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

MODEL GUIDELINES

EUROPEAN COMMISSION

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MODEL GUIDELINES

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

(A. Concept Paper - separate document)

B. Model Guidelines on Mainstreaming HIV/AIDS

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These Model Guidelines are 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.

ACRONYMS

ART	Anti-Retro Viral Treatment
ARV	Anti-Retro Viral
CCM	Country Co-ordination Mechanism
CDK	Clean Delivery Kit
DG DEV	Directorate-General for Development
DIPECHO	DIsaster Preparedness ECHO
EC	European Commission
ECHO	European Commission Directorate-General for Humanitarian Aid
EU	European Union
FAFA	EC-UN Financial and Administrative Framework Agreement
FAO	Food and Agriculture Organisation (UN)
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
IDP	Internally Displaced Person
IDU	Intravenous Drug User
IEC	Information, Education and Communication
ILO	International Labour Organisation (UN)
LFA	Logical Framework Analysis
LRRD	Linking Relief, Rehabilitation and Development
NGO	Non-Governmental Organisation
MAP	Multi-Country HIV/AIDS Program (World Bank)
MDK	Midwife Delivery Kit
MdM	Médecins du Monde (NGO)
MSF	Médecins Sans Frontière (NGO)
OI	Opportunistic Infections
PEP	Post Exposure Prophylaxis
PEPFAR	President's Emergency Plan for AIDS Relief (US)
PLWHA	People Living With HIV/AIDS
PMTCT or PPTCT	Prevention of Mother-To-Child Transmission, or Prevention of Parents-To-Child Transmission
SCF	Save The Children Fund (NGO)
STI	Sexually Transmitted Infection
SMART	Specific Measurable Accepted Realistic Timed (indicator)
TB	Tuberculosis
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDAF	United Nations Development Assistance Framework
UNHCR	United Nations High Commissariat for Refugees
UNICEF	United Nations Children's Fund
VCT	Voluntary Counselling and Testing
WFP	Word Food Programme
WHO	World Health Organisation

B.1. THE NEEDS - WHY IS ECHO CONCERNED BY HIV/AIDS ?

B.1.1. Introduction

In the first 20 years of its known existence, the HIV/AIDS virus (Human Immuno-Deficiency Virus/Acquired Immune Deficiency Syndrome) has been essentially considered as a long term development problem due to the implied costs and timeframe, and also often for reasons of political sensitivity. During that period though, the virus has killed an estimated 23 million people and with a few exceptions, efforts to stop its progression have been in vain. The latest UNAIDS (Joint United Nations Programme on HIV/AIDS) statistics indicate that more than 5 million persons were infected in 2003, the worst figures so far. As a result, HIV/AIDS has been declared a global health emergency by WHO in October 2003.

Recent studies have highlighted the particularly devastating effects of the pandemic as a self-feeding process in the context of complex humanitarian crises. It has been convincingly argued[1] that on the one side, the vast majority of humanitarian crises take place in countries where rates of HIV infection are already high and where communities have been made more vulnerable. On the other side, destruction and displacements usually caused by emergencies tend to multiply the risk of infection and the vulnerability of victims by lack of health services and poor hygiene, inadequate food and clean water, or by sexual abuse by armed groups, among multiple other reasons. 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.

Sub-Saharan Africa is by far the worst affected and the pandemic has become the leading cause of suffering and death. Out of 40 million 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. Sub-Saharan Africa combines most of the strongest causal factors, such as:

- lack of capacity of authorities, often combined with poor governance and corruption;
- protracted regional conflicts;
- strong cultural resistance to necessary behavioural changes;
- poverty, lack of health, hygiene, education;
- recurrent natural disasters, and
- agricultural and market liberalisation failures due to the above reasons.

At the current stage, the situation is particularly dramatic in *southern Africa* which gathers 30% of all PLWHA. Most visible in that region, HIV/AIDS threatens the social cohesion and coping capacity of communities. The pandemic attacks mostly young adults in their peak productivity years, young adults who are essential to a society's economic sustainability and to the political stability of already fragile countries. The 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 humanitarian assistance.

[1] HIV/AIDS and emergencies: analysis and recommendations for practice. ODI Humanitarian Practice Paper, Feb. 2002.

Studies[2] indicate that HIV/AIDS needs to be considered across the full spectrum of the sustainable livelihood framework. The pandemic increases levels of vulnerability to other shocks, impacts on the assets of households, affects the policies, institutions and processes that influence livelihoods, forces adaptations to livelihood strategies and results in changing livelihood outcomes. At a macro level it reduces overall levels of economic growth, erodes the ability of governments to provide public services such as health and education (already so scarce in Africa), and may potentially impact on governance and security issues. More specifically:

- in a fragile economic framework of survival agriculture, *food security* must be seen as a central issue;
- AIDS impacts on *human capital* by reducing the amount of labour and skills available to households, adding to the burden of care for the sick and the orphans, and reducing the transfer of knowledge to younger generations. It also affects the *financial capital* by increasing household expenditures (medical care, funerals) and reducing income; the *social capital* of communities is being over-stretched and some of the poorest households are being excluded from community support; finally vulnerable widows and orphans would either risk losing their access and rights to land, or have to sell key productive assets, hence diminishing their *natural* and *physical capitals*[3];
- in such a context, the gender dimension of AIDS is of course crucial, considering the often low status of women and the additional burdens that fall upon them as main producers of food and main carers for the sick and the children. The social status of elderly caretakers - once the mothers are themselves deceased is still to be explored.

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. The crisis of southern Africa is an illustration of the need of prevention and preparedness, to keep prevalence rates at low levels before it is too late.

In accordance with its mandate, ECHO is already present in most of the concerned regions. As shown below (table 1), out of the 62 countries in which ECHO was funding projects in 2003, 11 had high average levels of "burden adult" prevalence equal to or above 5 % of the population between 15 and 49 years old[4], all of them in sub-Saharan Africa. ECHO was present in three of the four most affected countries, all of them located in southern Africa: Lesotho (adult prevalence rate of 31%), Zimbabwe (33.7%) and Swaziland (38.6%).

Rising threats are 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 or Tajikistan where incidence rates may be among the highest in the world), and appropriate

[2] cfr supra, and "HIV/AIDS and humanitarian action", ODI/HPG Report 16th April 2004.
[3] "HIV/AIDS: What are the implications for humanitarian action? A Literature Review" ODI/ HPG, July 2003.
[4] Source: UNAIDS national response to HIV/AIDS, on web site (see annex D).

policies still often need to be enacted (except for Thailand or Cambodia). Country situations must be carefully monitored.

Scattered examples of positive reactions can be found and are listed in Annex A (Best practices). Uganda is probably the first African country (and up to now perhaps the only one) to set up and to implement an appropriate policy. Despite potentially high risks for the pandemic to spread, Brazil has been able to maintain prevalence rates well below 1%. Similarly, rates of new infections seem to be declining in two Asian countries (Thailand and Cambodia), where strong preventive measures have been adopted by the governments and pursued vigorously.

B.1.2. Sero-Prevalence Rates and ECHO Intervention Areas

The most common measure of the HIV/AIDS epidemic is the prevalence of HIV infections among a country's adult population-in other words, the percentage of the adult population living with HIV. Prevalence of HIV provides a valid picture -or rather a still photograph- of the overall state of the epidemic. In countries with generalised epidemics, this image is generally based on HIV tests made on anonymous blood samples taken from women attending antenatal clinics.

Caveats

However, prevalence does not offer such a clear picture of recent trends in the epidemic, because it does not distinguish between people who acquired the virus very recently and those who were infected a decade or more ago. (Without ART -anti-retroviral treatment-, a person might survive, on average, between up to 9 and 11 years after acquiring HIV; with treatment, survival is substantially longer.)

Countries A and B, for example, could have the same HIV prevalence, but be experiencing very different epidemics. In country A, the vast majority of people living with HIV/AIDS (the prevalent cases) might have been infected 5 to 10 years ago, with few recent infections occurring. In country B, the majority of people living with HIV/AIDS might have been infected in the past two years. These differences would obviously have a very significant impact on the kind of prevention and care efforts that countries A and B need to set up (e.g. focusing on awareness targeted on identified population at risk, prevention of parents-to-child transmission, detection of sexually transmitted infections and opportunistic infections for country B, and on livelihood and orphaned households -in particular where high prevalence has disrupted the coping capacity of communities- for country A). Similarly, HIV prevalence rates might be stable in country C, suggesting that new infections are occurring at a stable rate. That may not be the case, though. Country C could be experiencing higher rates of AIDS mortality (as people infected a decade or so ago die in large numbers), and an increase in new infections. Overall HIV prevalence rates do not highlight the specific details of a country's epidemic.

Furthermore, when a population is continually moving because of conflict, it is difficult to identify whether changes in rates are due to changes in specific risk factors. Normal functioning of antenatal clinics is also generally disrupted during conflicts, and 'sentinel' surveys in such premises can therefore be rather uncertain.

Incidence rates

Wherever possible, a measure of HIV incidence (i.e. the number of new infections observed over a year among previously uninfected people) would help complete the picture of current trends, rather like an animated image of the epidemic. Incidence indicates where the risks of rapid spreading are the highest, hence where urgent intervention is most needed, focusing on specific types of activities (above). The problem is that measuring HIV incidence is expensive and complicated -to the point of it being unfeasible at a national level and on a regular basis in most countries. There are e.g. very few comprehensive and recent surveys of incidence rates to be found in UNAIDS statistics, except for some of the most affected southern African countries (Malawi, Lesotho). They have therefore not been included in table 1 below.

None of this means, however, that recent trends are a mystery. Regular measurement of HIV prevalence among groups of young people can serve as a proxy, albeit imperfect, for HIV incidence among them. Because of their age, young people will have become infected relatively recently. Significant changes in HIV prevalence among 15-19 or 15-24 year-olds can therefore reflect important new trends in the epidemic. The steadily dropping HIV prevalence levels in 15-19 year-olds in Uganda, for example, indicates a reduction in recent infections among young people, and provides a more accurate picture of current trends in the epidemic (and, in this instance, of the effectiveness of prevention efforts among young people).

"High" and "low" rates

To illustrate the above, table 1 provides an overview of estimated average prevalence rates and ranges[5] registered by WHO among adults of working age (15-49 years old, or "burden adults") in all the countries where ECHO had implemented financial decisions in 2003[6]. Some of these figures differ significantly (+/-) from figures to be found on the UNAIDS web site, which appears sometimes outdated (they were often collected in 1999 or in 2000), except for the most affected southern African countries. The percentages shown in red outline the specifically high extent in southern Africa. Prevalence rates could be used as one of the indicators of vulnerability in ECHO's Global Needs Assessment (GNA), mirroring by this the UNDP human development report.

It must be noted that no accurate definition or scientifically based threshold could be found regarding the often quoted "low" and "high" prevalence rates. For the purpose of the present guidelines, this threshold has therefore arbitrarily been set at 5 %, pending further information.

[5] The wider the range, the more uncertainty there is surrounding the country's estimates. The width of the range depends mainly on the type of epidemic and the quality, coverage, and consistency of the country's surveillance system.

[6] Sources: UNAIDS and WHO web sites, and "Protecting the Humanitarian Space" brochure, ECHO 2003.

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Table 1

Regions and countries	Estimated adult prevalence rates (%)	Ranges (%)
Africa, Caribbean and Pacific		
Angola	3.9	[1.6 - 9.4]
Burkina Faso	4.2	[2.7 - 6.5]
Burundi	6.0	[4.1 - 8.8]
Central African Republic	13.5	[8.3 - 21.2]
Chad	4.8	[3.1 - 7.2]
Congo (Democratic Republic)	4.2	[1.7 - 9.9]
Congo (Republic)	4.9	[2.1 - 11.0]
Côte d'Ivoire	7.0	[4.9 - 10.0]
Dominican Republic	1.7	[0.9 -3.0]
Eritrea	2.7	[0.9 - 7.3]
Ethiopia	4.4	[2.8 - 6.7]
Fiji	NA	-
Haiti	NA	-
Lesotho	28.9	[26.3 -31.7]
Malawi	14.2	[11.3 -17.7]
Mali	1.9	[0.6 -5.9]
Namibia	21.3	[18.2 -24.7]
Niger	1.2	[0.7 -2.3]
Sierra Leone, Guinea, Liberia	respectively: NA / 3.2 / 5.9	NA/[1.2 - 8.2]/ [2.7 -12.4]
Somalia	1.0	NA
Sudan	1.6 - 2.8	NA
Swaziland	38.8	[37.2 -40.4]
Tanzania	8.8	[6.4 -11.9]
Uganda	4.1	[2.8 -6.6]
Zambia	16.5	[13.5 -20.0]
Zimbabwe	24.6	[21.7 -27.8]
Eastern Europe / NIS		
Mongolia	<0.1	[<0.2]
Northern Caucasus (Chechnya, Ingushetia, Dagestan)	NA	NA
Serbia-Montenegro	0.2	[0.1 -0.4]
Southern Caucasus (Georgia)	0.1	[0.1 -0.4]
Tajikistan	<0.1	[<0.2]

Regions and countries	Estimated adult prevalence rates (%)	Ranges (%)
Middle East / North Africa		
Algeria	0.1	[<0.2]
Iraq	<0.1	[<0.2]
Middle East (Palestinian Territories)	NA	NA
Western Saharan refugees	NA	NA
Yemen	0.1	[0.0 -0.2]
Asia		
Afghanistan, Pakistan, Iran	NA/0.1/0.1	NA/[0.0 -0.2]/ [0.0 -0.2]
Cambodia	2.6	[1.5 -4.4]
China including Tibet	0.1	[0.1 -0.2]
East Timor	NA	NA
India	0.7	[0.4 -1.3]
Indonesia	0.1	[0.0 -0.2]
Laos	0.1	[<0.2]
Myanmar (Burma)	1.1 - 2.2 (urban) / 0.04 - 0.07 (rural)	[0.6 -2.2]
Nepal / Bhutan	0.5 / NA	[0.3 -0.9]
North Korea	NA	NA
Philippines	<0.1	[<0.2]
Sri Lanka	0.07	[<0.2]
Thailand	1.5	[0.8 -2.8]
Latin America		
Guatemala, Honduras, Nicaragua, El Salvador	respectively: 1.38 / 1.8 / 0.2 /0.7	NA /[0.1 -0.3]/ NA [0.6 -1.8]
Colombia	0.7	[0.4 -1.2]
Argentina, Ecuador	respectively: 0.65 / 0.29	[0.3 -1.1]/ [0.1 -0.5]

B.2. THE LEGAL FRAMEWORK - WHAT CAN ECHO DO?

B.2.1. Mandate and Complementary Policies

The Council Regulation (EC) 1257/96 which determines the objectives and modus operandi of ECHO, includes general provisions that can adequately be applied to define a relevant role in fighting HIV/AIDS while remaining within ECHO's core mandate. In particular, the following statements taken from Chapter I of the Regulation should be highlighted, mirroring similar requirements 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, i.a.:

- results-oriented and needs-based approach (as opposed to the rights-based approach adopted e.g. by UN agencies), SMART[7] objectives and logical framework analysis (LFA);
- non-emergency ECHO decisions that can have a duration of twelve months -or eighteen where justified (the Regulation explicitly mentions only emergency actions with a duration of six months, as distinct from standard EC decisions);
- DIPECHO for disaster preparedness, mitigation and advocacy;
- focus on low visibility crises, where relatively small amounts of funding can have major effects;

[7] Specific, Measurable, Accepted, Realistic, Timed

- Linking relief, rehabilitation and development (LRRD, see below) and exit strategies;
- global co-operation frameworks with UN partners (Financial and Administrative Framework Agreement -FAFA, Good Humanitarian Donorship, focus on children, etc);
- at the end of 2003, tentative guidelines on "ECHO and HIV/AIDS" have been prepared, duly emphasising already the need to follow a do-no-harm approach.

LRRD has been the subject of a specific EC Communication[8] and several assessments. It is of particular relevance for HIV/AIDS, considering the necessary long-term perspective of activities, the long list of global actors involved (see Concept Paper, chapter A.2.1.) and the presence of ECHO among the six main funding approaches in the Commission's response (Concept Paper, A.2.2). Indeed, as demonstrated in the complete IASC Matrix (B.3.2), *every* HIV/AIDS-related activity would need to be considered by ECHO from the points of view of longer-term sustainability, 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 livelihoods in the worst-stricken areas. The reverse is true, and the EC's external 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 country co-ordination mechanisms (CCM) needs to be jointly considered. A major *caveat* should also be taken into account. The decision has been taken by the EC to channel most of the funds earmarked for HIV/AIDS through the Global Fund, and ECHO may have to focus most of its LRRD efforts accordingly. However, evidence points at the risk of increasing delays in disbursement of these funds, due to bottlenecks of e.g. internal mechanisms or of institutional weaknesses in the most vulnerable governments[9].

B.2.2. Parameters and Limitations

ECHO is faced with a number of well-known working parameters:

- Limited duration of financial decisions, and lack of a guarantee for sustained funding. The operational time horizon and medium to long-term policy horizons for ECHO are relatively short, (reflecting ECHO's mandate), when considering the requirements of the LRRD policy (above) and even more so against the long-term perspective necessary for combating HIV/AIDS.
- Relatively scarce in-house technical expertise on HIV/AIDS, which is common to many public sector donors.
- ECHO can only finance international/EU-based NGOs, UN organisations, and the Red Cross family.

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

[9] Problems of absorption capacity by local structures of the growing funds being committed to the poorest African countries, 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 (see Concept Paper, ch. A.2.1). Disbursement delays are likely to become increasingly incompatible for timely linking with ECHO's decisions timeframe.

- ECHO budget is theoretically established on the basis of identified and quantified needs, e.g. while preparing Global Plans. However, the overall final, yearly budget allocated is influenced also by competition from other Commission priorities, and inconsistencies between needs identified and the budget actually made available are not infrequent. There might be a further limitation for HIV/AIDS-related activities, considering the lack of reliable baseline surveys and monitoring indicators required to identify and quantify needs arising from the pandemic.

In addition, the Regulation does not specify "vertical" programmes targeted at particular diseases but clearly 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. The working parameters further 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, and financial means be undertaken. This is not desirable, for such in-depth changes might be detrimental to the effective implementation of ECHO's core 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 *per se* for ECHO.

B.3. THE APPROACH - HOW TO DO IT ?

B.3.1. Overall Strategy

ECHO needs to follow the parameters of intervention defined by:

(i) its mandate (situations of humanitarian emergencies in developing countries where local authorities cannot cope, with the objectives to save and preserve lives, to prevent or relieve physical, psychological or social human suffering, seeking results and co-ordinating with international efforts); and

(ii) the various levels of needs identified in the countries or regions *where humanitarian assistance is already being provided by ECHO*, HIV/AIDS activities being a component only of existing ECHO financed multi-sector programmes.

In doing so, ECHO should co-ordinate its approach as much as feasible with the most relevant activities listed in the UN IASC Guidelines (below), which must be considered as a prime mechanism to achieve ECHO's overall objective of "strengthening consistency and coherence", in line with the FAFA and Good Donorship policies recently signed with the UN. ECHO should adopt a two-pronged strategy, as follows.

First prong: against the global threat of HIV/AIDS, mainstreaming a core set of mandatory essential measures ("Priority 1" core objective, essential activities) for prevention and precaution purposes. See summary table 3 and chapter B.4.1 for details.

- Application of basic do-no-harm measures are to be considered as a moral duty by ECHO, as already indicated in the provisional Guidelines of 2003. The objective is to develop awareness at all levels and to avoid spreading the virus by negligence through funded programmes. Some of these measures need to be applied by all concerned partners, and include internal awareness and minimum own staff policy, culturally effective awareness/IEC[10] campaigns linked with appropriate condom distribution, universal precautions, safe blood supply, sectoral co-ordination, and monitoring of the same, where feasible.
- Other measures are meant to be applied by ECHO itself. In the framework of essential mainstreaming measures, ECHO must develop its own internal awareness, training and protection policy. ECHO's funding decisions should be based on specific country needs and vulnerability assessments, or mapping. Wherever feasible, these assessments should systematically include in country or in 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). This could be based mainly on UNAIDS information sources, though key other relevant donors and funding mechanisms could also be used, e.g. the Global Fund CCM, the World Bank MAP and the WHO 3X5 programmes[11].

Second prong: accepting proposals from partners aiming at combating the effects of HIV/AIDS in humanitarian emergency situations, as a component of already existing

[10] Information, Education and Communication.

[11] See description in Concept Paper, chapter A.2.1

multi-sector programmes. This part of the strategy is to be sub-divided in two, as follows (see summary tables 4 and 5, and chapters B.4.2 and B.4.3).

- "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 anti-retroviral treatment (ART), highly active ART, prevention of parents-to-child transmission, or livelihood support and food security for HIV/AIDS orphans and their caretakers.

B.3.2. IASC Guidelines

The IASC (UN Inter-Agency standing Committee) has published in December 2003 the "Guidelines on HIV/AIDS in emergency settings", a key tool for international co-operation in prevention and response to the pandemic, which has been agreed by all UN Agencies. These guidelines are therefore an important document in the framework of the FAFA and Good Donorship policies. They are centred around a common framework of multi-sector activities (the Matrix), summarised in the table 2 below.

In order to have a more comprehensive overview of the document, the table has reproduced *in extenso* the "emergency preparedness" and "minimum responses" activities listed by IASC in the sectors 2 (Assessment and monitoring), 3 (Protection), 4 (Water and sanitation), 5 (Food Security and Nutrition), 6 (Shelter and Site planning), 7 (Health), 9 (information, education and communication -IEC) and 10 (HIV/AIDS in the Workplace). However, whereas these activities are relevant to the overall objective of HIV/AIDS prevention, *they are not all relevant for ECHO funding within its working parameters*. Many preparedness activities should either be automatically included in any project preparation and proposal (all B.2, B.7.1, 7.3, etc). Others would potentially involve longer-term activities (C.2.2) or rather academic studies (B.3.1, B.7.12) which are hardly compatible with ECHO's short timeframe and results-oriented approach. In the table below, such activities have been put between brackets. Additional comments and caveats are provided after the table.

Activities foreseen in Sectors 1 (Co-ordination) and 8 (Education) are essentially meant to be used either by implementing agencies (field co-ordination) or by longer-term donors (access to education), and have therefore not been reproduced. Table 2 has also included a limited number of "comprehensive response" activities for ECHO's consideration. Reference numbers of IASC activities will further be used as cross-references with the recommended activities for ECHO, presented in the Summary Ranking Tables (B.3.3.).

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IASC framework for multi-sector activities

Table 2

A. Sectoral response	B. Emergency preparedness	C. Minimum response (to be conducted even in the midst of emergency)	D. Comprehensive response (Stabilised phase, LRRD)
1. Co-ordination			
2. Assessment and Monitoring	(B.2.1. Conduct capacity and situation analysis) (B.2.2. Develop indicators and tools) (B.2.3. Involve local institutions, beneficiaries)	(C.2.1. Assess baseline data) (C.2.2. Set up and manage a database) C.2.3. Monitor activities	
3. Protection	(B.3.1 Review laws & policies) B.3.2. Promote human rights and best practices B.3.3. Minimise risk of sexual violence, exploitation, HIV-related discrimination B.3.4. Train humanitarian workers on HIV/AIDS and sexual violence	C.3.1. Prevent and respond to sexual violence C.3.2. Protect orphans and separated children C.3.3. Ensure access to condoms for humanitarian staff	
4. Water and sanitation	B.4.1. Train staff on HIV/AIDS, sexual violence and non-discrimination	C.4.1. Include HIV considerations in water and sanitation planning	D.4.1. Establish water and sanitation committees D.4.2. Organise awareness campaigns
5. Food security and nutrition	(B.5.1. Contingency planning, supplies) B.5.2. Train staff on special needs of HIV/AIDS affected populations B.5.3. Include information about nutritional care and support of PLWHA in nutrition programs B.5.4. Support food security of HIV/AIDS affected households	C.5.1. Target food aid to affected and at-risk households and communities C.5.2. Plan nutrition and food needs for population with high HIV prevalence C.5.3. Promote appropriate care and feeding practices for PLWHA C.5.4. Support and protect food security of HIV/AIDS affected and at risk households and communities C.5.5. Distribute food aid to affected households and communities	D.5.1. (Develop strategy to) protect long-term food security D.5.3. Home based care programmes with communities
6. Shelter and site planning	B.6.1. Ensure safety of sites B.6.2. Train staff on special needs of HIV/AIDS affected refugees and IDPs; gender and non-discrimination	C.6.1. Establish safely designed sites	
7. Health	(B.7.1. Map services and practices) (B.7.2. Plan and stock supplies) (B.7.3. Adapt/develop protocols) B.7.4. Train health personnel (B.7.5. Plan quality assurance mechanisms) B.7.6. Train staff on sexual and gender based violence and link with HIV/AIDS (B.7.7. Determine prevalence of intravenous drug users) B.7.8. Develop instructions leaflets on cleaning injection materials B.7.9. Map, support prevention, care initiatives B.7.10. Train staff and peer educators B.7.11. Train health staff on reproductive health (RH) issues linked with emergencies, and the use of RH kits (B.7.12. Assess current practices in the application of universal precautions)	C.7.1. Ensure access to basic health care to the most vulnerable C.7.2. Ensure safe blood supply C.7.3. Provide condoms C.7.4. Institute syndromic STI treatment C.7.5. (Ensure appropriate care for intravenous drug users) C.7.6. Management of the consequences of sexual violence C.7.7. Ensure safe deliveries C.7.8. Apply universal precautions	D.7.3. Treatment of opportunistic infections (OI) and tuberculosis D.7.4. Provision of ARV treatment D.7.14. Prevention of mother-to-child transmission (PMTCT)
8. Education			
9. Behaviour communication change and IEC	B.9.1. Prepare culturally appropriate messages B.9.2. Prepare an IEC strategy B.9.3. Involve key beneficiaries B.9.4. Conduct awareness campaigns (B.9.5. Store key documents outside risk areas)	C.9.1. Provide information on HIV/AIDS and care	
10.HIV/AIDS in sthe workplace	(B.10.1.Review personnel policies) B.10.2. Develop policies where there are none B.10.3. Stock PEPs (post-exposure prophylaxis)	C.10.1. Prevent discrimination/stigma C.10.2. Provide PEPs to staff	

A few additional comments need to be made, and some exceptions provided for.

- Universal precautions, safe blood supply, IEC, and some basic staff training should be seen as elementary prevention measures and need to be placed among mandatory mainstreaming activities (activities B.2, C.2, C.3.3, B.7.12, C.7.2, C.7.8, B.9, C.9, etc).
- Despite its importance, "HIV/AIDS in the workplace" is still a recurrent weak point for many ECHO partners, raising numerous questions (e.g. on ethics, mandate and budget). Own staff policy activities need therefore to be sub-divided into a core set of necessary mainstreamed measures (a commonly acceptable minimum threshold, see chapter B.4.1) and other measures, to be further considered and discussed (B.10.1 and 2). Examples to illustrate the issue can also be found in Chapter B.3.4 below.
- Neither emergency rehabilitation/reconstruction of key primary health structures, following an approach appropriate to HIV/AIDS treatment and to LRRD, nor protection for returnees are mentioned as such.
- Some activities are probably not relevant to the current areas of activities of ECHO in major complex/protracted humanitarian crisis situations in sub-Saharan African such as "ensure appropriate care for intravenous drug users" (activity C.7.5).
- As already mentioned, some activities proposed in the Matrix in the "comprehensive response" phase only, should be considered in ECHO programmes (water and sanitation awareness and management committees, treatment of opportunistic infection and tuberculosis, some provision of ARV treatment, PPTCT...) *provided that*:
  - ECHO can work with partners of proven experience;
  - the concerned populations are relatively stable (i.e. likely to remain in the same area for the next 6 months);
  - the National Health Authorities accept the necessary protocols and principles.
- Most of the other "comprehensive response" activities have not been included in the table 2, being either too long-term (institutional strengthening) or too vertical in character (e.g. VCT -voluntary counselling centres- with high infrastructure costs and maintenance, difficult to set up in conflict areas, very long-term engagement, bound to lead to wide-scale ARV activities, etc). These activities should not be considered for funding by ECHO, since they are not compatible with its mandate.

B.3.3. Priority Ranking Summary Tables

In accordance with the provisions of the overall Concept Paper and the detailed Guidelines, the tables below are meant to be used as a point of reference checklist by ECHO's field based technical assistants. Their overall objective can be described as "to strengthen ECHO's consistency and coherence in its humanitarian activities when confronting HIV/AIDS".
The tables should facilitate the selection of activities to be funded in humanitarian situations where ECHO, following its mandate, is already present to mitigate the effects of natural or man-made disasters, and where the impact of HIV/AIDS is likely to be detrimental to the effectiveness of ECHO funded programmes. At this stage, HIV/AIDS alone is not to be considered as an entry point for ECHO funding in any given humanitarian situation.

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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. The tables are therefore designed to be used in all regions of the world, and are not restricted to health-related activities.

International co-ordination against HIV/AIDS is also a crucial issue. For cross-reference purposes, some numbers have been added [between brackets] corresponding to the activities most relevant for ECHO and listed in the IASC guidelines above.

It must be stressed that the tables, even more than the Model Guidelines as a whole, are a living document. Situations will change over the years, and so will responses; the ranking below should therefore be valid for 2005 only. Regular updates will be necessary, and the contribution of ECHO field experts in this continuous exercise will be essential.

There are five tables, corresponding to decreasing levels of priorities - and to increasing levels of pre-conditions. The tables are further divided by activities to be applied by the partners, or by ECHO itself.

Priority 1	in GREEN	core objectives of ECHO funding, essential activities to be mainstreamed in all (mainly health-related) projects.
Priority 2	in ORANGE	core objectives, strongly recommended activities wherever appropriate and feasible.
Priority 3	in RED	non core objectives, activities to be considered for funding, subject to strong pre-conditions only. Such objectives are not to be considered in principle for 2005.
To be avoided	in GRAY	ineligible or harmful activities, not to be funded in principle.

MODEL GUIDELINES

Priority 1 : Core objective - Essential activities

Objective: "to prevent contamination by negligence through ECHO funded programmes, by assessing the situation and applying a core set of mandatory precautions".
Focus on awareness at all levels, as a pre-requisite. Essential basic package of prevention activities to be mainstreamed in all (mainly health related) ECHO projects.

Table 3

Level of implementation	Specific objective	Activities	Indicators of effectiveness
To be applied by **ECHO**.	1. To develop internal capacity building, and to ensure protection for ECHO staff.	- Training of ECHO staff (HQ and field) on essential managerial elements of HIV/AIDS prevention and care programmes. [B.10.1,2] - Providing ECHO staff with relevant protection measures (updated information, full insurance coverage, access to condoms, PEP, VCT and ARV). [C.10.2, C.3.3]	- % of ECHO staff trained.
	2. To carry out regular assessment/ mapping of situation by ECHO in every country/ region of intervention.	- Listing and regularly updating capacities of partners. - Linking with co-ordination mechanisms and main international programmes (UNAIDS, Global Fund, World Bank, etc) active in the country/region, and collecting regularly their data. - When feasible, making realistic assessments of progress sof such programmes (incl. in ART), of local constraints and of potential effects -if any- on ECHO beneficiaries. - Linking regularly with other relevant EC programmes in the country/region, and trying to co-ordinate programming cycles to prepare LRRD where relevant.	- Adequacy of section on HIV/AIDS in reports and global plans. - LRRD mechanisms in place where relevant.
	3. To set up appropriate contractual and budgetary frameworks.	- Including in every operational contract, provisions stressing the need to identify and include elementary prevention measures: (i) relevant information/education/ communication for target population; (ii) relevant access to condoms for target population; (iii) universal precautions; (iv) safe blood supply; (v) minimum workplace policy measures (below). - Including corresponding budget provisions in contracts.	- Proposals, operational and financial reports from relevant partners satisfactorily include all elementary prevention measures.
	4. To monitor relevant projects.	- Harmonising information requirements and monitoring indicators in all relevant projects, wherever possible. [B.2.2, C.2.3] - Helping to disseminate lessons learnt and best practice.	- Results from projects can be compared.

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Level of implementation	Specific objective	Activities	Indicators of effectiveness
To be applied by all concerned **PARTNERS**.	1. To ensure awareness and prevention among partners' own staff (minimum package).	- Developing awareness by information on HIV/AIDS prevention, care, non-discriminatory attitudes and consequences of violence, focusing on local drivers and on partner's management teams where appropriate. [B.7.6, B.10.1, B.10.2; C.10.1] - Ensuring access of all staff to condoms; PEP, VCT and ARV when relevant. [C.10.2] - Providing full insurance coverage for expatriates.	- % of ECHO partner staff having basic knowledge on transmission and prevention of HIV infection/total. - % of ECHO partners having a HIV/AIDS workplace policy.
	2. To provide culturally effective awareness/ IEC to beneficiaries.	- Achieving balanced target groups (men as well as women, local decision makers, etc). [B.9.2,3] - Using appropriate trainer/motivator/peer educator (avoid "young white girls"). [B.9.1,4] - Using local languages and preferred local media support.	Relevant information in project proposal and progress reports.
	3. To ensure access to condoms for target population, where relevant/ feasible.	- Distributing male or female condoms if demanded and culturally accepted, in close co-ordination with IEC activity (above). [C.7.3]	Relevant information in project proposal and progress reports, e.g: - condoms/population (using ECHO or UN formulae).
	4. To apply universal precautions.	- Using clear protocols to reduce unnecessary procedures. - Disinfecting and sterilising. - Training staff in replacing protocols from injectable to oral medication. - Supplying auto disable and disposable needles. - Supplying gaps in gloves (single use), goggles, masks, soap, water at health facilities, etc. - Supplying containers for sharp objects; installing incinerators and training staff for safe disposal. - Advocating against unsafe practices. [C.7.8]	Relevant information in project proposal and progress reports: - staff informed/total; - sterilising functional; - needles/patients; - gloves/ out-, inpatients; - 1Lt/outpatint, 5 Lt/delivery and inpatient; - Container/patients; - Incinerator functional.
	5. To ensure safe blood supply.	- Avoiding unnecessary transfusions and use of blood and blood products. - Training on rational criteria to transfuse and to supply plasma substitutes as an alternative to blood. - Testing all blood used for transfusion and blood banks. - Supplying HIV tests and reagents in sufficient quantity (hepatitis B, syphilis are also recommended). - Select safe donors (i.e. unpaid). - Using referral of blood recipients as an alternative (where appropriate and needed). [C.7.2]	Relevant information in project proposal and progress reports: - staff informed/total; - donations tested/total; - transfusions/patients.
	6. To take part to sectoral co-ordination efforts.	- Attending pro-actively any relevant co-ordination forum (locally).	- Relevant activities of the partner are duly recorded by the co-ordinating body. - Lessons learned by the partner are disseminated through the co-ordinating body.
	7. To carry out internal monitoring and evaluation of projects.	- Making usable baseline surveys to measure progress. [C.2.1] - Developing indicators and benchmarks (SMART, results-oriented for precautions against spreading HIV/AIDS by negligence). [B.2.2] - Discussing indicators with ECHO and other partners to harmonise approaches and provide comparable results. - Monitoring outputs/outcome rather than inputs, whenever possible, to achieve Quality Assurance. [C.2.3]	- All ECHO funded projects provide usable and comparable output indicators.

Priority 2 : Core objective - Strongly recommended activities Wherever appropriate and feasible

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 ".

Multi-sectoral preventive and curative activities, to be implemented by ECHO partners wherever local conditions allow in addition to the Priority 1 essential package of activities.

Since it is difficult outside of a specific field context to list such activities by priority, they are presented here in alphabetical order.

Table 4

Sector of Intervention	Specific Objective	Activities	General Conditions	Indicators
1. Distribution (food aid, non-food items, etc).	To ensure adapted and safe distribution mechanisms to the affected households /communities, in particular in high prevalence areas.	- Targeting in priority single, infected and/or elderly caretakers, and orphans. [C.5.1, 2] - Setting up distribution schemes adapted to weaker individuals (more frequent with smaller packages, storage in villages). [C.5.4] - Designing safe distribution sites, to minimise risks of rape for women/ minors. [C.4.1] - Using school feeding, take-home rations for children if feasible. - Using home-based care services, if no other solutions are available. [D.5.3] - Providing information to concerned neighbours, to avoid discrimination /stigma.	- Existing sectoral ECHO programmes. - Presence of proven qualified partner(s). - Sustainability through local structures after ECHO's phase out.	- % of coverage achieved, measured against baseline surveys.
2. Health.	To guarantee treatment of Sexually Transmitted Infections (STI).	- Training staff on Syndromic approach for management of STI. [B.7.4] - Supplying drugs for the treatment of STI (following national protocol and/or essential drug list). [C.7.4] - Distributing condoms to STI patients. [C.7.3]	- Existing sectoral ECHO programmes. - Presence of proven qualified partner(s). - National protocols and/or essential drug lists are respected. - ARTs are not funded at this priority level (see below). - Sustainability through local structures after ECHO's phase out.	- Consultations /estimations. - Stocks of drugs /estimations. - Condoms/patient
	To guarantee treatment of Opportunistic Infections (OI).	- Providing prophylaxis for opportunistic infections (including TB) - Providing treatment for opportunistic infections (including TB) [D.7.3]		- Consultations /estimations. - Stocks of drugs /estimations.
	To ensure safe deliveries.	- Providing clean delivery kits (CDK). [C.7.7] - Providing midwife delivery kits (MDK).		- CDK/delivery - MDK/ TBA year
3. Nutrition.	To ensure that PLWHA and orphans are included as beneficiaries in nutrition programmes, with adequate response to their needs.	- Targeting assistance to affected and at-risk households (infected, single and/or elderly caretakers and orphans) and communities. [C.5.1] - Using guidelines adapted to needs of PLWHA (see e.g. Oxfam, SCF, WFP), focusing on women and children. [C.5.3] - Providing information to concerned neighbours, to avoid discrimination /stigma.	- Existing nutritional or feeding ECHO programmes, based on clearly established nutritional/ health criteria indicating an overall nutritional vulnerability for specific groups (not caused by HIV/ AIDS alone). - Presence of proven qualified partner(s). - Sustainability through local structures after ECHO's phase out.	- % of coverage achieved, measured against baseline surveys.

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Sector of Intervention	Specific Objective	Activities	General Conditions	Indicators
4. Protection against sexual violence.	To contribute to the prevention of sexual violence and to assist victims of rape cases.	- Ensuring that protection activities are cross cutting through all concerned sectors (see shelter, water and sanitation, distribution). [B.3.3, C.3.1] - Detecting victims of sexual violence and providing counselling. - Offering emergency contraception and post exposure prophylaxis (PEP). - Referring victims to support groups.	- Clearly established increased risk for sexual violence and rape (situation of war, violence, refugees, IDPs). - Presence of proven qualified partner(s).	- Reported rapes/10,000 women/month.
5. Rehabilitation, reconstruction.	To ensure that rehabilitation is adapted to the needs of PLWHA.	- Rehabilitating/ re-constructing e.g. essential health centres with adapted out- and in-patients facilities for PLWHA: detection, treatment of STI/OI, nutrition, water and sanitation, etc.	- Existing sectoral ECHO programmes. - Presence of proven qualified partner(s). - Sustainability through local structures after ECHO's phase out.	- % of PLWHA going to rehabilitated centres/month.
6. Shelter and site planning.	To adapt shelter and site design to specific needs of PLWHA, and to ensure their safety.	- Providing awareness and managerial training to camp staff. [B.6.2] - Designing safe displaced sites, to minimise exposure to rape for women and minors. [C.6.1] - Employing enough female guards and logisticians, e.g. in camps. - Placing PLWHA households in positions close to health and water-sanitation facilities. - Providing information to concerned neighbours, to avoid discrimination /stigma.	- Existing sectoral ECHO programmes. - Presence of proven qualified partner(s).	- Reported complaints. - Reported rapes/10,000 women /month
7. Water and Sanitation.	To adapt water and sanitation installations to specific needs of PLWHA, and to ensure their safety.	- Include HIV considerations in water & sanitation planning [C.4.1] - Designing safe water collection points, to minimise risks of rape for women/ minors. Stigma. - Providing information to concerned neighbours, to avoid discrimination /stigma.	- Existing sectoral ECHO programmes. - Presence of proven qualified partner(s). - Sustainability through local structures after ECHO's phase out.	- Adequate quantity of drinking water (Lt/day/PLWHA)-Sanitation facilities/PLWHA. - Decreasing violence (rates/ month). - Acceptance of PLWHA to water points.
8. Workplace policy (additional measures).	To improve awareness and prevention among partners' own staff.	- Providing regular refresher training courses. - Additional training of staff on gender issues, sexual violence, special needs, stigma and non-discrimination. Improving attitudes and dialogue skills. [B.3.4, B.4.1, B.5.2, B.6.2, B.7.6] - Extending insurance coverage to national staff and their direct relatives.	- Acceptance by the partner to carry out additional measures.	- % of partner staff having comprehensive knowledge/total. - % of national staff covered by insurance.

Priority 3 : Non core objective - Activities to be considered Subject to strong pre-conditions only

Objective: " to contribute to starting to help those affected regain a minimum level of self-sustainability ".

The two main types of activities below are by essence likely to lead to long-term commitments, which ECHO's mandate and working parameters are not intended to address. A number of caveats must therefore be strongly emphasised, and corresponding pre-conditions applied.

- ECHO's mandate specifies that interventions must take place to respond to natural disasters or man-made disasters that would happen suddenly (if not wholly unexpectedly). Bad governance alone and/or delays in starting longer-term development programmes may therefore not be considered as valid reasons for an intervention by ECHO.
- Any ECHO funding of such activities in the framework of disasters as mentioned above, could only be considered as temporary gap-filling measures, which must be strictly conditioned among others (see chapter B.4.3 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 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. This has to be avoided.

Except for a very few exceptions, and even then to a limited extent, no favourable conditions have so far been found, in any area of ECHO operation. The activities below should therefore probably not be funded in 2005, though they should regularly be re-considered in the future.

Table 5

Sector of Intervention	Specific Objective	Activities	Strong Pre-conditions	Indicators
1. Anti-retroviral treatments (ART).	To provide gap-filling ART or Highly Active Anti-Retroviral Therapies (HAART).	- Providing gap-filling HAART to e.g.: (i) beneficiaries already under treatment, interrupted by conflict or disaster; (ii) returnees already under treatment, not ensured in return area. [D.7.4]	- Existing long-term programme, LRRD ensured in timeframe of ECHO decisions. - Existing health ECHO programme; an interruption is clearly detrimental. - Qualified partner(s). - National Health Authorities accept protocol/ principle.	- Potential consequences if treatment interrupted.
	To provide gap-filling Prevention of Parents/Mother To Child Transmission (plus) (PPTCT or PPTCT+).	- As above. [D.7.14]		- Potential consequences if treatment interrupted.
2. Livelihood support to HIV/AIDS orphans and their surviving caretakers.	To contribute to food security and self-sufficiency of caretakers and orphans, hence providing gap-filling survival measures, in particular in high prevalence areas.	- Implementing basic income generating projects, adapted to the needs and reduced labour possibilities of such households (seeds for vegetable and community gardens, for labour-saving crops, labour-saving practices, small livestock, etc). [C.5.4, D.5.1] - Providing cash grants. - Implementing adapted food-for-work and cash-for-work projects. - Registering orphans. [C.3.2] - Providing adapted water and sanitation, possibly by home service. - NCU Neighbourhood Care Units.	- 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 phase out.	- % of coverage achieved, measured against baseline surveys.

To be avoided : Non eligible or harmful activities

A. NON ELIGIBLE IN PRINCIPLE (UNDER ECHO's CORE ACTIVITIES)

Table 6

Sector of Intervention	Activities
Health	• Establishing Voluntary Counselling and Testing (VCT) centres as a vertical intervention. • Detecting and treating Primary HIV Infections (PHI). • Forceful intervention against 'traditional' mutilation practices (including for babies/children). • Needle exchange and/or social marketing of condoms (including for prisoners, intravenous drug users, truckers, migrant workers, etc).
Education	• Education courses on HIV/AIDS at school.
Others	• Basic/academic research activities. • Attendance to scientific meetings and conferences. • Spiritual counselling.

B. HARMFUL

Table 7

	• Active promotion of male circumcision or female genital mutilation. • Spiritual counselling or promotion of religious-based behaviours that are not in accordance with the principles of the European Charter of Fundamental Rights.

B.4. DETAILED DESCRIPTION OF RECOMMENDED ACTIVITIES

In addition to the priority ranking tables, a complementary description for some of the proposed activities is provided below, with some rationales and illustrations.

B.4.1. "Priority 1" Core Objective Essential Activities

1. Own staff policies for partners or "workplace policy". As a key component of the do-no-harm approach, it is essential that ECHO partners apply a prevention policy and guidelines for their own staff, in particular for the local drivers. This is however still a widely debated issue from the ethical, legal and budgetary points of view, and mandatory mainstreaming measures should therefore be reduced to a minimum package or threshold of commonly acceptable measures, e.g.: awareness and condoms for all, focus on local drivers, training in elementary precautions and attitudes for all, PEP for exposed staff, ART during contracts for local staff, and full insurance for expatriates. The possible corresponding increase in staff costs should be assessed by ECHO, other donors and NGOs to see whether higher staff costs will have to be accepted in the future. Further measures ("Priority 2") should be considered on a case-by-case basis, such as: comprehensive insurance and coverage for all staff and direct relatives during contractual timeframe, training in gender issues, stigma, sexual violence, dialogue skills, special food and sanitation needs, etc. ECHO should also promote the annual partners' conference and strategic programming dialogues as a forum for debate and exchange of good practices and lessons learned on the subject. Since definitions and practices may still vary significantly different according to the position of individual partners; these matters are likely to generate intensive dialogues that should result in exchanges of good practices and lessons learned. The following selected examples (2 NGOs and 2 UN agencies) can be mentioned to illustrate the current situation.
   - The most comprehensive policy by far is applied by MSF/B (regions of Kenya, Somalia, south Sudan). The NGO provides for its whole staff, expatriate and local, the following benefits: (i) full medical insurance for staff and direct dependants (legitimate wife/-ves and children) with guaranteed confidentiality, (ii) awareness programme and condoms; (iii) PEP; (iv) ARVs (10 staff members and 2 dependants are currently being treated out of a total of 467, at a cost of US$30 per month, all inclusive); (v) counselling by an external firm. Such a highly favourable policy for local staff is however not applied by all other MSF family members, such as MSF/France (coverage only as long as the local staff member is employed).
   - Oxfam/UK has developed an "AIDS in the Workplace" programme focusing on having advisors in offices for training and counselling, and freely available condoms. Awareness raising of drivers is felt as an important issue, since these workers are likely to be away from their families for whole weeks, they often have low educational levels, and are therefore particularly at risk. Oxfam is also offering drugs and ARVs free of charge to infected staff members.
   - UNHCR applies the standard "UN in the workplace" policy, which arguably is not fully adapted: although IEC and condoms are widely available, PEPs can still not be found in all field stations, and the insurance policies for national staff -which theoretically include free ARVs and family coverage- are faced with problems of confidentiality and of partial contribution by the beneficiary.

- WFP is following the basic UN personnel policy on HIV/AIDS drafted in 1991, as well as relevant ILO rules. The agency is working on a more comprehensive set of measures for its expatriate staff: this is a very challenging task, since (i) new rules must be harmonised with no less than 17 other staff policies existing in the UN, and (ii) WFP has approximately 10,000 staff worldwide, including 8,000 with short-term contracts only, without benefits. Moreover, the very numerous truck drivers employed in WFP food distribution operations are actually sub-contracted and are usually not included in any prevention measure or policy (with a few exception such as Ethiopia, where condoms were provided by UNDAF). Whereas drivers are recognised as strong risk factors, WFP has currently no legal means to enforce any prevention policy on its sub-contractors, though it is trying to set up measures with some global US freight forwarders. The agency is however trying to disseminate examples of good practice in training (1 day course, with refresher every 3-6 months), and through peer education. There is furthermore no policy regarding coverage of infected local staff once their contract is completed.

2. Awareness (or Behaviour Change Communication) has been developed into the more comprehensive concept of information, education and communication (IEC) and must be seen as a crucial issue: *"the lack of information is a recipe for further emergency situations"* (SC UK/Nairobi). The main objective of IEC/awareness campaigns is to change behavioural patterns so as to minimise the risks of HIV infection and to avoid stigma e.g. against infected mothers and children. Campaigns need to be well planned, well executed and culturally appropriate, e.g. by using the local languages (mandatory) or drama/singing and dancing presentations in some countries. Balanced target groups must be achieved (including enough male participants and local decision makers), and some common errors must be avoided (e.g. using young white girls as trainers). IEC must nevertheless be considered only as a *first step* in prevention initiatives: it provides information about possible behavioural change, but does not automatically lead to actual change. IEC must therefore be included in a more comprehensive framework of prevention measures which will also address the social, economic -and possibly political- factors that are making the populations that are victims of humanitarian emergencies more vulnerable to HIV. IEC needs to be clear, simple, avoid confusion[12], and be focused on gender and local communities (training and capacity building of local communities, i.e. community leaders, local health practitioners, "motivators" etc). Communities seem to have much better knowledge of HIV/AIDS in urban areas (access to radios, education) than in rural areas (Oxfam/UK). Many other ECHO partners are already working on these issues[13], which require

[12] "We are confused" was a main finding of the 2003 behavioural survey in Swaziland, which concluded that people were highly knowledgeable about HIV/AIDS/STIs though this knowledge was not translated into desirable behavioural changes. Source: "What is driving the HIV/AIDS epidemic in Swaziland, and what more can we do about it", NERCHA/UNAIDS, Apr 2003.

[13] Figures from GOAL in South Sudan (Twic County) indicate that only 5-15% of the SPLA soldiers and civilians in the area (male and female 20/ 24 years) are correctly informed about exposure to HIV/AIDS and prevention methods. Their main source of information are often local medics (themselves poorly informed) and priests. MSF/FR stated that many potential victims were afraid (do not want to know, not HIV, not me, fear to be rejected by family, trust in local witchcraft first for HIV symptoms).

consistent funding assistance. Awareness should also target returnees from areas where prevalence rates are significantly different (often higher) than in their region of origin[14] and, where possible, soon-to-be demobilised soldiers before they are sent back home. Soldiers are major risk factors, they are generally very badly informed, but awareness activities should be easier to implement with a (supposedly) disciplined audience.

3. Condom distribution. Examples in Asia (Thailand, Cambodia[15], India[16]) and in Brazil tend to confirm that widespread distributions accompanied by IEC campaigns are showing positive results when correctly and consistently used, and when strongly supported by the Government. There are caveats, though. Findings from Uganda[17] seem to indicate that condoms in the African context may not be sufficient. Nearly all of the claimed decline in HIV incidence and much in prevalence rates in Uganda had actually been achieved by a very large mobilisation of faith-based organisations, highly influential in Africa, who promoted moral values (fidelity, abstinence) and which preceded the 1995 condom campaign. Would the introduction of a "divine" dimension make a difference on the behaviour of some Africans? The availability of condoms does not necessarily translate into acceptance and use, even for the partners' own staff[18]. Condom distributions must also be culturally appropriate: baseline surveys of gender roles, need for confidentiality or potentially counter-acting factors such as religious beliefs are pre-requisites for effectiveness. For example, female condoms should be made available to populations that have already had prior experience of its use, and where there is a demand. A survey made in 1999[19] found that the approach used with Burmese refugees in Thailand was not adapted to their specific cultural behaviour. The proposed sex education was conflicting with the traditional culture that refugees were trying to preserve, and so was the lack of confidentiality (the refugees asking for condoms had to sign their names and those of their parents in health clinics, and illegal Burmese migrants were obviously even more reluctant to contact the local bureaucracy).

4. Universal precautions are a set of simple, standard procedures to be used in the care of all patients at all times in order to minimise the risk of infections. Their guiding principle is that

[14] Medair/South Sudan: some infected returning IDPs might provoke a disaster within the Merlé tribe, due to e.g. the traditional sexual promiscuity after marriage (average of 8 different partners per year).

[15] According to early projections, Thailand's epidemic should have been in the millions by now - instead of hundreds of thousands-, had the country not promoted condom use vigorously. Similarly, the latest MAP (Monitoring the AIDS Pandemic) statistics clearly show a sharp decrease of new registered HIV infections in Cambodia, from more than 40,000 in 1994 down to less than 5,000 in 2004, in all sectors except in mother-to-child transmission. Corresponding mathematical models tend to show that when 60% or more of risky sexual intercourse (e.g. with prostitutes) are covered by a condom, that would be enough by itself to stop an early-phase epidemic in its tracks.

[16] A recent study of the World Bank, HIV/AIDS Treatment and Prevention in India, 2004, illustrated that increasing the current rate of condom use during high-risk contacts from 50% to 70% would be enough to change the direction of the epidemic in India.

[17] Source: cfr. 11 supra, pages 45-46

[18] The WFP stated e.g. that "in the wake of the Vatican pronouncement on the fallability of condoms, there was much misinformation and confusion among (African) drivers".

[19] Source: ODI, HPN network paper, box 3, Feb. 2002

all blood products and body fluids and tissues should be assumed to be potentially infectious. Key measures include:

- clear treatment protocols to reduce unnecessary procedures (i.e. unnecessary injection of medicine);
- to disinfect and sterilise;
- to train in replacing protocols from injectable to oral medication;
- to supply the demand gap for auto disable and disposable needles;
- to supply the demand gap for gloves (to be discarded after each patient), goggles, masks, soap & disinfectants;
- to supply containers for sharp objects; to install incinerators and to train for safe disposal;
- to advocate against unsafe practices in the private sector.

5. Safe blood supply. *The efficacy of HIV transmission through transfusion of infected blood is close to 100%*: the lack of effective preventive measures can therefore be highly dangerous, as it was unfortunately demonstrated in China (up to 1 million persons may have been infected in the 1990's by unsafe blood collections in the central provinces). Measures include:
   - to avoid unnecessary transfusions and use of blood and blood products;
   - to train on rational criteria to transfuse and to supply plasma substitutes as an alternative to blood;
   - to test all blood donated for transfusion and for blood banks; to supply HIV tests and reagents in sufficient quantity;
   - to select safe donors (i.e. unpaid); and
   - to use referral of blood recipients as an alternative (where appropriate and needed).

   It must be noted that safe blood supply needs adequate/compatible health structures, entailing appropriate rehabilitation works, equipment and training when needed and feasible, and LRRD linkages.

B.4.2. "Priority 2" Core Objective Strongly Recommended Activities (where appropriate/feasible)

1. Distribution: labour constraints and the burden of illness in high prevalence areas are likely to affect the capacity of the most vulnerable households to travel to distribution points, to wait, and to carry the food back home. In consequence, distribution schemes must be adapted (more frequent distribution of smaller amounts, adapted packaging, more widespread village-level storage), which may entail corresponding protection measures. In the worst affected areas with high prevalence, specific types of food distribution should be considered to mitigate the effects of the pandemic, such as:
   - school feeding, take-home rations for families caring for orphans, biscuits (easiest);
   - direct food support for orphans, the sick and their families, home-based care services (to be clearly identified);
   - food for work in the guise of: food for training in livelihood diversification, food for vocational training (especially for orphans), food for home-based services, etc.

2. Health is obviously an essential aspect of the response to HIV/AIDS, though it is not the only one. Health must therefore be considered in the framework of a more comprehensive set of multi-sector measures, listed below. Health measures (see detailed IASC guidelines in table 2) include safe blood supply, the provision of condoms, ensuring safe deliveries (e.g. by providing clean delivery kits and midwife delivery kits), managing the consequences of sexual violence, establishing syndromic (i.e. on the basis of syndromes, without always depending upon laboratory analyses) treatment of STI (sexually transmitted infections), etc. MSF stressed that treatment of opportunistic infections -including tuberculosis- provided a relatively easy and gradual "entry point" to the victims, without attached stigma. MdM stated the same about STI (sexually transmitted infections) which includes HIV/AIDS, and are known to spread fastest in contexts of poverty, social instability and violence. In emergencies, social norms of destitute and displaced people may be disrupted, prostitution may be used as a desperate coping mechanism, populations with different prevalence rates of HIV may interact (refugees, IDPs in large countries, but also returnees), or be subject to systematic sexual violence as an instrument of war and terror. Furthermore, the risk of HIV transmission is greatly increased in the presence of other (curable) STIs in both men and women. Measures include the promotion of safer sex, distribution of condoms, early and effective case finding, treatment and monitoring.

3. Nutrition: people living with HIV and with AIDS both have additional nutritional needs, and food rations must be adapted, with particular focus on infected children and women. HIV/AIDS exacerbates e.g. all underlying causes of child malnutrition. Children with HIV/AIDS and acute malnutrition may need an increase of up to 100% in energy requirements[20] and will recover less rapidly in therapeutic feeding centres (the average being 4-6 weeks). HIV-infected mothers may also need stronger nutrition treatment (plus 20-30% in energy requirements) as temporary revalidation for themselves, to return rapidly to their waiting family. Such statements are mitigated by WFP, which indicates that 2,100 Kcal/day may be enough for infected adults, but that better food quality may be more cost-effective. Studies have shown that some micro-nutrients are slowing disease progression and reducing mortality due to HIV or opportunistic infections. Specific approaches have already been developed i.a. by Oxfam, Save the Children and WFP. Pre-conditions to nutrition activities must be (i) the existence of feeding programmes (therapeutic or supplementary feeding centres, special programmes, etc) in which beneficiaries can be included, and (ii) clearly established nutritional and health criteria indicating an overall nutritional vulnerability for specific groups in the population (not caused by HIV/AIDS alone).

4. Protection measures are many-fold. Appropriate protection measures for the most vulnerable children are likely to be easier to implement in low prevalence areas, where the social cohesion and coping capacity of communities are generally less affected than in high prevalence areas.

[20] Source: WHO Expert Consultation on Nutrient Requirements for PLWHA, May 2003

Actions may include: to keep, as much as possible, orphans with their families, to ensure immediate care for separated children and registration for all children to ensure access to food, health, shelter and education, to provide psychosocial support, and to ensure adequate support to single parents or elderly caretakers. Women should benefit from protection measures against sexual violence and stigma in situations of war, violence or displacement (e.g. in access to water, see above or through PEP see below). Specific protection measures should also be considered for refugees (safe camp designs) and for returnees (UNHCR-proposed repatriation packages with IEC, condoms and peer education). Post exposure prophylaxis (PEP) is a short-term ARV treatment that reduces the likelihood of HIV infection after potential exposure. PEP treatment was originally designed to protect medical workers from accidents. Its utility has since been recognised in the case of e.g. humanitarian staff exposure (being a part of the staff policy), but also for victims of sexual violence, in the immediate aftermath of rape (within 72 hours). PEP could be considered in the frame of ECHO-funded programmes: the duration of the treatment is very short, though its current cost is still rather high, around US$7-800 (MdM).

5. Rehabilitation or reconstruction of relevant health structures must be appropriate to the needs of HIV/ AIDS-related activities (out- and in-patient facilities for detection and treatment of STIs and opportunistic infections, adapted nutrition therapy, water and sanitation facilities, etc), and LRRD must be ensured.

6. Water and sanitation: frequent exposure to parasitic and diarrhoeal illnesses associated with poor water and sanitation can speed the progress of HIV infection to full-blown AIDS. Refugee camp designs should for example be appropriate. On the other side, people with weakened immune systems are also more susceptible to parasitic infections. Access to isolated water points for young girls and women may be a potential source of sexual violence, and may require protection measures. Access to community water points may also sometimes be refused to known infected people. Oxfam/UK, which is implementing water and sanitation projects in the Democratic Republic of Congo, has accordingly focused its information and protection activities around water points where women have to go regularly, and where they are often at risk. Actions include safer access methods for communities, identifying the most vulnerable to violence, and fighting stigmatisation.

B.4.3. "Priority 3" Non-Core Objective Activities

1. **A.** ARV (anti-retroviral drugs) and ART (anti-retroviral treatment). As stated above, ECHO could potentially be faced in the future with the choice whether to fund some ART in *specific temporary, "gap-filling"* situations. Indeed, considering the very large scale ART programmes (GFATM, US PEPFAR, WHO 3X5) that are being developed by most major long-term donors, together with falling prices and some indications of achievements (see Annex B, section 3), the use of such drugs is likely to become increasingly widespread despite current bottlenecks, including among victims of humanitarian crises. As a result, ECHO is probably bound to find in the foreseeable future increasing numbers of beneficiaries already under treatment. Should such

treatment be temporarily interrupted (fighting, returns, etc.), and provided that the negative effects of such interruption are actually demonstrated, ECHO may have to consider a temporary intervention to maintain the effectiveness of its overall assistance. Related positive effects should also be considered to support ECHO's decisions in such cases. ART needs to be understood not only as a strategy to mitigate direct effects of HIV and AIDS, but also as an important prevention tool. In low prevalence areas (tentatively, sero-prevalence below 5%) ARV can contribute to maintaining the rates at low levels by reducing the risks of transmission, and by providing to potentially infected patients the most important incentive known to date for going to testing centres. The fear of knowing about one's own infection without available treatment, and the fear of attached stigma by family and community needs to be overcome. In high prevalence areas (sero-prevalence above 5%), ARVs might be the most adequate tool -pending a vaccine- to apply the ECHO mandate of "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", especially considering a results-oriented approach towards households with orphans and surviving caretakers. The key function of ART would be to combat the socio-economic impact of HIV/AIDS by reducing significantly the loss of lives and supporting the HIV/AIDS affected households by improving their productivity.

However as already mentioned, the funding of ART is in essence a long-term commitment, which can hardly be considered as a core activity for ECHO, even as a temporary gap-filling measure. *Strong pre-conditions* must therefore be applied, the fulfilment of which has not been found to this date in any area of ECHO operation. More specifically, the pre-conditions would include i.a. the following.

- ECHO funds are only intended to *bridge gaps in existing ART programmes* funded by other donors (e.g. categories 1 and 2 of GFATM funding), where delays are estimated to be clearly damaging to the most vulnerable beneficiaries already under treatment (disruption by conflict or disaster, returnees). In all cases, the partner and the long term donor must certify that every effort will be made to resume the programme and restart the funding within the timeframe, i.e. duration, of relevant ECHO financial decisions.
- The funding must be made in the overall context of *already existing* ECHO interventions (as a component only of larger programmes in complex humanitarian crises, targeting the most vulnerable, where the authorities cannot cope). ARVs need to be supported by, and linked with a comprehensive set of other humanitarian activities. For example, adequate nutrition is a *pre-requisite* for ARVs to be effective: those who take ARVs must not only be well-nourished, but must also consume a high-protein diet and eat several times a day. The programme must be linked to combating TB and other relevant opportunistic infections. One threat is indeed the resurgence of tuberculosis, much of it drug-resistant, partly sparked by AIDS but now generating its own momentum .
- The gap-bridging measures are proposed by *a qualified ECHO partner* (i.a. appropriate organisation, experience, staff training, own staff policy, field guidelines, M&E tools, use of generally accepted indicators, ability to co-ordinate with CCM/GFATM and/or to present acceptable proposals to DEV, World Bank MAP or other recognised bilateral or international sources of longer-term funding).

- An *agreement of the country CCM* (where existing and functional) must be obtained. Should this not be possible, a justification acceptable to the local EU Delegation and to DEV must be provided.
- ARVs should be of *generic nature* if this is allowed by the regulations[21], they should benefit from the latest price reductions where possible (see below), correspond to *WHO criteria* of origin and quality, and to *international standards* (WHO, UNAIDS, World Bank) of procurement rules, transport and storage.

From a technical point of view, ARVs are divided into different groups of drugs characterised by different pharmacological mechanisms. ARV treatment (ART) schemes are categorised as 1st line, 2nd line and other alternative drug combinations (the later for those patients who might not react to 1st line therapies, who develop severe side effects under the specific treatment, or who might have developed resistance to treatment). There is indeed a risk of a growing number of patients failing the 1st line treatment and falling back to different combinations of ARVs, much more expensive. ARVs should only be applied to approximately 10% of HIV-infected patients, at stages 3 and 4, the heaviest according to the international classification. The improved approach of HAART (Highly Active ARV Treatment) has proven to be effective in slowing down the progress of the disease, in prolonging the lives of peoples living with AIDS and in allowing them to continue a life close to normal, being able to care again for their family. ARVs may also have some negative side effects, such as allergic reactions, reduction of production of red and white blood cells, liver and kidney failures, etc. Effects in case of interruption of treatment are largely unknown, but interruption is thought to increase resistance to drugs and may lead to the need to restart the process with stronger and often much more expensive drugs (2nd line).

Finally, prices of ARVs have been significantly and regularly decreasing in recent months. According to a recent MSF comparative study[22] carried out in ten countries where the NGO is carrying out ARV programmes, the negotiated price of 1st line tri-therapy treatment has fallen to US$288/patient/year for Namibia (down from more than US$10,000 in the year 2000). On a much larger scale, the Clinton Foundation, acting as a facilitation body, supported by the World Bank, GFATM and UNICEF, has recently been able to negotiate the same drugs (with the pharmaceutical company Cipla) down to US$140/patient/year, based on an assumption of no less than 300,000 treatments per year. In comparison, the price of 2nd-line treatments for MSF is still at US$1,161 minimum (in Guatemala), ranging up to US$4,763 (in Cameroon). This reduction has assisted US and other major actors to obtain better value for money in their procurement processes.

[21] 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 last chapter (patents, regulations and WHO guidelines).

[22] Surmounting challenges: procurement of antiretroviral medicines in low- and middle-income countries, MSF, WHO and UNAIDS 2003

1. **B.** Prevention of Mother to Child Transmission (PMTCT or PPTCT-'Prevention of Parents to Child Transmission') may be considered for saving lives and for preventing stigma against infected mothers. Pre-conditions include (i) a relatively stable population, likely to remain in the same area for the next 6 months, and (ii) the acceptance of protocol and principle by the national authorities. HIV may be transmitted from infected mother to baby during pregnancy, birth process, or breastfeeding. Without intervention, 25-45% of children will become infected. There are 4 types of PMTCT interventions: short-term ARV prophylaxis to the mother during labour (1-time dose), safe obstetrical practices, ARV prophylaxis to the baby within 72 hours of birth (also 1-time dose), and education/informed choice on infant feeding methods. MdM strongly advocated "PMTCT-plus" (a more comprehensive set of services for a longer period of time including ART for the mother), since the effectiveness of saving the baby and seeing the mother die is dubious…

2. **A.** Food security is a key issue in the context of HIV/AIDS, with two-ways relationships. HIV/AIDS impacts on food security, whereas the lack of food security would in its turn increase vulnerability to HIV/AIDS: malnutrition increases the risk of transmission, and the lack of food would prompt e.g. distress migration or transactional sex. It should be noted that at the origin high prevalence areas do not necessarily equate to food insecurity, on the contrary. HIV/AIDS is more easily disseminated in areas where economic activity and commercial traffic are intensive.

   Even if households affected by HIV/AIDS are less productive than others, the provision of *agricultural inputs* may still be more cost-effective than continuous food aid distribution. These households can be assisted by friends and relatives from the local community. Cash grants may also be an interesting approach, although lessons learned are still lacking for this area. Activities to be potentially considered by ECHO may include:
   - provision of vegetables as part of seed packages: vegetables can easily be cultivated in nearby home gardens, do not require hard labour, provide a useful nutritional supplement and some source of income;
   - provision of seeds for types of crops that do not require extensive labour (cassava, sweet potatoes);
   - promotion of agricultural practices that can be labour-saving (conservation farming);
   - small livestock breeding; and
   - provision of seeds for community gardens, to enhance social capital and reinforce safety nets.

   Notwithstanding the above, the most vulnerable households headed by single mothers who have to care for young children, or by elderly caretakers risk being excluded from such schemes. This must be carefully assessed before starting a programme, including the social capacity of the community to re-distribute some of the gained assets to their most vulnerable members. Key recommendations for older persons (by Helpage) therefore include:
   - to increase understanding of the role of older women and men in caring for orphans;
   - to support older people as first-resort carers for orphans and vulnerable children.

2. B. Registration of orphans and orphan-supporting families, provided that adequate linkages are established with authorities to hand over data.

2. C. Water and sanitation: As for food distribution, the decrease of social capital (the diminished capacity of the community to provide a safety net for its most vulnerable members) may require specific measures in high-prevalence areas, such as:

- home care services for water: the most vulnerable bedridden people are often hidden at home, and they would need more water than usual for washing due to fevers, vomiting, diarrhoea, etc. Their households may not be able to bring sufficient water by their own means;
- to make sure that pump handles can be used by children and by the elderly;
- to place latrines, water points and washing facilities in locations decided by the women in the community, in places believed to be safer, if possible with lighting.

ANNEX A: Best Practice Activities

Very few - if any - examples of fully tested and proven best practice projects in combating HIV/AIDS were available for collection from humanitarian actors (despite widespread investigations), for several key reasons :

- as stated in the report, HIV/AIDS had until recently been considered as a long-term development problem, and the involvement of humanitarian actors is mostly very recent (with a few exceptions like MdM who developed a partnership with WHO on HIV/AIDS as early as 1987-89, but which lost most of its expert staff later on);
- most humanitarian actors -as for development ones, who are usually acting according to longer timeframes- are consequently either still engaged in a difficult learning process, or have not even started this process;
- analysing the multi-facetted aspects of HIV/AIDS is a very complex process, and defining and testing the responses, even more so;
- the worst of the pandemic is to be found in sub-Saharan Africa, where problems and responses are often even more complex than elsewhere, due to the combination of all strongest causal factors (bad governance, corruption, protracted regional conflicts, risky culturally-induced behaviours, poverty, lack of health, of hygiene and education, recurrent natural disasters, economic development failures, etc).

Although ECHO partners were not involved, the only clear example of apparent best practice in Africa -so far- is to be found in Uganda. In that country, HIV prevalence fell from 21.1% in 1991 to 9.7% in 1998 (rates measured in 15 antenatal clinics). These declines are repeated in other national data sets, and the current national rate of prevalence is thought to be around 5%, at least in the southern part of Uganda. The main reason has been identified as being in behavioural changes in sexual habits, and can be traced back to a range of integrated measures, such as:

- high-level political support and commitment (an overall pre-requisite in other apparent successes in e.g. Brazil and Thailand);
- decentralised planning, which was community-based and culturally appropriate;
- multi-sectoral responses, with a strong input from faith-based organisations. Indeed, nearly all of the decline in HIV incidence and much in prevalence rates in Uganda had actually been achieved by a very large mobilisation of faith-based organisations, highly influential in Africa, who promoted moral values (fidelity, abstinence) and which preceded the 1995 condom campaign.

Nevertheless, three approaches of potential best humanitarian practices can tentatively be suggested, as preliminary illustrations.

- The most regularly mentioned example of (apparently) successful African programme, by ECHO and other humanitarian stakeholders, is the one implemented by **Malteser Hilfsdienst e.V.** in Bukavu and some other locations in DRC (ECHO/COD/ 210/2003/01020, Programme d'aide humanitaire d'urgence aux zones de Santé de Kaziba, Nyangezi et Walungu, Province du Sud-Kivu). This is **an integrated and comprehensive approach supporting the health system at all levels and integrating HIV/AIDS activities** (specific activities have been developed for victims of sexual violence, including appropriate medical

treatment, support, and psycho-social follow-up). It might not be really innovative, but is an example as to how a health sector support project can develop relevant activities against HIV and AIDS. This example also highlights the collaboration between DG DEV and DG ECHO and is an excellent example for LRRD. The project was however disrupted by insecurity and fighting in the region.

- The last ECHO evaluation in Zimbabwe in 2004 stated that **the Zimbabwean Red Cross approach to support HIV-affected households** represents an effective activity using local volunteers and members of the national red cross living in the same community, to care for ill or affected individuals and their direct relatives ('it is wonderful to see what people do for nothing', they just need well targeted material support, training and supervision). Conclusions stated that home-based care (HBC) experiences should be evaluated more in detail and compared in order to judge the relevance of HBC programmes in a specific emergency setting. In the meantime, the project should probably remain an exception due to low cost/effectiveness (HBC is very expensive for the number of beneficiaries), the lack of clear identification of the most vulnerable, and an uncompleted coverage even in the limited project area.

- Another possible example of good practice may have been produced by the **FAO/Emergency Operations and Rehabilitation Division in Gitega, Burundi**. Although this project was not ECHO-funded and does not fall directly into the operational pattern of ECHO, it concerns **mitigation of the "livelihood" aspect of HIV/AIDS**, and more **particularly support to infected families or families with orphans**. For a total budget of only US$30,000 a year, 100 vulnerable families (+/- 600 beneficiaries) were provided with IGP (training in improved farmer techniques / market gardening and commercial marketing). Results included a more adapted food with more fresh products and some more money to pay for educational/school fees, uniforms or for "bi-therapy" costing US$50-60 and broad spectrum antibiotics to combat opportunistic infections. Keys to the success were identification of good local implementing partners, and of committed/ motivated recipient families. FAO has since received funding of US$300,000 from Swedish SIDA and of €300,000 from the Italian government for expanding the methodology to Angola, Uganda, South Sudan and DRC.

ANNEX B: Benchmarks and Indicators

As for the examples of best practices (Annex A), very few benchmarks and indicators, relevant and practical for application by ECHO and its partners, have been found. The main reasons are the same: either old indicators are not usable anymore (e.g. for drugs, where prices may be changing very rapidly), or new ones are still being developed. Furthermore, when indicators could be found, they generally provided information on inputs (quantities to be used, e.g. in the IASC guidelines, see below), but almost never -so far- regarding the measurement of results/outcomes or even less of cost-effectiveness.

Indicators take indeed a long time to define (being often reduced to the minimum jointly acceptable standard by all concerned actors -who may have rather different interests and approaches), and then to test in practice. This is even more true for outcome indicators, which also require a very long-term monitoring process for validation and for follow-up. At this stage, most actors interviewed have either just finalised their own policy and guidelines towards HIV/AIDS (there are a very few more advanced exceptions, though), or are still only considering some drafts.

Illustrations of the current shortcomings are provided e.g. by:

- current **SPHERE** indicators related to HIV/AIDS, which are still drafted in such vague or opaque and sometimes outdated terms, that they are hardly useful (see below);
- **WFP** will use its Vulnerability Analysis and Mapping (VAM) capacity -which is not an emergency instrument- to better understanding the dynamics of the pandemic and identify beneficiary groups. Sharing the results of such analysis -in due time- would therefore be of significant interest for ECHO's own mapping and programming purposes. Monitoring standards and indicators should however not be ready before another 6 months, and will then need to be tested for 1 or 2 years;
- the **FAO** has produced in 2002, in co-operation with WHO, a manual on nutritional care and support for PLWHA[23] which can be used as a very relevant information source for ECHO field based technical assistants, in particular regarding:
  - nutrition and special eating needs of PLWHA;
  - coping with various symptoms of HIV/AIDS (diarrhoea, nausea, skin problems, colds, fever..); and
  - Food safety and hygiene.

  However, although M&E are briefly mentioned (page 8), no indicators or benchmarks are provided.

In this Annex, collected data will be divided into several sections, and sub-divided by source:

- monitoring of results (or contribution thereof, which is much more complicated) of possible ECHO-funded activities;
- monitoring of possible cost-effectiveness of such activities; and
- benchmarks For ARVs and ARTs (for general reference purposes).

[23] Living well with AIDS, FAO, Rome 2002

1. Indicators for monitoring results

1.1. Indicators used in the proposed Logical Framework Analysis (B.3.3)

Collection of these indicators should be focused on the areas where projects are being funded by ECHO).

Mainstreaming

- Safe blood transfusion: n° of tests carried out, regular prevalence results, etc. (see also 1.2 below).
- Universal precautions: n° of gloves used, records of disposal facilities, of burning wastes (see 1.2).
- Condoms: how many / male/ female /month/ year (see also 2.1. below).
- Awareness: check the understanding of audience after "soap operas" or other culturally appropriate presentations.

Other activities

- STI/OI prevalence among the adult population.
- HIV sero-prevalence among the adult population.
- Rates of incidence (where and when feasible in emergencies).
- LRRD mechanisms in place.
- Women and children remain priority groups.
- Gender approach is followed.
- Number and % of PLWHA under ART.
- Number of deaths of AIDS (clinical staging), where feasible.
- Number of PMTCT/PPTCT performed.
- Acceptance of VCT: number and % of counselled and tested women, men, adolescents of target population (as general information, not ECHO-funded).
- % of PLWHA who regained a minimum level of self-sufficiency.
- Strong (% ?) impact on human, financial, social, natural, physical capitals.
- Number and % of orphans and caring single parents or elderly.

1.2. Other indicators

The **IASC Guidelines** provide also some indicators regarding e.g. safe blood supply, STI treatment, and condoms use (see under cost effectiveness below), such as:

- list of essential items for safe blood supply (perishable items, consumable non perishable items, recommended stationery and one-off items for collection, testing and transfusion of 1,000 units of whole blood): see IASC guidelines, page 66;

- calculation of supplies to ensure syndromic STI treatment to a population of 10,000 persons (out of whom 5% of the 50% of adults may have STIs) for 3 months: see IASC guidelines, page 74.

MODEL GUIDELINES

UNICEF is currently working on a set of outcome/effect and impact indicators that are designed to be built into country and regional strategies, and incorporated into long-term programming. In Somalia for example, a joint mid-term evaluation is scheduled at the end of 2005 to assess the effectiveness of the response and to allow corrective measures if necessary. It should be followed by a summary evaluation mid-2008.
These indicators are not yet finalised, though. At the current stage, UNICEF is using only a broad set of indicators to measure programme performance, such as:

- changes in HIV prevalence rates (against 2003 baseline);
- changes in STI prevalence rates (against 2003 baseline); and
- changes in awareness levels against set indicators (2003 baseline).

It should be noted that UNICEF/Somalia has also developed a set of indicators (still very broad, also) to be used to measure the application of Universal Precautions, as follows:

Targets	Activities	Indicators
By 2005, 90% of official health care providers and pharmaceutical shop attendants trained in Universal Precautions	Draft guidelines for improved blood transfusion services	Guidelines in use
	Increase number of facilities for safe blood transfusion	Increase in number of facilities
	Provide training for health care providers and pharmaceutical shop attendants on Universal Precautions	Number of care providers trained
	Bulk procure protective commodities / substances and distribute them	Procurement and distribution data
	Set up supervision and support mechanism for counsellors	Mechanism in place and functional
	Set up monitoring mechanism for HIV/AIDS and STI control	Mechanism in place and functional

The **UNHCR** has also developed a monitoring tool that could possibly be used by ECHO and its partners for Universal Precautions (efficiency and effectiveness of disposable containers, syringes and gloves, work of incinerators, etc), although a key constraint might often be the lack of preliminary baseline surveys.

The **SPHERE** health sector (control of communicable diseases standard 6) has so far produced the following key indicators :

- people have access to the following essential package of services during the disaster phase;
- free male condoms and promotion of proper condom use;
- universal precautions to prevent iatrogenic[24] and/or nosocomial[25] transmission in emergency and health-care settings;

[24] Induced in a patient by a physician's activity, manner, or therapy. Used especially of an infection or other complication of treatment.
[25] Of or being a secondary disorder associated with being treated in a hospital but unrelated to the patient's primary condition.

- safe blood supplies;
- relevant information and education so that individuals can take steps to protect themselves against HIV transmission;
- syndromic case management of sexually transmitted infections (STIs); (- not endorsed by Caritas)
- prevention and management of the consequences of sexual violence;
- basic health care for people living with HIV/AIDS (PLWHA); and
- plans are initiated to broaden the range of HIV control services in the post-disaster phase.

A guidance note further indicates that during the post-emergency and rehabilitation phase of disasters, the expansion of HIV control activities will be based on an "assessment of local needs and circumstances". Involvement of the community, especially PLWHA and their carers, in the design, implementation, monitoring and evaluation of the programme will be crucial to its success. In addition to services already implemented during the initial phase, more comprehensive surveillance, prevention, treatment, care and support services should be introduced. The provision of antiretroviral medications to treat PLWHA is "not currently feasible in most post-disaster humanitarian settings", although this may change in the future as financial and other barriers to their use fall. Protection and education programmes to reduce stigma and to protect people against discrimination should be implemented as soon as is feasible.

2. Indicators for monitoring cost-effectiveness

2.1. Condoms

The following indicators were found in the **IASC guidelines**:

- Calculation for sufficient supply of male condoms in stock for 3 months:
  number of sexually active males (15 years and above; if unknown, assume 20% of the population) X 20% (assumed % of users) X 1.2 (20% wastage) X 12 condoms/month = Y condoms X 3 months

- Calculation for sufficient supply of female condoms in stock for 3 months:
  number of sexually active females (assume 25% of the population) X 1% (assumed % of users) X 1.2 (20% wastage) X 6 condoms/month = Y condoms X 3 months

Remarks:
- the UN/IASC indicators are not fully in accordance with the formula currently preferred by ECHO (below), which includes condoms for 100% of penetrative sex encounters occurring (20% for the UN) and a wastage of 10% only, instead of 20%;
- the unit cost of male condoms can currently be estimated at 0.025 Euro.

Example of the ECHO formula to calculate maximum condom requirements in emergencies:

Target population	100%	=	10,000 Pop.
Sexually active couples	**20%**	=	2,000 sex active couples
Condoms **per month**	**x 12** encounters	=	24,000 condoms
Wastage/loss	+ 10%	=	+ 2,400 condoms
TOTAL CONDOM NEEDS per 10,000 Pop. monthly		=	**26,400 condoms** (X 0,025 = Euro 660/month)

Recommended distribution channels:

% STI clinics: 12 condoms per patient x 200 consultations	=	*2,400 condoms / month*
% Contraception: 12 condoms/month couple x 1,000 couples	=	*12,000 condoms / month*
% Extramarital sex: 12 condoms/month x 1,000 couples	=	*12,000 condoms / month*

2.2. General indicators

From a general point of view, some rather old cost-effectiveness indicators for prevention activities could be found in the "Science Express Policy Forum" (US), dated June 2001.
Although these might be slightly outdated (e.g. regarding the estimation of male condoms costs, which is about 30 times more expensive than in the ECHO formula above !), some verification with actual costs incurred by the ECHO funded projects might nevertheless be carried out:

Type of activity	Quantified objective	Cost (USD)
Male and female condoms	60% of sex workers reached; 60 to 80% condom use by those reached	US$15.83 per sex worker reached US$0.10 per male condom distributed US$1 per female condom
Treatment of STIs	60 to 100% of syndromic (or symptomatic) STI cases with access to health facilities	US$8.34 to 9.26 per STI case treated US$0.91 per woman screened for syphilis
Workplace policy: condom promotion and treatment of STIs	30 to 50% reached by peer counselling 70% of syndromic STIs treated	US$3.36 per employee reached US$8.34 to 9.26 per STI case treated US$0.10 per male condom distributed
Transfusion screening	100% of blood tested	US$4.88 to 15.00 per safe blood unit available
Prevention of MTCT	10 to 50% of women attending clinics tested of HIV+ women, 90% accept treatment and 50% use replacement feeding	US$3.80 per woman screened US$18.70 per woman receiving ARV US$50 per woman receiving formula
Peer counselling	60% of beneficiaries reached by peer counselling; 60 to 80% condom use by those reached	US$15.83 per person reached US$0.10 per male condom distributed

3. Current ARV and ART benchmarks (for general reference purposes)

3.1. Effectiveness

A leading advocate of the use of ART, MSF could confirm that "ARVs work in Africa", on the basis of a recent study[26] which demonstrated that more than 90% of the patients were duly adherent to treatment -i.e. they took their ARV pills in accordance with rules. The treatment success was confirmed by the patients' mean CD4 change (increase of cells/MM3/12 months).

Other recent studies[27] have shown the feasibility and effectiveness of HAART (Highly Active Anti-Retroviral Treatment) for up to 24 months in resource-poor settings (up to 43 MSF programmes in 20 countries world-wide, and more than 12,000 patients on HAART have been analysed). Results demonstrate a high probability of survival at 24 months for adult patients who survive the critical first months. MSF has defined as follows the criteria for inclusion of patients into HAART:

- advanced HIV stage (3 or 4) ; or
- HIV stage 1-2-3, plus CD4 count (increase of cells/MM3/12 months) above 200 ; or
- pregnant women in PMTCT programme, plus CD4 count above 350 ; or
- HIV stage 1-2-3, plus CD4 count above 15% for children.

Fixed-dose combinations are considered important tools for scaling up in resource-poor, high-prevalence settings. They are preferable because of their ease-of-use, distribution advantages (procurement and stock management), and effect on adherence and resistance (impossible to take a partial dose). Once-a-day dosing is an ultimate goal, but is not essential as field experience clearly shows that BID regimens with co-formulations are easy for patients to adhere to.

3.2. Prices

Current best price offers for a first-line triple combination:

Regimen	Best offer in US$ (October 2003)	Company
d4T(40mg)/3TC/NVP	270 (as triple FDC)	Cipla
d4T(40mg)/3TC/NVP	140 (as triple FDC)	Clinton Foundation*
d4T + 3TC + NVP	201 (individually)	Hetero
[d4T/3TC] + EFV(600mg)	482	(Ranbaxy) + Merck & Co.
AZT/3TC/NVP	365 (as triple FDC)	Cipla
AZT/3TC/NVP	239 (as triple FDC)	Clinton Foundation*
AZT + 3TC + NVP	310 (individually)	Aurobindo + Hetero

[26] Experience of the Chiradzulu programme in Malawi, case study, July 2004

[27] "Increased access to HAART in resource-poor settings in MSF programmes: outcome of adults at 18 and 24 months of treatment", and "Offering HAART to children in resource-poor settings: the experience of MSF"; MSF, Epicentre and Access Campaign, March 2004.

The prices have been negotiated by the Clinton Foundation with five manufacturers of ARVs and five manufacturers of HIV/AIDS diagnostic tests. These prices were announced originally in October 2003 and January 2004, and to date they have been made available by the manufacturers to humanitarian actors present in the 16 countries in the Caribbean and Africa where the Clinton Foundation's HIV/AIDS Initiative is active.
The drugs in these agreements include individual formulations and two- and three-drug fixed dose combinations which have been pre-qualified by the WHO to assure quality and efficacy. This standard is a prerequisite for procurement under Global Fund, World Bank and UNICEF policies.
These medicines are critical components of the four regimens recommended by the WHO as "first line" treatment for AIDS in its 3x5 initiative. In developing countries outside of Brazil, such life-sustaining therapy is available to fewer than 200,000 people living with the virus, though almost six million require it. Recent commitments of financial support for treatment, along with these lower prices for drugs and tests, can expand this coverage significantly.
The pharmaceutical manufacturers included in these agreements are Aspen Pharmacare Holdings in South Africa; Cipla in India; Hetero Drugs Limited in India, Ranbaxy Laboratories in India; and Matrix Laboratories in India. The price for the most common first line formulation under these agreements is as low as US$140 per person per year, one-third to one-half of the lowest price otherwise available in most settings. The diagnostic tests included in these agreements are offered by five leading medical technology companies and the prices available for these tests under the agreement include machines, training, reagents and maintenance and are up to 80% cheaper than otherwise available on the market[28].

3.3. Benchmarks for ARV regimens

The short-term priority is for first-line regimens which will facilitate the scaling-up of treatment. Second-line treatment is not a priority in the short-term.

The characteristics of an ideal first-line ARV combination are:
- effective and well tolerated, with minimal side effects;
- potent, even in advanced patients, and robust (favourable resistance profile);
- no interactions or contra-indications;
- appropriate for use in TB patients and in pregnant or lactating women;
- available in a fixed-dose combination (once or twice a day);
- stable in tropical conditions;
- not requiring laboratory monitoring;
- affordable.

A first-line regimen should be as simple as possible, to facilitate adherence. However, no existing first-line regimen fulfils all these criteria. On the basis of present knowledge and evidence, there is no ideal combination that can be used in patients with TB (using rifampicine) and in pregnant women.

[28] http://www.unaids.org/EN/in+focus/topic+areas/antiretroviral+therapy.asp

ANNEX C: Definitions

Review of Definitions Surrounding the HIV/AIDS Pandemic

According to the United Nations, a **disaster** is any "serious disruption of the functioning of a society, causing widespread human, material or environmental losses which exceed the ability of a society to cope using only its own resources" (UNDP, Overview of disaster management, 1992)

The IASC guidelines define an **emergency** as "a situation that threatens the lives and well-being of large numbers of a population, extraordinary action being required to ensure the survival, care and protection of those affected. Emergencies include natural crises such as hurricanes, droughts, earthquakes, and floods, as well as situations of armed conflict".

A **complex emergency** is "a humanitarian crisis where a significant breakdown of authority has resulted from internal or external conflict, requiring an international response that extends beyond the mandate of one single agency. Such emergencies have a devastating effect on great numbers of children and women, and call for a complex range of responses".

Mainstreaming: (by ECHO) when and where it is **relevant** (e.g. when HIV/AIDS has an impact on the planned activities and results of a humanitarian intervention) and **practically** feasible (e.g. this might not be possible in the immediate aftermath of a natural disaster, areas difficult to access, or due to logistical reasons or other similar situations) HIV/AIDS related activities should be taken into consideration fully and incorporated at each stage in the project management cycle, be it in the overall health, food, nutrition, shelter and/or other relevant sectors' activities supported by ECHO.

ANNEX D: Bibliography

Key information sources on strategies and statistics

- http://www.unaids.org and http://www.unaids.org/nationalresponse/search.asp (latest information on trends, prevalence rates, and national response plans, per region and per country)
- www.who.int/3by5/en/HIV_AIDSplan_annex1.pdf
- http://aidsscenarios.unaids.org/scenarios/ (set up of prospective scenarios on various impacts and responses to HIV/AIDS in Africa, on a 20-year time frame; to be launched at the end of 2004)
- http://www.census.gov/ipc/www/hivaidssn.html (US Bureau of Census)
- http://www.cdc.gov/hiv/pubs/facts.htm (US Center for Disease Control and Prevention)
- http://www.ias.se/aids2004/ (XV International AIDS Conference, 11-16 July 2004, Bangkok)
- UNDP Human Development Report (annexed table n°8 in the 2004 report).

Global programmes

- http://www.theglobalfund.org/en/ (GFATM global funding)
- http://www1.worldbank.org/hiv_aids/ (MAP programme)
- http://www.who.int/3by5/en/ (3X5 programme)
- http://www.usaid.gov/our_work/global_health/aids/pepfarfact.html (PEPFAR programme)

Some key partners

- www.helpage.org
- http://www.ifrc.org
- http://www.msf.org
- http://www.medecinsdumonde.org/
- http://www.savethechildren.org/health/hiv_aids/resources.asp (Save the Children)
- http://www.unhcr.ch/cgi-bin/texis/vtx/home?page=PROTECT&id=401915744 (HCR & HIV/AIDS)
- http://www.unicef.org/aids/ and www.unicef.org/aids/index_bigpicture.html
- http://www.wfp.org/index.asp?section=1

Sources of information regarding generic drugs (ARV) and prices

- http://www.accessmed-msf.org/ (MSF campaign for access to essential medicines)
- http://www.clintonpresidentialcenter.org/aids-initiative1.html (Clinton Foundation)
- http://www.actupparis.org/article644.html

Some current guidelines of reference

- IASC (UN Inter-Agency standing Committee) Guidelines for HIV/AIDS Interventions in Emergency Settings, 2003. CD-ROM and www.humanitarianinfo.org/iasc
- Oxfam's guide to mainstreaming AIDS in development and humanitarian programmes, 2003
- World Vision's toolkit for HIV/AIDS programming, 2003
- WHO/FAO "Living well with HIV/AIDS - A manual on nutritional care and support for PLWHA"

PROLOG CONSULT BELGIUM sprl

Boulevard Saint Michel 61

B-1040 Brussels - Belgium

Tel.: +32 (0)2 779 95 29

Fax: +32 (0)2 779 95 33

www.prologconsult.com