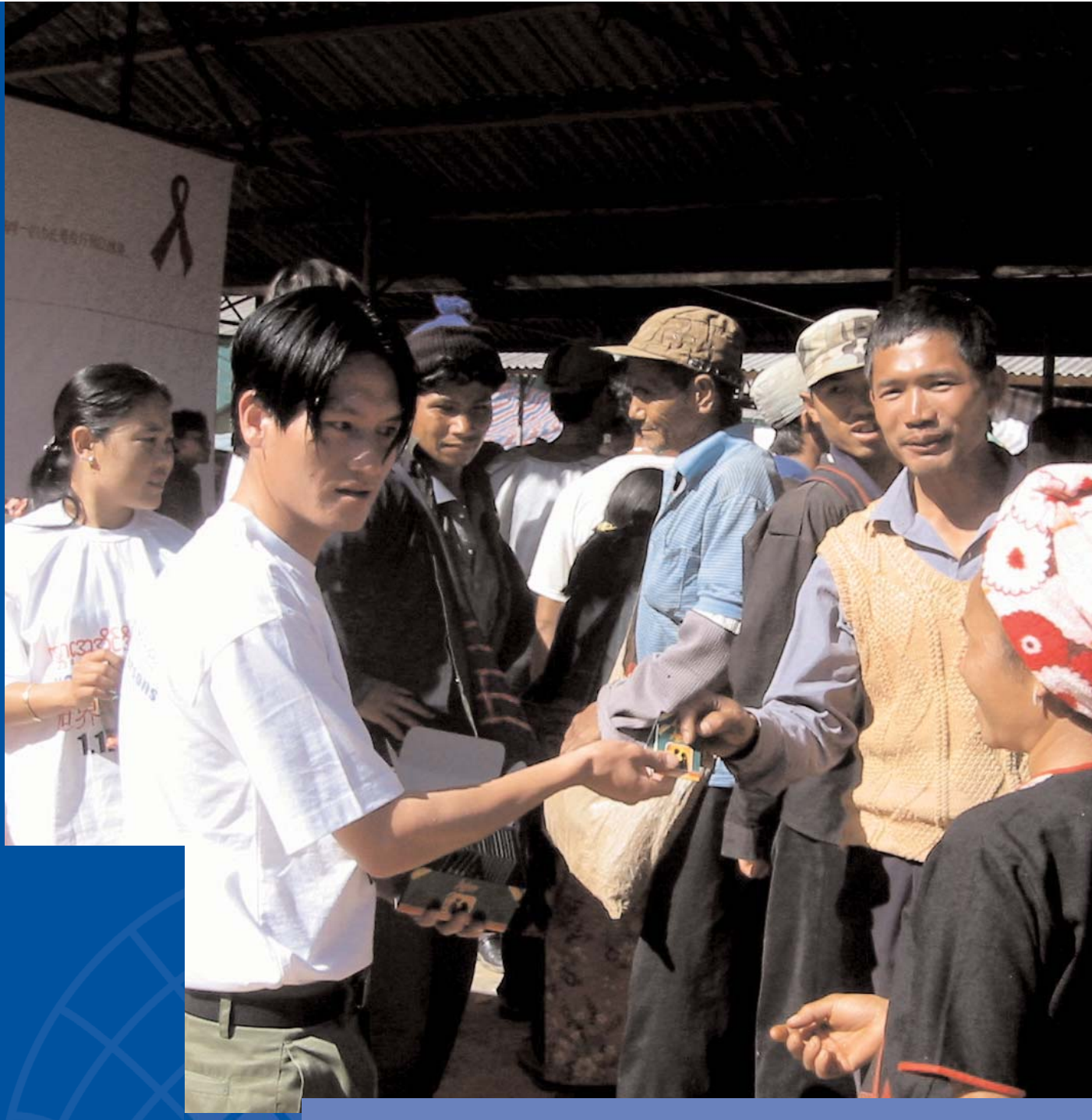

A Review of DG ECHO's Approach to HIV | AIDS

CONCEPT PAPER

EUROPEAN COMMISSION

Humanitarian Aid

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CONCEPT PAPER

A Review of DG ECHO's Approach to HIV/AIDS

A. Concept Paper

Table of Contents

(B. Model Guidelines - separate document)

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This document has been financed by and produced at the request of the European Commission. The comments contained herein reflect the opinions of the consultants only. The Concept Paper is meant to be a living document. HIV/AIDS-related situations will change over the years, and so will responses; the approach recommended below should therefore be considered valid for 2005 only. Regular updates will be necessary, and the contribution of ECHO field experts in this continuous exercise will be essential.

CONCEPT PAPER

ACRONYMS

ADB	Asian Development Bank
ALA	Asia and Latin America
ART	Anti-Retro Viral Treatment
ARV	Anti-Retro Viral
CCM	Country Co-ordination Mechanism
CDC	Centres for Disease Control and Prevention (US)
DG DEV	Directorate-General for Development
DG RTD	Directorate-General for Research
DIPECHO	DIsaster Preparedness ECHO
EC	European Commission
ECHO	European Commission Directorate-General for Humanitarian Aid
EDCTP	European and Developing Countries Clinical Trials Partnership
EDF	European Development Fund
EIB	European Investment Bank
EU	European Union
FAFA	EC-UN Financial and Administrative Framework Agreement
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GNA	Global Needs Assessment (ECHO)
HAART	Highly Active ART
HIV / AIDS	Human Immuno-Deficiency Virus/Acquired Immune Deficiency Syndrome
IASC	UN Inter-Agency Standing Committee
IAVI	International AIDS Vaccine Initiative
ICRC	International Committee of the Red Cross and the Red Crescent
IFRC	International Federation of the Red Cross and the Red Crescent
IPM	International Partnership for Microbicides
LFA	Logical Framework Analysis
LRRD	Linking Relief, Rehabilitation and Development
NGO	Non-Governmental Organisation
MAP	Multi-Country HIV/AIDS Program (World Bank)
MEDA	EU financial instrument of the Euro-Mediterranean Partnership
PEPFAR	President's Emergency Plan for AIDS Relief (US)
PFA	Programme for Action (EC)
PLWHA	People Living With HIV/AIDS
PPTCT	Prevention of Parents-To-Child Transmission
STI	Sexually Transmitted Infection
SMART	Specific Measurable Accepted Realistic Timed (indicator)
TB	Tuberculosis
TRIPs	Trade Related Aspects of Intellectual Property Rights
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNHCR	United Nations High Commissariat for Refugees
UNICEF	United Nations Children's Fund
WFP	Word Food Programme
WHO	World Health Organisation
WTO	World Trade Organisation

CONCEPT PAPER

A.1. SITUATION

HIV/AIDS presents new challenges for humanitarian aid and development efforts. The threat is global, though regional specificities in causal factors have so far produced various levels of impact. Its effects on already existing humanitarian situations are particularly devastating, but all interventions need to be considered in a long term perspective.

A.1.1. Background

The HIV/AIDS virus (Human Immuno-Deficiency Virus/Acquired Immune Deficiency Syndrome) was first identified in 1983. Over the past 20 years HIV/AIDS has become a pandemic, killing an estimated 23 million people and infecting perhaps 45 million. Examples of successful responses are still scattered (Uganda, Brazil, Thailand) and the virus continues its progression. UNAIDS (Joint United Nations Programme on HIV/AIDS) statistics indicate that more than 5 million persons[1] were infected in 2003, the worst result so far. Despite efforts, a cure has yet to be found. HIV/AIDS has been declared a global health emergency by WHO in October 2003.

Sub-Saharan Africa is by far the worst affected area and where the pandemic has become the leading cause of suffering and death. Out of 40 million[2] PLWHA (people living with HIV/AIDS) worldwide, between 25 and 28.2 million are to be found in that region –as well as two-thirds of the newly infected (especially women and children) and more than 12 of the 14 million related orphans. The situation is particularly dramatic in **southern Africa** where factors such as political weakness, economic migrations, poor education and culturally-induced behaviours have combined to produce 30% of all PLWHA. HIV/AIDS is by nature a cross-regional problem, against which any national or political barriers to a concerted response are irrelevant and need to be overcome. The pandemic has now reached a stage in southern Africa where high prevalence levels[3] threaten the livelihood of populations and the political stability of already fragile countries.

Rising threats are to be found in other regions, especially in Asia and Central Asia. They are often of less direct concern for ECHO humanitarian interventions, since governmental capacities are generally much stronger than in Africa –at least potentially. There are exceptions, though (Burma, Tajikistan), and appropriate policies still often need to be enacted (to the exception of Thailand or Cambodia).

- The pandemic is rapidly expanding in **Asia**, where 60% of the world's population is living. **India,** with an estimated 5.1 million PLWHA, is home to one in seven HIV-positive people worldwide already. Although prevalence rates are still quite low compared to Africa, sharp increases in HIV infections are found e.g. in **China** (30% yearly), **Indonesia** and **Vietnam.** The **Philippines** had a reported prevalence rate of only 0.1% in 2001, but present a very high potential for explosion, with major concerns such as risky behaviours and 7 million migrant workers. **Burma**[4] may develop one of the most serious epidemics in Asia, and protests against the local Junta dictatorship is preventing most overseas assistance.

[1] Actual figures are thought to range between 4.2 and 5.8 million. Source: UNAIDS epidemic update, December 2003.
[2] Actual figures are estimated to range between 34 and 46 million. Source: cfr. supra.
[3] See table 1 (prevalence levels) in the Guidelines.
[4] Burma has the third-highest incidence of infection in South-East Asia, after Cambodia and Thailand. Rates among injecting drug users are among the highest in the world, reaching up to 91% on the Chinese border. Source: "HIV/AIDS and emergencies: analysis and recommendations for practice", ODI/HPN, Feb. 2002.

- According to World Bank estimates, infection rates in **Russia** (1.3 million infected and over 3 million drug users) and in the five **Central Asian** countries -including **Tajikistan** where ECHO is present- might be among the highest in the world. Central Asian republics lie across a major drug trafficking route to Russia and to the EU. Although Tajikistan had a reported prevalence rate of only 0.01% in 1999, risk factors include drug users, poverty and political unrest resulting in increased migration. 40% of blood donors in 2002 were not tested.
- In **Latin America**, some 1.6 million people are living with HIV though the epidemic still tends to be concentrated mainly among injecting drug users and homosexuals. Brazil - the region's most populous country and home to more than one in four PLWHA – has set up a strong national policy and prevalence has been kept well below 1%.

A.1.2. Trends

Reliable projections are still not available, and impact analyses supported by UNAIDS are generally deemed insufficient. Nevertheless, the general opinion can be summarised by "better to prepare for the worst". Scenarios for Africa, a dedicated project recently initiated by UNAIDS[5] should provide more adequate information as from the end of 2004. Some statistical projections are available, though. The sub-Saharan region of Africa should see 6 million people die in 2004, and by 2010, unless effective action is taken to prevent it, the cumulative toll is expected to rise to 45 million. The number of orphans is expected almost to double in the next six years, rising to 25 million orphans globally in 2010[6].

Again, Africa is not alone, and a recent report[7] stated e.g. that by 2010, China could have as many as 10 million infections and 260,000 orphans without a more decisive policy. The economic costs of the virus in Asia and the Pacific region could have risen to US$17.5 billion annually, and the result would be millions more people thrown into poverty. Even in Thailand, which has developed a strong response to HIV/AIDS, analysis suggests that between 2003 and 2015, the pandemic may slow poverty reduction annually by 38%, unless appropriate measures are taken. During the same period, poverty reduction could slow by 60% a year in Cambodia and by nearly a quarter in India.

Although global donor spending on AIDS has increased 15-fold from US$300 million in 1996 to just under US$5 billion in 2003, it is less than half of what will be needed by 2005 (US$12 billion) in developing countries for prevention and care. Up to US$20 billion might be needed by 2007 to provide antiretroviral (ARV) therapy to six million people (over four million in sub-Saharan Africa), support for 22 million orphans, voluntary counselling and testing for 100 million adults, school-based AIDS education for 900 million students and peer counselling services for 60 million young people not in school. About 43% of these resources will be needed in sub-Saharan Africa, 28% in Asia, 17% in Latin American and the Caribbean, 9% in Eastern Europe, and 1% in North Africa and the Near East.

[5] See reference and comments in Annex D of Model Guidelines.
[6] Source: UNAIDS/UNICEF, 2002.
[7] Asia Pacific's Opportunity: Investing to Avert an HIV/AIDS Crisis, UNAIDS and ADB, 2004.

A.1.3. HIV/AIDS and Humanitarian Aid

Recent studies[8] have highlighted the particularly devastating effects of the pandemic as a self-feeding process in the context of complex humanitarian crises, in which ECHO is usually already present. HIV/AIDS is most easily spread in contexts of poverty and violence. During such crises, HIV/AIDS continues to spread through poverty (prostitution as last coping mechanism) or violence (mass rape as weapon of terror) and kills even faster among victims of armed conflicts, droughts or floods, displaced persons and children. It affects negatively food security, access to water and sanitation, and social cohesion; it makes poor communities even more vulnerable to other shocks. As a result, humanitarian actors are increasingly faced with the impact of HIV/AIDS on their targeted beneficiaries and hence on the effectiveness of their programmes. In failing to take HIV into account from the earliest stages of the planning and implementation of an emergency response, and in failing to use a comprehensive range of available multi-sector responses, levels of infection are likely to grow in previously low-prevalence areas. Furthermore, the pandemic attacks mostly young adults in their peak production years, those who are essential to a society's economic sustainability and political stability. In southern Africa in particular, the unprecedented devastation far exceeds the ability of the societies to cope by using only their own resources (one of the pre-conditions for humanitarian intervention) and could lead to their eventual disintegration, paving the way for potential future crises of even larger scale and complexity - and more ECHO interventions. The crisis of southern Africa is an illustration of the need for prevention and preparedness, in order to keep prevalence rates at low levels before it is too late.

Source: ECHO Photo Library

[8] i.a. HIV/AIDS and humanitarian action, ODI/ HPG research report, Apr. 2004; HIV/AIDS: What are the implications for humanitarian action? A Literature Review, ODI/HPG, Jul 2003.

A.2. RESPONSES

As a consequence of HIV/AIDS challenges, the borders between mandates and activities of many development and humanitarian actors have become blurred, hence the presentation below will be made by alphabetical order. It includes only some of the major global stakeholders, since an extensive list would be far too long for the present document. With a few exceptions (UNAIDS was launched in 1996), most of the programmes and initiatives are quite recent and are still undergoing a difficult internal learning process.

A.2.1. Key Global Actors

The **Global Fund** or **GFATM** (Global Fund to Fight AIDS, Tuberculosis and Malaria) was created in 2002 to attract and disburse resources to prevent and treat the three pandemics, as a partnership between governments, civil society, the private sector and affected communities. The Secretariat is based in Geneva. The European Commission and some EU Member States (France, Italy, Germany, UK, the Netherlands, Sweden) are among the major contributors, after the USA. The Global Fund launches 1-2 calls for proposals per year, in a process lasting 3-4 months before decision. Commitments are divided into four categories, the first two of which allow either immediate disbursement or requires first some clarifications. GFATM has put much emphasis on local ownership, e.g. through CCM (country co-ordinating mechanisms) and National Strategic Plans. Any non-CCM proposal (e.g. made directly by an NGO) must demonstrate clearly why it could not be considered under the CCM process at the country level, and the GFATM Board requires validation of these reasons. The Fund also applies four "sine qua non" conditions of management efficiency to accept a proposal[9].
However, local co-ordinating and managerial structures -especially in the most vulnerable countries- are still often very weak. Unrealistic GFATM expectations concerning local implementation and management capacity have often hindered access of recipients to available funds, or implementation of many accepted projects[10]. Furthermore, aiming at all three health targets (HIV/AIDS, TB and malaria) often creates conflicts of interest and overlapping of responsibilities by setting up a multitude of country co-ordinating bodies. As a result, the disbursement rates of the first three rounds of proposals are low. A learning process has taken place, but the gap between commitments and disbursements is still steadily increasing[11].

The **IASC** (UN Inter-Agency standing Committee) has published in December 2003 the "Guidelines on HIV/AIDS in emergency settings" (a version in French is expected by mid 2004).

[9] (i) An adequate financial management system (if this is too weak, e.g. for some African governments, some of the funds can be used for capacity building), (ii) an institutional programmatic structure ("who does what"), (iii) a procurement plan if necessary, and (iv) an M&E system.

[10] E.g. by UNICEF in Somalia (delay of almost 2 years for disbursement after approval of proposal by the Global Fund), or MdM in Cambodia and Ethiopia (delays of 18 months in both cases, mainly due to weak national management capacities at MoH level).

[11] Disbursements are expected to reach approx. US$2 billion in the 4th quarter of 2005 against commitments of nearly 5.5 billion; figures for the 4th quarter of 2004 are "only" 1 billion and 3.5 billion US$ respectively.

The guidelines present a common framework of multi-sector activities (the Matrix) agreed by all UN Agencies. Although their implementation and thus effectiveness depends heavily upon the quality of country teams (the agencies present, resources available, level of co-ordination), the guidelines are a key tool for co-operation at international and national levels in prevention and response to HIV/AIDS and wereill be consuslted as an input for ECHO's 'Model Guidelines'.

The **IFRC** has been supporting individual HIV/AIDS projects since the mid-1980s, though these have so far lacked the consistency and scale to make a significant impact on the pandemic. The IFRC has carried out a review of its policies, strategies and programmes in 2001[12] which outlined a number of shortcomings in this very large organisation, such as a lack of communication (e.g. in the dissemination of data and lessons learnt) between Secretariat and National Societies. The latterest have the responsibility to develop their own HIV/AIDS and/or health policies, to ensure that their practices are in conformity with the WHO and UNAIDS standards, and to encourage their governments to adopt such policies. Following its mandate, the **ICRC** is focusing on the less accessible areas (front lines) and on prisoners who are also highly vulnerable to contagion.

UNAIDS (the Joint United Nations Programme on HIV/AIDS) was created in 1996 by five UN agencies (UNDP, UNESCO, UNFPA, UNICEF, WHO) and by the World Bank who combined their efforts for a more effective global response. UNAIDS is not a funding instrument but the main advocate for global action on the epidemic. It aims at strengthening and supporting initiatives of prevention and care, and has established working units in most countries affected. UNAIDS can therefore be one of the main actors in HIV/AIDS policy development, technical support and co-ordination of country response, depending on the skills of its country team. UNAIDS is also promoting the "Three Ones" principles to enhance international co-ordination by applying (i) one agreed Action Framework for co-ordinating the work of all partners; (ii) one National AIDS Co-ordinating Authority with a multi-sector mandate; (iii) one country level M&E system.

UNHCR has focused its HIV/AIDS-linked assessments and activities on refugee caseloads. Protection of refugees during exile and repatriation to the regions of origin, where prevalence levels might be significantly different, are considered as the key issues in the 2002-2004 Strategic Plan. Studies have i.a. been carried out on refugees from south Sudan in the camp of Kakuma in Kenya, and on Angolan returnees from Zambia, DRC or Namibia. In all cases, it has been found that refugees have been relatively protected and that prevalence in the camps had been kept at a lower level than in the surrounding host population[13]. Several reasons were identified, i.a. (i) during protracted crises, refugees originating from low prevalence areas were relatively isolated from the epidemic in camps; (ii) thanks to protection efforts, camps often provided better education, awareness and medical structures than either host or return areas. To facilitate return,

[12] Rapid desk review of HIV/AIDS policies, strategies and programs of the IFRC, March 2001.

[13] In northern Kenya, HIV prevalence rate among refugees is 5% against 18% in the local population. Angolan refugees in the camps in Zambia and Namibia have an estimated rate of 5-10%, compared with 15-25% for the local populations. Source: UNHCR HIV/AIDS and Refugees, Misperceptions and new approaches, Jul 2003; Summaries of Missions and Workshops Jun 2002 – Jul 2003.

re-integration and to mitigate possible stigma, UNHCR has developed "repatriation packages" that include information, condoms and peer education, as well as monitoring tools e.g. for Universal Precautions.

In its medium-term Strategic Plan for 2002-2005, **UNICEF** has considered HIV/AIDS as a key priority. The Agency is trying to prevent new infections and to care for children infected and affected by the pandemic, more specifically in situations of armed conflict. UNICEF has focused its activities on priorities such as to assess and analyse the key causes of vulnerability to HIV/AIDS, to advocate protection, to support co-ordinated actions of prevention, information and protection, and to monitor effectiveness of actions.

The **USA** is the single largest donor to both GFATM (total pledges to date of US$1.969 billion) and to UNAIDS (US$129 million from 1995 to 2003). The Secretary of Health and Human Services is also providing global expertise through the national **Institutes of Health** and the **Centres for Disease Control and Prevention** (CDC) based in Atlanta, Georgia. The main[14] US programme is the so-called "Bush Initiative" or **PEPFAR** (the President's Emergency Plan for AIDS Relief). PEPFAR's budget is: US$15 billion, over 5 years. 20% of the amount is to be spent on prevention campaigns, and the remainder on treatment of the most vulnerable victims –especially children- in 15 countries, 12 of them in sub-Saharan Africa. The plan aims at treating 2 million HIV-infected victims with ARVs (200,000 already to be treated by the end of 2004), preventing 7 million new infections, and caring for 10 million other HIV-infected and AIDS orphans. However, PEPFAR is widely seen as a highly political tool. A possible related aim of the programme is also to support the American private drug industry (the medicines used must be approved by the US Food and Drug Administration and most generics would therefore be excluded, even those already approved by WHO). It has also religious criteria: 1/3 of the prevention money (US$1 billion) must be spent on programmes of sexual abstinence, in which the role of condoms is likely to be secondary. Rapid disbursement pressure led to problems of management overloading (CDC has recently been called in to monitor projects, since staff and US NGOs could not cope), of absorption capacity (Botswana), and complaints from recipient authorities about lack of consultation (Kenya).
Large private foundations were initiated i.a. by Bill and Melinda Gates (who contributed US$100 million to the Global Fund), Merck, Soros, Ted Turner, etc. The **Clinton Foundation** is mainly a facilitation body, without actual funding capacity; it is e.g. successfully helping to negotiate reductions of ARV (see foot note 24 and Annex B to the Guidelines, chapter 3.2).

Focusing its strategy on food insecurity brought on by HIV/AIDS, **WFP** has produced in 2003 a policy and a set of programming guidelines[15]. The agency wants to use adapted food aid and nutrition to provide a safety net to catch families before they become destitute, and thus even

[14] There are other US programmes such as e.g. CORE (Communities Responding to HIV/AIDS Epidemic), a USAID-funded initiative in co-ordination with CARE International (leading agency) and a large number of US NGOs and health organisations. CORE aims at responding to community needs with a multi-sector approach (livelihood, HR, IGP, food security, education, health, gender), pilot projects, capacity building and M&E.

[15] Programming in the era of AIDS: WFP's response to HIV/AIDS, WFP policy issues, January 2003.

more vulnerable to the risk of infection, with emphasis on women, orphans and affected children, and displaced persons. WFP has decided i.a. to incorporate (i.e. to mainstream) HIV/AIDS in all of its programming categories (country, regional, etc) and to adjust programming tools such as needs assessment, vulnerability analysis, design of rations and other nutrition-related activities in accordance with upgraded information and lessons learned. Proposed approaches include to set up alternative school feeding programmes, livelihood diversification to increase food security, reducing vulnerability of families (ensuring good nutrition, home-based care, prevention of parents-to-child transmission), etc. However, most measures are still being developed or adapted (rations, assessment tools), and WFP's own staff and human resources policy needs significant improvements (e.g. regarding sub-contracted truck drivers).

A key initiative led by **WHO** is the ambitious "Treat 3 Million by 2005" (3 X 5) programme, launched in 2003 after the global health emergency declaration, made with UNAIDS and GFATM, about the lack of access to ARVs in poor countries. WHO wants to start providing a fixed dose of ARV regimen to all people with HIV symptoms, to be delivered and monitored by health care workers, clinical officers, or community volunteers. 3 X 5 is following a rights-based approach, emphasising the "right to know" to turn around attitudes towards HIV testing, and the access to treatment as a human right. The programme has however been faced so far with a lack of funds, as well as the -already mentioned- lack of capacity in recipient countries.

In September 2000, the **World Bank** launched the **Multi-Country HIV/AIDS Program** (MAP) for Africa, another major source of global funding. Findings indicated that most sub-Saharan African countries had not made progress in reversing the spread of the epidemic despite having national plans, for several reasons, i.a.: inadequate government commitment and leadership, not enough resources had reached communities, and programs were too narrowly focused on the health sector. MAP was therefore created to boost access to HIV/AIDS prevention, care, and treatment programs, with emphasis on vulnerable groups (youth, women of childbearing age, etc). A key feature of MAP is direct support to community organisations, NGOs, and to the private sector for local HIV/AIDS initiatives. An initial amount of US$500 million (MAP 1) was made of flexible and rapid loans against simple eligibility criteria. A 2nd phase (MAP 2) was launched in 2002 with a similar amount in grants. So far, 28 African countries and three regional programs have received funds, and MAP projects are being prepared in another ten African countries. World Bank efforts are supported by other regional development banks such as the **Asian Development Bank**. ADB has earmarked US$140 million from its Asian Development Fund as grant money for combating HIV in Asia and the Pacific.

A.2.2. European Commission Activities in the Field of HIV/AIDS

A rather large number of related legal instruments have been issued in recent years by the EU, such as:

- European Community's Development policy;
- Council Regulation EC 550/97 on HIV/AIDS-related operations in developing countries;
- COM(2000)585 "Accelerated action targeted at major communicable diseases in the context of poverty reduction";
- COM(2001)96 "Programme for Action" (PFA), followed by its update COM(2003)93;
- Regulations 1567/2003 and 1568/2003 (see point 2 below);
- COM(2002)129 "Health and Poverty Reduction in Developing Countries";
- COM(2002)0592 "Council Regulation to avoid trade diversion", and more recently
- COM(2004)726 "A Coherent European Policy framework for External Action to Confront HIV/AIDS, Malaria and Tuberculosis".

In this framework, the Commission has been using six main funding approaches. DG DEV has become the overall co-ordinator for the PFA (Programme for Action) which covers some of these approaches, ei.ga. the contributions to the Global Fund,, or and the EDCTP. A Task Force to work on a "Harmonisation Action Plan for Health, HIV/AIDS and Education" has also been established. The approaches are set up below.

1. Country, regional or inter-regional European Development Fund (EDF), funds for Asia and Latin America (ALA) and MEDA (the principal financial instrument of the European Union for the implementation of the Euro-Mediterranean Partnership) programmes in the health sector, though amounts are relatively limited[16] for global needs (e.g. compared to macro-economic support in the social sector), disbursement rates are often low, and health includes a number of sector components besides HIV/AIDS. It should be noted that "Programme Guidelines for Health, AIDS and Population" were included in all Country Strategy Papers and National Indicative Programmes in 2002.
2. Two specific budget lines: line B7-6311 "HIV/AIDS, malaria and TB" with Regulation 1568/2003 has seen its budget increased threefold in 2003, to €73.35 M. In parallel, line B7-6312 on "Aid to population programmes" now includes "reproductive and sexual health and rights" (Reg. 1567/2003).
3. The EDCTP programme (European and Developing Countries Clinical Trials Partnership) managed by DG RTD (Research), with a budget of €600 M[17]. The objective is to accelerate the development and evaluation of new vaccines, drugs, and other preventive and therapeutic tools against HIV/AIDS, malaria and TB. The first call for proposals was launched in 2004.

[16] The 9th EDF has allocated €280 M (3.7%) for "health as a focal sector", and €25 M for a partnership with WHO on regional co-operation and capacity building on drug policy and regulatory schemes. €335 M have also been secured from intra-Africa Caribbean Pacific (ACP) funds on communicable diseases. Health programming in 2002-4 represents 2% of MEDA funds, 14.1% of ALA (Asia and Latin America) funds for Asia and 1.9% of ALA in Latin America. The current multi-annual provisions for all developing countries on "health and population" amounts to €423.2 M (less than 3.3% of the total EC development aid programming).

[17] €200 M from DG RTD/FP6, €200 M from Member States and €200 M –hopefully- from the private sector. In its 5th Framework Programme (FP5, 1998-2002), DG RTD allocated more than €109 M to research on HIV/AIDS, malaria and TB. Out of 77 projects funded, 32 concerned HIV/AIDS. FP6 (2002-2006) has allocated €400 M to the same fields.

4. NGO Co-Financing budget line No 21 02 03.
5. Humanitarian aid through DG ECHO.
6. Contributions to the Global Fund and other global Initiatives. The Commission has pledged €460 M (incl. From EDF) to the Global Fund 2002-2006 and is one of the three major contributors. Figures from DG DEV[18] indicate that, out of total pledges to GFATM of €3.93 billion in July 2003, €2.20 billion (55%) came from the EU (EC and MS), and €1.38 billion from the USA[19]. The challenge for the future is that the money is being spent with optimum effectiveness, i.a. aid is prioritised to those most in need.

At field level, contributions to the Global Fund appear as the main source of earmarked funding for HIV/AIDS. Country and regional programmes are facing a number of constraints. Despite some recent budget increases, the two special budget lines could barely commit the available amounts needed to cope effectively with the pandemic at country and/or regional levels[20].
In addition, a number of other relevant programmes and initiatives should be mentioned, such as:

- the "Tiered Pricing Programme" of DG TRADE for reduced-price drugs against AIDS, TB or malaria in poor countries. The programme has met limited success so far. DG TRADE is also covering the relevant aspects of the WTO agreement on Trade Related Aspects of Intellectual Property Rights (TRIPs) (with DG MARKT);
- support to the International AIDS Vaccine Initiative (IAVI), to the International Partnership for Microbicides (IPM);
- TACIS is trying to prioritise and co-ordinate HIV/AIDS actions through the New Neighbourhood instrument and initiatives such as the Northern Dimension Partnership and Wider Europe;
- RELEX has developed a €5 M programme in Burma/Myanmar, and
- EIB is considering financial support to local production capacity of condoms in South Africa.

[18] "The European Union confronts HIV/AIDS, malaria and tuberculosis, a comprehensive strategy for the new millennium" EC Nov. 2003.

[19] The financial statement of 31/12/2003 from the World Bank for the period running from May 2002 (inception) to December 2003 is slightly different: USA was the first single largest donor with US$ 622,725,000 out of US$1,729,202,748, the European Union being second with US$349,470,885. To this should be added the donations of 14 EU MS (approx. US$628 million).

[20] As stated by MdM, the global budget of the HIV/AIDS line in 2002 could hardly be compared with a single country programme of GFATM.

CONCEPT PAPER

A.3. POSITION OF ECHO

A.3.1. Legal Framework and Complementary Policies

The Council Regulation (EC) 1257/96 which defines the objectives and modus operandi of ECHO, includes general provisions that can also be applied to define a relevant role in fighting HIV/AIDS. In particular, the following statements should be highlighted in the Chapter I, mirroring similar commitments in the preamble.

- (Article 1) The Community's humanitarian aid shall comprise *assistance, relief and protection* operations (…) to help people in third countries, *particularly the most vulnerable among them, and as a priority those in developing countries*, victims of *exceptional situations or circumstances comparable to natural or man-made disasters*. It shall do so *for the time needed to meet the humanitarian requirements resulting from these different situations*. Such aid shall also comprise operations to *prepare for risks or prevent disasters* or comparable exceptional circumstances.
- (Article 2) The principal objectives of the humanitarian aid operations referred to in Article 1 shall be:
  (a) *to save and preserve life during emergencies and their immediate aftermath* and natural disasters that have entailed *major loss of life, physical, psychological or social suffering* or material damage;
  (b) to provide the necessary assistance and relief to *people affected by longer-lasting crises* (…) especially where *their own governments prove unable to help or there is a vacuum of power;*
  …(d) to carry out *short-term rehabilitation and reconstruction work* (…) with a view to (…) *preventing the impact of the crisis from worsening and starting to help those affected regain a minimum level of self-sufficiency, taking long-term development objectives into account where possible*.

The Article 2 further mentions *population movements*, *repatriation* and *preparedness for risks*; Article 4 covers *preparatory and feasibility studies*, small-scale *training schemes* (…), *public awareness and information campaigns* (…).

To better adapt its approach to challenging field requirements and to upgrade definitions of "humanitarian space", ECHO has further defined a number of complementary policy measures.

- Results-oriented and needs-based approach (as opposed to the rights-based approach adopted e.g. by UN agencies), Specific Measurable Accepted Realistic Timed (SMART) objectives and Logical Framework Analysis (LFA).
- Non-emergency ECHO decisions that can have a duration of twelve months –or eighteen where justified (the Regulation mentions only emergency actions with a duration of six months).
- DIPECHO for preparedness, mitigation and advocacy.
- Focus on low visibility or forgotten crises, where relatively small amounts of funding can have major effects.
- Focus on children.
- Global co-operation frameworks with UN and other actors, (e.g. EC-UN Financial and Administrative Framework Agreement (FAFA), follow up of the Good Humanitarian Donorship initiative.

- LRRD has been the subject of a specific Communication[21] and further assessments. It is of particular relevance for HIV/AIDS, considering the necessary long-term perspective of HIV/AIDS related activities, and the presence of ECHO among the six main funding approaches in the Commission's response. Indeed, e*very* HIV/AIDS-related activity would need to be considered by ECHO from the point of view of longer-term sustainability (see IASC Guidelines), from universal precautions and awareness to treatment of STI and opportunistic infections in appropriately rehabilitated health structures, gap-filling provision of ARVs, and support to livelihood in the worst-stricken areas. The reverse is true, and development services should consider in their country and regional programmes all HIV/AIDS-related activities initiated by ECHO. In particular, the role of EC Delegations in linking with concerned governments and their CCM (country co-ordinating mechanisms) needs to be jointly considered. A major *caveat* should also be taken into account. A decision has been taken by the EU to channel most of the funds earmarked for HIV/AIDS through the Global Fund, and ECHO may have to orientate certain of its LRRD efforts accordingly. However, evidence points to the risk of increasing delays in the disbursement of GFATM (Global Fund to Fight AIDS, Tuberculosis and Malaria) funds, due to bottlenecks of e.g. internal mechanisms or institutional weaknesses in the most vulnerable governments[22].
- At the end of 2003, provisional guidelines on "ECHO and HIV/AIDS" were prepared by ECHO, duly emphasising already the need to follow a do-no-harm approach. These provisional guidelines formed part of the input to the 'Model Guidelines', see part B below.

A.3.2. Parameters

ECHO works with a number of parameters including:

- the limited duration of financial decisions, and lack of guarantee of sustained funding. The time horizon of ECHO is quite short, especially considering the requirements of the LRRD policy (above) and even more so in the long-term perspective of combating HIV/AIDS;
- a relatively scarce in-house technical expertise on HIV/AIDS. This is common to many public sector donors and will require additional training or recruitment;
- ECHO can only finance international/EU-based NGOs, UN organisations, and the Red Cross family;
- The distribution of ECHO's budget is apportioned across humanitarian crises worldwide on the basis of identified and quantified needs. This starts with an assessment at field level, which is then reviewed at ECHO Headquarters using: a specific methodology, the 'Global Needs Assessment'; and after consultation with other humanitarian actors at meetings called 'Strategic Programming Dialogues'. However, the overall final yearly budget allocated to

[21] Commission Communication of 23.04.2001 on Linking Relief, Rehabilitation and Development - An Assessment. COM 2001 (153) final.

[22] Problems of absorption capacity by local structures of the growing funds being committed to the poorest African country, with an urge to fast disbursement, were recently illustrated in Botswana. This relatively well organised country has so far been unable to spend more than one third of the funds allocated by the US PEPFAR programme. Disbursement delays are likely to become increasingly incompatible with ECHO's decisions timeframe.

humanitarian aid is determined with regard to other Commission priorities, and periodically differences between the needs identified that ECHO would like to meet and the budget actually made available have arisen.

A.3.3. Recommended Approach

The Humanitarian Regulation does not cover specify "vertical" programmes targeted at particular diseases but places ECHO's core mandate in the framework of natural or man-made (if not totally unexpected, at least sudden) disaster situations involving emergency multi-sector assistance. *It clearly appears that ECHO has to remain within its core mandate, to continue delivering an optimum added value to the humanitarian space*. The working parameters preclude the positioning of ECHO as a front line, vertical HIV/AIDS actor, both in the technical field and as a donor, unless a complete reformulation of its legal base, organisational structure, human resources and financial means (see A.1.2) be undertaken. Such changes cannot at this time be justified, as the performances of most HIV/AIDS mandated front line organisations cannot yet be judged; in-depth changes might furthermore be detrimental to the effective implementation of ECHO's existing humanitarian interventions, which remain much needed in the short term.

As a result, without considerable changes, particularly in human and budgetary resources HIV/AIDS should not become an entry criteria[23] *per se* for ECHO. ECHO needs to follow the parameters of intervention defined (i) by its mandate and (ii) by the various levels of needs identified in the countries where programmes are *already being implemented* to mitigate the effects of natural or man-made disasters, and only intervene against HIV/AIDS where the impact of HIV/AIDS is likely to be detrimental to the effectiveness of ECHO funded programmes.

Even though the most devastating effects of HIV/AIDS are currently to be found in sub-Saharan Africa, the pandemic is a global threat that is felt across all sectors of humanitarian interventions. It is not restricted to health-related activities, and needs to be considered in all regions of the world. Various levels of pre-conditions need however to be envisaged by ECHO, according to the types of activities and to the local situation. For example, the dramatic situation in southern Africa is essentially of a developmental nature and is already a major concern for the largest front line actors. In accordance with its mandate, ECHO's presence in six southern African countries in 2003 (see table 1 of the Guidelines) is due to conflicts or to natural disasters. Arguably, the situation has also been fuelled by bad governance and delays in starting development programmes, though such factors may not be considered as valid reasons for an intervention by ECHO. In such contexts of very high prevalence rates and collapsing coping capacities of communities, ECHO may potentially in the future have to consider whether to fund some types of activities that are by essence likely to lead to long-term commitments, e.g. livelihood support to orphans and their

[23] Although country prevalence rates should be considered in ECHO's Global Needs Assessment (GNA).

caretakers, prevention of parents-to- child transmission (PPTCT or PPTCT+), anti-retroviral treatment (ART) or highly active anti-retroviral therapies (HAART)[24]. However, ECHO's mandate and working parameters cannot effectively address such activities, which could only be considered as *temporary gap-filling* measures, and must be strictly conditioned among others (see Guidelines B.3.3 and below) upon a relatively rapid or at least a clearly predictable time frame, relevant to ECHO's decisions, before handing over to local government structures or to long term donors for sustainability. Should this not be satisfactorily settled, ECHO might be faced at some point with the decision to stop altogether such activities and to leave beneficiaries to their fate. Such a dilemma clearly needs to be avoided. It should be mentioned that, to a very few exceptions -and even then to a limited extent- no such favourable pre-conditions have so far been found, in any area of ECHO operation.

ECHO should also base its approach on the *most relevant* activities among those listed by the IASC matrix (see Guidelines B.3.2), which must be considered as a prime mechanism to achieve the overall objective of "strengthening consistency and coherence", in due line with the FAFA and Good Humanitarian Donorship policies.

In this framework, ECHO should adopt a *two-pronged strategy* aiming at (i) *mainstreaming* do-no-harm measures, with focus on awareness and on avoiding to spread the virus by negligence wherever relevant (defined as "Priority 1" compulsory activities in chapter B.3.3. of the Model Guidelines), and (ii) funding selected activities in order to *mitigate the effects* of HIV/AIDS in humanitarian emergency situations, as a component of already existing multi-sector programmes, with various levels of pre-conditions ("Priorities 2 and 3" in the Guidelines). The strategy is further detailed under A.4.2. below.

[24] Considering the very large scale ARV programmes that are being developed by most major long-term donors, together with falling prices (US$140 /patient/year as negotiated recently by the Clinton Foundation) and some indications of achievements (MSF study of the Chiradzulu programme in Malawi in July 2004), the use of such drugs is likely to become increasingly widespread despite current bottlenecks, including among victims of humanitarian crises -and ECHO's potential beneficiaries.

A.4. MAIN CONCLUSIONS AND RECOMMENDATIONS

A.4.1. Conclusions

HIV/AIDS has been declared a global health emergency by WHO in October 2003. Beyond core health aspects, recent studies have described the particularly devastating effects of the pandemic as a self-feeding process in the context of complex humanitarian crises, where ECHO is usually already present. HIV/AIDS is most easily spread in contexts of poverty and violence. It affects negatively food security, access to water and sanitation, and social cohesion; it makes poor and destitute communities even more vulnerable to other shocks.

Whereas risks of contamination exist on a global scale, the impact of HIV/AIDS is particularly acute in sub-Saharan Africa and more specifically in southern Africa: prevalence rates are the highest in the world, and the extent of the pandemic threatens the very livelihood of populations as well as the political stability of several fragile countries.

There is a clear need for ECHO to include appropriate actions in its programmes, which can mostly be done whilst remaining within the core activities of the existing mandate. The EC Humanitarian Regulation and complementary policies already contain most necessary provisions to enable ECHO to fund effective prevention and response activities as components of overall humanitarian programmes.

In doing so, ECHO could best illustrate its added value to the humanitarian space, still targeting the most vulnerable in the worst humanitarian crises and low-visibility protracted situations, applying needs-based and results-oriented approaches. The priority generally given to women and children in ECHO programmes, and the gender-sensitive approach coincide quite closely with the necessary focus on vulnerable households with orphans, single mothers or elderly caretakers, i.e. the most destitute victims in high prevalence areas.

A long term perspective is essential, though, and ECHO needs to co-ordinate closely any HIV/AIDS-related activity with the major front-line actors (organisations with mandates to fight HIV/AIDS, global donors, technical advisors, and the main humanitarian agencies) who are implementing vertical programmes. In this context, the limited time horizon of ECHO financial decisions and the lack of an EC instrument with a longer-term vision are likely to become constraints in the EU's part of the fight against HIV/AIDS. The EU decision to commit most earmarked funds to GFATM -though logical from a global co-operation perspective- implies that ECHO may also have to focus most of its LRRD efforts on the Global Fund, whereas expected disbursement delays are likely to making linking increasingly incompatible with ECHO's financial decisions timeframe. There might in particular be a risk of extended durations for the recommended funding of some ARV treatments by ECHO, which must be carefully considered.

A.4.2. General Policy recommendations

In accordance with mandate provisions and field requirements, ECHO needs to consider HIV/AIDS as a important cross-cutting component of existing humanitarian programmes. A two-pronged strategy should be adopted, accompanied by some complementary measures or working tools, as follows.

Two-pronged strategy

1. Against the global threat, *mainstreaming* prevention of HIV/AIDS by introducing and maintaining a basic set of specific measures ("Priority 1" core objective, essential activities) with all relevant partners -and to ECHO itself- for prevention and precaution purposes. The objective is to develop awareness at all levels and to avoid spreading the virus by negligence. This is to be accomplished through incorporating in existing ECHO funded activities training, protection, culturally effective awareness/IEC linked with appropriate condom distribution, universal precautions, safe blood supply, mapping, co-ordination, a minimum own staff policy, and monitoring where feasible. As has already been recognised by ECHO, application of these do-no-harm measures must be considered as a moral duty.
2. To accept proposals from partners aiming at *mitigating the effects* of HIV/AIDS in humanitarian emergency situations, as a component of multi-sector programmes. This prong is to be sub-divided in two as follows.

   "Priority 2" core objectives, i.e. strongly recommended activities wherever appropriate and feasible, with the objective to "contribute to preventing any worsening in the impact of the crisis, saving and preserving life from the effects of HIV/AIDS during emergencies and their immediate aftermath". These include multi-sectoral preventive and curative activities (distribution of food and non-food aid, health, nutrition, protection, rehabilitation, shelter, water and sanitation, etc) to be implemented by ECHO partners wherever local conditions allow, in addition to the Priority 1 essential package.

   "Priority 3" non-core objectives, i.e. activities to be considered subject to strong pre-conditions only (see below). Their specific objective would be to "contribute to starting to help those affected regain a minimum level of self-sustainability", and they may include provision of gap-filling ART, HAART, PPTCT, or livelihood support and food security for HIV/AIDS orphans and their caretakers.

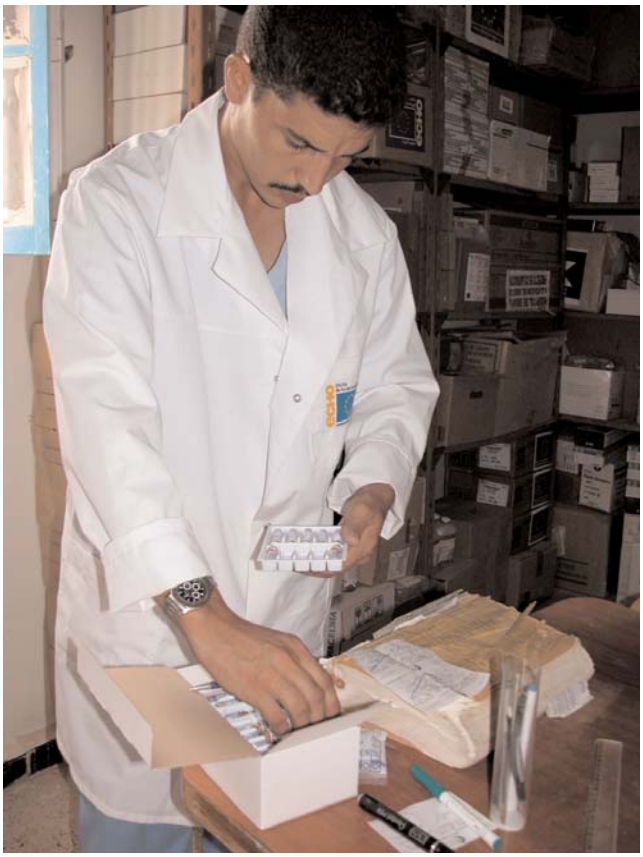
A complete description of relevant activities for the various strategy components can be found in the Model Guidelines (B.3 and B.4), with corresponding summary and priority ranking tables.

Complementary measures and tools

- As indicated among Priority 1 activities, ECHO's funding decisions should be based on specific country needs and vulnerability assessments, or mapping. Wherever feasible, these assessments should include in country or regional 'Global Plans' an analysis of the HIV/AIDS situation, the country strategy to fight the epidemic, the existing monitoring and evaluation system and the co-ordinating mechanism for the HIV/AIDS activities. Prevalence rates may be used as one of the indicators in ECHO's Global Needs Assessment (GNA) methodology. This input could be mainly based on UNAIDS information sources, though other key donors and funding mechanisms could also be used, e.g. the Global Fund CCM, the World Bank MAP and the WHO 3X5 programmes.
- An EC instrument with a long-term perspective needs to be defined -to be shared with other services, and possibly with other donors and partners concerned-, to better measure the potential developments of the pandemic and its long-term effects on EC and ECHO future engagements.
- To enhance the above, indicators must be adapted from monitoring tools already used by partners (National Information Systems, GFATM, UNAIDS, UNHCR) or developed for monitoring results and cost-effectiveness; prior baseline surveys in humanitarian contexts must be carried out whenever feasible.
- All ECHO technical assistants and desk officers need to be trained on basic aspects of prevention, care and treatment of HIV and AIDS in emergencies. Specific training needs have to be analysed and training modules have to be elaborated before starting the training. Additional recruitment might be considered.
- The funding of "Priority 3" non-core objectives must be subjected to strong pre-conditions, (see also additional details in the Guidelines), *i.a.*
  - for *anti-retroviral treatments*: existing long-term development programme, with LRRD ensured in the timeframe of ECHO decisions; existing health ECHO-funded programme, the interruption of which (by sudden disasters, for returnees without proper facilities, etc) is clearly detrimental to effectiveness, and damaging to the most vulnerable beneficiaries; qualified partner(s); acceptance of protocol/ principle by National Health Authorities; generic nature of ARVs if allowed by regulations[25], benefiting from the latest price reductions where possible, and corresponding to international standards (WHO, UNAIDS, World Bank) of quality, procurement rules, transport and storage;
  - for *livelihood support*: stabilised situation (no conflicts or displacements); existing ECHO food aid programme; presence of proven qualified partner(s); LRRD/ sustainability through local structures after ECHO's phasing out.
- Each humanitarian aid proposal submitted to ECHO for funding should contain a realistic exit strategy timeframe. This exit strategy should indicate the funding mechanism that will substitute the initial ECHO funding as soon as the humanitarian crisis has been solved or ECHO is leaving.

[25] The procurement of the drugs must be in accordance with the relevant provisions of the Annex V ("Procedures for the award of contracts") of the FPA, in particular with the chapters 2.2. ("Rules of origin"), 2.3. ("Derogation") and 4.4.1 ("Procurement procedures to be followed for supply contracts"), and more specifically with the sections (a) and (b) of this chapter (patents, regulations and WHO guidelines).

- In the LRRD framework, to reduce as much as possible delays originating either from GFATM or from local governments/CCMs, ECHO could consider promoting, in co-operation with DG DEV :
  - facilitation/Technical Assistant positions or focal points within concerned Commission Delegations or CCM/MoH to assist in the rapid disbursement of GFATM funds;
  - possibly, a facilitation position or a focal point in Geneva to assist humanitarian partners in submitting rapidly acceptable proposals to GFATM, and to follow up demands for amendments and clarification if needed.
- In addition, ECHO could use its position as a service of the Commission and as a key humanitarian donor with a large partnership network, for *leverage* effect to assist or promote efforts to push some crucial issues (e.g. agenda priorities for DG DEV or GFATM, own staff policy, proposed facilitation mechanisms, lessons learned, delays, etc).



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