoing work with gender and the Protection Project. Although this accounts for only a proportion of HIV transmitted there are possibilities for Oxfam GB to intervene proactively to decrease the risk.

For those women in camps risks can be minimised by placing latrines and facilities in accessible well-lit areas, making special arrangements for

unaccompanied minors and avoiding the sharing of living space with unrelated families.⁴

Culturally appropriate opportunities (that do not involve exchanging sex for money and resources) for women and young girls to earn income and food need to be explored.

SGBV prevention programmes are complex to implement.

“Negative results achieved involved the perception on the part of many male community members, that the only problem with rape was the risk of contracting AIDS. It was noticed during an initial campaign in phase one addressing reproductive health issues, that speaking of AIDS and STIs during mention of sexual violence led young males particularly, to believe that one must rape using a condom. After this was noticed, all awareness activities focused strictly on sexual violence and the respect of women ...”

***Program against sexual violence’ Congo Brazzaville
IRC/UNDP/UNIFEM***

Commercial Sex Work

What are women’s choices?

“It is better to get AIDS than to watch your kids starving”

Quote from focus group discussion during recent assessment in Zimbabwe (May 2002)

Women turn to commercial sex work as an alternative to poverty because their lives and livelihoods have been disrupted by war or because they have lost their property and their husband's earnings through divorce or widowhood and as a result of inequitable laws and custom.

Often, individuals engage in sex work to determine their own economic survival and in many cases, that of their children and other family members.

Commercial sex workers are often highly mobile, making grassroots organization and HIV-preventive programming difficult. In prevention planning and programming it must be remembered that sex workers, like other groups, are far from homogeneous. They include women and men, those who identify as gay or bisexual and young people, who may be relatively powerless and particularly vulnerable to exploitation and injecting drug users. There are a variety of contexts in which sex work takes place, for example, in brothels, bars, on the streets and through broker-mediated encounters.

Sex work in many countries is illegal and women and men who exchange sex for money may not always be visible or accessible. It may therefore be difficult to target such individuals directly. **A mainstreamed programme would recognise and acknowledge that this exists and seek to increase opportunities for employment for vulnerable families.**

⁴ UNHCR (1999) *Reproductive Health in Refugee Situations: an Interagency Field Manual and UNHCR (1995) Sexual violence against Refugees: guidelines on Prevention and Response*. Geneva

Parent to Child Transmission (PTCT also known as Mother to Child Transmission MTCT)

The term MTCT is still more common in the literature about AIDS but the term Parent to Child transmission is used here to reflect a truer picture of the route of transmission. An estimated 600,000 children are infected in this way each year, accounting for 90% of HIV infection in children. Without preventive treatment, up to 40% of children born to HIV-positive women will be infected. Of those who are infected through PTCT, it is believed that about 2/3 are infected during pregnancy and around the time of delivery, and about 1/3 are infected through breast-feeding.

A key strategy in preventing Parent to Child transmission (PTCT) is therefore preventing HIV infection in women of childbearing age. The risk of transmission varies between 15% and 30% amongst children who are not breastfed. Breastfeeding increases the risk by 10% to 20%. However, in situations where sanitation is inadequate and families are poorly resourced, death from diarrhoea is 14 times higher in artificially fed infants than in those who are breastfed. As a general principle, in all resource poor populations where the majority of women are of unknown HIV status, breastfeeding should continue to be protected, promoted and supported. Oxfam staff should be aware of the current Oxfam position on infant feeding in emergencies.

Age

At least half of today's 15 year olds in Sub-Saharan Africa are likely to contract HIV/AIDS at some point in their lifetime if present trends continue. AIDS is changing entire population structures with a massive death rate in people over 30.

In Botswana, if the course of the epidemic does not change, a 15 year old boy currently has a 95% risk of becoming infected with HIV in his lifetime.

With the breakdown in social structures young people have limited positive role models and parental protection. Opportunities for consensual sex are increased in emergency situations. Camp life may increase boredom and alcohol and drug use. There may be an overall lack of education and lack of knowledge about HIV and STIs.

Youth lacking occupation may use sex as a coping mechanism or to relieve boredom. Increasing the participation of youth in designing interventions could lead to innovative solutions for reducing the opportunities for risk taking. Targeting youth in Oxfam programmes may be seen as controversial in terms of their status within the community, particularly in addressing the often-stigmatised subject of HIV therefore broad based support from all sectors of the community has to be ensured.

Approximately half of all people who acquire HIV become infected before they reach the age of 25. Thus, it is crucial that work be undertaken to help young people protect their sexual health. However, there has been a great deal of uncertainty about how to approach HIV and AIDS prevention with young people with a continuing widespread concern that 'too much' sex education will encourage young people to become prematurely sexually active.

Several studies have shown however, that well-designed programmes of sex education, combining messages about safer sex as well as abstinence, may delay sexual debut, as well as increase preventive behaviours among those young people who are already sexually active⁵.

It is important to be aware that young people, especially girls in developing countries, do not always have the freedom to make their own choices about sexual behaviour. Young people also have immediate needs for shelter, food and clothes that take priority over the threat of a disease that may or may not kill them in years to come.

While young people may be at special risk of HIV infection, they also present an opportunity for halting the epidemic, since their sexual and other habits may not yet be firmly established.

In young people, health avoiding and risk taking behaviour is often related to a lack of correct information about sexual health and leaving (undiagnosed) STIs untreated. Risk taking and unsafe sexual behaviour may be related to a variety of factors including misuse of alcohol, feelings of fatalism, lack of future prospects, lack of self-esteem, feelings of powerlessness and a sense of complacency.

Military

Members of the military and paramilitary, police and other armed groups usually have a higher prevalence of HIV than civilians due to having more sexual partners (willing or coerced) due in turn to armed personnel having more mobility, money, ability to coerce and fatalistic outlook. Interaction with armed groups is thus an important risk factor for emergency affected populations.

In situations of conflict resolution HIV transmission may increase due to increased mobility of populations, demobilisation of soldiers and the presence of peacekeeping forces.

Sexually Transmitted Infections (STIs)

STIs are an important co-factor in the sexual transmission of HIV with the association being strongest for ulcerative conditions (i.e. Syphilis, chancroid, granuloma inguinale). STIs increase the shedding of HIV in the genital tracts of infected men and women. The ulcerating nature of some STIs also increases susceptibility to the virus.

This means that someone having unprotected sex with a HIV+ve person who has co-existing STI is at higher risk from contracting HIV. Also if someone with an STI has unprotected sex with a HIV+ve person then they are also at higher risk of contracting HIV.

Lack of education about STIs and lack of access to basic health services is increased in emergencies thus increasing the rates of STIs in turn increasing the risk of infection with HIV.

⁵ Grunseit, A (1997). *Impact of HIV And Sexuality Education on The Sexual Behaviour of Young People: A Review Update*. Geneva, UNAIDS.

Stigma and Human Rights abuses

HIV is known to be a cause of further discrimination against populations already disadvantaged by the emergency. Whilst this potential stigmatisation represents an important constraint, there is still a need to highlight HIV/AIDS vulnerability and risk and to implement interventions in order to prevent HIV transmission in the affected populations and to mitigate the impacts.

Creating an environment for PLWHA (People living with HIV/AIDS) to live free of stigma has a double impact. It encourages prevention for those who are still negative while at the same time allowing people who are positive to access appropriate care and support services to live positively and productively.

“If a pregnant woman is sick or has a sick, premature baby who dies before three months, then we know she is infected with HIV and turn away from her. This is our [HIV] test.” - Man, rural Zambia, PANOS study on Stigma, HIV/AIDS prevention of MTCT

Stigma associated with HIV/AIDS is particularly damaging because it often impacts upon the poorest and most vulnerable individuals and groups in society, many of whom are already disadvantaged and discriminated against on other grounds – for example women, orphans and vulnerable children, sex workers, men who have sex with men, gay men and injecting drug users.

HIV/AIDS-related stigma builds upon, and reinforces, existing prejudices. It also plays into, and strengthens, existing social inequalities – especially those of gender, sexuality and race.

Due to stigma and HIV/AIDS-related discrimination, the rights of people living with HIV/AIDS and their families are frequently violated simply because they are known, or presumed, to have HIV/AIDS. This violation of rights hinders the response to and increases the negative impact of the epidemic.

HIV and Human Rights

Oxfam should ensure that everyone has his or her basic human rights upheld

- No mandatory testing
- Right to informed consent and voluntary testing
- Confidentiality of HIV test results
- Protection: no forcible repatriation due to HIV status
- Stigma, denial and discrimination should be minimized
- Everyone has the right to live and die in dignity
- Everyone has the right to basic health care

Population Displacement

In general, the risk of HIV transmission in host-refugee sexual interactions depends on the relative HIV prevalence for the two populations and the

Section 6

HIV in
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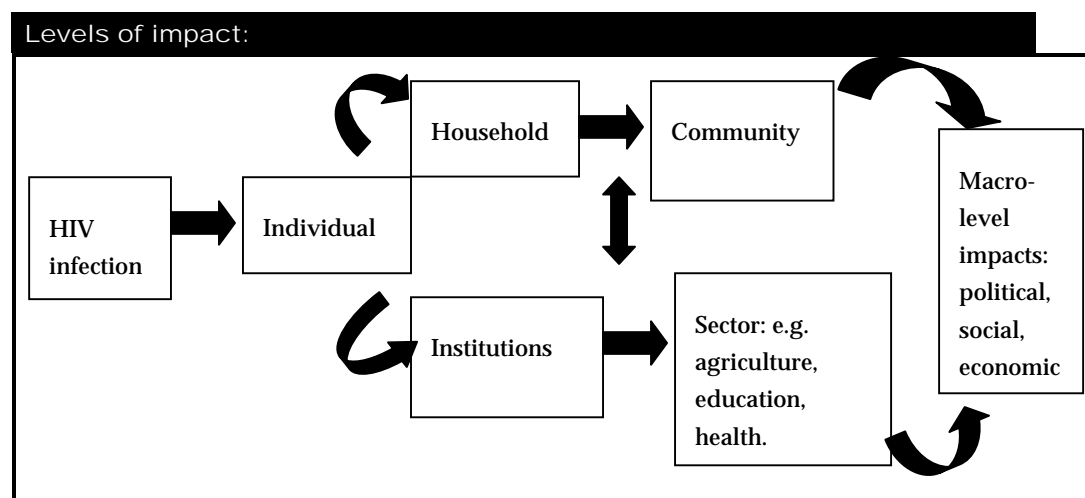
extent of the host-refugee interaction as well as the prevalence of Sexually Transmitted Infections (STIs). It partly depends on whether displaced populations are housed in closed or open camps or are integrated into the community.

Impact of the epidemic

The impact of HIV/AIDS is felt by both individuals and institutions, and goes far beyond the health sector. One of the biggest consequences of the HIV/AIDS pandemic is Food insecurity.

Impact mitigation must pay meaningful attention to those *infected* with HIV and those *affected* by HIV/AIDS.

When individuals are infected, a chain of impacts on households, communities, and institutions then follows:



Types of Impact

Human

Illness and Death

Psychological/emotional

Loss of knowledge transfer

Time diverted from production to caring

Greater aversion to new technology; inexperienced farmers

Financial

Loss of income of sick individual

Loss of income of carer

High expenses: Medical care, funerals, education of orphaned children

Sale of productive assets

Replacement labour needs to be imported

Social

Loss of role models
Fewer incentives for collective action
Disintegration of social networks
Weakened formal and informal institutions
Use of child labour
Exclusion due to stigma

Demographic

More children die young
Women die earlier
More orphans in the community. Elderly left with no carer or left alone to care for orphans.
More ill in the population
Fewer economically productive adults in the household
Child and adolescent headed households

Cultural

Land use. Reduced cultivation of land with land often left fallow
Changes in cultural norms and property rights: may include putting in place legal and other measures to secure the inheritance rights of women and/or children

Food Security

HIV/AIDS reduces:

- Food availability (through falling production, loss of family labour, land and other resources; loss of livestock assets and implements)
- Food access (through declining income for food purchases)
- The stability and quality of food supplies (through shifts to less labour intensive production)

Security and order

High rates of attrition among the military and the police can lead to political instability. Members of the military and police are also commonly perpetrators of sexual violence towards women.

Section 7

Mainstreaming HIV in Emergencies

The HIV Lens

It is important to realise that mainstreaming HIV/AIDS is a relatively new concept for most organisations including Oxfam and currently there are limited examples of what constitutes mainstreaming. The important thing to remember is that mainstreaming is about living and working in a time of AIDS. The AIDS pandemic has changed the context in which we work in both settled and crisis situations and the way we work both within our organisation and within our programmes must take account of this. Mainstreaming is about the modifications or changes we must all make to adapt to this change in context. In addition some integrated AIDS work may be appropriate in some situations of generalised prevalence. At the very least all staff in all situations should be aware of HIV/AIDS and the implications it might have for their own lives and for the way they work.

It is not possible to provide a blueprint for mainstreaming HIV in emergencies, as situations will vary greatly. Work may be undertaken in a camp situation or an urban or rural environment as a response to a mass exodus of people, flooding, drought or other calamity and each situation will present specific challenges. In addition work in areas of ongoing conflict may also require taking novel approaches to service provision where contact time with beneficiaries may be significantly reduced. However, the analysis of and response to each situation can be viewed through an HIV lens. This starts from the recognition that emergencies tend to increase both the susceptibility to infection and vulnerability to the impacts of the HIV epidemic. Vulnerability can be in terms of declining health status, eroded economic options, weaker social networks and fewer asset bases. Vulnerable people can include those **infected** with HIV and those **affected** by the illness or death of others.

HIV/AIDS impacts on households and communities in a sequential and cumulative manner in terms of the numbers infected, the timing of infections, and the timing of onset of symptoms. Interventions should be adapted to the current phase of the epidemic. We should not be blind to HIV/AIDS impacts nor should we be blinded by them. The focus of the HIV lens will depend on the context and will vary over time.

Guiding principles

- Advocate for the use and practical incorporation of existing policies and guidelines which promote good practice (e.g. Sphere, UNHCR guidelines for the protection of women, gender and protection standards)
- Respect for the rights of those infected and affected by HIV/AIDS and work to involve them in ways to secure those rights.
- Challenge assumptions, stereotypes, and stigma.
- Ensure that programmes build upon a sound analysis of gender and age, and of specific cultural and socio-economic situations.
- Ensure that all staff are aware of the risks that people face and how the programme can minimise them e.g. ensuring safety for women, making distribution systems fair.
- Manage and reduce the consequences of the epidemic on people's lives and livelihoods.
- Address the impacts of HIV/AIDS on individuals *and* on institutions.
- Where possible and appropriate, integrate AIDS awareness work and provision of condoms into humanitarian programmes

How to mainstream

Mainstreaming aims to PREVENT and MITIGATE the impacts of HIV/AIDS by MODIFYING existing programmes.

The main principle of mainstreaming is that assessments should continue to focus on what Oxfam does best with regard to meeting the immediate needs as identified by the affected populations. However, those involved in assessments should be aware of the hidden, silent nature of the HIV epidemic that may not be raised as an immediate concern and should work to ensure that they do not design programmes that unwittingly work to increase susceptibility to AIDS but rather work to prevent and mitigate its impact.

Oxfam staff should think about the needs and constraints imposed by the HIV/AIDS epidemic and thus modify any proposal taking these into account.

Lessons from development⁶ to be considered are:

- **Stick to core business** - consider modifying existing work to make it more relevant in reducing the vulnerability to HIV and to mitigating its impacts; be aware of the opportunity costs of taking on focused HIV interventions which can prevent enough attention being paid to mainstreaming modifications
- **Don't shift too far** – not all interventions have to be directly or only relevant to HIV/AIDS
- **Start simple** – worthwhile interventions that have worked don't have to be completely overhauled. Targeted interventions should identify vulnerable groups whether this vulnerability is due to HIV or not. Analysis of vulnerability should consider HIV and existing methodologies should be modified to take this into account.
- **Long-term outlook** - what activities may help people who are not directly affected to improve their resilience now so they will be less vulnerable in the future?

Modifying existing initiatives may mitigate the impacts if we consider how those infected and affected can be assisted to live productive lives. Key objectives comprise alleviating labour loss and shortages, mitigating AIDS-related economic crisis, promoting health, arresting agricultural disruption, enhancing food security, enhancing nutrition as a basic HIV/AIDS healthcare component, and maintaining community dynamics. Successful mitigation efforts can be preventive, too. To the extent that emergencies increase HIV/AIDS susceptibility and vulnerability, mitigation that succeeds in

⁶ Flyer 7: *Modifying an Existing Programme: Lessons Learned in Mainstreaming HIV/AIDS*. Oct 2001 Oxfam GB Dan Mullins Southern Africa RMC

alleviating or preventing the impacts of emergencies can also reduce HIV exposure and future impacts.

New interventions to address HIV/AIDS mitigation need only be developed if existing public health and food and nutrition interventions cannot be effective by adapting them using an HIV/AIDS lens.

Focused interventions can be considered at a more stable phase of the emergency.

Cross Cutting Issues

Gender

There should be a continuing focus on gender analysis, given the close link between gender inequity and vulnerability to HIV. Many of the ideas outlined in this book are relevant to a gender aware approach also and focus particularly on preventing sexual and gender based violence. Gender and protection are also therefore inextricably linked.

Protection

HIV/AIDS is a protection issue in relation to sexual and gender based violence and the lack of access to basic relief items that may lead to exchanging sex for food or non-food items. Oxfam should follow the counsel of the leading UN agencies and advise field staff to act on the assumption that sexual violence is a problem unless they have conclusive proof that this is not the case.⁷

HIV/AIDS should be addressed as a protection issue in its broader context through:

- Relief provision with minimum security risk
- Public Health Engineering and Promotion: setting gender appropriate camp layout - latrines, water points, washing facilities, shelter, to minimise the risk
- Raising awareness and ensuring that humanitarian staff understand protection issues and mechanisms for reporting infringements
- As in all Oxfam programmes participation and a rights based approach are paramount.

⁷ *Reproductive Health in refugee situations, an Inter-agency Field Manual, WHO, UNFPA, UNHCR, 1999*

What does a Mainstreamed Programme Look Like?

The nature of the HIV/AIDS crisis challenges the ways in which Oxfam has traditionally approached its humanitarian work:

- An HIV lens should be used in all stages of the programme cycle and assessments must establish basic data on HIV prevalence
- All programmes will need to pay more attention to issues of age and demography than has been the case until now, given the vulnerability of children and young people (especially girls), the deaths of young and middle-aged adults, and the consequent impact on the elderly, particularly women.
- Community-focused, group-based extension/livelihoods work (which tends to be targeted at the economically and productively active age group) may no longer be possible or relevant in situations where illness and death have had a major impact.
- Special measures should be taken to ensure that high risk and marginalized groups are not forgotten. These may include women (especially single women), adolescents, children, elderly, detainees & prisoners, minorities, commercial sex workers and their clients, men who have sex with men, etc.
- Adolescent boys and girls should be highlighted as a target group needing special attention. Ensure participation of target groups at all stages of design, implementation and evaluation.
- Every effort should be made to improve economic autonomy of women and adolescent girls and boys, e.g. through income generation interventions.
- Minimisation of workforce mobility/migration may already be a programme goal but an assessment of why mobility and migration occurs and what the risks are may help to define possible support
- Targeting of PLWHAs (People Living with HIV and AIDS) may increase stigma and discrimination against this group so should only be undertaken after careful consideration and with the participation and consent of the beneficiary group.
- Assumptions underpinning partnership with other organisations may need rethinking, given the impact of HIV/AIDS on institutional capacity. (Sickness, absenteeism, death, loss of institutional learning etc.)
- A holistic approach to interventions is necessary. Oxfam can work collaboratively with other organisations on HIV/AIDS, perhaps providing livelihood interventions in co-ordination with another NGO carrying out other social and medical interventions.

- Examine current interventions. Do interventions involve community events that, with the addition of alcohol vendors, provide an environment for unsafe sex? Work can continue but perhaps with women, men and young people as separate audiences.
- Are Oxfam personnel affected or are they vectors of transmission? Staff awareness raising should be a priority.
- Monitor and evaluate all interventions. It cannot be assumed that interventions used in a development setting will be effective in an emergency setting. Simply recording case studies from assessments, etc and feeding back to HD can help start this process.
- Labour saving approaches or techniques may be appropriate in some situations and labour requirements may need to be spread in peak periods.
- Quick returns on any investments need to be considered and smaller, more divisible units (e.g. rabbits and chickens) may be preferable to providing bigger livestock
- It may not be possible to rely on strong community/social support networks. (These may exist; don't assume they don't)
- It may not be possible to rely on a pre-existing skills base as much knowledge may be lost in households if family members have died
- Nutrition interventions may already be having some effect on HIV disease (reduced morbidity, improved immune status, reduced oxidative stress and viral load, improved anti-oxidant enzyme functions, weight gain, prolonged survival). The benefits are likely to be greatest at the early stages of infection.

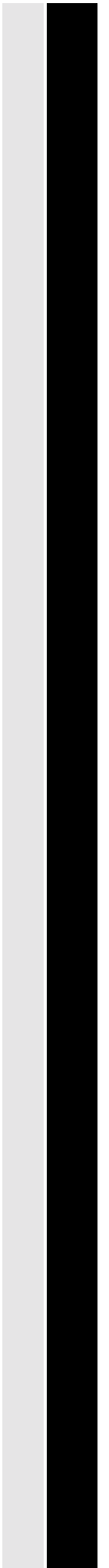
Organisational Impact and Staff Health: Mainstreaming Internally

Further information on Staff health policy is available from IHR and Staff Health.

- HIV/AIDS to be included in staff personal health briefings
- Male and female condoms to be included in the Medical Kit given to staff
- Inform staff of critical illness policy and their responsibilities for appropriate sexual behaviour.
- Are staff engaging in unsafe sex with community members? Facilitate sessions on sexual health and new Code of Conduct on Sexual Behaviour with male and female staff members in separate groups. Recognise that many staff are young, away from home, and wealthy and powerful compared to the communities that they are working with. Some staff may use their influence, or the organisation's resources, to coerce or buy sex. All staff should be familiarised with the disciplinary measures to be taken in cases of corruption and abuse. Note that although sexual conduct can influence HIV transmission this is mainly an issue of human rights and staff conduct.
- Provide condoms in the working environments. Putting them *only* in toilets can maintain the culture of shame surrounding sexual health but it does provide some degree of privacy.
- Daily work should finish in time for the staff to return to their homes. Institutionalise rest and recreation policies that minimise time away from home.
- Train and involve staff in different functions (multi-tasking) to enable cover for sick leave
- Standardise documentation systems so that everyone's work is more accessible and comprehensible to colleagues
- Engage in discussions with donors to sensitise them to the potential future impacts on institutional capacity.

Section 8

The Project Cycle



Emergency Preparedness

Full details on how to prepare an emergency preparedness plan are given in the **Emergency Response Manual**.

As part of this there are several specific aspects of information gathering that would help map susceptibility and vulnerability of a population (or certain sectors of the population) to HIV and AIDS. This context specific analysis should help determine the priority and nature of HIV related activities.

Much of the information should be gathered before any assessment and this can be augmented once in country. Specific information for each district or potential area of work will then have to be gathered as situations can vary widely within countries.

General points

Information gathering should always follow the approach suggested in the **ERM** and in the **Public Health Promotion Guidelines**. This will include an outline of

- Socio-economic data
- Local decision-making structures and processes, gender relations, networks, interest groups and elites, stakeholders
- Most important cultural beliefs particularly related to public health.
- Opportunities for communication and information gathering and sharing (languages, media, literacy etc)
- General health indicators of the population including access and use of health and welfare facilities (and who runs them: Government, religious or secular I/NGOs, private doctors, pharmacies, traditional healers, informal vendors etc)
- Pre-identification and analysis of partner preparedness and capacity

Wherever feasible and appropriate all country profiling information should be disaggregated by gender and age. This is particularly important in for understanding prevalence of HIV and the impacts of AIDS.

Sex and age breakdown of the affected population is collected for two age groups at least (<5 years age group) and (5 and >5 years of age group); if it is feasible to collect more detailed age data, the following breakdown is used: <1, 1-4, 5-14, 15-44, 45+. ⁸

The Country Specific **Epidemiological Fact Sheets on HIV/AIDS** (downloadable from www.UNAIDS.org) is a very broad indicator of general levels and patterns of HIV prevalence within a country. It helps indicate

⁸ From *The Sphere Project: Humanitarian Charter and Minimum Standards in Disaster Response, First final edition 2000. Minimum standards in Health Services - Analysis Standard 1: Initial Assessment.*

countrywide trends but is often 1 to 2 years out of date. An alternative source is www.census.gov/ipc/www.

This information should be updated by the latest epidemiological information available in country either from the Ministry of Health or from agencies carrying out HIV related activities. Whenever feasible similar information should be gathered at provincial and district levels.

UNAIDS' Epidemiological Fact Sheets have the following information where available:

- Demography: Population Pyramids, gender and age disaggregated; GNP per Capita; HDI; Literacy Rates, MMRs, Life Expectancy etc.
- Estimated numbers of PLWHA – disaggregated by Gender and age
- Estimated deaths due to AIDS
- Estimated numbers of orphans
- HIV sentinel surveillance information – disaggregated by vulnerable groups: pregnant women, commercial sex workers, injecting drug users, STI patients, blood donors, MSM.
- Reported AIDS cases by year of reporting and mode of transmission
- Curable STIs – incidence and prevalence
- Health Service Indicators including access to health care and condom availability
- Knowledge and behaviour related to HIV reported against the UNAIDS HIV prevention indicators 1, 4, 5.

Sources of information are cited.

In addition to the information above the following **checklist**⁹ could be incorporated into any existing Emergency Preparedness plan for the area/region in order to help contextualise HIV vulnerability. Coordination and information sharing with local and international NGOs working in HIV related activities should be encouraged.

Much of the information may often be politically, socially and culturally sensitive so judgement must be used at all times according to the specific working context.

The information gathered for the country profiling will be added to by the situational analysis when any emergency occurs. There is an increased likelihood of SGBV during displacement and this is reflected in the questions in the Public Health Assessment Tool. Protection also becomes an important issue as a means of prevention of HIV infection:

- What is the governmental stance on HIV: e.g. have there been any public statements on the issue? Is there political openness about the threats of the epidemic? Is there a national law prohibiting mandatory HIV testing? Are there laws requiring disclosure of HIV status? Are there laws prohibiting

⁹ This checklist is based on the key factors that increase the success of prevention strategies.

dissemination of HIV prevention messages through local media? Is homosexuality illegal? Is commercial sex work illegal?

- What is the stance of the leaders of the main religious groups?
- What is the stance of the key community groups: women's, youth, elders, business etc?
- Where formal education is available for young people does sex education form part of the curriculum? What are the cultural norms related to sexual relationships and rites of passage into adulthood including traditional practices? How do these differ for males and females?
- Are there ongoing outreach and peer programmes for Commercial Sex workers, their clients and/or other vulnerable groups? If non-governmental, who are the key agencies involved in this?
- Are there vulnerable groups specific to the area e.g. migrant workers, truck drivers, and demobilised soldiers?
- Is there a national STI control programme? Is this effective and accessible?
- Is there a national programme or social marketing programme for condom distribution? Is this accessible, effective and acceptable? If non-governmental, who are the key agencies involved in this?
- Is there access to HIV voluntary counselling and testing? If non-governmental, who are the key agencies involved in this?
- Are there support groups for PLWHA? Are they run by PLWHA? What is the cultural acceptance of PLWHA?
- What are the cultural beliefs in relation to pregnancy, childbirth and infant feeding? Are there practical, safe affordable and acceptable alternatives to breastfeeding in this area?
- How common is sexual and gender based violence? Is rape defined in law?

When carrying out a humanitarian assessment it is suggested that the Public Health Assessment Tool in the Emergency Response Manual is used to facilitate an integrated assessment.

The following questions have been incorporated into the latest version of the ERM and are included here for information. It should be emphasised that these questions would form part of the overall public health assessment and are not the main focus of the assessment.

In an area of high prevalence of HIV/AIDS it may be important to consider both MAINSTREAMING and INTEGRATED INTERVENTIONS such as condom distribution and education. These questions attempt to capture the opportunities for mainstreaming as well as the potential for integrated activities where necessary.

General Points

The same guiding principles of any assessment still apply i.e.

- Why should we/shouldn't we respond?
- If a response is necessary, why is this the way to do it?
- What extra value does Oxfam add to a response in comparison to other organisations?
- Does this response benefit the poor people?

The assessment of vulnerability and scale of the problem due to HIV/AIDS should be mainstreamed into the overall assessment and should not be prioritised over the other areas of Oxfam's current expertise. The opportunity costs to existing work of taking on any focussed HIV interventions should be assessed.

It is essential that assessment teams include at least one member with expertise in social and gender analysis.

The "green cards" for Oxfam indicators for Gender Awareness Response and for Protection should be utilised during any assessment.

Information gathering in emergencies is normally phased. Methodologies particularly suitable for sensitive topics such as HIV and AIDS are as follows:

Rapid Assessment: Discussions with Key informants and exploratory walks

Baseline Data: Mapping, Focus Group discussions: Questions should be in the third person and very general to facilitate discussion. PLA: Using PLA techniques people can often avoid eye contact with each other and may therefore feel more comfortable in highlighting taboo subjects.

First line questions

Ensure HIV/AIDS is included in the TOR of the assessment.

- Is HIV/AIDS relevant to the proposed project?
- Is the project operating in an area where (skilled/unskilled) labour is a constraint
- Is the project operating in social sectors affected by HIV/AIDS
- How are women affected by the emergency and what risks do they face of sexual and gender based violence?
- Will there be increased mobility of the labour force? Remember that there may be different rates of HIV prevalence in refugee or displaced groups from rural or urban areas and between refugee or displaced groups and the host population. This may inform the strategy you employ and you may have to have different approaches to address the needs of different groups
- Will the project have employee benefits (funeral expenses etc) increased by HIV/AIDS related illness?
- What potential impact might the project have on HIV/AIDS?
- Will certain groups be disadvantaged by the project (e.g. relocation or having income opportunities taken away – consider the situation of women especially?)

Rapid Assessment in Acute Phase

It is important to assess if the three recommended immediate interventions¹⁰ are in place. Oxfam may not be involved in implementing these activities but may be in a good position to advocate for them with other NGOs and international bodies. Strictly speaking these interventions represent integrated AIDS work rather than mainstreaming but are an obvious and important requirement in many emergencies.

Recommendation 1: Guarantee free availability of condoms

How culturally acceptable is the use of condoms? Are there free condoms available (male and female, or only male)? Where are they coming from? Is there any quality standard for them?¹¹ How are they distributed and are instructions for their use supplied in the local languages? Does this distribution system reach the wider population with which the emergency affected population come into contact? How does the quality, packaging and distribution compare to the socially marketed or commercially marketed condoms differ? Who uses them? (Married couples; single adults; adolescents; commercial sex workers...?) Have promotional campaigns been launched?

¹⁰ Guidelines for HIV Interventions in Emergency Settings: UNAIDS/96.1. This document is currently undergoing revision.

¹¹ Guidelines for condom procurement now exist and are available from Logistics

Recommendation 2: Universal Precautions

Are the staff in the health facilities for the emergency affected population practicing universal precautions? *Note: Since it is unlikely that Oxfam GB will be involved in clinical care it may be simply enough to highlight this issue with health agencies on the ground.*

Recommendation 3: Identify Coordinator for Reproductive Health activities

Oxfam GB should be involved in the coordination of overall health activities and will therefore be able to encourage the instigation of such a co-ordinator

Background Information Checklist for rapid assessment

Is there epidemiological data regarding the underlying HIV prevalence, disaggregated by gender, age and risk group?

Who are the marginalized / separated people in this population group. (**Single parent headed** households, unaccompanied children, disabled, sick, elderly, ethnic minorities, **adolescents, commercial sex workers**, etc) Do they have specific needs? How have they been affected by the current crisis?

Is there political openness about the threats of the HIV epidemic?

Are other agency interventions addressing the HIV epidemic?

Which other Oxfam's, or their counterparts, are working in the country or in the affected area? **Is there any current expertise in HIV interventions?**

Health Checklist for Rapid assessment

HIV is under recognised in emergency-affected populations. Up to 90% of HIV+ persons are not aware they have the virus. Is it possible HIV is an underlying factor in contracting or prolonging the "seen" diseases?¹²

Morbidity: Disaggregate data by gender and age where possible.

Health service provision

What preventive services are available and what is the extent of coverage? Is there a programme of STI treatment and prevention? What other Reproductive Health Services are available?

Public Health Promotion

Are there subjects considered taboo when using promotional media?

Are any health promotion initiatives or activities taking place? Are there any local structures with whom Oxfam could collaborate in health promotion activities? e.g. local community groups, Ministry of Health or NGO staff, schools or youth groups, **women's groups, PLWHAs**

¹² Chronic diarrhoeal illness, fever of unknown origin, recurrent pneumonia, wasting syndromes, meningitis, tuberculosis, failure to thrive in children, cachexia, developmental delay and recurrent bacterial infection are frequently consequences of AIDS related immunosuppression.

Specific issues relating to HIV

What cultural beliefs, attitudes and practices may have an impact on HIV transmission? (E.g. Marriage customs, polygamy, widow inheritance and acceptability of condoms: what do men and women do to prevent having babies? What are the traditional ways? What are the modern ways?)

Has the situation caused changes in sexual behaviour? Risky activities? Multiple partners? Coercive sex (through violence or economics)?

Have available health promoters or peer educators had previous education or experience in STIs and HIV?

Are people using health workers or traditional healers for treatment of STIs?

Has the situation increased the population's contact with armed groups?

Has the situation increased intravenous drug use?

What do most women do here during the day? Do any of them have jobs earning money? What do they do? What opportunities are there of earning income (that do not involve exchanging sex for money and resources)

What HIV prevention and care facilities were available in country of origin and what are available now? (E.g. Voluntary Counselling and Testing (VCT), psychosocial support, AntiRetroViral treatment for prevention of parent to child transmission)

Water and Sanitation Checklist for Rapid Assessment*Excreta disposal*

Are the facilities provided in accessible well-lit areas? Is there any external security threat (e.g. latrines placed adjacent to compound walls?). Are family latrines a safer and acceptable option?

Is there a need for special arrangements for vulnerable groups e.g. unaccompanied minors?

Try to find out the ways that female-headed households access male labour. Is sex exchanged for labour? (if latrines are to be built by the affected population)

Food And Nutrition Checklist for Rapid Assessment

Has transactional (economically coercive) sex increased?

Note: the 1991 UNHCR "Guidelines on the Protection of Refugee Women" suggests placing women in charge of distributing food so men cannot force them to exchange food for sexual favours, as well as providing refugee women economic opportunities to earn sufficient income to support themselves and their families without resort to commercial sex work.

What information on the current nutritional situation exists? (e.g. recent nutritional surveys, nutritional surveillance data from MCH Clinics/SFCs/TFCs, food security and early warning information). As a rule of thumb, most cases of severe malnutrition should recover and be discharged after 30 to 40 days in a feeding programme. HIV and TB may result in some individuals failing to recover.

What are the infant feeding practices amongst affected communities (include here details of breast-feeding, weaning practices, food taboos)? Is exclusive breastfeeding acceptable?

What traditional community feeding and care practices exist for special needs groups such as chronically ill /PLWHA, pregnant and lactating women and children (including orphans)

What traditional feeding and care practices exist to promote good health and nutrition for adults and which practices promote healthy infant feeding?

Exploratory Walk

Example of an observation guide during an exploratory walk

- Is there evidence of adolescents lacking useful occupation? Lacking supervision?
- Are there areas that look like they may have a high prevalence of sex work (including sex bartering)? Age and gender of those engaged in this.
- Is overcrowding evident?
- Is there any evidence of social marketing of condoms? (Posters, radio, boxes on display?)
- Are health clinics offering STI treatment?

Focus Group Discussion

Sample Questions

Are the displaced population and the local population mixing? What are the reasons (e.g. trade, family ties etc.)

How many women are without their husbands?

How is food distributed? What role do women have in food distribution? Do people have enough to eat? If not, why not? Do you know of women who have sex for money, protection (from aggression or violence) or food? Do you think that the food shortage had influence on this practice? How do women earn money or food without exchanging it for sex?

Is there a lot overcrowding? Does this make it difficult to have (sexual) relations?

What kinds of sicknesses do people get here? During the last year, how many people died in the community? Were they young or old? Male or female? What were the causes of death?

Have there been changes in marriage customs? What were the customs before the emergency? At what age do women generally marry?

How many children are without parents? How are they cared for?

What marks girls' and boys' passage from childhood to adulthood (e.g. FGC, ritual scarification?) Has the emergency changed these traditional societal roles? Who is responsible for the initiation rites for children?

Do children go to school? Where is the school? Until what age do they go? Do both boys and girls go? Where so young people learn about STIs, HIV or AIDS?

Have you heard of HIV or AIDS?

Are people in this community worried about getting STIs, HIV or AIDS?

How can someone get HIV or AIDS?

What can a person do to avoid getting HIV or AIDS?

What do people think about those people who have HIV or AIDS?

Are people with HIV/AIDS allowed to use the health services?

Mapping

Maps can show major action settings, social divisions, directions and distances between key sites.

Key gathering points for target group members: brothels, bars, massage parlours, truck stops, hotels or other locations

Sources of STI diagnosis and treatment services, condom sales outlets, or community distribution points for contraceptives

Mapping SGBV risk

Opportunity Matrix for Sexual Violence against women and children in Refugee Camp JHU¹³

	WHERE Does activity take place or where is good/service obtained?	WHO Is in charge of activity or distribution good/service	WHEN Does activity take place or good/service obtained	HOW Is good/service obtained (e.g. vouchers, named list, as needed?)	WHO Engages in activity or obtains good/service and WITH WHOM
Fuel					
Food					
Collecting Water					
Latrine					
Shelter					
Clothing					
Health Services					
Security					
Bathing					
Washing clothes/dishes					
Other...					

¹³ Dugan J. et al; *Assessing The Opportunity For Sexual Violence Against Women And Children In Refugee Camps. The Journal of Humanitarian Assistance. The authors have requested feedback from any field-testing of this document to jdugan@jhsp.edu*

The following questions should help to frame the planning and objective setting. Remember that mainstreaming HIV/AIDS is about modifying what you normally do to take account of the issue but there may also be some focused activities that you feel are relevant in the emergency context (see section on integrating HIV/AIDS):

To what extent does the existing or potential prevalence of HIV/AIDS affect the way we have to run our programme?

What factors in this emergency increase the susceptibility to HIV infection?

Who are the groups susceptible to HIV infections?

Who are the groups most vulnerable to the impacts of AIDS?

Does the project:

- rely on human resources? (e.g. trained engineers) Has this sector been impacted by increased HIV/AIDS morbidity and mortality?
- result in increased mobility? (e.g. construction work in different camps?)
- make assumptions about target groups? If targeting those in the economically “productive” age group this may have to be reconsidered.
- focus on vulnerable groups? Risk of HIV infection is often increased in these groups.
- target areas of very high HIV prevalence?

Possible Responses in Emergencies

The following table considers the whole scope of potential responses that could be undertaken by Oxfam or other agencies and provides examples of both mainstreaming, integrated and focused AIDS work.

Factors increasing HIV in emergencies and Possible Responses		
Level	Factors	Responses
Macro environment	Political and Economic Discrimination Poverty Political Instability War/Conflict Environmental Problems	Oxfam GB Strategy: use an HIV lens in programming and policy Oxfam GB campaigns: Cut the Costs etc Legal reform Human Rights based approach to programming Employment policy-non discrimination; policy for illness; right to confidentiality

**Emergency
environment**

<p>Gender Inequity</p> <p>Loss of role models</p> <p>Loss of knowledge transfer</p> <p>Lack of protection</p> <p>Overcrowding</p> <p>Security of latrines, facilities, fuel, food, water</p> <p>Survival/transactional sex; commercial sex</p> <p>Lack of support for PLWHA</p> <p>Sexual and gender based violence</p> <p>Females lack power to negotiate safe sex</p> <p>Presence of military; Rape and HIV as weapons of war;</p> <p>Demobilisation</p> <p>Peacekeeping</p> <p>Lack of Health Infrastructure: Non-availability of: Sexual health services; (screened blood; sterile equipment; Voluntary counselling and Testing; TB control; Care for PLWHA; Mother to Child transmission prevention services) Increased exposure of PLWHA to other sicknesses (esp. TB, Diarrhoeal diseases; malaria)</p> <p>Mixing of host and displaced populations</p> <p>Decrease of labour pool in areas of high prevalence</p> <p>Psychological impacts: wish to repopulate etc; fatalism</p> <p>Multiple sexual partners</p> <p>Boredom/alcohol/drug use</p> <p>Lack of condom use</p> <p>Lack of Knowledge of HIV/AIDS; myths and disinformation</p> <p>Unwanted pregnancy: ↑ MTCT</p> <p>Pregnancy at an early age</p>	<p>Gender sensitive programming</p> <p>Mainstream protection issues in programming: involve women in decisions about site and shelter planning</p> <p>Vulnerability assessment should include chronically ill with no need for HIV/AIDS as separate criteria</p> <p>Integrated Multisectoral approach required via partners or via networking with other agencies</p> <p>Income generation activities (IGAs); target women and youth</p> <p>Livelihood approach for food insecurity; e.g. Cash for work for home based care</p> <p>Involve youth in project planning and design; vocational training; Involve youth in IGAs</p> <p>Involve PLWHAs in project planning and design- depends on contextual environment; are there existing support groups? Where possible highlight and fight stigma</p> <p>Health promotion activities targeted at military?</p> <p>Support to treatment and care services through partner organisations? : STI treatment, health services for opportunistic infections; TB control, VCT; home based care; MTCT prevention services, etc</p> <p>Public health promotion and public health engineering to promote and maintain health and decrease water related diseases-target areas of high HIV prevalence?</p> <p>Malaria control programmes</p> <p>Public health promotion with safe sex messages including provision of condoms: target youth; Target transitional areas for demobilisation</p> <p>Access to health promotion activities for military</p> <p>Life skills for women and youth; condom negotiation skills; involve men</p> <p>Where possible highlight and fight stigma: rights based approach; involve PLWHAs, Individual focus; careful targeting; protection (no forced repatriation, confidentiality, non-discrimination)</p> <p>Ensure host and displaced populations involved in programme planning and design</p> <p>Mitigation of impacts: labour sharing; labour saving devices; divisible assets;</p> <p>Public health promotion with safe sex messages including provision of condoms: target youth; Target transitional areas for demobilisation</p> <p>Universal precautions enforced when dealing with bodily fluids</p> <p>Vocational training; involve youth; Alternative activities targeting men, Support to treatment and care services through partner organisations? : STI treatment, TB control, VCT; home based care; MTCT prevention services, etc Promote safe infant feeding,</p> <p>Challenge social norms-schooling, employment, inheritance laws,</p> <p>Challenge norms that allow/encourage men to have multiple sexual partners</p>	<p>Gender sensitive programming</p> <p>Mainstream protection issues in programming: involve women in decisions about site and shelter planning</p> <p>Vulnerability assessment should include chronically ill with no need for HIV/AIDS as separate criteria</p> <p>Integrated Multisectoral approach required via partners or via networking with other agencies</p> <p>Income generation activities (IGAs); target women and youth</p> <p>Livelihood approach for food insecurity; e.g. Cash for work for home based care</p> <p>Involve youth in project planning and design; vocational training; Involve youth in IGAs</p> <p>Involve PLWHAs in project planning and design- depends on contextual environment; are there existing support groups? 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Monitoring, Impact Assessment and Evaluation

Overview

Monitoring is the ongoing, systematic collection and analysis of information relating to the progress of work. In an unstable and rapidly evolving environment a formal evaluation is not always possible.

Full details of how to monitor, evaluate and assess impact can be found in the **Public Health Promotion Guidelines** and the **Emergency Response Manual**. The monitoring and evaluation of HIV/AIDS mainstreaming in emergencies has been very limited and there is virtually no evidence base for what makes a good or bad indicator. Proxy indicators will need to be used and assumed to have wider implications. It will also be necessary to make a distinction between evaluating mainstreaming and evaluating focused activities.

Direct measurement of HIV seroincidence is rarely used as an intervention outcome. HIV seroincidence is a relatively rare event (in a statistical sense) and would require a long time follow up. Biological indicators could also be collected from Ministry of health and medical NGOs and be used for assessing impact but again may only really be useful in the long term (see below).

Mainstreaming

Existing indicators used to measure gender aware interventions and participation will be useful but new indicators will need to be developed to take account of particular contexts. Try to keep information gathering to a minimum to ensure that it is analysed and learned from. Too much information will discourage proper analysis. The following indicators are given as examples and should be adapted, ignored or added to according to the context and project.

Process Evaluation

Sample Monitoring checklist

Coverage of vulnerable populations

- By geographic area
- By sources of susceptibility to infection
- By factors of vulnerability to impacts

Sample indicators for Household Food Security Project

- %age of HH in high prevalence areas with increased access to food aid

- %age of HH in high prevalence areas receiving assistance from community –based organisations
- # of HIV/AIDS infected and affected children receiving food aid
- #of vulnerable children under 5 years of age provided with food rations through guardians/families
- # of CBOs active in caring for vulnerable children and groups
- # of target population who adopt special (agricultural) technologies
- # of adolescents/orphans receiving special apprenticeship training

Impact Evaluation

Impact evaluation attempts to determine whether significant or lasting changes in the lives of poor people have occurred as a result of project activities. These changes can be positive or negative. In considering the impact of Oxfam's response it is important to consider the following:

- Impact on people's lives
- Beneficiary Participation
- Sustainability
- Impact on Gender Equity
- Impact on Policy and Practice.

Fundamental questions that should be answered include:

- What significant changes have occurred in people's lives and to what extent are these likely to be sustained?
- How far has greater equity been achieved between men and women and between other groups?
- What changes in policies, practices, ideas and beliefs have happened?
- Have those we hope will benefit and those who support us been appropriately involved at all stages and empowered through the process
- To what degree have we learnt from this experience and shared the learning?
- Were any vulnerable groups specifically targeted and empowered? Can any of the change be attributed to the project?

Sample indicators to measure empowerment of young people

- Duties and roles assumed by young people
- Amount of time contributed
- Membership of advisory committees
- Active young peoples participation
- Opinions of young people about their involvement

Sample indicators to measure empowerment of women

- Women's active participation
- Increase in women's ability to negotiate condom use

Biological indicators

- HIV prevalence
- STI prevalence – in the absence of HIV testing, STI prevalence can serve as a marker for HIV prevalence
- TB prevalence
- Number of adult AIDS cases
- Number of paediatric AIDS cases

AIDS surveillance in complex emergencies is impractical. It does not provide timely or useful data because of the delay between infection and onset of clinical symptoms, as well as substantial under-detection and under-reporting where stigma is attached to the diagnosis and medical care is limited.

Chronic diarrhoeal illness, fever of unknown origin, recurrent pneumonia, wasting syndromes, meningitis and tuberculosis may frequently be secondary to AIDS-related immunosuppression but are rarely attributed to HIV in reporting systems.

Section 9

Sector Responses



Overview

All Oxfam projects should follow the one programme approach and there should be integration of Public Health Engineering, Public Health Promotion and Food, Livelihoods and Nutrition interventions whenever possible and appropriate. Crosscutting issues include gender and age analysis, protection, a rights-based approach and participation. Sphere standards should be adhered to whenever applicable.

- HIV/AIDS information should be included in gender disaggregated baseline data collection, assessment, monitoring and evaluation; ensure issues of **confidentiality** are paramount when training staff in using any new HIV tools.
- Open PRAs may not elicit information about HIV/AIDS even though it may be an underlying problem. Information may be too sensitive or too personal. There may be a fatalistic attitude that nothing can be done or that everybody knows anyway. Openness has to be balanced with confidentiality and reducing stigma.
- Consider including people living with HIV and AIDS (PLWHAs) at all stages of the process so as to enhance visibility and benefit from their skills and experiences. This will depend on how visible HIV is in the community and how acceptable disclosure of people's status is.
- Engage people known and respected by women and youth in the community, e.g. TBAs, malaria agents and leaders
- Consider current interventions. Do interventions involve community events that, with the addition of alcohol vendors, provide an environment for unsafe sex? Work can continue but should condoms be routinely provided? Can gender or age group be used to separate audiences?
- Ensure participation of target groups at all stages of design, implementation and evaluation.
- Provide relief with minimum security risk.
- Ensure that staff understand protection issues and mechanisms for reporting infringements of rights.

Public Health Promotion & Engineering

Public Health Promotion and Engineering have an important role to play in the mitigation of the impacts of HIV infection. As in any Public Health emergency, provision of adequate water and sanitation facilities will promote and maintain good health. This is especially important where there is a high prevalence of HIV/AIDS. Life expectancy can be decreased by 3 to 5 years in areas where there is poor access to adequate health services, poor water and sanitation and lack of access to antiretroviral drugs. Parasitic and diarrhoeal illnesses can be increased in HIV positive people depending on the stage of their infection. Frequent exposure to these illnesses can speed the progress of their illness to AIDS.

- Consider the “out-of-sight” needs of the chronically ill bedridden people within the camp, including those with AIDS. They need a lot of water for washing due to the fevers, vomiting, and diarrhoea that they suffer from.
- Carers may be unable both to look after sick people and collect adequate amounts of water. Consider closer tap stands, assistance in gathering water, or special deliveries of water to bedridden people.
- Those people with weakened immune systems (also known as immunocompromised) are more susceptible to parasitic infections (especially giardia, cryptosporidium)
- Place latrines, water points, washing facilities, shelter in locations decided by the women in the community in places believed to be safer
- Install lighting to improve the security of the latrines, water points, washing facilities, shelter
- Consider family latrines; Consider the equitable distribution of latrines- women tend to use latrines more frequently than men and also are normally in charge of children’s hygiene therefore consider larger latrines or more latrines for women.
- People who are chronically sick may have difficulty in using the latrines – consider provision of bedpans or potties for these groups if acceptable.
- The provision of potties for children may also make life easier for many caretakers

Integrated Activities

A separate section on integrated HIV/AIDS work is included in Section 10

Food, Nutrition and Livelihoods

The role of the Food and Nutrition Section

The Administrative Committee on Coordination/Sub-Committee on Nutrition, recognises that¹⁴:

Access to food is one of the main problems of HIV-impacted communities

Nutrition and food security is a logical entry point for assisting affected communities

Stigma undermines social capital and limits health-seeking behaviour, including prevention of mother-to-child-transmission

Nutrition is a core component of the essential HIV/AIDS care package promoted by UNAIDS

In addition the following statement was made by 2002 World Food Summit Rome 10th –17th June:

"..this Summit will result in reconfirmed engagement in the response to HIV/AIDS, given its dramatic impact on all aspects of food security, from the production line, to marketing and consumption....The two emergencies should not be handled separately...In a world of AIDS, rural development, food security and agricultural policies cannot be handled in isolation from the epidemic." Statement by Marika Fahlen Director, Social Mobilization and Information, Joint United Nations Programme on HIV/AIDS (UNAIDS Press Release - Rome, 12 June 2002)

Oxfam and Food Security

Oxfam uses a livelihood approach to food security. Food security is defined as: *"..when everyone has access to and control over sufficient quantities of good quality food for an active healthy life"*. Within this definition, the two elements of food security are:

- Availability (the quality and quantity of food supply)
- Access (entitlement to food through purchases, exchange and claims).

In a livelihoods approach, the severity of food insecurity is gauged by its impact on people's ability to feed themselves (risk to lives) and its impact on livelihoods on self-sufficiency (risk to livelihoods).

From the outset of any emergency response Oxfam attempts to integrate both the traditionally "short term" approach (concerned with saving lives by reducing nutritional risk involving meeting short-term food needs through

¹⁴ Statement by the ACC/SCN at its 28th Session 6 April 2001, Nairobi, Kenya

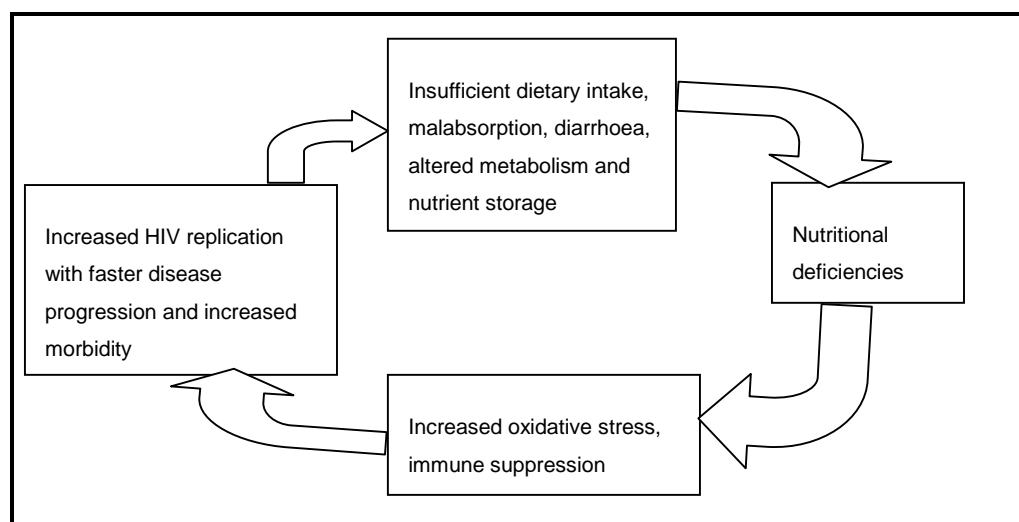
food aid) and the “longer-term” livelihood support usually (but not exclusively) involving interventions other than food aid.

Current food security interventions (not all of which are used by Oxfam) include:

Non-food Aid	General	Food Aid
Fuel Management	Advocacy	Direct Food Distribution (general and targeted)
Livestock (vaccination, restocking, destocking, fodder protection)	Early Warning Systems/Nutrition and Food security surveillance	Food for Work/Food for asset rehabilitation
Fishing (nets, boats)	Capacity building	School feeding
Gardens (kitchen/schools/market)	Nutrition education	
Seeds/tools/fertilisers/agricultural extension		Subsidised food sales
Food processing/milling		Targeted feeding programmes
Support market systems		Monetization of Food aid
Cash interventions/cash for work		
Income generation		

Nutrition and HIV/AIDS

The Vicious Circle of HIV and Malnutrition



HIV/AIDS affects nutrition in several ways: reductions in food intake due to reduced appetite or mouth infections, nutrient malabsorption, metabolic alterations, frequent bouts of diarrhoea and increased energy and protein requirements. As a consequence PLWHA lose weight. In the early stages of HIV infection adequate nutrition can help slow the progression to AIDS. Once metabolic alterations happen it becomes very difficult to reverse these. Diets

rich in protein, energy and micronutrients are likely to help build immune resistance to opportunistic infections.

Compared with average adult an individual with HIV requires 10-15% more energy a day, and 50-100% more protein per day¹⁵.

HIV may have an impact on rates of malnutrition but there exists no quantitative measures. As a rule of thumb, most cases of severe malnutrition should recover and be discharged after 30 to 40 days in a feeding programme. HIV and TB may result in some individuals failing to recover.

Micronutrients

Consuming micronutrients (especially Vitamins A, B6 and B12, iron and zinc and selenium) is important for building a strong immune system and fighting infections. Vitamin A deficiency is associated with higher maternal-child transmission rates, faster progression from HIV to AIDS, higher infant mortality and child growth failure. The B-group vitamins play important roles in immune regulations, and deficiencies play a role in disease progression.

The impact of taking micronutrient supplements on HIV infection is not well known. The most promising results are for Vitamin A and the B-group vitamins.

PTCT and Breastfeeding

Partial/mixed breastfeeding is associated with a risk of HIV transmission from parent to child. For the vast majority of mothers in resource poor settings, replacement feeding is not a safe alternative to exclusive breastfeeding for the first 6 months. All mothers who know they have HIV should receive counselling so that they can make the best decision about feeding options. The current Oxfam position on Breastfeeding in emergencies should be disseminated and implemented.

Practical Strategies (using conceptual framework for causes of malnutrition)

New interventions to address HIV/AIDS mitigation should only be developed if existing food, nutrition and livelihood interventions areas cannot be effective by adapting them through the use of an HIV/AIDS lens.

Immediate causes (Inadequate food; disease)

- Home and community gardens: Micronutrient consumption can be increased through eating varied foods or through special supplements
- Small Livestock: raising small animals (e.g., chickens, rabbits, guinea pigs) should be considered to help improve the consumption of protein, fat, as

¹⁵ Woods 1999; James and Shofield (1990); WHO (1985)

(http://www.usaid.gov/pop_health/aids/TechAreas/nutrition/nutrfactsheet.html)

well as micronutrients such as iron and Vitamin A. This should be integrated with any wider agricultural programming

- Provide selected vulnerable groups with additional rations or special diet (depends on context, stigma, confidentiality etc.) e.g. target single parent and child headed households with supplementary food rations
- Work with communities to investigate all options for obtaining nutrients and promote food habits that improve the intake of root vegetables, local vegetables and fruits, nuts, insects, oilseeds and other wild foods that may provide vital nutrients to the diet.
- Disseminate current Oxfam position statement on breastfeeding in emergencies and ensure it's practical implementation.

Underlying Causes:

Household Food security

- Labour saving methods for production of staples and promotion of labour saving implements: think about weeding and harvesting, threshing machines, mills, intercropping to reduce weeding time, zero or minimum tillage, reduced time spent fetching water
- Lighter ploughs, systems for labour pooling; labour saving techniques
- Labour sharing; income generating projects to produce food and cash targeting boys and girls and adolescents and women
- Broaden livestock programme to include rabbits and chickens. Affected families often prefer these as they give quick returns and, as assets, are more divisible than cattle and goats. May be less labour intensive to keep.
- Farmer field-schools avoid taking people too far away from their place of work; are women too busy caring for the sick to travel to farmer training days? Hold training days in the beneficiary communities? Allow children to participate with the broad agreement of the communities?
- Consider additional nutrients in food distribution where HIV prevalence is high. Likely only to have any impact where general ration is adequate (i.e. supplementing the ration with Corn Soya Blend [CSB] where the GFD (general food distribution) is inadequate could result in the CSB being distributed too widely within the household)
- Income generating activities and small-scale credit facilities (esp. women and older adolescents)
- Vocational skills training and Food for Training (esp. women and older adolescents)
- Apprenticeships and training in marketable skills to orphans, adolescent boys and girls and young women
- Asset replacement: seeds, tools, and livestock, community seed pools
- Food for work to encourage homestead production or for animal traction schemes (should be carried out in conjunction with an adequate GFD is adequate

Social and care environment

- Feeding programs at schools and hospitals to maintain attendance and adequate levels of care
- Involving communities in providing care and support to vulnerable households
- Promote “safe” infant feeding
- Cooperative day care centres to assist women cope with their workload
- See Public Health Promotion and Public Health Engineering section

Basic Causes (Formal and Informal structure; political ideology; resources)

- Discouraging norms that deny women the right to inherit livestock and land
- Enhancing national capacity to manage food aid and livelihood programmes
- Advocacy for the human rights of PLWHA and promotion of greater acceptability and openness towards people who may be isolated and hidden within communities
- Large rural construction projects with inappropriate temporary living conditions
- Letting land go fallow
- Low output farming leading to male out migration

Integrated Activities

In addition to the above mainstreaming activities it may be important to include all or some of the more focused activities in the response:

- PLWHAs are more vulnerable to infection because their immune systems have already been weakened. Properly handling food and water is especially important. Activity improves appetite, develops muscle, reduces stress, increases energy and helps maintain overall physical and emotional health. Social and everyday activities such as walking, cleaning and collecting firewood or water are important. Encourage seeking of appropriate health care for fever, diarrhoea, chronic cough, malaria, hookworm and other parasitic infections, and fungal infections
- Could livelihoods workers promote and distribute condoms? Would depend very much on each context but staff should be aware of the impact of HIV on their work.
- Channel HIV information and condom distribution via food/nutrition interventions e.g. at distribution sites or during community meetings
- Homecare and visits to orphans and HIV/AIDS patients

- Provide education on nutrition and feeding practices to ensure that PLWHAs maintain a healthy diet, manage illness and monitor and maintain nutritional status

Selecting Ration Size and Composition of food aid

Decisions about both the ration size and the composition of the foods included in a food basket should be made on the basis of reaching the objectives (e.g. addressing individual or community nutritional needs or serving as an incentive to participate in a program.) Before determining the ration size, a brief assessment should be conducted to determine the community definition of a household. The definition will vary, particularly in heavily HIV-prevalent areas where household composition changes as relatives and friends care for children and others. Calculation of rations can be done on an individual household basis, using guidelines for dietary needs of PLWHA¹⁶, but this would be time-consuming and unwieldy. Lobby WFP/Donors to implement minimum standards of ration size particularly in areas of high HIV prevalence

There will be situations where providing food aid is not an appropriate or desirable response.

Examples include:

- Where the risk is high of stigmatising PLWHA or affected households through food distribution. The advantages and disadvantages will have to be weighed up. Symptomatic HIV infection can be considered like any chronic illness with its accompanying impacts.
- When individuals or affected households are able to meet their own food needs
- When cash is more appropriate than food
- When available foods for food aid are inappropriate for dietary needs or cultural conditions. (This is a bit impractical as food aid is frequently inappropriate).

Issues in food and nutrition and HIV mainstreaming

Given the importance of nutrition in keeping the HIV positive individual healthy with the subsequent prolonging of an active, healthy and productive life should Oxfam consider intervening at the immediate causes of malnutrition?

At what point and for how long would food aid be most critical for PLWHA and affected households?

¹⁶ Relevant guidelines include Food and Nutrition Technical Assistance /USAID: HIV/AIDS: A guide for Nutrition, Care and Support July 2001.

Malaria Control Programmes

This looks only at HIV-1 virus as very little is known or documented about HIV-2 interaction with malaria.

Clinical malaria occurs with an increased frequency and severity in HIV-1-infected individuals, especially during pregnancy.

Although driven by very different transmission mechanisms and dynamics, wide geographical overlap and high prevalence of HIV-1 and malaria infections mean that even small interactions could lead to substantial population effects.

Until recently several reviews concluded that there was no significant interaction between HIV-1 and malaria but these studies were done early in the HIV-1 epidemic and didn't assess immunocompromised people with CD4 counts.

The decline in malaria mortality since the 1960s in Africa has reversed in the 1990s. Although there are other probable contributors, such as rising chloroquine resistance, the concurrent worsening of malaria with the evolution of the HIV-1 epidemic has led to a re-examination of potential interactions between these two infections.

The effect of HIV-1 on malaria

Malaria infection is more frequent and of higher parasite density in HIV-1-positive than in HIV-1-negative pregnant women of all gravidity in various malaria-endemic settings, with multigravidae most affected. Where HIV prevalence is high HIV-1 can account for up to 25% of placental malaria that can affect survival of the unborn infant (whether HIV +ve or not). HIV seems to impair the development of parity-related antimalarial immunity that parallels increasing gestational age and the number of pregnancies.

HIV-1 infection roughly doubles the risk of malaria parasitaemia and clinical malaria in **non-pregnant** adults, and advanced immunosuppression (low CD4 counts) is associated with high-density parasitaemia.

The effect of malaria on HIV-1

Mortality rates in infants born to women with both HIV-1 and placental malaria are higher than in those born to women with HIV-1 infection alone.

A possible explanation for the increased infant mortality is that pregnant women with both malaria and HIV-1 are at higher risk of developing severe anaemia than are women with either infection alone, and they also have a higher risk of delivering a premature or low birth weight infant.

In Malawi, blood concentrations of HIV-1 were seven-fold higher in HIV-1-infected adults with acute uncomplicated malaria than in HIV-1-infected

blood donors without malaria. As with other acute infections, increased viral load was reversed by effective malaria treatment.

This is important as high HIV-1 viral load increases the risk transmission of HIV-1 from an infected person to a non-infected person. Also, high viral loads are associated with progression of clinical HIV-1 disease.

Malaria, HIV-1, and health-service delivery

The rising incidence of HIV-1-associated febrile illnesses could lead to levels of use of antimalarial drugs beyond those anticipated from the direct effects of HIV-1 on malaria incidence. In turn, this rise would probably add to the problem of resistance to antimalarial drugs.

Very little is known about the effect of HIV-1 infection on response to malaria treatment.

Large-scale use of co-trimoxazole (trimethoprim-sulfamethoxazole) for prophylaxis of opportunistic infections in HIV-1 infected individuals may interact and accelerate *P. falciparum* resistance to sulfadoxine-pyrimethamine.

The extent to which the considerable short-term benefits from prophylactic use of co-trimoxazole for HIV-1/AIDS outweigh the long-term risks of increasing rates of resistance to both antifolates in malaria and other common infections remains to be determined.

Blood safety should be addressed. Inadequate prevention and control of malaria leads to excess malaria associated severe anaemia, which often requires blood transfusion. Blood often remains unscreened for HIV-1 in sub-Saharan Africa so any intervention that decreases the need for transfusion is welcome.

Implications for mainstreaming

In east and southern Africa where HIV-1 prevalence approaches 30%, about a quarter to a third of clinical malaria in adults and malaria in pregnancy can be accounted for by HIV-1. Thus programmes that both mainstream HIV and integrate malaria control elements will have a greater impact.

- The current Oxfam GB strategy for malaria control targets children and ALL pregnant women and a programme following the guidelines will therefore target the most vulnerable groups.
- Mainstreaming, however, is a relatively new concept and a better analysis of each situation will help to define other areas where modifications to our programme need to be made.
- Women's additional workloads such as caring for family members who have AIDS need to be considered when planning the programme and carrying out training and mobilisation activities.
- If retreatment of nets is envisaged care must be taken to ensure that those who are incapacitated by HIV/AIDS are helped to do this. (Some studies have shown that some insecticides can have an accelerating effect on the progression of HIV to AIDS)

- Targeting antenatal women for malaria treatment could perhaps be integrated with access to HIV-1 diagnosis and antiretroviral drugs. This would very much depend on the individual country context.

Section 10

Integrated AIDS Work



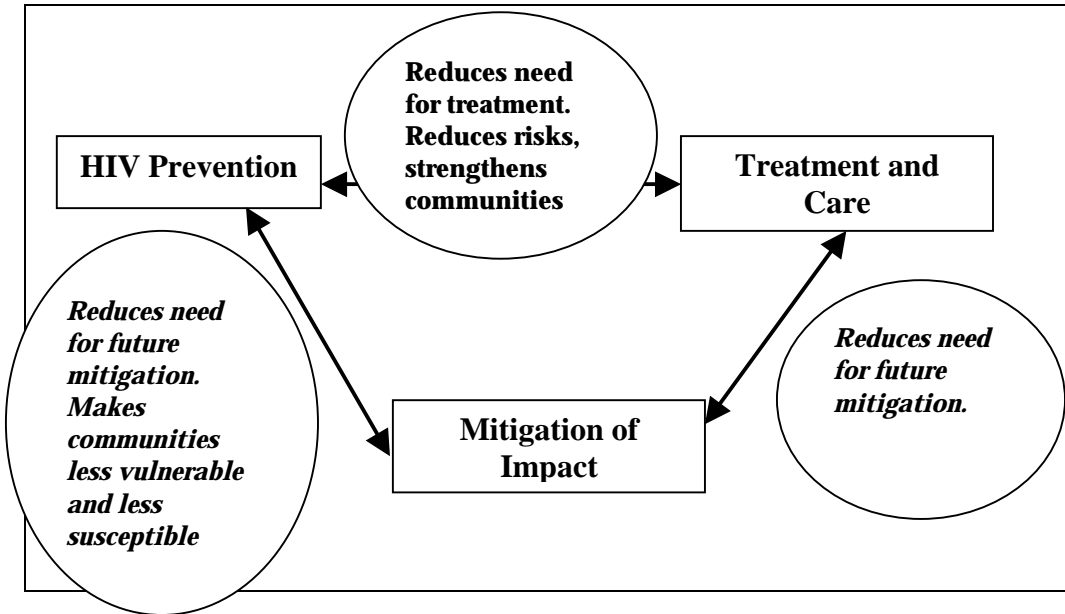
Integration: Prevention, Care and Mitigation

In some instances it may be necessary to include focused activities that should be integrated with the current emergency programme. It may be useful to think of such activities in terms of prevention, care and mitigation. These are closely linked and interdependent and should not be considered in isolation.

An Overview of Possible Responses from Longer term Work

Prevention of Infection	Care and support for PLWHA	Mitigation of Impacts
Cross-cutting issues: Gender, Protection, Participation, Rights based approach		
Public Health Promotion; Life skills training and condom negotiation	Stigma reduction*	Vulnerability targeting
Condom provision and Promotion	VCT	Stigma reduction
STI Management	Psychosocial support	Livelihoods approach: Labour sharing and labour saving
Voluntary counselling and Testing	Clinical management of opportunistic infections and HIV-related illnesses	Asset replacement; small divisible units
Prevention of MTCT	TB prevention and control	Food for work; Cash for work
Blood Safety	Home based care	Public Health Promotion to maintain health
Enforcement of Universal Precautions	Disease management with ARVs	Malaria Control programmes
Stigma reduction		Working with partners
Income generating activities to avoid high risk behaviour		

* How can those infected and affected assist their communities to reflect on norms and values which may contribute to the spread of the virus: machismo, gender stereotypes, alcohol and drug use, lack of respect for others, prejudices, etc?



Integrating AIDS work with Public Health Promotion

Overview

There is some evidence globally that well-designed prevention programmes can reduce the incidence of HIV but the hope of conquering the disease seems a long way off and HIV is here with us for the foreseeable future. In order to address this Oxfam needs to ensure that ALL staff view their programmes through the HIV lens and make the changes that are necessary to ensure their programmes continue to meet the needs of those that are most vulnerable.

However, mainstreaming is not enough even in the emergency context and there is a need for agencies (not necessarily Oxfam) to take on other aspects of HIV prevention, care and mitigation. Some of these issues are discussed in this chapter.

Whilst it is recommended that initially Oxfam sticks to core business and mainstreams HIV/AIDS in its Humanitarian work, there may be opportunities now or in the future to advocate for other agency involvement in the important work outlined below.

Strategies for Health Promotion

Information	Empowerment	Environment
Organising community events: drama, songs, quizzes, posters	Participation	Networking to other services e.g. STIs
Training peer educators	Peer groups sessions	Partnerships across sectors
	Condom use and negotiation skills	Strategies for reducing stigma
	Gender analysis	
	Shared understanding and responsibility	

- Integrate HIV information, education and communication messages into existing activities and provide information in culturally appropriate ways. Language, images and processes used should be those already existing in the community involved or generated by that community. Participatory methods are available and can be adapted (e.g. Stepping Stones – see Resources section at end). The readiness of communities to listen to and react to these issues has to be assessed. Shortcuts in health promotion development and implementation reduce the quality of the outcomes.
- A means of HIV/AIDS prevention (condoms – including female condoms) should be available and promoted through culturally appropriate

mechanisms. Understanding the perceptions of the population about condoms is key to the success of any initiative. Note that Women/young girls usually cannot negotiate condom usage; there may be a desire by individuals to replace lost loved ones and there exist different perceptions (West's means of limiting Africa's population¹⁷, condom promotes promiscuity, transmits HIV, use of condoms associated with commercial sex etc.) Possibilities include putting condoms in the monthly hygiene kits if the cultural context allows. Having distribution points near the food distribution points? Think of creative outlets for distribution: bars, tailors, barbers etc.

- Targeting of prevention messages is important. Messages aimed at members of affected and marginalized communities have often necessarily contained explicit images of sex between men or of injecting drugs. However this can sometimes cause problems if they become available to people outside the main target group. Establish agreed distribution policies and ensure broad based community support for any materials produced.
- PLWHAs have a crucial role in health promotion programmes. Their contribution as educators through public speaking, counselling, peer support and information, and as advocates and policy makers has resulted in greater acceptability and visibility of those infected within communities. A common strategy has been the utilization of PLWHAs as public speakers. This can have a profound impact on others' behaviour, as meeting a person infected with HIV provides a reality to what is often perceived as an abstract or distant issue. It can also vividly show that PLWHA can lead productive lives and can help reduce the associated stigma.
- Include activities that encourage people (both as individuals and communities) to appraise the risks that face them personally.
- Train **peer educators**. Education designed and delivered by peers is likely to be more effective than education developed and delivered by other 'external' agencies—especially in marginalized groups suspicious of government or other authorities.
- Consider provision of training in **life skills** for communication and (where it is feasible) sexual negotiation. Could be useful when supporting women's groups and youth groups. Partner organisations may have experience in this. Don't forget to include men.
- Bear in mind that people should have the knowledge, confidence, skills and means to express their sexuality in ways that are safe and respectful of themselves and others.
- Health Promotion needs a holistic communication strategy that emphasises health well-being rather than only focusing on the negative consequences of sex. Resources that are needed to support this include male and female condoms, access to VCT, access to STI information and treatment, access to essential drugs for opportunistic infection and ARVs

¹⁷ De Waal, A., *AIDS: Africa's Greatest Leadership Challenge, Roles and Approaches for an effective response*

- See section of Food and Nutrition for ideas on potential focused activities in this sector

Preparing educational sessions

HIV/AIDS is a sensitive subject so preparing education materials will be especially complex. Some guiding questions include:

- Who is the audience? Are they male, female, young or older, educated or less well educated? What is the level of their knowledge on the subject?
- Are the illustrations appropriate? Are the illustrations culturally sensitive and appropriate? Are they clear so that the participants can understand them? Do the illustrations reflect issues and images with which the participants are familiar?
- Does the educational material avoid discrimination? Does the material show people of similar racial origin, age, and sexual orientation? Do the illustrations foster stigma or fear? For example, showing a person dying of AIDS might lead some people to believe that all people living with HIV are about to die.
- Does the educational material generate feelings of fear? Messages such as "AIDS Kills" might scare people away, and such scare tactics rarely help promote effective behavioural change. Positive messages often promote changes in attitude and behaviour. However, some illustrations that catch people's attention, even negative illustrations, can be effective in raising people's awareness. The key is to know the target group well and choose your messages accordingly.
- Does the educational material avoid moralizing and preaching? People resist listening to someone telling them what they should and should not do. Such practices often lead the learners to become silent and less likely to engage in open and productive discussions. For example, if young people are told that they should not engage in sexual intercourse before marriage, they are less likely to then enter into discussions about safe sexual practices. The best materials provide information in a clear, respectful way and enable people to make their own decision.
- Do the educational strategies build upon already acquired skills, and promote confidence? It is important to build on the expertise of the group. What do they already feel confident in doing? How can that confidence be translated to other circumstances?
- Does it help to build a supportive environment? People learn best when they feel cared for and supported. If people work together toward the same ends, much can be achieved. Does the learning session provide an opportunity for ongoing support for one another? Can this group be supported in promoting effective change in other people, in changing health care practices, and even changing legislation?
- What educational materials work best for the participants? Consider using attractive posters, local radio, TV or newspaper announcements, leaflets, fact sheets, and training aids such as flip charts, or flash cards. Open discussions, interviews with PLWHAs and their families, listening to stories from other care providers, or patients, and advertisements are also

deliver powerful educational messages. It will be important for participants to visit PLWHAs in hospital and in the community.

Condom distribution

According to the UNAIDS Guidelines for HIV Interventions in Emergency settings “the most urgent (AIDS-related) task facing emergency relief agencies during the acute phase is to make condoms freely available to those who seek them”.

There are a lot of problems in regard to the usage of condoms that inevitably influence impact of this intervention. Among Rwandan refugees in Tanzania out of 87% who knew at least two methods of HIV protection, 16% had used condoms during their last sexual intercourse¹⁸. It was felt that an exclusive focus on condom use was not wise and that other strategies (promotion of fewer sexual partners and aggressive treatment of STDs etc.) are equally important.

Nevertheless, it would be advisable for Oxfam to consider distributing them for a number of reasons, especially if no other organization is doing so: the use of condoms is an effective method of protection; a lot of people have already been introduced to the idea of using condoms; regardless of the fact that people are still not accustomed to using condoms as much as they should at least people who want to protect themselves or others should have access to them.

The following illustration from UNAIDS shows the complex interaction of issues influencing condom use.

Figure 2 More realistic prevention model based on two decades of experience



Prevention of sexually transmitted HIV

The safest form of prevention of sexually transmitted HIV is abstinence. However, in most instances, abstinence is neither realistic nor desirable. Barrier methods that prevent semen and other bodily fluids from passing from one partner to another are the next most effective preventive methods. These barrier methods also reduce the risk of STIs, however, they also act as a contraceptive. Such barrier methods include the male and female condom.

¹⁸ Benjamin J. A., *AIDS Prevention for Refugees, The Case of Rwandans in Tanzania*

Male condom

The male condom is placed over the erect penis before penetration occurs. The condom then remains on the penis until after ejaculation when it should be immediately removed, knotted and discarded in a safe place such as a toilet, latrine, or in a safe disposal unit. It is vitally important that people are given accurate information and an opportunity to practice using condoms.

Information should include:

- How to place the condom on the erect penis, leaving space at the top to receive the ejaculate,
- How to unroll the condom down to the base of the penis
- How to ensure that the condom remains in place throughout intercourse
- How to remove the condom before the penis loses its erection

It is important to emphasize that individuals may practice using condoms on a model or other object, such as a banana or cucumber. A new condom must be used for each sexual act. Condoms should be easily accessible for both men and women, and are best distributed in places where a sense of privacy is increased and embarrassment is reduced. Wherever possible, free condoms should be available.

Female condom

In many situations in which Oxfam works, the female condom remains unfamiliar to the majority of men and women. However there may be some situations where it is appropriate e.g. for some commercial sex workers. The information given below is provided so that people reading the manual are aware of its existence and do not ignore the opportunity to promote it where appropriate.

The female condom is a soft yet strong polyurethane sheath, about the same length as the male condom, only wider. A plastic ring at the closed end helps keep the condom fixed within the vagina during sex. A larger ring at the opening stays outside the vagina, spreading over the woman's external genitalia.

The female condom provides extra protection to men and women because it covers both the entrance to the vagina and the base of the penis, both of which are areas where STI sores make it easy for HIV to enter. Female condoms should only be used once and do not require a prescription. However, they are more expensive than male condoms and not as easily acceptable or accessible. Because the external ring is visible outside the vagina, using a female condom might require the agreement of both partners. However, because it can be inserted hours before intercourse, it can provide protection in situations where consumption of alcohol or drugs may reduce the chances that a male condom will be used.

The female condom is inserted with the finger, making sure no damage is done to the polyurethane by fingernails or other sharp objects. The condom should then fit snugly against the cervix. During intercourse, it is necessary to guide the penis in or check that the penis has entered the condom and not entered the vagina outside the condom wall. The condom should be removed

as soon possible after male ejaculation, and disposed of in the same ways as the male condom.

Enlisting men in HIV/AIDS prevention

- Men are involved in almost every case of transmission
- They almost always have the power to protect themselves and their partners
- Men are at risk
- Men's behaviour puts women at risk

However, prevention is a very complex challenge. Some prevention strategies need to be addressed at the greater society (or macro) level, such as strengthening or changing government policies, modifying laws, and enforcing new laws or human rights policies. Other prevention strategies must address the behavioural, social and cultural context (the micro level) of the individual.

Strategies for Prevention include Public Health promotion, Life skills training and condom negotiation, condom provision and promotion, STI services, VCT, Prevention of MTCT, blood safety, enforcement of universal precautions, stigma reduction and income generating activities to encourage economic autonomy thus minimising transactional sex.

Public Health promotion strategies and income generating activities are covered in **Section 9 Sectoral Responses**. STI services will usually be provided by other governmental and health agencies and will not be further discussed here. Oxfam may be involved in supporting partner organisations that implement the other strategies and these are outlined briefly here.

There is increasing understanding about what works in HIV prevention. What seems to emerge as a consistent feature of HIV prevention programmes that work, is the involvement and active participation of community members or community groups and PLWHA. There is a need to assess the community perception of HIV whilst minimising the risk of stigma.

HIV prevention –What works?

- Voluntary Counselling and Testing
- Behavioural interventions (with services and condoms)
- STI prevention and treatment
- Antiretrovirals and safe infant feeding practices to prevent MTCT
- Safe transfusion practices; reduce number of transfusions

Prevention needs:

- Knowledge
- Skills
- Access to services and products

- Supportive environment

Contextual factors reducing transmission and impact

- Political openness, leadership and legal protection
- Religious Leadership
- Community Leadership
- Fora for discussing sex/Peer education
- Sex education in schools/for young people
- Involvement of PLWHA
- Resources/access for prevention, treatment, care and support

Key factors in heterosexual transmission of HIV

- Frequent change of sexual partners
- Unprotected sexual intercourse
- Presence of STIs and poor access to treatment
- Lack of male circumcision
- Social vulnerability of women and young boys and girls
- Economic and political instability of the community

Ways to reduce heterosexual transmission of HIV

- Better recognition of the symptoms of STIs and improved behaviour in seeking treatment and better management of STIs
- Sexual abstinence
- Delayed onset of sexual activity
- Fewer sexual partners
- Safer sex practices, including consistent, correct use of condoms
- Supportive social environment
- Reduced stigma and discrimination against people with HIV
- Promotion of male circumcision

HIV is known to be a cause of discrimination against populations already disadvantaged by emergencies. Whilst this potential stigmatisation represents an important constraint, there is still a need to highlight HIV/AIDS vulnerability and risk and to implement interventions in order to prevent HIV transmission in the affected populations and to mitigate the impacts.

Creating an environment for PLWHA to live free of stigma has a double impact. It encourages prevention for those who are still negative while at the same time allowing people who are positive to access appropriate care and support services to live positively and productively.

Complementary approaches to reducing stigma

- Rights based approach
- Involve PLWHA from the beginning if they are willing
- Individual focus
- Collective focus
- Policy –v- legal

Greater Involvement of PLWHA

Encourage people to live positively by:

- Reducing stigma
- Supporting PLWHA groups
- Beneficial disclosure after testing positive (access to drugs, for example)
- Workplace policies on discrimination
- Advocacy at national level

Targetting

HIV leads to AIDS, which is fatal, however, early diagnosis and access to food and basic care can prolong life and keep a person healthy and productive for a longer period of time. In contrast with other diseases, AIDS kills mostly members of the productive age group age 15-49 years, leaving behind the elderly and the young.

Therefore it is very tempting to target high-risk groups to help prevent infections and to target those already infected for care and mitigation interventions.

However, targeting interventions is hindered by the fear of infected people to self-identify as well as the stigma from communities. The private nature and

divergent cultural attitudes towards sex tend to lead to silence, denial, stigma, and discrimination at many levels. Targeting relief to HIV/AIDS affected households can increase stigma and exclusion unless done sensitively and with the full participation of those **infected** and **affected**.

PLWHA seldom know status. UNAIDS estimate that more than 90% of HIV positive persons do not know their status.

“With regards to potential problems of targeting HIV-affected families versus poor but not HIV-affected, there is a risk of stigma especially in areas where HIV sensitisation is limited. But in areas where sensitisation exists, communities know that people need support. “ -AIDS Service Provider in Kampala, Uganda

In general it is possible to target **prevention** strategies and public health promotion messages to those groups most susceptible to infection. It is also good practice as many of the messages aimed at members of affected and marginalized communities have often necessarily contained explicit images of sex between men or of injecting drugs. This can sometimes cause problems if they become available to people outside the main target group. Establish agreed distribution policies and ensure broad based community support for any materials produced.

Youth are a key group, as they are not yet infected.

Groups susceptible to infection

- The local armed forces, including child soldiers, who are targets as well as vehicles of spread for HIV
- Women, children and men in the refugee and internally displaced populations and surrounding host communities
- Young people (age 10-24 years), especially when out of school and unemployed (e.g. street children)
- Prisoners, especially where juveniles are mixed with long-stay inmates
- Substance users, e.g. injecting drug users and their sexual partners (particularly of importance where there is a high HIV level amongst injecting drug users and/or where commercial sex is used to support a drug habit)
- Commercial Sex workers - female and male
- Identifiable groups of clients of sex workers, such as:
 - Military personnel
 - Long-distance truck drivers
 - Businessmen
 - Migrant workers
 - Single men
 - Men who have sex with men
 - International humanitarian assistance personnel from the UN, NGOs
 - International military, police and civilian staff of peacekeeping forces

Targeting PLWHAs and HIV affected households

Persons who are identified as HIV positive are productive members of society until they begin to become ill with opportunistic infections.

Targeting households with an **infected** member or targeting households **affected** by the epidemic should be done with the aim of reducing further vulnerability and strengthening their coping capacity.

Existing Oxfam field tools for targeting interventions should identify vulnerability **whether or not this is due to HIV**. If a large number of vulnerable households are identified and there is a backdrop of high HIV prevalence then the livelihood activities could be adapted to take this into account. That is, the interventions are targeted or adapted according to the phase of the epidemic but the households are not.

Areas of known high prevalence of HIV could be targeted for activities that will promote and maintain health and increase household food security.

Beneficiaries are targeted on their vulnerability (E.g. food insecurity) not on HIV status alone. As in any emergency, a judgment will have to be made weighing up the different factors of vulnerability and deciding who is the most vulnerable. Don't seek out "HIV positive" but focus on vulnerable groups.

Indicators of vulnerability

Malnutrition, food insecurity, low income, degraded land, civil conflict, spatial isolation, illiteracy/education, deforestation, environmental hazards, access to markets, transport, stigma, marginalization, access to water, access to health services, prevalence of disease, quality of sanitation; chronic illness (this could include symptomatic HIV illness and AIDS)

A program working with communities may want to review whether it will be providing food for all households in a community or targeting specific groups—such as households with PLWHAs or orphans of HIV affected households. These decisions will depend on:

- The prevalence of HIV in the community
- People's awareness of and sensitisation to the disease
- Whether families will be stigmatised

Unfortunately, there are no hard and fast rules on how to quantify this and it will be a part of the overall context analysis. The social environment should be examined and interventions introduced that will reduce stigma and isolation of HIV positive individuals. A supportive social environment where targeting could be considered is characterised by

- Strong political commitment at all levels in addressing HIV/AIDS
- Low levels of active discrimination
- Minimal stigmatisation of PLWHA or households affected by HIV/AIDS

When targeting individuals using the criteria of chronic illness, HIV/AIDS can be included. It is not necessary to create a separate criterion for HIV/AIDS. However, note that this type of targeting has been very difficult in the past due to definition of chronic illness and degree of disability associated with different illnesses.

Donor strategy and resources often makes it difficult to access funding for marginalized groups.

Groups vulnerable to the impacts

- Single parent households
- Child and youth headed households
- Widows
- Grandparents, especially elderly women who bear the burden of care
- Young men and women
- Orphans

Households can look different in emergency affected areas, particularly during and after conflicts. These demographic changes can be increased in high prevalence HIV/AIDS areas. There are fewer working-age adults, more single-parent households, some youth-headed households, more three-generation households, more households with a missing middle generation, and more fostering in of other people's children, whether or not they are family members. There is a need to explore beyond households and families to other types of networks that exist between individuals within the same community and those that exist across different communities.

Interventions *could* be targeted through HIV/AIDS prevention and care services such as counselling and home-based care where these already exist, as this would suggest a certain degree of acceptance of HIV and its consequences. Use intermediaries: home based care groups, churches, and social networks

When Working with Young People

- Identify key points of entry for talking with young people and addressing their concerns and identify programmes with and for them. Recognise that young people are not a homogenous group.
- Collect and improve the quality of monitoring of age, culture and gender-specific information. Take into account the *diversity* of young people and their needs.
- Pay particular attention to **risk situations** (e.g. abduction and forced recruitment; sexual violence and exploitation; domestic violence;) and types of **young people at risk** (e.g. child headed household; adolescent headed households; unaccompanied minors or separated children; and girls.
- Include young people in needs assessments, programme design and implementation. Identify the capacities, not just the problems, of young people and support these for constructive self-organising
- Identify what livelihood activities young people are currently involved in and to what degree they are economically responsible for themselves and their families
- Work in a climate of *openness*. Ensure the broad support of the community leaders.
- Incorporate non-harmful local traditions in programming for young people
- Ensure all staff working with young people are trained in child rights and related issues
- Utilise peer education approaches where possible
- Support young people's initiatives such as youth centres, newsletters, radio shows, recreation and creative projects
- Promote gender equity and appropriate responses to girl's and boy's specific concerns and needs including sensitising men and boys to women's and girl's issues.
- Acknowledge the importance of a *gendered approach* to HIV prevention work, which includes discussions of power relations between boys and girls

When Working with Women and Men

- Acknowledge the importance of a *gendered approach* to HIV prevention work, which includes discussions of power relations between men and women.
- Use a *multifaceted approach* that addresses economic and other needs which may take priority over HIV/AIDS in the daily lives of women living in poverty in developing countries
- Focus on *improving communication between sexual partners* that acknowledges the difficulties women encounter in talking and negotiating with men about sex. Promote a more equitable and mutually respectful attitude.
- Increase awareness of the importance of *including men* in work for the prevention of HIV among men, women and children
- In condom promotion special focus should be on men in the reproductive age as men are more likely to be decision-makers emphasising use in all sexual relationships including wives/girlfriends

When Working with Commercial Sex Workers

- *Acknowledge the wider concerns* and priorities of sex workers, which include social, legal and economic issues as well as concern for their families and children
- Address the *prejudice* and stigmatisation that sex workers face
- Acknowledge the importance of helping to *empower* sex workers
- Support partner organisations that provide improved and more accessible *health services*, most especially for the diagnosis and treatment of STIs
- Seek the cooperation and *support of gatekeepers* in the sex industry, including brothel owners and bar owners as well as employers of potential clients of sex workers
- Legitimise the role of *sex workers as peer educators*, providing them with the respect of their peers
- Acknowledge the importance of providing sex workers with financial incentives for *peer-led work*; work, where possible, with men as well as women through a *focus on clients* and, in some cases, *boyfriends*. This is important given the prevalent power relations between both men and women and clients and sex workers
- Consider income generation activities to provide alternative means of income

When Working with Men who have Sex with Men

- *Acknowledge the wider concerns of Men who have sex with men (MSM) in developing countries, including issues such as harassment, poverty and responsibilities towards family members*
- *Recognize the importance and the difficulties of raising public awareness about issues concerning MSM, countering prejudice and discrimination, and the promotion of human rights. Homosexuality is often a hidden and denied*
- *Through partner organisations support training for professionals working with MSM, including health workers, and health promotion workers*
- *Address homophobia, including internalised homophobia*
- *Through partner organisations support access to voluntary counselling and testing services, along with appropriate referrals*

When Working with People who Inject Drugs

- Undertake HIV prevention activities when *seroprevalence is still low*, focus on *harm reduction* as well as *rehabilitation*;
- *Advocate* to protect the rights of people who inject drugs;
- Acknowledge the need for a *multi-pronged approach* including needle and syringe exchange and the provision of drug treatment, including detoxification, substitution pharmacotherapy, HIV/AIDS care and social network interventions; provide *drop-in services*, mobile services and outreach work. These services could be provided through partners or by other NGOs.

Home Based care

Care can, and should be integrated with prevention to provide for a comprehensive, holistic system of HIV management.

Care-givers/institutions must not be discriminatory or judgmental in order to provide accessible and acceptable programs of care and prevention based on respect for human dignity.

Preventing HIV-related infections is cost effective in preventing deterioration of the person's overall health status resulting in heavy costs to the health care system

Expensive in-patient care can be kept to a minimum with available, accessible and acceptable links and referral mechanisms in a comprehensive, holistic care continuum.

The more involvement of the local community and its resources, the more cost effective, comprehensive and holistic is the care. Local people are well suited to provide appropriate care.

Many people prefer to die at home; therefore, terminal care outside hospital should be a viable option.

In many countries, people with HIV/AIDS and their families are good advocates and a useful resource in planning and providing comprehensive, holistic care.

Home based care checklist

- Comprehensive care policies and guidelines for (a) clinical management, (b) nursing care, (c) counselling and voluntary counselling and testing, and (d) social support?
- Resource mobilization across the continuum of care to provide (a) discharge planning, (b) referral networks, (c) government/NGO links, and (d) community support to PLWHAs and caregivers?
- Integration of HIV/AIDS care with existing services such as (a) in- and outpatient care, (b) health centres and dispensaries, (c) tuberculosis, sexually transmitted disease and maternal/child and family planning clinics?
- Prevention intervention as part of care by (a) counselling partners of PLWHAs, (b) supplying condoms, (c) educating family members, and (d) stimulating support groups among PLWHAs?

Monitoring and Evaluation of Integrated or Focused AIDS work

Monitoring of Focused Activities

Numbers of condoms distributed can be used as a process indicator but it is often impossible to find out if they are being used, and if so are they being used properly and therefore able to have an impact on HIV transmission.

Monitoring and Evaluation Model

Assessment & Planning	Input	Process	Output	Outcomes (Intermediate Effects)	Impact (Long-Term Effects)
	Process Evaluation			Impact Evaluation	
Situation Analysis	Staff	Training	# Condoms distributed	Behaviour change	HIV Inc/prev
Response Analysis	Funds	Services	#Test kits distributed	Attitude change	AIDS morb/mort
Stakeholder Needs	Materials	Education	#Clients served	Knowledge change	STI inc/prev
Resource Analysis	Facilities	Treatments	#Tests conducted	Quality of Life	Social norms
Collaboration Plans	Supplies	Interventions	#Staff trained	Treatment Success	Coping capacity in community
				Increase in social support	Economic Impact
Program Development Data	Program based data			Population based biological, behavioural and social data	

Full behavioural studies are often impractical to implement in emergencies. Oxfam’s strength lies in community participatory appraisal methods for gathering information. Many of the indicators can be adapted and used as questions for focus group discussions, key informant interviews and household interviews. Remember that due to the stigma surrounding much of the issues related to HIV/AIDS people may be reluctant to answer for themselves so it is better to phrase the questions in the third person.

Focus groups should be conducted carefully with people being of similar age and same gender.

Sample Indicators for Home based care Project

A successful home based care project involves using existing services appropriately so that the PLWHA can use the site and service best suited to their health and/or social service need. Possible indicators include;

- Number of PLWHA accessing resources in the continuum of care
- Types of linkages between resources and services
- Number of drugs, medical supplies and condoms distributed
- Changes in hospital attendance
- Volunteer training given
- Number of Households helped in caring for young adults

Knowledge indicators

It has been established that knowledge of HIV transmission can be measured fairly accurately with very few questions. In operational research it appears that further questioning does not add to the value of the information collected. There are two main ways of collecting this information: using open questions where the person answers spontaneously or using prompted/direct questioning.

Spontaneous questioning

In what ways can people reduce their risk from getting infected with HIV?

Are there any other ways? (Circle all that are mentioned. More than one answer is possible. Do not read out the ways)

- Use condoms
- Have fewer partners
- Both partners have no other partners
- No casual sex
- No commercial sex
- Avoid injections with contaminated needles
- Avoid blood transfusion
- Other (specify)
- Don't know any

Indicators to measure Stigma

% of AIDS related funerals attended by at least 75% of the village population divided by the % of AIDS funerals

% of people going for VCT

% of people who seek care far away

Willingness to disclose, social isolation

Changes in community attitudes

Sample questions to measure stigma

If a relative of yours became sick with the AIDS virus, would you be willing to care for him or her in your household?

If a teacher has the AIDS virus but is not sick should he or she be allowed to continue teaching?

If you knew a shopkeeper or food seller had the AIDS virus would you buy food from them?

If a member of your family got infected with the AIDS virus, would you want it to remain a secret?

Social impact indicators

Increased numbers of orphans

Increased death rates of employees

Changes in funeral practices, fewer days of mourning

Increased rates of absence

Loss of key workers

Unavailability of people for meetings

Increased mortality of young adults

Decline in school attendances (particularly girls)

Changes in labour patterns

Breakdown of informal and formal caring structures

Loss of knowledge transfer

HIV as a security issue

A destabilizing factor

- Since early 2000, the UN Security Council has highlighted the threat posed by the HIV/AIDS epidemic to global peace and security. It has held several discussions on HIV/AIDS—the first time the world’s top political body has addressed a health and development issue. In July 2000, the Security Council passed Resolution 1308, emphasizing the need to combat the spread of the virus during peacekeeping operations.
- The links between AIDS and issues of security are many. As parents and workers succumb to AIDS-related illnesses, the structures and divisions of labour in households, families, workplaces and communities are disrupted, with women bearing an especially heavy burden. From there, the impacts cascade across society, reducing income levels, weakening economies and undermining the social fabric.

Flourishing amidst insecurity

- The epidemic thrives in settings already marked by high degrees of socioeconomic insecurity, social exclusion and political instability.
- In regions hit by famine, repression or violent conflict and war, populations are more at risk of HIV infection. Social systems are disrupted, families are separated and communities are displaced. This social dislocation and rampant insecurity create fertile settings for HIV transmission.
- The use of rape as an instrument of war and repression adds another serious dimension.
- The military is an increasingly important factor in the epidemic. Military personnel are at high risk of exposure to sexually transmitted infections (STIs), including HIV. In some countries with adult HIV prevalence rates of 20%, it is estimated that as many as 50% of military personnel could be HIV-positive.

When planning programmes and considering issues of security the impact of insecurity on HIV prevalence should be assessed. Programmes promoting health and condoms should be prioritised.

There is an UN Interagency Sub-committee on HIV in Emergencies that recommend the following minimum package for HIV prevention in emergencies. Oxfam is unlikely to be involved in these activities but it is worthwhile to be aware of the strategies that should be in place. The **Acute Emergency Response Package for HIV/AIDS** consists of essential interventions for HIV/AIDS control that are feasible in spite of the loss of health care and social infrastructure, targeting the most vulnerable groups with prevention measures and the initial basis for rehabilitation of the services that are needed. A field trial version of the Guidelines is scheduled for pilot testing in 3 countries in the course of 2002, and the lessons learned will be applied in the revision of this document after those trials.

This Acute Emergency Response Package for HIV/AIDS is a combination of activities to be accomplished through the assistance of necessary human resources and material/drugs and is designed for the acute (or initial) phase of an emergency. All interventions are aimed at providing services to refugees, IDPs and the surrounding population. In other words, the package of interventions does not target specific groups in the populations present, but rather an area affected by a humanitarian emergency.

The Acute Emergency Response Package for HIV/AIDS includes:

5. A field manual, setting out practical guidelines for relief managers and technical staff – "*Guidelines for HIV Interventions in Emergency Settings*"
6. Training material (basic training on how to use the package, as well as training material on specific topics), and
7. Drugs and supplies.

The drugs/supply items are available in sub-kits developed for specific population size. The kits are designed to meet the material needs of the first five interventions that are proposed for the acute emergency response, namely:

1. Condom supplies;
2. Material for the standard application of universal precautions;
3. Blood safety equipment;
4. Health education materials (IEC); and
5. STI Syndromic case management equipment and supplies

Prevention of PTCT

The United Nations agencies recommend a three-pronged strategy to prevent transmission of HIV to infants:

- Primary prevention of HIV among parents-to-be;
- Prevention of unwanted pregnancies among HIV-infected women;
- Prevention of HIV transmission from HIV-infected women to their infants through:
 - Provision of antiretroviral drugs to HIV-infected pregnant women and their infants,
 - Safe delivery practices, and
 - Counselling and support for safer infant feeding practices.

Prophylactic use of an antiretroviral regimen is just one component of an MTCT prevention programme. While the focus on the use of such regimens increases public awareness that transmission of HIV to infants can be prevented and provides a catalyst to action, the other components should not be neglected. MTCT-prevention programmes are often limited to interventions delivered to HIV-infected women during pregnancy and around the time of delivery. A significant impact will only be achieved when all components of the comprehensive programme are in place and functioning.

It is also important to provide and improve care and support services for HIV-infected individuals and their families, especially:

- Care of the HIV-infected mother
- Psychosocial support for the mother and her family.

A recent study showed that the administration of zidovudine (AZT) during pregnancy, labour, delivery and to the newborn reduced the risk of MTCT by 67%. This long-course regimen is often not available for women in developing countries because of cost and lack of adequate infrastructure. However, there is a concerted effort to provide short term AZT to all HIV-positive pregnant women. Short course AZT is taken orally from 36 weeks of pregnancy through labour and delivery. This treatment does not prolong the life of the mother, but has been found to be effective in reducing transmission of HIV to the infant.

Nevirapine is a much cheaper antiviral drug than AZT, costing about \$4 per mother and baby treated. Recent studies have shown it to be effective in reducing MTCT if a single dose is given to mothers just prior to delivery and to newborns immediately afterwards. In terms of both cost and infrastructure requirements Nevirapine offers a more optimistic and realistic alternative for ARV for developing countries.

Without access to ARV drugs, most of the 40 million people currently living with HIV will die. ARV drugs reduce viral load in blood and consequently in genital fluids, and may help prevent transmission of HIV and other sexually transmitted infections

ARVs are very expensive and unavailable to many PLWHA worldwide. However, where ARV is accessible and affordable certain guidelines must be followed. A joint publication by WHO and UNAIDS "Guidance Modules on antiretroviral treatments" (WHO/ASD/98.1 & UNAIDS/98.7) provides comprehensive guidelines.

The minimum requirements for introducing ARVs include:

- Availability of reliable, inexpensive tests to diagnose HIV infection.
- Access to voluntary and confidential counselling and testing.
- Reliable, long-term and regular supply of quality drugs.
- Sufficient resources to pay for drugs on a long-term basis (a life-long commitment).
- Support from a social network to help PLHA stay with the treatment regimen.
- Appropriate training for health care workers in the correct use of ARVs.
- Laboratory facilities to monitor adverse reactions.
- Capacity to diagnose and treat opportunistic infections with the availability of affordable drugs.
- Access to functioning and affordable health care services.
- Joint decision-making between health care worker and patient in all aspects of ARV treatment (including the decision to begin ARV).

It is clear that in emergencies many of these criteria will not be fulfilled and therefore the support to ARV services can only be supported in the later stable stages when there is clear expertise available.

Blood safety

Blood transfusions

There is a 90-95% chance that someone receiving blood from an HIV infected donor will become infected with HIV themselves. This risk can be virtually prevented by a safe blood supply, and by using blood transfusions appropriately.

Difficulties hindering a safe blood supply include:

- Lack of national blood policy and plan
- Lack of an organized blood transfusion service
- Lack of safe donors or the presence of unsafe donors
- Lack of blood screening, and
- Unnecessary or inappropriate use of blood.

Minimizing the risk of HIV infected blood transfusions

In many countries, regulations on blood donations, screening and transfusions exist, but are not adhered to. It is vitally important that regulations be established and rigorously enforced.

Three essential elements must be in place to ensure a safe blood supply:

1. There must be a national blood transfusion service run on non-profit lines that is answerable to the Ministry of Health.
2. Wherever possible, there should be a policy of excluding all paid or professional donors, but at the same time, encouraging voluntary (non-paid) donors to come back regularly. People are suitable donors only if they are considered to have a low risk of infection.
3. All donated blood must be screened for HIV, as well as for hepatitis B and syphilis (and hepatitis C where possible). In addition, both donors and patients must be aware that blood should be used only for necessary transfusions.

Avoiding unnecessary or inappropriate transfusions

Unnecessary transfusions increase the risk of transmitting HIV, especially in places where there is no adequate screening programme.

Blood substitutes should be given where appropriate. In addition the underlying cause for the blood transfusion should be considered. For example, blood transfusions are often given for anaemia. Instead, the underlying cause of the anaemia should be investigated. Anaemia may be due to malnutrition, slow blood loss, and to infections such as malaria. Blood is often needed during complications accompanying childbirth. However, providing proper care for women before, during and after delivery can decrease the need for blood transfusions.

Universal Precautions

Universal Precautions are simple standards of infection control practices to be used in the care of all patients, at all times, to reduce the risk of transmission of blood borne infections. They include:

- Careful handling and disposal of "sharps";
- Hand washing with soap and water before and after all procedures; use of protective barriers such as gloves, gowns, aprons, masks, goggles for direct contact with blood and other body fluids;
- Safe disposal of waste contaminated with blood or body fluids;
- Proper disinfection of instruments and other contaminated equipment;
- Proper handling of soiled linen.

Section 11

Partner Organisations



Overview

Supporting Partner organisations to mainstream HIV/AIDS will need to have been initiated prior to an emergency. However, in areas where there is a high prevalence of HIV/AIDS it may be necessary to support partners who are already engaged in focussed AIDS work to help to fill the gaps in service provision by covering other geographical areas or by scaling up their response. This chapter examines how partners might be identified and what work they might undertake. In some contexts existing partner organisations may have limited capacity to respond and in these instances advocacy and lobbying may be needed to encourage others to intervene.

Partnering can be an effective way to extend existing strategies to cover hard to reach vulnerable groups.

Why partner organisations are important

Partner organisations in HIV prevention activities can offer:

- ✓ Access to people and places⇒wide networks across the sectors, improved coordination
- ✓ Good ideas, information and skills
- ✓ Practical “reality checks”
- ✓ Lessons learned⇒more effective and creative solutions
- ✓ Influence⇒respected leaderships, broader acceptance of the issues
- ✓ Political Support
- ✓ Increased sustainability

Although separate and different, partner organisations should share Oxfam’s overall goal and vision for the project. It should be noted that there is no standard procedure or policy for Oxfam GB in choosing partners but some key documents are annexed as a guideline. (See annex 2: ERM 0.8 Counterpart appraisal and annex 3: Appraisal Partners PPSMG Section 9).

As “partnerships” can be taken to mean anything within a whole spectrum of collaboration it is very important to clarify from the outset what kind of partnership is envisaged: e.g. Funding only, training and capacity building, collaboration for certain parts of the programme, consultation, creating an entirely new CBO/NGO etc. What are the strengths that different partners bring e.g. youth groups, women’s groups etc?

What partners can do:

- Apprenticeships and training in marketable skills to orphans, adolescent boys and girls and young women
- Cooperative day care centres to assist women cope with their workload
- Homecare and visits to orphans and HIV/AIDS patients
- Labour sharing; income generating projects to produce food and cash targeting boys and girls and adolescents
- Savings clubs and credit schemes for funeral benefits
- Help to HIV-infected women and through access to legal advice
- Condom distribution networks via social, medical or welfare outlets: local NGOs, Health Authorities
- Condom distribution networks via commercial outlets: bars, hairdressers, barbers, tailors etc

Behavioural interventions such as Voluntary Counselling and Testing; Health Education and Risk Reduction; Street/community outreach
Clinical service providers such as local health authorities. Could simply be with awareness raising of the issues around HIV.

Checklist for working with partners in emergencies¹⁹

- Work with the partner to set qualitative and quantitative objectives for the program.
- Select a strategy or combination of strategies to attain the objectives, given your budget and other resources.
- Choose partners who hire staff and use outreach workers who are culturally sensitive to the target groups and who can speak their language, or train existing staff in working with the group. Carry out regular motivational activities to keep up staff and worker enthusiasm.
- In managing your strategy, pay particular attention to planning, staffing, logistics, and sustainability.
- Establish a system for receiving accurate and timely information on services, supplies, and activities so that you can identify problems as they arise and address them promptly.
- Advise partners to integrate the activities for target groups into their ongoing programs and activities.
- Any Oxfam Humanitarian HIV prevention and care activity must be incorporated into the wider public health programme. It is also important that it should fit in with the host country's national STI/HIV/AIDS programme where one exists. The Ministry of Health should have overall responsibility for development, planning, coordination, monitoring and evaluation of activities. Oxfam should ensure these are consistent with UNAIDS global strategy. Before beginning any project done in partnership it is good practice to write a Memorandum of Understanding, stipulating terms of collaboration, responsibilities, targets etc.

¹⁹ *Bringing Services to Hard to Reach Populations. Management Sciences for Health (<http://erc.msh.org/> accessed 10th May 2002)*

Lessons Learned

Lessons learned in working with partners for HIV mainstreaming and integrated HIV/AIDS work²⁰

- **Create political will.** This sets the direction for a national response and gives community groups the space to act. Where national policies and programmes have been established there is a greater level of acceptance of PLWHA
- **Engage the community.** Use existing groups and structures. May stimulate broader community involvement
- **Build Partnership and Trust Increases community ownership**
- **Include people with HIV/AIDS at all stages.** Often difficult because of the fear and stigma of disclosing and HIV+ status. However the consensual involvement and participation of PLWHA is critical to an effective humane and ethical response
- **Create an accepting community environment**
- **Use Multisectoral approaches**
- **Evaluate what you do.** Helps develop more relevant strategies and demonstrates that prevent works
- **Direct resources to community capacity building**
- **Recognise that success is not all-encompassing** New responses may be needed for different sectors and groups

²⁰ *Partners In Prevention: International Case Studies Of Effective Health Promotion Practice In HIV/AIDS.* UNAIDS/98.2

Issues to consider in identifying partners²¹

Working with partners is challenging. It means sharing resources, information, and decision-making. It requires giving up some control over inputs, changing objectives, and getting used to different attitudes and work styles. Successful partnerships depend on the ability to manage problems jointly, on flexibility in adjusting objectives and strategies, and on a willingness to share responsibility for failures as well as for achievements.

There has been a lot of work done on assessing partners for Gender sensitivity (“Traffic Lights”-See annex 4) and there are some parallels to be made with HIV mainstreaming. However, since 90% of HIV positive people are not aware of their status and there is a huge stigma attached to being HIV positive, it remains a great challenge to Oxfam GB to begin to raise issues concerning HIV stigma and discrimination.

The issue of partnering organizations for HIV work is in its very early stages within Oxfam GB and particularly for the HD so the actual process of identifying partners will be a learning process. Wherever possible the process and lessons learned should be documented and shared with programme managers and advisers.

In identifying and considering the issues that follow the actual process of information gathering will be based on indirect observation, listening, and direct questioning. The wording and directness of questioning will vary for different contexts in relation to the sensitivity of the subject. For discussing these topics with counterparts, draw up a checklist of questions that focus on the specific information needed. Phrase the questions to reflect the actual situation and to form a natural conversation flow.

Note that maintenance of **confidentiality** should be paramount—gathering information about individuals HIV can be harmful to the individual and the community if not handled properly.

Attitudes of partner organisations towards HIV

- The visibility of HIV/AIDS within a community – do partners want to cover it up if it is visible?
- Attitudes and beliefs of the partner *organisation* and *individuals* within the organisation
- Institutional practices, policies and beliefs
- Institutional impact of the HIV epidemic on the partner organisation. Is HIV affecting the workforce?

²¹ Adapted from “Pathways to Partnerships” Toolkit. International HIV/AIDS Alliance (no date given)

- Competing Priorities... more immediate crises; HIV/AIDS is a hidden, silent emergency...
- Subject fatigue
- Fatalism about any impact of interventions

Partnerships and Oxfam

- Perceptions about NGO resources. Do partners under or over estimate what Oxfam can do?
- Oxfam's reputation. Is Oxfam too "vocal"? Not "vocal" enough?
- Balance with other areas of work. Is partner support taking up too much time from other programme activities?
- Competition from other NGOs. Are there other NGOs or other organisations that don't have confidence in the partners and want to "take over" some of the partner activities?

Appreciate different perspectives

How do the partner and Oxfam view each other? Partners from different sectors may be more or less inclined to talk about sensitive or potentially taboo subjects or they might have fixed ideas on the subject. Are these perceptions accurate? How can Oxfam address misconceptions?

Pros and Cons

Understanding the pros and cons of working with specific partners can help Oxfam see what is realistically achievable. Entering a partnership with "open eyes" to all the advantages and disadvantages can help accentuate the strengths and mitigate the weaknesses of the partnership.

Ups and downs

All partnerships go through ups and downs. If Oxfam has been partners with an organisation for a long time it may be worthwhile, with Oxfam staff and with the partner, to discuss and map out the highs and the lows from the past to the present. Why were there highs? Can we build on these? Why were there lows? How can we avoid these in the future? Some reasons may include: Friendly/tense relations; frequent/infrequent communication; strong/weak communication; working together/working at odds with each other; different attitudes and beliefs...

What are the good things about working with this partner? What are the bad things? "Ranking" these items can help put things in perspective. How might continuance of the partnership affect the programme or Oxfam's relationship with the wider humanitarian and local community? Can we expect these same partners to mainstream HIV into their work? Should we be looking for new partnerships?

Jargon and language

The language of HIV and AIDS is often very technical and sensitive covering taboo issues such as blood, sex and death. Partner organisations may be

uncomfortable about using some of the language, either because they don't understand it or are embarrassed. Terms like safe sex, commercial sex worker, high risk groups, men who have sex with men can be extremely shocking for some sectors of the community. Language has power-to make people feel good or bad, to bring people together or keep them apart. Are Oxfam alienating potentially useful partners by using jargon that the partner finds inappropriate or doesn't understand? Can Oxfam and the partner come up with acceptable alternatives? Try to clarify what specific terms partners would be "Happy to use"; "Not sure about/needs more explanation"; "Not happy to use".

Language, images and processes used should be those already existing in the emergency affected population or should be generated by that population. Language and images used should be direct, explicit, understandable and simple and again, the affected population should generate these wherever possible.

Who can we Partner?

This can be brainstormed with staff to get ideas more relevant to each individual context.

Ministry of Health, Women's groups, Youth groups, groups run by or supporting PLWHA, National HIV/AIDS programmes, RH Agencies (including those that offer treatment for STIs, offer Family planning etc), Traditional Healers, Midwives/TBA groups, Religious groups, Human rights/Advocacy groups, groups offering psychosocial support, business leaders, Private sector (e.g. hair dressers, barbers, tailors, bars, commercial sex workers...)

Potential Partners	Role	Benefits
Ministry of Health		
Central level	National STI/HIV/AIDS programme? How does this fit in with UNAIDS global strategy? MoH coordinates different actors in overall programme Assess and monitor the epidemic Guidance and support for HIV prevention and care Technical assistance Legislative support Administrative support Monitoring and evaluation activity coordination	A national policy may lead to broader based acceptance of PLWHA. Advocacy possibilities for changing laws and policies. Oxfam can help MoH reach marginalized and vulnerable communities and present innovative programmes that work. Can provide resources and networks for scaling up successful pilot programmes.
Provincial Level	Coordination of activities Technical assistance Supervision of district/municipality ?Monitoring and evaluation	
District/Municipal Level	Local project development, coordination, supervision of monitoring and evaluation	
Health Centre/community level	Implementation of project activities including outreach Mobilise communities for participation Information, Education, Communication Monitoring	
Other Govt Institutions		
Department of Education	?Encourage inclusion of sexual and reproductive health issues (STIs/HIV/AIDS, unwanted pregnancy...) in school curricula	Respected professionals may promote wider acceptance of PLWHA. HIV is having wide

		institutional impact on HR pool of teachers-will increase awareness within this sector
Other organisations		
UNAIDS	Coordinates global fight against HIV/AIDS Provides technical assistance	Campaigning materials and technical resources of high quality. Can disseminate lessons learned to a wider audience Oxfam can provide "reality check" and ensure programmes are reaching the grass roots. May provide opportunities for advocacy for changes in UNAIDS or others strategies.
UNICEF	Works in partnerships with governments, targeting women and children May provide resources and funding	
WHO	Technical assistance and resources	
UNHCR	Coordinates the emergency response in a refugee crisis. May have some duties related to IDPs. May provide funds for implementing programmes	
UK NGO Consortium on HIV/AIDS	Coordinates UK NGOs. Technical guidelines for HIV interventions	Promotes coherent response between different NGOs
Public Health Institutions (e.g. Johns Hopkins Univ.)	May conduct action research	Helps refine and develop response
PSI (Population Services International)	Operates male and female condom social marketing projects in many countries. Does monitoring and evaluation, works through partner organisations. Develops clear simple culturally appropriate instruction sheets in local languages with pictures on how to use condoms. Uses branding.	Ready made logistic and distribution networks. Can supply condoms to small merchants who market them even in very remote areas.
NGOs International/national	Planning and implementation for: Distribution of materials Health education at community level Formation of community councils, groups, activists Education dissemination Advocacy roles Demand generation	
Coalition groups/Community Leadership	Mobilisation of community Distribution monitoring and evaluation	

Section 11

Partner Organisations

Who can we Partner?

	Community decision making	
<p>Community Partners</p> <p>Includes community agents, village mobilisers, women's groups, youth groups, PLWHA, health and other activists from religious institutions, traditional healers, traditional birth attendants, farmers leaders, ...</p>	<p>Mobilise social action for HIV prevention activities</p> <p>Information, Education and Communication</p> <p>Community based distribution systems</p>	<p>Often provides the initial impetus in starting a response.</p> <p>May stimulate broader community involvement.</p> <p>Makes a wider range of services available to communities including care and support.</p> <p>Shares skills and knowledge and builds consensus</p> <p>May influence social attitudes.</p> <p>Their small size gives them the ability to adapt to the changing realities of the population groups with which they work.</p> <p>CBOs often respond to very particular needs of specific communities that, for whatever reason, are not being served by government or NGOs.</p>
<p>Private Sector International/National</p> <p>(local examples include bars, hairdressers, barbers, tailors, commercial sex workers...)</p>	<p>Commercial distribution of condoms</p> <p>Information and Education</p> <p>New technologies</p> <p>Marketing/advertising</p>	<p>Businesses can improve the quality and impact of projects from the marketing lessons they have learned.</p> <p>Provide ready-made networks for distribution of IEC materials and other goods.</p>
<p>Mass Media including community radio stations</p>	<p>Disseminate key messages to sensitise, inform, educate and mobilise population</p> <p>Create demand</p> <p>Expose controversies and problems</p>	<p>Oxfam can ensure accuracy of messages and provide "expert" input</p>

Section 12

Resources and Annexes



Glossary

AIDS	Acquired Immune Deficiency Syndrome
ARV	Antiretroviral Drugs
CBOs	Community Based Organisations
DOTS	Directly Observed Treatment Short Course (for TB)
ERM	Emergency Response Manual
FGM/FGC	Female Genital Mutilation/Female Genital Cutting
GNP	Gross National Product
HAART	Highly Active Antiretroviral Therapy
HIV	Human Immunodeficiency virus
HDI	Human Development Index
MMR	Maternal Mortality Rate
MSM	Men who have sex with Men
MTCT	Mother to Child Transmission
PTCT	Parent to Child Transmission
PLWHA	People living with HIV and AIDS
SGBV	Sexual and Gender based Violence
STIs	Sexually Transmitted Infections
VCT	Voluntary Counselling and Testing
Incidence	refers to the number of times an event occurs in a given time, e.g. the number of new AIDS cases presenting each month or year, or the number of new HIV infections being detected during a specified period of time.
Prevalence	means the total number of specific conditions in existence in a defined population at a precise point in time, e.g. The number of AIDS cases or number of HIV infections which have so far been reported in your own country. The systematic collection of facts (data) about disease occurrence is part of surveillance. Prevalence for HIV/AIDS is usually measured as a proportion of the population aged 15 to 49.
'Mainstreaming'	the process through which institutional capacity to cope with and respond to HIV is increased. Mainstreaming requires an organisation to change and adapt its policies and practices to take account of working in a time of AIDS.
Integration of HIV	this refers to the inclusion of focused HIV work into existing programmes usually in the form of education for prevention but may also include treatment, care and mitigation work.

'Gender analysis' Looks at the impact of HIV/AIDS on women and men in relation to their roles and status in society. Analyses how social and power relations between men and women are reflected in the differences in their vulnerability to infection, and the relevance of HIV/AIDS interventions to their needs and roles in the household, communities, and at the macro level.

'Age analysis' Refers to the differential vulnerability to infection and its impact across different age groups, and within that across genders.

Syndrome a combination of signs and/or symptoms that forms a distinct clinical picture indicative of a particular disorder.

Seroconversion production of antibodies following exposure to the virus. Diagnosis is based on the detection of these anti-HIV antibodies in serum.

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Annexe 1: Condom Procurement

The Male Latex Condom: A guide for procurement

These notes attempt to provide a set of purchase specifications that ensures the highest level of safety consistent with high volume purchases, the needs of different population groups, harsh environmental conditions and the probability of less than ideal conditions of storage and distribution.

Condoms must be of a high enough quality to provide adequate protection against unwanted pregnancies and STIs including HIV.

Poor quality condoms risk the health and lives of the clients and also the reputation of the agency therefore always specify the quality of the product and verify the quality of the product before it is purchased. If a condom breaks during use it has **failed completely** and the user and partner are put at the same risk as if they had not used a condom.

A condom must be acceptable for its intended population. If is too wide, too narrow, not enough lubricant etc then it is not fit for use. It must have adequate strength and elasticity, be free from holes and have a package that remains airtight and hermetically sealed to protect it during its shelf life.

Do not use transparent packaging to show the colours of condoms, as this type of material is unsuitable for the protection of the condom in many environments.

Condoms can be coloured as long as the colour is firmly bounded to the latex and is not harmful.

Design requirements mainly concern local programme and consumer acceptability and should therefore be made in reference to the **consumers' preferences**.

The choice of the right supplier is a matter of critical importance. **Condom procurement is not like the procurement of other health care products**, because the manufacturers vary widely in their ability to produce high quality condoms on a consistent basis.

The supplier should be chosen on the basis of cost, quality of the product and the capacity to deliver in a timely fashion. When condoms are being procured directly from a manufacturer, a typical process including international competitive bidding, the pre-qualification process of suppliers and lot-by-lot compliance testing will take 12 to 16 months.

WHO does not recommend buying condoms from a commercial distributor or agent since such condoms are usually not traceable to their manufacturer, and quality issues are thus difficult to address.

This document reflects the *WHO specification* guides but programme managers should consciously review the requirements to ensure they are appropriate to the programmes needs.

The logistic team have the responsibility of ensuring that the condoms remain in peak condition once they arrive in the country.

Male Condom Specification

Width

WHO specifies a width of 49mm or 53mm with a tolerance of ± 2 for individual condoms and ± 1 for the average of the lot.

Length

Minimum condom length specified by WHO is 180mm for 53 mm width condoms and 170mm for 49mm width condoms.

Lubricants

The quantity of lubricant, including powder, in the condom package should be in the range 550 ± 150 mg (rounded to nearest 10mg). Too much lubricant can damage the hermetic seal of the condom package. Additional lubricant can be used **after** the condom is removed from the package immediately prior to use. Silicone lubricant should be used.

Spermicidal lubricant should **not** be used as they can cause irritation; they weaken the package, and can limit shelf life.

Avoid the use of “ultra thin condoms.

Packaging

The individual package should be square and not distort the rolled condom.

Packages must be opaque and not transparent.

Must include plastic layers and a layer of aluminium foil at least 8 micrometers thick.

Must be hermetically sealed and impermeable to oxygen, ozone, and water vapour, ultraviolet and visible light. If the sealed packages are in strips the individual packages are separated by perforations or other means that allow the packages to be separated by hand without interfering with the seal.

They should be marked with the manufacturers name, lot number, month and year of expiry

Shelf Life

The packed products should be stable for at least **3 years** when exposed to an average temperature of 35°C.

Exterior shipping cartons

The inner boxes should be packaged in plastic or other waterproof lining bags, which should be placed in three-wall corrugated fibreboard cartons made from weather resistant fibreboard with a bursting test strength of not less than 1900kPa.

The carton flaps should be secured with water-resistant adhesive applied to not less than 75% of the area of contact between the flaps or 75mm wide water-resistant tape applied to the full length of the centre seams and extending over the ends not less than 75mm.

Information markings should include the lot number, month and year of manufacture, month and year of expiry, manufacturers registered address, nominal width of condoms and the number of condoms in carton and instructions for storage. The text should be in the language specified by the purchaser.

Storage Guidelines

If condoms are hermetically sealed in aluminium foil and plastic laminated packaging and stored in cartons, they are robust with a shelf life of at least 5 years.

Stack cartons at least 10cm above floor level, on wooden or metal pallets, at least 30cm from the wall and other supplies and no more than 2.5metres high

Condom packaging should be printed with the manufacture date and the expiry date. The cartons should have the **lot number, month and year of manufacture, month and year of expiry, manufacturers registered address, nominal width of condoms** and the **number of condoms in carton**. The text should be in the language specified by the purchaser.

The packaging should be hermetically sealed aluminium foil packaging with a minimum thickness of 8 micrometers and layers of plastic material

Store away from oils, insecticides, chemicals, electric motors and fluorescent lights

Storage area should not have temperatures that exceed 35°C for extended periods

Store in a manner allowing “first expiry/first out”

Clean, well-lit and well-ventilated area, out of direct sunlight

Secure storeroom from water penetration

Protect areas from insects and rodents

Area should be properly secured

Checklist

Use a procurement agency (WHO, UNFPA) or Use IDA, PSI, ECCO?

Use existing local government contraceptive distribution programme (likely be limited to clinics)? Depends on reliability of system, likely to be disrupted in emergencies.

The factory should hold certificate of standard ISO 9000 (GMP)

Independent qualified testing should conduct the pre-qualification and lot-by-lot compliance testing

Ensure good storage conditions

Ensure rapid transportation under satisfactory conditions

Ensure good loading and unloading conditions, not exposed to environmental conditions

Ensure condoms distributed FIFO (First in, First Out)

Carry out regular random visual inspections on all levels of the distribution system

It is only possible to establish a system to manage complaints about condom quality if records of Lot numbers, distribution and storage are maintained. Documentary evidence should be asked for to verify the requirements.

Box 1: How many Male Condoms?²²

Condom needs can be calculated if you can estimate the following:

Take the size of target population (i.e. the refugee/displaced and the surrounding population)

Take 20% if this i.e. this represents approx the size of the sexually active male population

Then take the percentage of sexually active males using condoms using results from recent KAP surveys, for example. However, where the programme attempts to promote the use of condoms this will underestimate the needs. *(This step can be left out if no reliable data exists)*

Plan for 12 condoms per sexually active male per month as a minimum

Add 20% for wastage

Ensure a three-month supply available in the field, taking into account lead times for restocking.

E.g. a baseline calculation for procuring one month's supply of condoms for a refugee and adjoining population of approximately 10,000 people:

20% sexually active males	2000	=2000 males
20% using condoms	x0.2	=400 males
12 condoms per month per male	x12	=4800 condoms
+20% wastage	x0.2	=960 condoms
Estimated needs for one month	4800 +960	=5760 condoms

Different clients groups will have different needs (e.g. adolescents, commercial sex workers etc) but this can be estimated in the field in discussion with these groups.

Box 2: Standard or Specification?

Standards are usually developed by voluntary standards bodies, in collaboration with manufacturers and consumer groups. Occasionally regulatory authorities make them. The principal standards body is the International Organisation for Standardisation (ISO). A standard is concerned mainly with safety and security, covers only essential attributes and cannot be compromised.

A standard establishes a minimum level of quality that can ensure the safety and efficacy of the product.

A specification is a statement of the buyers' requirement and will cover all attributes of the product.

In some cases, the specification may demand a higher level of quality than a national standard and may have additional features such as discretionary design or packaging requirements.

The WHO specification guidelines are based when appropriate on ISO 4074 Standard for Latex Rubber Condoms.

National regulatory authorities issue standards; carry out audits; test products; have the authority to recall products and, with continued non-compliance, close factories.

²² Adapted from *Reproductive Health Care in Refugee Situations. AN interagency Field Manual UNHCR 1999*

Annexe 2 Choosing Partner Organisations

Emergency Response Manual

0.8 Counterpart Appraisal (Template)

General data:

Counterpart name:

Address:

Counterpart number:

Telephone, fax:

Counterpart since:

Email address:

Contact Person:

Is the potential partner registered under local and national law?

Appraisal of counterpart's record to date.

- 1) What are the main sectors/specialisation's the organisation is working in?
- 2) Does the potential counterpart have a satisfactory record in implementing programmes and projects. How many years experience with what types of projects?
- 3) Does the counterpart have a satisfactory record of working and/or advocating for social and gender equity within its field?**
- 4) Which geographical area does the counterpart normally work in?
- 5) Is the partner able or prepared to work outside their usual operating area?

Appraisal of counterpart capacity and structures

Quality and management of systems in general

Are the general management and systems of the organisation satisfactory?

Do they have their own Policy & strategy?

Do they have a written position or strategy on gender equity?

Is there adequate division of responsibilities in the leadership and delegation of authority to the different levels?

Are more than 30% of senior and middle management women and/or is the organisation actively seeking to appoint more women to decision making positions.

Are Programming systems in place (including Planning, Monitoring, & Evaluation)?

What effect will an emergency programme have upon the organisation and its current effectiveness?

Appraisal of relationship with beneficiaries

Is the counterpart's relationship with beneficiaries satisfactory, including ways of involving them?

Areas where each partner has a grass-roots presence

Does the partner have a well-known “constituency”, or community of interest, that any Oxfam team, from within or outside the region, needs to take into account when assessing the suitability of implementing impartial humanitarian programmes through them

What is the relationship with female and/or minority group beneficiaries (i.e. appropriate input from beneficiary groups participating in decision making processes around preparation, assessment, implementation, monitoring and evaluation of projects and programs).

Accountability to stakeholders, other than beneficiaries

Does the counterpart demonstrate adequate accountability to stakeholders (Gov. Bodies, relevant UN agencies, Inter-agency forums, Community Bodies), other than beneficiaries?

Quality of financial information and systems

Is there a sound financial management system, taking into consideration the following aspects?

Ethical and adequate financial policies and systems

Do the systems and procedures provide accurate information reflecting the true financial position of the project and the organisation? i.e. strategic plan, budgets, reporting, and audit reports)?

Do the chosen systems comply with the general accepted accounting principles as adopted for use in the country?

Is the organisation capable of managing and recording the proposed influx of resources?

Human resources

Staffing policies and practices

Are the staffing policies and practices appropriate and ethical, inclusive of gender and diversity, taking into account the required levels of expertise of and the conditions prevailing in the local labour market?

Staff expertise

Does the organisation have the general and technical expertise available that is appropriate and sufficient in view of its objectives, sectors and approaches? If not, are there adequate plans to address this in the near future?

What is the breakdown of the staff/specialities at present?

Summary of counterpart capacity and structures

In summary, does the counterpart have the capacity and structures (or the potential to build them) to develop and effectively manage the programme/project work envisaged?

Assessment in terms of Oxfam's humanitarian policies and aims

Is the Counterpart committed to the same humanitarian principles as Oxfam?

Is the counterpart committed to increasing social and gender equity?

Awareness and application of Sphere Project standards?

Knowledge of the Code of Conduct or Humanitarian Charter?

Adapted from “**APPRAISAL partners PPMSG section 9**” *Full document available from Programme Help Desk.*

1 Preliminary Appraisal

PRELIMINARY APPRAISAL - ESSENTIAL CRITERIA

The essential criteria to be checked are:

Will the project contribute to achieving the aims set out in the country/ regional and Oxfam strategic plans?

Does it comply with Oxfam’s charitable status? (See Appendix PM8-B - Charitable Status and Charity Law.)

Can the project be funded - from the existing budget or by fund-raising?

Does the Oxfam office have, or can it acquire, the resources to monitor and support the project?

Are the counterpart’s institutional aims and ways of working compatible with those of Oxfam?

If the answer to any of these questions is ‘no’, the project should be rejected. If there is any doubt about the answers to the questions, further enquiries or a visit to clarify the situation should be made before reaching a decision.

2 The Scale of the Appraisal

The factors influencing the scale of the appraisal will include:

The size of the project and the amount of Oxfam’s resources it requires;

Previous contact with the counterpart and the project sector/issue;

Previous appraisals;

Whether Oxfam staff have been involved in identifying and designing the project;

Whether it is a new project or a request for a supplementary grant.

The essential question when deciding on the scale of the appraisal is:

Given the circumstances, what are the key areas and concerns that Oxfam staff must assess?

3 The Appraisal of Counterpart Organisations

Appraisals of counterpart organisations, and potential counterparts, take place in a variety of circumstances:

When considering a particular project;

When Oxfam is looking to identify possible new counterparts in order to work together to develop and implement programmes (but there is no specific project being considered);

When assessing capacity-building needs in an on-going relationship;

When a counterpart wishes to conduct a self-assessment;

Where the request is for core funding.

The purpose of the appraisal should be clear to all involved; this is important to prevent misunderstandings and false impressions. The appraisal process should be appropriate to the circumstances and purpose of the appraisal.

The appraisal should include consideration of the culture, relationships and development approach of an organisation.

3.1 The appraisal process

The main areas to consider when planning the appraisal process will be:

How can the process be participatory and transparent?

Who is it necessary or appropriate to involve and how?

For assessing the counterpart's relationship with its beneficiaries, it will be essential to seek the views of the beneficiaries themselves.

3.2 The criteria for counterpart appraisal

In counterpart appraisals, it is suggested that the following broad aspects are considered, taking into account **the type of organisation** and **the situation** in which it is working:

CRITERIA FOR APPRAISING ORGANISATIONS

IDENTITY

What is the vision and purpose of the organisation?

By what values is it guided?

What is its legal status if any?

How is the organisation governed? What is the history of this?

What are the power structures and social relations of the organisation (internally & externally)? Do they encourage open communications and creativity?

What are the organisation's links and alliances with other organisations?

What is the position of women within the organisation?

What is the organisation's position on gender issues? What, if any, is its gender policy?

What is the likely potential of the organisation to evolve and change?

Considering the above: Does the organisation have a clear vision, purpose, principles and governance? Are these compatible with Oxfam's mandate, principles and charitable status?

RELATIONSHIP WITH BENEFICIARIES + DEGREE OF INVOLVEMENT

In what ways is the organisation accountable to and/or representative of its beneficiaries?

In what ways are beneficiaries involved in the organisation?

Are men and women beneficiaries involved in the identification, planning, implementation, monitoring and evaluation of projects?

What is the organisation's understanding of, and response to, the gender issues and gender relationships of its beneficiaries?

Considering the above: Is the nature of the relationship with the beneficiaries and their ways of

involvement satisfactory?

QUALITY OF MANAGEMENT AND SYSTEMS

What is the leadership style?

What is the structure of the organisation? Are accountabilities clear? Do staff feel empowered and involved?

What are the administrative systems? How efficient are they?

How good is the financial management?

* What is the quality of the systems and controls?

What assets and liabilities are there?

How good is their accountability to donors? (Reporting etc.)

What is their funding base? - What are other sources of income and who are other donors?

Are they able to mobilise new resources when required, or is there dependency on one source?

What experience or skills are there in project management?

Is there investment in staff training and development?

What are the personnel policies and practices of the organisation?

Are there any discriminatory practices?

Considering the above: Is the type and quality of management appropriate for the size and type of organisation? Is it appropriate for the project (if any under consideration)?

LEARNING AND ADAPTATION

Does the environment of the organisation encourage learning?

What type of monitoring and evaluation systems and ways of learning are there? How well do they function?

What evidence is there of learning and adaptation from past experiences?

Considering the above: Is there a recognition of the importance of learning? Is there a willingness to change and seek improvements?

KNOWN ACHIEVEMENTS (If any)

What have been their achievements in building the capacity of beneficiary groups?

What has been their record in poverty-focused interventions? Has there been a focus on poorer groups?

Have they contributed to influencing policy changes?

Have they proved able to respond quickly and appropriately to external emergencies?

What have been their achievements or experiences in the sectoral and specialist area of the proposed project?

What understanding of development processes and approaches does their work demonstrate?

PROJECT APPRAISAL QUESTIONS

1. What is the issue or problem under consideration?

Is there an explicit statement of the problem?

How was it identified and by whom?

2. What is the context of the issue or problem? Has it been sufficiently analysed?

What are the causes and associated problems?

What are the power and social relationships (local or national) that may have an influence?

What is its priority for the intended beneficiaries (or urgency if relief situation)?

What are the capacities of the intended beneficiaries and concerned organisations?

Are other organisations (NGOs or government) doing similar or related work and is there potential for cooperation or a risk of overlap? How does the proposal relate to other projects or programmes or change processes?

3. What is the main objective of the project? How does this address the issue or problem(s) analysed?

Have desired outcomes, of what the project can realistically try to achieve, been identified?

4. What are the wider changes that the project hopes to contribute towards in the longer term - the project aims?

Impact on the lives of the intended beneficiaries?

Change in the capacity of local/community institutions?

Would achievement of the main project objective be likely to contribute towards achieving these wider changes?

5. Who will benefit? Consider:

The processes of impoverishment and the levels of need of the intended beneficiaries.

Women, men, different age groups, different social groupings.

Numbers of beneficiaries.

Local/community institutions that will benefit.

6. What activities will take place and what outputs are sought? Are the intended outputs likely to contribute towards the achievement of the main objective?

7. Is the project design feasible and appropriate in terms of strategies, timing of events and practical and technical aspects?

Who will do What, When, Where, How? Are responsibilities and tasks clear?

Is the project size and scope compatible with the aim(s) and objectives?

Does the project plan include sufficient human and other resources?

8. What resources are requested... and what does Oxfam consider is needed?

Total cost of project? By year?

Are plans for income and expenditure realistic?

What is the capital cost?

What funds are sought from Oxfam?

What non-funding support is requested from Oxfam?

Are other sources of funding/support already guaranteed or sought?

What is the cost per beneficiary - where appropriate?

9. What has been, and will be, the extent of men and women beneficiary involvement?

Are the problems identified a priority area for them?

What has been the nature of their participation?

- How were they involved in identification and design of the project?

Will they be involved in project implementation, monitoring and evaluation?

Have women and men, and people of different ages and social groupings, been involved adequately?

10. Will a participatory monitoring system be established which will enable progress towards the main objective and aim(s) to be monitored, and learning and adaptation to take place?

11. What are the risks that may affect the project?

On what assumptions is the project design based?

What are the likely changes, influences or threats related to the project itself or the implementing agencies?

What are the likely changes, influences or threats in the external environment?

Does the project recognise these risks and take them into account?

12. Is there a possibility that the project may also have harmful or negative effects?

Will it negatively affect the environment, social structures or gender relations?

How can these be monitored?

What changes might reduce/compensate for these effects?

13. What is the likely sustainability of the benefits that the project hopes to achieve? Some factors to consider are as follows:

Are the intended beneficiaries adequately involved - women, men, people of different ages and social groupings?

What, and whose, capacities are being developed through the project?

Has the proposal addressed the social, economic, political, environmental and technological issues that could influence the sustainability of the project?

5.1 Do the project and the counterpart fit well together?

The advantage of the project/counterpart combination needs to be considered against possible alternative combinations (if there are any).

The position of the counterpart in relation to other counterpart organisations active in this geographic area or sector will need to be considered.

This does not mean that the project has to be undertaken by the strongest or most able counterpart; there may be strategic reasons for deciding to support a less experienced counterpart to undertake the work.

5.2 Identification of capacity-building needs and objectives

The development of capacity-building objectives should consider the following questions:

Are the needs contained in the proposal? Who identified them?

Who will benefit? Women? Men?

What are the desired outcomes?

What are the inputs required from Oxfam (funding/non-funding)?

Does Oxfam have the capacity to provide the support required?

What may be the wider and longer-term impact of this capacity-building?

Will the outcomes also benefit other programmes/beneficiaries?

What is the likely sustainability?

5.3 Does Oxfam fit well with the project and counterpart?

In some instances, Oxfam may not be the most appropriate source of assistance; there may be other funding agencies that are also considering the proposal and they may be better placed to provide assistance.

Key questions are:

Does Oxfam have the capacities, or can it develop the capacities, to support this project?

Is this an area where Oxfam has better skills and experience to offer than other agencies?

Is Oxfam likely to have an impact that other agencies cannot achieve?

Are there other agencies better placed to support this project?

7. Discussion of Oxfam's Requirements

It is important that the counterpart and Oxfam both understand their requirements and expectations of each other. If it looks probable that the project will proceed, the following topics (if they have not previously been covered), should be explained, discussed and agreed as appropriate.

The roles and responsibilities of Oxfam and the counterpart in implementing, monitoring progress and evaluating the project, including:

The frequency, and purpose of project visits and review meetings;

How the counterpart will monitor the progress of the project and its effects;

How indicators will be developed;

How the counterpart will learn from the experience;

When and how the project will be evaluated.

Oxfam's reporting and accounting requirements - to reflect Oxfam's accountability to donors and other stakeholders - including:

The timing and content of progress, annual and final reports;

The systems needed for project accounting and the timing and content of financial reports;

The flexibility allowed to the counterpart to make changes to the project or budget without reference to Oxfam;

An annual inspection of accounts if no independent audit is available;

The synchronisation of accounting and reporting cycles.

The possibility of donor funding being arranged by Oxfam, including:

Possible additional information, reporting, accounting, evaluation or visiting requirements;

Any objections the counterpart may have to funding from particular sources.

***Adapted from* 'TRAFFIC LIGHTS': A method for assessing and supporting the gender sensitivity of development organisations and their programmes. Implementation Proposal for Oxfam GB 2001-2**

The 'Traffic Lights' tool is a system developed by NOVIB for assessing its organisational practice on gender equity as well as that of its partners. There has been considerable interest from staff in Oxfam GB's international programmes in adopting this tool to enhance our practice on gender mainstreaming.

Partners: NOVIB have defined 7 criteria for assessing and selecting partners on the basis of their organisational commitment to addressing gender equity (see last page for criteria). A 'traffic light' system is used to rank, monitor and develop *all* partners against these criteria. Ranking is done during the annual planning process and during monitoring. Partners are ranked red (gender-blind), yellow (gender-aware) or green (gender-responsive) according to the number of criteria met. They are given support to improve their performance on these criteria and their progress is monitored. 'Yellow' partners, ie those who have already demonstrated an interest in improving performance, need a different type of support to 'red' partners who need more fundamental discussions on why gender should be an issue for them at all. If 'red' partners do not make progress toward positive change the partnership is eventually ended (in fact NOVIB has found that these partners need to be phased out anyway as they tend to show poor performance across the board.)

Gender Route System

31 long-term partners were selected to join the 'gender route' in 1995. This was a fast-track resource-intensive process for building the capacity of a few partners who already had a degree of gender-awareness and wanted to improve.

Lessons learnt

Early results broadly endorse the 'gender route' and 'traffic lights' system. Elements found to be crucial for organisational change are commitment of senior management, a strong gender infrastructure, gender equity in recruitment, and a culture of participation and consultation. Some changes to the 'traffic lights' will be suggested including a refinement of criteria, the weighting of criteria against one another, and how to ensure the systematic and consistent application across programmes.

Implementation in Oxfam GB

This section looks at how we can begin to adopt the 'traffic lights' and 'gender route' methods in Oxfam GB. Some regions have already begun the process of assessing the traffic light criteria as a tool for supporting gender mainstreaming.

At a recent workshop the UK Poverty Programme team debated the applicability of the criteria. There was considerable interest in 'traffic lights' as a useful tool, particularly to start debates with partners and to demonstrate to policy-makers some of the key issues involved in gender mainstreaming. Several suggestions for adapting the criteria were made including the following: 30% of women in management does not make sense in a context where men's participation in community projects is low; we need to include diversity, the empowerment of women, make the link to poverty more explicit, and address the inclusion of men on gender equity; criteria need to be weighted as to their relative importance; disaggregated data needs to be not only collected but used to inform programme plans.

Partner Criteria (for assessing gender sensitivity)

Active exchange of knowledge and information, or co-operation with others on gender issues and approaches takes place

More than 30% of senior and middle management are women and/or the organisation is actively seeking to appoint more women to decision-making positions

Gender-disaggregated baseline, monitoring and evaluation information is collected

A gender analysis has been developed and is reflected in policy, which in turn informs the development and implementation of all programmes and policies

Sufficient and appropriate gender expertise exists within the organisation

Women beneficiaries participate in decision-making process in planning, implementation, monitoring and evaluation of projects and programme

Activities challenge the division of labour between women and men, as well as stereotypes of masculinity and femininity

Green = 6-7 Gender responsive

Yellow = 3-5 Gender aware

Red = 0-2 Gender blind

Project Criteria

Women have equal participation in decision-making processes

Women have increased access to and control over economic and natural resources, and basic social services

Women have increased control over their own bodies

Women's organisations are established and/or strengthened

Women and men are sensitised on gender issues, and gender stereotypes are challenged

Minimum number of criteria to be met = 2